

Conduct Disorder and Parent Management Training

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P. Alex Mabe received his doctoral degree in clinical psychology from Florida State University in Tallahassee, Florida. Currently, he is professor and Chief of Psychology in the Department of Psychiatry and Health Behavior at the Medical College of Georgia. His publications include over 40 articles in the areas of clinical child and pediatric psychology. Additionally, he has made numerous presentations at national and international professional meetings on topics related to children's mental health, family and parent management training. Dr. Mabe is licensed as a psychologist in Georgia and South Carolina and has been providing clinical psychology services to children and their families in the Central Savannah River Area for over 25 years.

1. *Dr. Mabe, in your publication on the treatment of childhood conduct disorder you focus on a specific intervention that involves the parents as significant influences in the healing process. Could you first describe briefly what is meant by "conduct disorder" and its known causes?*

The essential features of CD are a repetitive and persistent pattern of behavior in which the basic rights of others and major age-appropriate societal norms or rules are violated.

Causes:

1. **Biological Predispositions-** Males of every species display more aggression than females. Genetically informed research has revealed a moderate degree of heritability for aggression, delinquency, and antisocial behavior from childhood to adulthood. Moreover, a growing body of behavioral genetics research has shown the ubiquity of genetic factors in individual differences in a wide variety of characteristics (such as impulsivity, tendency to addiction, attention deficits, and temperament) thought to play a role in the development of conduct problems. Exposure to a toxic or diseased prenatal environment plays a role in conduct disorder as well. Fetuses exposed to opiates or methadone are at heightened risk for conduct problems 10 to 13 years later as are fetuses exposed to alcohol, marijuana, and cigarette by-products during pregnancy. Because of genes or in utero experiences, some children are born with a hyperpersistent behavior facilitation system, an underactive behavioral inhibition system, autonomic nervous system hyperreactivity, cognitive problems in sustaining attention to cues, low cerebrospinal fluid concentrations of serotonin metabolites (5-HIAA, which affects delay of gratification; or a difficult style of temperament. A pattern of fussy, overly resistant-to-control, and difficult temperament in 6-month-old children that predicts mothers' ratings of conduct problems at the ages of 3 years.



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2. Sociocultural Context - Early contexts of disadvantage place a child at probabilistic risk for later conduct problems and that the path is likely to be indirect. Contextual features certainly affect individual differences in conduct problems within a broad society, and these features may be conceptualized at the subcultural, neighborhood, and family levels. Cultural values of defending one's honor), self-respect), and lack of respect for others have been implicated as risk factors for individual conduct problems, as have cultural norms regarding children's exposure to harsh physical discipline and television violence. There is compiled population-level and laboratory evidence to argue that a "culture of honor" is responsible for consistently higher rates of violence in the American South than in other geographic regions. Using neighborhood community violence rates as the unit of analysis, implicated the crowded inner city as a context for chronic conduct-problem development. Consistent differences in the distributions of chronic adolescent conduct problems across neighborhoods leave little doubt regarding the correlation between neighborhood factors and conduct problems; only the source and mechanism of these effects are at issue. Schools with high levels of aggression in the classroom are associated with an increased rate of conduct disorder among the children. At the family level, socioeconomic status at birth, indexed by income, occupation, and education of parents, is one of the strongest and most consistent of all risk factors for later conduct problems, throughout the childhood and adolescent years showed that family poverty plays a role in child conduct problems even after neighborhood poverty is controlled. Other family-level sociocultural contexts that represent risk factors for conduct problems include parental divorce, interparental conflict, and being born to a teenage or single parent.

3. Early Life Experiences ‐ Life experiences that involve harsh treatment, rejection of the self, and failure place a child at probabilistic risk for conduct problems. Early inconsistent and harsh discipline was implicated as a major risk factor for adolescent delinquency. Mothers who negatively reinforced their 4-year-old children's aversive responses to aversive stimuli by family members were likely to have children who developed chronic conduct problems later. When harsh physical discipline practices cross a boundary to become physical abuse, their effects are especially acute. Lack of warmth between parent and child is another aspect of parenting that contributes incrementally to child antisocial outcomes. Absence of effective prosocial teaching also contributes to the incidence of conduct disorder.

