TDMHSAS BEST PRACTICE GUIDELINES

Disruptive Behavior Disorders in Children and Adolescents

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Disruptive Behavior Disorders include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Sometimes Attention-Deficit/Hyperactivity Disorder (ADHD) is included in this category, but ADHD is treated in a separate section within these guidelines.

Contributing Factors

Recent literature identifies several factors related to the development of disruptive behaviors. It is important to note that separate pathways for the development of disruptive behaviors and impulsive/hyperactive behaviors have been proposed, with little genetic evidence emerging as a causal factor for conduct problems, while genetic links to ADHD are quite abundant. Although not discounted as a factor for the development of disruptive, currently there is little evidence for a genetic basis for behavior problems. Genetic contributions to childhood aggression appear to be relatively small (Jacobson, Prescott, & Kendler, 2002) and psychobiological influences are at best inconclusive (Hinshaw & Lee, 2003). Instead, a large emphasis is placed on the multifaceted and transactional causal factors for disruptive behaviors (Coie & Dodge, 1998; Hinshaw & Lee, 2003). The literature concerning underlying factors for disruptive behaviors converges on environmental factors. Most importantly, high levels of parental psychopathology, poverty, poor family functioning, dysfunctional parent-child interactions, and child abuse are thought to play a role in the severity of disruptive behaviors in children (Coie & Dodge, 1998). Associated variables with disruptive behaviors include, but are not limited to, cognitive deficits (Moffit & Lynam, 1994), difficulties in social-cognitive information processing (Crick & Dodge, 1994), and peer rejection (Coie & Dodge, 1998).

Prevalence

Although the prevalence of conduct problems varies depending on the definition used, in a literature review conducted by Hinshaw and Lee (2003), the prevalence in studies of children and adolescents with ODD ranged from 1 percent to more than 20 percent, while the prevalence

for CD ranged from less than 1 percent to over 10 percent. The progression of conduct problems appears to remain somewhat stable from early childhood to later childhood (Broidy, et al., 2003; Campbell, 1991; Olweus, 1979). Furthermore, studies have shown that ODD characteristics emerge 2 to 3 years earlier in childhood than do CD symptoms (Lahey et al., 1997; Loeber, et al., 1992; Loeber & Farrington, 2000), with the average age of onset for ODD being 6 years compared to 9 years for CD behaviors. Approximately 33 percent of children with ODD subsequently develop conduct disorder, 40 percent of whom will develop antisocial personality disorder in adulthood (Loeber, et al., 2000).

Developmental Trajectories

Despite some evidence that ODD is a developmental precursor to CD, a majority of children with ODD symptoms never develop the more severe conduct problems associated with CD (Loeber, Lahey, & Thomas, 1991). Specifically, about 67 percent of youth with ODD do not meet criteria for the diagnosis after a 3-year follow-up (AACAP, 2007). Adding evidence to this finding, Frick et al. (1993) conducted a meta-analysis of factor analyses of disruptive child behaviors, resulting in four clusters of conduct problems: oppositional, status violations, property violations, and aggression. The behaviors were categorized by the overlay of two continuums representing the dimensions of overt-covert behavior and destructive-nondestructive behavior. As the majority of ODD symptoms fell into the quadrant of overt-nondestructive behaviors, Hinshaw and Lee (2003) suggest that ODD appears to be a separate and coherent pattern of behaviors from other antisocial behaviors.

Concerning the developmental trajectories of conduct problems, the early starter and late starter pathways are becoming increasingly accepted (McMahon, 1994) and are reflected in the CD subtypes of Childhood-Onset and Adolescent-Onset in the *DSM-IV-TR* (APA, 2000). The early starter pathway is characterized by conduct problems and social skills deficits originating in school-age years with increasingly severe behaviors developing through adolescence and adulthood. This is evidenced by results from the Oregon Youth Study (OYS) longitudinal data demonstrating that antisocial behaviors by boys in grade 4 significantly predicted future delinquency (Patterson, Capaldi, & Bank, 1991). The early starter pathway is thought to consist of a relatively small group of children, mostly boys, who are at high risk for accelerated and chronic conduct problems and psychopathology (Moffit, 1993).

On the contrary the late starter pathway represents a larger group of children and is thought to begin in adolescence rather than childhood, consist of less serious conduct problems, be influenced by a deviant peer group, and have a short duration (Moffit, 1993; Patterson et al., 1991). The tendency for late starters is to experience a surge of antisocial behavior during adolescence; however, they are supposedly at less risk for chronic offending and continued conduct problems into adulthood, as they presumably possess higher levels of social skills. Further, this same research has demonstrated that late starters do not have the childhood history of cognitive deficits, learning difficulties, preexisting family adversity, or motor skill problems such as early starters exhibit (Patterson et al., 1991).

Conclusions regarding the viability of the early and late starter models, although gaining in popularity, are also challenged with competing models. Specifically, Loeber and Hay (1997) found evidence identifying three developmental pathways for conduct problems. These included the Overt Pathway with increasing levels of aggression, the Covert Pathway with concealed problem behaviors, and the Authority Conflict Pathway with oppositional and avoidance behaviors towards authority figures. Much like the early starter model, the overt pathway is thought to better describe children who experience a progressive escalation of conduct problems over time compared to those who are experiencing transitory or temporary ones. Thus, regardless of the model used to explain the progression of conduct problems, the prognosis appears to worsen with signs of early aggressive acts that are likely to predict more severe problems over time (Moffit, 1993; Serbin, Schwartzman, Moskowitz, & Ledginham, 1991).

Epidemiological Theories

Despite the contributing influences to the initial appearance of disruptive behaviors, their maintenance may depend on complex cognitive processes and environmental interactions. Two such well-researched mechanisms for continued behavior problems are social-information processing (Crick & Dodge, 1994; Lemerise & Arsenio, 2000) and coercive parent-child interactions (Patterson, 1982, 2002). The social information-processing model describes how cognitive distortions and deficiencies combine with emotional processes and social contexts to result in socially incompetent behavior for children. This pattern holds true for both peer relationships and responses to authority figures (Dodge & Price, 1994). In a coercive parent-child interaction, bi-directional exchanges between the parent and child become increasingly coercive and cyclical in nature, further intensifying the child's disruptive behaviors and the parent's inconsistent discipline practices. In addition to affecting family functioning, the coercive cycle also begins to generalize to the child's interactions with peers and teachers (Patterson et al., 1992).

