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Conduct Disorder: Is It Treatable?

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Abstract

Behavior problems are a growing problem in classrooms around the United States. One of the most common types of behavior disorders is Conduct Disorder. Is this a treatable disorder? Many treatment options are available. Only three will be discussed in this paper: Service Learning, Behavior Modification and Cognitive Behavior Therapy. Service Learning, Behavior Modification, and Cognitive Behavior Therapy have been shown to be effective in treating conduct disorders in residential settings but there are no follow-up studies to determine whether these treatments had long-term effects on the behavior once the students left the facility.

Introduction

Since the rash of school shootings in the 1990s, there is a heightened awareness of students with behavior problems in schools across the United States. Since the inception of Public Law 94-142, the Individuals with Disabilities Education Act of 1997, and more recently the No Child Left Behind Act, schools are required to deal with emotionally/behaviorally disturbed and socially maladjusted children and adolescents. Research by the Council for Exceptional Children has indicated that without treatment, the prognosis for those who display extreme aggressive, acting-out, and anti-social behaviors is very poor. If these students continue their extreme behaviors as they get older, they will be more likely than their peers to be unemployed, incarcerated, or in a mental institution (Wood, Cheney, Cline, Sampson, Smith, & Guetzloe, 1991). That being the case, it is important that an effective treatment be initiated.

In 1991, the federal definition of "seriously emotionally disturbed" did not incorporate socially maladjusted students. Because of that definition, behavioral disorders, such as Oppositional Defiant Disorder and Conduct Disorder (included in the socially maladjusted category), did not fall into a special education category because it is believed to be a learned behavior. In 1997 the reauthorization of the Individuals with Disabilities Education Act, makes it less complicated to expel dangerous or violent students with special needs from any classroom (Duckworth et al., 2001). As long as the behavior is not caused by a learning disability, the student may be suspended or expelled. However, in South Dakota, students who display Attention Deficit Hyperactivity Disorder (diagnosed before age seven) and a learning disability or a diagnosed emotional disability would qualify as a behavior-disordered student for special education services.

According to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, the definition of Conduct Disorder is a recurring and constant behavior pattern in which the community's standards or rules are violated (American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 4th ed.). (See chart in Appendix A for a complete list of characteristics.) Diagnosis should include a medical history, exploration of possible sexual abuse, psychological and neuropsychological testing, and psychoeducational assessment. Conduct Disorder is complex and every effort should be made to do a complete diagnosis. To know the causes is helpful for treatment. "No other disorder of childhood and adolescence is so widespread and disruptive of the lives of those who suffer it and the lives of others" (Kauffman, 1993). Conduct Disorder is twice as common in males than in females and comprises about 2%-9% of the general population (Braithwaite, Duff, & Westworth, 2001; Searight, Rottnek, & Abby, 2001; Tynan, 2001; Chandler, 2001).

Kauffman states that there are three subtypes of conduct disorder. One is "overt aggressive" which includes screaming, stubbornness, arguing, attacking people, and temper tantrums. Another is "covert anti-social" such as stealing, lying, and arson. The third is "versatile" which includes characteristics of both. The most difficult type to treat is covert antisocial (Kauffman, 1993; Dr. Fogas, 2004; Walker, Colvin, and Ramsey, 1995, as quoted in Coleman & Webber, 2002).

My research questions are: Is Service Learning a viable option in treating conduct disorders? Is Behavior Modification, an approach used most frequently, an effective method of treating conduct disorders? Is Cognitive Behavior Therapy a treatment option for conduct disorders?

Definitions

Service Learning is an integration of academics and community-based activities. The curriculum core such as Math, English, Social Studies, and Science are taught in a more practical, concrete manner rather than the abstract. In a study by Frey (2003), students planned grounds beautification at a senior apartment complex. In Science, students learned about plant types and care. Math classes taught measurement and budgeting skills. Their learned academic skills were used in planning and budgeting for a garden.

Behavior Modification, the most widely used method of treatment, is a system of rewarding positive behavior using a token economy such as points to earn privileges or concrete reinforcers such as candy and withholding rewards for negative behavior. Related to Behavior Modification is the concept of locus of reinforcement control. Locus of reinforcement control is the degree to which a person believes that his or her rewards or punishment is contingent on his or her behavior (Rotter, 1966, as quoted in McIntosh & Rawson, 2001). Internal locus of control is the perception that there is a relationship between what someone does and what happens to him or her. External locus of control states that there is no such relationship (Reimanis, 1974 as quoted in McIntosh & Rawson, 2001). Because Behavior Modification involves giving rewards for good behavior, the student believes or perceives that rewards are dependent on his or her behavior.

