Guidelines for Intervention with Children and Adolescents Diagnosed with Conduct Disorder

Children and adolescents diagnosed with conduct disorder present a formidable challenge to school social workers. Five guidelines for planning interventions with this population are presented. These guidelines are based on a synthesis of child development research and suggest that attention to the biological makeup of students as well as the design of multimodal and multisystemic interventions are critical to improving outcomes for children and adolescents diagnosed with conduct disorder.

Key words: children; conduct disorder; intervention; mental health; multisystemic

Having the right tools and knowing how to use them are critical for social workers who plan and guide mental health interventions in the schools. The focus of this article is the development of practice guidelines based on a synthesis of child development research pertaining to children and adolescents diagnosed with conduct disorder. School social workers can incorporate these guidelines into their design of interventions to increase practice effectiveness with this population. New knowledge based on current research can be defined as a tool to be added to the tools school social workers already have in their repertoire.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), "conduct disorder is one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children" (American Psychiatric Association [APA], 1994, p. 88). The manual reported prevalence rates of 6 percent to 16 percent for males under age 18 and rates of 2 percent to 9 percent for females (APA). The DSM-IV definition of conduct disorder used as the basis for determining the condition included behaviors such as aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. Furthermore, these behaviors must persist over time and across settings. Lewis (1990) referred to the conduct disorder label as the psychiatric synonym for the legal term "delinquent." Students with this diagnosis are likely to be involved with the correctional system and social services and are likely to come to the school social worker's attention as a result of being discharged from a more restrictive setting (residential treatment or boot camp) or are at risk of being referred to a more restrictive setting.

School social workers have a history of working with children and adolescents who have behavior problems and their families since the early 1900s (Trattner, 1984). Since that time they have been an integral part of the intervention process in school settings and, therefore, already possess many of the necessary tools for intervention with this population. Knowledge of mental health issues has become more essential in the schools since the passage of the Individuals with Disabilities Education Act of 1990 (P.L. 90-247). With increasing frequency school social workers are being asked to plan and guide interventions in the schools for children and adolescents identified as having a conduct disorder. Parents and teachers frequently feel frustrated, often expressing to school social workers that they have tried everything, and nothing works. School social workers feel pressured to understand what works with this population and to base interventions on effectiveness research. What follows is a presentation of five guidelines for school social workers to use as tools for planning interventions with children and adolescents diagnosed with conduct disorder.

Guideline 1: Interventions Need to Address the Biological Characteristics of the Child

Interventions focused primarily on the environment of the family and child have been criticized because they have not addressed the underlying biological characteristics of the child. Clarke and Clarke (1988) pointed out that a prevailing popular belief is that "there are no problem children, only problem parents" (p. 16). This assumption leads the school social worker away from assessing problems of a biological nature in the child. Recent research addressing this issue of biology versus environment has focused on determining who is causing the dysfunctional relationship—that is, who owns the problem, the child or the parent (Lytton, 1987, 1990).
This issue is of particular significance to the school social worker, because historically, the social work profession has been criticized for a "blame the parent, remove the child" philosophy that characterized the child-saving movement of the early 1900s (Costin, 1985). The ideology of the era declared that children needed to be saved from their "bad" environments, with parents considered to be the source of their children's problems (Petr & Spano, 1990). In addition, the unique social work focus on person-in-environment has led to an overemphasis on the person with the neglect of the environment or vice versa, with the pendulum swinging according to the latest theories.

Researchers in the field of child development emphasize that underlying biological factors contribute to the development of conduct disorders in children far more than the environment alone (Lewis, 1990; McCord & Tremblay, 1992). These underlying characteristics are defined as biopsychosocial vulnerabilities (Lewis). Unfortunately, the underlying pathology in the child is often overlooked because the child's behavior is so upsetting to parents, teachers, and professionals (Lewis; Lytton, 1990).

Aggression is an example of a temperamental factor that is integral to the conduct disorder diagnosis. Olweus (1979) found that aggressiveness in children is a highly stable personality trait across settings and comparable to intelligence quotient in terms of stability. Other researchers support this finding (Kazdin, 1987; Loeber, 1982; Quay, Routh, & Shapiro, 1987). In addition, Margalit and Shulman (1986) found a developmental delay in boys diagnosed with conduct disorder in regard to behavioral control and inhibition of aggression. Their study suggested that aggressiveness is caused by slow maturation. A gap existed between expected behavior and the boys' ability to control their behavior. This gap created frustration that led to "acting out" behavior.

