Chapter 9
Conduct Problems

Diagnosis

Blair, Leibenluft, and Pine (2014) referred to conduct problems as "…a pattern of repetitive rule-breaking behavior, aggression, and disregard for others" (p. 2207). It is these types of behaviors, when they reach a consistent pattern that interferes with a child's daily functioning, that are the focus of this chapter. Kazdin (1997) defined conduct disorder in this manner,

"The overarching feature of conduct disorder is a persistent pattern of behavior in which the rights of others and age-appropriate social norms are violated. Isolated acts of physical aggression, destruction of property, stealing and fire setting are sufficiently severe to warrant concern and attention in their own right. Although these behaviors may occur in isolation, several of these are likely to appear together as a constellation or syndrome and form the basis of a clinical diagnosis" (p. 162).

In the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), conduct problems are in a section entitled, "Disruptive, Impulse Control, and Conduct Disorders (CD)." According to the experts who developed this section of the manual these conditions involve, "… problems in the self-control of emotions and behaviors" (p. 461). These self-control problems are unique in that they, "…violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures" (p. 461).

Children who are diagnosed with CD are likely to have other diagnoses. For example, Kazdin (1997) reported that over 80 % of children met the criteria for CD and Oppositional Defiant Disorder (ODD). Many children with CD may be diagnosed with Attention-Deficit Hyperactivity Disorder (Blair, Leibenluft, & Pine, 2014; Kim-Cohen et al., 2005). Children with CD may be diagnosed with co-occurring learning problems, such as reading and/or math disorders. According to the DSM-5 (American Psychiatric Association, 2013), children with CD show at

L. Nabors, *Medical and Mental Health During Childhood*, Springer Series on Child and Family Studies, DOI 10.1007/978-3-319-31117-3_9

least one symptom indicating aggression toward animals or people, destruction of property, lying or theft, and serious rule violations (e.g., truant from school, runs away from home) before 10 years of age. Children may also have limited empathy and be callous. They can lack remorse or guilt related to violating social norms or the rights of others. They may display very little emotion to other people, which is termed shallow or deficient affect. The essential feature of CD is violating the rights of others or social rules persistently, in such a manner to impair child functioning. CD can occur as early as the preschool years, but is most commonly manifested in middle childhood and early adolescence.

Oppositional Defiant Disorder. A relatively milder version of conduct problems is ODD. Criteria for ODD include having a frequent and stable pattern of "…angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months" (p. 462, American Psychiatric Association, 2013). The behaviors associated with ODD need to interfere with the individual's functioning and cause distress to the individual and others in his or her life. The diagnosis is applicable to children as young as 5 years of age. If the symptoms are in a mild range, they may occur only at home. The behaviors also may be more frequent with adults and peers that the child knows fairly well, and thus the symptoms may not always be directly observable in the office or clinical setting. Symptoms can be in the range of mild (symptoms present in one setting), moderate (symptoms present in two settings), and severe (symptoms are present in three or more settings). Although some children with oppositional behaviors develop significant problems to merit a disorder of CD, not all children with ODD follow a progression to the development of a diagnosis of CD. However, although many children with ODD can develop normally, they are at greater risk for developing other mental health problems, including internalizing problems such as anxiety or depression.

Other Externalizing Behaviors. It is beneficial to explain other externalizing behavior problems that may be diagnosed in childhood. Intermittent Explosive Disorder can begin in late childhood and involves an inability to control verbal or physical aggression (the physical aggression does not result in damage of property or injury to others; American Psychiatric Association, 2013). The aggressive outbursts occur about twice weekly for at least 3 months and are damaging for the individual displaying the symptoms. Another externalizing problem can be fire-setting or pyromania. This can occur in childhood, but information about this disorder in children is needed. Kleptomania, or impulsive stealing that is not for monetary value, is most often diagnosed in adolescence. There is also a category in the DSM-5 for Other Disruptive, Impulse-Control, and Conduct Disorders for those children with symptoms that do not clearly "fit" the categories for ODD or CD.

The primary focus of this chapter is on ODD and CD. In samples of participating children and parents for research, children with both of these disorders are often grouped together, so conduct problems is a term commonly used throughout this chapter.

Prevalence

"Prevalence rates for CD vary, ranging from 2 to 10%, with a median of 4%" (p. 473, American Psychiatric Association, 2013). Prevalence rates increase into adolescence. Rates of CD are higher among males compared to females. Males with CD are likely to exhibit significant aggression. Females are aggressive as well, but also are thought to have higher rates of lying, truancy, and stealing. The prevalence for ODD is estimated to be about 3–4%. These types of problems are more commonly diagnosed in males than females (1.4–1) in childhood, but this difference becomes more equal in adolescence and adulthood.

Genetic and Environmental Influences

Many experts agree that when children exhibit conduct problems, there is an interaction between genetic and environmental influences such that both factors play a role in determining behaviors (e.g., Silberg, Maes, & Eaves, 2012; Tolan, Dodge, & Rutter, 2013). Genetic factors, which may predispose a child to exhibit conduct problems, include problems with regulation of emotions and poor frustration tolerance. These may be temperamental factors, which have a genetic loading, that impact the development of conduct problems. Children with conduct problems also may have reduced cortisol activity in their brains, lower heart rates, and lower skin reactivity. Differences in prefrontal cortex activity (a part of the brain involved with higher order thinking and regulation of emotions) and the amygdala (associated with memory and emotional reactions) have been noted in children with ODD and CD. (American Psychiatric Association, 2013).

