PAPER FOLIO ONE: DEFINING CONDUCT DISORDER AND ITS CONTRIBUTING VARIABLES
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Paper Folio One: **Defining Conduct Disorder and its Contributing Variables**

Paper Folio Two: **Intervention Strategies to Treat Conduct Disorder**

Paper Folio Three: **Conduct Disorder: An Individual Case**

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Paper Folio One

Defining Conduct Disorder and its Contributing Variables

Introduction

Coping with children with conduct disorder (CD) is one of the major issues in the educational system today. Teachers typically encounter at least two or more children in their classrooms each year who show this persistent pattern of antisocial behavior (Webster-Stratton, 1993). Such children exhibit high rates of non-compliance with teacher requests, aggression, cruelty towards peers, destructive acts, "smart" talking, lying, stealing, running away, and cheating. It is estimated that child conduct disorders encompass from one-third to one-half of all child and adolescent clinical referrals (Herbert, 1987). The prevalence of the disorder is increasing steadily and far exceeds the resources and funds available to treat it.

The objectives of this paper are to define conduct disorder and identify characteristics of children with the disorder; to identify at-risk children; to identify the external factors that put them at risk; to discuss the relationship between parenting and the development of the disorder; and to discuss issues of comorbidity between conduct disorders and other disorders.

Definition

According to the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV), American Psychiatric Association (1994) there is some controversy about whether the behavioral pattern defined as Conduct Disorder constitutes a mental disorder or is better conceptualized as a legal, moral, or social systems problem (Herbert, 1987). Although the DSM IV definition of mental disorder is broad enough to include Conduct Disorder, one can argue that the behaviors in question are the result of lack of personal

responsibility which should not be seen as a mental disorder. This debate has not been resolved.

The following is the DSM IV (1994) diagnostic criteria for Conduct Disorder.

A. A repetitive and persistent problem of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past twelve months, and at least one criteria present in the past six months.

Aggression to people and animals

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

Destruction of property

8) has deliberately engaged in fire setting with the intention of causing serious damage
9) has deliberately destroyed other's property (other than by fire setting)

Deceitfulness or theft

10) has broken into someone else's house, building, or car

11) often lies to obtain goods, favours, or to avoid obligations (i.e., "cons" others)

Serious violations of rules

13) often stays out at night despite parental prohibitions, beginning before the age of 13 years

14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

15) is often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

The DSM IV also specifies type of conduct disorder, based on age at onset: childhood-onset type and adolescent-onset type. Severity of the problem is also specified: mild, moderate, and severe.

Kazdin (1997) offers a useful summary of the definition. He uses the term conduct disorder to refer to anti-social behavior that is clinically significant and clearly beyond the realm of normal functioning. The extent to which antisocial behaviors are severe enough to constitute conduct disorder depends on several characteristics of the behaviors: their frequency, intensity and chronocity, whether they are isolated acts or part

of a larger syndrome with other deviant behaviors, and whether they lead to significant impairment of the child as judged by parents, teachers, or others.

Kazdin (1987b) has outlined several key characteristics of Conduct Disorder, differentiating it from other problems of childhood and from typical childhood behaviors. The first of these is *antisocial behavior*. Children with CD typically and persistently exhibit some combination of physical and verbal aggression, stealing, lying, and violation of social norms and the rights of others. A second component is *chronicity*. Children with CD exhibit these serious disruptive and aggressive behaviors over months and years and they often are unresponsive to short-term home and classroom interventions. A third dimension of conduct disorder is *impairment of functioning*. Children with CD exhibit antisocial behaviors in sufficient frequency and intensity to affect significantly their educational performance and interpersonal interactions.

Children At Risk

Personal characteristics associated with conduct disorder may appear in children during preschool years, sometimes as early as age two. These may include resistance to discipline and irritability, developmental cognitive and language difficulties, and early aggressive behaviors (Bates and Bayles, 1988). Also, areas such as social cognitive development, (Short & Simeonsson, 1986), sensation seeking (Newcomb & McGee, 1991), temperament (Webster-Stratton & Eyberg, 1982) and neurological functioning (Shapiro & Hynd, 1993) may be associated with the development and display of conduct disorder.

Selected personal characteristics that are of particular interest to me and which I consider to be of greater importance to this field of study will be discussed in greater detail:

Internal Factors

Child Temperament

The personal characteristics of child temperament (e.g., activity, adaptability, mood), as it relates to CD, has been researched a great deal in regard to conduct problems. This research has indicated a significant correlation between early assessments of temperament characteristics such as infant difficultness, unadaptability and negative affect, and later aggressive problems (Bates, 1990; Bates, Bayles, Bennett, Ridge, & Brown, 1991). Children who have such temperaments are challenges for parents under the best conditions; but when they coexist with parental problems such as psychological distress, limited economic resources, or other family stressors, the behavior disorders of the children are exacerbated (Horne et al., 1992).

Cognitive Factors

Cognitive factors play an important and well-documented role in antisocial behavior and conduct disorders (Dodge, 1993). Dodge (1993) suggests that children with CD distort social cues during peer interaction. Antisocial children often exhibit a cognitive response bias in which they interpret ambiguous interpersonal stimuli as being hostile. This cognitive bias may result in and justify aggressive responses to the misperceived hostile stimulus. It is thought that aggressive children search for fewer cues or facts when determining another's intentions and focus more on aggressive cues, thereby leading to a negative social interaction.

Data exists which indicates that children suffering from CD have deficits in problem-solving skills, particularly in generating multiple and/or pro-social problem solutions (Short & Shapiro, 1993). These children may generate fewer alternative solutions to social problems, seek less information, define problems in hostile ways, and anticipate fewer consequences for aggression (Webster-Stratton, 1993). They respond to conflict situations in a very narrow singular manner.

External Factors

Academic Variables

Academic performance is associated with child conduct disorder. Low academic achievement is recognized at an early stage for children with CD, often as early as the elementary grades (Kazdin, 1987). Some of the common academic difficulties for these children are reading disabilities, language delays, and attention problems (Sturge, 1982). These children also perform poorly academically and participate minimally in class activities and discussion (Frick et al., 1991; Hinshaw, 1992; Tremblay et al., 1992). Their difficulties within the classroom is often manifested in disruptive behavior in the classroom, increased rates of truancy, and dropping out of school (Robins, 1991).

The relationship between academic performance and conduct disorder is not unidirectional, but is considered to be a bi-directional relationship. It is unclear whether disruptive behavior problems precede or follow the reading and language delay and learning difficulties. However, it is clear that conduct problems and a lack of reading ability both place the child at high-risk for lower self-esteem, continued academic failure, further conduct problems, and school dropout (Webster-Stratton, 1993). The lack

of support for academic efforts within the home and the early development of behavior problems also lead to academic deficiency (Horne et al., 1992). Horne and colleagues (1992) also believe that contrary to the common belief in educational systems that poor academic success leads to behavior problems, it appears the more frequent scenario is the other way around. Academically-deficient students often have behavioral problems prior to their academic difficulties. For a student with CD, it is the problematic behavior patterns that cause socialization problems for the child within an educational system.

Once a child enters school, be it preschool or grade school, negative school and social experiences further exacerbate the adjustment difficulties of children with conduct problems. Children who are disruptive and aggressive with peers are often rejected by their peers, and this rejection can extend throughout the child's school years (Ladd, 1990). Because of their non-compliant disruptive behavior, aggressive children also develop poor relations with teachers and receive less support and nurturing in the school setting (Webster-Stratton, 1993). Some evidence suggests that teachers retaliate in a manner similar to parents and peers. Walker & Buckley (1973) reported that antisocial children were much less likely to get encouragement from teachers for appropriate behavior and more likely to get punished for negative behavior than well-behaved children.

It is evident from the preceding statement that the school setting has to be viewed as a risk factor for the development of conduct disorder. Rutter and colleagues (1976) found that characteristics such as emphasis on academic work, teacher time on lessons, teacher use of praise, emphasis on individual responsibility, teacher availability, school

working conditions, and teacher-student ratio were related to oppositional behaviors, delinquency, and academic performance.

Peer Relationships

In addition to personal and school factors, peer variables have been associated with conduct disorder. Children who exhibit antisocial behaviors are often rejected by their peers in response to their negative behaviors and develop inappropriate and ineffective social competence skills (Ladd, Hart, & Price, 1990). These children are often seen as outsiders and are often ignored or feared by their peers. The child develops weak emotional attachment with other children. The emotional attachment is often demonstrated by the child's inability to play appropriately with other children, lack of perspective taking or emphatic understanding of other children, and failure to develop close friendships (Horne et al., 1992). Weak attachments frequently result in behavior problems (aggressiveness, hyperactivity, and oppositional behavior). Children who display such these behavioral characteristics are subsequently rejected by their peers and develop inappropriate and ineffective social competence skills. In an attempt to be accepted by peers, these children may increase their coercive activity, thus trying to force their way into friendships. When these attempts fail, the child may rely even more heavily upon power and force to establish their role among their peer group (Horne et al., 1992).

