
Reattach Therapy – its Efficacy in Treating Conduct Disorder – a Case Study

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Case study

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Abstract

Introduction: Conduct Disorder with its prevalence varying from 5.8% to 8.7% is characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour with persistent violation of age – appropriate social expectations. Major symptoms can be aggressive, destructive behaviour, with no remorse about hurting others. Other symptoms include poor academic performance and social isolation.

Objective: The aim of this study is to find out the efficacy of ReAttach therapy in the treatment and management of Conduct Disorder.

Method - Case Report: A 13 year old adolescent living in a children's home was brought in with chief complaints of destructive behaviour with no fear of punishment, and caught rubbing fecal material on the walls. Aggression, physical violence and threatening behaviour towards fellow children, and cruelty towards animals. He was socially isolated, had poor concentration, anxious behaviour and poor academic performance.

Intervention: The ReAttach Therapy has been found to be the most effective treatment in this case study. Since this adolescent was defiant, destructive, aggressive, prone to lying and making up false stories, his therapeutic intervention through linear analytic verbal techniques and mainstream interventions may not have brought holistic effectiveness in treatment. ReAttach therapy opened up vast possibilities to capture intricate relationships between his maladaptive beliefs, emotions, and traumatic memories by providing access to his cognitive structures.

Conclusion: Post therapy results indicated a subjective and objective improvement in the patient after 5 sessions of ReAttach therapy.

Key Words: ReAttach therapy, Adolescent onset, Conduct disorder

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1. Introduction

Conduct Disorder is defined as a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are repeatedly violated beginning in childhood or adolescence (Saddok, 2009). These behaviours fall into four main groupings: aggressive behaviours that cause harm to or threaten harm to others, nonaggressive property destruction, covert aggressive behaviours of deceitfulness or theft, and rule violations (Saddock, 2009). Conduct Disorder is also characterised by antisocial, aggressive or defiant behaviour with significant violations. Other symptoms may include irritability, temper tantrums, poor academic performance and social isolation (DSM 5, 2013).

The disturbance that is found in behaviour must cause impairment to the child or adolescent in three domains of life i.e. social, occupational, or academic functioning. The behaviour pattern is generally pervasive and is present in a variety of settings such as home, school, or the community.

Conduct Disorder casts a long shadow over adulthood, often leading to an antisocial personality, drug misuse, increased rates of psychosis and earlier death. Adults with substance abuse, anxiety and eating disorders, and even individuals with schizophrenia spectrum disorders and mania, are more likely to have a history of conduct disorder (Kim-Cohen et al., 2003).

The prevalence of Conduct Disorder varies from 5.8% to 8.7% across the world, but the data varies from country to country. Current data indicates that the prevalence of conduct disorder in the USA is 2–5% in children between 5–12 years and 5–9% in adolescents between 13–18 years (Patel et al., 2018). The prevalence of Conduct Disorder among primary school children in a rural area of India was found to be 5.48%. The prevalence was found to be higher amongst the males, up to 66.67% whereas it was found to be around 33.33% in females (Mishra et al., 2015).

Conduct problems cause children, families and schools considerable distress, and they result in social and educational impairment (Loeber et al., 2000). Childhood conduct problems further predict the risk of numerous problems in adulthood, serious difficulties in education, work and finances, homelessness, abuse, dependence on tobacco, alcohol and drugs, and even poor physical health, including injuries, sexually transmitted infections, compromised im-

mune function, dental and respiratory problems, as well as a variety of mental disorders and suicidal behaviour (Moffitt et al., 2002). It has been found that Conduct Disorder generally has Attention Deficit Hyperactivity Disorder or Hyperactivity as comorbidity. Both Conduct Disorder and Hyperactivity were related to family adversity and adverse styles of parental discipline, subtly different patterns of associations are also evident. In particular, Conduct Disorder is linked with poverty, parental violence and contact with child care social agencies. (Moulton & Kosslyn, 2009)

The risk factors for ODD and CD are not well understood; however, it appears that genetic, environmental, and family factors all contribute towards it. Therefore, a review of a child's history should involve prenatal exposures, exposure to adverse childhood experiences, and cognitive or other developmental problems. It is also essential to assemble a history of the current illness, including age of onset, the environmental situations in which the symptoms manifest, the duration of the symptoms, any precipitating events or situations, and persons, places, or events that ameliorate or exacerbate the behavioural problems should be noted. An assessment for other psychiatric problems, such as substance abuse, trauma-related symptoms, and ADHD, should also be conducted.