Cognitive Behavior Therapy deals with both the behavioral and cognitive models of Conduct Disorder in the belief that Conduct Disorder is a function of flawed learning in addition to flawed cognitions. Cognitions are the means by which people think about

and observe the world around them, which, in turn, affects their behavior. The therapy involves teaching functional behavior and changing the thinking patterns mainly by the teaching and use of problem solving skills (Coleman and Webber, 2002).

Comorbidity, another term frequently used with emotional/behavioral disorders, refers to two or more distinguishable diagnoses. For example, if a student were diagnosed with Attention Deficit Hyperactivity Disorder and Conduct Disorder, then these two diagnoses would be comorbid.

Literature Review

Conduct Disorder is among the most common and complex type of behavior and/or emotional disorder, so the issue of treatment needs to be addressed (Kaufman, 1993). If this is true, then teachers need to become more knowledgeable about the causes and treatment options available for Conduct Disorder. Since each child is different and the causes for Conduct Disorder are different, the treatment option needs to be tailored to the needs of the student. A treatment option, which is effective for one student, may not necessarily work for another. Teachers and administrators need to find a behavior program that is in the best interest of the student and his or her family even if that means placing the student in a residential facility.

Several studies have pointed out that risk factors, such as family discord, abuse, substance abuse, and divorce (especially with absent fathers), are leading sources of behavior problems (Tynan, 2001: Webster-Stratton, 1998: Searight, Rottnek, & Abby, 2001: Braithwaite, Duff, & Wentworth, 2001). These and other risk factors increase exponentially with each added risk factor (Webster-Stratton, 1998). Risk factors such as attention deficit hyperactivity disorder also play a large role in Conduct Disorder; in fact

there is no such thing as Conduct Disorder on its own. Tynan states that the comorbidity of Conduct Disorder and Attention Deficit Hyperactivity Disorder is 50%. Another study states that it is as high as 95% (Braithwaite, Duff, & Westworth, 2001). Other disorders such as anxiety disorders and depression are also common comorbidities with Conduct Disorder (Chandler, 2001; Tynan, 2001; Braithwaite, Duff, & Westworth, 2001; Seawright, Rottnek, & Abby, 2001). What this illustrates is that diagnosing and treating Conduct Disorders is complicated and possibly very subjective.

Behavioral disorders are a problem in society and in the schools. Christians view students as made in God's image. Regardless of what they have done, individuals are still redeemable in God's eyes. Teachers need to accept students as they are without accepting the bad behavior. Special education teachers, who work with Conduct Disordered students, need to teach the whole child, therefore knowing the background or case history of each student is important. Often students have a Conduct Disorder for different reasons. To be effective, treatment must be all-inclusive, taking into account all the different Conduct Disorder risk factors that occur within the student and within his or her environment. Treatment should be individualized, considering the different avenues along which a student develops conduct disorder (Frick, 2001).

The purpose of this literature review is to examine whether Conduct Disorder is treatable at the educational level in a residential setting. The literature shows research in treating Conduct Disorder grouped into three areas: the pre-school years, children in elementary schools, and adolescents (middle and high school). Although there are many treatments and therapies are discussed in the literature, I will only concentrate on three of

them that occur in a residential setting: Service Learning, Behavior Modification and Cognitive Behavior Therapy.

Service Learning

A common definition of Service Learning is that it is an integration of classroom academics and community-based activities (Muscott, 2000; Muscott, 2001; Frey, 1999; Frey, 2003; O'Flanagan, 1997). The students are meeting a need in the community while they are extending their understanding of academics, community, and themselves (Muscott, 2000; Coleman & Weber, 2002, Frey, 2003). One could say that Service Learning is a community-based treatment when the students interact with members of the community. Four main themes for successful Service Learning projects for Conduct Disordered students should include: (1) focusing on strengths rather than weaknesses; (2) helping to cultivate a sense of power versus helplessness; (3) creating worthiness instead of worthlessness; and (4) offering opportunities for giving instead of depending. These themes give a sense of direction and a strong foundation (O'Flanagan, 1997).

Service Learning can be considered as responsive discipleship in all of its aspects: unwrapping of student gifts, the sharing of joys and burdens with each other, and seeking shalom, "that dynamic harmony of right relationships restored by God's grace" (Stronks & Blomberg, 1993). Stronks and Blomberg go on to emphasize that we teach students for kingdom service which will last for the rest of their lives. Through responsive discipleship, students will be "made new in their attitudes and transformed by the renewing of their minds" (Stronks and Blomberg, 1993). New attitudes and development of intrapersonal and interpersonal skills are some of the outcomes of Service Learning (Frey, 2003; Curwin, 1993; Muscott, 2000; Stronks & Blomberg, 1993). Research shows

"that Service Learning will teach empathy, commitment, generosity, acceptance of diversity, and civic responsibility" (Coleman & Weber, 2002).

