Assessment and Diagnosis of Conduct Disorder

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Assessment and diagnosis of mental disorders has become standard practice in the counseling profession. In this article, the authors examine problems and solutions associated with accurate assessment and diagnosis of conduct disorder. Problems of conduct disorder assessment and diagnosis include (a) client deceitfulness, (b) parent and teacher misinformation, (c) counselor countertransference, (d) diagnostic comorbidity, and (e) confounding cultural and situational circumstances. Counselors seeking to accurately diagnose conduct disorder should adhere to basic assessment principles: use multi-method, multi-rater, multi-setting approaches; closely review differential explanations and diagnoses; and regularly obtain peer consultation.

The ability to accurately assess and diagnose individual clients using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994) is an established requirement of professional counselors and other mental health professionals (Fong, 1995; Hohenshil, 1993, 1994). Although diagnostic procedures have been criticized as a negative labeling process, diagnosis is central to professional communication, treatment planning, counseling research, and third party reimbursement for mental health services (Morrison, 1995; Seligman, 1996; Szasz, 1961). In fact, diagnosis and treatment planning are now such standard components of counseling practice that lack of professional diagnostic training may be construed as unethical (American Counseling Association, 1995; Hamann, 1994). The purpose of this article is to provide a brief and practical overview of assessment procedures and diagnostic issues as they pertain to conduct disorder.

THE PROBLEM OF CONDUCT DISORDER

Definition and Prevalence

In the DSM-IV, conduct disorder is classified as an Axis I mental disorder “Usually First Diagnosed in Infancy, Childhood, or Adolescence” (APA, 1994, p. 37). The central feature of what is known as conduct disorder is a persistent behavior pattern wherein an individual violates others’ rights and disregards age-appropriate social norms. In the DSM-IV, 15 criterion behaviors are listed as potentially indicative of conduct disorder. These behaviors are divided into four categories: (a) aggression to people and animals, (b) destruction of property, (c) deceitfulness or theft, and (d) serious violations of rules (APA, 1994). To meet the DSM-IV diagnostic criteria for conduct disorder, individuals must exhibit 3 or more of the 15 criterion behaviors during the 12 months before a consultation and at least 1 criterion behavior during the 6 months before a consultation. In addition, behaviors associated with conduct disorder must cause clinical impairment of social, academic, or occupational functioning. Diagnostic specifiers include childhood- or adolescent-onset and severity levels of mild, moderate, or severe. Although conduct disorder may be diagnosed in adulthood, the focus of this article is the assessment and diagnosis of conduct disorder with child and adolescent populations.

According to the DSM-IV, conduct disorder occurs in 6% to 16% of boys and 2% to 9% of girls (APA, 1994). Other estimates confirm that this is a disorder of serious magnitude, both in terms of prevalence and scope. For example, the Institute of Medicine (1989) reported a 2% to 6% prevalence rate (which translates to between 1.3 million and 3.8 million cases). Furthermore, individuals with conduct disorder generally exhibit long-term dysfunctional behavior patterns as well as resistance to counseling assessment and treatment (Kazdin, 1995; Ross, 1996; Sommers-Flanagan & Sommers-Flanagan, 1997). The effects of conduct disorder and associated delinquent behavior patterns constitute a major social problem and one of the most frequent reasons for young client counseling referrals (Kazdin, Siegel, & Bass, 1990).

Problems With Identifying Conduct Disorder

Like many mental disorders described in the DSM-IV, accurate detection of conduct disorder is not as simple as it may seem after a quick perusal of the 15 criterion behaviors. It can be surprisingly difficult to accurately obtain information necessary to determine whether a particular young client meets the diagnostic criteria (e.g., have you frequently initiated physical fights, have you been physically cruel to animals, have you deliberately destroyed others’ property, and so forth).

