Understanding Oppositional Defiant Disorder and Conduct Disorder:
Diagnosis, Demographic Variations, Behavioral Trends, and an Adlerian Methodology

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Abstract

Individuals with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) often lead to enormous costs to society, especially when left untreated. This paper is designed to help clinicians understand and work with this population. First, this paper describes the current diagnostic criteria for ODD and CD, and the upcoming changes to these disorders in the Diagnostic and Statistical Manual of Mental Health Disorders 5 (DSM5). Second, issues of age, gender, and culture are explored as they relate to an individual’s presentation of ODD and CD. Third, behavioral trends are examined as they relate to prognosis and treatment options. Fourth, an Adlerian methodology is included to help clinicians qualitatively understand and work with this population.

*Keywords*: Oppositional Defiant Disorder, Conduct Disorder, Adlerian Psychology, DSM5.
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Helen and Leonard Major

Without their support this paper would not have been possible

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Understanding Oppositional Defiant Disorder and Conduct Disorder:
Diagnosis, Demographic Variations, Behavioral Trends, and an Adlerian Methodology

There is a great need for clinicians to effectively identify, understand, and treat individuals presenting with symptoms of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) because of the negative effects such individuals’ behavior has on their immediate environment and on society in general. These behaviors can range from bullying in the schoolyard or harassment in the workplace, to violent outbursts such as the shootings at Columbine by Eric Harris and Dylan Klebold, Virginia Tech by Seung-Hui Cho, or the most recent shootings by Adam Lanza at Sandy Hook Elementary.

The financial drain of employing school, community, police, court, prison, human resource personnel, and mental health professionals to manage the behaviors of this population is enormous (Essau, 2003). Potas, Vining, and Wilson (1990) estimated that the direct costs of juvenile crime and the associated costs of managing those individuals in Australia alone is approximately $1.5 billion US dollars per year. The cost of managing individuals with ODD or CD also continues to compound year after year, as they often exhibit symptoms over long periods of time even with treatment (Lahey, Loeber, Quay, Frick, & Grimm, 1997).

Individuals diagnosed with ODD or CD account for the majority of youth referrals to mental health services (Kazdin 1995, Frick 1998). The oversized impact of these clients on the mental health resources of a community can be seen when comparing the estimated occurrence of ODD and CD in the general population ranging from 2.6% to 15.8% with their estimated prevalence in clinical samples ranging as high as 28% to 65% (Boylan, Vaillancourt, Boyle, & Szatmari, 2007).
The costs of lost productivity from those affected by the negative behaviors of this population are harder to quantify, but likely to be even more expensive. For example, parents who are forced to take off work to deal with their difficult children, peers who are bullied until they are afraid to go to class or become isolated from other social connections, and co-workers who struggle because of negative work environments. All of these are examples of the indirect costs to society caused by individuals with ODD and CD.

Individuals acting out in ways that harm others when left untreated can escalate and become even more damaging and costly to society. Victims and bystanders are also at risk of developing their own mental health issues as a result of the abuse they suffer or witness. Examples of these include Adjustment Disorders, Major Depressive Disorder, Generalized Anxiety Disorder, and Post Traumatic Stress Disorder. In extreme events like school or workplace massacres, entire communities can be considered to be at high-risk for developing such disorders (Weintraub, Hall, & Pynoos, 2001).

The spread of disorders continues to drain the resources of community mental health centers, lowering their effective response to helping individuals suffering in these situations. This drain on community resources can result in a cycle of mental illness, as victims have difficulty accessing appropriate services, and possibly develop their own mental health disorders which in turn negatively affect their family, friends, and co-workers. If the mental health resources of a community are not capable of meeting their needs, this cycle of mental illness can become devastating to families as it is passed from one generation to the next.

The immediacy of these problems is further emphasized by the recent increases in rates of ODD and CD. These increases can best be seen in the rising rates of juvenile crime, which closely correlates with CD (Mordre, Groholt, Kjelsberg, Sandstad, Myhre, 2011) and its
sometimes precursor ODD. Silverthorn & Frick (1999) and Snyder & Sickmund (1995) found “that from 1983 to 1992, the juvenile violent crime rate increased 100% with an almost identical increase in the number of boys and girls seen in court for suspected delinquent activity” (as cited in Essau, 2003, p.3). Also of special note is that the recent rise in female criminal cases has continually increased at almost double the rate of males (Wilson, 2000).

The financial cost of ODD and CD, the emotional damage victims and bystanders can experience, the drain on community mental health resources, and the trending growth within the general population all emphasize the need for clinicians to be able to quickly identify, understand, and effectively intervene with this population. While several methods have been put forward for working with this population, many clinicians have only a basic understanding of how these disorders present in the field.

The goal of this paper is to help educate clinicians so that they will be better suited to identify, understand, and treat ODD and CD in the field. This paper begins by defining ODD and CD according to the criteria provided in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Health Disorders IV Text Revised (DSM-IV-TR) (2000). With a general summary of how these disorders present in an individual, a brief examination of proposed changes to these disorders in the upcoming APA’s Statistical Manual of Mental Health Disorders 5 (DSM5) is included. Because Antisocial Personality Disorder (ASPD) is linked with ODD and CD, it is also defined and described as a reference for clinicians to understand the total arch of the behaviors of which ODD and CD consist. Beyond the definition of these disorders, this paper examines how demographic variations can affect the presentation and/or treatment of ODD and CD, specifically focused on age, gender, and culture. To continue exploring variations in the presentation and treatment of these disorders, this paper
also examines the research used to understand behavioral trends within ODD and CD that have shown to be prognostically useful. Finally, to help provide both a qualitative understanding and a methodology for working with ODD and CD, the foundational aspects of Adlerian Psychology will be examined and applied to these disorders.

**Definitions and Diagnostic Criteria of ODD, CD, and ASPD**

According to the DSM-IV-TR (2000), ODD and CD can be hierarchically related (APA, 2000). A significant proportion of clients diagnosed with ODD progress to CD (Cohen & Flory, 1998; Loeber, Lahey, & Thomas, 1991), and the symptoms of 50% of children diagnosed with CD fail to disappear or moderate by adulthood (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). ODD, CD and ASPD represent different points on a spectrum of behaviors know as disruptive behavioral disorders. Each disorder describes behaviors that are disruptive and deliberately hostile to the societal norms that provide the framework of civility between individuals and groups. For example, a child who refuses to accept the authority of a parent or teacher; or an adult who is continually physically violent are behaving in a way that is both disruptive and deliberately hostile to the acceptable norms of society.

It is important to note, however, that for the purpose of this paper ODD and CD have many similarities, and unless otherwise specified, are treated interchangeably. Although ASPD is also a disruptive behavioral disorder, as a personality disorder it is of a different caliber than ODD and CD, which are seen as more amenable to treatment without resorting to institutionalization. The definition of ASPD is included in this paper because of its connection to ODD and CD, and the need for clinicians to understand the progression of behaviors from ODD to CD to ASPD. Despite this inclusion, ASPD will not be a focus of this paper.
It is also important to note that the behaviors associated with Attention Deficit Hyperactivity Disorder (ADHD) are disruptive, but not normally considered to be a deliberate and hostile attempt on the individual’s part to disrupt others. Thus ADHD is not generally a part of the hierarchy with the other three disorders, although it is often found as a concurrent disorder, and may contribute negatively to the behavior and treatment of individuals already diagnosed with a disruptive behavioral disorder.

The range of these disruptive and deliberately hostile behaviors can span anywhere from simple argumentativeness to murder and rape. The DSM-IV-TR (2000) places the least harmful of these behaviors under the diagnosis of ODD. CD represents an escalation of disruptive behavior, going past the resistance to authority or vindictive verbal harassment of ODD into an active violation of the rights of others or of societal norms. The most severe diagnosis in the hierarchy of disruptive behavior disorders is ASPD, which is characterized by a persistent continuation of the most severe behaviors of CD into adulthood.

**Diagnostic criteria for ODD**

The Symptoms of ODD consist of behaviors such as resistance to authority and vindictive reprisals using verbal harassment. Individuals with ODD do not generally go beyond that resistance to actively violate the rights of others or of major age-appropriate societal norms and rules. The current diagnostic criteria for ODD include:

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adult’s requests or rules
(4) often deliberately annoys people

(5) often blames others for his or her mistakes or misbehavior

(6) is often touchy or easily annoyed by others

(7) is often angry and resentful

(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder (APA, 2000, p. 102).