DSM-IV-TR Criteria for Disruptive Behavior Disorders
(American Psychiatric Association, 2000)

Oppositional Defiant Disorder (ODD)

- A pattern of negativistic, hostile, and defiant behavior that lasts at least 6 months and at least four of the following behaviors are present (Criterion A)*:
  1. often loses temper
  2. often argues with adults
  3. often actively defies or refuses to comply with adults' requests or rules
  4. often deliberately annoys people; often blames others for his or her mistakes or misbehavior
  5. is often touchy or easily annoyed by others
  6. is often angry and resentful
  7. is often spiteful or vindictive

*****Behaviors (items 1-7 above) must occur more frequently than is typically observed in children with similar developmental level and of comparable age

- Behavior causes clinically significant impairment in social, academic, or occupational functioning (Criterion B)

- Behaviors do not occur exclusively during course of a Psychotic or Mood Disorder (Criterion C) and criteria for Conduct Disorder or (if older than 18 years) Antisocial Personality Disorder are not met (Criterion D).

Differential Diagnosis

- Mood disorder
- Conduct disorder
- ADHD
- Substance abuse
- Intellectual Disability
- Impaired language comprehension
- Psychotic disorder
- Severe delinquent behavior
- Normal individualization (i.e., in adolescence)
- Intellectual Disability (mild to moderate forms)

Comorbidity

- 36 percent of females and 46 percent of males with ODD met criteria for at least one other disorder (Oppositional Defiant & Conduct Disorders, 2005)
- 50-65 percent of ODD youth have an accompanying diagnosis of ADHD
- 35 percent develop some form of affective disorder
- 20 percent exhibit some form of mood disorder

Developmental Considerations. Typically, ODD is not diagnosed in children between the ages of 18-36 months when similar behaviors are considered normative for that age group (Rapoport & Ismond, 1996). For example, temper tantrums are one of the DSM-IV criteria for ODD. Yet, temper tantrums are common behaviors in children between the ages of 2 and 3 years. After age 3, children become more able to express their frustrations in socially acceptable ways (Hall & Hall, 2003). ODD is better diagnosed in late preschool or early school years (AACAP, 2007).

Conduct Disorder (CD)

- The DSM-IV-TR (APA, 2000) categorizes CD behaviors into four main groupings: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b)

non-aggressive conduct that causes property loss or damage, (c) deceitfulness or theft, and (d) serious violations of rules. CD consists of a repetitive and persistent pattern of behaviors in which the basic rights of others or major age-appropriate norms or rules of society are violated. Typically the youth exhibits at least three of the following behaviors within the past 12 months, one or more of which occur in the past 6 months (Criterion A).

Aggression to people and animals

1. often bullies, intimidates, or threatens others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a gun, knife, broken bottle, bat, brick)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., extortion, mugging, purse snatching, armed robbery)
7. has forced someone into sexual activity

Destruction of property

1. has deliberately destroyed property of others (but not by fire setting)
2. has deliberately engaged in fire setting with the intention of causing serious damage

Deceitfulness or theft

1. has broken into someone else's car, house, or building
2. often lies to obtain favors or goods, or to avoid obligations (i.e., "cons" others)
3. has stolen items of nontrivial value without confronting a victim (e.g., forgery; shoplifting, but without breaking and entering)

Serious violations of rules

1. beginning before age 13, often stays out at night despite parental prohibitions
2. has run away from home overnight two or more times while living in home of parent or surrogate parent (or once without returning for a lengthy period)
3. beginning before age 13, is often truant from school

- The disturbance causes clinically significant impairment in academic, social, or occupational functioning (Criterion B)
- If the person is at least 18 years of age, criteria are not met for Antisocial Personality Disorder (Criterion C)
- CD is further indicated by age of onset as Childhood-Onset Type (onset of at least one characteristic of CD prior to age 10 years), Adolescent-Onset Type (absence of CD characteristics prior to age 10 years), or Unspecified Onset (age of onset unknown)
- CD is also specified by level of severity as being Mild (few conduct problems), Moderate (intermediate symptoms between “Mild” and “Severe”), and Severe (many conduct problems or conduct that causes considerable harm to others).

Differential Diagnosis

- Oppositional Defiant Disorder
- Mood Disorder
- ADHD
- Substance abuse
- Intellectual Disability
- Impaired language comprehension
- Psychotic disorder
- Severe delinquent behavior
- Normal individualization (i.e., in adolescence)

Comorbidity of Conduct Disorder.

- Comorbid ADHD is found in 25 percent of youth diagnosed with CD (Oppositional Defiant & Conduct Disorders, 2005)
- Children with ADHD are 2.5 times more likely to have early onset CD (Coghill, 2007)
- 39 percent of girls and 46 percent of boys with CD meet criteria for at least one other disorder
- An almost equivalent proportion of girls (12 percent) and boys (14 percent) with CD also have depression
- Girls diagnosed as CD are at greater risk of anxiety and depression
- More girls (16 percent) with CD have comorbid anxiety than boys (10 percent) (Child Research Net, 2004)

Disruptive Behavior Disorder Not Otherwise Specified (DBD NOS)

If conduct and oppositional defiant behaviors do not meet criteria for ODD or CD, a diagnosis of DBD NOS may be warranted. However, if the youth's behavior problems are subclinical to a diagnosis of ODD or CD, the behaviors must contribute to clinically significant impairment in the youth's functioning to constitute a diagnosis of DBD NOS. A diagnosis of DBD NOS should not be given if the symptom can be better accounted by a mood disorder, anxiety disorder, adjustment disorder, or ADHD.

