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## ISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

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### Introduction

All children and adolescents exhibit challenging or disruptive behavior at times due to stress or events that are taking place in their homes, schools, or communities. However, disruptive, impulse-control, and conduct disorders are more severe problems that last for a longer period than normal “acting out” behaviors (American Psychiatric Association [APA], 2015). This category of disorders involves problems concerning the self-control of emotions and behaviors (APA, 2013). These disorders are unique in that their associated behaviors are frequently in conflict with societal norms/authority figures and even violate the rights of others (e.g., aggression, destruction of property) (APA). The underlying causes of the problems in the self-control of emotions and behaviors can vary greatly among youth diagnosed with these disorders. Disruptive, impulse-control, and conduct disorders are associated with patterns of escalating problem behaviors leading to negative life consequences, including social, academic, and occupational functioning, substance abuse and, potentially, incarceration (American Academy of Child & Adolescent Psychiatry [AACAP], 2007).

#### ***Recent Changes from the DSM-IV to the DSM-5***

In 2013, the American Psychiatric Association (APA) released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* to replace the fourth text revision (*DSM-IV-TR*). The *DSM-5* chapter on disruptive, impulse-control, and conduct disorders is new to *DSM-5*. It combines oppositional defiant disorder (ODD), conduct disorder (CD), and disruptive behavior disorder not otherwise specified (DBDNOS) with disorders in the “Impulse-Control Disorders Not Otherwise Specified” chapter (intermittent explosive disorder [IED], pyromania, and kleptomania). Previously, ODD, CD, and DBDNOS were included in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” (Gathright & Tyler, 2014). Attention-deficit/hyperactivity disorder (ADHD) was previously included in the *DSM-IV-TR* as a disruptive behavior disorder, but it is now listed in *DSM-5* with the neurodevelopmental disorders. Figure 1 outlines the changes made to ODD and CD, the two most commonly occurring disruptive, impulse-control, and conduct disorders in youth.

**Figure 1**  
**Oppositional Defiant Disorder and Conduct Disorder**  
**Changes from the *DSM-IV-TR* to the *DSM-5***

### **Oppositional Defiant Disorder**

- The symptoms of ODD are now grouped into three types to highlight both emotional and behavioral symptoms.
- The *DSM-5* allows for a co-occurring diagnosis of ODD and CD.
- A new guidance note on the frequency typically required to be considered symptomatic distinguishes the symptoms of ODD from those which commonly occur in normally developing children.
- Children younger than five years old must exhibit this behavior most days, while children over five must exhibit at least once weekly.
- These symptoms should be present over a six month timeframe.
- Finally, the *DSM-5* establishes a severity rating because it has been shown that the pervasiveness of symptoms across settings is an important indicator of severity of the individuals ODD.

### **Conduct Disorder**

- The *DSM-5* did not change CD other than to add a specifier which distinguishes those with a callous and unemotional interpersonal style across multiple settings and relationships.
- The “with limited prosocial emotions” specifier points out additional traits like thrill seeking, fearlessness, and insensitivity to punishment. These individuals may be more aggressive for “instrumental gain.” Traits fitting this specifier are more likely to present in childhood-onset.
- Research shows that callous and unemotional individuals with CD may have a slightly more severe form of the disorder and a different treatment response. Multiple information sources are necessary to assess these criteria, as those who meet it may be less likely to report such behavior.

Source: APA, 2013.

The *DSM-5* is a manual for assessment and diagnosis of mental health disorders and does not include information for treatment of any disorder. In the future, more evidence supporting treatments of disorders with *DSM-5* classifications will be available as clinical studies utilizing *DSM-5* criteria are conducted. As a result, this *Collection* will reference studies that utilize *DSM-IV* diagnostic criteria to explain symptoms and treatments.

### **Categories**

The *DSM-5* criteria for disruptive, impulse-control and conduct disorders are outlined in the paragraphs that follow.

#### ***Oppositional Defiant Disorder (ODD)***

*The information in the following paragraph is from Gathright and Tyler (2014).* Four refinements have been made to the criteria for ODD. First, symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology. Second, the exclusion criterion for conduct disorder has been removed. Third, given that many behaviors associated with symptoms of ODD occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder. Fourth, a severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Youth must demonstrate at least four of the eight following behaviors for at least six months with at least one individual who is not a sibling to meet criteria for a diagnosis of ODD:

Angry/irritable mood

1. Often loses temper
2. Often angry or resentful
3. Often touchy or easily annoyed

Argumentative/defiant behavior

4. Often argues with authority figures or adults
5. Often actively defies or refuses to comply with adult's requests or rules
6. Often deliberately annoys others
7. Often blames others for his or her mistakes or misbehavior

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past six months (APA, 2013)

Oppositional behaviors often manifest in the home setting and with adults the youth knows well. Behaviors may or may not be present in the school and/or community settings, and thus may not be present in the mental health professional's office (APA, 2013). The severity of the disorder is indicated by the number of settings in which the symptoms are present (APA). In addition to the presence of the prerequisite number of symptoms, significant distress or impairment in functioning must also be present in order to make a diagnosis of ODD. These behaviors cannot occur solely during the course of a psychotic or depressive episode or be due to bipolar disorder or substance abuse. ODD can only be diagnosed when the criteria for disruptive mood dysregulation disorder are not met (APA).

### **Conduct Disorder (CD)**

Children and adolescents with CD exhibit persistent and critical patterns of misbehavior. Like children with ODD, youth with CD may have an issue with controlling their tempers; however, these youth also violate the rights of others (Center for the Advancement of Children's Mental Health at Columbia University, 2000). Behaviors exhibited by children with CD include aggression towards people and/or animals, destruction of property, deceitfulness, theft, and serious violation of rules (Murphy, Cowan, & Sederer, 2001). The *DSM-5* describes the actions of someone with CD as "poorly controlled behaviors that violate the rights of others or that violate major societal norms . . . as a result of poorly controlled emotions such as anger" (APA, 2013).