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Client deceit. As noted in DSM-IV field trials, young clients who engage in behaviors associated with delinquency or conduct disorder are frequently deceitful (Frick et al., 1994). This tendency makes it difficult for counselors to directly obtain diagnostic relevant information; young clients often lie about, minimize, or deny having engaged in any or all forms of misbehavior. The deception may be so obvious that it actually aids in the diagnosis, but often youths diagnosed with conduct disorder have become sophisticated at lying to and manipulating others without feeling the "bite of conscience" (Noshpitz, 1994a, p. 339). In addition, conduct disordered youth often avoid taking personal responsibility for their actions by blaming others for their social, legal, and academic problems (Dodge, 1993; Kazdin, 1995; Loeber, Lahey, & Thomas, 1991). As a consequence, self-report questionnaires or structured diagnostic interviews may be inaccurate because it is difficult to know if young clients are being truthful.

Parent and teacher misinformation. When it is likely that young clients are being untruthful about their misbehavior, it is logical for counselors to seek additional diagnostic information from collateral informants (e.g., parents and teachers). Unfortunately, depending on their relationship with individual youth, parents and teachers may be uninformed or misinformed regarding the nature and extent of client misbehavior. Previous research has shown that parents and children, teachers and children, and parents and teachers, often demonstrate low inter-rater reliability when it comes to identifying child problem behaviors (Kazdin, 1995). The DSM IV specifically warns diagnosticians of limits regarding the validity of reports from collateral informants: "the informant's knowledge of the child's conduct problems may be limited by inadequate supervision or by the child's not having revealed them" (APA, 1994, p. 86).

Counselor countertransference. Counselors may have strong personal or emotional reactions to working with young clients who display behaviors associated with conduct disorder. As stated by Sarles (1994), "transference-countertransference is a phenomenon that exists in every encounter with a child and adolescent patient and includes the full spectrum of emotions and reactions—eager anticipation, dread, waiting, envy, joy, anger, love, and hate" (p. 74). In particular, young clients who have engaged in aggressive or violent behaviors may evoke retaliatory feelings or impulses in their counselors (Wilcock, 1986, 1987). In such cases, counselors may impulsively "punish" a young client by labeling her or him with a conduct disorder diagnosis when a less severe or less negative diagnostic label would be more appropriate. Conversely, some counselors, due to inexperience or other factors, may grossly underestimate or minimize their clients' behavioral problems (Sommers-Flanagan & Sommers-Flanagan, 1995a, 1996).

Diagnostic comorbidity. Most child and adolescent psychologists consider comorbidity to be common when diagnosing children and adolescents (Harrington, 1993). Comorbidity is especially prevalent in cases of conduct disorder. For example, estimates suggest that conduct disorder and attention-deficit hyperactivity disorder (ADHD) coexist in 45% to 70% of diagnosed cases (Fergusson, Horwood, & Lloyd, 1991; Offord, Boyle, & Racine, 1991). It is estimated that among clinic-referred youth diagnosed as conduct disordered, 84% to 95% also meet the diagnostic criteria for oppositional defiant disorder (Hinshaw, Lahey, & Hart, 1993). Although the DSM IV specifies that in cases in which both oppositional defiant disorder and conduct disorder are present, "the diagnosis of Conduct Disorder takes precedence and Oppositional Defiant Disorder is not diagnosed" (APA, 1994, p. 89), comorbidity of oppositional and conduct symptoms can confuse counselors and complicate the differential diagnostic process. In addition, substance abuse and dependence disorders are also frequently comorbid with conduct disorder (Myers, Burket, & Gitto, 1993). Perhaps more surprising, some estimates of comorbidity between internalizing disorders and conduct disorder indicate that 18% to 35% of children with a depressive disorder also have conduct disorder (Harrington, 1993) and over 5% of children diagnosed as having an anxiety disorder simultaneously meet the diagnostic criteria for conduct disorder (Cohen et al., 1993; Keller et al., 1992). Sorting out differential diagnoses and comorbid conditions can be time-consuming and frustrating to counselors seeking an accurate diagnosis and associated treatment plan (Loeber et al., 1991).