4. Peer Experiences - The amount of exposure that a child has to aggressive peers in day care or preschool is predictive of later child aggressive behavior, perhaps because of modeling effects. Children rejected over a 2-year period were found to be more aggressive and less socially skillful, as rated by teachers, than were children rejected in only one grade. Children's social rejection by peers in the elementary school grades is a potent risk factor for adolescent conduct problems.

5. Social experiences with major institutions - Exposure to high rates of out-of-home day care in the first 5 years of life was a risk factor for teacher-rated, peer-rated, and directly observed aggressive behavior in kindergarten. children who spent fairly large amounts of time in unsupervised after-school self-care in the early



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elementary grades were at elevated risk for behavior problems in early adolescence. School failure represents another social institution risk factor for antisocial outcomes- early school failure itself seems to be more strongly predictive of adolescent outcomes than is low intelligence. Retained children are viewed negatively by peers, which may propel antisocial development.

6. Early exposure to violence on television/videogames - that most pervasive of all social institutions, is also a risk factor for adolescent aggressive behavior. Obviously a variety of heterogeneous predisposition, context, and life-experience factors in early life represent modest risk factors for chronic conduct problems. No single factor predicts a high proportion of the variance in outcomes. Most contemporary theories acknowledge the importance of each kind of factor, as well as the importance of their interaction. The major question has become how these factors relate to each other in leading to conduct-problem outcomes.

2. *I understand that Conduct Disorder is a multi-factorially determined problem, but can you explain in particular how parent-child interactions can be a precursor to the development of Conduct Disorder?*

Children need guidance, supervision, and discipline and in the absence of such, they will develop poor social skills, resulting in negative interactions with others, life failures, and the result will be the development of aggressive styles of relating to others.

Children need nurturing and warmth in order to develop secure attachments and empathy toward the feelings of others. In the absence of parental nurturance and warmth, children develop insecure attachments, low empathy for others, irritability, and low tolerance for frustration – leading to aggressive behavior.

Children need effective social models. If parents are exhibiting poor affective and behavioral control, children will adopt similar coping behaviors. Conversely, if the parents are modeling effective and prosocial ways of responding to problems, then children will learn to respond more appropriately to problem situations.

Children need effective contingency management that reinforces good behavior and does not reinforce bad behavior. Parent-child dyads that set-up negative contingency patterns in which bad behaviors is inadvertently reinforced and good behavior is not will develop a number of inappropriate behavior patterns including oppositional-defiant-conduct disordered behaviors.

3. *Given the complexity of conduct disorder and its multiple causes, particularly its relationship to family factors, can you discuss how you see the role of parents in helping improve the condition.*

Parents can improve child behavioral functioning through the following roles:

- a) Modeling prosocial behavior- including management of frustration and negative affect.
- b) Building a nurturing relationship so that the child can develop a more secure



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attachment and experience positive empathy and reciprocal interactions with another.

- c) Developing effective reward and discipline strategies that provide incentives for prosocial behavior and disincentives (response costs) for aggressive/ negative behavior.
- d) Protecting children from the adverse influences of negative environments and negative peers that increase stress and provide negative models for child behavior.
- e) Providing support for success in school and other achievement areas in life so that benefits from prosocial behaviors can be realized.

4. *Have you found in your research that children with conduct disorder are seen more as “criminals in the making” rather than children in need of psychological help?*

The diagnostic label of “Conduct Disorder” has had only minimal stigma effects on clinicians & e.g., therapeutic pessimism -prediction of poor outcomes, recommendations for more punitive rather than therapeutic responses to problematic behavior. The judicial system, however, show more stigmatizing views of individuals with a label of conduct disorder. The label of psychopathic as one might anticipate has an even more stigmatizing effect.

See - Dodge KA, Pettit GS. **A biopsychosocial model of the development of chronic conduct problems in adolescence.** *Developmental Psychology.* 39(2):349-71, 2003 Mar



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