Conduct Disorder and Oppositional Defiant Disorder

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Introduction

The leading cause of mental health referral for children and adolescents are Disruptive Behavior Disorders (DBDs: e.g., conduct disorder, oppositional defiant disorder). Numerous studies have documented that youth diagnosed with DBDs experience poor outcomes across multiple areas of functioning including disrupted interpersonal relationships with family (Barrett, Katsiyannis, & Zhang, 2010) and friends, lower educational and vocational functioning, and health risk (Hinshaw, 1992). In addition, youth diagnosed with a DBDs are at an increased risk of comorbid substance abuse and a variety of other mental health problems that often persist into adulthood (Chan, Dennis, & Funk, 2008). For example, youth diagnosed with conduct disorder are at increased risk for significant negative adult outcomes that can include being diagnosed with an antisocial personality or substance abuse disorder, criminal or violent offending, and imprisonment (Moffitt & Scott, 2008). Thus, it is not surprising that DBDs among children and adolescents have become a major public health concern for many parents, community leaders, policy makers, clinicians, and researchers. This concern is particularly heightened for African American youth who are at risk for developing a DBD (Crystal, Olfson, Huang, Pincus, & Gerhard, 2009). This chapter will examine two of the most prevalent disruptive behavior disorders of childhood: Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in African American youth (Roberts, Roberts, & Xing, 2007).

As the US Surgeon General observed, "Striking Disparities" in mental health treatment is a major public health challenge for people of color who are burdened by unmet mental health needs that undermine their overall health, productivity, and longevity (US Department of Health and Human Services, 2001). Many in the mental healthcare community have voiced concerns that current psychotherapies may not be particularly relevant for or helpful with ethnic minority populations (Nieuwsma, 2007). A well-established literature indicates that compared with Whites, ethnic minority youth underutilize mental health services (Atkinson & Gim, 1989; Garland et al., 2005), terminate treatment prematurely (Armbruster & Fallon, 1994; Miller, Southam-Gerow, & Allin, 2008; Sue, 1977), attend fewer sessions (Bui & Takeuchi, 1992), and realize

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fewer clinical benefits (Weersing & Weisz, 2002). This should not be surprising as mental health treatment is embedded in Western culture and derived from studies mainly with Anglo/European populations (Jezewski & Sotnik, 2001).

The primary purpose of this chapter is to examine the prevalence and treatment of ODD and CD and associated health disparities among African American youth. We first discuss the prevalence of ODD and CD among children and adolescents in general, and specifically with African American youth; present an overview of the DSM-V (American Psychiatric Association, 2013) diagnostic criteria for ODD and CD; and followed by a section on treatment of ODD and CD in African American youth. Each section includes pertinent empirical information on existing health disparities in the prevalence and treatment of ODD and CD for African American youth.

ODD and CD Prevalence Rates: General Population

There are several literature reviews summarizing prevalence rates of psychiatric disorders in youth, including ODD and CD specifically (e.g., Canino, Polanczyk, Bauermeister, Rohde, & Frick, 2010; Costello, Messer, Bird, Cohen, & Reinherz, 1998; Roberts et al., 2007). While prevalence rates for the presence of any psychiatric disorder in youth vary widely across studies (e.g., 13–51 %; Vicente et al., 2012), prevalence rates for ODD and CD seem to follow a consistent pattern. Estimated rates of ODD in the past 30 days to 3 months range between 2.7 % and 2.9 % (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kessler et al., 2012; Roberts et al., 2007), and increase to approximately 8.3 % as the timeframe for assessment increases (i.e., previous 12 months; Kessler et al., 2012). Estimated rates of CD in the past 30 days to 3 months range between 1.5 % and 2.7 % (Costello et al., 2003; Kessler et al., 2012), and increase to 2.1–5.4 % for the previous 12 months (Kessler et al., 2012; Merikangas et al., 2010; Roberts et al., 2007), and increase still further to 9.5 % when the timeframe is lifetime (Nock, Kazdin, Hiripi, & Kessler, 2006). When clinical impairment is adjusted, prevalence rates for ODD and CD decrease similarly across estimates. For example, Roberts et al. (2007) estimated the rates of ODD to be 2.7 %, which decreased to 1.3 % when adjusting for impairment. Similarly, Merikangas et al. (2010) estimated the rates of CD to be 2.1 %, which decreased to 1.7 % when adjusting for impairment.

In addition to considering assessment windows and clinical impairment, prevalence rates for ODD and CD vary slightly depending on age and gender. More specifically, while the above noted total prevalence rates for ODD appear to be consistent across sampled age ranges, prevalence for CD varies slightly depending on the ages of youth sampled. Primarily, as age increases, prevalence of CD increases as well. For example, lower prevalence rates for CD include children ages 8–15 (1.7–2.1 %; Merikangas et al., 2010). When 16 is the upper age limit, prevalence rates increase slightly to 2.7 % (Costello et al., 2003), and when 17 and 18 year olds are included, prevalence rate increases more substantially to 5.4 % (Roberts et al., 2007).

To our knowledge, there are few reports of recent prevalence rates for ODD by gender within the USA. Of the available reports, males (3.1 %) have a slightly higher prevalence rate than girls (2.1 %; Costello et al., 2003). Earlier reviews of the literature revealed inconsistent findings for gender differences in ODD (Lahey, Miller, Gordon, & Riley, 1999). Quantitative analyses of gender differences in prevalence rates of ODD revealed ODD is significantly more common in boys (Maughan, Rowe, Messer, Goodman, & Meltzer, 2004). A limitation of this study, however, is that estimates used clinically confirmed diagnoses of ODD. Research shows that girls are less likely to receive a clinically confirmed diagnosis of ODD (Heflinger & Humphreys, 2008), therefore these analyses may underestimate the prevalence of ODD in girls. Studies with power to detect gender differences in the examination of ODD are needed.

It is well established that CD is more prevalent in males (Lahey et al., 1999; Maughan et al., 2004). Our review of more recent prevalence

rates coincides with these previous reports. Prevalence rates of CD for boys range between 2.3 % and 4.2 % (Costello et al., 2003; Merikangas et al., 2010), and decrease when impairment is considered. Prevalence rates for girls range between 2.1 % and 2.7 %, and also decrease when impairment is considered.