In many cases, young clients are more effectively served if they are initially diagnosed and receive treatment for a more treatable Axis I disorder that may be generating or exacerbating conduct disorder symptoms. This is because DSM-IV conduct disorder is often (and correctly) viewed as a condition that is difficult to treat with outpatient counseling (Kazdin, 1996). It is not unusual to observe significant improvement of conduct symptoms after treatment of depressive, attention-deficit, substance abuse/dependence symptoms (Bernstein, 1996; Biederman, Baldessarini, Wright, Konar, & Faraone, 1993; Dodge, 1993; Tolan & Loeber, 1992).

Confounding cultural and situational factors. According to the DSM-IV, the importance of viewing conduct problems within social, cultural, situational, and gender contexts is crucial. In particular, research has shown that child and adolescent misconduct may occur at extremely high rates in response to family conflict (e.g., physical or sexual abuse; Feitel, Margesson, Chamas, & Lipman, 1982) and adverse social situations (e.g., homelessness, immigration; Canino & Spurlock, 1994; North, Smith, & Spitznagel, 1993). Based on the DSM-IV approach to diagnosis, it is inappropriate to label young clients as conduct disordered when various social, cultural, and situational factors may have caused or may be maintaining behavioral patterns of misconduct. In the DSM-IV (APA, 1994), it is stated: "Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context" (p. 88). This position may reflect a biological etiological bias, or a de-emphasis on labeling children as
having conduct disorders unless their behavior is consistent across situations.

In terms of gender differences, girls who display conduct disordered behavioral patterns are more likely to do so in a manner that is “nonconfrontational” (APA, 1994, p. 88). For example, girls are more likely to “exhibit lying, truancy, running away, substance use, and prostitution” (p. 88). In addition, a recent study indicated that 46% of minority female adolescents who had attempted suicide met the diagnostic criteria for conduct disorder (Trautman, Rotheram-Borus, Dopkins, & Lewin, 1991). This suggests that there may be a strong internalizing component to conduct disorder in young girls.

In summary, counselors face a number of problems when evaluating young clients for conduct disorder. Specifically, counselors must overcome (a) young clients who may skillfully misrepresent the “facts” of their situation, (b) parents and teachers who may be uninformed or misinformed regarding child problem behaviors, (c) young clients whose misbehavior both within and outside of counseling assessment sessions may produce counselor countertransference impulses and reactions, and (d) complex patterns of diagnostic comorbidity. As described in the DSM-IV, counselors must determine whether child misbehavior is caused primarily by an individual’s underlying dysfunction or by adverse familial, social, or cultural circumstances.

Case Example

Jimmy, a 14-year-old boy, was referred for counseling by youth probation services. Over the past 12 months and beginning shortly after his parents’ stormy separation and divorce, Jimmy had been suspended and finally expelled from school due to his participation in numerous fights, his verbal abuse of teachers, and his general misconduct. He was also cited for possession of alcohol, running away from home, and vandalism during the same time. In addition, Jimmy had a long history of problems with authorities and had academic difficulties before his recent increased acts of misconduct. Jimmy also threatened to “beat the holy sh*t” out of his mother’s “boyfriend.” During an initial counseling interview, Jimmy was blatantly disrespectful and provocative (e.g., he pulled out a knife and began playing with it, told the counselor he did not “believe” in counseling, and generally minimized his responsibility for his misbehavior).

The purpose of this case example is to illustrate diagnostic complexity associated with child and adolescent disorders in general and conduct disorder in particular. Specifically, although Jimmy is obviously displaying symptoms consistent with conduct disorder, there are also a number of other diagnostic considerations that require attention. First, the fact that Jimmy’s symptoms were exacerbated after his parents’ separation and divorce should alert counselors to the possibility of diagnosing him with adjustment disorder with disturbance of emotions and conduct (DSM-IV: 309.4). Second, Jimmy’s persistent irritability, defiance, and history of academic problems may warrant the diagnosis of dysthymic disorder (DSM-IV: 300.4), oppositional-
defiant disorder (313.81), attention-deficit/hyperactivity disorder (314.01), or various learning disorders. Third, Jimmy’s apparent ability to consistently and frequently cause angry reactions in peers and adults might produce an aggressive counter-reaction or countertransference within his counselor. Such a counter-reaction could result in Jimmy quickly being labeled as conduct disordered, therefore implying more restrictive treatment and poorer prognosis.