These findings support the idea that the biological characteristics of the child drive the relationship. The child's aggressive temperament, as well as his or her unresponsiveness to parenting strategies, may exhaust the parents so that they become more permissive of the child's behavior, serving to increase the child's aggressiveness. It may appear that it is the parenting style causing the problem, but the parent is merely responding functionally to the child's aggressive temperament expressed through aggressive behavior. Patterson (1974) referred to this as the "coercive spiral."

In addition to temperament, neurological difficulties such as hyperactivity have been the focus of numerous studies of conduct disorder. A 60 percent overlap was found in the diagnoses of attention deficit hyperactivity disorder (ADHD) and the conduct disorder diagnosis, with the overlapping characteristics being inattentiveness, impulsivity, and overactivity (Farrington, Loeber, & Van Kammen, 1990). Studies that follow children from the early years to late adolescence indicate not only that the prenatal, postnatal, and perinatal environment is an indicator of future conduct disorder, but also that children identified as hyperactive in childhood are more likely to be diagnosed with adolescent conduct disorder (Lambert, 1987; Lewis, 1990).

Studies of the psychiatric functioning of children and adolescents diagnosed with conduct disorder indicate that clinical depression, psychosis, and anxiety disorder are prevalent in this population (Lewis, Pincus, & Lovely, 1987; Robins, 1966). Research has indicated an exceptionally high correlation (.73) between conduct disorder and depression (Cole & Carpentieri, 1990; Marriage, Fine, Moretti, & Haley, 1986). Identification of both disorders is also important because of the possibility of the use of a pharmacological intervention to treat the disorder. Research has shown that when medication was used to treat depression, conduct problems remitted, only to reoccur when medication was withdrawn (Marriage et al.). DuPaul and Barkley (1992) also investigated the efficacy of medication with children identified with ADHD and diagnosed conduct disorder. They found that teachers and parents responded more positively when the child was on medication.

Guideline 2: Interventions Need to be Multimodal

There has been extensive research in the field of child development that focuses on environmental interventions with children who have conduct disorders. As noted in guideline 1, the development of
A conduct disorder is an interactive process between the biological makeup of the child and his or her environment. As children grow up, they increasingly interact with more systems that influence their development outside of the family, such as peers, the school system, and community facilities. Kazdin (1997a) noted that interactions are dynamic rather than static, thereby contributing to the complexity of treating the disorder as the child grows older.

Traditionally, parent interventions and school interventions have taken place separately. Ramsey, Patterson, and Walker (1990) studied the generalization of child behavior from the home setting to the school. They found that aggressive behavior in children was consistent in both the home and school settings. They concluded that treatments need to be delivered in more than one setting for effective change to occur. Ramsey et al. recommended that intervention be focused in three primary areas: "teaching family management techniques to parents, decreasing academic deficits, and remediating the peer-related and adult-related interactional social problems of the child" (p. 221). Because of the importance of addressing both the home and school settings, parental involvement is viewed as critical to the success of these interventions. Parents or primary guardians are an integral part of the treatment process and should be involved in all phases, from assessment to intervention and follow-up.

Tremblay et al. (1992) investigated the combined treatment effects of a two-pronged intervention consisting of social skills training for children and parent training for their parents. The results were positive and indicated that the children in the intervention group had fewer aggressive and antisocial behaviors and were more likely to be in their age-appropriate classrooms. The success of this program indicated support for interventions that included a remediation of deficits as well as parent training.

Another example of a multimodal intervention was the Seattle Social Development Project (Hawkins et al., 1992), a delinquency prevention project consisting of four years of experimental intervention in an urban school district with teachers, parents, and children in grades 1 through 4. This project reported success in reducing future delinquency in the intervention group when compared to the controls, as well as overall improved interactions in the family and school.

Currently, a multisite field trial entitled "The Fast Track Multisite Demonstration Project" is being conducted by the Conduct Problems Prevention Research Group (Bierman et al., 1996). This project is a six-year longitudinal study including a comprehensive intervention much like those already reviewed. This project includes several components: parent training, home visiting, parent-child relationship enhancement, academic tutoring, and social skills training. An evaluation of this program is not yet available.