Service Learning, as a viable addition to traditional education programs, began in the 1980s because of three reports. One report was sponsored by the National Commission on Youth and the two others by the Carnegie Foundation. The National Commission on Youth recommended service to the community as a plan to help youth transition between adolescence and adulthood. The Carnegie Foundation reports wanted service to be a solution for an ailing public school system. These reports sparked renewed interest in school reform to help families, schools, and communities connect with each other and to enhance the overall school experience. Many areas of the country made Service Learning a requirement for graduation. Service Learning in regular education is a beneficial addition to the curriculum. Creating Service Learning projects for behavior problem students, however, presents new challenges (Muscott, 2000).

Students with severe behavior problems or Conduct Disorder are usually not in a regular school setting. Because these students are disruptive in class, many end up in alternative school programs such as a day school, a residential school, or a hospital-based school. Students in a locked facility would not be able to do any community-based service projects. Yet these students could benefit from helping others by becoming peer tutors or even helping a student in a wheelchair with his books (Curwin, 1993). In fact, peer tutoring was discovered to be very beneficial for these students. This type of Service Learning is simple and is cost effective. Teachers can easily teach students how to be effective tutors and be on site if any questions or problems should arise. Two meta-analysis studies found that tutors received better grades, fewer disciplinary referrals, had

better school attendance, and significantly higher scores in self-esteem compared to a control group (Muscott, 2000). Changes in attitudes and behaviors can occur by simply helping someone else (Curwin, 1993; Frey, 2003). "For many at-risk students, opportunities to help others may provide a way to break the devastating cycle of failure—to substitute caring for anger and replace low self-esteem with feelings of worth" (Curwin, 1993).

Specific Service Learning projects, in which groups of behavior problem students develop and work on a specific project, have shown to change attitudes and behaviors. A project in Missouri that involved middle and high school students at an alternative school and senior citizens at a local apartment complex did just that (Frey, 2003). This project was divided into three steps: preparation and implementation, integrated classroom activities, and reflection. The students began by meeting with the manager of the apartment complex and school staff to plan a garden spot. They developed architectural plans, and drew landscape designs. With the local nursery, they made decisions involving plant types and made the necessary purchases. Every week the students went to the senior apartment complex to clean up the area and plant flowers, trees, and bushes. Middle school students made benches and donated them to the seniors. During the winter, the students continued to make weekly visits and began some indoor planting in the classroom. Classroom instruction included academic and social-emotional learning in science, math, social studies, and English. In science class, for example, the students learned about plant types. Math included budgeting and measuring. English classes involved writing thank-you notes and maintaining journal entries. Social Studies topics included citizenship and civic responsibility. Reflection was made use of regularly so that

the students could think about the effect of service learning on personal growth and collaborative growth (Frey, 2003). While the goal of the service project was grounds beautification, relationships developed between the students and the senior citizens that resulted in the students visiting and doing errands for the seniors. Through formal reflection, the students gained insight in cooperative growth. Quantitative data was collected by keeping track of out-of-school suspensions, profanity, non-compliance, and physical threats. Some of the positive outcomes of the direct service projects were these: Improved attitudes toward the community and others, evidence of an increase in self-esteem, learning to be more responsible for their actions and to solve problems (Frey, 1999; Frey, 2003). Out-of-school suspensions decreased 73%, incident reports decreased 60%, profanity decreased 50%, non-compliance reports dropped 66%, and physical threat reports decreased 88%. The four themes of: (1) focusing on strengths rather than weaknesses; (2) helping to cultivate a sense of power versus helplessness; (3) creating worthiness instead of worthlessness; (4) and offering opportunities for giving instead of depending (O'Flanagan, 1997), helped make this service-learning project a success.

Service Learning can be a workable treatment option for students with Conduct Disorder in a residential setting. One important finding according to Muscott and O'Flanagan was, "participants, their teachers, their parents, and their community supervisors overwhelmingly agree that their programs were worthwhile, useful, enjoyable, and powerful learning experiences" (Muscott, 2000; O'Flanagan, 1997). This applies to students with behavioral disorders as well as those that have no disabilities. For many it can be a life-changing experience.