Fourth, DSM-IV multiaxial diagnosis provides clinicians with procedures for expressing diagnostic uncertainty (i.e., if Jimmy’s counselor determines that a conduct disorder label is appropriate, a “provisional” conduct disorder diagnosis could be used to express some degree of diagnostic uncertainty).

To the extent that diagnostic labels provide information pertaining to treatment planning and prognosis, Jimmy should be provided diagnostic labels most likely to guide appropriate counseling interventions. If Jimmy was given a principal diagnosis of conduct disorder without acknowledgment of his adjustment demands and potential depressive (irritability) symptoms, a comprehensive treatment plan designed to address Jimmy’s individual psychopathology might not be designed and implemented (Sommers-Flanagan & Sommers-Flanagan, 1995b, 1996).

**PRINCIPLES OF CONDUCT DISORDER ASSESSMENT**

To systematically address problems associated with conduct disorder assessment and diagnosis, counselors benefit from adhering to the following assessment principles.

**Be Familiar With DSM-IV Behavioral Criteria**

Knowledge of DSM-IV (APA, 1994) diagnostic criteria for conduct disorder is essential. Counselors who hope to accurately diagnose this (and other) mental disorders should not rely on their memory of specific criteria. Instead, we recommend that counselors develop a 15-item checklist based strictly on DSM-IV diagnostic criteria for use during diagnostic interviews.

**Use Multi-Method, Multi-Rater, Multi-Setting Assessment Procedures**

There is no single fail-safe assessment procedure available for accurately identifying conduct disorder. Similarly, no individual rater (including the counselor) can consistently make unbiased judgments regarding conduct disordered youth. Additionally, conduct disordered youth tend to exhibit their core symptoms in some settings, but not others. Consequently, accurate conduct disorder assessment requires multiple methods, by multiple raters, in multiple settings (Kronenberger & Meyer, 1996).

**Be Aware of Potential Differential Diagnoses**

As discussed, conduct disorder symptoms may overlap with other DSM-IV disorders and conduct disorder symptoms may be secondary to more treatable diagnoses. Therefore,
counselors assessing youth who may meet diagnostic criteria for conduct disorder should remain aware of potential differential diagnoses. Counselors should develop a differential and coexisting diagnostic checklist and ask themselves if any of the following mental disorders also present: (a) adjustment disorder, (b) attention-deficit/hyperactivity disorder, (c) major depression, (d) dysthymic disorder, (e) oppositional defiant disorder, (f) substance abuse/dependence, (g) bipolar I disorder, or (h) child or adolescent antisocial behavior (V code). For young clients who are approaching age 18, it is also reasonable to consider whether the diagnosis of a personality disorder (Axis II) also might be appropriate.

Obtain Historical Information Before Completing Assessment Interviews

Many conduct disordered youth have extensive histories of delinquent behavior. However, because they may seem calm and cooperative during initial counseling sessions, counselors may minimize or overlook their illegal or antisocial behavioral history. Conversely, some clients initially seem defiant and disagreeable, in part, to affective irritability or misperceptions of hostile intent from others (Dodge, 1993; Sommers-Flanagan & Sommers-Flanagan, 1995b). A single clinical interview is not sufficient to obtain adequate historical or interpersonal information for this diagnosis. Prudent practice dictates that counselors gather detailed historical and interpersonal information (and appropriate releases of information) before the conclusion of assessment interviews. Useful diagnostic information can be obtained from schools, parents, probation officers, and other legitimate sources of historical information.

Rule Out Adverse Family Environments, Social Forces, and Cultural Circumstances as Potential Causal Factors

There are many family dynamics and family environmental factors associated with conduct disorder. These include family stress, family conflict, harsh or inconsistent discipline, physical abuse, and inadequate supervision and monitoring of child behavior (Dodge, Lochman, Harnish, Bates, & Pettit, 1997; Patterson, 1982; Patterson, Reid, & Dishion, 1992). In addition, as illustrated in the preceding case example, stressful family dynamics may directly produce an adjustment disorder with conduct symptoms and social and cultural factors may directly maintain behavioral patterns of misconduct. Consequently, counselors should include some form of family assessment and examination of contributing social and cultural factors in their conduct disorder assessment protocol (e.g., measures of inter-parental acrimony in divorce situations).

