

PRACTICE BRIEFS



Conduct Disorder

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ABSTRACT: Conduct disorder (CD) is characterized by behavior that violates either the basic rights of others, or significant age-appropriate societal norms or rules (American Psychiatric Association [APA], 2022). An ecological perspective is necessary to reliably identify risk and protective factors related to CD, requiring a thorough investigation of individual, parent/caregiver, family, school, and broader community factors. Relatedly, assessment procedures must be multi-method, multi-informant, and cross-context to appropriately guide treatment. In treating CD, the recommended approach is primarily therapeutic, with pharmacological interventions available to reduce specific maladaptive symptoms (Masi et al., 2023). Specific therapeutic interventions may include multisystemic therapy, parent management training, and direct skills training to youth, in addition to school-based approaches. To ensure fidelity of these treatments, providers must commit to ongoing critical and intentional self-analysis to address biases to appropriately utilize diagnostic criteria for decision-making.

Introduction

Conduct disorder (CD) is characterized by behavior that violates either the basic rights of others, or significant age-appropriate societal norms or rules (American Psychiatric Association [APA], 2022). CD begins in childhood or adolescence, and individuals diagnosed with the condition generally present behaviors perceived by others as deceitful, aggressive, and destructive. The symptom categories associated with CD include (a) aggression to people or animals, (b) destruction of property, (c) deceitfulness and theft, and (c) serious violations of rules. To qualify for a diagnosis, at least three symptoms from these categories must be evident in the past year, with at least one manifesting in the past six months. Additionally, the symptoms must cause clinically significant impairment in a major life domain, and if the individual is 18 or older, they must not meet diagnostic criteria for antisocial personality disorder (ASPD).

The severity of CD can be determined based on the number of excess conduct problems presented, beyond what is necessary for a diagnosis and the subsequent harm they cause. Counselors must further characterize an individual's presentation based on whether they evidence limited prosocial emotions, a lack of remorse or guilt, callousness, shallow or deficient affect, or unconcern regarding their performance in major life domains.

The onset of CD can occur as early as the preschool years of development, although significant symptoms tend to first emerge between mid-childhood and mid-adolescence (APA, 2022). Youth with childhood-onset CD (presenting before 10 years of age) often experience notable disruptions in their development, and are at a greater risk of conduct-, substance-, and criminal behavior in later life, when compared to those who first evidence symptoms characteristic of CD in adolescence (APA, 2022). Recent literature has found sex differences related to the onset of CD symptoms, indicating that males evidence a significant risk rate for childhood-onset CD when compared to females (Álvarez-Voces et al., 2026), and

more commonly present with that specific CD type (APA, 2022; Konrad et al., 2022). Although many individuals with childhood onset CD are first diagnosed with oppositional defiant disorder (ODD), scholars advocate for maintaining separate diagnostic criteria (Burke et al., 2022). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; APA, 2022) aligns with this perspective, as the conditions are not mutually exclusive, and the text acknowledges that not all children and adolescents diagnosed with ODD will go on to develop CD later in life.

CD can be accompanied by many comorbidities, which counselors must be mindful of to facilitate their diagnostic decision-making and treatment planning. Common co-occurring conditions noted in the literature include anxiety, posttraumatic stress disorder (PTSD), ODD, attention-deficit/hyperactivity disorder (ADHD), learning disorders, in addition to personality (e.g., ASPD and borderline personality disorder [BPD]), mood (e.g., bipolar disorder and depression), and substance-related disorders (APA, 2022; Konrad et al., 2022; Tesli et al., 2024). Research has suggested sex differences in comorbidity among youth, with females evidencing higher rates of co-occurring depression, anxiety, PTSD, and BPD, compared to males who more often present with concurrent ADHD (Konrad et al., 2022).

Hyde et al. (2026) endorse the adoption of an ecological perspective to understand the risk factors underlying the development of significant conduct problems in youth. An ecological perspective accounts for how various systems interact to influence an individual's social-emotional and behavioral outcomes. When adopting an ecological perspective, counselors should identify risk factors at the individual, parent/caregiver, family, community, and societal/structural levels to enhance their case conceptualization. At the individual level, counselors can review birth outcomes, temperament, the individual's biological sex and gender, and the presence of callous and unemotional traits. Notable parent/caregiver risk factors include quality of caregiving and discipline practices, caregiver mental health status, and caregiver age. Within the family unit, counselors can assess the presence and impact of inter-caregiver conflict, social support, and economic marginalization. Within the context of the community, providers can consider community violence, toxicant exposure, and access to quality childcare, in conjunction with society's sociocultural structure that influences functioning.