Students with behavioral disorders usually do not care about others because they have been given negative messages about themselves. Students with behavioral disorders are confronted daily with feelings of failure and worthlessness. These students need to see that they are useful. Changes will not happen overnight. "Most behaviorally disordered children want to be altruistic, helping or kind. However many have learned to view hurting behavior as fashionable while helping or being 'nice' to others is seen as a sign of weakness" (Nicolaou and Brendtro,1983, as quoted by Muscott, 2001). In addition, considering their school and learning past, these students need to be taught to overcome selfishness and give to others. The students need to be instructed to care about others (Ioele & Dolan, 1993, as quoted in Muscott, 2001).

In order to understand the power of assisting other people they need to ask themselves what improves their self-esteem more: A person they love saying, 'I need you,' or a person they love saying, 'You need me' (Curwin, 1993). Students need to have their altruism aroused by serving others and service is one way of encouraging the arousal (Curwin, 1993). Current research asserts that Service Learning, as a treatment option, does have a positive effect (Muscott, 1999; Muscott, 2000; Muscott, 2001; Frey, 2003, Curwin, 1993, O'Flanagan, 1997).

Behavior Modification

Behavior modification is not a new concept in the treatment of behavior disorders. A system of token economy for rewarding positive behavior and withholding rewards for negative behavior has been around since B.F. Skinner. In fact, Behavior Modification is the most widely used form in the treatment of behavior disorders used in regular classrooms. It can be used with other methods that will make it even more effective

(Coleman & Webber, 2002). Behavior Modification theory is based on the philosophy that disordered behavior has been learned and can be unlearned (Knight, 1998, Van Dyk, 2000, Reinert & Huang, 1987). The behaviorist believes that the risk factors or causes of disordered behavior are "counterproductive, since the original cause of a given behavior is unlikely to be what is maintaining the behavior at the present time" (Reinert & Huang, 1987). The behaviorist is not interested in what causes the deviant behavior but to him the important thing is what is maintaining it now (Reinert & Huang, 1987). This point of view "assumes that all students are alike... and can be evaluated by the same criteria" (Van Dyk, 2000). This is not true. This would be like treating a heart attack and not being interested in what caused it.

Many Behavior Modification programs for Conduct Disordered students rely on a point system. Plus points are given for positive behavior and minus points for negative behavior. Very specific behaviors are targeted for change. External rewards are given in the hope that good behavior will become internalized so that rewarding good behavior is no longer necessary. Punishment is the application of a negative consequence or the withdrawal of a positive consequence. This type of Behavior Modification is called operant conditioning. Withdrawal of tokens or privileges or denying access to toys or television is an example of cost response or negative reinforcement. Because it is easy to apply, negative reinforcement is widely used for reducing various unwanted behavior (Polsgrove, 1991).

Two studies using Behavior Modification were conducted in highly structured residential settings. One study was conducted in a camp setting and the other in a residential hospital setting.

McIntosh and Rawson (1997) wanted to determine the effect of locus of reinforcement control on Conduct Disordered students. McIntosh and Rawson (1997) worked with one hundred thirty students, aged six through twelve, in a ten-day Behavior Modification camp program. In their studies, McIntosh and Rawson (1997) found that "internally oriented children responded more favorably to behavior modification programs than did children who were externally oriented" (McColloch, 1976 & Ollendick, Elliot, Matson, 1980 as quoted by McIntosh & Rawson, 2001). Risk factors present were low economic backgrounds and broken homes. They hypothesized that older children would demonstrate more internal locus of control than younger children and that boys would become more internally oriented than girls. Even though this was a camp, the children attended classes in academic subjects each morning and had tutoring sessions, which were one-on-one on a daily basis. Daily group activities promoted cooperative learning situations. For example, one group had to complete a tree fort cooperatively. McIntosh and Rawson used a pre-test and a post-test using the Nowicki and Strickland Pre-school and Primary Internal-External Control Scale in two of the camp sessions. The Nowicki and Strickland Locus of Control Scale for Children was used in the other two sessions. The Nowicki and Strickland Locus of Control Scale uses forty items in a response scale to measure perceived control in relationships, achievement, and dependency. These tests were used because of their reliability in each age group. Their hypothesis was only partially supported in that both boys and girls had similar levels of internal locus of control. It was supported in that the older children did exhibit more internal locus of control possibly because older children perceived themselves as being more in control of their environment (McIntosh & Rawson, 2001).

Thus, the Behavior Modification program used in this setting helped the students perceive that there is a relationship between what they do and what happens to them afterward. In other words, it helped the student understand that every decision has an outcome.