As aggressive children continually fail to win acceptance and friendship through coercive efforts, they begin to develop relationships with others similar to themselves, resulting in a commitment to a deviant peer group (Dishion, Patterson, & Stoolmiller,1991). This deviant peer group frequently leads to gang activity or at least to

a group of individuals all of whom see themselves as rejected by the majority group of their peers. This deviant peer group primarily consists of individuals who are both socially and academically outside the mainstream of their social group. Frequently formed during adolescence, these deviant behavior groups become involved in serious delinquent and antisocial behaviors, where their delinquent behavior is reinforced (Dishion &Loeber,1985).

Parenting and Family Influences

Parenting and family influences have an affect on the development of Conduct Disorder (Frick, 1993; Loeber and Stouthhamer-Loeber, 1986). Although the two are closely linked, for the purpose of this paper they will be treated as separate entities.

Parenting

Research has indicated that parents of children with CD lack certain fundamental parenting skills. For example, parents of such children have been reported to exhibit fewer positive behaviors. They tend to be more violent and critical in their use of discipline. The discipline methods used by parents of children with CD are usually more permissive, erratic, and inconsistent. These parents are also more likely to reinforce inappropriate behaviors and to ignore or punish pro-social behaviors (Webster-Stratton & Spitzer, 1991; Webster-Stratton, 1993).

Patterson (1982) developed a "coercive hypothesis", based on a social learning model, to explain the role between parenting and the development of CD. His theory postulates that children learn to get their own way and avoid parental criticism by escalating their negative behaviors. This type behavior leads to increasingly negative

parent/child interactions. As this negative behavior pattern and parent child interaction continues over time, the rate and intensity of parent and child aggressive behaviors are increased. Horne et al. (1992) state that coercive parent-child interactional patterns lead to unstable or negative emotional patterns within the family, thereby increasing the child's susceptibility to delinquent behaviors. The coercive parental-child interactions are not by parental choice, but rather a result of not knowing how to effectively manage children.

Children have a direct effect on the parenting process. Children with CD engage in higher rates of deviant behaviors and non-compliance with parental commands than children without. According to Webster-Stratton (1993) such children, when interacting with their mothers exhibit fewer positive verbal and non-verbal behaviors (smiles, laughs, enthusiasm, praise) than children without CD. In addition, children with CD exhibit more negative nonverbal gestures, expressions, and tones of voice in interactions with both mothers and fathers. These children have less positive affect, seem depressed, and are less reinforcing to their parents thus setting in motion the cycle of aversive interactions with mothers as well as fathers.

Parent psychological factors place the child at considerable risk for conduct disorder (Webster-Stratton, 1993). Depression in the mother, alcoholism in the father, and antisocial behavior in either parent has been implicated in increasing the child's risk for CD.

It is hypothesized that maternal depression and irritability result in negative attention, reinforcement of inappropriate child behaviors, inconsistent limit-setting, and emotional unavailability to the child, all of which can lead to problems for the child. The

presence of antisocial behavior in either parent places the child at greater risk for conduct disorders. In particular, criminal behavior and alcoholism in the biological father are consistently demonstrated as parental factors increasing the child's risk (Frick, Lahey, Christ, Loeber, & Green, 1991).

Parental socialization practices have a direct effect on whether a child develops conduct disorder (Frick, 1993). Parental socialization practices refers to those aspects of child's family life through which a child learns to behave according to the demands of a situation, and to internalized parental values. It refers to the process by which a child learns to follow rules and social norms. Although direct methods of socialization (ex. discipline) are an important part of this process, socialization also takes place through indirect processes including the emotional bond between parent and child (Wells and Rankin, 1988).

In a meta-analysis by Loeber and Stouthhamer-Loeber (1986) several types of socialization variables emerged as being most consistently associated with conduct problems in past research: parental involvement in their child's activities, parental supervision of the child, and the use of harsh or inconsistent discipline.

Parental involvement in their child's activities, for example, time spent together, parent's interest in child's education, and parent's interest in their child's friends, is often considered one indicator of the degree and quality of the emotional bond between parent and child (Frick, 1993). A lack of parental involvement showed a significant relationship with severe conduct problems in 22 of 29 cases reviewed (Loeber and Stouthamer-Loeber, 1986).

The second socialization variable, parental supervision, was significantly correlated with conduct problems in 10 of 11 analyzes reviewed (Loeber and Stouthhamer-Loeber, 1986). Frick et al. (1992) believe that in some environments (ie. areas of high crime, vandalism, substance use) it is important that parents employ appropriate supervision of their children, and in fact some environments combined with inadequate parental supervision are good predictors of conduct problems.

The final socialization variable frequently linked to child conduct problems is parental discipline. In the Loeber and Stouthhamer-Loeber (1986) meta-analysis, two types of parental discipline (harsh/abusive parental discipline and parental inconsistency in providing discipline) were significantly related to child conduct problems in many studies.

Family Influences

A number of specific family characteristics have been found which contribute to the development and maintenance of child conduct disorder (Frick, 1993). Inter-parental conflict leading to and surrounding divorce are associated with conduct disorder. In differentiating between parental divorce, separation and discord, research has shown that it was not the divorce per se that was the critical factor in the child's behavior, but rather the amount and intensity of parental conflict and violence. Conflictual, unhappy marriages displaying aggressive behavior are more likely to incite the formation of conduct disorder (Stoneman, Brody, & Burke, 1988).

Amato and Keith (1991) provide the most comprehensive summary of the research surrounding divorce. The authors conducted a meta-analysis of ninety-two published studies on the impact of divorce on a child's psychological wellbeing. This

meta-analysis revealed that divorce consistently had a negative impact on the child's well-being, not just in the area of conduct problems. However, the type of child adjustment on which the divorce had the largest impact was in the area of "conduct", which included measures of misbehavior, aggression, or delinquency. The meta-analysis also provided evidence that it was the conflict between the parents before and during the separation that had the most detrimental impact on a child's adjustment.

Another aspect of family life that contributes to the development of behavioral difficulties are stressors such as unemployment and a single parent household. None of these factors create or demand that children experience problems and difficulties in development, but all may contribute to the development of problems if other factors are present (Horne et al., 1992).

Family demographics and environment can also contribute to behavior problems and the development of conduct disorder in children. The neighborhood and community in which the child is reared has a strong influence on the development, or lack of development, of behavior problems. Children who grow up in areas where there is high incident of vandalism and crime are more likely to engage in those behaviors themselves. Low-income families may live in neighborhoods in which aggressive behavior is likely to be reinforced by that community. No one factor causes delinquency or behavioral problems, but, rather, the interaction of factors working together result in children experiencing problems in their development (Horne et al., 1992).

Comorbidity

Another factor that must be looked at regarding the development of conduct disorder is comorbidity between conduct disorder and other behavioral disorders. Comorbidity among the disruptive disorders is extremely common. For example, in clinical samples, estimates of co-ocurrence of oppositional defiant disorder and conduct disorder among children with attention-deficit hyperactivity disorder range from 20% (Barkley,1990) to 60% (Biederman, Munir, & Knee,1987), and the rate of ADHD has been reported to be as high as 90% among children referred for conduct disorders (Abikoff, Klein, Klass, & Ganeles, 1987). Other disorders such as substance abuse disorder, bipolar disorder, personality disorder, and depression have been linked to conduct disorder (Reebye, Moretti, & Lessard, 1995; Kovacs & Pollock, 1995; Edell, W. et al., 1996; Rowe J.B. et al., 1996).

There seems to be considerable diagnostic ambiguity between CD, Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD) in the young preschool and early school-age group. Current reports suggest that as many as 75% of children identified as having ADHD, also can be identified as having CD (Safer & Allen, 1976). It has been proposed that hyperactivity may influence the emergence of ODD and CD. Loeber (1985) has suggested that hyperactivity is inherent in children with CD. However, careful assessment of the child may reveal that the child actually meets the criteria for one and not the other. The criteria for ADHD, CD, and ODD, although similar, are not identical and it is important that they be differentiated for both clinical and empirical reasons. Conclusions regarding comorbidity, treatment efficacy, and long-term outcome can be influenced by several factors, including diagnostic procedures and

sample characteristics. The need to distinguish between referred and non-referred samples is particularly crucial when considering treatment and comorbidity issues (Abikoff & Klein, 1992).

In summary, it can be said that the child who suffers from conduct disorder faces serious challenges in his/her life, and often are a major challenge for his/her family, teachers, and society in general. To improve life for the person with conduct disorder we must attempt to understand all facets of the disorder and the factors that cause it. From this understanding we must then develop effective intervention and treatment programs to help the child with conduct disorder, and prevent at-risk children from developing the disorder. These issues will be discussed in paper two.

