What Are Disruptive Behavior Disorders?

The topic for this KIT is disruptive behavior disorders (DBDs) which can include diagnoses of Oppositional Defiant Disorders (ODD) and Conduct Disorders (CD).

DBDs occur across the stages of child and youth development; have a significant impact on a child’s functioning across many social settings (for example, home, school, community, etc.); involve multiple service sectors (for example, mental health, education, child welfare, juvenile justice, etc.); and can result in great social costs to communities when untreated (U.S. Department of Health and Human Services, 1999). DBDs are described in more detail in Characteristics and Needs of Children with Disruptive Behavior Disorders and their Families.

What Are Evidence-Based Practices?

EBPs are interventions for which strong scientific proof shows that certain outcomes will be achieved. This does not mean that other interventions do not work or do not produce favorable outcomes. It may be that those interventions have not yet been fully researched—that research has not been conducted at a sufficiently appropriate level for scientists to say that strong evidence exists to prove or disprove that a specific intervention is effective.

Keep two major ideas in mind when discussing EBPs. The first is the idea of scientific proof or evidence—EBPs have been researched scientifically and evidence shows that they are effective. The second is the use (the practice) of evidence-based practices—the EBPs found in this KIT are meant to be used to the benefit of children, youth, and their families. Evidence for their effectiveness is based on how, with what children, and in what contexts they are used, among other things.

It is the responsibility of the provider to inform the consumer and family member about the best intervention that can be used to address the problem and to achieve desired outcomes. The health provider and consumer may jointly decide which intervention to select after weighing information about evidence and use.

This shared decisionmaking process is an important principle identified by the Institute of Medicine (2001). The shared decisionmaking process benefits greatly from an understanding of research designs, which are examined in Selecting EBPs for Children with Disruptive Behavior Disorders to Address Unmet Needs. For sources of more information about EBPs, see Table 1. Several definitions for EBPs are presented in Table 2.
<table>
<thead>
<tr>
<th>Prevention practice</th>
<th>Age of youth</th>
<th>Race/ethnicity of children and families who participated in EBP studies</th>
<th>Setting</th>
<th>Format</th>
<th>Length</th>
<th>Family component</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Triple P-Positive Parenting Program | 0–16         | Groups of children and families in Australia who were primarily White. One study was conducted in China with 90 Chinese children.       | Clinic, Home, School | Individual, Group | Varies: 1–2 sessions to 8–10 sessions | Parent training, home visits, partner support skills, mood management workbook material | ▫ Increase in parental confidence.  
▫ Decrease in child behavior problems.  
▫ Improvement in effective parenting styles. |
| Project ACHIEVE                  | 3–14         | Evaluation was carried out with groups that were approximately half white, and half diverse populations, primarily African American. | School  | Group        | School year                      | Parent training                                                                 | ▫ Decrease in discipline problems.  
▫ Decrease in special education referrals and placements.  
▫ Increase in positive school climate.  
▫ Improvement in academic achievement. |
| Second Step                      | 4–14         | Diverse groups studied. Two studies were conducted primarily with White children. In another two studies, the population was primarily African American; in one study the proportions of White, African American, and Hispanic participants were approximately equal. In another study, the majority of participants were African American and secondarily Hispanic. Another study included a small percentage of Asian Americans and one study was conducted in Germany. | School  | Group        | School year                      | Family Guide that includes a video-based parent training program that helps parents reinforce skills at home | ▫ Increase in positive social behavior and social reasoning.  
▫ Improvement in control of emotions.  
▫ Decrease in verbal and physical aggression and problem behaviors. |
| Promoting Alternative Thinking Strategies | 5–12     | Groups studied were approximately one-half White and one-quarter to one-third African American. Asian American, American Indian, and Hispanic children combined, made up the remainder of the groups. | School  | Group        | K–5th grade, 3 times a week for 20–30 minutes | None                                                                          | ▫ Increase in ability to label feelings.  
▫ Decrease in classroom aggression.  
▫ Increase in self control. |
| First Steps to Success            | 5–6          | The children involved in two studies were primarily White. Smaller case studies involved primarily African American and some American Indian children with minimal participation from Hispanic children. | School, Home | Individual | 3–4 months                       | Parent training delivered in the home                                         | ▫ Decrease in aggression.  
▫ Increase in time spent on academics.  
▫ Increase in positive behavior. |
### Table 3: Prevention/Multilevel Practices

<table>
<thead>
<tr>
<th>Prevention practice</th>
<th>Age of youth</th>
<th>Race/ethnicity of children and families who participated in EBPs studies</th>
<th>Setting</th>
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<th>Length</th>
<th>Family component</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Early Risers: Skills for Success | 6–12 | Evaluations included two groups of predominately White children and one group of predominately African American children. | School | Individual | School year and summer | Parent education workshops, individualized family support | Improvement in academic achievement.  
Improved control of emotions.  
Improvement of social skills. |
| Adolescent Transitions Program | 11–18 | Two studies included primarily White children. One study was primarily White and African American with very small proportions of Hispanic, Asian American, and American Indian children. | School | Individual, Group | Varies: 3–12 sessions | Family management groups, individual family therapy | Increase in positive parent-child interactions.  
Improvement in behaviors at school.  
Decrease in youth smoking. |