Guideline 3: Interventions Need to be Multisystemic

The following studies point to the importance of multisystemic intervention. A multisystemic intervention is one that takes place in more than one large (macro) system—that is, the school, social services agencies, or corrections and community agencies such as the YMCA. The influence of the schools as a systems variable can be demonstrated in a study conducted by Garmezy (1991). Particular school factors were identified as contributing to better outcomes in the children attending those schools. Schools with equal resources in poverty areas were compared, with findings indicating that there were high-achieving schools and low-achieving schools among this group.

The high-achieving schools demonstrated high expectations for students, class-based participatory instructional methods, positive management, and disciplinary control. School variables were identified as being an important part of an intervention process that can redirect a child who has antisocial tendencies to a more competent path.

Beyond determining the effects of schools, other systemic factors in the child's life need to be addressed, such as poverty, history of child abuse or neglect within the family, and lack of social
support (insularity). Whittaker, Schinke, and Gilchrist (1986) advocated the ecological paradigm and stated that effective programs are those that address skills training and social supports for families.

A treatment program entitled multisystemic treatment (MST) was developed, based on the ecological model, using family systems theory to work with the family and other systems to reduce the delinquent behavior of their child (Henggeler & Borduin, 1990). Others, primarily researchers, in the field identified MST as one of the most promising intervention programs for children with conduct disorders (Kazdin, 1997b; Tolan & Gorman-Smith, 1997).

Aftercare and community resources also are essential in maintaining effective interventions. Many researchers indicate that support systems after treatment have been neglected, although these systems are crucial to maintaining gains (Lewis, 1990; Maluccio & Marlow, 1973; Whittaker et al., 1986). Lewis stated that "it makes no sense to provide a troubled adolescent with sophisticated medical, psychological, and educational assistance while in residence, only to deprive him of these supports following discharge to the community" (p. 208). Maluccio and Marlow reviewed the literature on residential treatment for emotionally disturbed children and found that often the programs lacked a way to involve families in the treatment plan. These programs commonly neglected to provide an aftercare plan and failed to coordinate between various agencies once the child was discharged.

Guideline 4: Interventions Need to Focus on Prosocial Skills with Prosocial Peers

Peer networks are a crucial link in a child’s resistance to behavior change. Failing to address the social networks of conduct-disordered youths has been linked to treatment failure for these youths. The research that follows suggests that interventions are successful only if they target peer networks by including prosocial peers in the intervention process.

O’Donnell (1992) studied intervention programs that were not successful to understand why the results were not more positive. He found that what the unsuccessful programs had in common was that they brought delinquent youths together so that they were able to form social networks with other delinquent youths. Friendships formed in the programs were likely to continue when the program ended and contributed to an increase in future antisocial acts rather than a decrease after the intervention. As an example, the Group Guidance Project was targeted toward members of four gangs. Its first attempt at intervention involved dances and group activities at a community center. When negative gang activity increased, the researchers changed the intervention to involve individual treatment, such as helping gang members get jobs or employment training. This approach decreased their gang activity and delinquent behavior. Another example is the work of Chamberlain and Friman (1997) who analyzed a randomized field study that focused on boys in residential care. They found that the more time boys spent associating and being influenced by antisocial peers during treatment predicted the number of serious crimes committed after discharge.

An alternative to providing treatment in groups with all identified youths as high risk or delinquent is to provide treatment with prosocial peers. The St. Louis experiment conducted by Feldman (1992) investigated three sets of variables: (1) mode of group composition (all referred, nonreferred, and mixed); (2) group treatment method (social learning, traditional group work); and (3) group leader experience (experienced versus nonexperienced). The group method itself was found to be not as important as the quality of leadership and composition of the groups. Experienced leaders
demonstrated success with either method as long as the groups were mixed. The key to this successful intervention was to provide it in the youths’ own environment, typically a community center, and to include optimal exposure to positive peers. Another similar prevention effort that reported empirical effectiveness involving prosocial peers consisted of two prevention trials in the Baltimore City public schools (Kellam & Rebok, 1992).