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Paper Folio Two

Intervention Strategies to Treat Conduct Disorder

Introduction

Children with behavior disorders represent the largest group of clinical referrals among adolescents, and account for the major problems encountered in schools today (Abikoff & Klein, 1992; Horne et al., 1992). Conduct disorder, hereafter referred to as CD, is a complicated group of behavioral and emotional problems in children and adolescents, its major feature being a "repetitive and persistent pattern in which the basic rights of others or major age-appropriate societal norms are violated" (American Psychiatric Association [APA], 1994, p.85). Conduct disordered youth often exhibit negative behaviors such as social incompetence, peer rejection, substance abuse, academic failure, suicidal behavior, and a higher probability of physical injury and premature death. Family, school, and community resources are strained by the actions of such youth. The need for service far exceeds the availability of resources and personnel. It is estimated that fewer than 10% of children demonstrating such problems actually receive mental health services (Hobbs, 1982). It is imperative, therefore, to establish effective intervention and treatment strategies to help children who have CD, and identify at-risk children who may develop it.

Kazdin (1997) proposes that multiple factors contribute to the development and maintenance of CD in young children. These factors include, child, parental and family, school-related factors, and comorbidity between conduct disorders and other disorders. This paper will examine various intervention strategies (programs) used to help modify each of factors that contribute to the development of conduct disorder. These strategies will be outlined and discussion will be provided regarding their limitations and effectiveness.

Parental Factors

Parenting behaviors have been identified as factors that impact upon the development of conduct disorder. According to Webster-Stratton (1993), parenting interactions are clearly the most well-researched and most important proximal cause of conduct problems.

Generally, parents of children with conduct disorder lack fundamental parenting skills. These parents have been reported to exhibit fewer positive behaviors; to be more violent and critical in their use of discipline; to be more permissive, erratic, and inconsistent; to be more likely to reinforce inappropriate behaviors and to ignore or punish pro-social behaviors (Webster-Stratton & Spitzer, 1991; Webster-Stratton, 1993). Parental depression, substance abuse, parental antisocial behavior, and parents' marital relationship, and parental socialization practices have been identified by Frick (1993) as also influencing the development of conduct disorder in children. Horne et al. (1992) believe that teaching effective parenting skills should be equally as important as teaching driving, reading, and vocational skills.

A number of intervention approaches have been aimed at parents of conduct disordered children, and generally target the problems associated with CD as listed above. Three specific programs are discussed here.

A) The Parent Training Program (Oregon Social Learning Centre)

This most highly influential training program for parents of CD children was developed by Patterson, Reid, and their colleagues (Patterson, 1982; Patterson, Reid, Jones, & Conger, 1975). This parent training program was originally developed for pre-

adolescent children, engaged in overt conduct disorders. Parents begin the program by reading a programmed text, either Living with Children (Patterson, 1976) or Families (Patterson,1975) and completing a test on the reading material. Then the parents are taught a step-by-step approach wherein each newly-learned skill forms the foundation for the next skill to be learned.

Five family management practices form the core components of the program. First, parents are taught how to pinpoint the problem behaviors of concern and to track them at home (e.g., compliance vs. noncompliance). Second, parents are taught social and tangible reinforcement techniques (e.g., praise, point systems, privileges, treats). Over time the tangible reinforcers are replaced by the parents' social reinforcement. Third, the parents are taught discipline procedures. When parents see their children behaving inappropriately, they learn to apply a mild consequence such as a 5-minute time-out or a short term privilege removal (e.g. 1 hour loss of bike use). Different consequences are used and advocated for older children. Fourth, they are taught to "monitor" or to provide close supervision for their children even when the children are away from home. This involves parents knowing where their children are at all times, what they are doing, and when they will be home. In the final phase of the treatment, parents are taught problem solving and negotiation strategies and become increasingly responsible for their own programs. In addition, Patterson and Chamberlain (1988) report that approximately 30% of their time, within the program, is devoted to parents' personal adjustment problems such as depression, marital issues, and family crises.

This program has been modified for use with adolescents with conduct disorder (Marlow, Reid, Patterson, Weinrott, & Bank, 1988). In the modified program the

behaviors targeted are those believed to put the adolescent at risk for further delinquent behavior (e.g., curfew violations, substance use, time with "bad" companions); emphasizing the importance of parental monitoring and supervision especially with respect to school attendance; and using punishment procedures such as work details and restrictions on free time. Parents are also asked to report legal offences to juvenile authorities and then act as their child's advocate in court (Webster-Stratton, 1993).

The program for the preadolescents typically requires twenty hours of one-to-one therapy between the parents and the therapist in the clinic and includes home visits and homework assignments in order to foster generalization of parenting strategies. The program for parents of chronic delinquents averages forty-five hours and includes greater involvement of the adolescent in the treatment sessions, especially regarding the training and implementation of behavioral contracts with parents.

B) Helping the Non-Compliant Child

Another training program for parents of CD children was developed by Hanf (1973) and later modified and evaluated extensively by McMahon and Forehand (1984). This program was designed to treat noncompliance in young children ages 3 to 8.

The content of the first phase of this comprehensive training program includes teaching parents how to play with their children in a non-directive way and how to identify and reward children's pro-social behaviors through praise and attention. The objective is for parents to learn to break the coercive cycle by increasing their social rewards and attention for positive behaviors and reducing their commands, questions, and criticisms. Parents also learn to use social and tangible rewards for child compliance and to ignore inappropriate behaviors. Phase Two of the program includes teaching parents

ways to give direct, concise, and effective commands and how to use three minute time-outs for noncompliance. Progression to each new skill in the treatment program is based upon the parent's ability to achieve an acceptable degree of competence in a particular skill before moving on to the next one.

This program operates out of a clinical setting where the therapists work with individual parents and children rather than groups. Treatment methods include role-playing, modeling, and coaching. The clinicians use a playroom equipped with one-way mirrors for observation and "bug-in-the-ear" devices through which the therapist can directly prompt, coach, and give feedback to the parent playing with the child. Homework is assigned in the form of daily 10-minute practice sessions with the child using strategies learned in the clinic.

C) The BASIC and ADVANCE Programs

A third example of a comprehensive parent training program for young children with CD was developed by Webster-Stratton (1981a, 1981b, 1982a, 1982b, 1984). The BASIC program was designed for parents with children ages 3-8. Webster-Stratton's program uses components of Hanf and Kling (1973) and Forehand and McMahon's (1981) "child-directed play" approaches as well as the strategic use of differential-attention and effective use of commands. The program also includes Patterson's (1982) discipline components concerning time-out, logical and natural consequences, and monitoring. It includes teaching parents problem-solving and communication strategies with their children (D'Zurilla & Nezu, 1982). An advanced program, named ADVANCE, was recently developed to focus on personal parental issues other than parent skills, and cognitive perspectives such as: anger management, coping with

depression, effective communication skills, problem-solving strategies between adults, ways to give support, and how to teach children how to problem solve and manage their anger more effectively (Webster-Stratton, 1993).

The BASIC parent training program takes 26 hours (13 sessions) and its methods include a series of 10 video tape programs of modeled parenting skills (250 vignettes, each of which lasts 1-2 minutes) which are shown by a therapist to groups of parents (8-12 parents per group). After each vignette, the therapist leads a group discussion of the relevant interactions and encourages parents' ideas. The group process is based on a collaborative model which includes the therapeutic processes of empowering and supporting parents, teaching, leading, , reframing, predicting, and role-playing (Webster-Stratton & Herbert, 1993). The ADVANCE video tape parent program takes 28 hours and consists of 6 video tape programs which are also shown with therapist-led group discussions. The children do not attend the therapy in either of the programs, although parents are given weekly homework exercises to practice various skills with their children at home.

In terms of a general evaluation for these parent training programs, all have had reports of high parental ratings of acceptability and consumer satisfaction (Webster-Stratton, 1989). The success of short-term treatment outcome is seen in significant changes in parents' and children's behavior and in parental perceptions of children's behavior and adjustment (Webster-Stratton & Hollinsworth ,1991). Home observations indicate success in reducing aggression in children. In a study by Webster-Stratton (1985), to measure the effectiveness of the Basic Program in reducing the number of

aggressive incidences recorded in a household of a child with CD, the level of aggression at home was reduced between 20 and 60%.

Webster-Stratton's program (1984) incorporated components of Hanf and Kling's , Forehand and McMahon's, and Patterson's model. She combined their ideas with her own to develop the most effective methods for training parents- methods which were cost effective, widely applicable, and sustaining. The therapist-led, group discussion, videotape modeling method has been shown to be equally as good as, if not more effective than a parent training program based on the individualized "bug-in-the-ear" approach, a parent group discussion approach (without videotapes), or a completely self-administered video tape modeling approach (without therapist feedback or group discussion); (Webster-Stratton, Kolpakoff, & Hollinsworth, 1988,1989). This analysis suggests that parent-training methods based on video tape modeling plus parent discussion and support will produce more sustained long-term effects than programs which do not use these methods. The group approach is also a cost-effective alternative to the conventional parent-training format of individual therapy with a single family.