If not treated, there can be some severe functional consequences of Conduct Disorder. Decision-making difficulties in CD may stem from deficits in emotional and executive function. (Bechara et al., 1994). It may lead to school suspension or expulsion, and social reclusiveness. It is not uncommon for individuals with Conduct Disorder to come into contact with the criminal justice system for engaging in illegal behaviour. (DSM V, 2013)

Since lack of remorse or guilt emanating from lack of empathy and no concern about school or work performance are associated with the disorder, it is tough to persuade them to start treatment. With limited prosocial emotions, insensitivity to punishment and thrill seeking in troubling others, it is tough to bring change in them.

The multi-systemic therapy is imparted in the family environment to the adolescents with conduct problems. It combines intensive case management in the home setting with family interventions, and this has been found to be cost effective. Psychoeducational intervention to inculcate social skills, address conflict

resolution and anger control skills to target adolescents and parents are found to be helpful. (Sagar et al., 2019, p. 270)

Cognitive behavioural skill training has also been intended to address the social cognition deficit and to improve problem-solving skills in the social context in children and adolescents with CD. Most of these programs teach the skills to decrease impulsivity and an angry response. This approach mainly consists of problem-solving steps, for example, how to recognise problems, how to consider alternative responses, and how to select the adaptive one to deal more effectively with the problems in hand. In this approach, the therapist plays an active role, modeling the skills being taught, role-playing social situations with the child, prompting the use of skills being taught, and delivering feedback and praise for developing the skills. (Sagar et al., 2019, p. 270)

The above discussed clinical interventions for treatment generally include the psychosocial model of behavioural training which takes a long time with multiple sessions with parents or care takers. Whereas, ReAttach Therapy focusses on the individual and brings change in a short period of time, if successful. The significant others and the environment can be managed through Psychoeducation. Therefore, ReAttach Therapy seemed to be the viable alternative for intervention.

2. Objective

The aim of this study is to find out the effectiveness of ReAttach therapy in the treatment and management of Conduct Disorder in an adolescent.

3. Method

3.1 Case Report

A 13 year old adolescent living in a children's home was brought in with chief complaints of destructive behaviour in the form of rubbing and smearing fecal material on others' clothes in the almshouses and on the walls of the children's home. He was violent and showed bouts of physical aggression towards other children in the school, as well as in the children's home. When contradicted, he would throw temper tantrum and disobey without fear. He would steal and snatch things while threatening or beating the other children. When caught doing such behaviours, he would lie and argue with a figure of authority. He would often deliberately do things that annoy other people and often blamed others for his own mistakes. He showed frequent cruelty towards stray an-

imals. He had been spiteful or vindictive and frequently initiated physical fights with fellow children for the past year.

Very recently in school, he attacked a student on the head with a brick injuring him, and a police complaint was launched by the parents of the injured boy. Because of his behaviour, he has been socially isolated making him angrier and more spiteful. He showed temper tantrums, and defiance towards authority, no feeling of remorse, and disobeyed rules of the children's home. He had poor academic performance and couldn't concentrate on his studies.

The patient had an age appropriate build with strong muscular hands and arms. He was neatly dressed with average hygiene. He gave apprehensive looks initially, but settled down after sometime. He showed an anxious disposition and spoke in a hurry as if to defend himself, making his voice shaky. His intelligence was below average, and he had a good memory. No other mental health issues were detected.

Family history revealed that his mother had some psychiatric problems. She was raped when she was 14 years old and gave birth to this boy. He never knew who his father was, but, does ask about his mother now and then. He has no other known relatives. He had lived in a children's home for some years. Later he came to this children's home and has been living here for the past few years. No other information could be elicited about his family. He has been quiet initially, but for the past two years, there has been a drastic change in his behaviour. Picking fights, hurting others, lack of fear for authority figures, and not following the rules has been some of the dominant behaviours. Many other maladaptive behaviours and other symptoms mentioned above appeared during the past year.