Regularly Consult With Trusted Colleagues

Remaining aware of countertransference reactions to conduct disordered youth is a difficult, but worthwhile, challenge (Holmes, 1964; Sarles, 1994). For example, youth who are manipulative, sociable, and energetic may evoke receptive feelings within counselors, despite the clients’ long history of antisocial behavior. In contrast, depressed, angry, and oppositional adolescents—despite their lack of actual antisocial behavioral history—may leave counselors with retaliatory impulses. For counselors to more deeply understand their reactions to behaviorally disturbed youth clients, we recommend regular counselor participation in peer consultation groups.

Assessment Strategies

The following assessment procedures and overall approach to evaluating conduct disordered clients are designed to help counselors become more efficient in accurately diagnosing this challenging condition.

Interview Methods

There are many interviewing approaches that can be used to obtain information pertaining to the presence or absence of conduct disorder symptoms. These approaches vary in their structure and focus. Structured diagnostic interviewing. Researchers commonly use structured diagnostic interviews to identify conduct disorder in children and adolescents. Structured interviewing approaches are structured, rigorous, and focus exclusively on identifying the presence or absence of DSM-based diagnostic indicators (Hodges, 1987). Unfortunately, despite their rigor and focus, structured diagnostic interviewing approaches sometimes produce disappointingly low reliability coefficients and have other limitations as well (Costello, Edelbrock, Dulcan, Kales & Kleinic, 1994). Limitations of structured interview approaches include (a) length of administration, (b) restriction of counselor freedom and flexibility during interviews, (c) directness and lack of sophistication in format, and (d) a negative influence on initial rapport development between counselor and client. It is not surprising that structured interviewing approaches, although useful for research purposes, are used infrequently in clinical or counseling settings (Kronenberger & Meyers, 1986). Structured interviews commonly used in research settings include the Diagnostic Interview Schedule for Children-Revised (DISC-R, Costello et al., 1984) and the Child Assessment Schedule (CAS; Hodges, 1987).

One form of structured interview that is indispensable for evaluating potentially conduct disordered youth is the developmental history interview. Developmental information may be obtained either through an interview or questionnaire format (Barkley, 1990; Sommers-Flanagan & Sommers-Flanagan, 1993; Tolman & Cohler, 1992). Developmental information is necessary not only for diagnostic subclassification (i.e., childhood- vs adolescent-onset), but also for determining whether clients generally engage in reactive or proactive aggressive behaviors (Dodge, et al., 1997; Vitiello & Stoff, 1997). Reactive aggression (characterized by frustration, self-control deficits, and autonomic...
activation) and proactive aggression (characterized by emotional-autonomic control and reward expectation) is a subtyping concept that contains important treatment and prognosis information (Dodge et al., 1997).

Non-directive interviewing. Alternative interviewing assessment approaches focus on obtaining information and observations relevant to core themes of conduct disorder via less directive methods. Non-directive interviewing approaches are generally used by counselors to obtain information pertaining to more diverse facets of child and adolescent client functioning (Kazdin, 1995; Sommers-Flanagan & Sommers-Flanagan, 1993).

As just noted, counselors should try to obtain historical information regarding potentially conduct disordered clients before initial interviews. In particular, we recommend obtaining specific information pertaining to clients' legal records before conducting initial assessment interviews. Although such information is potentially biasing, it is extremely useful to know the extent of clients' antisocial and illegal behavior before first contact. However, we always inform young clients that we have general background information about them, while emphasizing, “Even though I know a bit about you, I’d like to hear your descriptions and your perspective on your situation in your own words.” In this manner, counselors can directly observe each client's style of reporting his or her misconduct (e.g., does the youth minimize issues and become defensive or does he or she take responsibility for previous delinquent behavior).