Research has also shown that parent and family characteristics such as marital distress, spousal abuse, lack of a supportive partner, maternal depression, poor problem-solving skills, and high life stress are associated with fewer treatment gains (Webster-Stratton, 1990). Families with socioeconomic disadvantages and a lack of social support for the mother outside of the home are less likely to maintain treatment effects. Webster-Stratton's ADVANCE program focuses specifically on the issues of anger management, coping with depression, effective communication skills, problem-solving strategies between adults, ways to give and get support, and how to teach children to problem-solve

and manage their anger. Those who participated in Webster-Stratton's ADVANCE program showed significant improvements in their marital and problem-solving skills. These people also showed significant improvements in their parenting skills as well (Webster-Stratton, 1992, & Webster-Stratton, 1994).

Child Treatment Programs

A variety of innovative child training programs have been developed in recent years to help children who exhibit behaviors consistent with conduct disorder (Bierman, 1989). There have been two basic types of child skills training approaches.

The first program/training approach attempts to train the child by targeting social behaviors based on the hypothesized social skills deficit. Such programs coach children in positive social skills such as play skills, friendship, conversational skills, academic and social-interaction training, and behavioral control strategies (Webster-Stratton, 1993). The second type of child training approach relies on cognitive-behavioral methods and focuses on training children in the cognitive processes (e.g., problem-solving, self-control, self-statements) or the affective domain (e.g., empathy training and perspective taking).

The method used by both of these approaches usually includes verbal instructions and discussions, opportunities to practice the skills with peers, and role-playing. Games, stories, and therapist feedback and reinforcement are also widely used (Webster-Stratton, 1993).

Dodge's (1986) information-processing model, based primarily on cognitive behavioral methods, has become the basis for many of the child training approaches that have been developed. The model describes how a child perceives and then decides how to

react to problematic social situations. According to Dodge (1986) aggressive children have been found to have difficulties at the five information processing steps of his model. The following are the five steps in Dodge's information processing model that often cause problems for aggressive children:

First, aggressive children attend to more of the hostile cues in social stimulus, tend to have a recency bias in their memory cues, and attend to fewer cues before forming an interpretation of the event. Second, when they form an interpretation of the encoded cues in an ambiguously-defined problem situation, aggressive children are more likely to perceive that others had actively hostile intentions. Third, after a problem is perceived, aggressive children think of strategies or solutions that are less competent, and involve more action-oriented efforts and fewer verbal assertion strategies. Fourth, aggressive children anticipate that aggressive solutions will have more positive consequences and newer consequences than do non-aggressive children, thus increasing the probability that aggressive children will select an action-oriented or aggressive strategy to resolve the problem. Fifth, the aggressive child can be socially unskilled in behaviorally enacting the selected strategy. Thus, aggressive children display cognitive distortions at the first two steps, cognitive deficiencies at the third and fourth steps, and a behavioral deficiency at the fifth step. Aggressive children's information processing is further affected by overt behavioral consequences and by general cognitive operations and schemas.

The child's behavioral product in the fifth step of the above model will become either more or less likely to be used in the future, depending upon the consequences that follow the behavior. The influence of operant conditioning is often under-emphasized as a component of cognitive behavioral interventions, but the behavioral consequences

provide the primary motivation for increasing and maintaining new behavior and for inhibiting old behavior (Lochman, Dunn, & Klimes-Dougan, 1993). Comprehensive cognitive-behavioral programs attempt to enhance the generalization of intervention effects by directly impacting on the consequences and by emphasizing that different situational contexts may have different behavior-consequence contingencies.

The role of other cognitive parameters in information processing must also be defined. Cognitive behavioral interventions appear more likely to be effective if they focus on how children appraise and resolve social problems under different levels of arousal, with different memory retrieval styles, and if they focus on the effect of cognitive schemas such as social goals (Lochman, White, & Wayland, 1991).

One intervention technique that deserves recognition and discussion is the Anger Coping Program developed by John E. Lochman and his colleagues (1986). The program was developed out of the conceptual and assessment model developed by Dodge (1982). The Anger Coping Program was developed as a school-based secondary prevention program for aggressive children. The program consists of 18 weekly group sessions conducted for 45-minute to 1-hour periods during the school day. Groups usually consist of 4-6 students identified by school personnel as highly aggressive and disruptive. The two group leaders consist of one school co-leader (counsellor, psychologist) and one co-leader from a local mental health clinic (psychology, psychiatry, and social work staff and trainees), if possible. Group sessions include discussion, activities, role-playing, videotaping, and goal setting. Topics dealt with during the groups include perspective taking, awareness of physiological arousal, use of self-instruction to inhibit impulsive responding, and social problem-solving (Lochman et al., 1987).

Numerous studies have been undertaken to measure the effectiveness of the Anger Coping Program (Lochman et al., 1981; Lochman, Burch, Curry, and Lampron, 1984; Lochman and Curry, 1986; Lochman, Lampron, Gemmer, Harris, and Wyckoff, 1989). Findings have shown that students who have received treatment showed a significant decrease in aggressive behavior and increased their time appropriately on task in the classroom (Lochman et al., 1981). Other studies have also seen decreases in aggressive behavior but added that the subjects showed significant lower rates of parent-rated aggressive behavior and tended to have higher levels of self-esteem and general self-worth following the intervention (Lochman & Curry, 1986; Lochman et al., 1989). The long-term effects of the program also have been analyzed as well. In a study of 31 boys who received the Anger Coping program, 52 untreated aggressive boys, and 62 non-aggressive boys at follow-up period of three years after the intervention, suggested that indicators of maintenance and preventive effects were found, but other behavioral gains were not maintained as well (Lochman, 1992). The Anger Coping Program group had higher levels of self-esteem, lower rates of irrelevant problem solutions on a problem-solving measure, and lower rates of alcohol, marijuana, and other drug use, in comparison to untreated aggressive boys. Boys in the Anger Coping Program group were functioning in a range comparable to the non-aggressive boys on the follow-up measures, indicating a prevention effect for substance use and a relative normalization of their self-esteem and social problem-solving skills. However, reductions of aggressive behavior were not maintained as well, and prevention effects for delinquency were not found. These results indicate that cognitive-behavioral treatment interventions can have clear and enduring

effects with children, but that other intervention components and augmentations should be considered to promote broader maintenance of gains.

School Intervention Strategies

At a 1992 conference in Baltimore, Maryland, more than thirty publishers offered a variety of packages designed for teachers and counsellors use in teaching effective social skills to children (Horne et al., 1992). This reflects publishers' awareness of the importance of assisting teachers and counsellors in this increasingly important aspect of the curriculum. School related factors have a great effect on the development of conduct disorder, and it is for this reason that intervention strategies used to treat the disorder should have a school focus or component (Webster-Stratton, 1993). Formal recognition of and attention to children exhibiting characteristics of conduct disorder seems critical for successful outcomes for the schools and the students. Lochman et al. (1987) suggest schools are a primary practical focus for secondary prevention interventions because of their efficient access to high-risk cases, the availability of potential helping resources (e.g., counsellors, teachers, social workers), and easier placement of the child in an intervention (Lochman et al., 1987). Teachers and classmates are in a good position to identify the most aggressive and disruptive children relative to the other children in their classes. Once identified the student can receive services from the classroom teacher and the school counsellor.

School-based interventions can be seen as either indirect or direct services, in which the psychologist or the intervenor indirectly helps the child by directly changing the teacher's behavior through consultation and training, or direct services in which the

intervenor provides intervention directly to the child. The most comprehensive strategies would include both indirect and direct interventions.

Before school intervention strategies are implemented it is imperative that the nature of conduct disorder is fully understood within the school. Historically, antisocial behavior constitutes a pervasive, costly, and increasing problem in the schools. Often the focus of the discussion centres on the disruptions within the classroom and school functioning, violence, destruction of property, and teacher and student stress and victimization. In addition to these notable negative effects of the disorder on educational institutions, outcomes for children with CD in the schools also are often negative. Many are placed in special education programs, and others who may perform marginally in the classroom are often referred to in-school suspension programs or to alternative schools. Many are suspended, drop out of school, or are remanded to the juvenile justice system (Short & Shapiro,1993).

School based prevention efforts have to be aimed directly at helping the child with CD. These school based efforts may prove to be a more effective and productive way of helping a child with conduct disorder than the traditional placement or exclusion strategies more commonly used for children with CD. Schools should recognize and try to accommodate the needs of a child with this type of behavior disorder. As previously mentioned, traditional school-based intervention strategies including counselling, in-school suspension, and alternative schools may have limited effectiveness because they neglect the complexity of the problem and the necessity of dealing with it on multiple levels, depending on the individual characteristics of children and their ecology. Effective service delivery may have to move from short-term, unidimensional strategies

to include comprehensive ways of preventing and intervening in schools and school systems. Failure to recognize and deal with CD and its problems may have serious and far-reaching consequences for schools, communities, and society as a whole.

Educators often view youth exhibiting the behaviors of CD as chronic troublemakers or discipline problems, who have no place in a public school. As a result the teacher is often unequipped, unprepared, and untrained to manage students with severe, difficult-to-manage characteristics of conduct disorder.