Parenting that is harsh, critical, and inconsistent can also be related to conduct problems in children (Kazdin, 1997; Okado & Bierman, 2015). Tolan et al. (2013) reported that young children who have attachments with parents that are not secure, experience negative parenting (with inconsistent rules and application of consequences for behavior), and experience inconsistent monitoring of their well-being and safety are more likely to experience behavior problems. Moreover, parent–child relationships that do not show warmth and support, but rather hostility and a lack of connectedness with others may be related to difficulties in functioning. A lack of warmth and hostility in families can be significant in children with CD. In fact, experts for the DSM-5 reported that a host of family risk factors for CD include but are not limited to, "parental rejection and neglect, harsh discipline, physical or sexual abuse, lack of supervision, early institutional living, frequent changes of caregivers, etc." (American Psychiatric Association, 2013, p. 473). Children with CD can grow up to have significant problems, including problems with the criminal justice system and issues with substance use and addictive disorders. There is a chance that children with CD can grow up to display Antisocial Personality Disorder,

but this is not a given (i.e., not a certain outcome) if a child is diagnosed with CD. Antisocial Personality Disorder has been considered sociopathy or psychopathy, which is distinguished by a lack of regard for rights of others and social rules. In the current diagnostic manual, Antisocial Personality Disorder is defined, in part, as a, "persistent pattern of disregard for the and violation of the rights of others, occurring since age 15 years…" (American Psychiatric Association, 2013, p. 659).

Impact on Children

Wu et al. (2015) highlighted two features of conduct problems, including consistent rule-breaking and aggression. Wu et al. (2015) described children with CD as having quick and angry tempers and mentioned that children with conduct problems break rules and do not take responsibility for their negative behaviors. They may tend to blame the victim in situations where one child is aggressive toward another. Wu et al. mentioned that children with conduct problems who exhibit aggression and the other aforementioned problems may have poorer outcomes. They may continue to display aggressive behaviors and a lack of responsiveness to rules and social customs. As one can imagine, conduct problems in children have a significant impact on their lives. These problems cause isolation and are associated with a host of other emotional and behavioral problems. These diagnoses can include internalizing problems, such as bipolar disorder, depression, and anxiety, as well as learning problems, intellectual disability, intermittent explosive disorder, and mood dysregulation. Conduct problems are very commonly diagnosed with Attention-Deficit Hyperactivity Disorder (Andrade & Tannock, 2012). Children with conduct problems have poor social abilities and may not have many friends (Andrade & Tannock, 2012; Olson, Lopez-Duran, Lunkenheimer, Chang, & Sameroff, 2011). Children with CD and ODD can experience isolation. They may have significant difficulty regulating their emotional reactions, which can contribute to difficulties with peers and adults as well (Havighurst et al., 2015). Eisenberg et al. (2005) proposed that children who experience risk for development of conduct problems are more likely to react negatively in emotional situations. They are expressing more negative emotions and reacting more negatively, which can further isolate them. Children with significant conduct problems may be at risk for long-term negative behaviors, such as hostility, aggression, rule-breaking, lying, and stealing. These behaviors may be related to psychiatric problems and a lack of positive relationships with peers and adults. Long-term risk for substance use, psychiatric disorders (including antisocial personality disorder), and poor relationships and school and work adjustment may result (Maughan & Rutter, 2001).

Argument for Subgroups. In a review article, in the *Psychological Bulletin*, Frick, Ray, Thornton, and Kahn (2013) proposed that there is a subgroup of children with conduct problems, who exhibit callous and unemotional traits. Children in this subgroup were at heightened risk for long-term psychosocial problems and problems relating to

others. Frick et al. mentioned that those studying conduct problems in children and adolescents need to begin to think about subgroups of children with conduct problems. Groups could be determined by the severity of the problems they exhibited as they aged. Those children with CD and callous and unemotional behaviors were at risk for long-term conduct problems. Children with these traits also exhibited cortical differences—that is differences in gray matter in the brain—in some studies. These cortical differences could also be responsible for some children's "hyporesponsiveness" to emotional stimuli. Hyporesponsiveness means that children are underresponsive to stimulation. They often are taking risks and seeking thrills to gain more stimulation. Frick, Ray, Thornton, and Kahn (2013) further distinguished this subgroup of children as having higher to highest levels of deficits in responding to punishment, insensitive to fear expressed by others, and thrill-seeking. Because children in this subgroup may exhibit these issues when they are very young, they may not develop conscientiousness. Although children with more severe problems could have a more bleak long-term prognosis, Frick et al. (2013) cautioned that positive outcomes could occur for children who were callous and unemotional. They proposed that children with the aforementioned symptoms and more severe externalizing problems needed referral to intensive, long-term intervention programs.

Frick et al. (2013) proposed that there was another group that did not exhibit callousness. Children with conduct problems in this group were likely to feel anxiety and worry over the plight of others. Frick et al. speculated that these children were more likely to have learned to exhibit conduct problems after experiencing harsh and inconsistent caregiving. Youth in this group also might exhibit deficits in verbal abilities. Although more information is needed to determine if subgroups exist, it is evident that those children with more severe symptoms, who do not care for the welfare of others, and who do not respond much to punishment are more likely to experience poor outcomes.

