Advances in Psychiatric Treatment (1997), vol. 3, pp. 128–137

Management of antisocial behaviour in childhood

Quentin Spender & Stephen Scott

Antisocial behaviour is the most common reason for referral to child mental health services. It is also a clinical problem of considerable importance, because there is a marked tendency for it to persist, and the long-term outcome includes antisocial personality disorder and criminality. Furthermore, effective treatments are now available, although not yet widely used in Britain.

We have used the term 'antisocial behaviour' to include children who do not necessarily meet the strict definitions of conduct disorder or oppositional defiant disorder, for which DSM–IV (American Psychiatric Association, 1994) and ICD–10 (World Health Organization, 1993) have quite similar diagnostic criteria. For both schemes, the diagnosis of conduct disorder requires a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate social norms are violated. DSM–IV stresses that the disturbance must cause clinically significant impairment in social or academic functioning, which is implicit in ICD–10. DSM–IV requires three of the symptoms in Box 1 during the preceeding 12 months, and ICD–10 merely specifies that three symptoms must be present, but both require one symptom to have been present within the previous month. For oppositional defiant disorder, both DSM–IV and ICD–10 require four symptoms from the list in Box 2 to have been present for the preceeding six months, although DSM–IV views it as a precedent to conduct disorder, whereas ICD–10 regards it as a milder form, and stipulates that no more than two of the symptoms in Box 1 should be present. The term 'disruptive behaviour disorder' is used in DSM–IV to include hyperactivity as well as conduct and oppositional defiant disorders.

Box 1. Conduct disorder behaviours (amalgamated from DSM–IV and ICD–10)

- Excessive fighting, with frequent initiation of fights
- Deliberate and repeated destruction of others' property
- Often lies to obtain goods or favours or to avoid obligations
- Repeated stealing outside the home without confrontation (e.g. shoplifting)
- Has stolen while confronting a victim (e.g. purse-snatching, mugging)
- Has used a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- Has broken into someone else's house, building or car
- Frequent truancy from school, beginning before 13 years of age
- Often bullies, threatens or intimidates others
- Has run away from home at least twice overnight, or once for more than one night – unless to avoid physical or sexual abuse
- Often stays out after dark, despite parental prohibition, beginning before age 13 years
- Physical cruelty to other people (e.g. ties up, cuts or burns a victim)
- Cruelty to animals
- Deliberate firesetting, with a risk or intention of causing serious damage
- Forcing another person into sexual activity against their wishes

Quentin Spender is a senior lecturer in Child and Adolescent Psychiatry at St George's Hospital Medical School (Tooting, London SW17 0QT) and a consultant in the Chichester Child and Family Service for Mental Health. Stephen Scott is a senior lecturer in Child and Adolescent Psychiatry at the Institute of Psychiatry and a consultant in the Maudsley Hospital children's department. Both have been investigating treatments for children with conduct disorder for some years.

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

Box 2. Oppositional defiant behaviours (amalgamated from DSM–IV and ICD–10)

Unusually frequent and severe temper tantrums for the child's developmental level
Often argues with adults
Often actively refuses adults' requests or defies rules
Often deliberately annoys people
Often blames others for his or her mistakes or behaviour
Is often touchy or easily annoyed by others
Is often angry or resentful
Is often spiteful or vindictive

For the sake of convenience, we will use the male pronoun, since antisocial behaviour is more common in boys. This paper focuses mainly on children below 12 years of age, as delinquency in adolescence presents a range of separate problems.

Aetiology

Figure 1 shows the predisposing, precipitating and perpetuating factors that need to be considered in understanding a child's antisocial behaviour. Predisposing factors include social adversity, parental background and child constitution. More proximal causes can be both precipitating and perpetuating: negative cycles of interaction are often self-maintaining, as suggested by the double-headed arrows (Fig. 1). It is well established that parental disciplinary style is important in the development of antisocial behaviour; but the child also contributes to this interaction (Anderson *et al*, 1986). Part of the child's contribution is genetic, as shown in adoption studies (Bohman, 1996) and twin studies (Silberg *et al*, 1996). The latter study suggests that genetic factors are stronger in those children who have comorbid hyperactivity.