Teachers have a major effect on children with CD. It has been found that childen with these behaviors receive less support from teachers, develop poor reationships with teachers, and that teachers react negatively to these students (Ladd, 1990). Rutter and colleagues (1976) found that characteristics such as emphasis on academic work, teacher time on lessons, teacher use of praise, emphasis on individual responsibility, teacher availability, school working conditions, and student teacher ratios were related to oppositional behaviors, delinquency, and academic performance.

Many parents of children with CD have had negative encounters with teachers concerning their children's behavior problems. Such encounters only add to a parent's feeling of incompetence and a sense of helplessness regarding strategies to solve existing behavior problems. This negative experience often alienates parents from the school. This pattern of child negative behavior, parent demoralization and withdrawl, and teacher reaction to behavior problems within the classroom ultimately can lead to a lack of coordination and support between the socialization activities between the school and the home.

Teachers need to be trained to understand the complexity of CD and the use of different teaching strategies to assist the child with CD. Many educators have limited skills for managing severe externalizing problems in their classrooms (Kaufman & Wong, 1991). Regular education teachers have had little formal training for dealing with internalizing problems such as depression, phobias, or suicidal behavior. Children with comorbid externalizing and internalizing problems require expertise in both of these domains. Current efforts to integrate students with disabilities into the regular education settings have expanded the teacher's responsibilities for coping with both types of problems. Additional teacher training is therefore critical for the success of integration efforts on behalf of children with externalizing and internalizing problems (McConaughy & Skiba, 1993). Teachers could also be introduced to the idea of incorporating models such as the Anger Coping model into the curriculum, using the CD student as the focus but benefiting all other students in the class as well. In a study of first-grade students, students were exposed to a cooperative classroom intervention called the Good Behavior Game (Barrish, Saunders, & Wolfe, 1969). Results indicated significant improvements in children's behavioral conduct relative to children in no-intervention control classrooms. In the same study, when a mastery learning procedure was used in the classrooms the mean level of academic performance was significantly enhanced. Cole and Krehbiel (1984) report that an academic intervention with socially rejected children, significantly reduced disruptive school behaviors, improved social status, and increased teacher attention.

School-related services to children with CD, historically have been school-based. Formal school-based services for children with conduct disorders have been limited to classrooms for children classified as seriously emotionally disturbed. However, the multidimensional, multi-determined nature of conduct disorder may exceed the current capabilities and resources of schools and school-based professionals. Children with conduct disorders often have multiple problems on multiple levels, requiring the services of multiple agencies and service providers. This has also been a problem because there has been very little coordination between helping services and agencies. Saxe, Cross, and Silverman (1988) noted that cross-agency coordination of children's mental health services is almost non-existent. The lack of communication between agencies leads to a duplicating ineffective service for the child with CD. Given the complexity, prevalence, and severity of conduct disorders, comprehensive coordination and collaboration may be a fundamental necessity for effective interventions (Short & Shapiro, 1993).

School personnel, parents and community agencies may need to become more involved in service activities outside of the school system. These might include parent training, family interventions, community coordination, and group work in addition to more traditional educational instruction and tutoring activities. In addition to improving skills among participants, these activities would increase awareness of school activities and commitment to the school and community as positive institutions within society. Schools may need to become more open and inviting to parents and community members. School-based activities might include academic and parenting instruction for parents, collaborative problem solving, and team and committee participation in school activities.

Comorbidity Issues

The issue of comorbidity between conduct disorder and other disorders is an important consideration when devising treatments and interventions for the problem behaviors. Conduct disorder is often comorbid with other diagnoses, most notably Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD). It is likely that comorbidity is the rule rather than the exception among cases referred for treatment (Kazdin, 1997). The research surrounding comorbidity and CD has been very narrow in its scope. It has been researched primarily on the basis of symptoms and diagnosis.

It is necessary to expand the notion of comorbidity beyond symptoms and diagnosis. A central issue for treating conduct-disordered youth is the degree of the impairment they experience. The impairment can include other disorders (e.g., depression, substance abuse), learning difficulties (specific reading disorders, language delays, learning disability), dysfunctional peer relations (rejection, absence of prosocial friends) and perhaps deficits in prosocial activities (participation in school activities and extracurricular activities). Problems of dysfunctions in each of these areas, apart from conduct disorder symptoms themselves, can influence the effects of treatment and long-term prognosis (Kazdin, 1997).

Research has not provided guidelines for how to address comorbid conditions. Kazdin (1996) suggests that much of the treatment research to date has eschewed diagnosis so that the number or proportions of youth which meet the criteria for any disorder is usually unclear. According to Kazdin (1997) very little can be said about

whether comorbid conditions invariably influence outcome, whether the influence and direction of that influence vary by the specific comorbid condition, or how to alter treatment in light of these conditions. This area of work represents major deficiency in knowledge base among even the most promising treatment of conduct disorder.

There are differing views regarding interventions for children comorbid with conduct disorder and another disorder. There is a keen interest, both in clinical work and in research, in using combinations of treatments for the treatment of psychological disorders (Kazdin, 1997). We cannot assume that a combination of treatments will have a more positive effect than singular treatments. In the case of child and adolescent therapy, combined treatments have not been well studied. Most often the effectiveness of a single therapy has not been studied in enough detail, and we do not know why it was effective or not, and what had caused the effectiveness or ineffectiveness. Combining techniques of which we know very little, is not a firm base to build more effective treatments (Kazdin, 1997). Kazdin believes that combined treatments may be useful and should be pursued; however, a move to combine treatments quickly is unwarranted. The effects of the combined treatment plan depend very much on the individual treatments included in the combination. He also believes there is a danger in using techniques that are unproven or have little evidence of their effectiveness, and that one cannot assume that combined treatments will automatically be neutral or better than their constituent treatments. Abikoff and Klein (1992) acknowledge that there are no empirical guidelines that identify optimal diagnostic criteria for treatment planning for children comorbid with CD and ADHD, and that the treatment of comorbid students have focused on pharmacological treatments.

Schacher and Wachsmuth (1990) believe that there is validity to the notion that correlates of the disorder do influence treatment. For example, parents of children comorbid for ADHD and CD tend to have high rates of psychopathology, poor parenting skills, and marital discord. They believe that treatments should be planned accordingly. Treatments could include parent management training, marital therapy, or parental psychotherapy or pharmacotherapy. At least, evaluations of these parameters should be included in the treatment studies. Also, given that the presence of ODD heightens the risk for CD associated with ADHD (Farrington et al., 1990), a reasonable clinical approach would include treatment strategies that target the child's oppositional behavior towards parents and other adults in the hope of preventing serious conduct disturbance. They also believe that treatment planning should take into account the pervasiveness of the disorder so as to implement interventions in certain settings.

It is difficult to comment on the effectiveness of various intervention strategies used to treat comorbid conduct disorder students because very little research, other than pharmacological research, has been done in this area (Abikoff and Klein, 1992). Researchers and practitioners must continue to strive to understand the issue of comorbidity and devise treatments and combinations of treatments to effectively treat CD. However, the key is research and documentation so that the knowledge base within this particular area of conduct disorder can expand and other researchers can draw on the information and contribute further to this field.

In conclusion, Conduct Disorder has proven to be a difficult, multi-dimensional class of behaviors that has been resistant to diverse treatment strategies. The characteristics and the stability of the disorder have been well documented, as well as the

factors that influence the development of the disorder such as child personal factors, peer factors, school factors, parent and family factors, comorbidty issues, and other correlates. To successfully treat conduct disorder a great deal of cooperation is needed. To focus exclusively on a single factor such as the home environment, parenting, schooling, or the individual child is too limiting to promote long-term benefits to the child. All treatment programs must cooperate together if the conduct-disordered child is to receive effective help. This means devising programs that would include the home, the school, community, and mental health services working and communicating together in providing interventions for the child.

Significant issues remain to be addressed to accelerate advances in the area of treatment for conduct disorder, for little in the way of effective treatment has been generated for Conduct Disorder (Kazdin, 1997). As previously stated treatment programs have to combine the resources of the school, community, the home, and mental health services to provide effective treatment. These treatments can be used as preventative measures as well, targeting at-risk children at the pre-school level. The pre-school level is the optimal age for this type of intervention to take place. Treatment strategies have to be researched fully and documented so that evidence of their effectiveness can be seen. Further development of treatment is clearly needed. Apart from treatment studies, further progress in understanding in the nature of conduct disorder is likely to have very important implications for improving treatment outcome.

In summary, this paper has outlined various intervention strategies (programs) aimed at each of the factors that contribute to the development of conduct disorder, namely child, parental and family, school related factors, and comorbidity factors. The limitations and effectiveness of each type of program has been outlined as well. It should also be noted that none of these programs will likely work as a singular treatment program for CD and that if the interventions are to be successful all of the contributing variables in the development of CD must be targeted and cooperation at all levels such as the home , school, and other outside agencies must take place.