Assessment

There are several questions to ask to determine whether children and parents endorse symptoms of CD. Questions to ask include: (1) I take/steal things that don't belong to me, (2) I tell lies, (3) I fight and hit other children a lot, (4) I start fires, (5) I hit and yell at Mommy and Daddy, (6) I like to break rules, (7) I break or ruin other kids' and my family's things, and (8) I hurt animals (Kim-Cohen et al., 2005). Duncombe, Havinghurst, Holland, and Frankling (2012) developed a screening assessment tool for parents and teachers to complete that may assist health educators in making referrals for children who are exhibiting conduct problems. Parents and teachers complete seven questions assessing a child's: (1) attention, (2) fighting and bullying, (3) friendship skills, (4) impulsivity, (5) temper, (6) arguing, and (7) rule-breaking. Children's behaviors are rated on a 5-point scale from "0" never to "4" almost always. Some might argue that self-report could be biased and that health professionals should observe children's behaviors in the home and school

settings to have an accurate assessment of the child's functioning. If two informants are used, the types of questions outlined in this assessment section can yield valuable information, because children with severe conduct problems will exhibit the types of behaviors that are "very noticeable."

CD can be assessed in preschool. Early identification may offer opportunities to "turn around" problem behaviors. Questions assessing aggression toward peers and small animals can be useful. Moreover, questions examining impulsivity and the child's ability to follow rules and instructions are appropriate. In addition, learning whether the child can regulate his or her emotional reactions will provide other important information.

Management

There are several treatments that are effective in improving behavioral, social, and emotional functioning of children with conduct problems. For instance, problem-solving training is an effective treatment for children with CD. Children learn step-by-step processes for solving problems, and often use role play, with trained therapists coaching them, to learn how to control angry reactions and solve problems in positive ways. Problem-solving programs usually involve brainstorming to solve problems with "checking" to make sure that the problem-solving approach worked. In order to begin to learn a problem-solving approach, the child and his or her coach (a trained educator or therapist) typically develop two or three acceptable plans to solve a hypothetical social or behavioral problem. Then, they select a best course of action and it is implemented. The child then checks the results of the problem-solving plan to see if it was successful. If the approach was not successful, the child needs to problem-solve again or try another plan. The child needs to implement plan two and again check for its success. Due to their impulsivity and seeing hostility in others, children with conduct problems do not always select a prosocial solution or try to find another solution if their first one did not work. Children with conduct problems may need additional practice, using role plays, to learn problem-solving steps. They may need behavior charts with rewards and contracts, which are monitored by adults with knowledge of children's behavioral goals to ensure that they use problem-solving steps.

Children with CD may benefit from participating in anger management groups or individual counseling (Powell et al., 2011). Therapy goals, in addition to using role plays to learn positive behaviors, may include activities to ensure that children are more aware of their emotions and learn anger management skills. Children with conduct problems may tend to react aggressively and strongly and thus learning their "anger triggers" or cues that signal that they are going to become angry can be very important. Children need to learn their cues for anger and aggressive behaviors, and then need to learn to calm themselves, using relaxation or positive self-talk, and then implement problem-solving skills. Individual therapy sessions or groups are avenues for learning about personal triggers and emotional regulation

and problem-solving skills. Children with conduct problems also may need to learn perspective-taking skills, where they practice thinking how the other person may feel and thinking how their actions may influence others. This may be especially important if the child has relatively weaker skills for being empathic and for a child who may be unemotional or callous.

Parent training is another critical component for management of conduct problems in children. Parents may need training because they are inconsistent in their discipline or ineffective in using appropriate behavior management strategies with their child (Patterson & Stouthamer-Loeber, 1984). Webster-Stratton's Incredible Years, for example, is built on a parent-training component where parents watch videos to learn how to use praise and rewards and avoid harsh and critical parenting (Webster-Stratton, Reid, & Hammond, 2004). In training sessions, parents also learn to use appropriate consequences, such as loss of privileges or time-out, if the child is misbehaving. For time-out, a child is placed in a chair for 1 min for each year of age. After a period of quietly sitting (parents are not to talk back and forth with the child while he or she is in time-out), then the child can resume activities. The boredom associated with time-out or withdrawal from doing fun things and from attention is a consequence for the child. Response cost is another term for loss of privileges or loss of being able to participate in a valued activity. A response cost is an alternative to using time-out. A response cost needs to be clearly specified at a time when the child and parent are calm. During this "meeting" the parent can explain the one or two behaviors that will result in a response cost. For example, "if you hit your brother or sister, then you will lose 20 min of computer time." It is important to try not to take all privileges away from the child, because this can be very disheartening and some children may behave badly if all privileges are taken away for long periods of time. Making sure that the punishment is fair, in terms of actually being a cost and ensuring that the penalty is not too stiff, is part of the art of parenting.

Modeling appropriate behaviors through role play activities and when there are "teachable moments" during daily activities is another assignment for parents. Children "learn what they live" and opportunities arise for modeling positive behaviors during daily interactions. Involving children in groups and clubs with positive peer and adult role models can be avenues for finding positive role models for children. Role plays, in which specific prosocial scripts are reviewed, are other ways to "practice" positive social routines with a child. Developing a list of problem situations and then reviewing successful behaviors with a child through role play several times a week are a possible homework assignment for parents working with their child to improve negative behaviors.

Children with conduct problems may have difficulty monitoring the appropriateness of their own behavior. They may need to learn self-monitoring skills and positive self-talk for working out aggressive or negative reactions. The child needs to learn to "watch" or monitor his or her own behavior to ensure that he or she is stopping to think about positive responses. The child needs to talk him- or herself through a series of positive actions and then praise him- or herself for positive behaviors. The child may not do this on his or her own. The parent can be taught to model this behavior for the child and practice it with him or her on a regular basis.

