Conduct problems (CP) in youth is one of the most common reasons that children and adolescents are referred to mental health clinics (Frick & Silverthorn, 2001). This is not surprising given that CP often cause significant disruptions for the child at home (Frick, 1998) and school (Gottfredson & Gottfredson, 2001), and it is the form of psychopathology that has been most strongly associated with delinquency and violence (Moffitt, 1993). An extensive body of research has led to an increased understanding of the many processes that may be involved in the development of severe CP (Dodge & Pettit, 2003; Frick, 2006). This research has many important implications for designing more effective interventions to prevent or treat these problems (Conduct Problems Prevention Research Group, 2000; Frick, 2006) and for improving the methods for assessing children and adolescents with severe CP (McMahon & Frick, 2005). The focus of this chapter is on the implications for assessments.

In the next section, we provide a brief overview of several key findings from research on CP in children and adolescents and highlight several findings that we feel have the most direct relevance to the assessment process. Specifically, we focus on research illustrating the great heterogeneity in the types, severity, and course of CP in youth, as well as the frequent co-occurring problems in adjustment that often accompany CP. We also summarize research showing important dispositional and contextual risk factors that have been related to CP and that could play an important role in the development or maintenance of CP. We then review some recent causal models that have been proposed to explain how these many risk factors could affect the development of the child and lead to CP.

After the brief overview of these select but critical areas of research, we then focus on the implications of this research for three types of assessments that are often conducted for children with CP. First, we focus on methods for determining whether the level of CP is severe, impairing, and developmentally inappropriate enough to be considered “disordered.” Second, we focus on assessments that can be used for developing case conceptualizations, which can guide comprehensive and individualized treatment plans for children with CP. Using interventions that rely on multiple types of interventions, which are tailored to the child’s individual needs, have proven to be the most effective for treating children and adolescents with CP (Conduct Problems Prevention Research Group, 2000; Frick, 2006). Third, we focus on measures that can be used to monitor and evaluate treatment progress and outcomes. Unfortunately, the availability of measures for this crucial assessment purpose is quite limited.

After summarizing research on CP and its implications for assessment, we conclude this chapter with a section highlighting some overriding issues related to assessing children with CP, such as the need to assess children with multiple measures that provide information on their adjustment in multiple contexts. We also provide a summary of some of the major limitations in the existing assessment technology and make recommendations for future work to overcome these limitations.
THE NATURE OF CP

Types and Severity of CP and Common Co-Occurring Conditions

CP constitutes a broad spectrum of “acting-out” behaviors, ranging from relatively minor oppositional behaviors such as yelling and temper tantrums to more serious forms of antisocial behavior such as physical destructiveness, stealing, and physical violence. There have been numerous methods used to divide CP into more discrete and homogenous types of behaviors (see Frick & Marsee, 2006; Hinshaw & Lee, 2003 for comprehensive reviews). For example, the Diagnostic and Statistical Manual of Mental Disorders (4th Edition–Text Revision) (DSM-IV-TR; American Psychiatric Association, 2000) makes a distinction between the categories of oppositional defiant disorder (ODD) and conduct disorder (CD). ODD is a pattern of negativistic (e.g., deliberately doing things that annoy other people and blaming others for own mistakes), disobedient (e.g., defying or not complying with grown-ups’ rules or requests), and hostile behaviors (e.g., losing temper). CD consists of more severe antisocial and aggressive behavior that involves serious violations of others’ rights or deviations from major age-appropriate norms. The behaviors are categorized into four groups: aggressiveness to people and animals (e.g., bullying and fighting), property destruction (e.g., firesetting and other destruction of property), deceptiveness or theft (e.g., breaking and entering and stealing without confronting victim), and serious rule violations (e.g., running away from home and being truant from school before age 13).

In addition to this division in the DSM-IV-TR, factor analyses have resulted in another method for differentiating among types of CP. In a meta-analysis of over 60 published factor analyses, Frick et al. (1993) found that CP could be described by two bipolar dimensions. The first dimension was an overt–covert dimension. The overt pole consisted of directly confrontational behaviors such as oppositional defiant behaviors and aggression. In contrast, the covert pole consisted of behaviors that were nonconfrontational in nature (e.g., stealing and lying) (see also Tiet, Wasserman, Loeb, Larken, & Miller, 2001; Willoughby, Kupersmidt, & Bryant, 2001). The second dimension divided the overt behaviors into those that were overt-destructive (aggression) and those that were overt-nondestructive (oppositional) and it divided the covert behaviors into those that were covert-destructive (property violations) and those that were covert-nondestructive (status offenses; i.e., those behaviors that are illegal because of the child or adolescent’s age). One way in which this clustering of CP is useful is that the four-symptom patterns are fairly consistent with the distinctions made in many legal systems for differentiating types of delinquent behaviors, which generally distinguish between violent offenses (overt-destructive), status offenses (covert-nondestructive), and property offenses (covert-destructive; e.g., Office of Juvenile Justice and Delinquency Prevention, 1995).

Two specific forms of CP—noncompliance and aggression—deserve additional attention. Noncompliance (i.e., excessive disobedience to adults) appears to be important as one of the earliest predictors of the development of CP and it seems to play an important role in many of the subsequent academic and social problems exhibited by children with CP (Chamberlain & Patterson, 1995; McMahon & Forehand, 2003). Most importantly, however, research has shown that when child noncompliance is improved as a result of intervention, there is often concomitant improvement in other CP behaviors as well and a subsequent reduction in later risk for CP (Russo, Cataldo, & Cushing, 1981; Wells, Forehand, & Grier, 1980).

There is also evidence that aggression is an important dimension of CP. By its very nature, aggression results in harm to another child (Crick & Dodge, 1996). Furthermore, research has consistently shown that aggressive behavior in children and adolescents is often quite stable after the preschool years (Broidy et al., 2003). Importantly, research has found that there appears to be several different forms of aggressive behavior (Crick & Dodge, 1996; Poulin & Boivin, 2000). The first type of aggression is often referred to as retaliatory aggression, hostile aggression, or reactive aggression, in which aggression is viewed as a defensive reaction to a perceived threat and is characterized by anger and hostility (Crick & Dodge, 1996). The second type of aggressive behavior is generally unprovoked and is used for personal gain (instrumental) or to influence and coerce others (bullying and dominance). This type of aggressive behavior is referred to as instrumental aggression, premeditated aggression, or proactive aggression (Poulin & Boivin, 2000).

Importantly, although these different types of aggression are often correlated (e.g., correlations
ranging from $r = .40$ to $.70$ in school-aged samples; Frick & Marsee, 2006), studies have consistently documented different correlates to the two forms of aggression (see Dodge & Petit, 2003; Frick & Marsee, 2006 for reviews). For example, reactive but not proactive aggression has been consistently linked to a tendency to misinterpret ambiguous behaviors as hostile provocation (Crick & Dodge, 1996; Hubbard, Dodge, Gillessen, Coie, & Schwartz, 2001) and to poorly regulated responses to emotional stimuli (Vitaro, Breugden, & Tremblay, 2002). In contrast, proactive but not reactive aggression has been associated with the tendency to view aggression as an effective means to reach goals (Crick & Dodge, 1996) and with reduced levels of emotional reactivity (i.e., skin conductance and heart rate acceleration) (Hubbard et al., 2002; Muñoz, Frick, Kimonis, & Aucoin, in press).

In addition to proactive and reactive forms of aggression, both of which are overt in nature, several researchers have identified a form of indirect aggression, called relational aggression, that involves strategies that attempt to harm another child through harming his or her social relationships (Crick & Grotpeter, 1995). These behaviors include excluding a child from groups, rumor spreading, and friendship manipulation. Several studies have shown that when girls behave aggressively, they are more likely to use relational aggression than overt aggression (e.g., Crick & Grotpeter, 1995; Underwood, 2003). Further, research has suggested that it may be possible to divide relational aggression into instrumental and reactive forms, similar to overt aggression (Little, Jones, Henrich, & Hawley, 2003). Importantly, children who show relational aggression show many of the same social (e.g., peer rejection) and dispositional (e.g., impulsivity and callousness) risk factors as physically aggressive youth (Crick, Grotpeter, & Bigbee, 2002; Marsee & Frick, in press).