Screening/Evaluation for Disruptive Behavior Disorders

AACAP Screening/Evaluation Recommendations

The AACAP (2007) delineated recommendations that address screening and/or evaluation for ODD and provided 11 recommendations for clinicians. Of the 11 AACAP recommendations, the first 6 recommendations focus solely on screening/evaluation, while the remaining 5

recommendations address treatment issues and are presented later in the treatment section. Although the AACAP recommendations are specific to ODD, they are based on a thorough review of the literature and clinical consensus regarding disruptive behaviors in general. Each recommendation falls into one of the following categories of endorsement: 1) **MS** – minimal standards; 2) **CG** – clinical guidelines; 3) **OP** – options; or 4) **NE** – not endorsed (AACAP, 2007).

- **MS**-designated recommendations are based on substantial empirical evidence (as obtained in well-controlled, double-blind trials) and expected to apply more than 95 percent of the time. The medical record should be well documented when the clinician does not adhere to standards of this nature in particular cases.
- Open trials and case studies typically provide evidence for **CG** standards. These standards tend to be applicable 75 percent of the time and there are typically exceptions to their application.
- **OP** standards might be considered, but are not required. For certain cases, they may offer the best treatment option, but there are times when these practices should be avoided altogether
- **NE** identifies that the practice is known to be ineffective or contraindicated.

- ***Recommendation 1****. Therapeutic alliances with the child and his/her family must be established to ensure successful assessment and treatment of disruptive behavior disorders.* Alliances with the parents and the child need to be established separately. Clinicians must quickly clarify their role as "helper" to the child. The best way to engage the youth is to empathize with his/her anger and frustration while failing to sanction oppositional/aggressive behavior. Likewise, the clinician must convey empathy with the parents' frustration without making them feel accused, judged, or that they have an ally. (**MS**)
- ***Recommendation 2****. Active effort must be made to address cultural issues in the diagnosis and treatment of disruptive behavior disorders.* Different ethnic subgroups have different standards of obedience and parenting and these differences are can be overlooked if the clinician and client do not share the same backgrounds. Therefore, clinicians should make every effort to be sensitive to areas of mismatch and be prepared to be educated. This sensitivity is especially critical in disruptive behavior disorders because discipline becomes a core point of discussion in every case. (**MS**)
- ***Recommendation 3****. Assessment of disruptive behavior disorders must include information obtained directly from the child, as well as from the parents/caregivers, regarding the core symptoms; age of onset; duration of symptoms; and degree of functional impairment.* It is important to distinguish ODD from typical oppositional behavior, transient antisocial acts, and CD. A functional behavioral analysis will assist in the identification of antecedents and consequences of the youth's behavior, as well as behaviors of parents' and others in the child's life. The youth's access to weapons and involvement in bullying should also be evaluated. In all cases, multiple settings, processes, and informants need to be considered for an exhaustive screening and/or evaluation. (**MS**)
- ***Recommendation 4****. Clinicians should pay careful attention to significant comorbid psychiatric disorders when diagnosing and treating disruptive behavior disorders.* Comorbidity of disruptive behavior disorders and ADHD is common and results in a poor prognosis. Young people with both disorders tend to show more aggression, a wider range

and persistence of problem behaviors, greater rejection by peers, and more underachievement in academics than youth with disruptive behavior problems alone. Concurrent substance use should always be considered in youngsters with disruptive behavior disorders, but especially in teens and when interventions do not yield the expected response. (**MS**)

- ***Recommendation 5.*** *Include information obtained independently from multiple outside sources.* External observations solidify the ongoing nature of the problem behavior. Clinicians need to be aware that parents and educators tend to agree more with each other on externalizing behaviors than with the youth. Children's self-reported behaviors are better predictors of stability after one year, especially when covert acts are involved. (**CG***)*
- ***Recommendation 6***. Use specific questionnaires and rating scales in evaluating children and/or adolescents for disruptive behavior disorders and in tracking progress. An array of tools has been developed to measure disruptive and other aggressive behaviors of children and adolescents for diagnostic and symptom tracking purposes. Most have good-to-excellent psychometric qualities (i.e., have exceptional validity and reliability for the intended purpose). Some tools offer abbreviated versions that can be completed quickly by the respondent. Nearly all tools are designed to evaluate oppositionality, hyperactivity, and impulsivity in young people of school age. (**OP**)

Clinical Interview

The interview with the youth should include family history, the patient's personal substance use and sexual history (including sexual abuse of others). DSM-IV target symptoms may not be apparent or acknowledged by the youth during the interview, but may be detected by interviewing parents and other informants. The interview with the youth should also include assessment of the youth's capacity for attachment, trust, and empathy; impulse tolerance and control; ability to accept responsibility for actions and experience guilt or remorse. Additionally, assessment of cognitive functioning, mood, suicidal potential, and substance use should occur. A urine or blood drug screen may be indicated, especially when clinical evidence suggests substance abuse that the patient denies. Self-report instruments might provide useful information (AACAP, 1997).

Evaluation of a youth to determine whether s/he meets criteria for a Disruptive Behavior Disorder diagnosis can be accomplished via thorough review of collateral information and a comprehensive clinical interview. The evaluator should interview both the youth and the parents to obtain history information about the youth. Comprehensive family assessment is an especially important part of the evaluation, particularly when the problems are not acknowledged by the youth, and should include information such as the family's coping style, resources, stressors, social support, parenting style, socioeconomic status, and family history of mental health and/or substance abuse problems. Additionally, interviews with other collateral sources (i.e. other family members, professionals) familiar with the patient and assessment of the youth's social functioning and peer relationship, as well as standardized assessments using caregiver and teacher informants, are indicated. History-taking should also include the patient's prenatal and birth history, including substance abuse by the mother, maternal infections, and medications. Developmental history should include problems with attachment, temperament, aggression,

oppositional behavior, attention, and impulse control. Assessment of physical and sexual abuse, both as a victim and perpetrator, should occur (AACAP, 1997).

Tables 1 and 2 include evidence-based questions for assessing the likelihood of meeting DSM-IV-TR criteria for a Disruptive Behavior Disorder.