Description of ODD

Usually identified in early childhood, individuals with ODD are the consistent trouble-makers in a group. Their opposition to authority is often in excess of what would be considered normal for their age. For example, younger children with ODD will throw temper tantrums more often and with less provocation than children without ODD. Common behaviors in adolescence include irritability, strong feelings of resentfulness and anger, and vindictive reprisals for perceived slights, whether warranted or not. Individuals with ODD are very reactive to others, often perceiving negative intentions in ambiguous cases. Both younger children and adolescents with ODD are characterized by their deliberate use of disruptive behaviors to annoy, undermine, and embarrass others, particularly those in authority (APA, 2000).
Distinct from CD or ASPD, ODD is not generally associated with physical aggression or violence. ODD is often apparent in individuals before the age of eight, rarely developing after adolescence. Symptoms often increase in frequency and variety as the individual develops. ODD is more commonly diagnosed in boys than girls; however in recent years the rate of ODD diagnosed in girls has been increasing. Boys also tend to exhibit more confrontational and aggressive behaviors than girls. Symptoms usually present within the home, and are often evident in other settings where the individual has to deal with authority figures. Individuals with a diagnosis of ODD are at higher risk of several other mental health disorders, particularly CD (APA, 2000).

Proposed changes to ODD in the DSM5

The DSM5 has proposed several minor changes to the diagnostic criteria for ODD. The first proposed change is the reorganization of the symptoms into three groups. The first group is “Angry/Irritable Mood” consisting of symptoms 1, 6, and 7. The second group is “Argumentative/Defiant Behavior” which consists of symptoms 2, 3, 4, and 5. The third group is “Vindictiveness” which consists solely of symptom 8. The rationale behind this change is to show both the emotional and behavioral aspects of ODD, and to help predict co-morbid disorders based on the emotional and vindictiveness groupings (APA DSM-5, 2012a).

The second proposed change is to remove criteria D, that if criteria for CD or ASPD are met, a co-morbid diagnosis of ODD cannot be given. The rationale behind this change is that the diagnosis of ODD, when controlling for co-morbid CD, was still able to predict comorbidity with several mood disorders and specific behavioral outcomes (APA DSM-5, 2012a).

The third proposed change is to develop a scale based upon the prevalence of symptoms in multiple environments. The rationale behind this change is that studies found that the higher
the number of settings a client displayed impairment in (such as at home, at school, and with peers), the level of impairment displayed in those settings also increased (APA DSM-5, 2012a).

A fourth change is under consideration, which is to add a note to the diagnostic criteria suggesting a potential objective/standard definition of the frequency of symptoms to be considered significant, although factors of each individual client would still be used to make the final diagnosis. The rationale behind this change is that it provides clearer guidance to clinicians when diagnosing clients with ODD. The potential disadvantage of this change is that it conflicts with past research using different threshold levels of symptoms, and it may be difficult to generalize objective thresholds that hold true across different populations such as age, gender, and culture (APA DSM-5, 2012a).

**Diagnostic Criteria for CD**

Many juvenile delinquents fall into the category of CD, which is different from ODD because of both the greater severity of symptoms, the greater use of proactive aggression as opposed to reactive aggression, and the use of physical aggression. The current diagnostic criteria for CD include:

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

**Aggression to people and animals**

(1) often bullies, threatens, or intimidates others

(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

**Destruction of property**

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others’ property (other than by fire setting)

**Deceitfulness or theft**

(10) has broken into someone else’s house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., “cons” others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

**Serious violations of rules**

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder

*Code* based on age at onset:

**312.81 Conduct Disorder, Childhood-Onset Type:** onset of at least one criterion characteristic of Conduct Disorder Prior to age 10 years

**312.82 Conduct Disorder, Adolescent-Onset Type:** Absence of any criteria characteristic of Conduct Disorder Prior to age 10 years

**312.89 Conduct Disorder, Unspecified Onset:** age at onset is not known

*Specify* severity:

**Mild:** few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others

**Moderate:** number of conduct problems and effect on others intermediate between “mild” and “severe”

**Severe:** many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others (APA, 2000, p.98).

**Description of CD**

The behavior of individuals with CD is much more severe than those with ODD. Symptoms generally begin to appear between early childhood and high school, but onset is rarely after sixteen years of age. These individuals are intimidating, evoke fear reactions from others, and are usually not deterred by strong disciplinary measures. Hostile behavior includes verbal and physical aggression, which the individual often believes is justified. In addition to reacting
to others aggressively, individuals with CD will likely initiate hostility without provocation, and may engage in acts of sexual coercion or forced sexual contact. They have difficulty fulfilling responsibilities such as finishing homework or maintaining employment, and often engage in risky behavior such as drugs, violence, and unsafe sexual practices. There is little regard for the property, welfare, or feelings of others. The goal of individuals with CD may be to physically or emotionally harm a victim, or a hedonistic tendency to do what will feel good in the moment regardless of long-term consequences to themselves or others. Cases of CD can range from mild to severe, depending on the number of symptoms present, and the level of harm that has been caused to others (APA, 2000).

CD is split into two main types, Childhood-Onset and Adolescent-Onset Type, with Unspecified Onset Type being used when the beginning of symptoms is unknown. Individuals with the Childhood-Onset Type begin to present symptoms before the age of ten, and usually develop full symptoms of CD before puberty. These individuals are often male, are more aggressive, and have difficulty forming normal social relationships with peers, family, and authority figures. They are also more likely to have concurrent disorders such as ADHD, or a previous diagnosis of ODD. There is a higher likelihood that these individuals will continue to exhibit symptoms into adulthood, and potentially develop ASPD (APA, 2000).

Individuals with the Adolescent-Onset Type usually don’t present any symptoms prior to age ten. They are less likely than those with Childhood-Onset Type to display aggressive behaviors, and often have normal social relationships with some peers, family, and authority figures. There is a lower ratio of boys to girls diagnosed with Adolescent-Onset Type than Childhood-Onset Type, but boys are still more prevalent than girls in clinical and community samples. Individuals with Adolescent-Onset Type are less likely to see their symptoms continue
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into adulthood, and have lower rates of developing ASPD than those diagnosed with Childhood-Onset Type (APA, 2000).

Proposed Changes to CD in the DSM5

There is one major change proposed for CD in the DSM5: the addition of a Callous and Unemotional (CU) specifier. The specifier would consist of four symptoms that are characteristic of the client’s normal pattern of functioning and relationship to others. Two of these symptoms need to have been displayed over the previous year and in multiple situations/relationships, and reported by more than one source to meet criteria for adding the CU specifier to someone already diagnosed with CD. The proposed symptoms include:

1. Lack of Remorse or Guilt: Does not feel bad or guilty when he/she does something wrong (exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules. The person rarely admits to being wrong and typically blames others for any negative consequences that result from his or her actions.

2. Callous-Lack of Empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on him or herself, rather than their effects on others, even when they result in substantial harm to others.

3. Unconcerned about Performance: Does not show concern about poor/problematic performance at school, work, or in other important activities. The individual does not put
forth the effort necessary to perform well, even when expectations are clear; and typically blames others for his or her poor performance.

4. Shallow or Deficient Affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions “on” or “off” quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others) (APA DSM-5, 2012b).

The rationale for the CU specifier comes from a large body of evidence detailing how CU traits help identify a specific subgroup of individuals already diagnosed with CD who consistently have more negative prognoses and are more resistant to treatment than those diagnosed with CD who do not present with CU traits. For example, among adolescents in the criminal justice system, convicted violent sex offenders often presented with higher rates of CU traits than did either non-violent or violent offenders (Caputo, Frick, and Brodsky, 1999). Also among children with Childhood-Onset CD, those presenting with higher levels of CU traits often developed more severe symptoms and had higher rates of legal trouble (Christian, Frick, Hill, Tyler & Frazer, 1997). In addition to presenting with more severe symptoms, youth with CU traits show higher levels of premeditated aggression and the use of aggression as a tool to achieve specific goals such as intimidating others for gain (Frick, Cornell, Barry, Bodin,& Dane, 2003; Kruh, Frick, & Clements 2005).

While there are many individual concerns that have been raised about the inclusion of the CU specifier for CD, the major one is whether the specifier helps the individuals it would identify more than it would potentially harm them. One concern in particular that has been raised is if the term CU itself will create a pejorative definition which will affect others’ judgment of
the individual. Murrie, Boccaccini, McCoy, & Cornell, (2007) as cited in Frick and Moffitt (2010) state that terms such as “Psychopathy” were not viewed any worse than “Conduct Disorder” by decision making professionals. Thus it is likely that the term “Callous-Unemotional Traits” which is similar to “Psychopathy” will not cause undue harm to individuals labeled as such.

A second concern of using a subtype modifier for CD arose from the variability and natural changes of personality in children as they grow. Research has shown that the CU traits are relatively stable over several periods in child development and into adulthood. In younger children a moderate level of stability has been found in those with CU traits over the span of a year (Dadds, Frazer, Frost & Hawes, 2005). Additional research also found that for 8 year old boys studied over a 9 year span parents reported high rates of stability for CU traits, while teachers reported more moderate but still stable rates of CU traits (Obradovic, Pardini, Long, & Loeber, 2007). In adolescents with assessments starting at an average age of approximately 13, both parent and child self-reporting showed a moderate to high level of stability for CU traits respectively over a 3 year period (Munoz & Frick, 2007). Further studies have shown that childhood and adolescent CU traits often continue into adulthood and are connected with worse outcomes even when controlling for other factors (Loney, Taylor, Butler, & Iacono, 2007; Burke, Loeber, & Lahey, 2007; Lynam, Caspi, Moffitt, Loeber, & Stouthamer-Loeber, 2007).