The criteria for CD are that a child must exhibit three of the following 15 symptoms in the past twelve months, with one being 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 dangerous weapon that can harm others
4. Has been physically cruel to others
5. Has been physically cruel to animals
6. Has stolen while confronting a victim
7. Has forced someone into sexual activity

Destruction of property

8. Has deliberately set fires with intention to cause serious damage
9. Deliberately destroyed the property of others

Deceitfulness or theft

10. Broken into someone else's house or car
11. Often lies to obtain goods or favors, or to avoid obligations
12. Steals items of a nontrivial value without confronting the victim

Serious violations of rules

13. Stays out at night despite parental objections (beginning before age 13)
14. Has run away from home at least twice for an extended period of time
15. Often truant from school (beginning before age 13) (APA, 2013)

These disturbances must cause clinically significant impairment in social, academic, or occupational functioning (APA, 2013). If the youth is 18 years of age or older, criteria are not met for antisocial personality disorder.

The *DSM-5* notes that CD can appear as early as the preschool years, with ODD a common premorbid condition that may progress to CD. Middle childhood to middle adolescence is the time frame in which CD most often manifests (APA, 2013). CD is categorized into three types, according to the age at which symptoms of the disorder first occur. These types are listed below.

1. **Childhood-onset CD** occurs when the youth shows one symptom characteristic of CD prior to age 10.
2. **Adolescent-onset CD** occurs when the adolescent shows no signs of CD before age 10.
3. **Unspecified-onset CD** means the individual meets the criteria for a diagnosis of CD but there is not enough information available to determine whether the onset of the first symptom was before or after age 10.

Youth diagnosed with childhood-onset CD are typically male, often display physical aggression, have disturbed peer relationships, and may have had ODD during early childhood. These youth typically develop full criteria for CD before they reach puberty. These children may have concurrent ADHD or other neurodevelopmental difficulties (Braithwaite et al., 2011; APA, 2013). Some may also have limited prosocial emotions. Children with this specific type of conduct disorder are often described as callous and unemotional (APA, 2013).

In adolescent-onset CD, adolescents are less likely to display aggressive behaviors than youth in the first subtype. They will also have more normal peer relationships and are less likely to develop adult antisocial personality disorder (APA, 2013). Unlike childhood onset, which affects more males than females, adolescent-onset CD is more balanced between males and females (APA).

Children and adolescents diagnosed with CD have more difficulty in areas of academic achievement, interpersonal relationships, drugs, and alcohol use (Boesky, 2002). They also are often exposed to the juvenile justice system because of their delinquent or disorderly behaviors. For example, Ferguson and Horwood, (as cited in Boesky), found that 90 percent of children with three or more CD symptoms at age 15 self-reported that they were frequent offenders a year later, compared to 17 percent of children with no CD symptoms. In addition, according to Murphy, Cowan, and Sederer (2001), 25 to 40 percent of children with CD have adult antisocial personality disorder later in life.

### ***Intermittent Explosive Disorder (IED)***

Intermittent explosive disorder (IED) involves impulsive or anger-based aggressive outbursts that begin rapidly and have very little build-up (APA, 2013). The outbursts often last fewer than 30 minutes and are provoked by minor actions of someone close, often a family member or friend. The aggressive episodes are generally impulsive and/or based in anger rather than premeditated. They typically occur with significant distress or psychosocial functional impairment.

Aggressiveness must be “grossly out of proportion” to the provocation and accompanying psychosocial stressors (APA, 2013). The recurrent outbursts are neither premeditated, nor are they to achieve an outcome. Thus, outbursts are impulsive or based in anger, and are not meant to intimidate or to seek money or power. Finally, the outbursts must cause the individual considerable distress, impair his or her occupational or interpersonal functioning, or be associated with financial or legal consequences.

The *DSM-5* now includes two separate criteria for types of aggressive outbursts. The first is characterized by episodes of verbal and/or non-damaging, nondestructive, or non-injurious physical assault that occur, on average, twice weekly for three months (APA, 2013). These could include temper tantrums, tirades, verbal arguments/fights, or assault without damage. This criterion includes high frequency/low intensity outbursts (APA).

The second criterion is characterized by more severe destructive/assaultive episodes that are more infrequent and occur, on average, three times within a twelve-month period (APA, 2013). These could be destroying an object without regard to its value or assaulting a person or an animal. This criterion includes high-intensity/low-frequency outbursts.

The following is a summary of these new *DSM-5* diagnostic criteria:

#### **Diagnosis requires a failure to control aggressive impulses manifested by either:**

Verbal aggression like temper tantrums, tirades, arguments or fights; or physical aggression toward people, animals, or property.

- This aggression must occur, on average, twice per week for three months.
- The physical aggression does not damage or destroy property, nor does it physically injure people or animals.

**or**

Within 12 months, three behavioral outbursts resulting in:

- Damage or destruction of property, and/or
- Physical assault that physically injures people or animals.

The *DSM-5* limits diagnosis of IED to individuals at least six years old or older, or who are at the equivalent developmental level. Children should not be diagnosed with IED if their impulsive and aggressive outbursts occur in the context of an adjustment disorder (APA, 2013). Additionally, the outbursts cannot be better explained by or attributable to another disorder.

### ***Pyromania***

The essential feature of pyromania is the deliberate and purposeful setting of fires (APA, 2013). It involves multiple episodes. The symptoms of this disorder include:

- Deliberately and purposefully setting a fire more than one time.
- Tension or emotional arousal being present before the act of setting the fire.
- Having a fascination with, interest in, curiosity about, or attraction to fire and its uses and consequences.
- Feeling pleasure, relief, or gratification when setting fires or when seeing the aftermath of a fire or the damage it caused.
- The fires are not set for monetary gain, to cover up criminal activity, to express anger or vengeance, in response to any hallucinations or delusions, or as a result of impaired judgment (from another disorder or substance).
- The firesetting is not better explained by CD, a manic disorder, or antisocial personality disorder.

Pyromania as a primary diagnosis appears to be very rare. In people incarcerated for repeated firesetting, only about 3 percent meet all the symptoms for pyromania. For more information on this disorder, please refer to the Juvenile Firesetting section of this *Collection*.

### ***Kleptomania***

Kleptomania involves the impulsive and unnecessary stealing of things that are not needed (APA, 2013). Individuals may hoard the things they steal, give them away, or even return them to the store. The disorder is not about the objects stolen; it is about the compulsion to steal and the lack of self-control over this compulsion. Females with kleptomania outnumber males at a ratio of three to one (APA).