ODD and CD Prevalence Rates: Cross-Cultural Comparison

The aforementioned prevalence rates are not without limitations, several of the studies use samples from specific areas of the USA. For example, Costello et al. (2003) focused on a rural area of a Southern state and Roberts et al. (2007) focused on a metropolitan area within a Southwestern state. Still, these rates are likely representative of the population as a whole.

Epidemiological and cohort studies from several countries in other continents report similar prevalence rates of ODD and CD to that reported from studies in the USA: North America (Benjet, Borges, Medina-Mora, Zambrano, & Aguilar-Gaxiola, 2009), South America (Anselmi, Fleitlich-Bilyk, Menezes, Araújo, & Rohde, 2010; Fleitlich-Bilyk & Goodman, 2004; Goodman et al., 2005; Petresco et al., 2014), Europe (Ford, Goodman, & Meltzer, 2003; Frigerio et al., 2009; Heiervang et al., 2007; Kim-Cohen et al., 2005; Lynch, Mills, Daly, & Fitzpatrick, 2006; Petersen, Bilenberg, Hoerder, & Gillberg, 2006; West, Sweeting, Der, Barton, & Lucas, 2003; Zwirs et al., 2007), and Asia (Alyahri & Goodman, 2008; Farbstein et al., 2010; Gau, Chong, Chen, & Cheng, 2005; Leung et al., 2008; Pillai et al., 2008). More specifically, prevalence rates for ODD are reported to range between 1.2 % and 3.2 % when assessed in the previous 3 months, and increase with age and length of assessment window to 4.0–8.7 %; and similar to prevalence studies in the contiguous USA, rates decrease significantly when impairment is adjusted (e.g., Canino et al., 2004; Ford et al., 2003; Leung et al., 2008). Prevalence rates for CD are reported to range between .6 % and 9.0 % also decreasing when impairment is adjusted (Canino et al., 2004; Ford et al., 2003; Leung et al., 2008) and are highest among older populations and when the timeframe for assessment increases. Furthermore, CD is more prevalent in boys than in girls, with rates ranging from 1.4 % to 14.5 % compared to .4–3.5 %, decreasing to 3–4 % and 0–.9 % (respectively) when impairment is considered. Contrary to studies in the USA, there are consistent reports of gender differences in ODD in other countries, with boys expressing more symptoms than girls (Alyahri & Goodman, 2008; Farbstein et al., 2010; Fleitlich-Bilyk & Goodman, 2004; Ford et al., 2003; Kim-Cohen et al., 2005; Petresco et al., 2014; Zwirs et al., 2007).

ODD and CD Prevalence Rates: African American Youth

Given that African American youth are less likely to initiate care (Cook, Barry, & Busch, 2013) even when their mental health condition is associated with severe impairment (Merikangas et al., 2011), and African American youth are less likely to have specialty mental health care or general medical services for mental health issues (Angold et al., 2002; Costello, He, Sampson, Kessler, & Merikangas, 2014), one might expect ODD and CD to disproportionately affect African American youth.

A thorough literature search has revealed inconsistent results regarding prevalence rates for ODD and CD in African American youth. Various investigators and research teams have found prevalence rates of ODD and CD in African American youth lower or similar to Caucasian American youth (Angold et al., 2002; Costello, Keeler, & Angold, 2001; Roberts, Roberts, & Xing, 2006), prevalence rates that match that of Caucasian American youth (Angold et al., 2002; Costello et al., 2001), or prevalence rates that are higher than Caucasian youth (Bird et al., 2001). For example, Angold et al. (2002) and Costello et al. (2001) both found 3-month prevalence rates for ODD to be lower in African American youth (1.1–1.7 % and 1.5–3.6 %, respectively) compared to Caucasian American youth (2.7–4.2 % and 1.5–3.6 %, respectively)

between the ages of 9 and 17. Similarly, Angold et al. (2002) and Costello et al. (2001) both reported similar 3-month prevalence rates of CD for 9-17 year old African American youth (1.4–4.0 % and 5.3 %, respectively) and Caucasian American youth (1.2–4.4 % and 5.5 %, respectively). Roberts et al. (2006) found that when the definition of disruptive behavior disorder (usually defined as just ODD and CD) included Attention Deficit/Hyperactivity Disorder, African American youth had lower prevalence for CD (African American: 5.7 %, Caucasian American: 7.5 %) and when adjusting for impairment (defined similarly to other studies), rates decreased and African American youth remained lower than Caucasian American youth (African American: 4.5 %, Caucasian American: 6.4 %).

As previously mentioned, other investigators have found higher prevalence rates of ODD and CD among African American youth compared to that of Caucasian American youth. Using a sample drawn from four geographic regions of the USA, Bird et al. (2001) as part of the National Institute of Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA; Lahey et al., 1996) study found a prevalence rate of ODD of 9.1 % for African Americans that was higher than the rate found for Caucasians (8 %; Bird et al., 2001). Braun et al. (2008) using NHANES data found that African Americans had a higher rate of CD (2.98 %) compared to Caucasians (1.94 %), Mexicans (1.36 %), or "other Hispanics" (2.68 %). Similarly, Bird et al. (2001) in a cross-sectional study of 9–17 year olds found that African American youth had a significantly higher prevalence rate of CD (9.9 %) compared to that of Hispanics (5.8 %) and Caucasians (5.4 %). Studies that specifically examine prevalence rates among low-income African American youth generally find that the rate of CD is considerably higher compared to studies using nationally representative samples. For example, Byck, Bolland, Dick, Ashbeck, and Mustanski (2013) using a community-based sample found that the prevalence rate of CD among low-income African American adolescents was 7.7 %, which is almost 30 % higher than the rate found in studies using NCS-A data (see Kessler et al., 2012). Given that some prevalence studies show lower rates, that some show similar rates, and that others show higher rates, more research is needed to fully understand and identify factors that contribute to the discrepancy in prevalence rates found across studies.

Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a manual published by the American Psychiatric Association and is used by mental health professionals to make formal psychiatric diagnoses. The American Psychiatric Association released the latest version of this manual, the DSM-V, in 2013. While the prevalence rates discussed above are all based on the DSM, Fourth Edition (DSM-IV)/DSM-IV, Text Revision (DSM-IV-TR) definitions of ODD and CD, rates reported here are similar to prevalence rates estimated using the prior DSM version, DSM-III (for a review see, Canino et al., 2010; Roberts, Clifford Attkisson, & Rosenblatt, 1998; Vicente et al., 2012).

ODD Diagnostic Criteria

According to the DSM-IV, criteria for ODD include a pattern of behavior lasting at least 6 months and include at least four of the following:

1. Often loses temper
2. Often argues with authority figures/adults
3. Often actively defies or refuses to comply with adults' requests or rules
4. Often deliberately annoys people
5. Often blames others for his or her mistakes or misbehavior
6. Is often touchy or easily annoyed by others
7. Is often angry or resentful
8. Is often spiteful or vindictive

These behaviors must meet three criteria: (1) must be displayed more than what is typical for same age peers, (2) must cause significant clini-

cal impairment in a major area of functioning (i.e., social, academic, occupational), and (3) must not occur exclusively during the course of a Psychotic or Mood Disorder. In addition, the child may not meet diagnostic criteria for Conduct Disorder, and for those older than 18, Antisocial Personality Disorder.

CD Diagnostic Criteria

According to the DSM-IV, criteria for CD include a pattern of behaviors that violate social and cultural norms and infringe upon the rights of others and can be grouped into four problematic clusters:

1. Aggression to people and animals,
2. Destruction of property,
3. Deceitfulness or theft, and
4. Serious violations of rules.

Across all clusters, three (or more) behaviors must be present for the past 12 months, with at least one present for the past 6 months. Similar to the diagnostic criteria for ODD, in addition to meeting this threshold, these behaviors must meet two additional criteria: (1) must cause significant clinical impairment in a major area of functioning (i.e., social, academic, occupational), and (2) if the individual is 18 years or older, they cannot meet criteria for Antisocial Personality Disorder.

Changes Made to DSM-V

There were several changes made from the DSM-IV-TR to DSM-V criteria for ODD and a minor, yet notable, change for CD. First, DSM-V now provides cluster types for ODD symptoms, including: angry/irritable (often loses temper, is often touchy or easily annoyed, is often angry and resentful), argumentative/defiant behavior (often argues with authority figures/adults, actively defies or refuses to comply with adults' requests or rules, deliberately annoys others, and blames others for his or her mistakes or behavior), and vindictiveness (spiteful or vindictive). Criteria for vindictiveness are now specified as at least twice within the past 6 months. Second, DSM-V now states that the symptoms cannot occur during interactions with siblings. Third, DSM-V no longer considers CD and ODD distinct constructs as the criteria for DSM-IV suggest. More specifically, ODD may be diagnosed in the presence of a CD diagnosis. Fourth, additional information concerning the severity of the symptoms based on the number of settings in which symptoms were seen was added to the DSM-V. A notable change from the DSM-IV-TR to DSM-V criteria for CD is the specification of whether an individual demonstrates lack of remorse or guilt, callousness or lack of empathy, lack of concern about performance, or shallow or deficient affect.

Given the changes from the DSM-IV-TR to DSM-V, it is likely that future studies will show a change (probably an increase) in estimated prevalence rates for ODD. As discussed above, prevalence rates for ODD decrease with age. Given the new diagnostic criteria, we may see prevalence rates of ODD increase as more clinicians will consider this diagnosis when also considering a diagnosis of CD.

Distinctions Between CD and ODD

The distinction between Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) is based on violations of legal statutes and social mores. Children with ODD do not typically engage in repeated physical assault, destruction of property, or deceit. On average, ODD-type behaviors appear 2–3 years earlier, and "the diagnosis implies more circumscribed disturbances of lesser severity than CD" (Steiner & Remsing, 2007, p. 128). Though behaviors of children with ODD and CD may overlap, there are distinctions to be made between different types of problematic behaviors.

Although ODD and CD represent very different types of behavior problems, follow-up statistics reflect the overlap between them. About 25 % of children diagnosed with ODD will later exhibit behaviors associated with CD. At least 80 % of

adolescents showing symptoms of CD have a prior history of ODD. Thus, while most children with CD include a significant history and presentation of oppositional and defiant features, far fewer children with ODD will develop the more severe symptoms of CD. It should be noted, however, that there is still debate in the field whether ODD and CD are age-related manifestations of the same condition (Moffitt & Scott, 2008).

Disparity in the Diagnosis and Epidemiology of ODD and CD

An additional discussion in the field regarding ODD and CD is racial disparity. Any discussion of racial disparities in the diagnosis and epidemiology of ODD and CD must be couched within the context of the current state of epidemiological research in mental disorders of childhood and adolescence, which is still in its infancy relative to that of adults. As of the 1990s accurate information was unavailable on the number of children and adolescents in the USA with mental health disorders; a condition that led the President's Commission on Mental Illness and Health (Nemeroff et al., 2008) to highlight the need for scientifically rigorous studies to examine the incidence and prevalence of mental disorders in the USA. Responding to this need, the National Institute of Mental Health (NIMH) requested applications "to develop feasible, reliable, and valid methods for the assessment of mental disorders, risk factors, and service utilization in youths aged 9–17 years in large scale, population-based surveys" (p. 856; Lahey et al., 1996). The MECA (Lahey et al., 1996) study ushered in such studies designed to identify the distribution of mental health disorder including the more recent National Health Interview Survey (NHIS; Froehlich et al., 2007), NHANES (Braun et al., 2008; Merikangas et al., 2010), and the NCS-R (Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, Merikangas, & Walters, 2005) and NCS-A (Kessler et al., 2012).