Frick and Moffitt (2010) also point out another concern, that the failure to include the CU specifier may lead decision making professionals to believe that ‘Conduct Disorder’ and ‘Psychopathy’ are equivalent, leading to harsher judgments for individuals labeled with CD but who do not display CU traits, or prescribing treatments to individuals with CU traits that are proven to be less effective when working with individuals displaying those traits.
The other proposed change to CD is to modify the severity scale for CD, however recommendations for this scale are reported as ‘forthcoming’ as of this writing (APA DSM-5, 2012c). It is likely that this scale would suffer from the same issues listed for the potential severity scale being considered for ODD.

**Diagnostic Criteria for ASPD**

Individuals with ASPD are adults who are consistently hostile and disruptive both physically and verbally. They can be charming and even appear kind, but this behavior is generally to manipulate others for their own personal gain. They have little or no remorse over any pain they cause, and have difficulty empathizing with others’ pain. Although ASPD is outside the scope of this paper, it is included here for the purpose of completeness, and to provide a more complete picture for clinicians of the importance of identifying and treating ODD and CD, as they can be predictors of an eventual diagnosis of ASPD. The diagnostic criteria for ASPD are as follows:

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3. impulsivity or failure to plan ahead
4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least 18 years of age

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a Manic Episode (APA, 2000, p.706).

Description of ASPD

ASPD is different from ODD and CD in that it represents a life pattern that is unlikely to change, and often requires extreme measures to manage, such as incarceration. As a personality disorder it cannot be diagnosed in individuals until after the age of eighteen, and only with the condition that symptoms have met criteria for several years. These individuals often believe themselves to be superior to other people, and that others who are suffering deserve what they get for being weak. They often use charm and deceit to endear themselves to others, and explain away any responsibility they have for the consequences of their actions. They often exploit others sexually, and if they have children often fail to take proper care of them. Individuals with ASPD often have little interest in forming lasting social relationships, seeing others only as tools, or as a means to an end. Others often find the need to defend themselves against individuals with ASPD, whether physically, verbally, or emotionally (APA, 2000).

ASPD represents the most extreme cases of disruptive behavior disorders, and by definition is part of a long-standing pattern that is expected to continue. In later adulthood the symptoms of individuals with ASPD may moderate themselves. The majority of those
diagnosed with ASPD are male, and there has been shown to be a connection with lower socio-economic status (APA, 2000).

**Proposed changes to ASPD in the DSM5**

There are several changes proposed for Personality Disorders that go beyond any one specific Personality Disorder, such as ASPD. Because ASPD is not the focus of this paper nor is a knowledgeable discussion of these changes within its scope, the current DSM-IV-TR (2000) diagnostic criteria will be sufficient without further explanation of how the DSM5 proposes Personality Disorders be changed.

**Demographic Variations of ODD and CD**

Age, sex, and cultural background all play a role in the expression of ODD and CD. Making appropriate accommodations for these differences in an individual’s presentation is necessary for clinicians to accurately diagnose, understand, and treat ODD and CD. The different presentations of ODD and CD in regards to age are particularly troublesome, as it is natural for children to go through several phases of rebelliousness as they grow. The discussion of sex and gender for ODD and CD generally concerns the contrast which female behaviors present compared to the male behaviors that are used as a de facto standard for these disorders. Unfortunately not enough research has been done to discover or understand these differences. Finally, the unique aspects of various cultures can change how ODD and CD present, and should be taken into account when working with individuals differing from the majority of research which has been done on mostly American and European males. The quantity and quality of research in these and other areas not mentioned is slowly improving; however care should be used whenever assessing someone representing one or more of these variables.
Age

Unlike adults, children are rapidly and constantly changing both physically and psychologically (Garber, 1984). As children grow and change, it is natural for them to go through periods of rebelliousness and opposition to authority. Children are expected to display labile moods, hostility, and attempts to flout the control of authorities, particularly during those times known as the terrible twos and adolescence. Research has shown that children as young as 3 or 4 can have externalizing problems that are abnormal for their age (Bates, Bayles, Bennett, Ridge, & Brown 1991). The fact that children as young as 3 or 4 can present abnormal opposition and conduct problems reveals the importance of understanding the unique presentation of these behaviors at various ages, and that these unique presentations should be accounted for in future criteria for ODD and CD.

The DSM-IV-TR (2000) uses the age of ten as the tipping point between its Childhood-Onset Type and Adolescent-Onset Type in CD. However this differentiation is only used prognostically, and does not comment at all about how age could affect the presentation of symptoms for individuals with CD. However it is clear that 3 and 4 year olds with externalizing behavior problems are not going to present with the same issues as 10 year olds. Neither will 11 year olds and 17 year olds going to present with the same issues. The severity of impairment based on the same behavior at various ages may also be an important factor. For example: a 4-9 year old who purposely engages in actions that could result in serious injury to another person may represent a more severe level of impairment than the same act committed by a 14-17 year old who has easier access and more ability to commit the act, as well as knowledge of the real consequences of hurting someone else. Discovering how ODD and CD are displayed by specific
age groups should be an important area of research in the future, and an issue for clinicians to be aware of when assessing ODD and CD in youth.

Another important factor to consider is the onset and speed of progression that abnormal behavior takes in an individual, particularly with the Childhood-Onset Type of CD that is a predictor of longer-term antisocial behavior (Hinshaw, Lahey, & Hart, 1993; Loeber, 1988; Moffitt, 1993; Patterson, Capaldi, & Bank, 1991).

It is thought that these children progress from relatively less serious forms of [Conduct Problems] (e.g., noncompliance, temper tantrums) to more serious forms (e.g., aggression, stealing, substance abuse) over time, that more overt behaviors (e.g., defiance, fighting) appear earlier than covert behaviors (those that occur behind the backs of adult caregivers, such as lying and stealing), and that later [Conduct Problems] expand the child's behavioral repertoire rather than replace earlier behaviors. Furthermore, there is an expansion of the settings in which the [Conduct Problems] occur over time, from the home to other settings such as the school and the broader community (McMahon, 1994, p. 902).

In contrast, the Adolescent-Onset Type of CD presents with different features when compared with the Childhood-Onset Type. First, it is associated with proportionally more moderate (non-physical) behaviors and better treatment outcomes (McMahon, 1994). Second, it is more common than Childhood-Onset Type. Third, there are specific risk factors that may predispose an individual to the Childhood-Onset Type of CD.

There is already a great deal of research about age and the treatment of mental disorders, however there is still much to be done. In regards to ODD and CD several questions remain with little or no research available. For example, how does age of onset affect ODD, and if it is
different than the age of onset for CD, why is that? Another issue is: What happens to children diagnosed with ODD after adulthood? Presumably there are several adults with symptoms that fit criteria for ODD without crossing into CD or ASPD, so how should they be assessed or identified, with what unique needs might they present, and what treatments are most effective for them? Until researchers take up these questions, assessment by clinicians for ODD and CD will remain difficult as the variables associated with age skew their presentations in the field from the diagnostic norms set by the APA.

**Gender**

The effect that gender has on the presentation of ODD and CD has been poorly researched, largely because these disorders have been defined by the stereotypically masculine forms of aggression such as, active defiance, physical harm, and/or threats of physical harm (Crick, 1997, Keenan, Loeber, Green 1999, Webster-Stratton, 1996). The result is that girls presenting different behaviors have often been ignored in the research conducted to study aggression in children (Crick, 1997). However, girls need to be represented in the research on these disorders for two important reasons. First, because the unique differences in aggressive behavior that are gender normative for girls may be resulting in the under diagnosis and lack of appropriate services to help girls with ODD and CD. Second, because rates of more traditional forms of aggression in girls are increasing (Loeber, 1990).

According to the U.S. Department of Justice (1990), “…between 1965 and 1987, the frequency of aggressive acts committed by minors in the United States increased steadily for both sexes. However, the rate for girls increased at a faster rate than that of boys, narrowing the male: female ratio from 11:1 in 1965 to 8:1 in 1987” (as cited in Crick, 1997, p. 610). Research has also shown that the rates of CD in preadolescent and adolescent boys and girls are very
similar (McGee, Feehan, Williams, & Anderson, 1992; Zoccolillo, 1993). “[In fact,] CD in girls is a relatively common psychiatric diagnosis among clinic-referred girls (Zoccolillo, 1993), ranging from 2% to 9% (American Psychiatric Association [APA] 1994), and is among the most common causes of clinical referral for girls (Cohen, 1989)” (as cited in Keenan et al., 1999, p. 3). Of particular concern due to the rising prevalence of CD in girls is their greater likelihood to expose their children to multiple risk factors such as early pregnancy, prenatal drug abuse, drug use, neglectful or hostile home environments, and choosing antisocial or abusive partners. All of which are factors that increase the child’s likelihood of eventually developing their own behavioral disorders (Keenan, et al., 1999).