Ansari and Gouthro (1996) worked with 60 older students aged 12 through 18 in a hospital residential treatment facility to determine whether a program using a token economy system of Behavior Modification worked at reducing undesirable behavior. Risk factors were poor academic achievement indicating learning disabilities, broken homes, and absent fathers. The students were in school, had occupational therapy, vocational training, recreation, and leisure activities. The students were awarded points for appropriate behavior, which led to privileges the following day if enough points were obtained. The core of the program was the modeling of pro-social behaviors by the staff in the students learning and living environments. Each increase in points gave the students more responsibilities and privileges. Using a retrospective analysis, Ansari and Gouthro measured mean points obtained in the first four weeks (pre-test) and then the last four weeks (post-test) of the program. Those students, who only received the Behavior Modification program with no other treatment, scored higher by 66% than those who participated in other treatments along with the Behavior Modification program. Other treatments included Behavior Modification in combination with individual therapy, group therapy, chemotherapy, family therapy, and combination therapies. Age did not make a difference. Behavior Modification was successful for females, students diagnosed with Conduct Disorder after age six, students living with parents, and those that did not have learning problems. No significant differences were found when the subjects were male,

had Conduct Disorder diagnosis, came from a single-mother family, and had learning problems. Comorbidity between Conduct Disorder and learning problems made a difference in whether treatment was successful or not. It is to be noted, that the students with risk factors, such absent fathers and learning difficulties, did not have a positive outcome.

Neither McIntosh and Rawson (2001) or Ansari and Gouthro (1996) used a control group since both considered it unethical to use one. Both used a point system: positive points earned the students special activities or awards or privileges. While Ansari and Gouthro used older adolescents in an eight-week study (longer and shorter stays were also analyzed), McIntosh and Rawson used younger children in an intensive 10-day program. Both sets of students were in school part of the day.

Cognitive Behavior Therapy

Cognitive Behavior Therapy is a combination of behavioral and cognitive objectives intent on reducing undesirable behavior in the belief that behavior disorders are a function of flawed learning and flawed cognitions (thinking and perception). A cognitive psychologist believes that one can teach people to change their emotional and behavioral responses by changing their perceptions and beliefs (Coleman & Webber, 2002). Cognitive Behavior Therapy considers Conduct Disorder as a problem in self-regulation or self-management, so Cognitive Behavior Therapy teaches strategies to Conduct Disordered students to mediate their own behavior with: (a) self-instruction, which is talking to oneself to control one's own behavior; b) self-monitoring, which records information on behavior for the purpose of changing the rate of behavior; and (c) self-

evaluation, which observes behavior and assessing it according to a goal (Coleman & Webber, 2002). Students learn these techniques through the use of problem-solving skills.

Cognitive Behavior Therapy accounts for about 22% of all treatments used for conduct disorder (Kazdin et al., 1990, quoted in Mpofu & Crystal, 2001). Nevertheless, it has a high failure rate (Kazdin, 1996 as quoted by Mpofu and Crystal, 2001; van de Wiel, Matthys, Cohen-Kettenis, & van Engeland, 2002). Mpofu and Crystal (2001) assert that Cognitive Behavioral Therapy is best used with older children and adolescents. A meta-analysis of 64 studies on the use of Cognitive Behavioral Therapies with adolescents (aged 11 through 13) and children (aged 7 through 11) found that Cognitive Behavioral Therapies were twice as effective with the adolescents (Durlak et al, 1991, as quoted by Mpofu & Crystal, 2001). This may be because Cognitive Behavioral Therapy assumes considerable abilities in perspective taking and verbal comprehension and expression that younger children do not have. According to Piaget, children think more concretely while adolescents think abstractly. This idea raises questions about the treatment's applicability to children. Children understand the world in a different way than adolescents do. It is important, however, to treat Conduct Disorders at an early age before it becomes more resistant to treatment. Modified child versions of Cognitive Behavior Theory should take into account the child's stage of cognitive development.