Unfortunately, because of different methods of determining diagnostic status used in the previously reported epidemiological studies and major methodological challenges of these studies in systematically tracking the prevalence and distribution of mental disorders using nationally representative samples, our current understanding of multicultural similarities and differences in the magnitude, risk factors, course, treatment, and service utilization of mental disorders in children and adolescents is limited. In addition, the recent change to DSM-V with the inclusion of culture and cultural factors in psychiatric diagnosis, with its required changes to existing instrumentation for diagnosing and assessing mental disorders, may even further lessen our understanding of racial disparities, at least in the short-term.

Although DSM-V (American Psychiatric Association, 2013) presents a better understanding of biological and cultural variations in human psychopathology and now notes that impulse control and conduct problems often occur to some degree in developing individuals, the frequency, persistence, pervasiveness, and cross-situational consistency in behavior relative to what is normatively expected given a person's age, gender, and culture that determine whether diagnostic criteria are met for these disorders need further development (DSM-V, 2013). That is, noting that behaviors consistent with the diagnostic criteria for ODD/CD can be impacted by culture has failed to address adequately concerns of racial disparity in diagnosis and treatment of African American youth.

There are several reasons for this continued concern. First, African American youth are disproportionately exposed to environmental risk factors (e.g., SES, parental stress, harsh discipline) and environmental toxins (e.g., tobacco smoke, lead exposure) associated with problems of self-control of emotions and behaviors relative to their Caucasian counterparts (Yung & Hammond, 1997) yet their rates of treatment access are comparatively much lower (Kodjo & Auinger, 2004). Second, there is a strong association between race and misdiagnosis (McNeil, Capage, & Bennett, 2002; Worthington, 1992). For example, Loring and Powell (1988) found that the more severe labels of psychopathology were given to African Americans. Third, African

American youth who display antisocial behaviors are more likely to be referred to the justice system than to the mental health system (Teplin et al., 2002) as evidenced by their disproportionate overrepresentation in correctional facilities (Timmons-Mitchell et al., 1997). For example, while African Americans comprise one third of youth in the general population, they account for two thirds of youth in juvenile detention facilities (Soler, 2007).

The evidence is strong of racial disparities in confinement of minority youth in juvenile correctional facilities, due in part to societal factors such as economics, education, policing decisions, discrimination, and unfortunately, mental health treatment or the lack thereof. The overrepresentation of African American youth in correctional facilities is particular troubling as such "interventions" are often iatrogenic and serve to exacerbate conduct problems—one of the most consistent predictors of problem behavior is association with deviant peers. Finally, compared to Caucasians, racial/ethnic minorities have less access to mental health services, receive poorer quality services, are less likely to receive mental health services, and are underrepresented in mental health research (Feinstein et al., 1998; Garland et al., 2005; US Department of Health and Human Services, 2001; Wu et al., 2002). Furthermore, minorities are significantly less likely than Caucasians to seek mental health services (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995; McMiller & Weisz, 1996; Padgett, Patrick, Burns, & Schlesinger, 1994), experience greater barriers to receiving services when they do seek treatment, and are more likely to drop out of treatment once they receive services.

Given the aforementioned disparities, more strategies to facilitate African American youth and their families entering and completing evidence-based treatments (EBTs) are needed. If strategies are successful in enrolling more African American youth into EBTs, then the next logical question is what EBTs would be beneficial to African American youth with CD and ODD? We will examine this issue in next section that looks at the effectiveness EBTs for CD and ODD with African American youth and also examine if cultural adaptations are needed to further enhance their effectiveness with African American youth.

ODD and CD Treatment

Identification of effective EBTs for African American youth with CD and ODD is a major public health priority (Loeber, Burke, Lahey, Winters, & Zera, 2000). If African American youth do not receive adequate treatment early during childhood, a higher degree of impairment and unfavorable long-term prognosis is likely (Lahey, Loeber, Quay, Frick, & Grimm, 1997). An area in treatment outcome research with African American youth that has begun to receive increasingly more attention is to examine whether current EBTs are cultural appropriate in meeting the mental health needs of African American youth with CD and ODD. Specifically, researchers have begun to ask if treatments need to be culturally designed or do existing empirically supported treatments need to be adapted to be effective with African American youth? Although such questions are important they have been difficult to ask given that historically African Americans in general, and African American youth, specifically, have been underrepresented in clinical trials (USDHHS, 2001). Thus, the overwhelming majority of EBTs examined to date have largely been developed for and implemented with Caucasian youth (Eyberg, Nelson, & Boggs, 2008). The following section will review evidence-based treatments that have been to be effective in treating ODD/CD.

ODD and CD Treatments: General Population

Historically, few interventions have demonstrated effectiveness in treating serious disruptive and externalizing behaviors (e.g., delinquency, drug use)—more often than not the major reason for mental health referrals in children and adolescents

(Burns & Friedman, 1990; Jensen, Hoagwood, & Petti, 1996). More recently, however, family-based EBTs for youth with externalizing disorders have been quite encouraging to the field. Family-based treatments are superior to other treatment modalities in dealing with serious disruptive and externalizing behaviors (Diamond & Josephson, 2005). Family-based EBTs for DBDs often teach parents and other caregivers how to set limits, respond consistently and non-abusively to misbehavior, and monitor a youth's behavior and whereabouts. In addition, individual child treatments have been developed that have shown promise in addressing specific diagnostic symptoms as well as skill and behavioral deficits often observed in children and adolescents with DBDs (Burke, Loeber, & Birmaher, 2002). These treatments have included psychopharmacological treatments and cognitive behavioral therapy (CBTs). Before describing family-based treatments for ODD/CD we briefly review individual child-focused EBTs that have demonstrated effectiveness with youth presenting with ODD/CD.

Psychopharmacological treatments have demonstrated effectiveness with some ODD/CD. Psychopharmacological interventions have included mood stabilizers, typical and atypical antipsychotics, clonidine, and stimulants (Burke et al., 2002). For example, two randomized clinical trials comparing the effects of lithium to placebo reported that lithium was efficacious for short-term treatment of aggressive inpatient children and adolescents with CD (Campbell et al., 1995; Malone, Delaney, Lueber, Carter, & Campbell, 2000).