Table 1: Caregiver Interview Questions to Assess Oppositional Defiant Disorder (Angold & Costello, 1996)

1. Has your child in the past 3 months been spiteful or vindictive, or blamed others for his or her own mistakes? *(Any "yes" is a positive response.)*
2. How often is your child touchy or easily annoyed, and how often has your child lost his/her temper, argued with adults, or defied or refused adults' requests? *(Two more times weekly is a positive response.)*
3. How often has your child been angry and resentful or deliberately annoying to others? *(Four or more times weekly is a positive response.)*

Note: A positive response for all three is 91% specific for meeting DSM-IV criteria on full interview. Any negative response is 94% sensitive for ruling out oppositional defiant disorder.

Table 2. Youth Interview Questions to Assess Conduct Disorder (Searight, Rottnek, & Abby, 2001)

1. Have you had any run-ins with the police? If yes, what were the circumstances?
2. Have you been in physical fights? If yes, what were the circumstances? How many?
3. Have you been suspended or expelled from school? If yes, what were the circumstances?
4. Have you ever run away from home? Overnight? How many times?
5. Do you smoke, drink alcohol or use other drugs? If yes, what is the frequency and duration of your use? Which drugs?*
6. Are you sexually active?*

*Age should be taken into account for Questions 5 & 6.

Note: If the child is 10 to 14 years of age, cigarette smoking, sexual activity, and alcohol or drug use can serve as "red flags" for conduct problems (Searight, Rottnek, & Abby, 2001).

Standardized Assessments

Central to every clinical assessment utilizing psychological instruments is the process of test selection, administration, and interpretation. Although professional ethical guidelines speak directly to these issues, readers are nonetheless strongly encouraged to review the manuals of the instruments in the next paragraph to ensure that the instrument has been normed on similar populations to the youth being assessed, the instrument has been subject to peer review, administration procedures are followed, and the limitations of conclusions that have been drawn are identified.

Although time consuming, a clinician may wish to use the **NIMH Diagnostic Interview Schedule for Children Version IV** (**DISC-IV**; Shaffer, et al., 2000) to arrive at a DSM diagnosis. Additionally, several standardized instruments provide general information on a broad range of characteristics for children and adolescents. A sample of commonly used evidence-based assessments is as follows:

Screeners (parent informant, unless otherwise specified)

- **Brief Infant-Toddler Social and Emotional Assessment (BITSEA) –** (Briggs-Gowan & Carter, 2006): Identifies social-emotional and behavioral problems/delays, and social-emotional competence deficits in children ages 12-35 months. Also available in a more comprehensive version (ITSEA; Carter & Briggs-Gowan, 2005).
- **NICHQ Vanderbilt Assessment Scale** – (National Initiative for Children's Healthcare Quality, 2002): Although primarily used to screen for ADHD symptoms in children ages 6-12 years old, it also includes screening items for symptoms of oppositional-defiance and conduct problems for school-age children. Parent and teacher ratings should be considered in the context of age-appropriate behaviors.
- **Pediatric Symptom Checklist (PSC) –** (Jellinek, Murphy, et al., 1988): Screens for cognitive, emotional, and behavioral problems to inform appropriate early interventions for children ages 4-16 years. A Youth-Self Report (Y-PSC) is available for adolescents ages 11 years and older.

Broadband Sociobehavioral Assessments (parent informant, unless otherwise specified)

- **Behavior Assessment System for Children, Second Edition (BASC-2) –** (Reynolds & Kamphaus, 2004): Evaluates the multidimensional aspects of behavior, adaptive functioning, and self-perceptions of children and young adults age 2-25 years. Additionally, teacher and self-report rating scales are available, as well as a Structured Developmental History (SDH) and Student Observation System (SOS).
- **Child Behavior Checklist (CBCL) –** (Achenbach & Rescorla, 2000, 2001): Measures diverse aspects of behavioral, emotional, and social functioning in children ages 1.5-5 years (Preschool Form) and ages 6-18 (School-Age Form). Also available are teacher and self-report questionnaires for some ages, as well as a semi-structured clinical interview for children and adolescents (McConaughy & Achenbach, 2001).
- **Child and Adolescent Functional Assessment Scale (CAFAS)** – (Hodges, 2000a, 2000b): Assesses the degree of impairment in youth ages 7-17 years with emotional, behavioral, psychiatric, or substance use problems. It is frequently used for youth who access services across the System of Care (mental health, child welfare and social services, youth & adolescent justice, education, prevention, and community-based programs).
- **Conners 3rd Edition (Conners 3)** – (Conners, 2008): Assesses cognitive, behavioral, and emotional problems in children ages 6-18 years, with a focus on ADHD and comordbid disorders, such as ODD and CD. Includes additional teacher and self-report

questionnaires. Also available for children ages 2-6 years (Conners Early Childhood; Conners, 2009).

- **Eyberg Child Behavior Inventory (ECBI) and Sutter-Eyberg Student Behavior Inventory – Revised (SESBI-R)** – (Eyberg & Pincus, 1999): Measures the frequency and intensity of conduct problems in children ages 2-16 years. The ECBI is the parent informant form, while the SESBI-R is the teacher informant form.

Personality Assessments (self-report informant)

- **Adolescent Psychopathology Scale (APS)** – (Reynolds, 1998): Assesses psychopathology, personality, and social-emotional problems in youth ages 12-19 years.
- **Jesness Inventory – Revised (JI-R)** – (Jesness, 1996): Measures personality and psychopathology in children and adolescents age 8 and older with more severe behavioral problems, including those with potentially violent behaviors. It differentiates between social maladjustment and emotional disturbance.
- **Millon Adolescent Clinical Inventory (MACI)** – (Millon, Millon, Davis, & Grossman, 2006): Assesses personality patterns as well as self-reported concerns and clinical symptomsfor ages 13-19 years.
- **Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)** – (Butcher, et al., 1992): Aids in the assessment of a wide range of clinical conditions for children between the ages of 14-18 years with a minimum reading level of 4.4 grade.