### Table 4: Treatment Practices

<table>
<thead>
<tr>
<th>Prevention practice</th>
<th>Age of youth</th>
<th>Race/ethnicity of children and families who participated in EBPs studies</th>
<th>Setting</th>
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<th>Family component</th>
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</thead>
</table>
| Incredible Years    | 2–12 | Four studies have had primarily White participants with no description of other ethnic or racial groups.  
Two studies included African American, Hispanic, and other multiethnic groups in small proportions. | School, Home | Group | Less than 22 weeks | Parent training | Increase in parents’ use of effective limit setting, nurturing, and supportive parenting.  
Improvement in teachers’ use of praise.  
Decrease in conduct problems at home and school. |
| Helping the Noncompliant Child | 3–8 | No specification of ethnicity or race among the studied groups was available. | Clinic, Home | Individual | 8–10 sessions | Parent training | Improvement in parenting skills.  
Decrease in oppositional behavior. |
| Parent-Child Interaction Therapy | 2–7 | One study included approximately three-fourths White and one-fourth diverse populations (primarily African American). Support exists for a culturally sensitive adaptation for Puerto Rican and Mexican American families. | Clinic | Individual | 10–16 sessions | Parent training, coaching | Improvement in parent-child interaction style.  
Improvement in child behavior problems. |
| Parent Management Training – Oregon | 4–12 | Evaluated primarily on White children and parents. A culturally sensitive adaptation of PMTO for Hispanic families has been evaluated as well. | Clinic, Home | Individual | 20 sessions | Parent training | Decrease in child’s behavioral problems.  
Increases in effective parenting. |
<table>
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<th>Age of youth</th>
<th>Race/ethnicity of children and families who participated in EBPs studies</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Brief Strategic Family Therapy™</td>
<td>6–18</td>
<td>Evaluated primarily with Hispanic families. One study’s sample was one-fifth African American.</td>
<td>Clinic, Home</td>
<td>Individual</td>
<td>12–16 sessions</td>
<td>Family therapy</td>
<td>Decrease in substance abuse. Increase in commitment to therapy. Decrease in problematic behavior. Increase in family functioning. Decrease in aggression.</td>
</tr>
<tr>
<td>Problem-Solving Skills: Training</td>
<td>6–14</td>
<td>Studied with groups of approximately three-fourths White and one-fourth African American children.</td>
<td>Clinic, Home</td>
<td>Individual</td>
<td>20 sessions</td>
<td>Parent training</td>
<td>Improvement in behavior. Improvement in positive family functioning.</td>
</tr>
<tr>
<td>Coping Power</td>
<td>9–11</td>
<td>Groups studied were approximately half White and half African American children. One study was in the Netherlands with Dutch children.</td>
<td>School</td>
<td>Group</td>
<td>15–18 months</td>
<td>Parent training</td>
<td>Decrease in substance abuse. Improvement in social skills. Decrease in aggressive thoughts.</td>
</tr>
<tr>
<td>Mentoring</td>
<td>6–18</td>
<td>The major study included a group of approximately three-fourths African American children and one fourth Hispanic children.</td>
<td>School, Home</td>
<td>Individual</td>
<td>1 year or longer</td>
<td>None</td>
<td>Increase in confidence in school performance. Improvement in family relationships. Increase in positive behaviors.</td>
</tr>
<tr>
<td>Multisystemic Therapy</td>
<td>12–18</td>
<td>Most groups that have been evaluated have been approximately 60% African American children and 40% White children, except for two that were approximately 70% White and 30% African American. One study included an 84% multiracial group of African American and Whites. One study was conducted in Norway with Norwegian children.</td>
<td>School, Home</td>
<td>Individual</td>
<td>3–5 months</td>
<td>Family therapy, parent training</td>
<td>Decrease in arrests and re-arrests. Increase in school attendance. Decrease in behavior problems. Decrease in substance use.</td>
</tr>
<tr>
<td>Functional Family Therapy</td>
<td>11–18</td>
<td>Groups were predominantly White families. In unpublished studies, diverse populations (primarily African American and Hispanic) made up between one fourth and one half of the group. One study was conducted in Sweden.</td>
<td>Clinic, Home</td>
<td>Individual</td>
<td>8–12 sessions</td>
<td>Family therapy</td>
<td>Decrease in out-of-home placements. Decrease in re-arrest rates. Improvements in family communication style. Improvement in family interactions.</td>
</tr>
<tr>
<td>Multidimensional Treatment Foster Care</td>
<td>3–18</td>
<td>Studies were primarily of White children. African American, Hispanic, and American Indian children were represented in very small proportions.</td>
<td>School, Clinic, Home</td>
<td>Individual</td>
<td>6–9 months</td>
<td>Training, weekly meetings</td>
<td>Decrease in arrest rates. Decrease in violent activity involvement. Increase in permanent placement success.</td>
</tr>
</tbody>
</table>