Individual EBTs, such as child-focused problem-solving skills programs (Kazdin, 1996; Webster-Stratton & Hammond 1997) and moral development interventions (Arbuthnot, 1992) have been effective in reducing DBD behaviors and building prosocial skills. Additionally, interventions in anger control/stress inoculation, assertiveness training, and rational-emotive therapy are considered probably efficacious for ODD and CD problems (Brestan & Eyberg, 1998).

Parent and family-based treatments, having been examined in numerous randomized clinical trials, are considered by many to be the treatment of choice for treating youth with DBD (Burke et al., 2002). These interventions are generally based on behavioral and systemic models of human behavior and often target child DBD by providing parents (or other caregivers) with the skills and competencies needed to effectively manage problem behavior. For example, parent management training (PMT) strategies are considered well established in treating DBDs (Brestan & Eyberg, 1998; Kazdin, 1997). Similarly, Parent Child Interaction Training (PCIT) is considered effective. In several randomized clinical trials PCIT has produced significant decreases in problem behavior in children diagnosed with ODD relative to comparison conditions (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). PCIT consists of two phases: a child-directed interaction in which parents are trained in nondirective play skills and parent-directed interaction, which focuses on improving parenting skills by teaching parents how to give clear instructions to their children, to praise children for compliance, and to punish children for noncompliance (e.g., timeout from reinforcement).

Several family-based treatments have been found to be particularly effective for conduct disorder and delinquency in adolescents (Henggeler & Sheidow, 2012). For example, Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care, and Brief Strategic Family Therapy have significantly reduced CD and serious problem behavior in adolescents.

Overall, several psychopharmacological treatments, individual treatments, and parent and family treatments have resulted in reductions of ODD and CD problem in the general population. In the next section, we will examine the effectiveness of some of these treatments for African American youth.

ODD and CD Treatments: African American Youth

Several peer-reviewed meta-analyses and literature reviews have examined the effectiveness of EBTs in treating minority youth exhibiting externalizing disorders such as ODD and CD. For

example, Huey and Polo (2008) and Ho, McCabe, Yeh, and Lau (2011) examined studies that included samples of minority youth (e.g., African American, Hispanic, Native Americans). In each of these reviews (Ho et al., 2011; Huey & Polo, 2008), treatments were classified using a treatment classification system developed by Chambless et al. (1996). This classification system classifies treatments as well established, probably efficacious, or possibly efficacious. To be classified as well established, a treatment must have had two or more between group trials conducted by independent investigators and must find that the treatment produced significantly better outcomes than a placebo or a comparison treatment condition. Probably efficacious is defined as treatments with one trial that found that a treatment produced superior clinical outcomes relative to a placebo or another treatment or two trials comparing the treatment to a no-treatment control group. Possibly efficacious treatments only require one study showing that the treatment was efficacious without conflicting evidence (Chambless & Hollon, 1998).

In addressing the issue of whether a treatment is effective with African Americans (i.e., culturally appropriate) we will also use the Chambless et al. (1996) classification system, as well as a classification framework used by Ho et al. (2011) that placed studies in one of three categories: (1) A treatment developed specifically for African American youth and evaluated using samples that include a large proportion of African American youth and families; (2) A treatment developed without African American youth in mind but evaluated using a sample that includes a substantial proportion of African American youth and their families; and (3) A treatment developed without African American youth in mind and then culturally adapted and evaluated using a sample that includes a substantial proportion of African American youth and families. Consistent with an earlier observation of the extant treatment literature, we found that the overwhelming majority of treatment outcome studies being conducted were not specifically designed with African American youth in mind.

The next section will describe treatments that fall within one of Ho et al. (2011) categories beginning with a description of a study where a treatment was developed for and evaluated with African American youth.

EBTs Developed for and Evaluated on African American Youth

Few treatments have been specifically developed for African American youth with ODD or CD and then tested specifically with African American youth. One of the few exceptions is Multiple Family Groups (MFG; McKay et al., 2011) designed for African American children with behavioral difficulties. Specifically, MFG was developed for urban African American youth (age 7–11 who met diagnostic criteria for ODD or CD) and their adult caregivers who received treatment at 13 urban outpatient clinics. MFG is 16-week group treatment that typically includes 6–8 families. MFG intervention-protocols guide each group session. These protocols were specifically designed in collaboration with urban African American parents.

The goals of MFG are to increase a parent's skills in improving family relationships (e.g., parental discipline, monitoring, family communication, family support, stronger affective bonds between youth and adult caregivers), managing parental stress, increasing emotional and instrumental supports, and reducing stigma associated with mental health care. Each of these goals were targeted as research has shown that each of these area can impact inner-city child and parent outcomes as well as families' enrollment and retention in mental health services. MFG specifically targets ODD problems, parental stress, and factors that can affect treatment engagement and retention.

In one study, 321 youth (7.79 % Caucasian American; 29.60 % African American; 48.91 % Latino American; 2.49 % Native American; 0.31 % Asian/ Pacific Islander; and 6.54 % others) from 13 outpatient clinics were randomly assigned to either MFG or standard outpatient mental health care services (McKay et al., 2011).

The study included 4 assessments (baseline, 8 weeks [midway through treatment]; post-treatment [16 weeks]; and 6-month follow-up). Each MFG session entailed five stages: (a) creating social networks; (b) information exchange; (c) group discussions; (d) individual family practice; and (e) homework assignment. Results indicated that parents in the MFG reported significantly fewer ODD symptoms in their children and significant less parental stress than parents in the comparison condition at post-treatment and 6-month follow-up. While the study found that results were not significantly different across racial groups, the findings do suggest that MFG is possibly an efficacious treatment in addressing ODD problems in African American youth.

EBTs Developed without African American Youth in Mind, Then Evaluated Treatment Effects on African American Youth

EBTs developed without African American youth in mind, but then evaluated with samples that include African American youth include cognitive behavioral therapy (CBT), parent management training, parent–child interaction therapy, and several of the family-based treatments mentioned earlier. In general, EBTs described in this section can be categorized as well established, probably efficacious, and possibly efficacious.