Assessing for Cognitive and Academic Deficits

Evaluation of learning disorders and academic functioning is an important component in the assessment of children with Disruptive Behavior Disorders. Although the exact percentage is lacking, a significant number of children with disruptive behavior disorders have learning problems, especially in the area of verbal skills. Difficulties in reading and language may contribute to academic difficulties, especially in more advanced grades when so much depends on understanding and using the written word. Language deficits may also contribute to an inability to articulate feelings and attitudes, resulting in a child resorting to physical expression in lieu of verbal expression. Additionally, unrecognized and untreated learning disabilities and cognitive deficits create deep frustration for a child, which can lead to school avoidance/truancy. Moreover, for some children, delinquent behavior, however unlawful or unacceptable, may provide them with both the status among their peers and the opportunity for some reinforcement that they are unable to find at school (AACAP, 2010).

Treatment of Disruptive Behavior Disorders

AACAP Treatment Recommendations

- ***Recommendation 7****. Clinicians should develop individualized treatment plans based on the specifics surrounding each case.* In the case of Disruptive Behavior Disorders, interventions

should target the behaviors that have been evaluated as dysfunctional. Because of comorbidity and multiple dysfunctions, effective treatment is often multitarget, multimodal, and extensive, combining individual therapy, family therapy, pharmacotherapy, and ecological interventions (like placement and interventions designed for the school setting). (**MS***)*

- ***Recommendation 8****. Parent interventions recommended by the clinician should conform to evidence-based practice (EBP).* Parent management training techniques are the most empirically supported programs for school-age youth. The principles underlying these approaches are: 1) reduce positive reinforcement of disruptive behavior; 2) increase reinforcement of prosocial and compliant behavior; 3) apply consequences and/or punishment for disruptive behavior, where punishment typically takes the form of time out, loss of tokens, and/or loss of privileges; and 4) make the response of parents predictable, contingent, and immediate. (**MS**)
- ***Recommendation 9****. Pharmacotherapy may be helpful as an adjunct to treatment, for symptomatic treatment, or to treat comorbid disorders.* When considering a medication trial, ensure that strong treatment alliances have been established first. Medications are often used in treatment when the Disruptive Behavior Disorders co-occur with some other disorder like ADHD. (**CG**)
- ***Recommendation 10****. Depending on the severity, persistence, or unusualness of the disruptive behavior, intensive and prolonged treatment may be necessary.* Occasionally ODD cases will reach the subthreshold level for CD. These are cases in which youth have failed to demonstrate progress under the current treatment regimen. Hence, increased levels of care such as day treatment, residential, or hospitalization may be warranted, with an emphasis on the least restrictive setting for the shortest possible interval. Risks and benefits of placement in structured settings should be weighed carefully because gains typically do not continue when the youth returns to family and the community. (**CG**)
- ***Recommendation 11****. Certain kinds of interventions will not work, for example, one-time, time-limited, short-term interventions or inoculation approaches (i.e., boot camps, shock incarceration).* Such approaches are ineffective at best, and sometimes become injurious for the youth. Shock strategies, in particular, tend to result in heightened fear and/or aggression. (**CG**) – (AACAP, 2007)

General Treatment Issues

Critical to the application of any treatment modality is sensitivity to individual and group differences. As the field of mental health assessment and treatment advances, individual characteristics and histories will likely play an increasing role in diagnoses and in the selection of treatment modalities. Currently, the DSM-IV-TR emphasizes the need for practitioners to consider cultural variables prior to making a diagnosis. Illustratively, a child from an impoverished or war-torn area who may have needed to engage in antisocial practices for survival (e.g., stealing food) would not necessarily be appropriate for a CD diagnosis based on that behavior. Regarding treatment, gender specific interventions will likely continue to experience growth, and mental health practitioners are strongly encouraged to stay abreast of developments (e.g., Weis, Whitemarsh, & Wilson, 2005).

Psychosocial/Psychotherapy

Evidence-based practice (EBP) points to therapy as the first-line and usual treatment for Disruptive Behavior Disorders (AACAP, 2007; Eyberg, Nelson, & Boggs, 2008; SAMHSA, 2011a, 2011b). Garland and colleagues (2008) identified 21 common core elements that contribute to the success of evidence-based parent training and individual youth skills training treatments for children with disruptive behavior problems. In terms of therapeutic content, effective behavior problem treatments incorporate teaching behavioral principles of positive reinforcement and punishment, building the parent-child relationship, using problem-solving skills, developing anger management skills, and providing affect education. Likewise, effective techniques used by therapists when working with children with disruptive behavior problems and their caregivers include implementing behavioral principals, teaching through didactic instruction, assigning and reviewing homework, roleplaying or engaging in behavioral rehearsal, modeling, providing psychoeducational materials, and reviewing goals and progress.

For mild to moderate disruptive behaviors, often the therapy is behavioral and may be implemented through parent training to address coercive parent-child interaction patterns. Recent research also confirms the effectiveness of parent training conducted in a group setting, compared to family therapy involving the parent and the child (MentalHealth.net, 2006). Cognitive-behavioral therapy is typically the individual psychotherapy that is used to help the children/adolescents decrease their negativity and oppositional behaviors, while improving their social-information processing skills (Behavior Guide Staff, 2006). Additionally, while a review of the literature provides support for both parent-training and child-training EBPs for youth with disruptive behavior, clinicians are recommended to consider parent training as the first line of approach for young children and reserve direct child-training approaches for older youth who presumably have greater capacity to benefit from the cognitive-behavioral approaches of child training programs (Eyberg, Nelson, & Boggs, 2008).

For more significant conduct problems, a multidisciplinary and multimodal approach to treatment is highly recommended. CD typically develops due to an interaction and gradual accumulation of risk factors, and there are a number of interactive risk and protective factors that can influence outcomes. Assessment of these factors is important not only in diagnosing CD, but in guiding treatment interventions. Overall, the greater the number of risk factors and earlier they appear, the higher the risk for serious conduct problems (Offord & Kraemer, 2000). In general, treatment is not brief since establishing new attitudes and behavior patterns takes time. Early treatment is recommended in order to increase treatment efficacy and long-term outcomes (AACAP, 2012).