Risk factors in the case of the Adolescent may have been a genetic predisposition from parental source, probable exposure to adverse childhood experiences, inconsistent caregivers, turbulent or unstable upbringing, lack of stable emotional anchor and consistent environment could be the reasons for precipitation and manifestation of the symptomology. Since there was no access to his prenatal, perinatal, postnatal or the childhood history, no other factor could be taken in to consideration.

The patient was assessed for diagnosis by the following tools.

3.2 Assessment Tools

Initial session was devoted to the history taking and clinical interview. Then patient was assessed with the help of two evaluations. One through Core Symptoms Evaluation and another comprehensive evaluation for symptomology of Conduct Disorder by DSM-V.

1) Core Symptoms Evaluation – Reattach therapy Institute.

It is a 35 items self-report evaluation with rating scale of 0-5, based on the thoughts or problems that someone might experience and how much these thoughts and problems affect you. The evaluation is calculated on subscales of

- Risky behaviour
- Short Symptom Inventory
- Happiness
- Total score

It gives a comprehensive measurement of symptomology instead of compartmentalised, narrow, disorder-based psychopathology.

2) Conduct Disorder Rating Scale – Parents’ form (in this case filled by ‘Mother Manager’ and guardian of the Children’s home), and a Teacher’s form.

The rating Scale has 20 items on the parents’ form, and 15 items on the teacher’s form that describe the child’s behaviour in three domains of his life, i.e. home, school and playground for the past 12 months. (Waschbusch & Elgar, 2007). The assessment confirmed the diagnosis as Conduct Disorder with comorbidity of anxious predisposition. The

patient was assessed with the above-mentioned evaluations to record pre and post therapy assessment for symptomology of Conduct Disorder.

Diagnosis: Conduct Disorder 312.82 (F 91.2) Adolescent onset type

3.3 Intervention

ReAttach therapy was planned for the patient with five ReAttach sessions to be given. The patient was slightly perturbed during the first session, but later was cooperative and receptive during the next four sessions. The intervention may work well for the patient, but for the immediate environment, psychoeducation helps in accepting and recognising the change in the patient. For this purpose, the ‘Mother Manager’ and other care takers were psycho-educated about his condition and were told to be considerate and patient with him. Special attention was suggested for his studies. Other children of his age were also psycho-educated so that during recovery he’d not feel socially isolated. His teacher was also psycho-educated through his care taker to provide conducive environment for change happening within him.

4. Results

Assessments for both pre therapy and post therapy intervention are given in two tables, Table 1 and Table 2. Results of Core Symptoms Evaluation – Reattach are given in table 1 and Conduct Disorder Rating Scale results are provided in Table 2.

Table 1

Results of Core Symptoms Evaluation – Reattach

S.no	Test Condition	Cluster-1 Risky behaviour	Cluster-2 Short Symptom Inventory	Cluster-3 Happiness	Cluster-4 Total score
1.	Pre-Therapy	12	24	01	82
2.	Post-Therapy	01	03	04	07

Table 2

Results for Conduct Disorder Rating Scale

S.no	Rating Scale assessment type	Pre-Therapy Symptoms	Post Therapy Symptoms	Present Observa- tion
1.	Parents/Caretaker form	Moderate to Severe	Nil	Improvement in behaviour Present
2.	Teacher’s form	Moderate to Severe	Nil	No symptoms pre- sent

As validated by the results given in table 1 and table 2, Post therapy assessments indicate a subjective and objective improvement in his behaviour, thoughts, and emotional reactions after 5 sessions of ReAttach therapy.

5. Discussion

Conduct disorder is more prevalent among children and adolescents from families living in poverty and of low socio-economic status. Since the patient has had a turbulent past and probable genetic predisposition for mental illness, the symptomology ranged from moderate to severe with 11 symptoms present out of 15, which increased the probable risk of developing antisocial behaviour in adulthood. The number of Conduct Disorder symptoms present prior to age 15 significantly increased the risk of serious assaults over the lifespan, aggressive behaviour in the past 6 months, and violent crime after controlling for alcohol and illicit drug use. (Hodgins et al., 2007)

The intervention in form of ReAttach therapy, used in the present scenario of Conduct disorder can be explained on the basis of the following theories and principles along with its major elements.

5.1 Physiological aspect of Conduct Disorder

Studies have shown that individuals with conduct disorder, antisocial behaviours, and aggression often demonstrate many signs of physiological under arousal and decreased sensitivity to stress.