Another difficulty with researching gender in relation to ODD and CD is that there is a controversy about whether behavioral differences between boys and girls represent variations of these disorders that should be accounted for in the diagnosis (Zoccolillo, Tremblay, & Vitaro, 1996), or true differences between genders that result in lower rates of these disorders being diagnosed for girls (Zahn-Waxler, 1993).

At the heart of this controversy is whether or not the differences between the way boys and girls (and men and women) generally manifest efforts to hurt and coerce others is equivalent from a diagnostic perspective, or represent distinct symptoms that need to be understood and addressed separately from each other. For example, it has been shown that boys typically present with overt aggressive acts that physically harm or threaten to physically harm others, whereas girls are more focused on social or relational types of aggression to manipulate and attempt to control others (Crick & Grotpeter, 1995). Instead of punches and kicks, girls often use social ostracism, rumor spreading, character assassination, telling falsehoods to manipulate public or individual opinion, and/or threats to do these things (Crick, 1997, SooHoo, 2009).
While there is a clear phenomenological basis for viewing physical and social/relational aggression as separate behaviors, the intent of the perpetrator appears to remain the same. Social/relational aggression “… is a psychological and emotional form of abuse that uses relationships to inflict injury upon another” (Dellasega & Yumei, 2006, as cited in Soohoo, 2009 p. 1). In addition to the intent of the aggression, the level of psychological harm to the victim can also be practically identical. Described as “psychological warfare,” girl-to-girl bullying (a typical example of social/relational aggression) is “dehumanizing” and is used “… to determine who is valued and who is not … [contributing] to a social hierarchy of privilege and oppression” (SooHoo, 2009, p. 1). Because the intent of the perpetrator and the psychological effect it has on the victim appear to be the same, it seems reasonable that social/relational aggression should be considered diagnostically significant when assessing for ODD and CD in both girls and boys, although the criteria should remain phenomenologically separate for more precise assessments.

Adding evidence that social/relational aggression is a significant aspect of female aggression is the result of a longitudinal study by Keenan, Wroblewski, Hipwell, Loeber, & Stouthamer-Loeber (2010). The study found that girls with CD scored in approximately the 75th percentile of Crick and Gropter’s (1995) Children’s Peer Relationship Scale – relational aggression subscale, compared to girls without CD who scored in approximately the 35th percentile.

A third difficulty when researching gender in relation to ODD and CD is that girls face an extreme double standard compared to boys in terms of what is considered appropriate or normal behavior. Often the phrase “boys will be boys” can sum up a laissez-faire attitude toward male misbehavior, even of a physically aggressive nature that leads to physical harm. Several popular books have recently come out which decry the over regulating of boys’ physical aggression, or
the lost “maleness” of boys. An example of this can be seen in Kindlon and Thompson’s New York Times best seller *Raising Cain: Protecting the Emotional Life of Boys* (2000). In their book the authors advocate a need for authorities to accept higher levels of activity in boys than girls (Bartlett, 2009).

Girls on the other hand are often portrayed as “the good ones” who are well behaved, successful in school, and don’t cause problems. The spirit of this double standard can be summed up in the popular nursery rhyme *What Are Little Boys Made Of?* which was first attributed to Robert Southey in the 19th century. One modern variation goes like this:

What are little boys made of?
What are little boys made of?
Slugs and snails
And puppy-dogs’ tails,
That's what little boys are made of.

What are little girls made of?
What are little girls made of?
Sugar and spice
And everything nice,

The contrast in the way girls are treated when they use physical aggression and violence is stark. A girl’s “...engagement in physical violence stigmatizes [her] in ways that is not the case for boys and young men” (cf. Brown, 2005; Chesney-Lind & Irwin, 2004; McLaughlin, 2005; Street, 2005, as cited in Charlton, 2007, p. 126-127). Such behavior can cause other
women to view a girl who is acting aggressively to be seen as less feminine, less deserving of preferential treatment, and become ostracized from the normative group.

The bias about girls being “sugar and spice and everything nice” represented by the nursery rhyme above can also be found deeply embedded in beliefs and opinions of many of those authority figures tasked with raising and disciplining children. Warrington and Younger wrote in 2000 of a teacher working with an all-girl class who said:

When I taught a bright all-girl group, they were committed, quiet, they all got on, left me feeling a bit of a spare part at times. I wanted a bit more sparkle and challenge; girls are more consistent, more middle of the road, less bragging, very often unwilling to dare, and to take risks (as cited in Charlton, 2007, p.123).

This double standard for female expressions of misbehavior goes deeper than just proscribing against masculine types of aggressive behaviors for girls. It has resulted in the unwritten rule that if a girl steps out of line she will become one of those “bad girls” who is no longer afforded the protection of society against abuse and hostility (typically of a sexual nature from men, making a “bad girl” equate to being a ”slut”).

That [the use of social/relational aggression by girls] goes unrecognized is, however, significant because [it] exacerbates a sense of invisibility. Misbehaviour is seen and read in masculine terms, where “good girls” are treated leniently and “bad girls” are treated harshly, and this reveals why female students do not engage in [aggressively masculine behaviors] as, apparently, girls learn how to manoeuvre just below the radar of the adults who have them under surveillance (Francis, 2005; Lloyd, 2005, as cited in Charlton, 2007, p. 124).
In a very recent and frightening trend, this double standard can be seen with crystal clarity in the comments of several US politicians and judges who are deciding how girls and women are viewed in American society. For example, Missouri’s 2012 United States Senate candidate, Republican Todd Akin, embodied the bias that girls should be virtuous and pure, but if they aren’t (in this case because they engaged in promiscuous sex), than they no longer deserve any protection or sympathy from society and must live with the consequences of their choices when he infamously said “If it’s a legitimate rape, the female body has ways to try to shut that whole thing down” (Jaco, 2012, para. 4).

Even more recently Judge Derek Johnson of Orange County California was quoted using this same logic during the sentencing of convicted rapist Metin Gurel:

If someone doesn't want to have sexual intercourse, the body shuts down. The body will not permit that to happen unless a lot of damage is inflicted, and we heard nothing about that in this case. That tells me that the victim in this case, although she wasn't necessarily willing, she didn't put up a fight. And to treat this case like the rape cases that we all hear about is an insult to victims of rape. I think it's an insult. I think it trivializes a rape.

(Martin, 2012, para. 2)

This is despite evidence presented that “On the day he raped her, prosecutors said, Gurel had threatened to mutilate her face and vagina with a heated screwdriver” (Goffard, 2012, para. 3). With these types of statements by the United State’s political leaders and authorities, women don’t need it spelled out any more clearly that if she does something to threaten her status as a ‘good girl,’ she will be at the mercy of an uncaring and unforgiving system, making it anathema that she would willingly defy these unwritten rules even if she was tempted to.
This double standard in the socialization of girls is likely to be a major player in the reasons why girls and women present aggression differently than boys. However, it leaves many questions about how these differences in behavior should be understood in terms of mental health and the diagnostic criteria for ODD and CD.

Although recently there has been a greater interest in the different presentations between boys and girls with ODD and CD, there are still several aspects of the female presentations of ODD and CD that have little or no research. For example: How co-morbidities specifically affect girls, how callus and unemotional affects present differently in girls than boys, or how girls present aggressive misbehavior differently to male authority figures as opposed to female authority figures. Of the available research, it is often the case that the results remain inconclusive, such as female age of onset with reports ranging from early onset beginning at ages 7-9 (Keenan, et al., 2010) to a delayed-onset in adolescence (Silverthorn and Frick in press, as cited in Keenan et al., 1999). While there is much left to research in regards to gender and ODD and CD, the situation is slowly changing with the increasing rates of girls becoming involved in legal systems and being diagnosed with ODD and CD.

**Culture**

While the DSM-IV-TR (2000) attempts to identify diagnostic criteria for disorders that supersede individual variations between cultures, the presentation and diagnosis of many disorders, ODD and CD among them, are bound to the cultures in which they were identified and researched. For example: the third criteria for ODD, “often actively defies or refuses to comply with adult’s requests or rules” (APA, 2000, p. 102) can vary widely depending on several cultural variables such as socio-economic status, language, race, region, and religion. Different cultures can also have highly contrasting expectations of children depending on the sex or age of
the child. For example many religiously conservative families expect their daughters to stay at home and raise children rather than continuing with further education or careers. Even different generations can add complexity to the situation. For example, a young child’s liberal and permissive parents die, and the child is suddenly placed with his/her grandparents who use a more conservative and authoritarian style the child is not used to.