**Epidemiology of CP**

Prevalence estimates for CP in community samples of youth generally range between 6% and 10% (Loeber, Burke, Lahey, Winters, & Zera, 2000). When broken down by type of CP diagnoses found in DSM-IV-TR, ODD seems to be present in 3−5% of youth and CD is found in about 1−4% of youth (Loeber et al., 2000). Differences in prevalence rates across ethnic groups have not been found consistently. For example, higher rates of CP in African American youth have been found in some samples (Fabrega, Ulrich, & Mezzich, 1993) but not in others (McCoy, Frick, Loney, & Ellis, 2000). More importantly, it is unclear whether any association with minority status and CP is independent of the fact that ethnic minorities are more likely to experience economic hardships and live in urban neighborhoods with higher concentrations of crime than nonminority individuals (Lahey, Miller, Gordon, & Riley, 1999).

There is, however, consistent evidence for differences in prevalence rates of CP for children of different ages. The level of CP tends to decrease from the preschool to school-age years (Keenan & Shaw, 1997) and increase again in adolescence (Loeber et al., 2000). For example, Loeber et al. (2000) reported prevalence rates for CD of 5.6, 5.4, and 8.3 for boys aged 7, 11, and 13, respectively, and prevalence rates for ODD of 2.2, 4.8, and 5.0 for boys of the same age in a sample of 1,517 youth in a large urban area. However, the increase in the prevalence of CP from childhood to adolescence may not be consistent for all types of CP. Specifically, there is evidence that mild forms of physical aggression (e.g., fighting) show a decrease in prevalence rates across development, whereas nonaggressive and covert forms of antisocial behavior (e.g., lying and stealing) and serious aggression (e.g., armed robbery and sexual assault) show an increase in prevalence rates from childhood to adolescence (Loeber & Hay, 1997).

There also appear to be sex differences in the prevalence of CP. Overall estimates of the sex ratio for boys and girls with CP range from 2.1 to 4:1 (Loeber et al., 2000). However, this overall ratio hides several important developmental differences. Specifically, there are few sex differences between boys and girls in the prevalence rate of most types of CP prior to age 5 (Keenan & Shaw, 1997). However, after age 4 the rate of girls’ behavior problems decreases while the rate of behavioral problems for boys either increases or stays at the same rate, leading to a male predominance of CP throughout much of childhood (Loeber et al., 2000). Numerous studies have also noted that the sex ratio between girls and boys with CP narrows dramatically from about 4:1 in childhood to about 2:1 in adolescence due to an increase in the number of girls engaging in CP in adolescence (see Silverthorn & Frick, 1999 for a review).
CP and Co-Occurring Problems in Adjustment

A consistent finding in research with children who show CP is that they often have a number of problems in adjustment, in addition to their CP, and these problems are critical to address in interventions. Attention-Deficit Hyperactivity Disorder (ADHD) is one of the most common comorbid conditions associated with CP. In a meta-analytic study, Waschbusch (2002) reported that 36% of boys and 57% of girls with CP had comorbid ADHD. Importantly, this review also suggested that the presence of ADHD often signals the presence of a more severe and more chronic form of CP in children. Internalizing disorders, such as depression and anxiety, also co-occur with CP at rates higher than expected by chance (Zoccolillo, 1992). In most cases, CP precedes the onset of depressive and anxiety symptoms and these symptoms are often viewed as consequences of the many adjustment problems experienced by a child with CP (Frick, Lilenfeld, Ellis, Loney, & Silverthorn, 1999; Loeb & Keenan, 1994). CP is also related to substance use (e.g., Hawkins, Catalano, & Miller, 1997; McMahon & Frick, 2005). The comorbidity between CP and substance abuse is important because, when youths with CP also use substances, they tend to show an early onset of substance use and they are more likely to abuse multiple substances (Lynskey & Ferguson, 1995). With preschool-aged children, language impairment may be associated with CP (Wakschlag & Danis, 2004) and, in older children, CP is often associated with academic achievement below a level predicted by their intellectual level (Hinshaw, 1992).

Multiple Risks Associated with CP

Most researchers agree that CP is the result of a complex interaction of multiple causal factors (Frick, 2006; Hinshaw & Lee, 2003; McMahon, Wells, & Kotler, 2006). These factors can be summarized in five categories: biological factors, cognitive correlates, family context, peer context, and the broader social ecology (e.g., neighborhood and community). Although a number of biological correlates (e.g., neurochemical and autonomic irregularities) to CP have been identified and are likely important for causal theories (see Dodge & Pettit, 2003; Raine, 2002), they are not reviewed here because the current state of knowledge is not sufficiently developed to have clear implications for assessment.

In contrast, there are several aspects of the youth's cognitive and learning styles that have been associated with CP that may be important to the assessment process (see Frick & Loney, 2000). First, compared to others, youths with CP tend to score lower on intelligence tests, especially in the area of verbal intelligence (Loney, Frick, Ellis, & McCoy, 1998; Moffitt, 1993). Furthermore, these scores are predictive of the persistence of CP and engagement in delinquent behaviors during adolescence (Frick & Loney, 1999). Second, many children and adolescents with CP tend to show a learning style that is more sensitive to rewards than punishments. This has been labeled as a reward-dominant response style, and could explain why many of these youths persist in their maladaptive behaviors, despite the threat of serious potential consequences (Frick et al., 2003; O’Brien & Frick, 1996). Third, many youths with CP show a variety of deficits in their social cognition—that is, the way they interpret social cues and use them to respond in social situations (Crick & Dodge, 1994; Webster-Stratton & Liason, 1999). For example, children and adolescents with CP have been shown to have deficits in encoding social cues (e.g., lack of attention to relevant social cues), to make more hostile attributional biases and errors in the interpretation of social cues, to have deficient quantity and quality of generated solutions to social conflict, and to evaluate aggressive solutions more positively (Dodge & Petit, 2003).

The critical role of parenting practices in the development and maintenance of CP has been well established (e.g., Chamberlain & Patterson, 1995; Loeb & Stouthamer-Loeb, 1986). Types of parenting practices that have been closely associated with the development of CP include inconsistent discipline, irritable explosive discipline, poor supervision, lack of parental involvement, and inflexible rigid discipline (Chamberlain, Reid, Ray, Capaldi, & Fisher, 1997). In addition to parenting practices, various other risk factors that may have an impact on the family and may serve to precipitate or maintain CP have been identified. These familial factors include parental social cognitions (e.g., perceptions of the child), parental personal and marital adjustment (e.g., depression, ADHD, antisocial behavior, and substance abuse), and parental stress (McMahon & Estes, 1997; McMahon & Frick, 2005).

Research suggests that the child’s relationship with peers can also play a significant role in the development, maintenance, and escalation of CP. Research
has documented a relationship between peer rejection in elementary school and the later development of CP (Roff & Wirt, 1984). In addition, peer rejection in elementary school is predictive of an association with a deviant peer group (i.e., one that shows a high rate of antisocial behavior and substance abuse) in early adolescence (e.g., Ferguson, Swain, & Horwood, 2002). This relationship is important because association with a deviant peer group leads to an increase in the frequency and severity of CP (Patterson & Dishion, 1985) and it has proven to be a strong predictor of later delinquency (Patterson, Capaldi, & Bank, 1991) and substance abuse (Dishion, Capaldi, Spracklen, & Li, 1995; Ferguson et al., 2002).

Finally, there are factors within the youth’s larger social ecology that have been associated with CP. One of the most consistently documented of these correlates has been low socioeconomic status (SES) (Frick, Lahey, Harddagen, & Hynd, 1989). However, several other ecological factors, many of which are related to low-SES, such as poor housing, poor schools, and disadvantaged neighborhoods, have also been linked to the development of CP (see Frick, 1998; Peeples & Loeber, 1994). In addition, the high rate of violence witnessed by youths who live in impoverished inner-city neighborhoods has also been associated with CP (Osofsky, Wewers, Hann, & Fick, 1993).