Attachment-oriented interviewing. Opportunities for attachment to a secure, predictable caretaker are often lacking in the personal history of young clients who develop conduct disorder (Bradford & Lyddon, 1994; Rosenstein & Horowitz, 1996). Assessing client attachment to caretakers, both current and in the past, can provide important information about the opportunity and ability to form attachments. Rather than asking clients directly about their current parental or guardian relationships, we recommend two approaches.

First, counselors can observe and categorize client attachment behaviors as they occur in relation to the counselor during counseling sessions. In such cases, behaviors can be categorized into one of four attachment styles: (a) secure prototype, (b) preoccupied prototype, (c) fearful prototype, or (d) dismissing prototype (Bradford & Lyddon, 1994). Research indicates that conduct disordered clients tend to interact with counselors in a disrespectful manner that discounts the counselors' relevance and importance, and suggests a lack of empathy. This attitude toward the counselor is consistent with the dismissing prototype (Rosenstein & Horowitz, 1996).

Second, counselors can assess attachment issues by asking one or more of the following questions.

1. If you could have anybody in the universe as a parent, or as parents, whom would you choose?

After young clients select their ideal parent, inquiry should occur regarding why that particular parent would be ideal. Counselors then listen for themes of nurturance, safety and protection, intimacy and closeness, association with fame, wealth, or power. Subsequently, counselors can inquire about how fantasized or wished-for parents would compare with current parenting figures. Responses emphasizing feelings of betrayal, disappointment, and rage would be considered as indicators of failed or weakened attachment. In contrast, answers that include empathy for a less-than-optimal caretaker is likely contraindicative of conduct disorder. We emphasize that single interview responses provide only a small piece of the diagnostic puzzle.

2. What are some reasons people decide to have kids? Which do you think are good reasons?

Often this question and follow-up questions will elicit information about attitudes toward the client's own parents. Responses that indicate parenting is primarily forced on people by unwanted pregnancies, or responses indicating that people choose to be parents to obtain gratification of some type for themselves, offer insight into the attachment or lack of attachment childhood experience.

3. If you needed help or were really frightened, or even if you were just totally out of money and needed some, who would you turn to right now?

This question focuses on the youth's sense of secure base. Many youth with failed or inadequate attachments will indicate they wouldn't turn to anyone, or they would turn to their peers (who may be gang members). Some will volunteer their externalized sense of betrayal or hatred for family members who "should" have been there for them but who have let them down on numerous occasions (Noshpitz, 1994b).

Morality/values-oriented interviewing. It can be difficult to obtain information pertaining to morality and values through directive interviewing techniques. Sophisticated conduct disordered youth are likely to present themselves as morally upstanding young people who have simply been mistreated by adult authority figures. Unfortunately, many young clients have actually been mistreated by adults, including teachers, principals, probation officers, and parents, which further complicates the issue. However, as Dodge's (1985; Dodge et al., 1997) research on aggressive youth has shown, reactively aggressive conduct disordered youth are more likely to perceive mistreatment when, in fact, they have primarily been treated in a fair and just manner.

Useful approaches to indirectly assessing client values and attributional styles frequently emphasize simulations (Weiss, Dodge, Bates, & Pettit, 1992). Simulations are verbal descriptions of situations or scenarios to which clients are asked to respond. Sources of simulations are varied. For example, the Comprehension subtest of the Wechsler Intelligence Scale for Children, Third Edition (WISC-III; Wechsler, 1991) contains several items that assess interpersonal values and social morality. In addition, Goldstein, Glick, Reiner, Zimmerman, and Coulthar's Aggression Replacement Training (1987) contains numerous scenarios that can be used to assess client level of moral development. With potentially conduct disordered teenagers, we use a simulation referred to as "the out-of-town parent scenario" (Sommers-Flanagan...
& Sommers-Flanagan, 1997): "What would you do if your parents were going to be out of town for the weekend and you will be staying at home by yourself?"