A study done in 2010 by Canino, Polanczyk, Guilherme, Jose, Luis, and Frick attempted to determine the prevalence rates of ODD and CD across several countries. The study found that the prevalence of ODD and CD remained similar despite the continent of the study (primarily North America and Europe). However, some data appears to confirm that cultural perceptions of the role of girls in society play a role in the rates of CD and ODD. For example, in the majority of studies with information on the prevalence of CD by sex within populations, boys had significantly higher rates than girls. The main exception to this was the one study from Africa, with Ethiopian boys presenting with CD at 4% and girls presenting with CD at 6%. Similarly, the majority of studies showed that prevalence rates of ODD for boys were significantly higher than for girls, with some showing approximately equal rates. The major exception from this trend comes from the mainland of China in Hong Kong, with boys presenting with ODD at 6.9%, and girls presenting with ODD at 10.4%. The other results from Asia came from the more Westernized Taiwan, and culturally different Bangkok, Thailand. Furthermore, the only two Arab locations in the study both showed rates approximately half that of the study’s overall 3.2% average of ODD, with Yemen at 1.8% and the Al Ain District of the United Arab Emirates at 1.5%.

The same study also brings up the question of why there appeared to be such large variations within seemingly homogenous populations, such as the United States. The authors
suggest that the different editions of the APA’s Diagnostic and Statistical Manual (DSM) used to judge criteria (DSM-III 1980, DSM-III-R 1987, and DSM-IV-TR 2000) and various evaluation methods used (CAPA Children and Adolescent Psychiatric Assessment, DISC Diagnostic Interview Schedule for Children, CBCL Child Behavior Checklist, K-SADS Kiddie Schedule for Affective Disorders and Schizophrenia for School Age Children, etc.) account for these variations. However it remains plausible that such wide variations between regions within the United States and Canada are also due to cultural differences. For example, prevalence rates of CD among boys ranged from 0.8% in Oregon to 16% in New York.

Other more localized instances are also apparent. One study of the whole of North Carolina performed in 2002 using the DSM-IV-TR (2000) and the CAPA showed rates of CD at 5.4% and ODD at 1.8%. However, a second study of solely Western North Carolina in 2003 using the same diagnostic criteria and evaluation methods showed rates of both CD and ODD at 2.7%. Based on the information provided by the authors, it is reasonable to presume that the difference between these two studies is due to local factors that differ between North Carolina as a whole and Western North Carolina individually. Similar questions also arise in situations involving Great Britain, England and Wales, and West of Scotland, although there may be more variables between diagnostic criteria and evaluation methods that could explain the variations between these three studies.

Although there is some research about cultural differences in ODD and CD, much of it is quantitative and lacks the qualitative information that is needed to understand how a different cultural presentation of ODD or CD might present. Simply understanding prevalence rates, age of onset, and other statistical variations is not enough to grasp what it means for a girl born in the United States of America to Mexican parents on a work visa who is presenting with behaviors
that are considered negative by her Mexican Catholic family, but acceptable by her White American Protestant peers, or vice versa. Although there is a great deal of research on immigrants and the children of immigrants, combining that information with diagnostic criteria and how cultural differences affect the presentation of different disorders should be a major area of research in the future.

Further Areas of Research for ODD and CD

Age, gender, and culture are all very important variations within ODD and CD, but there are several other issues facing the assessment and treatment of individuals diagnosed with ODD and CD that need more research. Issues such as how illicit drug use affects individuals with ODD and CD, how different methods of rewards and punishment might help authority figures work with these individuals, and what parents and authorities can do to reduce the risk factors that contribute to the chance that a child will later present symptoms that qualify them for the diagnosis of ODD or CD all deserve more time and research in order to help lower the rates and costs of ODD and CD on society.

Behavioral Trends within ODD and CD

With all of the complexity that the diversity of people can bring to disorders like ODD and CD, it is also important to focus on the behavioral trends within the disorders themselves. There have been several attempts in the past to do this, for example the DSM-III’s (1980) Undersocialized-Socialized, and Aggressive-Nonaggressive scales, the DSM-III-R’s (1987) Solitary Aggressive, Group, and Undifferentiated Types; The DSM-IV-TR’s (2000) Childhood-Onset Type and Adolescent-Onset Type for CD; and the DSM5’s recommendation to include a CU traits modifier. In addition to the trends embraced by the APA, several other concepts about how to assess and understand trends that have appeared in individuals with ODD and CD have
come about, such as Reactive-Proactive, Destructive-Status violations, and Covert-Overt. Exploring the dynamics of each of these dimensions reveals another facet of the story behind individuals struggling with ODD and CD, and may be useful for clinicians to help assess and treat this population.

**DSM-III & DSM-III-R: Undersocialized-Socialized, Aggressive-Nonaggressive, Solitary-Aggressive, Group, and Undifferentiated**

With the APA’s release of the DSM-III in 1980, ODD (then called Oppositional Disorder) and CD generally encompassed the same types of behaviors as they do today, with only minor changes over time. However the DSM-III’s (1980) definition of CD also contained two subscales not included in the DSM-IV-TR (2000), Undersocialized-Socialized, and Aggressive-Nonaggressive. The Undersocialized-Socialized subscale focused on the individual’s ability to relate interpersonally with others. The Aggressive-Nonaggressive subscale focused on the individual’s level of physical aggression. These subscales could then be used to further distinguish the behavioral issues with which a client struggled, creating four subcategories: Undersocialized-Aggressive, Undersocialized-Nonaggressive, Socialized-Aggressive, and Socialized-Nonaggressive. At the time of the DSM-III (1980) substantial research already existed showing that certain types of individuals with CD (namely those with Undersocialized-Aggressive Type) were more likely to develop long-term negative outcomes. Unfortunately there was a great deal of confusion surrounding these terms when used in the field. The Socialized-Nonaggressive quadrant also seemed to imply a spectrum that included normal behavior that was outside traditional concepts of CD.

With the DSM-III-R (1987) efforts were made to clarify the ambiguity of these subscales. The DSM-III-R (1987) replaced the scales with three categories: Solitary-Aggressive Type,
Group Type, and Undifferentiated. The Solitary-Aggressive Type was essentially the continuation of Undersocialized-Aggressive, characterized by violent behavior and a failure to build emotional relationships with others. The Group Type identified individuals who had symptoms of CD, but were able to build and maintain relationships with others. The Undifferentiated Type was used when an individual’s presentation did not fit either the Solitary Aggressive or Group Types. Ultimately, the definitions of these subtypes were also vague and contained pejorative connotations that did not accurately describe which behaviors they were meant to identify (Frick & Moffitt, 2010).

These scales and categories were early attempts to convey more specific information about an individual client, especially information that pertained to their potential outcomes. For example, the Undersocialized-Aggressive and Solitary-Aggressive Type are essentially the spiritual predecessors of the newly proposed CU specifier for the DSM5. Unfortunately the problems with these various labels meant that the possibilities they presented for assessment and diagnosis failed to materialize. For example, the Socialized-Aggressive label could potentially have spurred an earlier focus on social/relational aggression, which has just recently become the subject of research for the presentation of aggression in girls. Despite the good intentions of these scales and categories however, there was too much confusion about what was meant by the terms used, and consequently they were removed in the APA’s next edition of the DSM.

**DSM-IV: Childhood-Onset and Adolescent-Onset Types**

At the time of the DSM-IV’s (1994) creation, the research continued to show that there was a trend of individuals within CD that consistently had more negative outcomes and more severe symptoms, however they did not know how to organize this information in a way that was accessible to clinicians in the field. The committee responsible for the DSM-IV (1994) also
wanted to avoid the controversies and failures of the last two attempts to create modifiers for CD, and so they stayed to a strictly quantitative modifier that could be used to identify those at higher risk of a negative prognosis.

The result was the Childhood-Onset Type modifier for CD. This type, as stated above, was correlated with worse outcomes, and was easy to determine (assuming accurate information was available about the age of onset for various symptoms), and contained neither pejorative language, nor confusion about what was actually being assessed. Because of the Childhood-Onset Type’s similar correlation to worse outcomes as the Undersocialized-Aggressive Type and Solitary-Aggressive Type, it acted in many ways as the practical equivalent and successor to these modifiers.

In contrast to the childhood-Onset Type, the Adolescent-Onset Type correlated with less severe symptoms, and a more positive prognosis. This was somewhat similar to both the DSM-III’s (1980) Socialized-Aggressive and DSM-III-R’s (1987) Group Type. These individuals were often able to form emotional relationships with some people, and sometimes were the result of adaptive behaviors to maladaptive situations. For example, members of urban gangs who were not by nature aggressive and violent, but because of their life circumstances perceived that aggression and violence were their best options.