Guideline 5: Interventions Need to Include Cognitive Processing

In addition to the inclusion of prosocial peers, child development research suggests the need to address more than just behavior. Interventions also must focus on the beliefs and the decision-making process of the child. The importance of addressing cognitive processing has been studied extensively by Dodge, although his studies were specific to boys (Dodge, 1986; Dodge & Frame, 1982). His research focused on how the aggressive child interprets environmental stimuli and then acts on them. Dodge (1986) found that the behavior of the aggressive child was related more to an interpretation of the situational stimulus than to the stimulus itself. An example of this is when an aggressive child is bumped by another child by accident. The aggressive child will interpret being bumped as a purposeful act by the other child and respond aggressively. Another example is when a peer is looking at the aggressive child with a neutral facial expression; the aggressive child will interpret that expression as being hostile.

Most often school social workers in elementary schools observe these interactions during recess. During this time children are physically active and less actively supervised; therefore, accidental bumping or balls hitting children are likely to occur, as well as children ganging up to pick on or bully other children. For more detail, Dodge and Schwartz (1997) provided an explanation of the social information-processing model.

Schonfeld, Shaffer, O'Connor, and Portnoy (1988) suggested that the origins of cognitive deficits reside in the learning environment of youths with conduct disorder, not in inherited cognitive abilities. Although this perspective contradicts other research findings cited earlier, it suggests that the child's deficits in cognitive functioning can be improved through environmental intervention. School interventions can address inherent cognitive deficits and deficits that might be attributed to the environment. For example, Arllen and Gable (1992) recommended several school interventions that have been based on the research of Dodge and others that pointed to skill deficits in the child. These interventions share several common elements: teaching anger control, problem solving, and social skill training. In addition, group management systems are taught to the teachers to change inappropriate classroom behaviors. Furthermore, Kazdin (1997b) emphasized that problem-solving skills training programs conducted in schools have documented success, indicated by replicated field studies. Finally, Pepler and Rubin (1991) reported the success of cognitive skills training in inpatient and outpatient settings.

Closely related to a cognitive focus on skills is moral motivation training, advocated by two researchers who attributed the failure of most programs to a lack of attention to the belief systems of youths. These authors based their work on Kohlberg's levels of moral development. Arbothnot (1992) stressed that a cognitive process precedes every antisocial act. If the child is operating from a preconventional level of moral development, he or she may not take into account the victim's perspective and may only view the situation from an egocentric perspective. The results of this research intervention, which focused on moral decision making, demonstrated a significant drop in antisocial behavior in the participants, with these changes maintained at a one-year follow-up. Arbothnot stressed that the reason these programs, which only addressed behavior, failed is that they do not address the adolescent's worldview. Changing the youth's belief system, however, addresses the cognitive processes that permit the immoral and illegal behavior (Arbothnot, 1992). Schulman (1990) also advocated interventions that emphasized teaching adolescents how to behave morally and scrutinize their belief systems.

The significance of the research reviewed in this last section cannot be over emphasized. The
research indicates that professionals must do much more than just extinguish antisocial behavior; they must develop intervention strategies to promote positive behavior and change belief systems in youths so that they will choose to behave according to societal norms.

Discussion

In summary, the five guidelines for school social workers are (1) interventions need to address the biological characteristics of the child; (2) interventions need to be multimodal; (3) interventions need to be multisystemic; (4) interventions need to focus on prosocial skills with prosocial peers; and (5) interventions need to include cognitive processing.

The five guidelines can affect social work practice in the schools in several different ways. The first is a shift from thinking of conduct disorder as a product of bad parenting or simply as a product of the environment, such as an outcome of poverty or ethnic minority status. According to guideline 1, the school social worker needs to view the development of conduct disorder as an interactive process in which the biology of the child has a significant influence on the environment. Thorough assessment of the child's developmental history with a focus on biological vulnerabilities is crucial. This part of the assessment process represents a shift in roles. Instead of the school social worker being solely responsible for the process, a multidisciplinary team would be needed, including professionals with specific competences, such as a neurologist or a psychiatrist, as well as other important people in the child and family system, such as the child's teacher or family social worker. This represents a shift to an inclusionary model where all members have input into the development of an intervention versus an exclusionary model where one professional conducts the assessment and an intervention is imposed on the family. Teaming is a skill that social workers already possess and should be a strength that they can bring to the intervention design process, as well as the tools of problem solving and focusing on strengths. In addition, problem solving and the strengths assessment have become integral tools of the competent school social work professional in recent years (Saleebey, 1992).