Kleptomania typically follows one of three patterns of stealing: 1) brief episodes of stealing with intermittent and long periods of remission, 2) longer periods of stealing with brief periods of remission, or 3) chronic and continuous episodes of stealing with only minor fluctuation in frequency (APA, 2013). Kleptomania is very rare, with a prevalence rate of 0.3 to 0.6 percent in the general population. Accordingly, it will not be discussed in this section of the *Collection*.

### ***Other Specified Disruptive, Impulse-Control, and Conduct Disorder***

A diagnosis of other specified disruptive, impulse-control and conduct disorder is available when patterns of behavior do not fit the criteria for ODD or CD, yet present significant disruption and impairment in functioning, and thus require intervention (APA, 2013). The specific reason for the diagnosis, such as “recurrent behavioral outbursts of insufficient frequency,” must be included (APA).

In the *DSM-IV-TR*, symptoms and behaviors for this disorder were included in the diagnosis of disruptive behavior disorder, not otherwise specified (DBDNOS).

### ***Unspecified Disruptive, Impulse-Control, and Conduct Disorder***

Another alternative diagnosis is unspecified disruptive, impulse-control and conduct disorder. It is diagnosed when the diagnosing clinician does not specify the reason the criteria are not met for a specific diagnosis. This often occurs when there is insufficient information for a specific diagnosis, such as an emergency room visit (APA, 2013).

In the *DSM-IV-TR*, symptoms and behaviors for this disorder were included in the diagnosis of disruptive behavior disorder, not otherwise specified (DBDNOS).

### **Prevalence**

Prevalence of disruptive, impulse-control, and conduct disorders varies by disorder. Figure 2 outlines the prevalence rates for CD, ODD, and IED, the three disorders in this chapter more commonly found in youth.

**Figure 2**  
**Prevalence of Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), and Intermittent Explosive Disorder (IED)**

**CD** occurs in between two and 10 percent of the population, with a median prevalence rate of 4 percent. Prevalence rates increase from childhood to adolescence and are higher in males than in females.

**ODD** occurs between one and 11 percent of the population, though the average prevalence estimate is around 3.3 percent. It may be more prevalent in males, with a ratio of approximately 1.4:1 prior to adolescence. This prevalence does not consistently continue into adolescence or adulthood.

**IED** occurs in approximately 2.7 percent of the population and is more prevalent among individuals younger than 35-40 years.

Source: APA, 2013.

The Centers for Disease Control and Prevention employed the National Survey of Children's Health (NSCH) to provide a combined prevalence estimate for ODD and CD. In 2007, parent-reported data asking about prior diagnoses and conditions identified 4.6 percent of children aged 3 to 17 years with ODD or conduct disorder. An estimated 3.5 percent had a current condition. Boys were twice as likely as girls to have these conditions. Age was associated with an increased reporting of ODD and CD (Nock et al., 2007).

### **Causes and Risk Factors**

The majority of the research on the causes of disruptive, impulse-control, and conduct disorders focuses on CD or on CD and ODD combined (AACAP, 2007). As with most psychiatric disorders, there is no single cause of these disorders. Rather, they arise out of a complex combination of risk and protective factors related to biological and environmental/social influences (AACAP). These risk factors, which are outlined in the following paragraphs, are believed to build gradually upon each other as the child develops (AACAP).

#### **Biological Factors**

Researchers agree that there is a strong genetic and biological influence on the development of disruptive, impulse-control, and conduct disorders. These and related behavioral disorders (e.g., ADHD, substance use disorders, and mood disorders) tend to cluster in families (AACAP, 2007).

Research has consistently found that youth with disruptive, impulse-control, and conduct disorders have an underaroused baseline (e.g., low resting-heart rate) (Mawson, 2009). Several theories have tried to explain why underarousal may be associated with increased behavior problems. Some researchers suggest that underarousal results in sensation-seeking and perhaps in disruptive behaviors to maintain optimal arousal (Esyneck, 1997). Others have suggested that the underarousal results in an under-reaction of guilt or anxiety, which would otherwise inhibit these behaviors in typically developed individuals (van Goozen et al., 2004).

Additional biological factors including reduced basal cortisol reactivity and abnormalities in the prefrontal cortex and amygdala. Studies concerning these biological factors do not separate ODD from CD, so it is unclear if there are specific markers to either disorder (APA, 2013). The *DSM-5* points out that neuroimaging can show structural and functional differences in the frontotemporal-limbic

connections in the ventral prefrontal cortex and amygdala; however, these findings cannot diagnose CD (APA).

Children with ODD often have parents with mood disorders, while children with CD often have parents with antisocial behavior (Searight, Rottnek, & Abby, 2001). Parents of children with CD are more likely to be depressed, to have issues of substance use, and/or to have antisocial personality traits (Searight, Rottnek, & Abby).

### **Psychological Factors**

Attachment theories have not been consistently confirmed in studies of disruptive, impulse-control, and conduct disorders (AACAP, 2007). Researchers have studied the relationship between these disorders and unresponsive parenting or impaired attachment between the child and the caregiver. However, empirical findings have been inconsistent (AACAP). Youth with disruptive, impulse-control, and conduct disorders consistently exhibit deficiencies in social processing and problem-solving. Specifically, they tend to miss social cues, attribute hostile intentions to the behaviors of others, have difficulty formulating solutions to social problems, and expect reinforcement from aggressive behaviors (AACAP).

Incidence of CD is increased in children with biological or adoptive parents and family members who also have CD or who have substance use disorder and/or depressive or bipolar disorders. Incidence of CD is also increased in children who have biological parents who have schizophrenia or ADHD. Uniquely, childhood-onset CD is particularly present comorbid with other familial disorders, and this does not present similarly in any other mental disorder (APA, 2013).

### **Social Factors**

Several social factors have been associated with the development of disruptive, impulse-control, and conduct disorders, including poverty, lack of structure, community violence, and dysfunctional family environment. Youth who are neglected through lack of parental supervision and positive parenting behaviors and/or who experience harsh treatment, including child abuse, are at higher risk (AACAP, 2007). Those with deviant peer associations are also more likely to meet the criteria for these disorders. This may be because youth can learn deviant behaviors from others and can have their negative behavior patterns reinforced in deviant relationships. Youth with deviant peer relationships may experience poorer treatment outcomes (AACAP).