**Causal Theories of CP**

Although there is general agreement that CP in children and adolescents is associated with multiple risk factors, there is less agreement as to how these risk factors play a role in the development of CP. Also, in addition to accounting for the large number of risk factors, causal theories of CP need to consider research suggesting that there may be many different causal pathways through which youth may develop these behaviors, each involving a different constellation of risk factors and each involving somewhat different causal processes (Frick, 2006).

The most widely accepted model for delineating distinct pathways in the development of CP distinguishes between childhood-onset and adolescent-onset subtypes of CP. That is, the DSM-IV-TR (American Psychiatric Association, 2000) makes the distinction between youths who begin showing CP before age 10 (i.e., childhood-onset) and those who do not show CP before age 10 (i.e., adolescent-onset). This distinction is supported by a substantial amount of research documenting important differences between these two groups of youths with CP (see Moffitt, 2003; Frick, 2006 for reviews). Specifically, youths in the childhood-onset group show more serious aggression in childhood and adolescence and are more likely to continue to show antisocial and criminal behavior into adulthood (Frick & Loney, 1999; Moffitt & Caspi, 2001). More relevant to causal theory, many of the dispositional (e.g., temperament risk and low intelligence) and contextual (e.g., family dysfunction) correlates that have been associated with CP are more strongly associated with the childhood-onset subtype. In contrast, the youths in the adolescent-onset subtype do not consistently show these same risk factors. If they do differ from other youths, it seems primarily to be in showing greater affiliation with delinquent peers and scoring higher on measures of rebelliousness and authority conflict (Moffitt & Caspi, 2001; Moffitt, Caspi, Dickson, Silva, & Stanton, 1996).

The different characteristics of youths in the two subtypes of CP have led to theoretical models that propose very different causal mechanisms operating across the two groups. For example, Moffitt (1993, 2003) has proposed that youth in the childhood-onset group develop CP behavior through a transactional process involving a difficult and vulnerable child (e.g., impulsive, with verbal deficits, and with a difficult temperament) who experiences an inadequate rearing environment (e.g., poor parental supervision and poor quality schools). This dysfunctional transactional process disrupts the child’s socialization, leading to poor social relations with persons both inside (i.e., parents and siblings) and outside (i.e., peers and teachers) the family, which further disrupts the child’s socialization. These disruptions lead to enduring vulnerabilities that can negatively affect the child’s psychosocial adjustment across multiple developmental stages. In contrast, Moffitt views youths in the adolescent-onset pathway as showing an exaggeration of the normative developmental process of identity formation that takes place in adolescence. Their engagement in antisocial and delinquent behaviors is conceptualized as a misguided attempt to obtain a subjective sense of maturity and adult status in a way that is maladaptive (e.g., breaking societal norms) but encouraged by an antisocial peer group. Given that their behavior is viewed as an exaggeration of a process specific to the adolescent developmental stage and not due to enduring vulnerabilities, their CP is less likely to persist beyond adolescence. However, they may still...
have impairments that persist into adulthood due to the consequences of their CP (e.g., a criminal record, dropping out of school, and substance abuse) (Moffitt & Caspi, 2001).

This distinction between childhood-onset and adolescent-onset trajectories to severe CP has been very influential for delineating different pathways through which youths may develop CP, although it is important to note that clear differences between the pathways are not always found (Lahey et al., 2000) and the applicability of this model to girls requires further testing (Silverthorn & Frick, 1999). Researchers have also begun extending this conceptualization in a number of important ways. For example, research has identified a subgroup of youths within the childhood-onset pathways who show high rates of callous and unemotional (CU) traits (e.g., lacking empathy and guilt). Importantly, Frick and Dickens (2006) reviewed 22 published studies showing that CU traits either co-occurred with (n = 10) or predicted (n = 12) serious antisocial and aggressive behavior. They also reviewed five studies showing that CU traits were related to poorer treatment response among youths with CP.

There is also evidence that the subgroup of CP youth with CU traits exhibits a distinct temperamental style from other youth with CP that has been variously labeled as low fearfulness (Rothbart & Bates, 1998) or low behavioral inhibition (Kagan & Snidman, 1991). This temperament could place a young child at risk for missing some of the early precursors to empathetic concern that involve emotional arousal evoked by the misfortune and distress of others (Blair, 1995; Frick & Morris, 2004), make them less responsive to typical parental socialization practices than other youths (Oxford, Cavell, & Hughes, 2003; Wootton, Frick, Shelton, & Silverthorn, 1997), and lead to impairments in their moral reasoning and empathic concern toward others (Blair, 1999; Pardini, Lochman, & Frick, 2003).

The few studies that have distinguished between youths within the childhood-onset group who differ on the presence of CU traits also provide some clues as to the mechanisms that may be involved in the development of CP in children and adolescents without these traits. These youths with CP who are not elevated on CU traits are less likely to be aggressive than those who are high on CU traits and, when they do act aggressively, it is more likely to be reactive in nature (Frick, Cornell, Barry, Bodin, & Dane, 2003) and in response to real or perceived provocation by others (Frick, Cornell, Bodin et al., 2003). Also, antisocial youths who do not show CU traits have CP that is more strongly associated with dysfunctional parenting practices (Oxford et al., 2003; Wootton et al., 1997). Finally, youths with CP, who do not show CU exhibit high levels of emotional distress (Frick et al., 1999; Frick, Cornell, Bodin et al., 2003), are more reactive to the distress of others in social situations (Pardini et al., 2003) and are highly reactive to negative emotional stimuli (Kimonis, Frick, Fazekas, & Loney, 2006; Loney, Frick, Clements, Ellis, & Kerlin, 2003).

Overall, these findings suggest that a large number of children and adolescents with CP but without CU traits have problems regulating their emotions (Frick & Morris, 2004). These problems in emotion regulation can lead to very impulsive and unplanned aggressive and antisocial acts for which the child or adolescent may be remorseful afterwards but still may have difficulty controlling in the future (Pardini et al., 2003). The problems in emotion regulation can also make a youth particularly susceptible to becoming angry due to perceived provocations from peers leading to violent and aggressive acts within the context of high emotional arousal (Hubbard et al., 2002; Loney et al., 2003).

**ASSESSMENT FOR DIAGNOSIS**

When a child or adolescent with CP is referred for assessment, there are four primary goals for the assessment. First, it is important to determine whether or not the youth is, in fact, demonstrating significant levels of CP to rule out the possibility of the occasional inappropriate referral due to unrealistic parental or teacher expectations. Second, it is important to identify the types and severity of the youth’s CP and to determine the degree and types of impairment associated with them. Some level of CP is normative and, as noted previously, there can be a range of CP that vary greatly in terms of how severe and impairing the behaviors are for the child. Assessing the level and severity of CP displayed by the child is critical to determine whether treatment is indicated and how intensive it needs to be. Third, given the high degree of comorbidity associated with CP, it is critical to at least screen for a wide variety of emotional, behavioral, social, and academic problems that can further influence the
child’s adjustment. Fourth, given the large number of risk factors that can contribute to the development and maintenance of CP, and that could be important targets of intervention, it is critical to assess the many dispositional and contextual risk factors that research has linked to CP in children and adolescents.

There are three primary assessment methods that can be used to accomplish these goals: behavior rating scales, structured diagnostic interviews, and behavioral observations. Each of these methods has specific strengths and weaknesses that they bring to the assessment process and we summarize these in the following paragraphs. In Table 3.1, we list some of the most commonly used empirically supported instruments for each method of assessment and we provide summary evaluations of their adequacy in terms of normative data, reliability, validity, generalizability, and clinical utility.

**Behavior Rating Scales**

Behavior rating scales are a core part of an assessment battery for assessing children and adolescents with CP. As noted in Table 3.1, there are a number of rating scales that are commercially available and they have a number of useful characteristics for meeting the goals outlined above.

