**Conduct Disorder – Evidence-Based Assessment**

Based on:


Paul J. Frick and his research team at UNO and the University of Southern Mississippi offered a very useful guide in this article for the assessment of conduct disorder, based on available evidence, and implications for diagnostic practices in light of the upcoming publication of DSM-5. Unlike many professional publications, this article is very accessible and translates easily into what you might actually do in your office.

It is noted that earlier work has reviewed the challenges involved in the assessment of conduct problems, with the main challenge being the need to evaluate the many forms that conduct problems take and the need to have treatment recommendations apply to a specific presentation of individual youth. A short review of diagnostic criteria as outlined in DSM-IV is offered, and the authors suggest that an understanding of the etiology and course of the disorder is important in preventing future difficulties. Research has resulted in the classification of important subgroups of youth with conduct disorder.

Previous versions of DSM have categorized conduct disorder into childhood-onset and adolescent-onset subtypes, recognizing that the age of onset provides important information about prognosis, etiology, and treatment. DSM-5 is proposed to continue that distinction. Greater severity and a longer persistence of problems have been associated with childhood-onset conduct disorder when compared to the adolescent-onset subtype. The major change proposed for DSM-5 is the addition of a specifier “With a callous-unemotional presentation”. In this case, the youth must meet the criteria for conduct disorder and show, for at least 12 months across multiple settings and relationships, two or more callous-unemotional characteristics from the following list:

- Lack of remorse or guilt
- Lack of empathy
- Unconcern over performance in important activities
- Shallow affect

Age of onset continues to be an important distinguishing characteristic. Early-onset, for example, usually suggests deficits in executive function and low intelligence – symptoms not as typically associated with the later onset variant. Early starters are characterized as impulsive, fearless, and emotionally overreactive, while late starters are more typically rebellious and rejecting of traditional status hierarchies. Greater family dysfunction and economic disadvantage are usually associated with the younger group, while delinquent peer associations are very common in the older group. Behaviorally, the early starters have a higher likelihood of demonstrating adult antisocial behaviors, while adolescent starters are more likely to “calm down” as adults. Males dominate (10 times more likely
than females) in the early starters, while the ratio (1.5 times more likely than females) decreases markedly in the adolescent-onset group. The distinctions appear to be fairly clear, thus the decision to continue this division in DSM-5. Research consistently suggests that childhood-onset CD has a poorer prognosis and is associated with greater risk of antisocial behavior, violence, and adult criminality.

The article points out that it is also important to understand that the development of conduct disorder tends to follow a progression from less to more severe problem behaviors, and that this progression is more rapid in childhood-onset type. The incidence of stealing and truancy increases with age, as does the total number of conduct disorder symptoms, but the initiation of physical fights tends to decrease.

The “callous-unemotional” specifier is thought to be descriptive of a minority of youth with conduct disorder – those who have traits similar to adult psychopathy. These characteristics are more likely to be displayed by those with the childhood-onset subtype of conduct disorder. Youth with these traits are more likely to display fearlessness and a “reward-dominant response style”. This article cites studies indicating that they are “less likely to become emotionally aroused by others’ distress” (p. 3).

It is generally conceded that conduct disorder is difficult to treat, but that is particularly true with those with callous-unemotional traits. Recent research is described, however, that suggests that improvements can be seen with “intensive interventions that focus on strategies such as use of positive parenting strategies . . . and improving interpersonal problem-solving skills” (p. 3). The authors note that this seems to be consistent with the reward-oriented response style that is characteristic of these children.

Assessment considerations are reviewed. It is suggested that tools must assess a wide range of conduct problems and provide a norm-referenced indication of the level of severity. Also, assessment devices should screen for a wide range of problems, since there comorbidities are frequent. Assessments should address both risk and protective factors, as well as key constructs (such as age of onset, callous-unemotional traits) that could distinguish different developmental pathways.

A useful table is provided that outlines various assessment tools, ranging from unstructured clinical interviews to narrow-band rating scales. This list includes tools such as the Diagnostic Interview Schedule for Children, Behavior Assessment System for Children – 2nd edition, and several other measures, resulting in clear suggestions for an assessment battery. Caveats are offered about the influence of rater variables, such as experience with other children with emotional and behavioral difficulties, parental distress, etc. It is noted that one clear concern is the difficulty in deriving accurate information from child informants – conduct-disordered kids lie. A multi-informant model is considered to be essential.

The following suggestions are summarized in the articles’ section on recommendations:

- Obtain information from multiple informants and multiple sources
- Assess whether the child meets diagnostic criteria
- Obtain information about developmental level
• Gather information about onset and diagnostic symptoms through an interview with parent or similar informants
• Collect norm-referenced information through the use of a broad-based rating scale such as the BASC-2 or the Achenbach System of Empirically Based Assessment (ASEBA)
• A narrow-band measure of callous-unemotional traits should be used, such as the Inventory of Callous Unemotional Traits (ICU) to provide an assessment of this risk factor
• Directly assess the child through observation and an interview.