Many young clients respond to this scenario by indicating they would invite some friends over for a party. Follow-up questions include the following:

- "What if your parents had asked you not to have a party—would you have one anyway?"
- "How many people would you invite? How many do you think would come?"
- "Would you have alcohol or drugs at the party? If so, what would you have?"
- "How would you make sure your parents wouldn’t find out about the party?"
- "What if your parents did find out? How would you explain it to them?"

Clearly, this type of scenario and follow-up questioning makes it somewhat more difficult for young clients to resist expressing their interpersonal values.

**Counselor naiveté**: Feigning naiveté while interviewing potentially conduct disordered young clients allows counselors to directly observe clients as they misrepresent or lie about important clinical or diagnostic information. This approach is based on the assumption that youth who are exhibiting delinquent behavior patterns may try to deceive counselors through minimization, denial, and untruthfulness (APA, 1994; Noshpitz, 1994a). Because this pattern is one of the diagnostic criteria for conduct disorder, it is worth exploring in the diagnostic interview (APA, 1994). However, direct confrontation regarding the accuracy of client statements is sometimes, but not always, the best approach when the goal is to observe untruthful behavior (Doren, 1986; Ekman, 1989; Kernberg & Chazan, 1981). Instead, it may be beneficial to interview potentially conduct disordered youth using a style similar to the television detective, Columbo.

Viewers of this show will recall that Columbo used a style that seemed to be naive, when in reality, he was scanning the behavior and information offered in an intelligent and sophisticated manner. The following case example is illustrative. Kerry, a 12-year-old girl, came to her assessment appointment with a map torn from the pages of a regional magazine. Upon inquiry, she indicated that she obtained the map from a school program wherein students received a subscription to the magazine. The counselor was fairly certain that he recognized the map from the most recent issue of that magazine in the waiting room of his office. He asked Kerry where she had obtained the map. Kerry responded: "We got our maps about a month ago in class." The counselor stated: "Huh, that's interesting because it's not from the latest issue . . . and that issue didn't come out until a few days ago." Kerry responded, without hesitation: "Oh, I'm in a special program. You see, if you're in a special membership category, you can get a whole year's supply of magazines in advance." Eventually, after a few more questions, Kerry protested, "You don't believe me, do you?" However, rather than having directly indicated disbelief, the counselor had merely inquired and could therefore state: "Well, I'm not sure one way or the other, Kerry. I am just curious."

When interviewing with feigned naiveté rather than with a more confrontational stance, young clients who are skilled in their storytelling will often proceed with falsehoods when telling the truth would be easier. Counselors should track the process and the false information in an open-ended manner that allows clients to either tell the truth or produce more inaccurate information. Usually, with clients who have more conduct disordered qualities, an interaction that challenges their deception frequently ends with flat denial and indignation. We have had young clients request polygraphs and fingerprinting to prove their innocence or truthfulness in the face of clear and incontrovertible evidence of their falsehoods.

Obtaining truthful statements from the client is not the object of this type of interviewing approach. Rather, observing the degree of inaccuracies and the style in which deception is put forth is important in the diagnostic process. Feigned naiveté allows interviewers to stay disengaged, indicating neither belief nor disbelief (Doren, 1986). Eventually, for therapeutic purposes, confrontation or interpretation of client deceit is necessary (Meeks, 1980; Sarles, 1994; Sommers-Flanagan & Sommers-Flanagan, 1997).

**Structuring assessment interviews**: Despite our emphasis on less structured or directive interview techniques, as previously noted, counselors should keep a checklist of DSM-IV behavioral criteria available during interviews with potentially conduct disordered youth and with their parents, teachers, or probation officers, and inquire directly about information that may be missing toward the end of the assessment interview. However, when using such a checklist, questions can be made more meaningful by avoiding wording derived directly from the DSM-IV. For example, when inquiring about "initiation of physical fights" (APA, 1994, p. 90) and using weapons, we initially warn young clients that a series of specific questions are coming up and then use questions such as the following.