At school entry, a child may rapidly exhibit all the difficult behaviours in the lower oval of Fig. 1, while at home the parents must continue coping

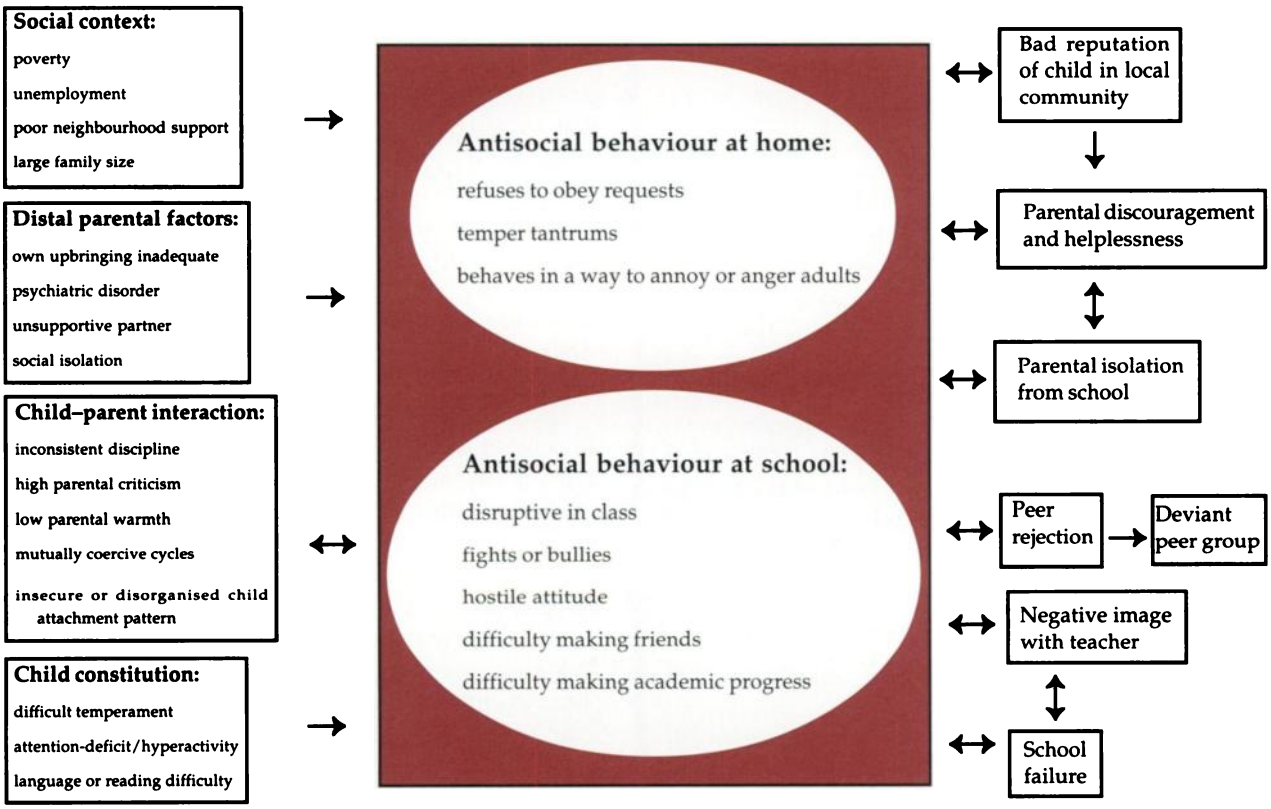

Fig. 1. Influences on antisocial behaviour seen at home and at school, and how the consequences may perpetuate it

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

with the behaviours in the upper oval. The consequences, both at home and outside, may perpetuate the child's difficulties. Parents often become disheartened, feeling criticised by neighbours and professionals, and give up trying to find more effective ways of handling their difficult child. The child elicits more and more criticism from adults around him, and it becomes increasingly difficult for him to think of himself as a success. He slips further behind his peers academically and socially, and eventually resorts to a deviant peer group of others with the same problems, who then encourage each other in antisocial acts.

At every stage, there are ways to intervene to prevent this downward spiral. Strategies demonstrated to be successful include high-quality nursery school provision for two years before school entry (Johnson, 1988). Treatment options are discussed below.

Assessment

The history should include detailed examples of the child's actions and the parental response, including how everyone felt at the time. Questions should be addressed to the child throughout, and not just to the adults present.

Developmental history

A difficult temperament from birth ("he wouldn't feed, and he kept waking up") may predispose to behaviour problems and permanently impair the affection of the mother for her child. Maternal postnatal depression may compound this, and contribute to attachment difficulties. Attachment problems may also result from significant conflict, within the first few years of the child's life, between parents, such as violence, witnessed or experienced by the child, or repeated separations and coming-back together. Language delay may lead to frustration and is associated with increased conduct problems.