Multisystemic Therapy. Multisystemic Therapy (MST) is an intensive home- and community-based treatment, which focuses on the entire ecology of chronic and violent juvenile offenders: their family, peer, school, community, and individual factors (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). MST is based on nine treatment principles that, in part, enable therapists to do the following:

(a) Understand the relationship between a youth's presenting problems and the broader systemic context in which the youth is embedded (e.g., family, school, peer, community, and individual factors).
(b) Leverage systemic strengths that the youth and family may have to facilitate change.
(c) Identify and understand sequences within and between systems that may contribute to youth and family problems.
(d) Create interventions that are developmental and culturally appropriate given the youth's and family's context.
(e) Promote generalization of treatment effects by ensuring that interventions are being developed with and carried out by adult caregivers of youth.

MST is considered a well-established EBT (Ho et al., 2011) based on outcomes from a number of randomized clinical trials (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Henggeler et al., 2006)—several conducted by independent investigators (Butler, Baruch, Hickey, & Fonagy, 2011; Ogden & Halliday-Boykins, 2004; Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006). In most of these randomized clinical trials there was significant African American representation. For example, 56 % of 96 participants in Henggeler et al. (1992) were African American; in Borduin et al. (1995) 30 % of 200 participants were African American; in Henggeler et al. (1997) 81 % of 155 participants were African American; in Henggeler et al. (2002) 50 % of 118 participants were African American; and in Henggeler et al. (2006) 67 % of the 161 participants were African American.

Across studies, MST produced greater reductions in criminal offending, re-arrests, time incarcerated, and substance use than comparison conditions (Henggeler et al., 1992, 1997, 2002, 2006). A long-term follow-up study of 13.7 years indicated that MST participants had significantly lower recidivism rates (50 % vs. 81 %) than participants in the comparison condition (Schaeffer & Borduin, 2005). Similarly, MST participants had fewer arrests and fewer days of confinement in adult detention centers than participants in the comparison condition. Overall, results were not significantly different across racial groups. In fact, across studies the effectiveness of MST has not been moderated by demographic characteristics

such as age, race, gender, social class, or pretreatment criminal offending (Henggeler et al., 2009).

One question that has risen in the evidence-based practice movement is what happens when an EBT is transported out of the comfortable and rather sterile environments of academic settings where the vast majority of randomized clinical trials are conducted. MST is one of the few EBTs that has generated evidence of its efficacy in effectiveness contexts (i.e., real-world practice settings). For example, a randomized clinical effectiveness trial of MST was conducted by an independent investigator that found outcomes favoring MST (Timmons-Mitchell et al., 2006). Timmons-Mitchell et al. (2006) randomly assigned 93 youth (i.e., 77.5 % Caucasian American youth, 15.5 % African American youth, 4.2 % Latino American youth, and 2.8 % Bi-racial youth) to MST or a treatment as usual (TAU) comparison condition. MST youth had a lower recidivism rate than TAU youth at 18-month follow-up. Results were similar across racial group, which indicate that MST is an effective treatment for African American youth even when implemented by independent investigators in effectiveness contexts. It should be noted however, that reductions in recidivism in this trial represented a lower effect size than typically found in efficacy trials conducted by MST model developers. This lower effect size is not surprising as effect sizes are dramatically reduced when EBTs are delivered in real-world practice settings where the majority of African American youth are treated. Taken together, MST is a well-established EBT that was not developed with African American in mind, but has proven effectiveness with African American youth.

Parent Management Training The goals of Parent Management Training (PMT) are to reduce problems, such as physical and verbal aggression, property destruction, defiance, and noncompliance. Intervention strategies include didactic teaching, role-plays, modeling, practice, homework (to teach adult caregivers how improve their problem-solving), monitoring, and discipline skills. PMT has been shown to be an efficacious treatment for youth with conduct and oppositional defiant problems (Miranda et al., 2005).

One empirically validated PMT is the Incredible Years (IY) Parent Program (Taylor & Biglan, 1998; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton & Hammond, 1997). IY is a school-based prevention program for low-income families. In one study, a racially diverse sample ($N = 426$, 17 % African American, 6 % Hispanic American, 6 % Multiracial, 4 % Asian American, and 4 % Native American) enrolled in Head Start was used.

Results demonstrated that IY participants across racial groups demonstrated significantly fewer conduct, noncompliance, and negative affect problems than youth in the comparison condition. Additionally, IY youth demonstrated significantly higher social competence than youth in the comparison condition (Webster-Stratton, 1998).

In another IY study (Reid, Webster-Stratton, & Beauchaine, 2001), 370 Caucasian American, 120 African American, 71 Hispanic American, and Asian American mothers and Head Start youth were randomly assigned to IY or a comparison condition. IY mothers were more positive, competent, consistent, and satisfied than comparison condition mothers at post-treatment. IY youth demonstrated greater positive affect than comparison youth at 1-year follow-up. Results indicate that IY is an effective treatment for African American youth. Significant differences across racially diverse groups during treatment, at post-treatment and at follow-up were not reported. However, there were significant differences between Caucasian families and minority families (17 % vs. 28 %) who chose not to enroll in the program indicating recruitment of minority families into an IY treatment program may be more difficult than recruitment of Caucasian American families. Other researchers have found similar results (Harachi, Catalano, & Hawkins, 1997).

Cognitive Behavioral Therapy and Skills Training Although not adapted for African American youth, several Cognitive Behavioral Therapy (CBT) interventions have been found to reduce conduct- and oppositional-related problems in African American youth. Larkin and Thyer (1999) used several CBT interventions including problem-solving, self-instructions, modeling, role play, social skills training, and

covert imagery to treat a group of randomly assigned ethnically diverse elementary school youth (32 % African American, 19 % Caucasian American, 5 % Asian American, 2 % Latino American, and 2 %) with behavioral problems. Youth across ethnic groups improved on perceived self-control and self-esteem measures.

