Child Planning: A Treatment Planning Approach for Children with Conduct Disorder

A Treatment Overview for Children with Conduct Problems

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms of children with lying problems or history, and learn different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations

***For a full list of 21 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Probable Causes

Symptoms

Diagnosis

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

What is conduct disorder (CD)?

Conduct disorder is a behavior disorder, sometimes diagnosed in childhood, that is characterized by antisocial behaviors which violate the rights of others and age-appropriate social standards and rules. Antisocial behaviors may include irresponsibility, delinquent behaviors (such as truancy or running away), violating the rights of others (such as theft), and/or physical aggression toward others (such as assault or rape). These behaviors sometimes occur together; however, one or several may occur without the other(s).

There are three types of conduct disorder. They’re categorized according to the age at which symptoms of the disorder first occur:

Childhood onset occurs when the signs of conduct disorder appear before age 10.

Adolescent onset occurs when the signs of conduct disorder appear during the teenage years.

Unspecified onset means the age at which conduct disorder first occurs is unknown.

Some children will be diagnosed with conduct disorder with limited prosocial emotions. Children with this specific type of conduct disorder are often described as callous and unemotional.

Causes:
The conditions that contribute to the development of conduct disorder are considered to be multifactorial, with many factors (multifactorial) contributing to the cause. Neuropsychological testing has shown that children and adolescents with conduct disorders seem to have an impairment in the frontal lobe of the brain that interferes with their ability to plan, avoid harm, and learn from negative experiences. Childhood temperament is considered to have a genetic basis. Children or adolescents who are considered to have a difficult temperament are more likely to develop behavior problems. Children or adolescents from disadvantaged, dysfunctional, and disorganized home environments are more likely to develop conduct disorders. Social problems and peer group rejection have been found to contribute to delinquency. Low socioeconomic status has been associated with conduct disorders. Children and adolescents exhibiting delinquent and aggressive behaviors have distinctive cognitive and psychological profiles when compared to children with other Mental Health Disorders problems and control groups. All of the possible contributing factors influence how children and adolescents interact with other people.

Currently, two possible developmental courses are thought to lead to conduct disorder. The first is known as the "childhood-onset type" and occurs when conduct disorder symptoms are present before the age of 10 years. This course is often linked to a more persistent life course and more pervasive behaviors. Specifically, children in this group have greater levels of ADHD symptoms, neuropsychological deficits, more academic problems, increased family dysfunction, and higher likelihood of aggression and violence.

There is debate among professionals regarding the validity and appropriateness of diagnosing young children with conduct disorder. The characteristics of the diagnosis are commonly seen in young children who are referred to mental health professionals. A premature diagnosis made in young children, and thus labeling an individual, may be inappropriate. It is also argued that some children may not in fact have conduct disorder, but are engaging in developmentally appropriate disruptive behavior.

The second developmental course is known as the "adolescent-onset type" and occurs when conduct disorder symptoms are present after the age of 10 years. Individuals with adolescent-onset conduct disorder exhibit less impairment than those with the childhood-onset type and are not characterized by similar psychopathology. At times, these individuals will remit in their deviant patterns before adulthood. Research has shown that there is a greater number of children with adolescent-onset conduct disorder than those with childhood-onset, suggesting that adolescent-onset conduct disorder is an exaggeration of developmental behaviors that are typically seen in adolescence, such as rebellion against authority figures and rejection of conventional values. However, this argument is not established and empirical research suggests that these subgroups are not as valid as once thought.

In addition to these there appears to be a relationship among oppositional defiant disorder, conduct disorder and antisocial personality disorder. Specifically, research has demonstrated continuity in the disorders such that conduct disorder is often diagnosed in children who have been previously diagnosed with oppositional defiant disorder, and most
adults with antisocial personality disorder were previously diagnosed with conduct disorder. For example, some research has shown that 90% of children diagnosed with conduct disorder had a previous diagnosis of oppositional defiant disorder. Moreover, both disorders share relevant risk factors and disruptive behaviors, suggesting that oppositional defiant disorder is a developmental precursor and milder variant of conduct disorder. However, this is not to say that this trajectory occurs in all individuals. In fact, only about 25% of children with oppositional defiant disorder will receive a later diagnosis of conduct disorder.