Family history

A genogram is well worth the time spent on it. There is often a family history of behaviour problems or hyperactivity. Repeating patterns can sometimes be seen after gleaning minimal information about the grandparental generation, or the parents' experience of being parented. Interaction patterns within the nuclear family are more easily grasped with a diagram: is a younger sister perceived to be everything that her older brother is not, or is the eldest son credited by his mother with all the bad qualities of his long-departed father, or criminal uncle?

When this particular child is seen as much more difficult than the siblings, it is worth being curious about why. The explanation may be at least partly genetic. Giving this explanation can help both parents and child by lessening blame, but some parents may feel responsible for the child inheriting their own worst characteristics.

A problem-saturated description

Assessment and treatment are normally regarded as separate processes, but the way the assessment is done can have either a restraining or a liberating effect on treatment options. The first stages of treatment must be part of the initial session, and the way questions are asked may have a major impact on how members of the family see the difficulties they present with, so that the enquiry itself can be seen as part of the treatment (Tomm, 1987). There are many techniques for engaging families (Carpenter & Treacher, 1983), and these are often especially important with families of antisocial children. Any opportunity should be taken for praising parents, and framing in a positive light attempts to manage a difficult situation. It is all too easy, as a psychiatrist, to adopt an expert role, which can make parents feel in a 'one-down' position. They may, for instance, hear the message that they have been doing things wrong for years. It is therefore important to establish a collaborative relationship. Parents are, after all, experts on their own children, and have already conducted many experiments as to what works and what does not.

The danger of inviting the parent(s) to give an account of the problems in front of the child is that a predominantly negative picture is built up, confirming the child's already negative self-image. There are several ways round this. One is to see the parent(s) without the children. Some workers do this as a routine way of starting the assessment; but it may increase parental self-blame, and, therefore, may be best left until it is suggested by the parent(s). Another is to forgo a detailed description of the problem areas, at least initially, and focus instead on relationships within the family, and with friends. A third is to adopt a solution-focused approach (de Shazer *et al*, 1986), and emphasise the positive aspects, especially the exceptions to repeated difficulties. Examples might

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

include paying particular attention to times when the child has controlled his temper, or occasions when adults have acted effectively in achieving compliance. The 'miracle' question can be very useful in eliciting unachievable goals: "If you were to wake up tomorrow morning and find that everything was all right, what would be different?" Much smaller, achievable goals can then be generated. Finally, it is always useful to get the parent(s) to describe the positive attributes of the child in front of him.

Individual interview

It is easy, but foolhardy, to justify not paying individual attention to the child by lack of time, resources, or the need to take a family approach. Without an individual interview, it is difficult to understand the child's point of view, and there is some information which is likely to emerge only in the absence of parents, such as the revelation of abuse. Time spent with the child may make it easier for other members of the family to engage with the professional(s) involved.

Some children with conduct disorder may refuse to be seen on their own at all (which may give useful information about the insecurity of attachment and difficulties separating, as well as the ability of the child to relate to adults). With insecure children, a worthwhile interview of the child can sometimes be done in the presence of the parent(s).

Some children may have particular difficulty putting their feelings into words; others may volunteer untruthful answers. In either case, non-verbal techniques may be particularly useful, such as drawing a picture of the family or playing with figures.

Areas of success in school may be the least threatening area for initial enquiry. Closest friends, after-school activities and peer contact outside school are also fruitful avenues for exploration. A question about bullying should be included in every assessment, although children are increasingly reluctant with increasing age to admit to being bullied (Dawkins & Hill, 1995); they are even less likely to admit to being a bully.

A child may find it difficult to be open about life within the family, particularly in a first interview. This may be out of loyalty, or for fear that his comments will be fed straight back to his parents. Questions about relationships between two other family members, such as a sibling with a parent, may be easier than questions about his own relationships.

A child's view about himself is particularly important. Repeated critical comments from parent or teacher to child may contribute to low self-esteem, which is so commonly seen in conduct disorder. In extreme cases, this may make it impossible for the child to hear praise from parents or teachers, and he may repeatedly describe himself as "no good".

At least one suitably worded question should be asked about physical or sexual abuse. It is also important to ask about symptoms of depression and suicidal ideation. In older children, routine questioning should cover the use of drugs, alcohol and cigarettes.