The *DSM-5* notes that children and adolescents are more likely to have ODD in families where child care is disrupted by different caregivers or in families with “harsh, inconsistent or neglectful child-rearing practices” (APA, 2013). Social predictors outside of the family include peer rejection, delinquent peer groups, and a violent neighborhood (APA).

### **Comorbidity**

Studies of the comorbidity rates for ODD have estimated that 14 percent to 40 percent of youth have comorbid ADHD, and 9 percent to 50 percent have a comorbid anxiety or depressive disorder (Angold, Costello, & Erkanli, 1999; Riley, Amhed, & Locke, 2016). The *DSM-5* allows for a comorbidity of ODD and CD, and it specifies that ADHD and ODD are common in those with CD (APA, 2013). Studies indicate that the majority of children with ODD do not develop CD, but ODD is usually present as a forerunner to childhood-onset CD (AACAP, 2007). Research suggests that early intervention and treatment of ODD may avert the development of CD (Murrihy, Kidman, & Ollendick, 2010).

While some characteristics of ODD and CD overlap, there are important distinctions (Searight, Rottnek, & Abby, 2001). Youth with ODD do not typically display significant physical aggression and may be less likely to have problems with the law (Searight, Rottnek, & Abby). Moreover, because ODD is seen as a

disorder of noncompliance and CD involves the violation of another's rights, it is helpful to view these mental health disorders as two points on a continuum, rather than as two separate mental health disorders.

Symptom severity and treatment prognosis are generally influenced by the type of comorbid conditions. For example, youth with comorbid ADHD and ODD typically display more aggressive behaviors, experience greater academic difficulties, and are rejected by peers more often than youth with ADHD alone (AACAP, 2007). Furthermore, youth with both ADHD and ODD are more likely to transition to a diagnosis of CD (AACAP; APA, 2013). Several studies have documented a strong association between disruptive, impulse-control, and conduct disorders and adolescent substance use, particularly in the face of treatment failures (AACAP). The *DSM-5* points out this comorbidity with substance use and notes that it is unclear whether the association is independent of the comorbidity with CD (APA).

Increases in oppositional and antagonistic behaviors are somewhat typical of the onset of adolescence. Youth with autism spectrum disorder, anxiety, or depression may also be more likely to exhibit these symptoms (AACAP, 2007). Clinicians, therefore, should give careful consideration to determining whether oppositional behaviors represent a true comorbid condition or are manifestations of typical development or of a primary mental health disorder.

Connor (2002) found that language and learning disorders are a common precursor to disruptive, impulse-control, and conduct disorders. Youth with CD are more likely to show deficiencies in academics and a variety of cognitive processes. There is a strong relationship between CD, academic failure, and learning disabilities (Tynan, 2010). Academic failure, particularly in reading and other verbal skills, may justify the diagnosis of a learning or communication disorder (APA, 2013).

Gender and age are also crucial factors in determining and diagnosing comorbid conditions in youth with CD. Loeber et al. (2000) conducted a literature review of the co-morbidity of CD. Their review suggested a higher risk for adolescent females with CD and a relatively predictable association between CD and comorbid conditions. Adolescent females are also more typically at risk for anxiety and depression.

IED is frequently comorbid with depressive, anxiety, and substance use disorders. Additionally, antisocial personality disorder and borderline personality disorder frequently co-occur with IED. ADHD and other disorders involving disruptive behaviors can also increase the risk of IED development (APA, 2013).

## **Assessment**

The accurate diagnosis of disruptive, impulse-control, and conduct disorders requires an assessment involving at least two different methods, such as behavior rating scales from multiple informants and structured diagnostic interviews (Christophersen & Mortweet, 2001). Interviews typically focus on the family's history and the caregivers' child-rearing practices. After interviewing the child and parents, the provider should interview teachers and evaluate the course of the child's development, including conducting a review of school records. Particular attention should be paid to any oppositional or aggressive behavior that is not age-appropriate. In the course of assessment, the mental health provider may also identify co-occurring disorders.

For a diagnosis of ODD, a pattern of negative, hostile, and defiant behavior must be present. This may or may not be accompanied by a negative or irritable mood (APA, 2013). ODD frequently occurs prior to presentation of childhood-onset CD (APA). To make a diagnosis of CD, the provider must ascertain whether the child or adolescent has shown at least three major symptoms in the past twelve months, with one of the symptoms having occurred in the last six months (APA). Individuals with CD are likely to underreport their symptoms, so clinicians must often rely on additional informants (APA).

A functional analysis of the child's behavior will not only assist in making an appropriate diagnosis, but also aid in developing an effective treatment plan (Mash & Terdal, as cited in AACAP, 2007). This

involves identifying antecedents and consequences of the child’s problematic behavior through a parent interview and/or direct observation in an environment where the behavior occurs. The functional analysis may help determine whether caregivers are inadvertently reinforcing negative behaviors or if the child lacks appropriate emotion regulation skills.

Table 1 lists the suggested assessment tools for disruptive, impulse-control, and conduct disorders.

**Table 1**  
**Suggested Assessment Tools for Disruptive, Impulse-Control, and Conduct Disorders**

<b>Name of Measure</b>	<b>Measure Type</b>	<b>Who Completes</b>	<b>What Is Learned</b>
Washington University version of the Kiddie-Schedule for Affective Disorders and Schizophrenia	Clinical interview	Clinician with youth and parent	Diagnosis
The Children’s Interview for Psychiatric Syndromes (ChIPS)	Clinical interview	Clinician with youth and parent	Diagnosis
NIMH Diagnostic Interview Schedule for Children-IV (NIMH DISC-IV)	Clinical interview	Parent	Diagnosis
Achenbach System of Empirically Based Assessment (ASEBA)	Behavior checklist	Parent, youth, teacher	Syndrome scale scores and competence scores
Child Behavior Checklist (CBCL)	Behavior checklist	Parent, youth, teacher	Syndrome scale scores and competence scores
Youth Self-Report (YSR)	Behavior checklist	Parent, youth, teacher	Syndrome scale scores and competence scores
Teacher Report Form (TRF)	Behavior checklist	Parent, youth, teacher	Syndrome scale scores and competence scores
Strengths & Difficulties Questionnaire	Behavior checklist	Parent, youth, teacher	Four problem scales and one “strengths” scale
Behavior Assessment System for Children-2 <sup>nd</sup> edition (BASC)	Behavior checklist	Parent, youth, teacher	Syndrome scale scores and adaptive scores

Sources: Achenbach & Rescorla, 2001; Reynolds & Kamphaus, 2004; Gathright & Tyler, 2014.