Dykeman (2000) used cognitive behavior therapy to treat expressed anger in a small sample of eight boys aged 14 through 18 who had Conduct Disorder. One pair of students, with similar anger expression difficulties, met with a counselor for twenty-four one-hour sessions over a period of eight weeks. During the sessions the students discussed situations that triggered their feelings of anger and then discussed their

perceptions of others' thoughts, feelings, motivations, and behavior. In order to understand perceptions of others, role-play and role-reversal were used. The counseling sessions consisted of three stages. In stage one the counselor "empowered students to develop a sense of power, efficacy, and control" (Dykeman, 2000) during the counseling. During stage two the counselor acted as a mediator to engage in mutual problem solving by persuading each pair of students to a) "recognize and identify the problem; b) consider possible options and outcomes; c) choose a problem solving strategy; and d) plan on how to evaluate outcome" (Dykeman, 2000). Rating forms were used for the problem-solving strategies and included worksheets on emotional regulation and distress tolerance. In the final stage, the counselor "enabled the student's ability to engage in mutually shared reflection" (Dykeman, 2000). Also during the counseling sessions, the students discussed worldwide social problems and tried to understand other people's perspectives on social problems. Dykeman (2000) used the State-Trait Anger Expression Inventory (Dykeman, 2000) for both the pre-test and post-test. The State-Trait Anger Expression Inventory (STAXI) is a self-report that measures the experience and expression of anger. He showed that Cognitive Behavior Therapy was able to reduce inappropriate expressions of anger and maintain control over their anger. Results indicated a significant reduction in anger expression and a significant increase in anger control from pre-test to post-test. Considering these results, anger management programs show promise for use with adolescents in educational settings (Dykeman, 2000); however, he suggests further research is required since his population was so small and only included males.

If the setting for learning skills is a school, Frick (2001) found that outcomes were positive when using Cognitive Behavior Therapy. There are difficulties encountered in

getting students to use the skills in the classroom that were learned in the program outside the school and to maintain it after an extended period of time (Frick, 2001; Durlak, 1991, as quoted by Mpofu & Crystal, 2001). Frick (2001) asserts that this is one of the limitations of cognitive behavior therapy. In other words, if the student is learning Cognitive Behavior Therapy skills in a program outside a school setting, it is difficult for that student to put those skills into practice in a classroom. There is no carry over.

Cognitive Behavior Therapy works better when parents are involved in the counseling and therapy (van der Weil, Matthys, Cohen-Kettenis, van Engeland, 2002). This is also what McIntosh and Rawson and van der Wiel et al. discovered in their research and is usually referred to as a Multi-Modal or Multi-Systemic approach; it treats both the student and the context that causes, sustains, and escalates the conduct disorder, which is usually the home environment (Mpofu & Crystal, 2001). Multi-Modal or Multi-Systemic is based on the theory that there are many influences on a child: family, peers, schools, and the community. Treatment focuses on how the child interacts with these influences and what is appropriate for the child and his or her family.

Cognitive Behavior Therapy is based on the belief that Conduct Disordered students do not make appropriate use of their cognitive abilities. This treatment helps students identify problems, recognize causes of the problems, learn that actions have consequences, and learn alternative ways of handling difficult situations. Cognitive Behavior Therapy works best when parents are involved in treatment.

Summary

Behavior Disorders are an increasing problem in society. Everyone *involved—parents, school personnel, and outside agencies—should be better informed on* treatment options to help at-risk students develop into mature and responsible adults. Research indicates that the key for success is early intervention. Studies have shown that treatment should cover as much of the student's day as possible and include all caregivers, should be consistent across all environments and time and maintained for as long as necessary, should include as many types of interventions as necessary, and should address the comorbidities (Chandler, 2001). The older the student becomes, the more difficult and longer the treatment is.

Service Learning is a viable option for use with students with Conduct Disorders because it gives them self-esteem and creates empathy toward others. Students have feelings of worthiness and learn the value of working with others. Students with Conduct Disorder or any behavior disorder typically have low self-esteem beneath their tough exteriors. If we try to help them, we inadvertently give them a negative message stating that they need help. To break this cycle, adults need to show them how to be altruistic (Curwin, 1993). New attitudes and development of interpersonal and intrapersonal relationships are a very positive outcome of Service Learning. These students develop a purpose in life. In the studies by Frey (2003) and Curwin (1993), significant changes in attitude and behavior occur. Even something as simple as peer tutoring can result in better grades, fewer disciplinary referrals, better school attendance and improved self-esteem (Muscott, 2000). Service Learning is a powerful learning experience for those with Conduct Disorder because they are learning to be selfless.

Behavior Modification is the most common treatment choice for Conduct Disorders, and many residential facilities use it in one form or another. It usually takes the form of token economy where points are awarded for positive behavior. Students earn privileges by earning positive points for good behavior. The study done by Ansari and Gouthro (2001) showed that, to be effective, a longer and more extensive program is needed for students with conduct disorder. It also showed that Behavior Modification on its own worked best. Older children responded more effectively to improvement in internal locus of control in the study with McIntosh and Rawson (1987), even though the younger ones did respond with some noticeable behavior changes. This is probably because older children perceive themselves as being more in control of their environment. While some children with severe behavior disorders responded very well to this treatment, both studies suggested more research is needed in this area.