Arousal theory hypothesises that low levels of arousal are related to conduct problems in two ways.

Sensation-seeking theory (Zuckerman & Neeb, 1979) argues that low physiological arousal is a constant and unpleasant state for antisocial individuals. As such, risk-taking activity including aggression and conduct problem behaviours are considered a mode of sensation seeking through which the individual seeks to normalise or optimise arousal levels.

Fearlessness theory (Raine, A., 1993) says that low levels of physiological arousal indicates towards the markers of decreased sensitivity to fear leading to no fear of punishment. A lack of fear and anxiety in childhood to cues of social punishment may contribute to disturbed fear conditioning, the preferential use of aggression to solve interpersonal conflicts, and a lack of moral and conscience development in antisocial individuals (Sadock, 2009).

When physiological factors such as low resting heart rate are combined with environmental risk factors such as having a teenage mother, or being economi-

cally disadvantaged, as was true in case of this patient, the risk for antisocial behavior becomes much greater in adulthood.

5.2 Mental Imagery and Conduct Disorder

Scientific interest in mental imagery dates back to the 19th century (Galton, F, 1880). Peter Lang was one of the first scientists to formulate a testable theory of emotion-inducing mental imagery (Lang, 1977). This theory of emotional imagery was originally developed to explain the role of mental imagery in facilitating behavioral fear extinction in imaginal exposure therapy (Lang, 1979). But the usage of mental imagery for emulation has also been described. Emulation is defined as the episodic construction of a hypothetical scenario that simulates not only perceptual information about an event, but also rich semantic and affective information about plausible causes and consequences of the imagined scenarios (Moulton & Kosslyn, 2009). There have been some more recent theories which have indicated to a larger role mental imagery can play in planning, problem solving, and self-regulation (Gilbert and Wilson, 2007, SuddenDorf and Corballis, 2007, Taylor et al., 1998).

Mental imagery named as **mentalization** has been used as basic element in Cognitive Bias Modification during ReAttach Therapy as an effective model (Bartholomeus, 2018).

5.3 ReAttach intervention and Conduct Disorder

This intervention has been found to be the most effective treatment in this case study. Since this adolescent was defiant, destructive, aggressive, prone to lying and making up false stories, his therapeutic intervention through linear analytic verbal techniques and mainstream behavioural interventions may not have brought holistic and comprehensive effectiveness.

The ReAttach Therapy is an effective and tailor-made intervention, which works wonders by combining major elements like, controlling physiological arousal by tapping, mental imagery in form of Cognitive Bias Modification through mentalisation, and restructuring of maladaptive schemas through CBM. There are six basic steps of ReAttach (Bartholomeus, 2018):

- Proactive Arousal and Oxytocin regulation
- Joint Attention: for Creating connection.
- Multiple Sensory Processing.

- Social Cognitive Training for self and relationships
- Improving connectivity within the default mode network (DMN)
- Cognitive Bias Modification: optimising attachment and mentalisation.

ReAttach therapy with Multi-Sensory Integration Processing by Cognitive Bias Modification opened up vast possibilities to capture intricate relationship between his maladaptive beliefs, facts, assumptions, emotions, thoughts and traumatic memories by providing access to his cognitive structures. (Bartholomeus, 2018). The distortion inherited in the schemas was identified and restructured by using the words and sensory inputs, which were integrated through CBMs and which worked holistically and extensively in his treatment. During optimal arousal in ReAttach, processing and differentiation of problematic schemas and pathological concepts occurs. Once processed, the psychopathology caused by those schemas reduces. (Bartholomeus, 2015).

The effectiveness of ReAttach therapy has been proved again, as during the intervention, combining tactile sensory input at the time of optimal arousal, mental imagery was introduced where the patient imagined himself in the best of behaviour with others and he found happiness in helping others and doing things for others.

When new positive experiences and skills were added with verbal instructions, along with mental imagery, during the phase of optimal arousal, it may have led to self-regulation as well as perception of a new experience of seeing himself in a different behaviour and consequences. In relation to Lang's original postulation that 'Only mental imagery has the capacity to activate physiological and behavioural response systems', the added stimulus through tapping along with verbal input worked wonders and helped him to integrate those experiences in day to day life, and led him to manage himself in a better way.

This intervention brought changes in his behaviour patters. He started volunteering to help in the community kitchen, bringing flowers for decoration and helping other children with their work. He took up the responsibility of watering the garden and looking after the plants.