Correspondingly, there is an established link between conduct disorder and the diagnosis of antisocial personality disorder as an adult. In fact, the current diagnostic criteria for antisocial personality disorder require a conduct disorder diagnosis before the age of 15. However, again, only 25-40% of youths with conduct disorder will develop antisocial personality disorder. Nonetheless, many of the individuals who do not meet full criteria for antisocial personality disorder still exhibit a pattern of social and personal impairments or antisocial behaviors. These developmental trajectories suggest the existence of antisocial pathways in certain individuals, which have important implications for both research and treatment.

Who is affected by conduct disorder?

Approximately 1 percent to 4 percent of children ages nine to 17 years old have conduct disorders. The disorder is more common in boys than in girls. Children and adolescents with conduct disorders often have other psychiatric problems as well that may be a contributing factor to the development of the conduct disorder. The prevalence of conduct disorders has increased over recent decades. Aggressive behavior is the reason for one-third to one-half of the referrals made to child and adolescent Mental Health Disorders services.

Symptoms:

Most symptoms seen in children with conduct disorder also occur at times in children without this disorder. However, in children with conduct disorder, these symptoms occur more frequently and interfere with learning, school adjustment, and, sometimes, with the child’s relationships with others.

The following are the most common symptoms of conduct disorder. However, each child may experience symptoms differently. The four main groups of behaviors include the following:

aggressive conduct

aggressive conduct causes or threatens physical harm to others and may include the following:
intimidating behavior

bullying

physical fights

cruelty to others or animals

use of a weapon(s)

forcing someone into sexual activity, rape, molestation

destructive conduct

Destructive conduct may include the following:

vandalism; intentional destruction to property

arson

deceitfulness

Deceitful behavior may include the following:
lying

theft

shoplifting

delinquency

violation of rules

Violation of ordinary rules of conduct or age-appropriate norms may include the following:

truancy (failure to attend school)

running away

pranks

mischief

very early sexual activity

The symptoms of conduct disorder may resemble other medical conditions or behavioral problems. Always consult your child's (adolescent's) physician for a diagnosis.
Additionally, the symptoms of conduct disorder can be mild, moderate, or severe:

Mild: Has mild symptoms, it means they display little to no behavior problems in excess of those required to make the diagnosis. Conduct problems cause relatively minor harm to others. Common issues include lying, truancy, and staying out after dark without parental permission.

Moderate: Has moderate symptoms if they display numerous behavior problems. These conduct problems may have a mild to severe impact on others. The problems may include vandalism and stealing.

Severe: Has severe symptoms if they display behavior problems in excess of those required to make the diagnosis. These conduct problems cause considerable harm to others. The problems may include rape, use of a weapon, or breaking and entering.

Also check for:

- Takes inappropriate risks
- Does not stop and think about consequences
- A record of deceiving others
- History of lying-conning
- Good at manipulating
- Doesn't accept responsibility for misbehavior
- Constantly blaming others
- Unapologetic of his or her behavior
- Insensitive to the needs of others
Recklessness caused by poor judgment

A record of stealing at home

Ill-mannered towards authority figures

Recurrent disrupting behaviors

Frequent disagreement with authority figures

Doesn't act in accordance with rules or standards

Extreme fighting

Intimidation of others

Malice or violence toward people

Malice or violence toward animals

Destruction of property

Diagnosis and Treatment:

A child psychiatrist or a qualified mental health professional usually diagnoses conduct disorders in children and adolescents. A detailed history of the child's behavior from parents and teachers, observations of the child's behavior, and, sometimes, psychological testing contribute to the diagnosis. Parents who note symptoms of conduct disorder in their child or teen can help by seeking an evaluation and treatment early. Early treatment can often
prevent future problems. Further, conduct disorder often coexists with other mental health disorders, including mood disorders, anxiety disorders, post-traumatic stress disorder, substance abuse, attention-deficit/hyperactivity disorder, and learning disorders, increasing the need for early diagnosis and treatment. Always consult your child's (adolescent's) physician for more information.