Cognitive Behavior Therapy is another treatment option. Along with a Behavior Modification program, it also teaches pro-social skills to replace the undesirable behavior. It has been effective with adolescents but not with children whose cognitive skills are not yet fully developed. Programs need to be developed for younger children since earlier intervention has been shown to be more effective. At present, Cognitive Behavior Therapy works well in a residential setting but loses its effectiveness when students need to maintain the skills taught outside that environment. Cognitive Behavior Therapy also works better when combined with other treatment options.

To treat Conduct Disorder effectively, treatment must be comprehensive and individualized, taking into account how the student came to have Conduct Disorder. There is no such thing as a "one size fits all" treatment for Conduct Disorder. Leading up

to a diagnosis of Conduct Disorder in childhood could include high rates of Attention Deficit Hyperactivity Disorder and family dysfunction. In adolescence, it could include rebelliousness and association with a deviant peer group or gang (Frick, 2001). "The overarching implication is that there is not likely to be any single 'best' treatment for CD. Instead, interventions must be tailored to the individual needs of children with CD—needs that will likely differ, depending on the specific mechanisms underlying the child's behavior disturbance" (Frick, 2001).

Discussion

Both Behavior Modification and Cognitive Behavior Therapy have a distinctly non-Christian philosophy because the philosophies of both are based on behaviorism. Cognitive Behavior Therapy is also known as Cognitive Behavior Modification because it changes behavior as well as thinking (Coleman & Webber, 2002). The roots of behaviorism lie in the philosophy of realism, materialism, and positivism. Most educational theories are built on an ineffective view of human nature. Behaviorism sees humans as evolving animals. Behaviorists say that if one can manipulate the environment one can create positive student results. Christians say that humankind cannot solve its own problems regardless of what or who manipulates it (Knight, 1998). Christians perceive humans as image bearers of Christ. Before behavior can be changed, students must be transformed and renewed in their hearts. Behavior Modification focuses on outward behavior and gives students no choice over what affects them most (Van Dyk, 2000). However, Cognitive Behavior Therapy involves both the behavior as well as the thinking. Students participating in Cognitive Behavior Therapy are not given guidance on

what is right and what is wrong. If students do not know right from wrong their thinking remains flawed.

I teach at an auxiliary residential program of the Sioux Falls South Dakota School District. Students at Volunteers of America-Dakotas are placed there because they are in the care of the Department of Social Services or the Department of Corrections. Most of these are students with chronic and intense behavior problems. Because of abuse or chemically dependent parents, many students are taken from their homes. They are waiting for a foster home placement. Others are in this structured environment because they have run away from less restrictive environments. Some individuals are placed there by the courts for chemical dependency treatment. Many others are unwanted by parents or foster homes because of uncontrollable behavior or abuse to others in the family. Additionally, girls that are pregnant or recently have had babies live at New Start and attend school there.

Volunteers of America uses a Behavior Modification point system in the residential setting and in the classroom whereby the students earn levels of privileges. All of the staff, including the teachers, follows this for consistency. I have used Behavior Modification in the past and continue to do so because I have seen it work for the students. We are permitted to use extra Behavior Modification techniques such as a soft drink for having completed fifteen assignments perfectly in a week or a movie on Friday afternoons if students complete their schoolwork before lunch on Friday. With long-term students, the need for extrinsic motivation is replaced by intrinsic motivation. Students, who have earned the privilege of going out, do small Service Learning projects such as delivering groceries and shoveling snow for shut-ins and delivering neighborhood papers.

If the student reaches a certain level, he or she may volunteer at a nursing home without supervision of staff, for example,

Volunteers of America staff, outside school hours, uses a Multi-Modal or Multi-Systemic approach for all the students. A Multi-Modal or Multi-Systemic approach to behavior disorders uses more than one treatment option and involves the parents or guardians. Use of Behavior Modification can be observed through the use of a point system. Service Learning is done on a small scale with long-term students who reach a certain privilege level. The psychologists, psychiatrists, and counselors, who work with the students individually and in groups, practice Cognitive Behavioral Therapy. If a student can successfully integrate back into their home school, the program is successful.

Service Learning, Behavior Modification, and Cognitive Behavior Therapy have been shown to be effective in some situations and with certain populations. However, there are no studies demonstrating whether the treatments were successful once the student returned in his or her natural environment. Conduct Disorder is treatable because there have been many advances in the understanding and causes of Conduct Disorder. The key to treatment is the understanding of the causes and maintenance factors of Conduct Disorder and to diagnose and treat these factors early (Webster-Stratton, 1998; Frick, 2001; Mpofu and Crystal, 2001).