First, most scales have subscales assessing different types of CP and they can be completed by adults who observe the youth in important psychosocial contexts (i.e., parents and teachers) and by the youth himself or herself. By having multiple informants who see the child in different settings, this can provide important information on the pervasiveness of the child’s behavior problems and can help to detect potential biases in the report of any single informant. Most of the scales listed in Table 3.1 provide analogous content across the different raters. One notable exception is the Behavior Assessment System for Children, 2nd Edition (BASC-2; Reynolds & Kamphaus, 2004). In this scale, the teacher and parent versions are fairly similar in content, with the main difference being that teachers also rate behaviors indicative of learning problems and study skills. The content of the self-report version, however, is quite different. For example, the child does not rate his or her own level of CP but, instead, the self-report version provides more extended coverage of the child’s attitudes (e.g., attitudes toward parents and teachers), his or her self-concept (e.g., self-esteem and sense of inadequacy), and his or her social relationships.

Second, rating scales provide some of the best norm-referenced data on a child’s behavior. The most widely used rating scales (see Table 3.1) have large standardization samples that allow the child’s ratings to be compared to the ratings of other children of the same age. This provides critical information to aid in determining whether the child’s behavior is abnormal, given the child’s age. For example, the standardization sample for the Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2000, 2001) is representative of the 48 contiguous United States for SES, gender, ethnicity, region, and urban–suburban–rural residence (Achenbach & Rescorla, 2000, 2001). Similarly, the BASC-2 standardization samples ranged from 3400 to 4800 children and adolescents spanning 375 testing sites across the United States and Canada (Reynolds & Kamphaus, 2004).

Third, most rating scales contain many subscales, in addition to those assessing CP. These typically include scales assessing anxiety, depression, social problems, and family relationships. Thus, these rating scales can be very helpful in providing a broad screening of many of the most common co-occurring problems that are often found in children with CP and many of the risk factors that can play a role in the development and maintenance of CP. However, rating scales can vary on how well they assess the various co-occurring conditions. For example, the ASEBA does not include separate depression and anxiety scales, nor does it include a hyperactivity scale. Further, with the exception of the Child Symptom Inventory-IV (CSI-IV; Gadow & Sprafkin, 1998), which was explicitly designed to assess content reflected in the DSM-IV-TR, some of the scales do not correspond well to this classification system. For example, the attention problems scales on the ASEBA include items related to attention deficits (e.g., “can’t concentrate” and “can’t pay attention for long”), as well as items such as “acts too young for his/her age” and “nervous or high strung” that are not specific to inattention. However, the ASEBA now also includes DSM-oriented scales, such as Oppositional Defiant Problems and CP on the CBCL/6-18 (Achenbach, Dumenci, & Rescorla, 2003), and parent ratings on a Dutch version of the CBCL have been shown to predict DSM-IV diagnoses (Krol, De Bruyn, Cooien, & van Aarle, 2006).

Although an advantage of these rating scales is the breadth of their coverage of multiple areas of child functioning, the cost is that they often have only
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</table>

Note: ASEBA = Achenbach System of Empirically Based Assessment; BASC-2 = Behavior Assessment System for Children, 2nd Edition; CSI-IV = Child Symptom Inventory for DSM-IV; ECBI = Eyberg Child Behavior Inventory; SESBI-R = Sutter-Eyberg Child Behavior Inventory-Revised; DICA = Diagnostic Interview for Children and Adolescents; DISC = Diagnostic Interview Schedule for Children; BCS = Behavioral Coding System; DPICS = Dyadic Parent-Child Interaction Coding System; BASC-SOS = The BASC-2-Student Observational System; ASEBA-DOF = ASEBA Direct Observation Form; CAFAS = Child and Adolescent Functional Assessment Scale; CGAS = Children's Global Assessment Scale; L = Less than Adequate; A = Adequate; G = Good; E = Excellent; U = Unavailable; NA = Not Applicable.
minimal coverage of CP. There are, however, several rating scales that focus solely on CP and provide a more comprehensive coverage of various types of CP. For example, the Eyberg Child Behavior Inventory and Sutter–Eyberg Student Behavior Inventory-Revised (ECBI & SESBI-R; Eyberg & Pincus, 1999) are completed by parents and teachers, respectively. Both scales include 36 items describing specific CP behaviors and are scored on both a frequency-of-occurrence (Intensity) scale and a yes–no problem identification (Problem) scale. The inclusion of both frequency and problem ratings is very helpful in the diagnostic process to determine the level of impairment associated with the child’s or adolescent’s CP.

Interviews

The second major method for assessing CP is interviews. Interviews can be divided into two general categories: unstructured clinical interviews and structured diagnostic interviews. The clinical interview with the parent is important in the assessment of CP for a number of reasons. Besides providing a method for assessing the type, severity, and impairment associated with CP, the clinical interview with the parent helps to assess typical parent–child interactions that may be contributing to the CP, the antecedent conditions that may make CP behaviors more likely to occur, and the consequences that accompany such behaviors and either increase or decrease the likelihood that CP will reoccur. A number of interview formats are available to aid the clinician in obtaining information from the parents about their child’s behavior and parent–child interactions (e.g., McMahon & Forehand, 2003; Patterson, Reid, Jones, & Conger, 1975; Wahler & Cormier, 1970). An individual interview with the child or adolescent may also be useful in providing the therapist with an opportunity to assess the child’s perception of why he or she has been brought to the clinic and the child’s subjective evaluation of his or her cognitive, affective, and behavioral characteristics (e.g., Bierman, 1983).

One criticism of the unstructured interview has been the difficulty in obtaining reliable information in this format. Structured interviews were developed in attempt to improve the reliability of the information that is obtained. As listed in Table 3.1, two structured diagnostic interviews that are frequently used in the assessment of children with CP are the Diagnostic Interview Schedule for Children (DISC; e.g., Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) and the Diagnostic Interview for Children and Adolescents (DICA; e.g., Reich, 2000). These and other similar interviews (see Loney and Frick, 2003 for a review) provide a structured format for obtaining parent and youth reports on the symptoms that constitute the criteria for ODD and CD according to DSM-IV-TR.

Similar to behavior rating scales, these interviews provide very structured question and answer formats and, thus, often lead to very reliable scores. The questions are typically asked in a stem and follow-up format. That is, a stem question is asked (e.g., “Does your child get into fights?”) and follow-up questions are only asked if the stem question is answered affirmatively (e.g., “Is this only with his or her brothers and sisters?” and “Does he or she usually start these fights?”). Also similar to behavior rating scales, most structured interviews assess many other types of problems in adjustment, in addition to CP. Thus, they can be very helpful for providing an assessment of possible comorbid conditions that are often present in youth with CP.

However, as noted in Table 3.1, unlike behavior rating scales, structured interviews often do not provide normative information on a child’s or parent’s responses. Instead, structured interviews typically focus on assessing how much CP and other problems in adjustment impair a child’s or adolescent’s social and academic functioning. Also, unlike behavior ratings scales, most interview schedules provide standard questions that assess the age at which a child’s behavioral difficulties began to emerge and how long they have caused problems for the child. As noted previously, the age at which CP emerge can be very important for designating distinct groups of youth with CP who have different factors leading to their behavior problems. Also, the assessment of age of onset of CP and other problems in adjustment allows for some estimate of the temporal ordering of a child’s problems, such as whether the child’s CP predated his/her emotional difficulties. Such information could help in determining whether the emotional distress is best conceptualized as being a result of the impairments caused by the CP.

However, there are a number of limitations in the information provided by structured interviews (see Loney & Frick, 2003). If the child has a number of problems, and many stem questions are answered affirmatively requiring the administration of
extensive follow-up questions, the interviews can be very lengthy. That is, their administration time can range from 45 minutes for youths with few problems to over 2 hours for youths with many problems in adjustment (Loney & Frick, 2003). Further, most structured interviews do not have formats for obtaining teacher information, and obtaining reliable information from young children (below age 9) has been difficult with most structured interviews (Kamphaus & Frick, 2005). Perhaps one of the major limitations in the use of structured interviews, however, is evidence that the number of symptoms reported declines within an interview schedule. That is, parents and youths tend to report more symptoms for diagnoses assessed early in the interview, regardless of which diagnoses are assessed first (Jensen, Watanabe, & Richters, 1999; Piacentini et al., 1999). This finding calls into question the validity of diagnoses assessed later in the interview. Unfortunately, CP is often assessed last in most of the available interview schedules and, as a result, could be most influenced by this limitation.