## **Treatments**

Although ODD, CD, and IED are considered separate diagnoses, the treatment principles for these disorders are very similar. Individualized treatment plans should be developed to address the particular problems and severity of each child and family situation. A summary of treatments are outlined in Table 2 and discussed in the paragraphs that follow.

**Table 2**  
**Treatments for Disruptive, Impulse-Control, and Conduct Disorders**

<b>What Works</b>	
Assertiveness training	School-based group treatment for middle- school youth
Parent management training (PMT) <ul style="list-style-type: none"> <li>• Helping the Noncompliant Child</li> <li>• Incredible Years</li> <li>• Parent-child interaction therapy</li> <li>• Parent MT to Oregon model</li> <li>• Positive parenting program</li> </ul>	PMT programs focus on teaching and practicing parenting skills with parents or caregivers
Multisystemic therapy (MST)	MST is an integrative, family-based treatment for youth with serious antisocial and delinquent behavior. Interventions last 3-5 months and focus on improving psychosocial functioning
Cognitive behavioral therapy (CBT) <ul style="list-style-type: none"> <li>• Problem-solving skills training</li> <li>• Anger control training</li> </ul>	CBTs emphasize problem-solving skills and anger control/coping strategies
CBT & parent management training	Combines CBT and PMT
<b>What Seems to Work</b>	
Multidimensional treatment foster care	Community-based program alternative to institutional, residential, and group care placements for use with severe chronic delinquent behavior; foster parents receive training and provide intensive supported treatment within the foster home
<b>Not Adequately Tested</b>	
Atypical antipsychotics medications	Risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify); limited evidence for effectiveness in youth with ID or ASD
Stimulant or atomoxetine	Methylphenidate, d-Amphetamine, atomoxetine; limited evidence when comorbid with primary diagnosis of ADHD
Mood stabilizers	Divalproex sodium, lithium carbonate; limited evidence when comorbid with primary diagnosis of bipolar disorder
Selective serotonin reuptake inhibitors (SSRIs)	Limited evidence when comorbid with primary diagnosis of depressive disorder
<b>What Does Not Work</b>	
Boot camps, shock incarcerations	Ineffective at best; can lead worsening of symptoms
Dramatic, short-term, or talk therapy	Little to no effect as currently studied

## **Psychosocial Treatments**

Eyberg, Nelson & Boggs (2008) identified 16 evidence-based treatment programs for disruptive, impulse-control, and conduct disorders. Nearly all employ parent behavior management training as the primary intervention. The key strategies of these approaches include the following:

- Identification and reduction of positive reinforcement of structured behavior;
- Increased reinforcement of prosocial and compliant behavior;
- Utilization of nonviolent and consistent discipline for disruptive behaviors; and
- Emphasis on predictability and immediacy of parental contingencies (AACAP, 2007; Capaldi & Eddy, 2015).

*The following is taken from Capaldi and Eddy (2015).* There are two classes of evidence-based interventions for treatment of CD and ODD that are shown to be effective: parent management training and social skills training, in which youth are taught cognitive and behavioral techniques and strategies that are useful in solving interpersonal problems. Over the past 50 years, a variety of these programs have been shown to have a positive effect. A separate meta-analysis of psychosocial interventions showed that those that included a parent component, either alone or in combination with other intervention components, were most likely to reduce problem behaviors (Epstein et al., 2015). These findings suggest the importance of working with parents or caregivers when attempting to reduce disruptive child behaviors.

Multisystemic therapy (MST) is an individualized case management program that incorporates many aspects of parent management and child social skills training for youth with serious behavior disorders who are at risk for out-of-home placement (Henggeler et al., 2009). MST attempts to intervene with the multiple factors that can contribute to antisocial behavior at the individual, family, and broader social levels, including peer, school, and neighborhood factors (Capaldi & Eddy, 2015). Trained clinicians identify strengths in each youth's social network and capitalize on these to promote positive change. By helping both parents and youth to manage their lives more effectively, the need for out-of-home placement may be eliminated. Treatment is designed in collaboration with the family, and therapists have low caseloads and are available around the clock. The average duration of treatment is four months; during this time, therapists work very closely (e.g., multiple times per week in the home and community) with youth and families (Capaldi & Eddy). In a variety of studies, reductions of 25 to 70 percent in long-term re-arrest rates and of 47 to 64 percent in out-of-home placements have been achieved, and positive improvements in youth and family functioning have been observed for several years following intervention (Capaldi & Eddy).

The only available study on psychosocial treatments for IED found that patients receiving active cognitive-behavioral therapy (CBT) or group therapy showed significant improvements compared with waitlist controls. These improvements spanned several target symptoms of IED (Grant & Leppink, 2015).

Severe and persistent cases of ODD that develop into CD may require an alternative placement when the safety of the youth and/or those around him or her are in jeopardy (AACAP, 2007). Youth may require out-of-home placement when they require crisis management services or when their family is unable or unwilling to collaborate with treatment. When considering day treatment, residential treatment, or hospitalization, the least restrictive setting should be selected for the shortest possible time to ensure safety and progress (AACAP). Other placements that may be considered are therapeutic foster care or respite care.

## **Pharmacological Treatments**

Pharmacological treatments for disruptive, impulse-control, and conduct disorders have not been well-studied (AACAP, 2007). Stanford, Howard, and the AACAP Workgroup on Juvenile Impulsivity and

Aggression (Connor et al., 2006) recommend that medication only be used to treat youth with ODD or CD when evidence-based psychosocial treatments have failed. Medication should not be the sole treatment for CD or ODD (AACAP). In addition, effect sizes for psychosocial interventions are larger than effect sizes for psychotropic medication with this population.

In a separate review of evidence-based treatments for CD and ODD, a variety of medications have been examined as adjuncts to treatment (Capaldi & Eddy, 2015). In cases of severe aggressive behavior, for example, lithium or one of the neuroleptics (also known as antipsychotics) may be prescribed. However, the neuroleptics have more numerous and serious side effects. Again, even in extreme cases, medication is not recommended as either the sole or the primary treatment (Capaldi & Eddy).