**DSM5: Callous and Unemotional Traits**

With the upcoming advent of the DSM5, researchers have proposed the CU specifier as a new way to assess and identify those individuals who present with a specific set of behaviors that have been correlated to the most negative outcomes within CD. Researchers have specifically linked these CU traits with four behavioral, cognitive, and social differences from antisocial individuals without CU traits. First, antisocial children raised by caretakers utilizing
dysfunctional parenting styles were more likely to develop CU traits than antisocial children raised by caretakers with functional parenting styles. Second, individuals displaying CU traits struggle to accurately recognize commonly accepted signals for distress in others, and have a poorer ability to respond to negative stimuli when compared to antisocial individuals without CU traits. Third, individuals with CU traits were found to be less amenable to negative reinforcement, being more likely to predict positive outcomes when breaking social norms, and having more facility with verbal communication than antisocial individuals without CU traits. Fourth, individuals with CU traits often sought out dangerous or thrill seeking activities, and showed less anxiety or concern compared to other antisocial individuals without CU traits (Frick & Moffitt, 2010).

It also proved to be important to include this specifier because individuals with high levels of CU traits showed different responses to treatment than antisocial individuals without CU traits. For example, the presence of CU traits in young boys was correlated to poorer outcomes in parenting interventions that involved disciplinary measures (Hawes & Dadds, 2005). Another study found that children with CU traits enrolled in behavioral therapy but without medication showed little improvement in comparison to other children with antisocial behavior, and struggled to score in normative behavioral ranges even when controlling for medication (Waschbush, Carrey, Willoughby, King, & Andrade, 2007).

**Other Dimensions of ODD and CD**

The various iterations of the DSM have each had their unique take on how ODD and CD present, but there have been several other concepts that have not been included as part of the APA’s canon. Three of those concepts will be examined here as they have the potential to be useful in the future when assessing and treating ODD and CD. These three concepts are
Reactive vs. Proactive Aggression, Destructive Aggression vs. Status Violations, and Overt vs. Covert behaviors of aggression.

**Reactive vs proactive aggression.** An important dimension of ODD and CD is whether a diagnosed individual’s aggression is reactive or proactive in nature. For example are children reacting to what they see as threats to themselves, or are they proactively planning to use violence when they could have used other socially acceptable means to achieve their goals? (Crick & Dodge, 1996; Dodge & Coie 1987). This difference is tacitly acknowledged by the separation of ODD’s more reactive behaviors from CD’s more proactive behaviors. However, this separation does not address many possible ways for clients to be reactive or aggressive, such as when a child with ODD proactively harasses others, but does not physically assault them.

By bringing the reactive or proactive nature of a client’s aggression to the forefront of a diagnosis it may be possible to give clinicians a more effective way to determine what treatment will best suit the client’s needs. For the Reactive individual, it may be as simple as working to help them reframe their understanding of the behaviors of others. For example Dodge and Coie (1987) found that children with ODD and CD are often characterized as having negatively skewed interpretations of social cues. Perhaps these skewed interpretations result in a lifestyle where the individual sees normal attempts at control by an authority as an assault on their rights as an individual. If this is the case it would be reasonable for that individual to conclude the need to defend themselves, perhaps even violently.

The Proactive individual displays aggressive behavior on an entirely different level. This Type of aggression is associated with the Undersocialized-Aggressive Type that has been connected to worse outcomes and linked to ASPD (Frick & Ellis, 1999). Identifying this Type of behavior in a client who only meets criteria for ODD may help to clue in clinicians that there is a
greater chance of this individual developing CD, or that specific treatments may prove more useful for them.

While more research needs to be done, this dimension may provide a key to distinguishing between individuals who will likely progress on to more severe forms of behavior as time goes on.

**Destructive aggression vs. status violations.** The role of aggression in ODD and CD can be further explored with the distinction between Destructive Aggression as opposed to aggression focused against Status Violations (social conventions). Individuals who engage in fighting, destruction of property, and/or sexual assault etc. are very different than individuals who only lie, shoplift, or violate social norms without physically hurting others. Research has associated children with violent and destructive tendencies to show poorer outcomes, and have less positive responses to treatment (Hamalainen & Pulkkinen, 1996). Oddly, the DSM-IV-TR (2000) contains this information in the criteria for diagnosing CD (symptoms 1-9 represent destructive aggression, and 10-15 represent status violations), however it does not make use of this distinction when diagnosing CD. Nor does the DSM5 appear to have added much information about this scale.

**Overt vs. covert behaviors.** Frick, Lahey, Loeber, Tannenbaum, Van Horn, Christ, Hart, & Hanson (1993) used a similar model to the destructive-status violation dimension to examine how it correlated to a Covert-Overt dimension, and found four subtypes that correspond closely with legal definitions of juvenile delinquency (Frick and Ellis 1999): “overt-destructive (e.g., aggressive behavior), overt-status violations (e.g., oppositional and argumentative behavior), covert-destructive (e.g., property violations), and covert-status violations (e.g., status offenses).” Little additional research appears to have been done to understand how Overt vs.
Covert behaviors correlate with various outcomes, but the breakdown of behaviors appears to accurately map onto several concepts presented in this paper. The Overt-Destructive individual is likely to be connected with individuals who also meet criteria for the CU specifier. The Overt-Status Violator appears to consist of individuals who would also meet criteria for ODD. Both Covert-Destructive and Covert-Status Violators could prove to be a useful way to assess and identify uniquely female presentations of ODD and CD.

The Foundational Aspects of Adlerian Psychology and their Application to ODD and CD

To effectively identify, understand, and treat ODD and CD, it is important that in addition to quantitative research, clinicians also have a method to qualitatively understand these disorders. Adlerian Psychology is uniquely positioned to do this because of its foundational principles, such as Holism, The Ideographic Client, Social Field Theory, Phenomenology, Soft Determinism and The Creative Self, The Final Goal, and The Life Style. The final section of this paper will therefore focus on a brief understanding of several of these foundational principles, and how they can help clinicians with clients diagnosed with ODD and CD.

Holism

Adlerian Psychology “… postulates that the person is an indivisible unit, [and] that the person needs to be understood in his or her totality” (Mosak & Maniaci, 1999, p. 14). When working with individuals diagnosed with ODD and CD this view is critical because these clients are often at odds with the common wisdom of society in ways that those diagnosed with several other types of mental disorders are not. As described above, many with these disorders believe that their behavior is justified, acting from a moral high ground, and/or the path that will lead them to the most success. However, as anyone who has tried can tell you, attempting to change
only the behaviors that an individual believes to be justified, morally right, and/or the most expedient available is a recipe for failure.

Furthermore, the use of theories that only focus on the unwanted or disruptive parts of an individual have the tendency to set up an adversarial relationship between a clinician and his or her client, which is not conducive to developing the trust and rapport needed to help the client change. This is especially true with those who are by nature oppositional and resistant to authority. By working with the whole individual, Adlerian Psychology bypasses much of the initial resistance that often occurs with this population.

Finally, the principle of Holism helps clinicians to focus on the deeper reasons behind the behaviors of this population. Without this holistic understanding, often the changes that are made by individuals diagnosed with ODD and CD are temporary, or only applied to the unique situation for which the change was designed to improve. By focusing on the deeper motivation of oppositional and aggressive clients’ behaviors, clinicians can help facilitate changes that can bring harmony between the unique life goals of this population and the wider goals of society, rather than trying to force clients to submit to society because of fear of punishment.

**The Idiographic Client**

In the words of Adler (1956), “Each individual always manifests himself as unique, be it in thinking, feeling, speaking, or acting. We are always dealing with individual nuances and variations” (p.194). This view is especially important when working with individuals diagnosed with ODD and CD, who often feel disrespected and misunderstood by society and authority. As with clients who feel attacked when professionals fail to acknowledge the reasons behind their negative behaviors, so will clients feel attacked by professionals who assume that their thoughts, feelings, and goals are necessarily similar or in line with the rest of society. It is reasonable to
believe that if clients’ goals lined up with the rest of society, they would not have been behaving in a manner that met the criteria for ODD or CD in the first place. As individuals who are by nature oppositional and aggressive, those diagnosed with ODD and CD feel this perceived injustice even more keenly than others. It is with this sense of injustice that the stage is set for an adversarial conflict with any professional who fails to respect their clients’ ideographic qualities.

By acknowledging and respecting clients’ nuances and variations, clinicians have a chance to move past the sense of injustice that so often fuels the oppositional and aggressive behaviors of this population. By giving the acknowledgement and respect to their clients’ unique desires, clinicians can build what is sometimes their clients’ first relationship based on respect. This can sometimes act as a precedent and catalyst for clients to look for ways that their unique character can engage with society at large in positive ways. All of this works in conjunction with the Adlerian principle of Holism to create deeper and more lasting changes for clients.