Contributions from other informants

Telephoned or written enquiry to the child's school, after parental consent, is an essential part of assessment. There is a low correlation between reports from home and school, but in severe cases there is usually more agreement.

It is useful to have separate opinions on ability and performance, emphasising particular skills, and perhaps including specific attainment target scores. Contact with the educational psychologist can often help the assessment, as well as fostering cooperation between different professionals for the child's benefit.

Peer relationships can be particularly important. Children developing conduct disorder are often noticeable at school entry for their difficulty with learning in groups and impaired ability to make friends. They may respond to other children's social overtures by attempts at being aggressive, simply because they know no other way. The teacher's observations of emotional difficulties can reveal signs of anxiety, social withdrawal, or low self-esteem.

In some cases, attendance may be an issue, and it may then be worthwhile communicating with the educational welfare officer. Information from other professionals who are involved, such as social workers, is vital in giving insights into the family from a different perspective, what sort of professional help may have worked or not worked so far, and details of previous parental difficulties, as well as whether there is an entry on the child protection register.

Comorbidity

Assessment of comorbidity is essential. It is extremely common, its presence changes the nature of the problem to be addressed, and it is often remediable.

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

Hyperactivity

Clinical experience suggests that the more symptoms of hyperkinetic disorder are present, the more difficult it is for parents, teachers and mental health professionals to make behavioural management techniques work. The techniques may be more effective in combination with a successful pharmacological regime. Sometimes, particularly in younger children, the antisocial behaviour subsides with medication alone (Murphy *et al*, 1992), but this is less likely to occur in adolescents, perhaps because it has become more of an ingrained habit.

It should be a routine with any child referred with antisocial behaviour to think and ask about problems of inattention, overactivity and impulsivity. Useful adjuncts to a standard history include asking each parent to complete the Conner's parents' questionnaire (either 48-item or 10-item form), and asking the teacher to complete the 28-item Conner's teacher's questionnaire (Goyette *et al*, 1978).

If the diagnostic criteria for hyperkinetic disorder are met, then a trial of medication should be considered (Cameron & Hill, 1996).

Reading problems

The association between specific reading difficulties and disruptive behaviour in primary school is well established. A reading age of two standard deviations below that expected for IQ is found in at least one-third of children with conduct disorder. This may partly be due to the frustration of not being able to read leading to poor behaviour, and partly due to attention problems (Maughan *et al*, 1996), which may be either a cause or a consequence of the reading delay. Reading delay consonant with low IQ is also commonly seen in these children. It is therefore important to include an appraisal of reading, spelling and writing (since these often go together) in the assessment of any child referred with conduct disorder. The teacher's opinion may be sufficient. However, many children seem to have their literacy difficulties underestimated, and, when in doubt, every effort should be made to obtain psychometric testing by the educational psychologist, or arrange for a clinical psychologist to do this. Adequate remedial teaching will improve reading skills (Snowling, 1996), and is likely to improve academic attainments and self-esteem, as well as reducing frustration in class and disaffection with what school stands for. However, we are unaware of any studies of whether reading remediation reduces antisocial behaviour at school.

Other learning difficulties

Other specific learning difficulties, such as language disorders, may contribute to disruptive behaviour, and are easily missed. Late diagnosis of pervasive developmental disorders such as autism, and to an even greater extent Asperger's syndrome, is not uncommon. The degree of disruptive behaviour is very variable, but can pose major management difficulties.

Generalised learning disability is often more apparent in the classroom than specific learning disability, but can still be easily overlooked, especially in a class in which there are a number of under-achievers. There is a tendency for children with lower IQ to respond better to behavioural management than to interventions which require much cognitive processing or insight (Yule & Carr, 1987). Even though disruptive behaviour is a frequent association of moderate or severe learning difficulties, appropriate educational provision is often easier to find than for specific learning difficulties.

Emotional problems

An emotional dimension to conduct disorder is much more common than an accompanying substantive emotional disorder, such as depression or anxiety. A psychodynamic view would see the behaviour as mainly a surface manifestation of deeper conflicts, or as a way of expressing the feelings in behaviour rather than words – hence the term 'acting out'. There is a traditional distinction between pure conduct disorder and mixed disorders of conduct and emotion, but in practice the dividing line between the two is unclear, and the outcome is similar for both. Emotional distress of some degree is present in most pre-adolescent children presenting with antisocial behaviour, but the antisocial behaviour can act as a smokescreen, and prevent child psychiatrists from being sensitive to sadness, worry or anger.