Despite a lack of research, atypical antipsychotics are the most commonly prescribed medication for aggression associated with ODD and CD (AACAP, 2007). The largest body of research suggests that risperidone has some efficacy with ODD. However, risperidone usually is considered a second- or third-line option because it has been associated with adverse effects in children and adolescents and requires caution in younger populations, despite its potential efficacy (Grant and Leppink, 2015).

Medications may also be helpful when there are co-occurring disorders, making it more likely that the youth will be able to participate in and benefit from intervention strategies (Capaldi & Eddy, 2015). Pharmacological interventions may be helpful, for example, when a child or adolescent has a disorder that is responsive to medication, such as ADHD or bipolar disorder. ODD has a high comorbidity rate with ADHD, and medications often prescribed for ADHD, such as stimulants and atomoxetine, may help improve oppositional behaviors as well (AACAP, 2007). Stimulants have also improved ODD symptoms in randomized trials (Grant and Leppink, 2015). There is limited research suggesting that mood stabilizers or selective serotonin reuptake inhibitors (SSRIs) may be helpful when there is a co-occurring mood disorder, such as bipolar or major depressive disorder (AACAP). Alpha-2 agonists (clonidine and guanfacine) have shown some efficacy in treating ODD but have not been studied extensively (Grant and Leppink).

It is important to note that aggression and oppositional behaviors can reflect temporary environmental changes. Utilizing medication during these circumstances may result in misattribution of improvement to the medication, rather than environmental stabilization, and thus result in an unnecessary risk of side effects. In all cases, medications should be started only after an appropriate baseline of symptoms or behaviors has been obtained and only in conjunction with psychosocial treatment (AACAP, 2007).

### ***Unproven Treatments***

Research indicates that treatment of disruptive, impulse-control, and conduct disorders should be delivered with enough frequency and duration to produce the desired treatment outcomes (Children's Mental Health Ontario, 2001). There are several treatments that have been untested, proven ineffective, or proven to be harmful. Scare tactic approaches (e.g., boot camps, shock incarcerations) are ineffective and can even worsen symptomatic behaviors by heightening a fear-aggression reaction and/or modeling of even more deviant behaviors (Capaldi & Eddy, 2015; AACAP, 2007). Boot camps have consistently demonstrated good initial results but long-term declines, such as higher arrest rates and more serious crimes committed (Tynan, 2010). Moreover, group treatment may also have possible negative adverse effects. Poor long-term outcomes following this treatment may be due to group reinforcement of negative or criminal activity, accompanied by lack of family or community change (Capaldi & Eddy; Tynan). Individual psychotherapy as a single treatment also has not proven effective for CD, although individual sessions may facilitate treatment compliance (Tynan). Dramatic, one-time, time-limited, or short-term interventions are also ineffective treatment approaches (AACAP).

## **Cultural Considerations**

The *DSM-5* states that ODD in children and adolescents is relatively consistent across countries that differ in race and ethnicity (APA, 2013). ODD and CD are more prevalent among adolescents from families with low socio-economic status (Loeber et al., 2000). CD is more common in neighborhoods characterized by social disorganization and high crime rates (Loeber et al.). More research is needed to assess the differences between CD and ODD in rural and urban environments, given that results from current research are mixed and the poor prognosis of CD is associated with urban areas (Loeber et al.). In fact, the *DSM-5* cautions against misdiagnosing CD in particularly dangerous areas where disruptive behavior is viewed as normal, including high-crime areas and war zones (APA, 2013).

Research on treatments for disruptive, impulse-control, and conduct disorders has adequate representation of African-American children, suggesting that treatments are generally as effective with those populations as for Caucasian children (Eyberg et al., 2008). Latino children and children from other minority groups, however, have been under-represented in most studies of treatments. In the absence of research on cultural-specific practices, clinicians should take care to ensure that treatment goals and strategies are in sync with cultural beliefs and practices.

When compared to the United States, IED is less prevalent in some regions, like Asia and the Middle East, as well as countries like Romania and Nigeria. The *DSM-5* notes that either the explosive actions that characterize the disorder are not discussed during questioning or are less likely to occur because of cultural expectations (APA, 2013).

Males with CD are more likely to fight, steal, vandalize, and have discipline issues in school. Males are likely to be physically aggressive and harm their social relationships, which is known as “relational aggression.” Females, on the other hand, are more likely to lie, skip school, run away, abuse substances, and get involved in prostitution. Females are more likely to harm their social relationships than be physically aggressive (APA, 2013).

## **Overview for Families**

A child being disagreeable is normal. Oppositional behavior is a serious concern only if it is extreme when compared with children of similar age and developmental level, and if it affects the child’s social, family, and academic life (AACAP, 2013a). Defiant and oppositional behavior can manifest itself as oppositional defiant disorder (ODD), the more severe conduct disorder (CD), or intermittent explosive disorder (IED).

ODD manifests as a pattern of hostile behavior, including but not limited to:

- Frequent temper tantrums
- Excessive arguing with adults
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Spiteful attitude and revenge seeking (AACAP, 2013a)

The symptoms of CD are much more severe, including but not limited to:

- Abnormal aggression to people and animals
- Steals from victim while confronting them
- Has used a dangerous weapon to harm others
- Forces someone into sexual activity
- Destruction of property
- Deceitfulness, lying, or stealing
- Serious violations of rules (AACAP, 2013b)

While the symptoms of both ODD and CD include conduct problems that bring the child into conflict with adults, ODD is less severe and does not include aggression toward people or animals, destruction of property, or patterns of theft (APA, 2013).

The symptoms of IED include short, impulsive or anger-based aggressive outbursts that begin rapidly and have very little build-up (APA, 2013). The aggressive episodes are generally impulsive and/or based in anger rather than premeditated.

Children diagnosed with IED display:

- Verbal or physical aggression that occurs, on average, twice per week for three months but does not result in damage or injury to people or animals, **or**
- Behavioral outbursts that occur three or more times a year that do result in damage or injury to people or animals

Disruptive disorders often co-occur with other disorders such as ADHD. CD can also be a result of brain damage or past child abuse (AACAP, 2013a; AACAP, 2013b).

Treating children with these disorders can be complex. Any child exhibiting symptoms should have a comprehensive evaluation. Evaluators should also look for other disorders, as they are often present.