The child also may benefit from having a reward chart where he or she earns stickers, which lead to treats and rewards, for those times that the child engages in self-monitoring. Parents need to ensure that the positive self-talk resulted in a positive outcome. Self-monitoring also can be used to control negative behaviors. Thus, a child can be self-monitoring to praise him- or herself for not behaving negatively toward others. A child is then rewarded for an absence of negative behaviors. Although this can seem like a "bribe" to some parents, it is important to explain that providing a reward for self-control and positive self-talk is a way to show children how important the behavior is to parents and a mechanism to help them pay attention to what they are doing. Rewards can be small, but it is important to ensure that the rewards are meaningful to the child.

Other skills are taught in parent training. Two of these skills are shaping appropriate behaviors and teaching anger management skills (e.g., expressing feelings and learning to control impulsive responding). In shaping of appropriate behaviors, parents are taught to model appropriate behaviors and reward children's approximations (small steps) toward a desired behavior. In terms of friendship skills, a first step might be to teach a child to greet another child. After the child has practiced the behavior, then the parent should praise and reward the child for his or her effort. If the child gains this skill, then a possible next step is to reward a child for learning how to ask to join in play with other children. Another goal might be working with a child to take turns in conversations with others. In a step-by-step process, each goal or task is broken into smaller, more manageable "chunks" of behavior and the child is praised or rewarded for mastery of each step in the chain of behaviors. In the long run, the child is learning better friendship skills, one skill at a time.

Another component of parent training might be teaching contingency contracting with an older child. This is a behavioral contract that "spells out" the desired behavior for a child. The child agrees to exhibit a behavior in return for a privilege or reward. At times the child signs the contract and at other times verbally agrees to the contract. There may often be consequences for misbehavior recorded in the contract. Contingency contracts may work better if they are specific in nature, spelling out the steps of the desired behavior in very clear language. Contingency contracting may be an effective tool if applied consistently without adopting a harsh or punitive attitude toward the child. Consequences need to be used consistently and fairly with children who have conduct problems.

Parents are also taught to spend time in child-directed play with their child, where the child is leading play and parents are supporting the child in his or her activities. This can be called "positive time." This time can help to "break up" the negative cycle of interactions that are occurring between a parent and child. Behavior can move in cycles and parents and children may be trading negative behaviors (Patterson, 1982). Accordingly, it may be child negative behaviors are influencing parent reactions in a negative manner. Although parents may be harsh with the child, it also is the case that the child's own negative behaviors bring out a harsh reaction in the parent. This bidirectional influence could play a role in the negative parent–child relationship cycle. Positive time with the child is on the child's own terms and the parent acts more like a sportscaster, talking about what the child is doing during play. The child selects the activities and as long as the child is not

aggressive or hurting people or property, the child continues to direct play and the interaction. The parent's role becomes more positive, rather than directive, during child-directed play sessions. These sessions can be short (10 min per day), but should occur consistently or routinely. Hawes, Price, and Dadds (2014) recommended that children and parents also engage in eye contact. They reported that reciprocal eye contact can promote emotional awareness and awareness of the other person in interactions. Hawes et al. emphasized parent–child engagement as key method for improving emotional connectivity of the child.

Furthermore, it is important to remember that child negative behaviors also can impact how parents react to their child. Thus, it is realistic to think that parent behavior could be influencing the child and child conduct problems could be influencing parent behaviors and this bidirectional influence could also play a role in the development of conduct problems displayed by young children.

Powell et al. (2011) examined teacher training to promote effective child behavior in school settings. With the exception of child-directed play, they recommended many of the principles mentioned in the preceding paragraphs can be applied at school. They recommended providing teacher training in the use of praise and rewards to help children learn positive behaviors and use self-control (e.g., self-control techniques involve breathing, relaxation, and positive self-talk to inhibit aggressive responses). They recommended the use of positive goal-setting with child monitoring (using monitoring charts can be helpful) to assist in teaching the child to monitor his or her own behaviors and begin to learn self-control.

Early intervention, in the preschool years, may prevent behavior problems in later years. Selecting children in the top 5 % of problem behaviors that involve aggression toward others and rule-breaking in the preschool period may yield an appropriate sample for intervention programs that target parent and teacher training in contingency management where adults learn the use of rewards, loss of privileges, and consequences and learn ways to consistently apply rules to help a young child improve his or her behaviors. Teachers and parents also may need to learn how to "tune in" to a child's emotional reactions and teach him or her to regulate emotions and learn routines for solving social and other behavioral problems in positive ways.

Medications

Wu et al. (2015) reviewed pharmacological treatments for conduct problems. The cursory review in this paragraph is very general, and professionals working with children with CD should consult child psychiatrists to learn more about medication management. Wu et al. mentioned several medications that were successful in reducing aggressive behaviors exhibited by children with CD. Antipsychotic medications, such as thioridazine, have reduced aggression. However, these types of medications can cause motor movements and impact motor behaviors. Wu et al. reported that nontraditional antipsychotic medications, like risperidone, can reduce children's aggressive behaviors, without as significant of effects on motor

symptoms. Stimulant medications, such as those used to treat Attention-Deficit Hyperactivity Disorder, may also have a positive influence on children's behaviors. Antihypertensive medications, most notably clonidine, have been used to treat children with CD. This drug can have a positive impact on behaviors, but has side effects such as drowsiness, weakness, and constipation. Although medication management is a helpful tool in the treatment of CD, a thorough evaluation of the child's functioning is needed. In the long run, combined medication and behavioral/psychological treatments are frontline interventions for children with CD.