Behavioral Observation

Behavioral observations provide a third common way of assessing CP behaviors. Behavioral observations in a child’s or adolescent’s natural setting (e.g., home, school, and playground) can make an important contribution to the assessment process by providing an assessment of the youth’s behavior that is not filtered through the perceptions of an informant and by providing an assessment of the immediate environmental context of the youth’s behavior. For example, behavioral observations can indicate how others in the child’s environment (e.g., parents, teachers, and peers) respond to the child’s CP; this could be very important for identifying factors that may be maintaining these behaviors.

Two widely used, structured, microanalytic observation procedures available for assessing CP and parental responses to these behaviors in younger (3–8 years) children in the clinic and the home are the Behavioral Coding System (BCS; Forehand & McMahon, 1981) and the Dyadic Parent–Child Interaction Coding System (DPICS; Eyberg, Nelson, Duke, & Boggs, 2005). The BCS and the DPICS are modifications of the assessment procedure developed by Hanf (1970) for the observation of parent–child interactions in the clinic. As employed in clinic settings, both the BCS and DPICS place the parent–child dyad in standard situations that vary in the degree to which parental control is required, ranging from a free-play situation (i.e., Child’s Game and Child-Directed Interaction) to one in which the parent directs the child’s activity, either in the context of parent-directed play (i.e., Parent’s Game and Parent-Directed Interaction) or in cleaning up the toys (i.e., Clean Up). Each task typically lasts 5–10 minutes. In the home setting, observations usually occur in a less structured manner (e.g., the parent and child are instructed to “do whatever you would normally do together”). In each coding system, a variety of parent and child behaviors are scored, many of which emphasize parental antecedents (e.g., commands) or consequences (e.g., use of verbal hostility) to the child’s behavior. One of the main limitations of these observational systems is the very intensive training (e.g., 20–25 hours for the BCS) required of observers so that they reliably code the parent and child behaviors. This characteristic often limits the usefulness of these systems in many clinical settings (Frick, 2000). However, simplified versions of both the DPICS and the BCS have been developed to reduce training demands and may ultimately prove to be more useful to clinicians (Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994; McMahon & Estes, 1994).

As noted previously, an important type of CP, especially in young children, is noncompliance. A direct observational assessment of child noncompliance can also be obtained in the clinic with the Compliance Test (CT; Roberts & Powers, 1988). In the CT, the parent is instructed to give a series of 30 standard commands without helping or following up on the commands with other verbalizations or nonverbal cues. In one version of the CT, two-part commands are given (e.g., “(Child’s name), put the (toy) in the (container).”). In another version, the commands are separated into two codeable units (e.g. “(Child’s name), pick up the (toy). Put it in the (container)...”). The CT takes between 5 and 15 minutes to complete. The CT has proven useful in identifying noncompliant preschool children in research and clinical settings (Roberts & Powers, 1990).

Many common CP behaviors are by nature covert (e.g., lying, stealing, and firesetting), which makes them more difficult to capture through observational techniques. However, Hinshaw and colleagues have developed and evaluated an analogue observational procedure to assess stealing, property destruction, and cheating in children aged 6–12 years (Hinshaw,
Hunley-Ch03.indd   51

There are also several behavioral observational systems that have been developed for use in school settings (Nock & Kurtz, 2005). For example, the BCS (Forehand & McMahon, 1981) has been modified for use in the classroom to assess teacher–child interactions, both alone (e.g., Breiner & Forehand, 1981) and in combination with a measure of academic engaged time (AET) (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). Academic engaged time is the amount of time that a child or adolescent is appropriately engaged in on-task behavior during class time and is assessed using a simple stopwatch recording procedure (Walker, Colvin, & Ramsey, 1995).

The BASC-2-Student Observational System (SOS; Reynolds & Kamphaus, 2004) provides a system for observing children’s behavior in the classroom using a momentary time-sampling procedure. The SOS specifies 65 behaviors that are common in classrooms settings and includes both adaptive (e.g., “follows directions” and “returns material used in class”) and maladaptive (e.g., “fidgets in seat” and “teases others”) behaviors. The observation period in the classroom involves 15 minutes that are divided into 30 intervals of 30 seconds each. The child’s behavior is observed for 3 seconds at the end of each interval and the observer codes all behaviors that were observed during this time window. Scores from this observation system have differentiated students with CP from other children (Lett & Kamphaus, 1997).

Another classroom observational system, the ASEBA-DOF (Achenbach & Rescorla, 2001) was designed to observe students, aged 5–14, for 10-minute periods in the classroom. Three types of information are recorded. First, at the end of each minute during the observational period, the child’s behavior is coded as being on- or off-task for 5 seconds. Second, at the end of the observational period, the observer writes a narrative of the child’s behavior throughout the 10-minute observational period, noting the occurrence, duration, and intensity of specific problems. Third, and also at the end of the observational period, the observer codes 96 behaviors on a 4-point scale (0 = “behavior was not observed,” through 3 = “definite occurrence of behavior with severe intensity or for greater than 3 minutes duration”). These ratings can be summed into Total Problem, Internalizing, and Externalizing behavior composites. The ASEBA-DOF has been shown to discriminate between referred and nonreferred children in the classroom (e.g., Reed & Edelbrock, 1983), as well as between children with CP from children with other behavior problems (e.g., McConaughey, Achenbach, & Gent, 1988).

One limitation in observational systems is the potential for reactivity, whereby the child’s behavior can change because the child knows that he or she is being observed (Aspland & Gardner, 2003). An alternative to observations by independent observers that can reduce reactivity is to train significant adults that can reduce reactivity to train significant adults in the child’s or adolescent’s environment to observe and record certain types of behavior. The most widely used procedure of this type is the Parent Daily Report (PDR; Chamberlain & Reid, 1987), a parent observation measure that is typically administered during brief (5–10 minutes) telephone interviews. Parents are asked which of a number of overt and covert behaviors have occurred in the past 24 hours. The PDR has shown moderate convergent validity with other parent report measures of child CP (Chamberlain & Reid, 1987; Webster-Stratton & Spitzer, 1991).

Functional Impairment

Most of the measures described above focus on the type, frequency, and severity of the child’s CP. However, it is being increasingly recognized that the child’s or adolescent’s level of functional impairment can vary greatly, even with similar levels of CP (Bird, 1999; Bloomquist & Schnell, 2002). Knowledge of impairment is important for a number of reasons. First, it can determine how intensive an intervention may need to be for a child and the most appropriate setting for this treatment (Frick, 2004), it can provide useful information to the clinician concerning possible intervention targets (Frick, 2006), and it may also serve as an important indicator of intervention...
outcome (Hodges, Xue, & Wotring, 2004). As noted above, structured interviews based on the DSM-IV-TR allow for the assessment of impairment. In Table 3.1, we list two measures designed specifically to assess the youth’s level of impairment: the Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983; Bird et al., 1993) and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000). Also, several of the broad rating scales summarized in Table 3.1 include subscales that assess important areas of potential impairment of children with CP. For example, the BASC-2 (Reynolds & Kamphaus, 2004) contains scales assessing the child’s academic adjustment (e.g., learning problems, attitude toward school and teacher, and study skills), social adjustment (e.g., social stress and interpersonal relations), and self-concept (e.g., self-concept and sense of inadequacy).

Overall Evaluation

In summary, assessing the types, severity, and age of onset of CP displayed by the child, as well as assessing common co-occurring problems in adjustment, are all critical to the assessment of children and adolescents with CP. Behavior rating scales, unstructured and structured interviews, and behavioral observations all can help in this process and each have their unique strengths and weaknesses. Thus, typical assessments of children with CP would include multiple methods of assessment that utilize the strengths of these different approaches.