Social-Cognitive Interventions with African American adolescents have been examined in three investigations (Hudley & Graham, 1993; Huey & Rank, 1984; Lochman, Coie, Underwood, & Terry, 1993). Lochman et al. (1993) examined the effectiveness of a program entitled, Social Relations Interventions Program for aggressive, rejected children with social-cognitive difficulties. These researchers used social problem-solving, positive play training, group skill training, and strategies to deal with strong negative emotions to treat 52 African American aggressive and rejected, and nonaggressive and rejected youth who were randomly assigned to the intervention condition or control condition. Post-treatment and 1-year follow-up data indicated the intervention condition was effective only for aggressive and rejected youth with reductions in aggression and social rejection and improvements in peer prosocial behavior.

Hudley and Graham (1993) examined the effectiveness of an Attributional Intervention to train aggressive African American youth not to infer hostile intent in negative social encounters to ambiguous causes. These researchers randomly assigned 100 African American youth (aggressive and nonaggressive) to Attributional or Attention Control conditions. Youth in the Attributional Intervention group were less likely to infer hostile intent in ambiguous situations, less likely to endorse hostile retaliation or to use verbally aggressive behaviors at post-treatment. Teachers also rated the Attributional Intervention youth as less aggressive.

Huey and Rank (1984) examined the effectiveness of a Group Assertiveness Training on 48 aggressive African American youth who were randomly assigned to Group Assertiveness Training, a discussion group, or a no-treatment group. Participants in the Group Assertiveness Training exhibited less aggressive behavior than participants in the other two groups.

Parent–Child Interaction Therapy Parent–Child Interaction Therapy (PCIT: Eyberg & Robinson, 1982) uses developmental principles to teach parents behavioral interventions to address disruptive behaviors in young children. PCIT teaches youth's adult caregivers an Authoritative Parenting Style. An Authoritative Parenting Style includes nurturance, good communication, and firm control. Authoritative parenting has been linked to reductions in child behavior problems in a number of studies (e.g., Linver, Brooks-Gunn, & Kohen, 2002) that included African American families (Querido, Warner, & Eyberg, 2002).

Fernandez, Butler, and Eyberg (2011) examined the impact of PCIT on a small group of low socioeconomically disadvantage American families ($N=18$) with preschoolers with disruptive disorders. Following PCIT mothers of preschoolers reported significant improvements in their youth's disruptive disorders but not in maternal depressive symptoms or parenting stress. Unfortunately, there was a 56 % dropout rate for these African American families from this PCIT trial. Although favorable behavior changes occurred for disadvantage young African American youth when the youth and families completed treatment, recruitment, engagement, retention, and addressing treatment barriers, such as maternal depression and parental stress, need to be a focus of future studies. Overall, this study demonstrates that PCIT is a possibly efficacious treatment in addressing disruptive problems.

Multicomponent Treatments Several researchers have examined the synergistic effects of treatments that include multicomponents on the conduct-related problems in African American youth. Kazdin, Siegel, and Bass (1992) examined the impact of three interventions conditions (i.e., Problem-Solving Skills Training [PSST] alone, Parent Management Training [PMT] alone, and PSST and PMT combined) in a randomized trial of 30 African American and 60 Caucasian American youth with severe antisocial behaviors. PSST combines CBT techniques to teach problem-solving skills. PMT teaches parents positive reinforcement, shaping, negotiating and contracting,

time out, and appropriate reprimands. While all three conditions led to significant improvements in youth problem behavior (decreased delinquency and aggression, increased prosocial behavior), combining PSST and PMT led to significantly more improvements in antisocial behavior, delinquency, and symptoms of parental dysfunction. Additionally, the combined PSST and PMT condition placed a greater proportion of youth into the nonclinical range of functioning at post-treatment (Kazdin et al., 1992).

Coping Power (Lochman, Lenhart, & Wells, 1996) is a multicomponent prevention intervention that has been used effectively with African American youth. Coping Power consists of a child component (developed from an Anger Coping Program [Lochman, Lampron, Gemmer, & Harris, 1987]) that teaches contingency reinforcement, alternative solutions, problem-solving, anxiety reduction, and anger-reduction skills. Coping Power includes a parent component (derived from social learning theory-based parenting programs for aggressive youth [Patterson, Reid, Jones, & Conger, 1975]) that teaches parents to identify prosocial and disruptive behaviors, reward appropriate behaviors, set rules, and to apply consequences. To examine the efficacy of Coping Power, 116 African American youth and 77 Caucasian American males were randomly assigned to Coping Power with child only component, Coping Power with both child and parent components, or a no-treatment control condition. Results demonstrated that Coping Power improved adolescent males' social informational processing (e.g., attributions related to aggression), temperament, and views of their parents being consistent with parenting. The two Coping Power interventions at 1-year follow-up assessment led to greater reductions in youth's reports of delinquent behavior and parents' report of youth's alcohol and marijuana use, and teacher-rated improvements in youth's school performance than the control condition. Moreover, parents in the Coping Power condition with both child and parent components reported greater reductions in their youth's substance use and delinquent behavior than parents in the other two conditions. Additional studies of Coping Power (Lochman & Wells, 2002a, 2002b, 2003) have continued to demonstrate Coping Power's favorable results with African American youth.

Although the aforementioned treatments were not designed with African American youth in mind, they have produced significant reductions in conduct and oppositional problems at post-treatment and follow-up assessments for African American youth. Of the interventions reviewed, only one treatment, MST, is considered well-established EBT. Five treatments (parent management-based protocols [IY], two CBT-based protocols [Attributional Treatment and Group Assertiveness Training], and two multicomponent treatments [the Coping Power Program and Combined PSST+PMT]) are considered probably efficacious. Three treatments (Cognitive Behavioral Group therapy, Social Relations Interventions, and PCIT) are considered possibly efficacious for African American youth. Overall, results indicate that the aforementioned treatments can deliver positive treatment outcomes for African American youth with conduct and oppositional problems.

Conclusions

As previously mentioned, DBDs among children and adolescents have become a major public health concern for many parents, community leaders, policy makers, clinicians, and researchers. This concern is particularly heightened for African American youth who are exposed to a number of factors (e.g., low SES) that increase their risk for developing a DBD (Crystal et al., 2009).