Categorizing EBPs

To determine how much evidence exists to support a particular treatment, the Hawaii Department of Health, Child and Adolescent Mental Health Division (2004) combines criteria used by the American Psychological Association along with a broader range of evidence. This results in five categories for EBPs: 1) best support, 2) good support, 3) moderate support, 4) minimal support, and 5) known risks. To achieve the level of best support, a treatment must be supported by at least two studies (conducted by two independent teams of investigators) showing

the treatment to be superior to a placebo or another treatment, or equivalent to an already established treatment. The research must also clearly specify the client sample and the treatment protocol using a manual. A treatment with a good level of support must have at least one study as outlined above, or two studies showing the treatment as superior to a waitlist control group. Moderate support is established by one research study as indicated for best support sans a treatment manual.

Best Support

Parent Management Training – Oregon (PMTO). PMTO (Patterson, Reid, Jones, & Cogner, 1975) is a well-established behavioral parent training program based on social learning theory that teaches caregivers basic behavioral principles to reward positive behavior while setting limits with consequences. It typically is implemented in 20 sessions over the course of 13 months in both the clinic and home settings. It has five essential components: skill encouragement, discipline, monitoring, problem-solving skills, and positive involvement. Outcome studies have indicated decreasing significant reductions in child behavior problems, coinciding with positive effects in reducing coercive parenting and increasing effective parenting (Bernal, Klinnert, & Schultz, 1980; Patterson, Chamberlain, & Reid, 1982). The treatment targets children ages 4-12 and its effectiveness has been evaluated mostly with populations of White children and parents, although a culturally-sensitive adaptation of PMTO has also been evaluated (SAMHSA, 2011).

Mulitsystemic Therapy (MST). MST (Henggeler & Lee, 2003) is a home-based approach that is the most effective treatment for CD to date. It incorporates techniques that foster these youth to "detach" from their deviant peers while simultaneously building stronger bonds to family and school. In addition, it enhances family management skills such as discipline and monitoring. MST is an evidence-based practice program and listed among the model programs for CD (SAMHSA, 2011a). Researchers evaluating MST delineate the following criteria for successful outcomes: 1) adequate supervision; 2) training of therapists; and 3) institutional program support studies (Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001). Juvenile offenders demonstrated lower recidivism rates after more than a year of treatment and a decrease in arrest rates following more than 2 years of treatment with MST. Lower rates of psychiatric hospitalization and improved youth and family functioning were observed in other studies (Hoagwood et al., 2001).

Good Support

Brief Strategic Family Therapy (BSTF). BSFT (Robbins & Szapocznik, 1999) is a structured, problem-focused, directive treatment approach for conduct problems, associations with antisocial peers, early drug use and the accompanying maladaptive family interactions (relations), and other recognized youth risk factors. BSFT is designed to target both the problem behaviors of the youth as well as family functioning. BSFT addresses family behavior, affect, and cognitions in order to restructure interactions and change systems. BSFT strategies and treatment plans are designed specifically for each family and are based on a structured diagnostic

plan. BSFT has demonstrated effectiveness for children & adolescents ages 6-18 in decreasing substance abuse, improving engagement in therapy, decreasing problematic behavior, increasing family functioning, and decreasing socialized aggression and conduct disorder (SAMSHA, 2011).

Coping Power Program (CPP). CPP (Lochman, Barry, & Pardini, 2003) is a school-based, multicomponent cognitive-behavioral intervention delivered to aggressive children and their parents during the children's transition from elementary to middle school (Office of Juvenile Justice and Delinquency Prevention, 2011). It targets children between the ages of 9-11 and its effectiveness has been studied with White and African American children, although some research was conducted with children in the Netherlands (SAMHSA, 2011). The program aims to increase competence, study skills, social skills, and self-control in aggressive children as well as improving parental involvement in their child's education. The child component of CPP consists of 34 group sessions and periodic individual sessions that lasts approximately 15-18 months, although an abbreviated version that is implemented across one school year is also available. The child curriculum focuses on anger management, problem-solving skills, attributions, and peer pressure. The parent component is administered over 16 sessions and emphasizes parenting skills on rule-setting, appropriate punishment, stress management, and family communication, as well as stress-management skills. Outcome studies report decreases in substance abuse, improvement in social skills, and a less aggressive belief system (SAMHSA, 2011a).

Functional Family Therapy (FTT). FTT (Alexander & Parsons, 1973) is a family therapy intervention for the treatment of delinquent, violent, behavioral, academic, and conduct problems with youth and families. FFT targets the family system as the entry point for systematic and individualized treatment. The FFT service delivery system consists of an integrated set of guiding theoretical principles, a systematic clinical intervention program, and well-developed, multi-domain clinical assessment and intervention techniques. FFT also has a systematic training and supervision system for therapists, implementation protocols, and a systematic quality improvement system. FFT has demonstrated effectiveness for children ages 11-18 in reducing recidivism and out-of-home placements and improving family communication style, family concept, and family interaction (SAMSHA, 2011).

Incredible Years (IY). IY (Webster-Stratton & Reid, 2003) is group intervention for children ages 2-12 with aggressive behaviors. It is intended to improve social competence at home and school through a series of Child Training, Parent Training, and Teacher Training groups. The IY curriculum is distinguished from other parent training and social problem-solving training methods by its use of videotaped vignettes. The Child Training focuses on children problem-solving conflicts at home and school while encouraging the development of social skills. With a duration of 20-26 weeks, the Parent Training component emphasizes social learning and child development principles as caregivers are taught child-directed interactive play skills and behavioral management techniques. IY uniquely addresses social and emotional coaching, bridging communication between home and school, and developing coping skills for caregivers to better manage their own interpersonal issues. The Teacher Training occurs in a 6-day workshop for teachers and counselors that addresses managing difficult child behaviors in the school setting and promoting positive peer relationships by building social skills. Outcome

research shows increases in parent limit-setting, nurturing, and supportive parenting, improvements in teachers' use of praise, and decreases in conduct problems at home and school (Webster-Stratton, Reid, & Hammond, 2001, 2004). IY has been used with White, African American, Hispanic, and other multiethnic groups (SAMHSA, 2011).