A particular example of emotional problems which can underlie antisocial behaviour results from child sexual abuse. Children may have very strong negative feelings about the abuse, but may feel unable to disclose. Sexualised behaviour is often a feature, but may be absent. Boys who have been sexually abused are at risk of abusing other boys. Children who have been physically abused may present with aggressive behaviour or bullying. If, in addition, they have witnessed domestic violence, they are even more likely to model their behaviour on the abuser. If the abuser

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

Box 3. Examples of factors found in the assessment of antisocial behaviour which may need attention

Social factors
Housing
Is there enough support in the community?
Are there any cultural/ethnic/religious issues?

Family factors
What are the moment-to-moment interactions? (i.e. is discipline consistent? Is warmth expressed and praise given? Is criticism harsh? Is there adequate joint activity and play, as opposed to neglect?)
Are there issues to do with a reconstituted family?
Is there room for improvement in inter-parental consistency?
Is there any parental psychopathology?
What is the current influence of the grandparents?
Is a parent's experience of being a child relevant to parenting style?
What is the relationship of the parent(s) to teaching staff?

School factors
Academic progress/special educational needs
Levels of activity, concentration and task-completion in the classroom
Behaviour in the classroom, in the playground and at dinner time
Relationships with peers and adults

Child factors
Temperament
Nature of attachment to main care-giver
Medical problems?
Specific learning difficulties?
Comorbid hyperactivity?
Depression or anxiety?

was the biological father, there is the third risk factor of genetic predisposition.

Treatment

Depending what the assessment finds, attention may need to be given to the factors in Box 3 (refer also to Fig. 1). Any such factors which are present provide opportunities for helping the child and family. This help could be in the form of casework, which many would consider the best initial treatment for conduct disorder. Although common sense suggests that addressing these factors must be beneficial, the approach remains unevaluated.

Systemic family therapy is a model of treatment which can also address some of the factors in Box 3. This can be employed without focusing on the child's behaviour, or in combination with behavioural family therapy (Sanders & Dadds, 1993; Crane, 1995). The treatment model which has been found most successful in outcome studies is parent training (Patterson *et al*, 1993). The only trial comparing systemic family therapy with parent training showed the latter to be more effective, at least in increasing compliance (Wells & Egan, 1988).

The social learning theory underpinning parent training was confirmed in practice by observational studies carried out by Patterson and colleagues at the Oregon Social Learning Center (Patterson, 1982). They pointed out three simple mechanisms whereby undesirable behaviour is maintained. First, undesirable behaviour is positively reinforced by receiving angry or irritable attention. Unpleasant consequences may nevertheless be reinforcing, particularly for a child who is starved of pleasant attention. Second, desirable behaviour is extinguished by lack of attention and its failure to be effective in getting what the child wants. Third, negative reinforcement refers to the removal of an unpleasant stimulus ('negative' referring to the absence of something acting as a reinforcer). For example, a child whose whining is rewarded by the parent giving in (removal of prohibition), or an adult whose escalating coercion is rewarded by the child finally being quiet (removal of child's noise), is likely to continue these behaviours.

Individual parent training therapy was developed on the basis of social learning theory. Perhaps the best known prototype for parent training was set out by Forehand & McMahon (1981), and another manual was developed by Barkley (1987). There are detailed, explicit instructions for precisely how the therapist should instruct the parent to behave. Sessions take place 'live', in the presence of the child, and techniques are repeatedly practiced. In this way, the parent actually experiences handling the child differently, rather than just talking about it.

To the surprise of some parents, the programme starts with details of how to play with the child, and promote 'good' behaviour through selective attention, praise and rewards. Only later are techniques taught for handling misbehaviour, such as: ignoring less serious irritations; clear commands; immediate consequences for violating rules; and time out from positive (social) reinforce-

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

ment for more serious acts. The early stages, with encouragement of pro-social behaviours, are central to the success of the programme. They enable improvement in the parent–child relationship, with a softening of negative feelings towards the child, and increased expression of love and affection.

The success of these programmes hinges on how they are put into practice. Many parents will say "I've tried praise/rewards/putting him into his room – but it didn't work". The therapist's skill includes a good knowledge of basic behavioural programmes, and tailoring them to overcome common pitfalls and obstacles.