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Paper Folio Three

Conduct Disorder: An Individual Case

Introduction

The purpose of this paper is to examine a number of variables that contribute to the development of conduct disorder in light of an individual student who presented behavior consistent with conduct disorder (CD). For the purposes of this paper the student will be called Paul. Various aspects of Paul's personal, family, and social life, and educational experience will be discussed.

Limitations

This particular study is limited in its scope and its generalizability, as it deals with the life of one particular student. However, it will provide a useful and relevant look at a student who exhibits behavior consistent with conduct disorder and the various influences in his life that appear to put him at risk.

Definition

The term conduct disorder has generated a great deal of research throughout the years, most notably from people such as Kazdin (1997), Webster-Stratton (1993), Lochman (1993), Frick (1993), Abikoff & Klein (1992), and Horne et al., 1992). Conduct disorder constitutes a class of chronic, severe anti-social behavior that typically begins in early childhood and extends into adulthood (Robins & Ratcliff, 1979). Conduct disorder is a complex problem with multiple facets, co-variates, and determinants. The extent to which these anti-social behaviors are sufficiently severe to constitute conduct disorder depends on several characteristics of the behavior, including their frequency, intensity, chronicity, whether they are isolated acts or part of a larger syndrome with other deviant behaviors, and whether they lead to significant impairment of the child as judged by parents, teachers, or others (Kazdin, 1997). Jessor (1991) has proposed that

these dimensions provide a useful framework for understanding and preventing childhood psychopathology, including conduct disorder.

Contributing Variables

Webster-Stratton (1993) supports the notion that multiple influences and factors contribute to the maintenance of conduct disorder in young children. These include child/personal, parent, family, peer, and school related factors. Horne et al. (1992) suggest that environmental factors also have an effect on the maintenance of conduct disorder.

Child/Personal Variables

Three specific areas, which are known to be contributing factors to CD, will be reviewed under this heading: temperament, cognitive deficits, and academic deficiencies.

Temperament

The child's temperament (e.g., activity, adaptability, mood) is an area that has been studied the most in relation to conduct problems (Thomas and Chess, 1977). There are significant correlations between early assessments of temperament characteristics such as infant difficulty, unadaptability and negative affect, and later aggressive problems. Factors such as family conflict or support and quality of parent management strategies appear to interact with temperament to influence outcomes (Webster-Stratton, 1993).

Cognitive Factors

Cognitive factors play an important and well documented role in anti-social behavior and conduct disorder (Dodge,1993). Milich and Dodge (1984) suggest that children with conduct disorder distort social cues during peer interaction, and often interpret ambiguous interpersonal stimuli as being hostile. These misinterpretations often lead to an aggressive response to a misperceived hostile stimulus. Data also exists which indicates that children who display behaviors associated with CD have deficits in problem-solving skills, particularly in generating multiple and/or prosocial learning problem solutions (Short & Shapiro, 1993). Webster-Stratton (1993) suggests that children with CD may generate fewer alternative solutions to social problems, seek less information, define problems in hostile ways, and anticipate fewer consequences for aggression.

Academic Deficiencies

Low academic achievement often manifests itself in children with conduct disorder in the elementary grades (Kazdin, 1987). Hogan and Quay (1984) associate reading disabilities, language delays, and attention problems to conduct disorder. Antisocial behavior has been linked to poor academic performance, to low participation and disruptive behavior in the classroom (Frick et al., 1991; Hinshaw, 1992; Tremblay et al., 1992; Rinker, 1990). Herbert (1987) associated increased rates of truancy with conduct disorder. Robin (1991) showed a link between conduct disorder and dropping out of school. According to Webster-Stratton (1993) conduct problems and a lack of reading ability both place the child at high risk for lower self-esteem, continued academic failure, further conduct problems and eventual school drop-out.

Parental and Family Influences

Parenting interactions are clearly the most well researched and most important proximal cause of conduct problems (Webster-Stratton, 1993). Research has indicated that parents of children with CD lack fundamental parenting skills. For example, parents of such children have been reported to exhibit fewer positive behaviors; to be more violent and critical in their use of discipline; to be more permissive, erratic, and inconsistent; to be more likely to fail to monitor their children's behaviors; and to be more likely to reinforce inappropriate behaviors and to ignore or punish pro-social behaviors (Webster-Stratton, 1993)

Patterson and colleagues (1986) developed the "coercive hypothesis" which postulates that children learn to get their own way and escape or avoid parental criticism by escalating their negative behaviors, which in turn leads to increasingly aversive parent interactions. As the coercive training in a family continues over time, the rate and intensity of parent-child aggressive behaviors are increased. The coercive parent-child interactions are not by parental choice, but rather a result of not knowing how to effectively manage children with problem behaviors.

The child's family context can be narrowed to several aspects that seem particularly influential on the development of conduct problems. These factors include the parents' psychological adjustment, their marital relationship, and the socialization practices they employ (Frick, 1993).

One type of parental adjustment with a well-documented link to child development is parental depression. Studies have found between that between 40% (Orvaschel, Walsh-Allis, and Ye, 1988) and 74% (Hammen, Adrivan, Gordon, Burge, &

Jenicke, 1987) of the children of depressed parents exhibit significant anti-social problems.

Children with conflict problems are more likely to have parents who abuse drugs than other children (Frick et al., 1992). A comprehensive review of the literature found that parental alcoholism is associated with a number of child adjustment problems, not just conduct problems (West and Prinz, 1987).

Inter-parental conflict leading to and surrounding divorce is associated with the development of conduct problems (Amato and Keith, 1991). Researchers found that it was not the divorce per se that is the critical factor in the child's conduct problem, but rather the intensity of parental conflict and violence associated with divorce (O'Leary and Emery, 1982). Marital conflict is associated with child adjustment difficulties, inconsistent parenting, the use of increased punitiveness and decreased reasoning, and fewer rewards with children (Stoneman, Brody, & Burke, 1988). Conflictual unhappy marriages displaying aggressive behavior are more likely to incite the formation of conduct disorder (Webster-Stratton, 1993).

Other family factors such as poverty, unemployment, crowded conditions, and illness have negative effects on parenting, and are related to a variety of forms of child psychopathology, including conduct disorder (Webster-Stratton, 1993).

Environmental Factors

Environmental factors can contribute to behavior problems and the development of conduct disorder in children. The neighborhood and community in which the child is reared has a strong influence on the development, or lack of development, of behavior problems. Children who grow up in areas where there is high incident of vandalism and

crime are more likely to engage in those behaviors themselves (Horne et al., 1992). Low-income families may live in neighborhoods in which the aggressive behavior is likely to be reinforced by the community. No one factor causes delinquency or behavioral problems, but rather, the interaction of factors working together result in children experiencing problems in their development (Horne et al., 1992).

Peer Variables

Peer variables have also been associated with conduct disorder. Children that behave aggressively, are rejected by their peers (Ladd, Hart, & Price, 1990). This rejection leads to the development of ineffective and inappropriate social competence skills. These children are seen as outsiders or bullies and are often ignored or feared by their peers. In an attempt to be accepted by peers, these children often increase their coercive activity, thus trying to force their ways into friendships. When these actions fail, the child may rely even more heavily upon force and power to establish their role with their age mates (Horne et al., 1992). After failing to win acceptance into peer groups through coercive efforts, they begin to develop friendships with others similar to themselves thus forming a deviant peer group (Dishion, Patterson, & Stoolmiller, 1991). The deviant peer group may consist of several highly aggressive children, all exhibiting similar characteristics. These deviant peer groups usually are formed in early adolescence and become involved in serious delinquent and antisocial behavior. Peer rejection can extend across school years (Webster-Stratton, 1993).

The child with CD can have further adjustment difficulties if he or she has negative experiences socially and academically in school. Because of their non-compliant disruptive behavior, aggressive children also develop poor relationships with

teachers and receive less support and nurturing in a school setting (Webster-Stratton, 1993). One study reported that antisocial children were much less likely to get encouragement from teachers for appropriate behaviors and more likely to get punished for negative behavior than well-behaved children (Walker & Buckley, 1993).

Treatment

Kazdin (1997) states that little in the way of measurable effective treatment has been generated for conduct disorder, however, there have been significant advances in treatment areas. Conduct disorder has been resistant to diverse treatment strategies. Successful interventions for the disorder take into account the complexities of the syndrome, thus requiring collaboration and coordination across a number of settings and among the numerous community agencies that serve these children with the troubled behavior patterns. Webster-Stratton (1993) suggests that only integrated and comprehensive interventions which target multiple symptoms of conduct disorder across risk factors, settings, and agents can hope to change the developmental trajectory for the child with CD.

The most effective programs will be those that facilitate children's social competence and conflict resolution skills and prevent the downward slide into peer rejection, deviant peer groups, failure and school dismissal. The most effective programs will be those which involve schools, teachers, and the child's peer group in the interventions alongside the family intervention.