Multidimensional Treatment Foster Care (MTFC). MTFC (Chamberlain & Smith, 2003) is a community-based program for youth with chronic and severe delinquent behavior. It has also been adapted to preschoolers (MTFC-P) to meet the developmental needs of children who exhibit early aggressive or externalizing behavior. In combination, the MTFC intervention spans the ages of 3-18. It is delivered by therapeutic foster families who receive 20 hours of preservice training on a specific token reinforcement system and who provide intensive treatment to youth in their care for a 6-9 month placement. Foster care providers attend weekly meetings and maintain daily contact with a MTFC-trained case manager. The youth also meets at least weekly with an individual therapist to address anger management, problem-solving, and educational/vocational planning. Additionally, the youth works with a behavioral support specialist for 2-6 hours weekly to enhance prosocial skills during one-on-one interactions in the community. Youth also receive periodic medication management appointments with a psychiatrist. MTFC aims for the youth to sustain contact with their biological family and for the biological family to receive intensive parent management training services while the child is in placement to improve reunification efforts and aftercare adjustment. Research indicates fewer runaways, decrease in arrest rates, decrease in violent activity involvement or incarceration after completing the program, and fewer permanent placement failures (Chamberlain & Reid, 1998; Leve, Chamberlain, & Reid, 2005). The treatment has been shown effective with White children, while African American, Hispanic, and American Indian children have been represented in smaller numbers in available research studies (SAMHSA, 2011).

Parent-Child Interaction Therapy (PCIT). PCIT (Eyberg & Funderburk, 2011) is a behavioral family-oriented therapy for children ages 2-6. It integrates concepts from social learning theory, traditional play therapy, and attachment theory to enhance the parent-child relationship, increase children's prosocial behaviors, and increase parents' behavior management skills. The program is implemented in two phases: The first phase is the Child-Directed Interaction (CDI) phase during which caregivers develop child-centered interaction skills. The second phase is the Parent-Directed Interaction (PDI) phase during which effective discipline skills are the focus. A critical goal of PCIT is to increase positive, nurturing interactions by including the child and caregiver in treatment, both in session and during daily homework assignments. In contrast to traditional approaches to parent training that focus on discussion and role play of techniques, caregivers in PCIT rehearse skills weekly in session through live interactions with their children. Further, during parent-child interactions, immediate feedback is given by the therapist from an observation room, while the parent wears a radio frequency earphone. Outcome studies show improvements in parent-child interaction style and child behavior problems (Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, et al., 1998). Regarding cultural differences, PCIT has been studied with White and African American families, as well as adapted for use with Puerto Rican and Mexican American families (SAMHSA, 2011).

Problem-Solving Skills Training (PSST). PSST (Kazdin, 2003) is a behavioral treatment designed for children ages 7 to 13 years with disruptive behavior. In PSST, children are taught problem-solving strategies and are encouraged to generalize these strategies to real-life problems. Skills include identifying the problem, generating solutions, making a decision, and evaluating the outcome. Therapists use in-session practice, modeling, roleplaying, corrective feedback, social reinforcement, and token response-cost to gradually develop problem-solving skills (Eyberg, Nelson, & Boggs, 2008).

Moderate Support.

Helping the Noncompliant Child (HNC). HNC (Forehand & McMahon, 2005) targets children between the ages of 3 and 8 who exhibit noncompliant behavior. The caregiver and child are typically seen twice a week for 10 weeks of conjoint sessions concentrated on differential attention and compliance training. The therapist provides caregivers feedback through modeling, roleplays, and in-vivo exercises at home and in the clinic setting. Positive treatment outcomes include increased parenting skills and improvement in child behavior and compliance (Wells & Egan, 1988).

Mentoring. Mentoring programs (Jekielek, Moore, Hair, & Scarupa, 2002) involve use of trained adults who serve to provide positive role modeling and leadership for youth. Mentoring programs vary in terms of specific training, length of services, and other programming, but generally have no cost for youth served. Mentoring programs, such as Big Brothers Big Sisters of America, have some effectiveness for youth ages 6-18 in increasing confidence in school performance, improving family relationships, and increasing prosocial behaviors (SAMSHA 2011).

Rational Emotive Behavior Therapy (REBT). REBT (Ellis & MacLaren, 2007) is a cognitive-behavioral, short-term treatment (10-20 sessions) and is designed to improve the moral reasoning and judgment skills of youth with conduct disorder. REBT focuses on cognitive restructuring through use of techniques which challenge the youth's thinking and irrational beliefs, while promoting rational self-talk and various strategies to achieve these goals. Some strategies include disputing irrational beliefs, reframing, problem solving, behavior reversals, roleplaying, and modeling. Research has found that children and adolescents who received REBT demonstrate fewer disruptive behaviors and higher school achievement as compared to adolescents who received client-centered therapy or no treatment (FFTA, 2008).

Group Therapies for Disruptive Behavior Disorders

Group treatment seems to be effective when youth diagnosed with disruptive behaviors are younger. Some of the most effective treatments involve a group parent management training for the parents/caregivers in conjunction with group social skills training for the children. Group treatments involving adolescents, on the other hand, tend to worsen their behavior, especially if the group discussions focus on oppositional and illegal behaviors (Bernstein, 2012).

Pharmacotherapy

Medications should NOT be prescribed as first-line treatment for children and adolescents with ODD UNLESS the child or adolescent has a comorbid condition that is better treated through pharmacology. For example, a youth with ODD may additionally be diagnosed with ADHD. Stimulant medication may be prescribed for ADHD, as an adjunct to parent/family education and training for ODD (Oppositional Defiant & Conduct Disorders, 2005). As with a diagnosis of ODD, medications should NOT be the sole treatment for youth with CD. ***At most, medications should be adjunct to behavioral interventions for CD***. Pharmacological therapy is recommended only in cases of comorbid disorders, particularly ADHD because it has the most frequent connection to CD (Bernstein, 2012). Research does not indicate a single effective pharmacological treatment for CD. In comorbid situations, the other disorder should be treated first (Oppositional Defiant & Conduct Disorders, 2005).