Psychosocial Functioning

Children who have conduct problems can be very aggressive (Okado & Bierman, 2015). Young children who are very aggressive and cannot regulate their mood, especially in terms of reacting in anger or aggressively toward others, may be at risk for conduct problems as they age (Okado & Bierman, 2015). Children with CD can be cruel to peers and adults. They can be described as lacking feelings for others and not caring for the well-being of others (Blair et al., 2014). Children with emotional dysregulation and aggression are likely to face peer rejection and difficulty forming positive social relationships. As mentioned, children with conduct problems may be unemotional (Frick et al., 2013). Hawes, Price, and Dadds (2014) mentioned that callous and unemotional traits (i.e., limited prosocial emotions) are a hallmark feature of this diagnosis. Consequently, children with conduct problems might not respond or respond very minimally to distress in other individuals. They may be overly sensitive to threat in the behavior of others and see aggression and hostility in others' behaviors, even if the behaviors were not intended to be aggressive. This may cause children to quickly respond to events that most would consider as being "neutral" in terms of their meaning in a hostile or aggressive manner. If CD persists from the childhood years, then the youth is at risk for substance abuse problems, truancy, and criminal behaviors (e.g., stealing; Blair et al.).

When CD is left untreated or if the child is unresponsive to treatment, psychiatric problems in adulthood are possible (Hawes et al., 2014). Rouquette et al. (2014) found an association between conduct problems in children involving aggression, oppositional and defiant behavior, hyperactivity, fearfulness and feelings of helplessness and having a diagnosis of CD in adolescence. More research into the link between feelings of helplessness and fear and conduct problems will be needed, because these types of behaviors are not always synonymous with conduct problems in other studies. It may be that overly harsh parenting, a lack of emotional connection with others, and seeing the world as a hostile place lead to feelings of fear and helplessness. These types of feelings could lead to more aggressive behaviors. This idea is speculative, and needs to be explored in future longitudinal studies assessing children's psychological functioning and feelings and reactions over extended periods of time.

There may be a physiological explanation related to the diagnosis of CD, especially in boys. Herpertz et al. (2005) found that autonomic responsiveness to stimuli that might be expected to cause a positive or negative emotional reaction was very low in boys with CD. They concluded that boys with CD were very low in physiological responsiveness (e.g., heart rate) to stimuli that might be expected to cause physiological arousal in children without this diagnosis. If boys with conduct problems are under-reactive and they react less to emotion-provoking stimuli, this may be why they are considered unemotional or callous. Youth who are under-responsive may seek stimulation or tolerate high stimulation experiences at a different level than children with what might be considered a more normal physiological reaction to fear-producing stimuli. This phenomenon needs to be studied in depth as many of the participants had other diagnoses, and studies with girls are needed. However, it provides an intriguing consideration for some of the behaviors displayed by males diagnosed with conduct problems.

Children with conduct problems may attribute hostile intentions to others' behaviors (Powell et al., 2011). Dodge (1980) is one of the first researchers to discuss this hostile attribution bias. In his experiments, Dodge showed that children who were classified as being aggressive were more likely to attribute hostile intentions to another child's behavior in ambiguous situations. This was especially true if the outcome of the ambiguous situation was negative for a character described in the situation. The ideas of a hostile attribution bias became a cornerstone of understanding aggressive behaviors for years. Children with conduct problems are deficient in skills for emotional regulation and understanding emotions in social exchanges, which makes teaching them social problem solving very important.

Parent discipline may be inconsistent and harsh (Kazdin, 1997; Kim-Cohen et al., 2005). Parents can display less warmth (hostile parenting may occur) and more inconsistent levels of punishment, but this pattern of behavior may not directly influence conduct problems (Okado & Bierman, 2015). Furthermore, parents can have a history of psychiatric problems or criminality (Powell et al., 2011). Negative behaviors related to psychiatric instability may also influence an inconsistent parenting style and can be related to attachment difficulties between the parent and child. It may be that parents have no role models for positive parenting skills and learning these skills can help them teach their child how to behave.

Interventions

Several training programs, which involve a parent training component, are reviewed in this section of the chapter. There are many effective training programs for parents, which are combined with child and school interventions. The reader is guided to an expert review by Furlong et al. (2013). This review is a Cochrane Review and these reviews are very useful and typically present information on evidence-based interventions. The interventions presented in this section have a heavy

parent-training component and the articles are centered on early intervention. Early intervention, in the preschool years, is recommended by experts (Kim-Cohen et al., 2005).

The Conduct Problems Prevention Research Group (2011) examined outcomes for the Fast Track Intervention. Children at high risk for conduct problems were identified in kindergarten and followed from 3rd through 12th grade. These children were diagnosed with a variety of externalizing disorders including Attention-Deficit Hyperactivity Disorder, ODD, CD, and other externalizing problems (e.g., Disruptive Behavior Disorder). Parents participated in behavior management training (there were also home visits) and children learned problem-solving and social skills (participation in friendship groups). In addition, classroom behavior and academic skills training were provided. Children participating in the intervention have exhibited more positive behaviors and fewer negative behaviors, such as aggressive behaviors. Children who were assigned to treatment were less likely to be diagnosed with CD or ODD over time. These results are important, because they show that the trajectory toward negative and conduct problems can be turned around in a positive direction.