Behavior rating scales, similar to the BASC-2 and ASEBA, typically provide the best norm-referenced information that allows for the comparison of a child’s level of CP to a normative comparison group. Rating scales also typically have formats for obtaining information from several different informants who see the child in different settings (e.g., parents and teachers) and they provide a time-efficient method for assessing a number of possible co-occurring problems that may be present in youths with CP. In contrast, structured interviews, similar to the DICA and DISC, tend to be more time-consuming and are often limited in the normative information that they provide. However, they typically provide more information on the level of impairment associated with the child’s CP and the age at which the problem behavior began. Finally, behavioral observation systems, such as the BCS and DPICS, provide an assessment of the child’s behavior that is not filtered through the perceptions of an informant, and they provide a method for assessing the environmental contingencies that can be involved in the development or maintenance of CP. However, many behavioral observation systems require extensive training to reliably code the child’s behavior and they are often limited in the normative information they provide.

ASSESSMENT FOR CASE CONCEPTUALIZATION AND TREATMENT PLANNING

The research reviewed previously indicated that children with CP often have multiple comorbid conditions that are important to consider in treatment planning and there are often multiple risk factors that can be involved in the development or maintenance of CP. As a result, many of the rating scales and structured interviews described in the previous section on diagnosis are also included in Table 3.2 because they are also critical for case conceptualization and treatment planning purposes. These measures provide a broad assessment of the child’s functioning and capture the many important co-occurring problems in adjustment and risk factors that can be used in treatment planning.

A key area of research for guiding the assessment process is the research documenting various potential developmental pathways to CP. As reviewed previously, children with CP can fall into childhood-onset or adolescent-onset pathways, depending on when in development their level of severe antisocial and aggressive behavior started. Also, within the childhood-onset group, there seems to be important differences between those who do and do not show high levels of CU traits. Knowledge of the characteristics of children in these different pathways, and the different causal mechanisms involved, can serve as a guide for structuring and conducting the assessment (McMahon & Frick, 2005). Further, interventions can be tailored to the unique needs of youth in these different pathways (Frick, 2006).

Specifically, knowledge of the developmental pathways can provide a set of working hypotheses concerning the nature of the CP behavior, the most likely comorbid conditions, and the most likely risk factors (McMahon & Frick, 2005). For example, for a youth whose CP appears to onset in adolescence, one would hypothesize based on the available literature
### Table 3.2 Measures for Case Conceptualization and Treatment Planning

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Norms</th>
<th>Internal Consistency</th>
<th>Inter-Rater Reliability</th>
<th>Test–Retest Reliability</th>
<th>Content Validity</th>
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Note: APSD = Antisocial Process Screening Device; ASEBA = Achenbach System of Empirically Based Assessment; BASC-2 = Behavior Assessment System for Children, 2nd Edition; CSI-IV = Child Symptom Inventory for DSM-IV; ECBI = Eyberg Child Behavior Inventory; SESBI-R = Sutter-Eyberg Child Behavior Inventory-Revised; DICA = Diagnostic Interview for Children and Adolescents; DISC = Diagnostic Interview Schedule for Children; BCS = Behavioral Coding System; DPICS = Dyadic Parent–Child Interaction Coding System; PDR = Parent Daily Report; BASC-SOS = The BASC-2 Student Observational System; ASEBA-DOF = ASEBA Direct Observation Form; U = Unavailable; NA = Not Applicable.
that he or she is less likely to be aggressive, to have intellectual deficits, to have temperamental vulnerabilities, and to have comorbid ADHD. However, the youth's association with a deviant peer group and factors that may contribute to this deviant peer group affiliation (e.g., lack of parental monitoring and supervision) would be especially important to assess for youth in this pathway. In contrast, for a youth whose serious CP began prior to adolescence, one would expect more cognitive and temperamental vulnerabilities, comorbid ADHD, and more serious problems in family functioning. For those youths in this childhood-onset group who do not show CU traits, the cognitive deficits would more likely be verbal deficits and the temperamental vulnerabilities would more likely be problems regulating emotions, leading to higher levels of anxiety, depression, and aggression involving anger. In contrast, for a youth with childhood-onset CP who shows high levels of CU traits, the cognitive deficits are more likely to involve a lack of sensitivity to punishment and the temperamental vulnerabilities are more likely to involve a preference for dangerous and novel activities and a failure to experience many types of emotion (e.g., guilt and empathy). Further, assessing the level and severity of aggressive behavior, especially the presence of instrumental aggression, would be critical for youths in this group.

As most clinicians recognize, people do not often fall neatly into the prototypes that are suggested by research. Therefore, these descriptions are meant to serve as hypotheses around which to organize an evidence-based assessment. They also highlight several specific important pieces of information that are needed when assessing children and adolescents with CP. One of the most critical pieces of information in guiding assessment, and perhaps ultimately intervention, is determining the age at which various CP behaviors began. This information provides some indication as to whether or not the youth may be on the childhood-onset pathway. Unfortunately, there has been little consistency in the literature concerning the most appropriate operational definition of childhood- versus adolescent-onset or even whether this distinction should be based on chronological age or on the pubertal status of the child (Moffitt, 2003). For example, the DSM-IV-TR makes the distinction between children who begin showing severe CP behaviors before age 10 (i.e., childhood-onset) and those who do not show severe CP before age 10 (i.e., adolescent-onset) in its definition of CD. However, other research studies have used age 11 (Robins, 1966) or age 14 (Patterson & Yoerger, 1993; Tibbets & Piquero, 1999) to define the start of adolescent onset. Thus, onset of severe CP before age 10 seems to be clearly considered childhood-onset and onset after age 13 clearly adolescent-onset. However, how to classify children whose CP onset between the ages of 11 and 13 is less clear and probably dependent on the level of physical, cognitive, and social maturity of the child.

Based on this research, it is therefore important for treatment planning to assess the age at which the child began showing serious CP. As noted above, an important advantage that many structured interviews have over behavior rating scales and behavioral observations is that they provide a structured method for assessing when a youth first began showing serious CP, thereby providing an important source of information on the developmental trajectory of the CP behavior. For example, in the DISC-IV (Shaffer et al., 2000), any question related to the presence of a CD symptom that is answered affirmatively is followed by questions asking the parent or youth to estimate at what age the first occurrence of the behavior took place. Obviously, such questions can also be integrated into an unstructured interview format as well.

In either case, however, there is always some concern about how accurate the parent or youth is in reporting the timing of specific behaviors. There are three findings from research that can help in interpreting such reports. First, the longer the time frame involved in the retrospective report (e.g., a parent of a 17-year-old reporting on preschool behavior vs. a parent of a 6-year-old reporting on preschool behavior), the less accurate the report is likely to be (Green, Loeber, & Lahey, 1991). Second, although a parental report of the exact age of onset may not be very reliable over time, typical variations in years are usually small and the relative rankings within symptoms (e.g., which symptom began first) and within a sample (e.g., which children exhibited the earliest onset of behavior) seem to be fairly stable (Green et al., 1991). As a result, these reports should be viewed as rough estimates of the timing of onset and not as exact dating procedures. Third, there is evidence that combining informants (e.g., such as a parent or youth) or combining sources of information (e.g., self-report and record of police contact), and taking the earliest reported age of onset from any source, provide an estimate that shows somewhat greater validity than any single source of information alone (Lahey et al., 1999).
If the youth’s history of CP is consistent with the childhood-onset pathway, then additional assessment to examine the extent to which CU traits may also be present is important. The Antisocial Process Screening Device (Frick & Hare, 2001), described in Table 3.2, is a behavior rating scale completed by parents and teachers to identify children with CP who also exhibit CU traits (Christian et al., 1997; Frick, Bodin, & Barry, 2000; Frick, O’Brien, Wootton, & McBurnett, 1994). A self-report version of this scale is also available for older children and adolescents and it has been validated in a number of studies (Muñoz & Frick, in press). A more extended assessment of these traits is also in the early stages of development (Essau, Sasagawa, & Frick, 2006; Kimonis et al., in press). However, both these scales currently lack normative data from which to make interpretations and, as a result, are not included in Table 3.2.