Promotion of protective factors related to CD is also crucial to ensure optimal outcomes for youth at risk for and diagnosed with CD. Aligning with an ecological perspective, scholars acknowledge that protective factors exist within the individual, their family, and broader contexts (including one's community), varying in influence depending on the youth's developmental stage (Park et al., 2024) and gender (Williams-Butler et al., 2024). Therefore, to guide appropriate identification and assessment of CD, the presence of protective factors must be assessed in conjunction with a youth's risk factors, given their unique and significant influence on developmental outcomes.

Assessment Strategies

Accurate identification of CD in youth requires a meticulous and thorough assessment conducted by competent providers, considering its highly diverse nature and numerous potential comorbidities (Barker & Hawes, 2026; Masi et al., 2023). The assessment process should be multi-method, involve multiple informants, and be focused on collecting data across home, school, and other meaningful contexts. This approach helps to ensure the reliability and validity of data used to form clinical impressions and guide treatment. It is important to screen for comorbidities and protective factors, while also investigating (a) diagnostic symptoms, (b) developmental factors, (c) biopsychosocial history (including the youth's family and trauma history), and (d) cultural factors (Barker & Hawes, 2026).

Possible assessment options include (a) unstructured diagnostic interviews based on *DSM-5-TR* symptom criteria (APA, 2022); (b) structured diagnostic interviews such as the clinician-administered version of the Kiddie Schedule for Affective Disorders and Schizophrenia for School Aged Children-Computerized (Kaufman et al., 2021) and the Clinical Assessment of Prosocial Emotions (Hawes et al., 2020); (c) broad band behavior rating scales, including the Behavior Assessment System for Children (4th ed.; Reynolds & Kamphaus, 2026), (d) measures specifically designed to assess behaviors related to disruption, impulse

control, and CD (e.g., Antisocial Behavior Index for Youth Adulthood; Duarte et al., 2020; Child and Adolescent Behavior Inventory; Burns et al., 2022), (e) systematic and direct behavioral observations (Alperin et al., 2023), in addition to (f) tools to facilitate one's understanding of the youth and family's cultural background (e.g., *DSM-5* cultural formulation interview; Hass & Abdou, 2019).

Burke et al. (2022) acknowledged that standardized interview tools require significant training and may increase the duration of one's assessment process. They recommend using rating scales to identify areas of concern, before subsequent administration of diagnostic interview protocols most pertinent to the reasons for referral and other problem areas that are ruled in.

Treatment Approaches

To ensure optimal outcomes for their clients and families, practitioners must be knowledgeable of a variety of modalities described in the treatment literature for youth with CD. These include, but are not limited to, multisystemic therapy, behavioral interventions, and medication management. Practitioners should also familiarize themselves with approaches relevant to educational contexts, as nearly one-fifth of youth utilize school-based mental health services (National Center for Education Statistics, 2025).

Multisystemic Therapy

Multisystemic therapy (MST) is an intensive intervention designed to reflect the multifactorial contributors to juvenile problem behavior (Littell et al., 2021). Services are generally provided in the home and on a short-term basis over a period of four to six months, during which providers are available to 24/7 to interface with the client, family, school, and peer group (Littell et al., 2021). Specific treatment approaches within the MST framework include cognitive behavior therapy, behavioral parent training, and structural family therapy, with goals that may include positive parenting practices, reduction in antisocial behaviors such as truancy, violent behavior, and substance use; improved emotional regulation; and reduced involvement with delinquent peer groups (Nuntavisit & Porter, 2022).

Though commonly implemented to treat CD, a recent meta-analysis indicates variable effectiveness of MST in treating youth with social-emotional and behavioral difficulties. Specifically, Littell et al. (2021) reported positive outcomes, such as reduced likelihood of out-of-home placement in the United States, fewer arrests, reduced delinquency on self-report measures, and improved parenting practices. Despite these positive outcomes, use of MST yielded no significant differences in client symptomatology, relationships with peers, and substance use. According to Littell et al. (2021), these findings are further complicated by potential publication bias. For example, 61% of studies reviewed included potential conflicts of interest (i.e., were conducted by MST developers or those with financial interests), and more than half were flagged as selectively reporting outcomes.

Behavioral Interventions

Parent management training (PMT) programs may be used to support youth with CD. Within these frameworks, a counselor systematically trains parents to improve the parent-child relationship and teach contingency management practices such as positive reinforcement, time-out, and elimination of corporal punishment (Weisenmuller & Hilton, 2021). PMT has demonstrated effectiveness in children with clinically disruptive behavior on outcomes such as reduction in problem behavior and improved social skills; however, Parent-child interaction therapy (PCIT), which teaches parenting skills with direct child involvement, was found to be more effective at reducing clinical levels of disruptive behavior compared to standard PMT (Helander et al., 2024).