An Individual Case of Conduct Disorder

It is clear from the above that there are a number of variables that affect the development of conduct disorder. Each person that portrays behavior consistent with CD may experience these factors to differing degrees. Through the presentation of Paul's case we will examine the variables that may have led to his development of behavior consistent with CD. The treatment strategies used by the helping agencies to treat children with CD are also diverse and complicated. The strategies used by the helping agencies that worked with Paul will also be discussed.

Personal/Academic Data

Paul's case supports the research on CD that states that children with behavior consistent with CD often have academic difficulties or learning disabilities (Hogan and Quay, 1984; Kazdin, 1987). According to data collected from a Pre-Psychiatric Assessment, Paul reached all of his developmental milestones on time. His guardian described him as pleasant child with no behavior difficulties. This conflicts with Webster-Stratton's and Eyberg's (1982) research that states that child that develop CD are often of a fussy and irritable temperament as children, and are resistant to discipline. Paul appeared to have no significant cognitive defects. On the Wechsler Intelligence Scale for Children-Revised (1974), administered in December of 1985, he had a verbal high average IQ, and average performance IQ and an average full scale IQ measure. On the Peabody Picture Vocabulary Test-Revised (1981), a test that measures vocabulary, Paul was defined as a rapid learner. Slight reading difficulty was detected on the Slosson Oral Reading Test (1981). On the T-Early Reading Ability, he was a ½ year below his age mates, thereby indicating an absence of a learning disability.

Paul, however, had a history of academic difficulties. As early as grade one he was receiving small group placement for academic support with the focus primarily on reading and more one on one assistance. This continued for the second grade, he repeated second grade. Teachers reported his academic difficulties were mainly due to time off task.

Small group placement continued through his primary and elementary years. In Jr. High he began to have increased difficulty with his academic program. High absenteeism began to occur from Grade 6-8. Paul failed Grade 7 and Grade 8 partly because both years he was absent for a total 66.5 days. His high rate of absenteeism and time off task due to suspension and behavior are seen as factors for his lack of academic success.

Parental and Family Variables

Paul's parental and family variables are also consistent with present research findings related to CD, specifically how inconsistent discipline practices and permissive parenting can lead to CD (Webster-Stratton, 1993). Divorce is a factor in Paul's case. Divorces that take place and have violence and conflict surrounding them can incite the formation of CD (Stoneman, Brody, and Burke, 1988). The marriage of Paul's parents ended when he was an infant so he was spared growing up in a house where both parents were in constant conflict. Both parents moved to the mainland and neither parent wanted custody of the child. Paul was adopted by his aunt, Mrs. Jones, an elderly widow woman, who lived by herself at the time. She was unemployed and living on her old age pension and social services. Although, the income seems menial, Paul never went without anything in the material sense. The situation would be considered poverty on a national

scale, but in relation to the community, their standard of living would be considered average or slightly above average.

Ms. Jones worked hard at raising Paul and showed genuine concern with his well-being. There seems however, to be significant deficits in her parenting skills. Ms. Jones' permissiveness in regards to the parenting of Paul was evident as on a number of occasions. Paul was allowed to smoke in the house in front of his aunt at an early age. He was also permitted to stay up as long as he wished and curfews were not enforced regularly. Her use of discipline with Paul was erratic and inconsistent . For example, if he was suspended from school for inappropriate behavior there were no consequences at home. At times punishment such as grounding, no TV, or phone were attempted but not carried out fully. A grade five teacher stated in a report that Paul never had to follow a set of rules at home and that he was permitted to do whatever he wanted, therefore he found it difficult to conform to normal classroom behavior.

On a number of occasions Ms. Jones would allow Paul to stay home from school when he had tests or assignments due. In meetings with school officials, she would often take "his side" in claiming that the school was being too hard on him and was "putting too much pressure on him". She also provided notes on a number of occasions when Paul missed tests due to absenteeism.

A teacher claimed during a PPT (Program Planning Team) meeting that telephone calls home were having no effect. Ms. Smith also reiterrated this by claiming that "there's nothing she can do with him", "I can't control him". It seems that Paul was able to manipulate his guardian and win her support. This is seen through the laying of blame on the school for Paul's problems, allowing him to stay home from school for sickness and lack of sleep without forcing the issue of a medical check-up.

Environmental Factors

Home et al. (1992) believe that the environment in which a child lives can contribute to behavior problems and the development of CD.The community certainly has played a role in Paul's case, however not in the same manner that is discussed in the present research. The community, although, it is very poor and is primarily made up of low income earners, does not reinforce aggressive behavior. It is a rural, isolated community with a low a social-economic status. RCMP records indicate a reduction in the crime rate over the past 3 years, specifically in the area of Break and Entries and Vandalism. Per capita, the community seems to be in par with the rest of the province for the rate of crime and types of crime committed. The poor social economic status and the isolation of the community add limits as to what can be done within the community for recreation. This lack of options could, and often do lead to mischief, vandalism, loitering and other types of undesirable behaviors on the part of teenagers. In terms of recreational opportunity, the only outlet for kids in the community was through various athletic teams and programs. This satisfies the needs of many youth however, for children who are not athletic or uninterested in athletics, they are further isolated from their peers.

Peer Variables

Paul's relationship with his peers clearly supports the research put forth by (Ladd, Hart, and Price, 1990) that states that children who are aggressive are often rejected by their peers and that this rejection can lead to the development of conduct disorder. It also supports Horne et al. (1992) who state that rejected children often depend upon bullying and control to establish their roles with their age-mates.

From the early stages of school Paul was rejected socially be his peer groups. His aggressive behavior and bullying can be attributed to this. Teachers reported during a PPT meeting, that other students fear him. He was also referred to a school board Psychologist in March 1995 for an assessment due to inappropriate physical contact and bullying.

The School Psychologist reported that Paul was receiving positive attention from his "acting out" with younger students. This attention helped develop his identity through negative inappropriate behavior. The psychologist felt he would probably work better with older students, and that this should be considered when reaching a recommendation for advancement or placement. It was noted that Paul tends to be aggressive, tends to dominate younger students, and has an attention seeking personality. This aggressive behavior in class caused problems for a physically handicapped child in a wheel chair. The students' parents voiced their concern to the school, the school board, and the P.T.A, about how Paul's inappropriate aggressive behavior in the classroom could bring about serious harm or even death to their child.

There is also evidence of the development of a deviant peer group for Paul, which is consistent with the hypothesis put forth by Dishion, Patterson, and Stoolmiller (1991). Although, he was for the most part rejected by the majority of peers, there was a group of young men his age where his aggressive tendencies, behaviors, etc. were accepted, reinforced, and valued. The group for small placement for academic support contained five other students, not unlike Paul, where their negative behavior in the classroom interfered with their learning. Negative behavior within this group, in terms of classroom behavior, was very common. At one point during this group's grade nine year, six of nine students in the class room were on probation for breaking the law. Five of the classmates had spent time in facilities such as the Whitbourne Correctional Center for boys and open custody in St. John's.

Counsellor records indicated trouble with the law for vandalism and break and entry. Paul began smoking at age of 12. It was noted in the counsellor's records on Paul that he was identifying with other problem children, particularly those in trouble with the law, and those whom would be considered to be major discipline problems within the school.

School Experiences

Paul's school experience can best be described as negative. His behavior within the school setting can be attributed as the main reason for the negative experiences. At an early age Paul was identified as easily distracted and disruptive within the classroom setting. His early academic troubles were attributed to time off task and involved behavior such as not paying attention in class, not completing assigned work, being disruptive within the class, and refusing to participate in in-class activities and discussion.

As he grew older his academic difficulties increased and his negative behavior in the classroom escalated as well. It would be impossible to list all of the incidences of negative behavior in Paul's school history. The items included here are summaries of teacher incident reports that are collected within a school setting and kept in the student's personal file. These reports are usually written when a student has been removed from class and all attempts at disciplining the student without administrative intervention have failed. They are normally written for what teachers consider the more serious discipline problems. From September 27, 1993 to January 31, 1995 there were forty-five incident reports recorded in Paul's personal file.

Most of these reports concern the breaking of established rules within the classroom and school settings. They include such things as being disruptive in class, throwing objects, and being a general distraction to others. Others involve the use of foul language and inappropriate behavior such as belching, spitting on the classroom floor, and the like. Some of the more serious include being verbally abusive to teachers and fellow students, threatening to do physical harm to teachers and students, fighting, and the destruction of school property (tearing up books, exams, ripping a sink from the washroom wall).

The following are summaries of incident reports taken from Paul's personal file at the school. On December 14, 1993 Paul refused to do his assigned work and tore up his exam and threw it in his teacher's face. In a separate incident, during a Physical education class he began fighting with and kicking another student. He then began to use foul language directed to the teacher who had intervened. He threatened the teacher with violence and then threw a stick at her. In another incident a teacher was attempting to

keep Paul on task during a class assignment when Paul yelled out loudly, " Fuck this I'm going down to see Mr. X (principal) and getting the fuck out of here." A final example involved Paul's calling a female teacher " a fucking bimbo." These incidences are given in an attempt to provide a general "feel" for the incident reports provided by teachers regarding Paul's behavior within school. They should are not considered to be his most serious or least serious in nature.