A more cost-effective way of providing this treatment was developed by Webster-Stratton (Webster-Stratton *et al*, 1989). She developed a model of group treatment which enabled the parents of about eight children to receive tuition in parenting techniques at the same time. One of its essential features is its collaborative nature (Webster-Stratton & Herbert, 1994). It is not only the children, but also their parents who may have difficulty fitting in with rules, tend to be disorganised, and find authority unhelpful, if not downright persecutory. Techniques of parenting are demonstrated during the session, using video-taped examples of families trying them out, and role-plays. The two group leaders should know about the details of these techniques, which require a sound knowledge of child development and social learning theory. But the parents are seen as experts about their own children, and conduct experiments (homework) between each weekly group to see how the techniques will work best for their own child. Every opportunity should be taken by the group leaders to praise the parents for their success, and the relationship between group leader and parent should be a model for the way the relationship between parent and child should develop. Essential practical features of parent

Box 4. Practical points about parent training

The essential nature of play

The parent–child relationship needs to be re-forged,which is far more than can be achieved simply by improving parental responses to the child's behaviours. If a parent cannot play with the child, the likely outcome is poor.

The importance of praising parents

Most parents of antisocial children have low self-esteem and little belief in their own abilities. If they have no experience of being praised, it is very difficult for them to praise their children.

The importance of praising children

Much of the change in the parent–child relationship and in the child's behaviour comes from the promotion of positive behaviour through praise and rewards, not just through better disciplining of antisocial behaviour. It is therefore important to persist with the practice of praise. Attention to detail is essential for charts and rewards, which must be changed regularly. Although often reporting that praise 'makes no difference', once encouraged to apply the techniques properly parents may be surprised by how well their child responds.

The usefulness of role play

Role play is always more powerful than repeated description and explanation. It reveals what the parent actually does, and gives an opportunity to try out new ways of doing things, and to re-order feelings and cognitions to enable this. For instance, a parent may be having difficulty playing with the index child because of an envious sibling. Getting the parent to play her child, and other group members to play the sibling and the parent, may help clarify the issues involved, develop understanding of the points of view of all three, and brainstorm solutions to this common problem.

Examination of the parents' own childhood

This can be valuable, providing it is linked clearly to finding practical ways to manage the index child differently.

Note that parents change at different rates and benefit from different parts of the programme. Also, it is important for therapists themselves to have a source of advice and support.

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

Box 5. Components of treatment which may be added to parent training therapy

Home visits – to encourage parents to experiment with the techniques. A cheaper alternative is to make encouraging telephone calls during the week between each group.

Systemic family therapy – this may be needed to address the way relationships within the family are contributing to unhelpful cycles of interaction. These cycles may change only if the underlying beliefs are examined, which may mean exploring life scripts that derive from previous generations, or helping family members tell a new story about themselves. A recently published model incorporates attachment theory into a principally structural model (Byng-Hall, 1995).

Additional therapy for parents – may include attention to depression, marital problems, communication skills, problem-solving and self-control (Sanders, 1996).

Practical assistance – with issues such as housing, finance, and support within the community (of the sort that social services can provide).

Individual therapy for children – psychodynamic therapy may be the most appropriate for children who have experienced sexual abuse, but for conduct disorder in general, cognitive problem-solving skills training is preferred (Kazdin, 1995). Therapy focuses on the development of self-awareness and alternative responses in interpersonal situations. Treatment outcome shows significant reduction in antisocial behaviour at home and at school, but children must be old enough to understand the cognitive techniques, and must have some support from their family.

Group therapy for children – similar social learning principles, modified with the use of puppets, together with tuition in the recognition of feelings, and a behavioural token regime, can be used for direct work with children aged four to seven years whose parents are enrolled in a parent management training group. The combination of child and parent treatment has more benefits, particularly at one-year follow-up, than either treatment alone (Webster-Stratton, 1997).

Liaison with school – at its most basic level, this informs the school about the assessment and treatment of the child, as well as obtaining essential information for the assessment. A school meeting including parent(s) and relevant teachers may be a useful part of treatment, especially if it results in improved communication between school and home. At a more labour-intensive level, teachers may be willing to incorporate components of the child's treatment in the classroom, and this may be enhanced by providing in-service training for teachers, which will benefit other children in the class (Gray *et al*, 1994).