## **Resources and Organizations**

### **American Academy of Child & Adolescent Psychiatry (AACAP)**

Conduct Disorder Resource Center

[http://www.aacap.org/aacap/Families\\_and\\_Youth/Resource\\_Centers/Conduct\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/Home.aspx)

### **American Psychiatric Association (APA)**

<https://www.psychiatry.org/>

### **American Psychological Association (APA)**

<http://www.apa.org/>

### **Association of Behavior and Cognitive Therapies**

<http://www.abct.org/Home/>

### **Mental Health America (MHA)** (formerly National Mental Health Association)

Fact Sheet on Conduct Disorder

<http://www.mentalhealthamerica.net/conditions/conduct-disorder>

### **Oppositional Defiant Disorder Resource Center**

[http://www.aacap.org/aacap/Families\\_and\\_Youth/Resource\\_Centers/Oppositional\\_Defiant\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx)

### **Society of Clinical Child and Adolescent Psychology**

<https://www.clinicalchildpsychology.org/>

## References

- Achenbach, T., & Rescorla, L. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.
- American Academy of Child & Adolescent Psychiatry (AACAP). (2013a). Facts for families: Children with oppositional defiant disorder. Retrieved from [https://www.aacap.org/aacap/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/Children-With-Oppositional-Defiant-Disorder-72.aspx](https://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-With-Oppositional-Defiant-Disorder-72.aspx)
- American Academy of Child & Adolescent Psychiatry (AACAP). (2013b). Facts for families: Conduct disorder. Retrieved from [http://www.aacap.org/aacap/families\\_and\\_youth/facts\\_for\\_families/FFF-Guide/Conduct-Disorder-033.aspx](http://www.aacap.org/aacap/families_and_youth/facts_for_families/FFF-Guide/Conduct-Disorder-033.aspx)
- American Academy of Child & Adolescent Psychiatry (AACAP). (2007). Preventive effects of treatment of disruptive behavior disorder in middle childhood on substance use and delinquent behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(1), 33-39.
- American Psychiatric Association (APA). (2015). *Understanding mental disorders: Your guide to DSM-5*. Arlington, VA: Author.
- American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) (DSM-5). Washington, DC: Author.
- American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.) (DSM-IV-TR). Washington, DC: Author.
- Angold, A., Costello, E., & Erkanli, A. (1999). Comorbidity. *Journal of Child Psychology & Psychiatry*, 40, 57-87.
- Block, J. (1978). Effects of a rational-emotive mental health program on poorly achieving, disruptive high school students. *Journal of Counseling Psychology*, 25(1), 61-65.
- Boesky, L. (2002). Juvenile offenders with mental health disorders: Who are they and what do we do with them? In *Oppositional Defiant Disorder and Conduct Disorder* (pp. 36-60). Maryland: American Correctional Association.
- Braithwaite, K., Duff, J., & Westworth, I. (2001). Conduct disorder in children and adolescents.
- Brinkmeyer, M., & Eyberg, S. (Ed.). (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.
- Capaldi, D. M., & Eddy, J. M. (2015). Oppositional defiant disorder and conduct disorder. In T. Gullotta, R. Plant, & M. Evans (Eds.), *Handbook of adolescent behavioral problems*. Boston, MA: Springer.
- Center for the Advancement of Children's Mental Health at Columbia University. (2000). Anxiety disorders. Retrieved from <http://www.kidsmentalhealth.org>. *Not available December 2017*.
- Center for Mental Health in Schools at UCLA. (2008). Conduct and behavior problems related to school aged youth. Los Angeles, CA: Author. Retrieved from <http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf>
- Chamberlain, P., & Smith, D. (Ed.). (2003). *Antisocial behavior in children and adolescents: The Oregon multidimensional treatment foster care model*. New York: Guilford.
- Children's Mental Health Ontario. (2001). Evidence based practices for children and adolescents with conduct disorder. Retrieved from [https://cmho.org/documents/EBP\\_conduct\\_disorder.pdf](https://cmho.org/documents/EBP_conduct_disorder.pdf)
- Christophersen, E., & Mortweet, S. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems*. Washington, DC: American Psychological Association.
- Committee to Evaluate the Supplemental Security Income Disability Program for Children with Mental Disorders. (2015). *Prevalence of oppositional defiant disorder and conduct disorder: Mental disorders and disabilities among low-income children*. Washington, DC: National Academies.
- Connor, D. (2002). *Aggression and antisocial behavior in children and adolescents: Research and treatment*. New York: Guilford.
- Connor, D., Carlson, G., Chang, K., Daniolos, P., Ferziger, R., & Findling, R. (2006). Juvenile maladaptive aggression: A review of prevention, treatment, and service configuration and a proposed research agenda. *Journal of Clinical Psychiatry*, 67(5), 808-820.
- Deffenbacher, J. L., & McKay, M. (2000). *Overcoming situational and general anger*. Oakland, CA: New Harbinger.
- Epstein, R. A., Fonnesebeck, C. J., Potter, S. A., Rizzone, K. H., & McPheeters, M. L. (2015). Psychosocial interventions for child disruptive behaviors: A meta-analysis. *Pediatrics*, 136(5), 947-960
- Eyberg, S., Nelson, M., & Boggs, S. (2008). Evidence-based psychological treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology*, 37(1), 215-237.