Guideline 2 suggests another fundamental shift in practice. Rather than viewing services in a categorical way, school social work services are viewed as uniquely designed for a specific child. Instead of thinking that the child fits in one category, such as special education, juvenile corrections, psychiatry, or social services and that it is the sole responsibility of one institution to "fix" the child, social workers need to conceptualize shared responsibility with a focus on connections between systems. This type of thinking emphasizes the context of the child and family and concentrates on integration rather than isolation. This may mean a case manager role for the school social worker to coordinate the intervention that takes place in multiple settings.

Guideline 3 suggests an emphasis on community ownership. Even if the child is removed from the school to a residential treatment center or juvenile facility, he or she may eventually return to the same school. Two important questions to ask are (1) What can the school do to create a supportive context for the child and family? (2) What can the systems in the community do to support the success of the child in his or her return to the school? The school social worker can facilitate the shift to collaborative ownership by fostering connections among multiple systems. The goal must be to help the child adapt to his or her "natural" environment. In addition, the school social worker is in a unique position to recognize the context of the child and family. School social workers can help the family negotiate resources such as food and housing, as well as help the family with issues of child or domestic abuse.

Regarding the last two guidelines, school social workers already possess the necessary skills to work with children in groups and incorporate prosocial peers with conduct-disordered youths. Group work has a long tradition in the school social work field. Likewise, the cognitive-behavioral approach has been used successfully by school social workers to teach skills to parents and youths to remediate deficits and promote adaptation in the areas of communication, interactions, and community living.
A case example pulling together all of these guidelines will now be presented to facilitate operationalization of the tools in actual practice.

Case Example

Turner, school social worker for Fairview Junior High School, received three calls that week from distressed and despairing parents. The three students had a lot in common with each other. The students were boys; two were 14 years old; one was 13. The problems reported by the parents regarding these three students were very similar; all three boys were getting in repeated fights with classmates at school and were on probation for repeated offenses, such as shoplifting, stealing, and vandalism. In addition, one mother reported that her son punched holes in the walls at home.

Turner reviewed what intervention attempts had already taken place for each student. In all three cases the students had been receiving therapy at the local child guidance clinic. In addition, they were all in cognitive skills groups in the school. She concluded that these efforts were having no effect in reducing each student's problematic behaviors at school, in the home, and in the community.

At this point Turner decided on an action plan that would put into place the majority of the tools mentioned in this article. She approached the principal and four of the teachers at the junior high school and proposed that they restructure their cognitive skills groups from being only for high-risk students to including their prosocial peers. Also, she proposed increasing the number of cognitive skills groups in the school as a prevention measure.

Turner talked to each of the parents that had called her about starting a parent support group that would also include parenting-skills training. This group would start with the three parents and be open to new members. To make this group operational, Turner approached the local boys and girls club to see if they would be willing to work with the school on this multimodal intervention attempt. She proposed that the boys and girls club be used in several ways. The first was to be the site for the parent group. This way the students could participate in activities while their parents were in the first part of the group and during the second part of the group, the students would be active participants of the group. In addition, involvement of the boys in after-school activities at the boys and girls club would be encouraged. To encourage a multisystemic effort, other partners in the intervention effort would be asked to become involved, such as the juvenile justice center and the child guidance clinic. They would be asked to work together with the school in creating and working toward an intervention designed to address students with conduct problems.

Turner realized that her plan would take a lot of hard work and collaboration on the part of the school with parents and other community agencies but decided that these efforts would help not only the students who had identified conduct disorders but also those in the early stages of developing a conduct disorder. This effort would be preventive and proactive compared with the former reactive approach. Turner felt energized and excited about the new approach, because she felt that many of her social work skills would be used.

This case example can be regarded as a speculative attempt to give the reader an example of how social workers in a school might use the guidelines to create a new approach in their school system. Children and adolescents diagnosed with conduct disorder are challenging. These guidelines will empower the school social worker to be proactive in designing multimodal interventions that will help students return to a positive developmental path.

References


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