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Appendix A

Definitions: An Overview

	Conduct Disorders	Oppositional Defiant Disorder	Anti-Social Personality Disorder	Intermittent Explosive Disorder
Criteria:	Bullies, threatens, intimidates others	Often loses temper	Failure to conform to social norms with respect to lawful behaviors by repeatedly performing acts that are grounds for arrest	Several discrete episodes of failure to resist aggressive impulses that result in serious aggressive acts or destruction of property
	Initiates physical fights	Often argues with adults	Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure	Degree of aggressiveness expressed during episodes is grossly out of proportion to any precipitating psychosocial stressors
	Has used a weapon to cause serious harm to others	Often actively defies or refuses to comply with adults' requests or rules	Impulsivity or failure to plan ahead	Aggressive episodes are not better accounted for by any other mental disorder and are not due to substance abuse or a general medical condition.
	Has been physically cruel to	Often deliberately	Irritability and aggressiveness,	

	animals	annoys people	as indicated by physical fights or assaults	
	Has been physically cruel to people	Often blames others for his/her mistakes or misbehavior	Reckless disregard for safety of self or others	
	Has stolen while confronting a victim	Is often touchy or easily annoyed by others	Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations	
	Has forced someone into sexual activity	Is often angry or resentful	Lack of remorse, as indicated by being indifferent to or rationalizing, having hurt, mistreated, or stolen from another	
	Has deliberately engaged in fire setting with the intent of causing damage	Is often spiteful or vindictive		
	Has deliberately destroyed others' property			
	Has broken into someone else's house or car			
	Often lies to obtain goods or favors to avoid obligations			
	Has stolen items of nontrivial value without confronting victim			
	Often stays out at			

	night despite parental prohibitions (before age 13)			
	Has run away from home overnight at least twice			
	Is often truant from school (before age 13)			
Subtypes:	Childhood onset (before age 10)	None	History of conduct disorders before age 18	None
	Adolescent onset (absence of criteria before age 10)			
Associated Features and Disorders:	Low self-esteem	Low self esteem	Inflated and arrogant self-worth	Generalized impulsivity
	Poor frustration tolerance	Low frustration tolerance	Lack empathy	Generalized aggression
	Irritability	Mood lability	Excessively opinionated	Narcissistic traits
	Temper outbursts	swearing	Superficial charm	Obsessive traits
	Recklessness and risk-taking behavior	Substance abuse	History of many sexual partners	Paranoid traits
	Higher accident rates	Conflict with adults	Irresponsible as parents	Schizoid traits
	Early onset sexual behavior	Harsh, inconsistent or neglectful child-rearing practices	Irresponsible and exploitative in sexual relationships	Stress
	Substance abuse		Depressed	Divorce
	Higher suicide rates		Inability to tolerate boredom	Job Loss
	Lower than average intelligence		More likely to die by violent means	Hospitalization due to fights and accidents

Specific culture, age and gender features:	Behavior is symptomatic of an underlying dysfunction	Oppositional symptoms increase with age	Low socioeconomic status	More common in males than females
	Males: fighting, stealing, vandalism, school discipline problems. Confrontational aggression	More prevalent in males before puberty	More prevalent in males but may be under diagnosed in females	
	Females: lying, truancy, running away, substance abuse, prostitution. Nonconfrontational aggression	Rates equal after puberty		
		Males more confrontational and more persistent symptoms		
Prevalence:	Higher in urban than rural settings	Not gender specific	Urban settings	Rare
	Males: 6%-16%	2%-16%	Males- 3%	
	Females-2%-9%		Females- 1%	
			Within clinical settings: 3%-30%	
Course:	Begins as early as 5-6 years	Becomes evident by age 8	Chronic	Late adolescence to third decade of life
	Rare after age 16	Starts at home		
	Early onset-worse prognosis and increased risk of anti-social personality disorder	Developmental antecedent to Conduct Disorder	Becomes less evident as individual ages	Mode of onset-abrupt
Familial Pattern:	Genetic and environment components	Genetic and environment components	Genetic and environment components	None

	Risk higher if parent or sibling is diagnosed with antisocial personality disorder	Risk higher if parent has mood disorder, Oppositional Defiant disorder, conduct disorder, ADHD, antisocial personality disorder or substance abuse.	More common if parents are diagnosed with the same	
	More common in children whose parents have substance abuse, mood disorders, schizophrenia, ADHD, or conduct disorder	More common in families with marital discord		

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