Treatment for conduct disorder:

Specific treatment for children with conduct disorders will be determined by your child's (adolescent's) physician based on:

- your child's (adolescent's) age, overall health, and medical history
- extent of your child's (adolescent's) symptoms
- your child's (adolescent's) tolerance for specific medications, procedures, or therapies
- expectations for the course of the condition
- your opinion or preference

Treatment may include:

- cognitive-behavioral approaches

  The goal of cognitive-behavioral therapy is to improve problem solving skills, communication skills, impulse control, and anger management skills.

- family therapy
Family therapy is often focused on making changes within the family system, such as improving communication skills and family interactions.

peer group therapy

Peer group therapy is often focused on developing social skills and interpersonal skills.

medication

While not considered effective in treating conduct disorder, medication may be used if other symptoms or disorders are present and responsive to medication.

Prevention of conduct disorder in childhood:

Some experts believe that a developmental sequence of experiences occurs in the development of conduct disorder. This sequence may start with ineffective parenting practices, followed by academic failure, and poor peer interactions. These experiences then often lead to depressed mood and involvement in a deviant peer group. Other experts, however, believe that many factors, including child abuse, genetic susceptibility, history of academic failure, brain damage, and/or a traumatic experience influence the expression of conduct disorder. Early detection and intervention into negative family and social experiences may be helpful in disrupting the development of the sequence of experiences that lead to more disruptive and aggressive behaviors.

DSM V Diagnosis:

Conduct Disorder 312.8x (F91.x) 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 at least three of the following 15 criteria in the past 12 months from any of the categories below, 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 the 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.

Specify whether:

312.81 (F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.
312.82 (F91.2) Adolescent-onset type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years.

312.89 (F91.9) Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.

Specify if:

With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual’s typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual’s self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).

Lack of remorse or guilt: Does not feel bad or guilty when he or 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.

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 himself or herself, rather than their effects on others, even when they result in substantial harm to others.

Unconcerned about performance: Does not show concern about poor/problematic performance at school, at 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.

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).

Specify current severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking).

Moderate: The number of conduct problems and the effect on others intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism).

Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. this may include:

issues with family of origin,
current stressors,

present and past emotional status,

present and past social networks,

present and past coping skills,

present and past physical health,

self-esteem,

interpersonal conflicts

financial issues

cultural issues

There are different sources of data that may be obtained from a:

clinical interview,

Gathering of social history,
physical exam,

psychological testing,

contact with client's or patient's significant others at home, school, or work

The integration of all this data is very critical for the clinician's effect in treatment. It is important to understand the client's or patient's present awareness and the basis of the client's struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There are 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the loss of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client's or patient's own prioritization of the problems presented. The client's or patient's cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client's or patient's needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic
and Statistical Manual or the International Classification of Diseases (ICD).

CONDUCT DISORDER BEHAVIORAL DESCRIPTOR:

Takes inappropriate risks, does not stop and think about consequences before taking action.

A record of deceiving others through lying, conning, and manipulating.

Unwillingness to accept responsibility for misbehavior, constantly blaming others for his or her behavior.

Unapologetic of his or her behavior.

Insensitive to the needs of other people, or recklessness caused by poor judgment.

A record of stealing at home, school, and in the community.

Ill-mannered towards authority figures, recurrent disrupting behaviors.

Frequent disagreement with authority figures at home, school, and in the community.

Constant rejection to act in accordance with rules or standards in the home, school, or community.

Extreme fighting, intimidation of others, malice or violence toward people or animals, and destruction of property.
Step 2, Long Term Goal Development:

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution of the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

LONG TERM GOALS:

1. Improve anger management skills and display an adequate amount of respect to others and their property.

2. Solve the main problems that trigger carry out problems.

3. Have parents set up and uphold suitable boundaries.

4. Show a greater sense of empathy, concern, and sensitivity towards the feelings and situations of others.

5. Abide by rules and standards in the home, school, and community.

6. Discontinue all illegal and antisocial behavior.

7. Stop all acts of violence or cruelty toward people or animals and the destruction of property.

8. Display a greater sense of control over one's own behavior and emotions.
Step 3, Objective or Short Term Goal Construction:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurables objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in none measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “13. Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem” Remember, that it must be stated in a way one can measure effectiveness.