Recommendations about schooling – it is salutary how often this seems the only helpful thing that can be done, because parent or child change appears impossible. Some schools for emotional and behavioural disturbance provide a therapeutic environment, in which a behavioural regime is supplemented by encouragement to put feelings into words. Parents need to be empowered to insist on their child getting whatever additional educational help he needs. A free government booklet on special educational needs may help with this (Department of Education, 1994).

training are shown in Box 4, and a manual is available (Webster-Stratton & Herbert, 1994).

Such a program is effective for about two-thirds of parents of children aged three to seven years (Webster-Stratton *et al*, 1989). Although no more effective at one year than self-administered videotape training or group discussion without videotape, it was the most effective at three-year follow-up (Webster-Stratton, 1990). Predictors of lack of response were single-parent families, lower income, and increased drug abuse, alcoholism and depression in the immediate family. Unresolved attachment status in the parent, on the adult attachment interview, may also predict lack of therapeutic response (Routh *et al*, 1995).

As well as lengthening the duration of treatment, which appears to be effective, additional treatment components can be added (see Box 5).

Conclusion

The trend in current research is towards combining different treatment modules, so that the different

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

components of the disorder all improve concurrently. For instance, a research programme might combine parent training, child cognitive–behavioural training, and a school-based intervention. Such costly combinations are beyond the reach of most clinical services in the UK, but services for conduct-disordered children can be improved bit by bit. Thorough assessment which detects comorbid conditions will allow many children to benefit. Many clinics in the UK are offering parent training, and this is clearly a feasible option (Smith, 1996). Additional components can be added as staff training and resources allow.

Acknowledgement

We thank Dr Brian Jacobs for helpful comments on an earlier draft.

References

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM–IV). Washington, DC: APA.

Anderson, K. E., Lytton, H. & Romney, D. M. (1986) Mothers' interactions with normal and conduct-disordered boys: who affects whom? *Developmental Psychology*, **22**, 604–609.

Barkley, R. A. (1987) *Defiant Children: A Clinician's Manual for Parent Training*. New York: Guilford.

Bohman, M. (1996) Predisposition to criminality: Swedish adoption studies in retrospect. In *Genetics of Criminal and Antisocial Behaviour* (CIBA Foundation Symposium 194) (eds G. R. Bock & J. A. Goode), pp. 99–114. Chichester: John Wiley & Sons.

Byng-Hall, J. (1995) *Rewriting Family Scripts*. New York: Guilford.

Cameron, M. & Hill, P. (1996) Hyperkinetic disorder: assessment and treatment. *Advances in Psychiatric Treatment*, **2**, 94–102.

Carpenter, J. & Treacher, A. (1983) On the neglected but related arts of convening and engaging families and their wider systems. *Journal of Family Therapy*, **5**, 337–358.

Crane, D. R. (1995) Introduction to behavioural family therapy for families with young children. *Journal of Family Therapy*, **17**, 229–242.

Dawkins, J. & Hill, P. (1995) Bullying: another form of abuse. In *Recent Advances in Paediatrics* (ed. T. J. David), pp. 103–122. London: Churchill Livingstone.

de Shazer, S., Berg, I. K., Lipchick, E., *et al* (1986) Brief therapy: focused solution development. *Family Process*, **25**, 207–222.

Department of Education (1994) *Special Educational Needs – A Guide for Parents*. London: HMSO.

Forehand, R. L. & McMahon, R. J. (1981) *Helping the Noncompliant Child: A Clinician's Guide to Parent Training*. New York: Guilford.

Goyette, C. H., Coners, C. K. & Ulrich, R. F. (1978) Revised Conners parent and teacher rating scales. *Journal of Abnormal Child Psychology*, **6**, 221–236.

Gray, P., Miller, A. & Noakes, J. (1994) *Challenging Behaviour in Schools*. London: Routledge.

Johnson, D. L. (1988) Primary prevention of behaviour problems in young children: the Houston Parent–Child Development Center. In *Fourteen Ounces of Prevention: A Casebook for Practitioners* (eds R. H. Price, E. L. Cowen, R. P. Lorion, *et al*) Washington, DC: APA.

Kazdin, A. E. (1995) *Conduct Disorders in Childhood and Adolescence* (2nd edn). London: Sage.

Maughan, B., Pickles, A., Hagell, A., *et al* (1996) Reading problems and antisocial behaviour: developmental trends in comorbidity. *Journal of Child Psychology and Psychiatry*, **37**, 405–418.

Murphy, D. A., Pelham, W. E. & Lang, A. R. (1992) Aggression in boys with attention-deficit/hyperactivity disorder: methylphenidate effects on naturalistically observed aggression, response to provocation, and social information processing. *Journal of Abnormal Child Psychology*, **20**, 451–466.