The key implication from research on the developmental pathways to CP is that the most appropriate treatment for a child or adolescent with CP may differ depending on characteristics of the child and factors in his or her environment that are operating to maintain these behaviors. This approach is very consistent with functional behavioral assessment (FBA) methods that focus on conducting an individualized assessment of each child’s needs and matching intervention strategies to those needs (LaRue & Handelman, 2006; Walker, Ramsey, & Gresham, 2004). The typical FBA involves a specification of problem behaviors in operational terms (e.g., what types of CP are being exhibited in the classroom), as well as identification of events that reliably predict and control behavior through an examination of antecedents and consequences. For example, an FBA at school would determine whether the child’s CP is occurring only in certain classes or situations (e.g., during class change and at lunch) and if there are certain factors that reliably lead to the CP (e.g., teasing by peers and disciplinary confrontations with teachers). It would also determine the consequences that are associated with the CP that may contribute to their likelihood of occurring in the future (e.g., getting sent home from school and preventing further teasing). Information relevant to an FBA can be gathered through interviews with significant others in the child’s environment or through direct observations of the child in his or natural environment. Thus, several of the behavioral observation systems described previously are also quite important for case conceptualization and treatment planning for the child with CP.

**Overall Evaluation**

In summary, this section highlighted several critical issues for using assessment information for planning treatment for children with CP. First, because children with CP often have many co-occurring problems in adjustment that are important to address in treatment, it is critical that methods for assessing potential comorbid problems, such as behavior rating scales and structured interviews, can be used in treatment planning. Second, because children who show different developmental trajectories of their CP may require different approaches to treatment, it is critical to assess key characteristics that distinguish among children in these trajectories. Specifically, assessing the age at which the child began to exhibit CP, either through structured or unstructured interviews, and assessing the presence of CU traits using a scale such as the APSD, are both critical to the treatment planning process. Third, because environmental contingencies have proven to be very important for understanding factors that can either lead to or maintain CP in children and adolescents, assessment of these contingencies through unstructured interviews or behavior observations is also critical for the treatment planning process.

**ASSESSMENT FOR TREATMENT**

**MONITORING AND TREATMENT OUTCOME**

Most of the applications of research for guiding the assessment process have focused on making diagnostic decisions (e.g., determining whether CP should be the primary source of concern and whether it is severe and impairing enough to warrant treatment) and on treatment planning (e.g., determine what types of intervention may be needed by the child) (McMahon & Frick, 2005). However, an important third goal of the assessment process is monitoring the progress of intervention and evaluating treatment outcome. That is, evidence-based assessments should provide a means for testing whether interventions have brought about meaningful changes in the child’s or adolescent’s adjustment, either for better or worse (i.e., an iatrogenic effect). This is particularly important in
the area of CP, given a number of documented cases in which treatments have lead to increases, rather than decreases, in problem behavior for some youth with CP (Dishion, McCord, & Poulin, 1999; Dodge, Dishion, & Lansford, 2006).

A few of the behavior rating scales and observational measures described previously have demonstrated sensitivity to intervention outcomes. These are described in Table 3.3. For example, scores from the ASEBA have proven to be sensitive to changes brought about by the treatment of youth with CP (e.g., DeGarmo, Patterson, & Forgatch, 2004; Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993). Also, the ECBI/SESBI-R scales have proven to change after parent management training interventions with young children (e.g., Eisenstadt et al., 1993; McNeil et al., 1991; Nixon, Sweeney, Erickson, & Touyz, 2003; Webster-Stratton & Hammond, 1997). Importantly, because these rating scales often provide norm-referenced scores, these scales can be critical for determining not only whether or not the intervention has led to significant decreases in the child's level of CP but also whether the behavior has been brought within a level that is normative for the child's age.

However, behavior rating scales completed by parents who are involved in treatment could be influenced by expectancy effects on the part of the parents who anticipate positive responses to an intervention. Thus, it is important to include ratings of the child's behavior from others who may not have been involved in the treatment or to include behavioral observations of treatment effects whenever possible, especially if the observer is unaware if the child and his or her parents were involved in treatment or unaware if the observation is pre- or posttreatment. Two observational systems described previously, the BCS and the DPICS, have been used in this way as an outcome measure for parenting interventions for CP (e.g., Eisenstadt et al., 1993; Herschell, Calzado, Eyberg, & McNeil, 2002; McMahon, Forehand, & Griest, 1981; Peed, Roberts, & Forehand, 1977; Webster-Stratton & Hammond, 1997). The PDR, which uses the parent as an observer, has also been used as a treatment outcome indicator but, similar to behavior rating scales, the observations by parents who are involved in treatment could be biased (Bank, Marlowe, Reid, Patterson, & Weinrott, 1991; Chamberlain & Reid, 1999; Webster-Stratton & Hammond, 1997).

As noted previously in the discussion of measures used to diagnosis severe levels of CP, children with the same level of CP can vary greatly on the level of impairment associated with their CP. Thus, assessing the child's level of functional impairment after treatment is also an important assessment goal. The two measures of functional impairment included in Table 3.3, the CAFAS and the CGAS, have both proven to be sensitive to treatment effects (Hodges et al., 2004; Shaffer et al., 1983). Also, a number of the rating scales noted in Table 3.3, such as the ASEBA and BASC-2, assess important areas of potential impairment for children with CP such as the child's academic and social adjustment.

Although many measures have been used to assess treatment outcome, there has been very little research on the use of assessment measures to monitor the effects of ongoing intervention for CP. Exceptions to this are the structured observational analogues employed in some parent management training programs for young oppositional children that are employed repeatedly throughout the course of treatment, not only to monitor progress, but also to determine whether the parent has met specific behavioral performance criteria necessary for progression to the next step of the parenting intervention (Herschell et al., 2002; McMahon & Forehand, 2003).

Another assessment domain related to treatment outcome that has had only minimal research focus is in the assessment of treatment satisfaction. This is a form of social validity that may be assessed in terms of satisfaction with the outcome of treatment, therapists, treatment procedures, and teaching format (McMahon & Forehand, 1983). Given the diversity of treatments that are needed for youth with CP, no single consumer satisfaction measure is appropriate for use with all types of interventions for youth with CP and their families. The Therapy Attitude Inventory (TAI; Brestan, Jacobs, Rayfield, & Eyberg, 1999; Eyberg, 1993) and the Parent's Consumer Satisfaction Questionnaire (PCSQ; McMahon & Forehand, 2003; McMahon, Tiedemann, Forehand, & Griest, 1984) are examples of measures designed to evaluate parental satisfaction with parent management training programs (e.g., Brinkmeyer & Eyberg, 2003; McMahon & Forehand, 2003). Importantly, these measures largely focus on the parents' satisfaction with treatment. Children and adolescents themselves have rarely been asked about their satisfaction with treatment, with the exception of some evaluations of Multisystemic Therapy with adolescents (e.g., Henggeler et al., 1999).
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Note: ASEBA = Achenbach System of Empirically Based Assessment; ECBI = Eyberg Child Behavior Inventory; SESBI-R = Sutter-Eyberg Child Behavior Inventory-Revised; BCS = Behavioral Coding System; DPICS = Dyadic Parent–Child Interaction Coding System; PDR = Parent Daily Report; CAFAS = Child and Adolescent Functional Assessment Scale; CGAS = Children's Global Assessment Scale; PCSQ = Parent's Consumer Satisfaction Questionnaire; TAI = Therapy Attitude Inventory; L = Less than Adequate; A = Adequate; G = Good; E = Excellent; U = Unavailable; NA = Not Applicable.
There are several important issues involved in selecting measures suitable for treatment monitoring and outcome evaluation (McMahon & Frick, 2005; McMahon & Metzler, 1998). First, the way questions on a rating scale are framed could affect its sensitivity to change. For example, the response scale on a behavior rating scale may be too general (e.g., “never” vs. “sometimes” vs. “always”) or the time interval for reporting the frequency of a behavior (e.g., the past 6 months) may not be discrete enough to detect changes brought about by treatment. Second, a consistent finding when using structured interviews is that parents and children often report fewer symptoms on the second administration (Jensen et al., 1999; Piacentini et al., 1999). Thus, structured interviews are typically not good measures of treatment outcome because it is unclear whether any reductions in CP between pre- and posttreatment measures are due to the treatment or due to this normal decrease in symptoms over repeated administrations. Third, assessment-by-intervention interactions may occur when evaluating treatment outcomes. For example, as a function of intervention, parents may learn to become more effective monitors of their child’s behavior. As a consequence, they may become more aware of their children’s CP. Comparison of parental reports of their child’s behavior prior to and after the intervention may actually suggest that parents perceive deterioration in their children’s behavior, when in reality the parents have simply become more accurate reporters of such behavior (Dishion & McMahon, 1998).