The Incredible Years Program can be used with very young children. This program was developed by Webster-Stratton to treat conduct problems in preschool-age children (e.g., Webster-Stratton et al., 2004). Posthumus, Raaijmakers, Maassen, Van Engeland, and Matthys (2012) provided a summary of the Incredible Years Program (more information is available at http://incredibleyears.com/, accessed January 2, 2016). This program provides parent training through observation and discussion of parent–child interactions presented on videotape. A group leader discusses appropriate parenting practice such as use of praise, rewards, child-directed play (the child directs the play interaction with the parent), limit-setting, handling misbehavior, and how to use positive and consistent guidelines with children. There also is an advanced component to this program which involves more information about communication skills and how to problem-solve. In addition, Webster-Stratton and Reid (2010) mentioned that including a teacher training component as part of the Incredible Years programming can assist in teachers in working with children to use encouragement, incentives (rewards), and support child emotion-regulation, social skills development, and problem-solving skills development in the school setting.

Posthumus, Raaijmakers, Maassen, Van Engeland, and Matthys (2012) examined the effectiveness of the Incredible Years Program with a sample of preschool-age children (4 years) from the Netherlands. Parents met with experts and watched over 200 videotaped interactions of parent–child interactions. There was a control group, but this was not a randomly assigned group. The children also were displaying aggression. Child progress was assessed using parent report on surveys and observations of videotapes of parent–child interactions in the home. Results indicated that parents were less critical (using lower levels of critical statements with their child) after participating in treatment and the results "held" in a 2-year follow-up study. Parent use of praise was improved after the intervention ended; however, this gain was not maintained at the 2-year follow-up assessment. Posthumus et al. reported that parent behavior had a strong impact on children over time for parents who received treatment. Conversely, child behavior did not continue to exert a

strong impact on parent behavior. This could be an important finding, because parents could be continuing to positively influence the child and could have acquired skills to help them stop or reduce their critical and harsh reactions to child misbehavior. This could mean that the harsh cycle of negative behaviors between the parent and child was disrupted. Posthumus et al. mentioned that the Incredible Years Program is effective in reducing problem behavior in young children. Thus, the Incredible Years Program had a positive impact, but more research is needed to determine if this program actually helps to prevent CD from developing.

Hutchings et al. (2007) examined the influence of the Incredible Years Program in a large-scale trial in England, with preschoolers. They used parent report of behavioral progress and observations in the home to record child progress in changing disruptive behaviors. Children showed reductions in disruptive and hyperactive behaviors. Parents reported greater competence in their parenting skills. Hutchings et al. recommended that in the future researchers should examine the fidelity with which the program was delivered. This means examining whether the intervention programs was delivered according to the steps outlined in the manual.

Havighurst et al. (2015) examined the effectiveness of an emotion-focused coping program for elementary school-aged children with behavior problems and their caregivers. They intervened with children, in kindergarten through third grade (5–9 years of age), who were in the top 8 % in terms of displaying disruptive behavior problems. Their goal was to teach children appropriate skills before behavior problems strengthened in intensity. They used the Turning In To Kids Program; this program is oriented toward emotions and problem-solving. The Turning In To Kids Program teaches parents to help the child recognize and understand his or her emotional experience and teach the child problem-solving skills. The child learned to regulate his or her emotions and implement appropriate behaviors. There was a child, parent training, and school component. Children learned emotional competence and problem-solved different social situations in small groups. Teachers learned a curriculum that emphasized social problem-solving, self-control, and emotional coping. Parents learned similar skills. Children who participated in the intervention showed improvements in their abilities to understand others' emotions.

Roles for Health Educators

Health educators have varied roles to play in the care of children with conduct problems, depending on their training and their areas of expertise. If the child has more severe problems, then specialized training would probably be needed to provide services. Training in setting limits and safety training (training focusing on keeping the child and professional safe if the child is aggressive) are necessary for those who desire to help children with severe conduct problems on special inpatient units. A long course of treatment with therapeutic aftercare in group home settings may be necessary for children with severe conduct problems. Learning to follow rules, respect others' personal boundaries, and follow rules would be a few of the

skills the health educator would need to implement in inpatient and group home settings. The health educator or counselor would benefit from receiving specialty training in parent training programs for children with disruptive and oppositional behaviors. The health educator or counselor would need to gain knowledge about teaching parents how to set limits, give clear instructions, establish and remain consistent about consequences, and use rewards and praise appropriately. Teaching parents about steps for shaping positive behaviors and steps for problem-solving with the child would be important skills to teach parents. When children are younger, working on eye contact could be another component of parent training. The health educator or counselor would need similar knowledge of behavior management skills and teaching social skills and problem-solving when working with teachers and other school staff. Interventions with children who have conduct problems are often intensive and long term. The health educator needs to care for his or her own mental, physical, and spiritual health in order to "go the distance" in terms of continuing with treatment.

Case Study

Larry was an elementary student who was referred to the school mental health counselor for cutting a girl's pigtail with his scissors. His teacher was very upset. She reported that Larry had problems getting along with the other boys and girls. He was frequently in fights with other boys and girls on the playground and in the neighborhood. She also stated that he never completed his homework and tended to make noise and talk with others, disrupting the classroom and making it difficult for the other children to complete their work. He tended to argue with the teacher, which she described as "talking back and being rude and disrespectful to adults." Larry's teacher had been having difficulty reaching his grandmother, who was his legal guardian. His mother was using drugs and the family did not know where she was. There was not information on Larry's father, and Larry had never met him.

The school counselor was able to reach Larry's grandmother for an interview. His grandmother provided consent for the counselor to work with Larry. At her interview, Larry's grandmother appeared distraught and said she was unsure of how to help Larry. She admitted that Larry was very difficult to manage at home. In fact, she reported that she had given up trying to teach Larry how to behave. He was very rough with his siblings, bruising them and pulling their hair (his grandmother reported that his siblings had bald spots). She mentioned that Larry had almost set the house on fire while rewiring the toaster for an "experiment." He also experimented with cats in the neighborhood, pulling out their hair. His grandmother said that she had questioned Larry about the cats, but did not receive clear information about why he was harming them. His grandmother said, "I feel like I need to sleep with one eye open with Larry. I never know what he will do next and I don't think he cares for the feelings of others."