The more serious cases would result in a suspension from school. The suspensions would range from one day in-school suspensions, where the Paul would be allowed to attend school and do assigned work in isolation from his/her peers, to one day to five day suspensions where he would not be allowed to attend school. Five- day suspensions are the maximum legal suspension permitted by the school board.

The severity of some of the incidents regarding threats and physical assaults, and the interference with the quality of learning that the other students in the class led to the implementation of a half-time program of education for Paul at the school. He was permitted to attend school for a half day only. It was felt that Paul could not cope with a full day of classes and that this half-time program would best suit his needs. The other half of his daily studies would be completed at home, where he would complete assigned material with the help of a certified teacher as his tutor, provided by social services.

Treatment Interventions

The interventions used to help Paul cope with his academic program and his behavior problems can best be described as diverse. The programs and interventions used to help him involved the school, teachers, family, and the individual. The interventions used required collaboration and coordination between different helping agencies involved in Paul's life, this was consistent with Webster- Stratton's (1993) research regarding the treatment of CD. All of the interventions that were attempted had limited success due to his resistant attitude.

Individual counselling was the primary intervention strategy used to help Paul. Personal counselling and crisis interventions were completed on a weekly basis by the school counsellor. Most of the counselling records dating back to 1988 indicate counselling centered around Paul's disruptive and inappropriate behavior within the classroom and school setting.

A number of behavior modification programs were put in place involving the use of student contracting and motivational strategies. In the early grades, Paul's favorite ice-cream was used as a reward for positive behavior. For completion of homework assignments, a sticker program was introduced. Paul would receive a sticker if he completed homework and assignments. Four stickers would result in extra gym time for Paul and a selected friend. As Paul got older the behavior modification programs began to change. Paul's rewards were tied to his interests such as extra time for Industrial Arts, Gym, weight lifting, and chess. The counsellor thought that through the use of chess Paul might find a more appropriate way to "show off" and still become accepted by his peers.

A number of the personal counselling sessions were utilized to help Paul overcome some of the personal problems that he was experiencing. Many of the session would be considered crisis interventions, where Paul would have to meet with the counsellor following some type of crisis such as being sent out of class, fighting, or the like. Within these counselling sessions topics ranging from problems at home, peer relations, self-image, his negative behavior, and thoughts of suicide were discussed. The topic of suicide came up in September of 1992, when Paul disclosed to the counsellor that he was thinking of killing himself. The counsellor assessed the seriousness/risk of the threat. As a result a number of interventions were established. Paul signed a "no attempt suicide" contract. His aunt was made aware of the stress he was under in school and the school board educational psychologist was consulted. Paul's probation officer was contacted, and the school administration and teachers were notified of the matter. Paul was also provided with the phone number for the 24 Hour Kids Help Line and Social Services Child Protection division.

Paul also received individualized tutoring and academic support. He received help from his aunt and was assigned tutors from the school. However, he would seldom arrive home or to the scheduled session with books or materials to complete his work.

Group counselling was also used as a treatment intervention. The counsellor discontinued the group therapy because of the resistant power struggle and the group's negative attitude towards the process. It was felt that the members of the group would not become involved at a level where realistic discussion of problems could take place. For the group counselling sessions the counsellor used Arnold P. Goldstein's The Prepare Curriculum (1988). This is a series of coordinated psycho-educational courses explicitly

designed to teach an array of pro-social, psychological competencies to adolescents and younger children who are demonstrably deficient in such competencies. It seeks to teach interpersonal skills to aggressive, antisocial youth as well as to those who are withdrawn and socially isolated. It seeks to teach empathy to the insensitive, cooperativeness to the uncooperative, problem solving to the inadequate, negotiating skills to the acting out, anger control to the compulsive, allocentrism to the egocentric, group processes to the isolated, stress management to the anxious, social perspectiveness to the socially confused, and more. Group members were selected by the counsellor and administration based upon their problem behaviors within the school. Paul was a member of this group. The counsellor selected the following areas of focus for this group: anger control training, asking for help, apologizing, responding to teasing, self-control, dealing with the group, and empathy training. All of these would require the use of a prepared course/program as outlined in the text. All activities/sessions would involve modeling, role playing, and performance feedback within the structure of the group. In terms of evaluating the success of the activities, self reports, teacher reports, and parent reports were used.

Specific family counselling was not utilized. However, a number of home visits were made by the counsellor to discuss, with his aunt, Paul's behavior, and the interventions that were put in place within the school. The aunt was provided with the names of outside agencies that could help Paul. She was also provided with information on positive reinforcement techniques regarding the use of leisure time, television, video games, and allowances, none of these met with much success. Individual counselling sessions with the aunt were also utilized. On a number of occasions she had missed Program Planning Team (PPT) meetings that would look at Paul's progress in his

academic program to date and discuss his behavior. Through the contacts with Paul's aunt the counsellor was able to gain much needed support and cooperation in the development of Paul's academic program. This cooperation was utilized when his aunt agreed to keep him home when the school requested that she do so and was also needed for the implementation of a half-time schooling program that Paul was later placed on.

A number of interventions took place at the school level and involved the cooperation of the administration and the teachers alike. All of Paul's teachers were asked to record his behavior daily in the form of a behavior log. Both positive and negative behaviors were recorded. Also, the more serious incidents of non-compliance with school rules and incidents of inappropriate behavior were recorded on Incident Reports. This was done so that an ongoing log of the student's in-school behavior could be established. Meetings were held periodically to ensure that teachers were consistent on their knowledge of rules and the reporting of incidents.

PPT meetings were also held periodically to discuss Paul's educational program and his progress to date. Teachers, administrators, and Paul's guardian would be present. There appears to be no changes in Paul's disruptive behavior as a result of these meetings.

In-school and out-of school suspensions were also used as interventions in attempts to curb Paul's disruptive and inappropriate behaviors. In-school suspensions are essentially suspensions that involved Paul's attending school but the completion of all work was done in a secluded area. Paul failed to abide by the school rules pertaining to this type of discipline procedure. He would often leave the area he was placed in or cause a disturbance in an effort to gain attention. These suspensions often lead to out of school

suspensions because of his troublesome behavior. After school detentions were often attempted, but Paul would leave the building and refuse to stay thereby, destroying the effectiveness of this type of disciplinary action.

Out of school suspensions became more frequent as the other interventions began to fail. They were used because of his resistance to following school rules and his failure to comply with other forms of discipline. The number of suspensions had a very limited effect on his oppositional behavior toward peers and teachers.

As previously discussed, the lack of success at each level of intervention/treatment lead to the implementation of half time schooling program for Paul. The school and school board felt that given Paul's history of disruptive behavior and the potential danger he was to his classmates and teachers, he would probably best cope with school on a half time basis. He would attend school in the morning for a shortened academic program and with the help of a tutor complete assigned work at home in the afternoon.

In terms of intervention, there was a great deal of cooperation and consultation occurring between all of the helping agencies involved in Paul's particular case. There was ongoing consultation with board officials to discuss various forms of interventions that could be used to help Paul and discussions were also held to clarify board policy regarding legal issues and the like. Referrals to outside agencies for assistance were also utilized. For example, Paul's case was referred to a Psychiatrist. His probation officer was also contacted on a number of occasions to discuss his behavior in school and to gather information regarding his probation order. Meetings and exchanges of information

between the helping agencies were held so that each person involved was brought up-to-date regarding Paul's case and given the opportunity to contribute to the case as well.

Summary

It can be said from the information provided in this paper, that Paul portrayed behavior consistent with CD, as outlined by the DSM IV definition. However, within his personal file there is no diagnosis of the disorder by the psychiatrist that he had seen. The only mention of CD is put forth by the guidance counsellor at Paul's school, who mentioned in a report that he suspected that Paul displayed behavior consistent with CD. A psychiatric diagnosis could have enabled the school and school board to plan programs targeting his behavior. He may have been able to avail of the mental health services outside of the school and educational setting. The guidance counsellor, in this case, used a variety of interventions that targeted Paul's negative behavior and attempted to work cooperatively with other helping agencies to provide services to Paul. These strategies had been identified by the research as being necessary for the successful treatment of CD (Kazdin, 1997).

The specific factors that put Paul at risk of developing CD are very hard to determine. However, variables such as parenting, peer rejection and relationships, and negative school experiences seem to have contributed to Paul's behavior. It is clear that counsellors, teachers, and other in the helping professions need to recognize at-risk children, such as Paul and the variables that put them at risk. Schools can put in place programs and interventions that can help them overcome and avoid many of the problems they may have to face later in life, such as social incompetence, peer rejection, substance

abuse, academic failure, suicidal behavior, and a higher probability of physical injury or premature death.

To whom this may concern,

I, hereby give permission to Tom Moret to use and have full access to my cumulative educational records and personal files for educational research purposes. I understand that all information gathered will be kept strictly confidential and at no time will my identity be revealed.

OCT 29, 1998

Date

Participant's Signature

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