Overall Evaluation

Unfortunately, the development of measures to adequately monitor treatment progress and treatment outcome for children and adolescents with CP has not advanced as far as the development of measures for diagnosis and treatment planning. This is a particularly unfortunate state of affairs in the treatment of CP, given that several treatments have proven to have potentially harmful effects on youth by leading to increases in behavior problems after treatment. However, several behavior rating scales, most notably the ASEBA and ECBI, have proven to be sensitive to the effects of treatment and they both provide norm-referenced scores to determine whether the child’s level of CP was brought within a level that is normative for his or her age. Several behavioral observations systems, such as the BCS and DPICS, have also been used to both monitor the progress of treatment, as well as to evaluate treatment outcome. There have been a few measures developed to assess child’s or parent’s satisfaction with treatment. However, development of better evidence-based measures for this purpose is a critical area for future research.

CONCLUSIONS AND FUTURE DIRECTIONS

In this chapter, we have summarized several areas of research that have important implications for guiding assessments for youth with CP and summarized some recommended methods for accomplishing three primary assessment goals: diagnosis of non-normative and impairing forms of CP; case conceptualization and treatment planning; and monitoring and evaluating treatment outcome. In this concluding section, we seek to highlight some overarching issues that influence methods for meeting all of these assessment goals and to highlight some important areas for future research.

The first overarching issue is the need for a comprehensive assessment in most cases when assessing youth with CP. That is, an adequate assessment of a youth with CP must assess multiple aspects of the child’s or adolescent’s adjustment (e.g., CP, anxiety, and learning problems) in multiple settings (e.g., home and school) (Kamphaus & Frick, 2005; McMahon & Estes, 1997; McMahon & Frick, 2005). However, it is also important to note that all of the individual assessment techniques summarized in Tables 1 through 3 have limitations. Thus, it is critical to assess the child using multiple methods whenever possible (Kamphaus & Frick, 2005). Because of issues of time, expense, and practicality, how best to acquire and interpret this large array of information become important issues. One approach is to use a multistage method, which starts with more time-efficient measures (e.g., broadband behavior rating scales and unstructured clinical interviews) that are followed by more time-intensive measures (e.g., structured interviews and behavioral observations) when indicated (McMahon & Estes, 1997; McMahon & Frick, 2005; Nock & Kurtz, 2005).

Whether or not a multistage method is used, there are few guidelines available to guide clinicians as to how to integrate and synthesize the multiple pieces of information that are obtained in the assessment to
make important clinical decisions. This endeavor is made more complicated by the fact that information from different informants (Achenbach, McConaughy, & Howell, 1987; De Los Reyes & Kazdin, 2005) and from different methods (Barkley, 1991) often shows only modest correlations with each other. As a result, after collecting multiple sources of information on a youth's adjustment, the assessor often must make sense out of an array of often conflicting information.

Several strategies for integrating and interpreting information from comprehensive assessments have been proposed (Kamphaus & Frick, 2005; McMahon & Forehand, 2003; Wakschlag & Danis, 2004). For example, Kamphaus and Frick (2005) outline a multistage strategy for integrating results from a comprehensive assessment into a clear case conceptualization to guide treatment planning. At the first step, the assessor documents all clinically significant findings regarding the youth's adjustment (e.g., elevations on ratings scales, diagnoses from structured interviews, and problem behaviors from observations). At the second step, the assessor looks for convergent findings across these methods. At the third step, the assessor attempts to explain, using available research as much as possible, any discrepancies in the assessment results. For example, a finding that a child and parent are reporting high rates of anxiety but not the teacher may be explained by research suggesting that teachers may not be aware of a student's level of anxiety in the classroom (Achenbach et al., 1987). At the fourth step, the assessor then develops a profile of the areas of most concern for the child and develops a coherent explanation for the child's CP, again using existing research as much as possible. This process was illustrated previously in using research on the developmental pathways to CP to guide a case conceptualization. Although this approach to interpreting results of a comprehensive assessment is promising, much more research is needed to guide this process of integrating data from comprehensive assessments.

Another issue that requires further attention is the great need to enhance the clinical utility of evidence-based assessment tools (Frick, 2000; Hodges, 2004). Many of the assessment measures that have been used in research have not been developed in such a way that make them useful in clinical practice. For example, Frick and Loney (2000) reviewed a number of performance-based measures that have been used in research with children with CP. They concluded that few of these measures have been used in the same format across multiple samples that would allow for the development of meaningful cutoff scores that could be used in clinical assessments. Also, as noted previously, many of the observational systems used to assess parent–child interactions require such intensive training of observers that their potential utility in many clinical assessments is also limited. Although we did review a few attempts to develop brief and clinically useful assessment methods, there are still too few such methods available.

Perhaps the most important limitation to evidence-based assessments of CP is the remaining disconnect between assessment concerning case conceptualization and treatment planning, on the one hand, and the availability of evidence-based interventions that map onto those assessment findings on the other. For example, interventions for youth who are engaging primarily in covert forms of CP (e.g., stealing and firesetting) are much less developed than those for more overt types of CP such as noncompliance and aggression (McMahon et al., 2006). Similarly, subtype-specific interventions for reactive and proactive aggression, and for relational aggression (e.g., Leff, Angelucci, Grabowski, & Weil, 2004; Levene, Walsh, Augimeri, & Pepler, 2004) and for the treatment of youths with and without CU traits (e.g., Frick, 1998, 2001, 2006) are in relatively early stages of development. Of note, however, is the clear evidence suggesting that high levels of noncompliance in a preschool-age child are best treated using one of several well-validated parent management training interventions (McMahon et al., 2006).

A critical issue in advancing the link between evidence-based assessment and treatment planning involves emerging research on the different developmental pathways to CP. As noted previously, this area of research may be the most important for understanding youths with CP because it could explain many of the variations in severity, the multiple co-occurring conditions, and the many different risk factors that have been associated with CP. This research could also be very important for designing more individualized treatments for youths with CP, especially older children and adolescents with more severe antisocial behaviors (Frick, 2006). However, in order for research on developmental pathways to be translated into practice, it is critical that better assessment methods for reliably and validly designating youths in these pathways be developed. This is especially the case for girls and for ethnically diverse


Leff, S. S., Angelucci, J., Grabowski, L., & Weil, J. (2004). Using school and community partners to design, implement, and evaluate a group intervention for relationally aggressive girls. In S. S. Leff (Chair), *Using partnerships to design, implement, and evaluate aggression prevention programs*. Symposium conducted at the meeting of the American Psychological Association, Honolulu.


AQ1: Please confirm whether the editorial changes made to the sentence "Using interventions that rely on …" retain the intended meaning.

AQ2: Please confirm whether the editorial changes made to the sentence "The behaviors are categorized …" retain the intended meaning.

AQ3: Please update the reference Muñoz et al., in press.

AQ4: Please update the reference Marsee & Frick, in press.

AQ5: As per the table structure provided we have changed the column head from 'Measure' to 'Instrument.' in this chapter. Trust this is okay.


AQ7: Please update Kimonis et al., in press.

AQ8: Since the values for BCS was given twice under 'Behavioral observations,' we have retained BCS values only once. Please confirm whether okay.

AQ9: Please update Kimonis et al., in press.

AQ10: Please update the reference Marsee and Frick, in press.

AQ11: Please update the references Muñoz & Frick (in press) and Muñoz et al. (in press).

AQ12: There is no citation in text for the reference Rothbart and Jones (1998).