Patterson, G. R. (1982) *Coercive Family Process*. Eugene, OR: Castalia.

——, Dishion, T. J. & Chamberlain, P. (1993) Outcomes and methodological issues relating to treatment of antisocial children. In *Handbook of Effectice Psychotherapy* (ed. T. R. Giles), pp. 43–88. New York: Plenum.

Routh, C. P., Hill, J. P., Steele, H., *et al* (1995) Maternal attachment status, psychosocial stressors and problem behaviour: follow-up after parent training courses for conduct disorder. *Journal of Child Psychology and Psychiatry*, **36**, 1179–1198.

Sanders, M. R. (1996) New directions in behavioral family intervention with children. In *Advances in Clinical Child Psychology* (eds T. H. Ollendick & R. J. Prinz), pp. 283–330. New York: Plenum.

—— & Dadds, M. R. (1993) *Behavioral Family Intervention*. Boston, MA: Allyn & Bacon.

Silberg, J., Meyer, J., Pickles, A., *et al* (1996) Heterogeneity among juvenile antisocial behaviours: findings from the Virginia twin study of adolescent behavioural development. In *Genetics of Criminal and Antisocial Behaviour* (CIBA Foundation Symposium 194) (eds G. R. Bock & J. A. Goode), pp. 76–98. Chichester: John Wiley & Sons.

Smith, C. (1996) *Developing Parenting Programmes*. York and London: Joseph Rowntree Foundation and the National Children's Bureau.

Snowling, M. J. (1996) Contemporary approaches to the teaching of reading. *Journal of Child Psychology and Psychiatry*, **37**, 139–148.

Tomm, K. (1987) Interventive interviewing: part II. Questioning as a means to enable self-healing. *Family Process*, **26**, 167–183.

Webster-Stratton, C. (1990) Long-term follow-up of families with young conduct problem children: from preschool to grade school. *Journal of Clinical Child Psychology*, **19**, 144–149.

—— (1997) Treating children with early-onset conduct problems: a comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, in press.

——, Hollinsworth, T. & Kolpacoff, M. (1989) The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. *Journal of Consulting and Clinical Psychology*, **57**, 550–553.

—— & Herbert, M. (1994) *Troubled Families – Problem Children*. Chichester: Wiley.

Wells, K. C. & Egan, J. (1988) Social learning and systems family therapy for childhood oppositional disorder: comparative treatment outcomes. *Comprehensive Psychiatry*, **29**, 138–146.

World Health Organization (1993) *The ICD–10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*, Geneva: WHO.

Yule, W. & Carr, J. (1987) *Behaviour Modification for People with Mental Handicaps* (2nd edn). New York: Croom Helm.

Multiple choice questions

1. The following contribute to a diagnosis of conduct or oppositional disorder:
   a frequent bullying of others at school
   b smoking before the age of 13 years
   c significant impairment of functioning at home or at school
   d stealing food from the cupboard at home when hungry

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press

e running away from home to excape sexual abuse.

2. The following are characteristic features of conduct disorder:
   a an ability to put feelings into words
   b low self-esteem
   c refusing to obey parental instructions until a parent gives in
   d scapegoating within the family
   e responding to teasing at school by initiating a fight.

3. Risk factors in the child for the development of antisocial behaviour include:
   a spelling age delayed by more than three years
   b a slow-to-warm-up temperament
   c witnessing domestic violence
   d disorganised attachment
   e above average IQ.

4. Risk factors in families for the development of antisocial behaviour in children include:
   a small family size
   b grandparents who have a coercive disciplinary style
   c frequent critical comments
   d a family history of hyperactivity
   e giving in to temper tantrums.

5. The following statements are true of treatment options for conduct disorder:
   a parent training has been shown to be more effective than family therapy
   b it is important to show the parents where they have gone wrong
   c simultaneous children's groups and parents' groups are likey to be more effective than either alone
   d parents should be taught effective limit-setting before being allowed to play with their children
   e individual therapy for children under eight is more effective than parent training.

MCQ answers

1	2	3	4	5
a T	a F	a T	a F	a T
b F	b T	b F	b T	b F
c T	c T	c T	c T	c T
d F	d T	d T	d T	d F
e F	e T	e F	e T	e F

https://doi.org/10.1192/apt.3.3.128 Published online by Cambridge University Press