- Eysenck, H. (1997). Personality and the biosocial model of antisocial and criminal behavior. In A. Raine, P. Brennan, D. P. Farrington, & S. A. Mednick (Eds.). *Biosocial bases of violence* (pp. 21-38). New York: Plenum.
- Gathright, M., & Tyler, L. H. (2014). Disruptive behaviors in children and adolescents. University of Arkansas for Medical Sciences Psychiatric Research Institute. Retrieved from <https://psychiatry.uams.edu/files/2015/02/disruptive.pdf>
- Grant, J. E., & Leppink, B. A. (2015). Choosing a treatment for disruptive, impulse-control, and conduct disorders. *Current Psychiatry*, *14*(1), 29-36.
- Henggeler, S., & Lee, T. (Ed.). (2003). *Evidence based psychotherapies for children and adolescents*. New York: Guilford.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents* (2nd ed.). New York: Guilford.
- Huey, W., & Rank, R. (1984). Effects of counselor and peer-led group assertive training on black adolescent aggression. *Journal of Counseling Psychology*, *31*(1), 95-98.
- Kaminski, J. W., & Claussen, A. H. (2017). Evidence base update for psychosocial treatments for disruptive behaviors in children. *Journal of Clinical Child and Adolescent Psychology*, *46*(4), 477-499.
- Kazdin, A. (Ed.). (2003). Evidence-based psychotherapies for children and adolescents. New York: Guilford.
- Kazdin, A., Bass, D., Siegel, T., & Thomas, C. (1989). Cognitive-behavioral therapy and relationship therapy in the treatment of children referred for antisocial behavior. *Journal of Consulting and Clinical Psychology*, *57*(4), 522-535.
- Kazdin, A., Esveldt-Dawson, K., French, N., & Unis, A. (1987). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. *Journal of Consulting and Clinical Psychology*, *55*(1), 76-85.
- Kazdin, A., Siegel, T., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology*, *60*(5), 733-747.
- Lochman, J., Barry, T., & Pardini, D. (2003). *Anger control training for aggressive youth*. New York: Guilford.
- Loeber, R., Burke, J., Lahey, B., Winters, A., & Zera, M. (2000). Oppositional defiant and conduct disorder: A review of the past 10 years, part I. *Journal of the American Association of Child and Adolescent Psychiatry*, *39*(12), 1468-1484.
- Mash, E., & Terdal, L. (Eds.). (2001). *Assessment of child and family disturbance: a behavioral-systems approach*. New York: Guilford.
- Mawson, A. (2009). On the association between low resting heart rate and chronic aggression: Retinoid toxicity hypothesis. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, *33*(2), 205-213.
- McCloskey, M., Noblett, K., Deffenbacher, J., Gollan, J., & Coccaro, E. (2008). Cognitive-behavioral therapy for intermittent explosive disorder: A pilot randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *76*(5), 876-886.
- McMahon, R., & Forehand, R. (1981). Suggestions for evaluating self-administered materials in parenting training. *Child Behavior Therapy*, *3*(1) 65-68.
- Murphy, M., Cowan, R., & Sederer, L. (2001). Disorders of childhood and adolescence. In *Blueprints in psychiatry* (2nd ed.) (p. 42). Malden, MA: Blackwell Science.
- Murrihy, R. C., Kidman, A. D., & Ollendick, T. H. (Eds.) (2010). *Handbook of clinical assessment and treatment of conduct problems in youth*. New York: Springer.
- Nock, M. K., Kazdin, A. E., Hiripi, E., & Kessler, R. C. (2007). Lifetime prevalence, correlates, and persistence of oppositional defiant disorder: Results from the national comorbidity survey replication. *Journal of Child Psychology and Psychiatry*, *48*(7), 703-713.
- Patterson, G., Reid, J., Jones, R., & Conger, R. (1975). *A social learning approach to family intervention: Families with aggressive children*, vol 1. Eugene, OR: Castalia.
- Raine, A. (2002). Annotation: The role of prefrontal deficits, low autonomic arousal and early health factors in the development of antisocial and aggressive behavior in children. *Journal of Child Psychology and Psychiatry*, *43*(4), 417-434.
- Reynolds, C., & Kamphaus, R. (2004). *Behavior assessment system for children - 2*. Circle Pines, MN.
- Rifkin, A., Karajgi, B., Dicker, R., Perl, E., Boppana, V., Hasan, N., & Pollack, S. (1997). Lithium Treatment of Conduct Disorders in Adolescents. *American Journal of Psychiatry*, *154*(4), 554-555.
- Riley, M., Ahmed, S., & Locke, A. (2016). Common questions about oppositional defiant disorder. *American Family Physician*, *93*(7), 586-591. Retrieved from <https://www.aafp.org/afp/2016/0401/p586.html>

- Sanders, M. (1999). Triple p-positive parenting program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review*, 2(2), 71-90.
- Searight, H., Rottnek, F., & Abby, S. (2001). Conduct disorder: Diagnosis and treatment in primary care. Retrieved from <http://www.aafp.org/afp/20010415/1579.html>
- Tynan, D. (2010). Conduct disorders. EMedicine Clinical Reference. Medscape.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author.
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (1998). Conduct disorder in children and adolescents. Publication no. CA-0010. Retrieved from [www.mentalhealth.org/publications/allpubs/CA-0010/default.asp](http://www.mentalhealth.org/publications/allpubs/CA-0010/default.asp). *Not available December 2017*.
- van Goozen, S., Snoek, H., Matthys, W., Rossum, I., & Engeland, H. (2004). Evidence of fearlessness in behaviourally disordered children: A study on startle reflex modulation. *Journal of Child Psychology and Psychiatry*, 45, 884-892.
- Webster-Stratton, C., & Reid, J. (Eds.). (2003). *The incredible years—parents, teachers and children training series: A multifaceted treatment approach for young children with conduct problems*. New York: Guilford.

### **Additional References of Interest**

- Bodenhamer, G. (1992). *Back in control*. New York: Prentice Hall.
- Bodenhamer, G. (1995). *Parent in control*. Fireside.
- Greene, R. (1998). *The explosive child: A new approach for understanding and parenting easily frustrated, 'chronically inflexible' children*. New York: HarperCollins.
- Hendren, R. (1999). *Disruptive behavior disorders in children and adolescents*. (Review of Psychiatry Series, Vol. 18, No. 2). Washington, DC: American Psychiatric Press.
- Horne, A., & Sayger, T. (1992). *Treating conduct and oppositional defiant disorder in children*. Boston: Allyn & Bacon.
- Koplewicz, H. (1994). *It's nobody's fault: New hope and help for difficult children and their parents*. New York: Random House.
- Ollendick, T. H., Greene, R. W., Austin, K. E., Fraire, M. G., Halldorsdottir, T., Allen, K. B., ... Wolff, J. C. (2016). Parent management training and collaborative & proactive solutions: A randomized control trial for oppositional youth. *Journal of Clinical Child & Adolescent Psychology*, 45(5), 591-604.
- Phelan, T. (2016). *1-2-3 magic: 3-step discipline for calm, effective, and happy parenting*. Naperville, IL: Sourcebook.
- Riley, D. (2012). *The defiant child: A parent's guide to ODD*. Lanham, MD: Taylor Trade.
- Samenow, S. (2001). *Before it's too late: Why some kids get into trouble—and what parents can do about it*. New York: Three Rivers.

#### **DISCLOSURE STATEMENT**

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