In the general population, the total prevalence rates for ODD appear to be consistent across sampled age ranges, whereas the prevalence rate for CD varies slightly depending on youth ages. Primarily, as youth's age increases, prevalence of CD increases as well. Regarding gender, reports of recent prevalence rates for ODD by gender within the USA indicate that males (3.1 %) have a slightly higher prevalence rate than girls (2.1 %) (Costello et al., 2003). It is well documented that CD is more prevalent in males (Lahey et al., 1999; Maughan et al., 2004). Epidemiological

and cohort studies from several countries report similar prevalence rates for ODD and CD to that reported from studies in the USA.

Given that African American youth are less likely to enter care (Cook et al., 2013) even when their mental health condition is associated with severe impairment (Merikangas et al., 2011), and African American youth are less likely to have specialty mental health care or general health care services for mental health issues (Angold et al., 2002; Costello et al., 2014), it would be reasonable to expect that ODD and CD to disproportionately affect African American youth. A thorough search of the literature, however, has revealed mixed results regarding prevalence rates for ODD and CD in African American youth. As noted above researchers have found that prevalence rates for ODD and CD among African American youth are either lower (Angold et al., 2002; Costello et al., 2001; Roberts et al., 2006) or similar to that of their Caucasian counterparts (Angold et al., 2002; Costello et al., 2001), whereas other investigators have found higher prevalence rates of ODD and CD in African American youth compared to that of Caucasian youth (Bird et al., 2001; Braun et al., 2008; Byck et al., 2013).

While the discrepancy in prevalence rates can be attributed to methodological differences in studies (types of measures used to identify disorder, regional versus national sample, geographical location from which a sample is drawn, etc.) these rate differences may also reflect that there is still much we need to learn to assess, diagnose, and treat African American youth. As such, additional research is necessary that focuses specifically on identifying the circumstances under which prevalence rates for African American youth are similar to or different than those of other racial and ethnic groups.

In addition to prevalence rates, we examined current diagnostic criteria for ODD and CD in the recently released DSM-V. We noted several changes that were made from the DSM-IV-TR to DSM-V criteria for ODD and CD. For example, one change is that DSM-V no longer considers CD and ODD distinct constructs as the criteria for DSM-IV suggested, with ODD now being allowed to be diagnosed in the presence of a CD diagnosis. In addition, with the inclusion of culture and cultural factors into DSM nomenclature it is likely that future epidemiological studies will show an increase in estimated prevalence rates for ODD and CD.

Unfortunately, the inclusion of culture and cultural factors into DSM-V (American Psychiatric Association, 2013) has failed to squelch concerns about racial disparity in diagnosis and treatment of African American youth. There are several reasons for continued concern. First, African American youth are disproportionately exposed to a host of environmental risk factors (Yung & Hammond, 1997); have lower access rates to treatment, particularly EBTs, have higher rates of misdiagnosis (McNeil et al., 2002; Worthington, 1992); and have a higher likelihood of being referred to the criminal justice system than to the mental health system (Teplin et al., 2002) as evidenced by their disproportionate overrepresentation in the correctional facilities (Timmons-Mitchell et al., 1997).

Given the aforementioned disparities, strategies are needed to facilitate African American youth and their families entering into and completing EBTs are sorely needed. The latter point is especially critical given that meta-analyses conducted by Huey and Polo (2008) clearly indicate that when AA youth enter and complete an EBT their rate of improvement is consistent with that of Caucasian youth. If African American youth can be more successful in entering and completing EBTs, the next logical question is how effective are these EBTs with African American youth? We began to explore this question by reviewing the effectiveness EBTs for CD and ODD in African American youth and exploring if adaptations to these treatments are needed. We examined EBTs used to address CD and ODD in African youth with two frameworks (Ho et al. 2011; Huey & Polo, 2008).

Regarding treatments developed for and tested with African American youth, we found that very few treatments have been developed and tested specifically for African American youth with CD and ODD. MFG was one exception. We considered MFG as a possibly efficacious treatment.

Concerning EBTs developed without African American youth in mind, but evaluated treatment effects on African American youth, we found a greater number of treatments. Although the treatments were not designed with African American youth in mind, they have produced significant reductions in conduct and oppositional problems at post and follow-up treatment assessment periods. One treatment in this group, MST, is considered a well-established EBT. Five other treatments (parent management-based protocols [IY], two CBT-based protocols [Attributional Treatment and Group Assertiveness Training], and two multicomponent treatments [the Coping Power Program and Combined PSST+PMT]) are considered probably efficacious. Three treatments (Cognitive Behavioral Group therapy, Social Relations Interventions, and PCIT) are considered possibly efficacious for African American youth. Overall, results indicate that the aforementioned treatments can deliver positive treatment outcomes for African American youth with CD and ODD problems.

Although several unadapted EBTs had produced favorable results with African American youth with CD and ODD, the question of whether treatment effect varied due to ethnicity remains mostly unanswered due the overall small number of studies and sample sizes. Cautiously, one could suggest that the very limited literature seem to indicate that these treatments were not more efficacious or effective for different ethnic groups. This assertion is consistent with some researchers (Kazdin, 1993) who have asserted that there is little empirical support for the superiority of culturally adapted treatments over unadapted treatments. Other researchers (Forehand & Kotchick, 2002) have argued that culturally adapted treatments are necessary and worthwhile in certain circumstances. Given our findings related to issues pertaining to enrollment, retention, and completion of some CD and ODD treatments by African American youth, support for adaptation in certain situations can be argued. Perhaps, a reasonable middle ground has been proposed by Lau (2006) who suggested that ethnic-specific treatment adaptation may be necessary when the available evidence shows significant variability in outcome across ethnic groups.

Given that EBTs for CD and ODD in African American youth are in their infancy, we concur with Huey and Polo's (2008) recommendation to use EBTs as the first choice for interventions for African American youth with CD and ODD. As mentioned previously, there are a number of EBTs for CD and ODD in African American youth that are well established, probably efficacious, or possibly efficacious. Similar to Ho et al. (2011), we also suggest that researchers examine the effectiveness of unadapted and adapted EBTs for African American youth with CD and ODD.

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