At his interview, Larry seemed somewhat detached and uncaring. He showed no emotion and never reported feelings of caring of others. Larry stated that he cut the

girl's pigtail to test how sharp his scissors were. When asked about his friendships at school Larry replied, "They all know that I am the toughest kid in this school and I rule." Larry said he liked to rule others in his gang in the neighborhood, which he created. Larry said he created the "Rule Gang to be like the guys who have gangs in L.A. (Los Angeles)." When asked about his experiment with the toaster, Larry stated that he wanted to see if he could create fire. He reported that he and members of his school gang often met after school to try to start fires in the woods nearby the school. Larry admitted that he liked hurting cats. As far as his brothers and sisters, Larry said that he hurt them and did not really care about it.

The school counselor was alarmed at Larry's lack of feeling for other children and small animals. Larry did not feel he had to follow rules. He did not show empathy for others and appeared callous and unemotional. Larry did not appear to be forming close, loving relationships with any adults or children in his life. The counselor called a nearby children's mental health center with an inpatient unit. The counselor arranged an intake meeting with Larry and his grandmother. The school social worker arranged for a taxi to transport Larry and his grandmother to the mental health center.

At the intake session at the inpatient center, Larry admitted to killing a small cat to see what this felt like. He admitted to stealing money from his grandmother's wallet. Larry showed no remorse for harming others and stealing. He admitted to setting fires. He said he had rewired the toaster at home to turn it into a fire machine, because he wanted to try setting the house on fire. Larry admitted to setting many small fires in the woods and in his neighborhood.

Larry's grandmother cried during most of the interview. She said that, "I can't handle Larry, and his little sisters are so afraid of him. He hurts them every week and they have bruises and bald spots." Larry did not have any relatives who were willing for him to live with them. They had known of his aggressive and harmful behaviors and felt that he would harm others in their family. His mother could not be located. Larry's grandmother reported she did not want custody of Larry anymore and repeated that our family "can't handle him."

Larry was remanded to custody of the state and referred for an inpatient hospital stay. During this stay he participated in intensive therapy, group counseling, and was followed by a psychiatrist. His placement was at a juvenile center with other boys who had conduct problems. Treatment in this setting involved a great deal of supervision and structure. Children received rewards and privileges for appropriate behavior. They participated in daily group counseling and had their own individual counseling sessions. They were followed by a child psychiatrist. After completing his inpatient stay, he was going to be discharged to a therapeutic group home.

Summary

This chapter presented a brief overview of conduct problems in children. Behaviors that are disruptive to a significant degree, exemplify a marked disregard for social rules, and are aggressive can indicate serous conduct problems. For young children,

parent interventions aimed at improving child social behavior and reducing negative behaviors (e.g., impulsivity, aggressiveness, and rule-breaking) may have an impact and reduce the chance that serious behavior problems will persist. Child training is important in order for children to learn social problem-solving skills and receive training to improve emotion regulation and friendship skills. Children need to learn to curb aggressive and hostile reactions. School-based training for teachers can be a critical component of an intervention program. There are many interventions, and those interventions that were presented in this chapter offer a brief glimpse of some of these effective interventions. Interested readers are encouraged to receive additional training and practice under supervision of experts in the field to gain experience in the treatment of conduct problems. Reduction in conduct problems can improve functioning of children, reduce school failure, and address patterns of aggression and rule-breaking behaviors that involve significant problems in social settings.

Exercises/Review Questions

1. What are key questions for assessment of conduct problems in children?
2. Is a genetic or environmental explanation more appropriate (or perhaps neither one) for the development of CD in children?
3. What is a hostile attribution bias? How could this be problematic in young children's peer interactions?
4. Search the internet for information about the Incredible Years Program. If you were running a community mental health center, would training in this program be beneficial for counselors in your program? Please provide details related to your opinion about this program.
5. What types of interventions would you focus on, if you were asked to develop a teacher training program for children with conduct problems? Please use the internet to search for ideas in addition to utilizing information presented in this chapter.

Key Concepts

Oppositional defiant disorder
Conduct disorder
Prosocial behaviors
Callous and unemotional traits
Problem-solving approach to working with children with conduct disorders
Modeling appropriate behaviors
Shaping appropriate behaviors
Hostile attributions toward others' behaviors
Fast Track Intervention
Positive time with children
Incredible Years Program
Turning to Kids Program

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andrade, B. F., & Tannock, R. (2012). The direct effects of inattention and hyperactivity/impulsivity on peer problems and mediating roles of prosocial and conduct problem behaviors in a community sample of children. *Journal of Attention Disorders, 17*(8), 670–680. doi:10.1177/1087054712437580.

Blair, R. J. R., Leibenluft, E., & Pine, D. S. (2014). Conduct disorder and callous–Unemotional traits in youth. *New England Journal of Medicine, 371*(23), 2207–2216.

Conduct Problems Prevention Research Group. (2011). The effects of the fast track preventive intervention on the development of conduct disorder across childhood. *Child Development, 82*(1), 331–345.

Dodge, K. A. (1980). Social cognition and children's aggressive behavior. *Child Development, 51*, 162–170.