- "In how many fights have you been in your life?"
- "Do you usually start the fights?"
- "What's the worst you've ever been hurt in a fight?"
- "What's the worst you've ever hurt someone else?"
- "Have you ever used a weapon in a fight . . . or had someone use one against you?"

As noted by ourselves and other authors (e.g., Fong, 1993; Sommers-Flanagan & Sommers-Flanagan, 1993), assessment interviews generally should proceed from open-ended and less directive approaches to more directive inquiry (as above) regarding specific diagnostic symptoms. Subsequent to open-ended inquiry regarding general concerns and symptoms, counselors should obtain developmental history information from parental figures either via interview or questionnaire. In addition, when interviewing conduct disordered clients, counselors must occasionally shift their fe-
cus to assessment of high risk behavior (i.e., suicide, violence potential; Sommers-Flanagan & Sommers-Flanagan, 1995c; Tolan & Cohler, 1992).

**Self-Report Questionnaires**

A large number of self-report questionnaires are available to counselors for assessing dimensions of conduct disorder. Self-report questionnaires include, but are not limited to (a) the Minnesota Multiphasic Personality Inventory, Adolescent Form (MMPI-A, Butcher et al., 1992), (b) Adolescent Antisocial Behavioral Checklist (Ostrov, Marohn, Offer, Curtiss, & Feckzo, 1980, and (c) the Means-End Problem-Solving Procedure (Platt & Spivak, 1975). In addition, the Child Behavior Checklist (CBCL; Achenbach, 1992) and the Behavior Assessment Scales for Children (BASC; Reynolds & Kamphaus, 1992) both contain youth self-report forms.

**Parent and Teacher Rating Scales and Behavioral Observation Systems**

These are similar to self-report questionnaires; a large number of parent and teacher rating scales are available to counselors. Both the CBCL and BASC contain parent and teacher report versions. Also, the Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978) is one of the most widely used parent rating scales for conduct disorder in children of 2 to 17 years.

In addition to parent and teacher rating scales, counselors can directly observe and code child behavior using a variety of behavioral coding systems. These include the Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 1983) and the Forehand Observation System (FOS; Forehand & McMahon, 1981). Unfortunately, these systems and most coding systems for use in clinics, homes, and schools are time intensive and relatively expensive.

**Projective Methods**

Projective assessment methods can provide counselors with supplementary information relevant to diagnosing conduct disorder. Projective assessment methods are generative; that is, they require clients to generate information based on their own creativity, memories, background, and experiences when presented with ambiguous stimuli.

Although projective techniques can be useful in the assessment of conduct disorder, they often produce data that are complex and difficult to interpret. Many counselors and psychologists consider projective assessment methods to have limited reliability, validity, and use (Kronenberger & Meyer, 1996). In many cases, this is a reasonable complaint. Consequently, counselors should never use projective methods solely for diagnostic purposes, especially without adequate training. Projective techniques provide interesting and important information that may aid diagnosis and treatment planning; they should be used for supplementary information and should be interpreted with caution.

The most common projective assessment approaches include Rorschach Inkbloths (Exner, 1986), various apperception tests [e.g., the Roberts Apperception Test (RAT), Child Apperception Test (CAT), and Thematic Apperception Test (TAT); Murray, 1943], incomplete sentences, and human figure drawings (Macloud, 1949). Although these approaches can provide counselors with useful information regarding personality dynamics and behavioral impulses, none of these approaches are specifically normed on conduct disordered youth and so, as previously indicated, interpretive caution is advised.

**CONCLUSION**

In this article we have described problems, principles, and strategies associated with assessment and diagnosis of conduct disorder. We recommend following a multi-method, multi-rater, and multi-setting approach to assessing conduct disorder using various interviewing techniques, self-report questionnaires, projective assessments, behavioral observations, and parent-teacher ratings. We hope that by adhering to the assessment principles and strategies described in this article, counselors can avoid potential mistakes associated with conduct disorder assessment and diagnosis. Furthermore, counselors should remember that assessment and diagnosis of conduct disorder remains a dynamic field and that diagnostic criteria will undoubtedly continue to evolve as additional research information becomes available.

**REFERENCES**


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