Social Field Theory

Social Field Theory in Adlerian Psychology explains that individuals cannot be separated from, or understood without, the social context of their specific situation (Adler, 1956). This principle is essential for working with individuals diagnosed with ODD and CD because most often the problems which brought them in for services are due to their inappropriate behaviors in a specific social context. For example, many parents may be okay with their child arguing and saying shit or damn around the home. However, if this same child continues to behave this way at school, church, or at other public functions, suddenly his or her behavior is viewed in a much more negative light. This example, while being a simple one, can be used to help professionals to understand that individuals diagnosed with ODD and CD are not just unreasonably aggressive or hostile, but that in their world, these behaviors make sense and are justified.
Because no behavior can be understood in a vacuum, Social Field Theory is what provides clinicians with a medium to examine what their client is experiencing, what the client is trying to accomplish, and why the client wants it. For example, a male client diagnosed with ODD reports a history of trouble working with female supervisors. He is about to start a new job with a female supervisor, and wants to avoid the problems he has had in the past. A clinician using Social Field Theory might inquire about each time the client has had problems with a supervisor, female and male. As the clinician gathers the information about the social context of each situation the client reports, a mosaic is created of the client’s social context and relationships. By examining this mosaic, clinicians can identify certain themes that become clear, and are often different than what the client had initially identified. For the client above, the real issue could be that he struggles with environments where the rules and expectations aren’t clearly spelled out and strictly enforced, which has led him to become frustrated and insubordinate when confronted by supervisors who use a more passive or lax style of management.

With this new knowledge in hand, this client now has the opportunity to change his perceived pattern of difficulty with female supervisors. First, he can begin to change his bias about female supervisors. Second, he can begin to recognize and anticipate when situations with vaguely communicated expectations will arise. Third, he can begin to take an active part in communicating his need for clearer instructions to his new supervisor. Furthermore, as he practices and becomes more experienced with these changes, he will begin to generalize them to other situations. For example, the client may improve his relationships with women in general because he understands that communication styles are different and need to be accounted for.
Lastly the client may realize that he has the opportunity to actively communicate his needs for clarity beyond the workplace, and improve his relationships with friends and family as well.

**Phenomenology**

Adler believed that each individual experiences the world subjectively; ascribing their own unique interpretations onto the information their senses give them. In Adlerian Psychology this principle is called Phenomenology (Mosak & Maniacci, 1999). Phenomenology is the reason that clinicians need to view clients through the lens of Holism, Ideography, and Social Field Theory. Because of the unique view each individual has of his or her life, a situation that may have a general interpretation by society (ie hitting people is bad) does not necessarily mean the same thing to each individual who experiences it. A clear example of this can be seen with a man diagnosed with CD who assaults another person for calling him a coward. While the socially acceptable thing to do in that situation would usually be to just walk away, an individual with CD may see the insult as a true attack on his character that demands a physical response.

For clinicians, understanding this principle is essential to working with individuals diagnosed with ODD and CD, because these clients have a higher tendency to misinterpret social cues, and to overestimate the success of their aggressive actions. Clinicians that assume they understand why a client decided to assault another individual will miss opportunities to explore what could be vital issues in that client’s life. For example, the man above may have grown up in a gang, and believed letting someone call him a coward would mean others might see him as weak. In this context, being perceived as weak could result in his death, and therefore deciding to use physical violence to respond to a verbal insult becomes a reasonable conclusion.

One of the best ways to help clients begin to change their behavior is to educate them about phenomenology. Just as with Social Field Theory, when individuals can understand and
recognize situations where they may be getting themselves into trouble, they can choose to change their behavior so as to either avoid or positively affect the situation before it gets out of hand. Had the client above understood Phenomenology, he might have realized that although he felt being called a coward was a direct assault on his safety, there were additional interpretations that could have been made that didn’t lead to violence.

**The Creative Self and Soft Determinism**

In Adlerian Psychology the term The Creative Self refers to the principle that it is not the specific biological or demographic circumstances you are born into, but how you respond to these inherent qualities that define who you are. Adler (1956) wrote that “… every child is born with potentialities different from those of any other child. [Adler’s] objection to the teachings of the hereditarians … is that the important thing is not what one is born with, but what use one makes of that equipment” (p. 176).

Adlerian Psychology also follows the philosophical view of Soft Determinism, which posits that individuals cannot control the world, but they can affect and influence the opportunities and challenges they face. A great example of Soft Determinism starts at birth. For example, infants have almost no control over their situation, in fact the only effective tool they have is to cry and hope someone else will help them. As they grow older, their power to assert limited control over their life increases. For example, choosing to either join the military or become a hair stylist will affect the probability that they will become the victim of gun violence. However, neither the soldier nor the hair stylist can completely protect themselves from getting shot, whether by an enemy bullet or by a late night robber.

These two principles can prove very useful to clinicians working with clients diagnosed with ODD and CD. Soft Determinism provides a framework for therapists to understand how a
reasonable person with free will could make such seemingly negative choices by understanding two important concepts:

“First, choosing does not always mean wanting. I may choose a broken leg, even though I do not want it, if it means jumping from this burning building in order to save my life. … Second, Freedom to choose is not the same as freedom of choice. Life does impose certain limits, and within those limits I am free to choose. Freedom of choice typically implies unlimited choice” (Mosak & Maniacci, 1999, p.18)

Just as the person who jumped out of a burning building, for the majority of individuals with ODD and CD the decision to use aggression or violence is not from a place of free choice, but from a believed necessity.

Working with clients who feel forced to use aggression and violence requires a concept which helps empower choice, which the principle of The Creative Self provides. Individuals who understand that different ways to react to any given situation exist do not have the pressure to respond with the first impulse that comes to them. In the case of individuals with ODD and CD that first impulse is often aggression, but knowing about Soft Determinism and The Creative Self provides them with different options they can choose. By educating clients about the principle of Soft Determinism a clinician can help them learn how to assess and make choices that have higher rates of success and less possibility of blowback then resorting to aggression normally will.

**The Final Goal: Teleology and The Psychology of Use**

In Adlerian Psychology, there are two foundational principles bound together in what is called the Final Goal. The first is the principle of Teleology, which states that individuals are guided by a Final Goal in life. The second principle, The Psychology of Use, posits that every
emotion, thought, and action an individual makes is in pursuit of this final goal. To quote Adler, it “… becomes evident that in every mental phenomenon we discover anew the characteristic pursuit of a goal, and all our powers, faculties, experiences, wishes, fears, defects and capacities fall into line with this characteristic” (p. 94).

It is important to remember that because of the principle of Phenomenology, each individual’s relationship to the Final Goal is ultimately a fiction, or as Adler (1956) described it, a “final fictional goal” (p. 87). As infants, individuals experiences a unique array of events based upon their specific biological and social situation, and then create their own unique interpretations of those situations. Thus, the Final Goal is founded on a subjective phenomenological understanding of their unique experiences for all individuals, and therefore represents an abstract ideal of what they wish they could be.

The value of the Final Goal for clinicians working with clients diagnosed with ODD and CD is that it describes both the motivation for their behavior, and the ultimate direction of that behavior. For example, a possible Final Goal for a client with ODD or CD could be that he or she must always be in control in order to belong, have significance, or to be safe. In this context it makes sense that this client would vigorously resist any attempt by parents or teachers to assert their authority over him or her. Furthermore, because control is paramount to this client, his or her response is to reassert control by opposing that authority. This is in contrast to someone whose Final Goal is to be liked, who would generally acquiesce to the authority in question, so that he or she could curry favor and avoid conflict.

The Life Style

The Life Style is one of Adler’s and Adlerian Psychology’s most profound concepts. In some ways it is the penultimate combination of the principles described above. It is a road map
for a clinician to understand and work with an individual as a whole unit that is unique onto him or herself, experiences the world subjectively, has the free will to choose his or her actions, yet is bounded by the limitations of specific circumstance and is driven to a specific end goal. To quote Mosak and Maniacci’s (1999) excellent description of the Life Style:

The life style can be conceived of as the “rule of rules” (Shulman, 1973a,b). It is the subjective, unarticulated set of guidelines individuals develop and use to move them through life and toward their goals. It develops, [in early childhood], through the interactions children have with their significant [caretakers], peers, and social world; through their experience of culture and community; through their biological growth and dysfunction; and, perhaps most significantly, through their perceptions and choices. It is both conscious and nonconscious, in that it exists on what current theorists call a tacit-implicit level as well as an explicit, verbal level (Guidano & Liotti, 1984; Mahoney, 1991). (p. 47).

The Life Style is composed of four convictions that describe an individual’s Self-Concept, Self-Ideal, World View (Weltbild), and Ethical Convictions. The Self-Concept represents how individuals believe they currently are. The Self-Ideal represents how they believe they should be, and in many ways represents their Final Goal. The World View represents how they believe the world functions. The Ethical Convictions are the basis for their definition of right and wrong in the world, or how the world should function. These four convictions are obtained by analyzing Early Recollections, which usually consist of the earliest clear memories a client is able to report.