It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

EXAMPLES OF SHORT TERM GOALS:
Identify and express how feelings are linked to misbehavior.

Have client and parents agree and abide by a contingency contract, a reward or token system to reinforce desirable behavior.

Increase the frequency of praise, encouragement and positive reinforcement to the client.

Intensify compliance with rules at home and school.

Spot out family dynamics or stressors that cause and or trigger behavioral problems.

Step 4, Strategies or Interventions:

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client's needs and presenting problem.
EXAMPLES OF INTERVENTIONS:

Discuss with parents, school officials, and criminal justice officials about the necessity to place the client in an alternative setting.

Consistently build the level of trust with the client.

Help the client in finding a link between feelings and reactive behaviors.

Firmly challenge the client’s attitude and antisocial behaviors, point out possible consequences for each factor.

Challenge statements in which the client lies and or places the blame on others for his her problem behaviors and or actions.

Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. it is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.

Possible BEHAVIORAL DESCRIPTORS FOR CONDUCT DISORDER IN CHILDREN:

DSM V CODE Paired with ICD_9-CM Codes (Parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Diagnostic Suggestions for Children Suffering Conduct Disorder:
Attention-Deficit/Hyperactivity Disorder

Specify whether:

314.01 (F90.2) Combined presentation
314.00 (F90.0) Predominantly inattentive presentation
314.01 (F90.1) Predominantly hyperactive/impulsive presentation

Specify if: In partial remission

Specify current severity: Mild Moderate Severe

314.01 (F90.8) Other Specified Attention-Deficit/Hyperactivity Disorder
314.01 (F90.9) Unspecified Attention-Deficit/Hyperactivity Disorder

313.81 (F91.3) Oppositional Defiant Disorder

Specify current severity: Mild Moderate Severe

312.34 (F6381) Intermittent Explosive Disorder

Conduct Disorder

Specify whether:

312.81 (F91.1) Childhood-onset type
312.32 (F91.2) Adolescent-onset type
312.89 (F91.9) Unspecified onset

Specify if: With limited prosocial emotions

Specify current severity: Mild Moderate Severe

Problems Related to Family Upbringing

V611.20 (Z62.820) Parent-Child Relational Problem
V61.8 (Z62.891) Sibling Relational Problem

Sample Treatment Plan:
Present Behavioral Descriptors of Problem:

Takes inappropriate risks does not stop and think about consequences before taking action.

Unwillingness to accept responsibility for misbehavior constantly blaming others for his or her behavior

Long Term Goals:

1. Identify and express how feelings are linked to misbehavior

2. Have parents set up and preserve appropriate boundaries and follow through constantly with consequences for misbehavior

3. Help the client in finding a link between feelings and reactive behaviors

Short Term Goals Objectives:

1. Identify and express how feelings are linked to misbehavior

2. Have parents set up and preserve appropriate boundaries and follow through constantly with consequences for misbehavior

Strategy or Intervention for Goal 1:

Help the client in finding a link between feelings and reactive behaviors

Firmly challenge the client’s attitude and antisocial behaviors point out possible consequences for each factor

Challenge statements in which the client lies and or places the blame on others for his her problem behaviors and or actions
Strategy or Intervention for Goal 2:

1. Help the parents in adding structure to help the client learn to delay gratification for longer-term goals

2. Design and implement a token economy to increase the client's positive social behaviors and deter impulsive acting-out behaviors

DSM V Diagnosis:

DSM V CODE Paired with ICD_9-CM Codes (Parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Diagnostic Suggestions for Children Suffering Conduct Disorder:

314.01 (F90.1) Attention-Deficit/Hyperactivity Disorder - Predominantly hyperactive/impulsive presentation

312.32 (F91.2) Conduct Disorder - Adolescent-onset type

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