Duncombe, M. E., Havighurst, S. S., Holland, K. A., & Frankling, E. J. (2012). Psychometric evaluation of a brief parent- and teacher-rated screen for children at risk of conduct disorder. *Australian Journal of Educational and Developmental Psychology, 12*, 1–11.

Eisenberg, N., Sadovsky, A., Spinrad, T. L., Fabes, R. A., Losoya, S., Valiente, C., … Shepard, S. A. (2005). The relations of problem behaviour status to children's negative emotionality, effortful control, and impulsivity: Concurrent relations and prediction of change. *Developmental Psychology, 41*, 193–211.

Frick, P. J., Ray, J. V., Thornton, L. C., & Kahn, R. E. (2013). Can callous-unemotional traits enhance the understanding, diagnosis, and treatment of serious conduct problems in children and adolescents? A comprehensive review. *Psychological Bulletin, 140*(1), 1–57. doi:10.1037/a0033076.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2013). Cochrane review: Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. *Evidence-Based Child Health: A Cochrane Review Journal, 8*(2), 318–692.

Havighurst, S. S., Duncombe, M., Frankling, E., Holland, K., Kehoe, C., & Stargatt, R. (2015). An emotion-focused early intervention for children with emerging conduct problems. *Journal of Abnormal Child Psychology, 43*(4), 749–760. doi:10.1007/s10802-014-9944-z.

Hawes, D. J., Price, M. J., & Dadds, M. R. (2014). Callous-unemotional traits and the treatment of conduct problems in childhood and adolescence: A comprehensive review. *Clinical Child and Family Psychology Review, 17*(3), 248–267. doi:10.1007/s10567-014-0167-1.

Herpertz, S. C., Mueller, B., Qunaibi, M., Lichterfeld, C., Konrad, K., & Herpertz-Dahlmann, B. (2005). Response to emotional stimuli in boys with conduct disorder. *American Journal of Psychiatry, 162*(6), 1100–1107.

Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., … Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *BMJ Online First, 334*(7595), e1–e7. doi:10.1136/bmj.39126.602799.55.

Kazdin, A. E. (1997). Practitioner review: Psychosocial treatments for conduct disorder in children. *Journal of Clinical Psychology and Psychiatry, 38*(2), 161–178.

Kim-Cohen, J., Arseneault, L., Caspi, A., Tomás, M. P., Taylor, A., & Moffitt, T. E. (2005). Validity of DSM-IV conduct disorder in 4 ½–5-year-old children: A longitudinal epidemiological study. *American Journal of Psychiatry, 162*(6), 1108–1117.

Maughan, B., & Rutter, M. (2001). Antisocial children grown up. In J. Hill & B. Maughan (Eds.), *Conduct disorders in childhood and adolescence* (pp. 507–552). Cambridge, England: Cambridge University Press.

Okado, Y., & Bierman, K. L. (2015). Differential risk for late adolescent conduct problems and mood dysregulation among children with early externalizing behavior problems. *Journal of Abnormal Child Psychology, 43*(4), 735–747.

Olson, S. L., Lopez-Duran, N., Lunkenheimer, E. S., Chang, H., & Sameroff, A. J. (2011). Individual differences in the development of early peer aggression: Integrating contributions of self-regulation, theory of mind, and parenting. *Development and Psychopathology, 23*, 253–266.

Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia Press.

Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development, 55*(4), 1299–1307.

Posthumus, J. A., Raaijmakers, M. A., Maassen, G. H., Van Engeland, H., & Matthys, W. (2012). Sustained effects of Incredible Years as a preventive intervention in preschool children with conduct problems. *Journal of Abnormal Child Psychology, 40*(4), 487–500.

Powell, N. P., Boxmeyer, C. L., Baden, R., Stromeyer, S., Minney, J. A., Mushtaq, A., & Lochman, J. E. (2011). Assessing and treating aggression and conduct problems in schools: Implications from the Coping Power program. *Psychology in the Schools*, *48*(3), 233–242. doi: 10.1002/pits.20549.

Rouquette, A., Côté, S. M., Pryor, L. E., Carbonneau, R., Vitaro, F., & Tremblay, R. E. (2014). Cohort profile: The Quebec longitudinal study of kindergarten children (QLSKC). *International Journal of Epidemiology, 43*(1), 23–33. doi:10.1093/ije/dys177.

Silberg, J. L., Maes, H., & Eaves, L. J. (2012). Unraveling the effect of genes and environment in the transmission of parental antisocial behavior to children's conduct disturbance, depression and hyperactivity. *Journal of Child Psychology and Psychiatry, 53*(6), 668–677.

Tolan, P. H., Dodge, K., & Rutter, M. (2013). Tracking the multiple pathways of parent and family influence on disruptive behavior disorders. In P. H. Tolan & B. L. Leventhal (Eds.), *Disruptive behavior disorders, advances in developmental psychopathology: Brain research foundation symposium series* (pp. 161–192). New York, NY: Springer. doi:10.1007/978-1-4614-7557-6_7.

Webster-Stratton, C., & Reid, M. J. (2010). The Incredible Years parents, teachers, and children training services. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 194–201). New York, NY: Guilford.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early conduct problems: Intervention outcomes for parent-, child- and teacher training. *Journal of Clinical Child and Adolescent Psychology, 33*, 221–239.

Wu, T., Howells, N., Burger, J., Lopez, P., Lundeen, R., & Sikkenga, A. V. (2015). Conduct disorder. In G. M. Kapalka (Ed.), *Treating disruptive disorders: A guide to psychological, pharmacological, and combined therapies* (pp. 120–143). New York, NY: Routledge.