By analyzing these Early Recollections, a clinician trained in the use of the Life Style can learn how a client generalizes from his or her past experiences to understand future probabilities,
creating a general map to the client’s experience of life. First, it shows how a client makes sense of his or her self, his or her place in the world, how others should behave, and how the world works in general. Second, it reveals what it means to the client to succeed or fail. Third, it predicts how a client will respond to perceived successes or failures.

For example, when a client’s Self-Concept fails to live up to his or her Self-Ideal, World View, or Ethical Convictions, he or she is likely to feel inferior/inadequate (Mosak & Maniacci, 1999). These feelings of inferiority/inadequacy then pressure the client to strive to regain his or her sense of superiority/adequacy. "Adler (1927/1965) initially defined human development as a movement from a felt minus position (inferiority feelings) to a felt plus position" (Bitter, 2012, p. 91). In Adlerian Psychology, it is how individuals attempt to compensate for their inferiority/inadequacy that results in mental health or illness. If the behavior to compensate for their inferiority/inadequacy contributes positively to society, or what Adler called “The Social Interest,” this is unlikely to result in issues that would require professional help. The behaviors associated with ODD and CD, however, almost always go against The Social Interest.

All of the information gathered in the Life Style can be presented to the client, who then has the opportunity to confirm, improve, or change the predictions made in it so it becomes as accurate as possible. This gives the clinician an excellent opportunity to begin educating the client about the principle of the Final Goal, and how the client can begin to consciously influence what actions he or she takes to reach it (Mosak & Maniacci, 1999).

The following is a simplified example of how the Life Style can work with clients diagnosed with ODD or CD. Johnny is in 10th grade, and has been involved in several incidents of hostility towards his teachers and parents over the last year. These behaviors have included often losing his temper, arguing constantly, failing to comply with rules and responsibilities,
purposely attempting to annoy and disrupt others, and acting with spite and vindictiveness. After being referred to counseling by the school’s vice-principle, Johnny has been diagnosed with ODD. The counselor, a trained Adlerian therapist, decided to examine Johnny’s Life Style to try and help him. Johnny’s four convictions were as follows:

1. Self-Concept: I am intelligent
2. Self-Ideal: In order to be successful/good, I must be a winner
3. World View: Only smart people succeed/win in life
4. Ethical Convictions: The smartest/best person or idea should always succeed/win

Under normal circumstances things are okay for Johnny. He sees himself as being an intelligent individual, which not surprisingly is what his World View tells him he must be in order to live up to his Self-Ideal of being a winner. This is also consistent with his Ethical Convictions, that as long as he is smart enough he can and should be successful/win.

The problems begin when this congruent Life Style is threatened by experiences that are incongruent with the map of the world it has created for Johnny. In one example, Johnny got into an argument with his teacher about the motivations behind the American Civil War. Johnny’s teacher, having a curriculum he needed to get through, dismissed Johnny’s ideas and tried to move on with class. At this Johnny became upset, because he believed he was right, and his Ethical Conviction stated that “The smartest person/idea should always succeed/win.” This incongruity posed a threat to the map created by his Life Style, and prompted Johnny to keep pressing his teacher so that Johnny could prove his Life Style was correct. Johnny’s teacher however soon became frustrated and continued to dismiss Johnny’s idea and move the class along. Unfortunately at this point Johnny began to get aggressive with the teacher, yelling that
“Anyone who didn’t even know about the economic issues behind the start of the American Civil War was too dumb to teach this class.” At this the teacher sent Johnny to in school suspension.

While others watching this situation may wonder what Johnny could have to gain by behaving so insubordinately, from his perspective he had won the exchange and resolved the potential inferiority/inadequacy of failing to win the argument. As Johnny saw it, the teacher had failed to best Johnny in a battle of wits, which according to Johnny’s World View is how one wins/succeeds. So for Johnny, he proved he was the smarter of the two, and therefore won and was living up to his Self-Ideal.

Despite winning the exchange however, now Johnny is faced with the fact that although his World View says, “Only smart people succeed/win in life,” his teacher had succeeded in kicking him out of the class, which creates an incongruity with his Ethical Conviction that, “The smartest/best person or idea should always succeed/win.” It is likely that because of this incongruity Johnny will feel betrayed by the system, because although he “won” the exchange fairly according to his Self-Concept, Self-Ideal, and World View, the teacher did not obey the rules about how the world should work. This is likely to result in Johnny becoming angry and spiteful towards his teacher and anyone who sides with his teacher.

For clinicians, there are several areas in which the information in the Life Style can help them to intervene with clients in a respectful, effective, and lasting manner. The first area is helping clients to recognize their Life Style, and how they have been living by unconscious rules. This in itself can bring about change as clients realize that they have other options to choose from to obtain their goals if their current ones aren’t working.

The second area is helping clients to recognize the incongruities or mistaken beliefs within their Life Style. In the case of Johnny, for example, he held the mistaken belief that he
was only successful/good if he won an argument. This led to an incongruity in his Life Style when he lost the argument with his teacher. Recognizing these incongruities gives clients a place to begin reasserting their choice, or their Creative Self, to achieve their Final Goal.

The third area is helping clients to determine how they want to change. Clients have three options when dealing with an incongruity in their Life Style. The first way is to redefine what their convictions mean. In Johnny’s case, he could redefine winning from his Self-Ideal to mean that he received the highest grade, rather than knowing the most accurate information. Instead of being known as an oppositional trouble maker, with this new definition of winning, Johnny would likely become known for his respectful handling of sensitive subjects.

The second way is to readjust their Self-Concept or World View to become congruent with their Self-Ideal or Ethical Convictions. In Johnny’s case for example, he could change his Self-Concept from “I am intelligent” to “I am patient and innovative.” With this new Self-Concept, instead of challenging the teacher, Johnny might go home and write a paper on his point and present it the next day. Instead of being punished, it is possible Johnny would get extra credit for his hard work.

The third way clients can change is to adjust their Self-Ideal and Ethical Convictions to become congruent with their Self-Concept and World View. In Johnny’s case for example, he could change his Ethical Conviction from “The smartest/best person or idea should always succeed/win” to “Winning/Success in life should come from personal gratification rather than external verification.” With this new Ethical Conviction, Johnny could have let the issue with his teacher go, and be satisfied that he knew the right answer whether his teacher acknowledged it or not.
Conclusion

As rates of ODD and CD continue to increase, it becomes more important than ever for clinicians to have an in depth understanding of how these disorders affect individuals and communities, how they are defined and diagnosed, how they can present differently due to demographic variables, how trends in presentation can help inform prognosis and treatment options, and a methodology for qualitatively empathizing with the experience of their clients. This paper, while not exhaustive, has collected research to highlight how these issues can help clinicians in the field when working with clients diagnosed with ODD and CD.

Understanding the diagnostic criteria, and the proposed changed in the upcoming DSM5 is the starting point for every clinician to understand these complex disorders. While ODD and CD have remained largely unchanged since their inception in the DSM-III (1980), new research continues to tweak what each criterion is measuring, what that criterion says about that client, and how to organize this data. The upcoming changes in the DSM5 provide an opportunity for new and old clinicians alike to refocus on these disorders, as the need to identify, understand, and treat ODD and CD continues to be a major challenge in the field of mental health.

In regard to demographic diversity, the majority of research on ODD and CD has sadly been limited in scope. However understanding how the presentation of ODD and CD can differ based on demographic variations in the individual being assessed is required for clinicians to accurately diagnose these disorders. Variations such as Age, Gender, and Culture are some of the most important variations for clinicians to be aware. When considering the age of a client, several issues can arise, such as the natural changes as a child grows older, the types of behaviors to expect from aggressive children at various ages, and the progression of their aggressive behaviors. The issue of gender is a complex one in regards to ODD and CD, and is made more
so by a dearth of comprehensive research on the unique presentation of female aggression. The most important factor to emerge from the research available is to pay attention to how girls and women use social relationships as a medium to communicate their aggression. The differences in cultures also present a confusing array of issues for clinicians to be aware. Even extremely minor variations in location, language, religion, and many other aspects of culture can affect how a client presents these disorders in the field. All of these and other variations require respect and empathy from clinicians who desire to effectively help their clients who are diagnosed with ODD and CD.

The behavioral trends within ODD and CD are important clues that can help clinicians to give proper treatment for their clients. The APA has acknowledged several of these trends, the currently accepted one being Childhood-Onset Type, and potentially the CU specifier in the DSM5. There are several other trends that were highlighted in this paper, as well as others that were not included. By understanding these trends and continuing to research them, clinicians can position themselves to continue improving their care for clients with ODD and CD.

Finally, having a methodology to qualitatively understand ODD and CD is the bridge that clinicians need to effectively use the research that has been done on these disorders. Adlerian Psychology has many advantages for working with this population, due to its focus on individual, phenomenological, and goal driven principles. The Life Style in particular is a technique which can be useful in educating both the clinician and the client about what is possible in a client’s life, and where and how changes can be made to help a client reach his or her desired goals.
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