Therapeutic interventions may also train social-emotional skills in youth with CD. The coping power intervention, which specifically targets anger and aggressive behavior by teaching problem-solving and coping strategies, is delivered in a group format with supplemental bi-weekly parenting sessions (Bierman & Sanders, 2021). Similarly, problem-solving skills training is designed to teach social

problem-solving in a group format to clients aged 7–13, with outcomes including improvement in pro-social behavior and decreases in aggression (Masi et al., 2023).

Despite the utility of PMT, clinical considerations such as client age and family culture must be considered. PMT has demonstrated effectiveness in young children with an average age of 5.5 (range: 2–13); thus, results should be interpreted with caution in treating adolescents with CD (Helander et al., 2024). Older clients with CD may respond best to cognitive behavior therapies in conjunction with parent training (Masi et al., 2023). Cultural values are another client characteristic that must be considered in PMT service delivery, as parenting practices that are emphasized are heavily individualistic (Weisenmuller & Hilton, 2021).

School-Based Treatment Approaches

Practitioners should also consider school-based treatment approaches in supporting youth with CD, as the public school system increases access to services at no cost to families. The Promoting Alternative Thinking Strategies (PATHS) program is a school-based intervention implemented two to three times per week and is designed for students in preschool through sixth grade to learn skills such as social problem-solving and self-control (Shi et al., 2022). Additionally, students may qualify for special education services under the eligibility category of “Emotional Disturbance” if their behaviors significantly impact their education and require specialized instruction, as evidenced by characteristics such as difficulty sustaining interpersonal relationships and/or inappropriate behaviors given typical circumstances (Sallese et al., 2024).

Pharmacological Interventions

Therapeutic interventions are preferred treatments for youth with CD; however, pharmacological treatments may be implemented to treat specific associated symptoms of CD, including aggressive and impulsive behaviors, and mood regulation (Masi et al., 2023). Expert opinion provided by Masi et al. (2023) has indicated that second-generation antipsychotic drugs, such as Risperidone, are preferred when treating extreme aggression. Conversely, youth who present with mood dysregulation and exhibit irritability may respond well to lithium salts and antiepileptics (Masi et al., 2023). ADHD is commonly comorbid with CD (APA, 2022), and in these cases, psychostimulant medications may help clients regulate impulses, while also serving as a protective factor against ASPD, substance use disorder, and criminal behavior in adulthood (Canadian ADHD Resource Alliance, 2020; Masi et al., 2023; Stutzman & Dopheide, 2024).

Cultural and Ethical Considerations

Burke et al. (2022) highlighted several factors that may affect the clinical judgment of providers in their assessment of disruptive, impulse control, and conduct-related disorders, including racial and gender biases. The *ACA Code of Ethics* (American Counseling Association, 2014) requires counselors to minimize the impact of such biases on their practice. To this end, counselors must engage in critical and intentional self-analysis to identify how one’s values and beliefs affect service provision (Burke et al., 2022).

Conclusion

CD is a pervasive condition that demands availability of competent providers. Although there are a host of clinical instruments and interventions available to assess and treat CD in youth, their utility cannot be maximized until professionals commit to culturally responsive practices to promote the best outcomes for their clients. Counselors must adopt an ecological perspective to case conceptualization to move beyond viewing CD as pathology isolated within the individual and take into consideration a client’s social and cultural contexts. Doing so can promote a more comprehensive understanding of a client’s risk and protective factors, current symptoms, relevant comorbidities, and prognosis. Counselors must also commit to ongoing critical and intentional self-reflection to address biases and prejudices, that

may impair their clinical judgment, especially when working with minoritized clients and their families. To ensure optimal outcomes for clients, counselors should thoroughly examine the evidence-base for all planned assessment and intervention methods, continually monitor fidelity of their implementation, and engage in progress monitoring using tools validated for the specific populations they serve. Key indicators of treatment effectiveness include increases in prosocial behavior, reduction in clinically disruptive behaviors, and a reduction in delinquency and arrests.

Resources

- [**What are disruptive, impulse control and conduct disorders?**](#), American Psychiatric Association
- [**OSEP fast facts: Children identified with emotional disturbance**](#), Individuals with Disabilities Education Act
- [**Program guide: Promoting Alternative Thinking Strategies \(PATHS\)**](#), Collaborative for Academic, Social, and Emotional Learning

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To Cite This Practice Brief:

- Grant, G., & Weaver, C. (2026, September). *Conduct disorder* [Practice Brief]. Counseling Nexus. <https://doi.org/10.63134/HRXX8214>