Although the evidence for using medications to treat Disruptive Behavior Disorders continues to expand, the evidence used to prescribe medications for these youth is not as robust as it is for psychosocial interventions. Much research remains to be completed before the multifaceted aspects of disruptive behaviors can be fully addressed (SAMHSA, 2011b). Recently, however, the *Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth* (TRAAY; Jensen, MacIntyre, & Pappadopulos, 2004) compiled available evidence and expert consensus to develop pharmacological treatment guidelines that address aggressive behaviors, one symptom associated with Disruptive Behavior Disorders.
TRAAY (2004) emphasizes conducting a thorough initial diagnostic evaluation and determining whether the aggressive behaviors are acute or chronic in nature. For acute aggressive behaviors, it is recommended to use crisis management techniques before consideration of medication or emergency treatment. For chronic aggression, TRAAY clearly indicates beginning with psychosocial and educational interventions and assessing treatment effects prior to instituting medication management of symptoms. If pharmacological treatment is deemed appropriate, primary disorders (such as ADHD) should be treated before a first-line atypical antipsychotic is prescribed for aggression. TRAAY (2004) indicates to "start low, go slow, taper slowly" in terms of dosage, while routinely assessing for side effects and drug interactions. Physicians are cautioned to ensure an adequate trial of the medication and avoid using four or more medications simultaneously. If aggressive symptoms persist, then a different first-line atypical antipsychotic could be used or the medication regimen could be augmented with a mood stabilizer. If the aggressive symptoms respond to a first-line atypical antipsychotic by going into remission for a period of 6 months or longer, then the medication can be tapered or discontinued.

(***In the event of comorbid ADHD,*** please refer to the Table of Typically Prescribed Medications in the section on Attention Deficit Disorders for recommended medications and maximum dosages.)

Prevention of Disruptive Behavior Disorders

As for most disorders, early intervention is the most effective way to prevent disruptive behavior disorders in children. Prevention programs typically employ multi-level interventions across the

home, school, and clinic environments. Several evidence-based prevention programs exist, including:

- Adolescent Transitions Program (Dishion & Kavanagh, 2003)
- Early Risers: Skills for Success (August, Realmuto, Hektner, & Bloomquist, 2001)
- First Steps to Success (Walker, Golly, McLane, & Kimmich, 2005)
- Project ACHIEVE (Knoff & Batsche, 1995)
- Promoting Alternative Thinking Strategies (PATHS; Greenberg, Kusché, & Mihalic, 1998)
- Second Step (Committee for Children, 2012)
- Triple P – Positive Parenting Program (Sanders, Markie-Dadds, & Turner, 2003)

Other prevention strategies involve the clinician in consultation with primary care physicians (PCPs), teachers, and other professionals. Parent management strategies that contain psychoeducational packages (including social skills and various cognitive interventions) have also shown promise for school-age children that are at risk for the disorder (AACAP, 2007). Further, home visitation strategies have produced very positive outcomes in areas related to ODD in preschool children when employed as a preventive intervention. Typically, nurses functioned as the home visitor (Olds, et al., 2007).

Self-Help Resources

Tips for Parents

AACAP additionally offers simple, inexpensive ways parents can help their child with Disruptive Behavior Disorders, as shown in Table 3.

Table 3: Tips for Parents of Children with Disruptive Behavior Disorders (AACAP, 1999)

- Build on the positive. Find ways to praise your child and provide positive reinforcement.
- Be a good model for your child. If you may make the conflict worse, TAKE A BREAK!
- Choose your battles wisely.
- Prioritize things you want your child to do.
- Set reasonable, age appropriate limits with consequences that can be easily and consistently enforced.
- Seek and obtain support from other adults, especially those that also interact with your child, like your spouse, teachers, and coaches.
- Always manage your own stress.

Bibliotherapy for Disruptive Behavior Disorders

Parenting Books for Preschool through School-Age Children.

- *Families: Applications of Social Learning to Family Life (Revised)*, by Gerald R. Patterson (1975).

- *Living with Children: New Methods for Parents and Teachers (Revised)* , by Gerald R. Patterson (1977).

- *The Incredible Years: A Trouble-Shooting Guide for Parents of Children Aged 2-8 years,* by Carolyn Webster-Stratton (2006).

- *The Kazdin Method for Raising the Defiant Child,* by Alan E. Kazdin (2009).

- *Parenting the Strong-Willed Child: The Clinically Proven Five-Week Program for Parents of Two- to Six-Year-Olds*, by Rex Forehand & Nicholas Long (2002).

- *Raising an Emotionally Intelligent Child,* by John Gottman, Joan Declaire, and Daniel Goleman (1998).

- *Survival Guide for Preschool Parents: How to Manage Challenging Behavior,* edited by Jerry Heston & Melissa L. Hoffmann (2007).

- *Your Defiant Child: Eight Steps to Better Behavior*, by Russell A. Barkley & Christine M. Benton (1998).

Parenting Books for Adolescents.

- *Parents and Adolescents Living Together: Part 1, The Basics (2nd Edition)*, by Gerald R. Patterson & Marion S. Forgatch (2005).

- *Parents and Adolescents Living Together: Part 2, Family Problem Solving (2nd Edition)*, by Marion S. Forgatch & Gerald R. Patterson (2005).

- *Your Defiant Teen: 10 Steps to Resolve Conflict and Rebuild Your Relationship* by Russell A. Barkley and Arthur L. Robin (2008).

Clinician Resources.

- *Helping the Noncompliant Child, Second Edition: Family-Based Treatment for Oppositional Behavior* by Robert J. McMahon and Rex L. Forehand (2005).

- *Defiant Children, Second Edition: A Clinician's Manual for Assessment and Parent Training by* Russell A. Barkley (1997).

- *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Russell A. Barkley, Gwenyth H. Edwards, and Arthur L. Robin (1999).

- *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents*, by Alan E. Kazdin (2008).

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- *The Behavior Survival Guide for Kids: How to Make Good Choices and Stay Out of Trouble* by Thomas McIntyre (2003).

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