After five sessions, his anxious predisposition had improved. Although, he is still lagging behind in his studies, his concentration whilst studying has improved slightly. Presently, he is being given personal

attention and extra study hours at the children's home.

This intervention also helped the patient in development of Theory of Mind. When earlier he was socially isolated due to lack of empathy, as he had no understanding for other's feelings, thoughts, reasons, and needs. Now he has developed a positive feeling of attachment towards the 'Mother Manager' and caretaker as well as other children in the home.

6. Conclusion

The ReAttach intervention has proved to be an effective intervention in this case. There has been a considerable improvement in the behaviour pattern of the patient which has paved way to his better integration and adjustment in the present environment, and opened the door to a better life for him in the future where he could become a well-adjusted and positive contributing member in society.

7. Limitation of the study

This being a single case study, the results can only be validated when more such interventions might bring equivalent results. There may have been many unknown factors which played a role in effective treatment of the patient.

8. Future directions

The effectiveness of ReAttach Therapy may be further studied on Oppositional Defiance Disorder as well as Conduct Disorder to avoid long term damage to the underprivileged population, so that they can lead an effective life, and be a contributing member of society.

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Conflict of interests

The author declares no conflict of interests.

References

- Bechara, A., Damasio, A. R., Damasio, H., & Anderson, S. W. (1994). Insensitivity to future con-

- sequences following damage to human prefrontal cortex. *Cognition*, 50(1–3), 7–15. [https://doi.org/10.1016/0010-0277\(94\)90018-3](https://doi.org/10.1016/0010-0277(94)90018-3)
- Brewer, W. F., & Schommer-Aikins, M. (2006). Scientists Are Not Deficient in Mental Imagery: Galton Revised. *Review of General Psychology*, 10(2), 130–146. <https://doi.org/10.1037/1089-2680.10.2.130>
- Diagnostic and statistical manual of mental disorders. (2013). Am Psychiatric Assoc.
- Gilbert, D. T., & Wilson, T. D. (2007). Prospection: Experiencing the Future. *Science*, 317(5843), 1351–1354. <https://doi.org/10.1126/science.1144161>
- Hodgins, S., Cree, A., Alderton, J., & Mak, T. (2007). From conduct disorder to severe mental illness: associations with aggressive behaviour, crime and victimization. *Psychological Medicine*, 38(7), 975–987. <https://doi.org/10.1017/s0033291707002164>
- Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior Juvenile Diagnoses in Adults with Mental Disorder. *Archives of General Psychiatry*, 60(7), 709. <https://doi.org/10.1001/archpsyc.60.7.709>
- Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy*, 8(5), 862–886. [https://doi.org/10.1016/S0005-7894\(77\)80157-3](https://doi.org/10.1016/S0005-7894(77)80157-3)
- Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, 16(6), 495–512. <https://doi.org/10.1111/j.1469-8986.1979.tb01511.x>
- Loeber, R., Burke, J. D., Lahey, B. B., Winters, A., & Zera, M. (2000). Oppositional Defiant and Conduct Disorder: A Review of the Past 10 Years, Part I. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(12), 1468–1484. <https://doi.org/10.1097/00004583-200012000-00007>
- Mcardle, P., O'Brien, G., & Kolvin, I. (2002). Hyperactivity and conduct disorder: exploring origins. *Irish Journal of Psychological Medicine*, 19(2), 42–47. <https://doi.org/10.1017/s0790966700006935>
- Mental Disorders and Disabilities Among Low-Income Children. (2015). *Mental Disorders and Disabilities Among Low-Income Children*, 1–472. <https://doi.org/10.17226/21780>
- Mishra, N., Mishra, A., & Dwivedi, R. (2015). Prevalence Of Conduct Disorder In Primary School Children Of Rural Area. *Journal of Evolution of Medical and Dental Sciences*, 04(12), 1917–1922. <https://doi.org/10.14260/jemds/2015/278>
- Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002). Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. *Development and Psychopathology*, 14(1), 179–207. <https://doi.org/10.1017/s0954579402001104>
- Moulton, S. T., & Kosslyn, S. M. (2009). Imagining predictions: mental imagery as mental emulation. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 364(1521), 1273–1280. <https://doi.org/10.1098/rstb.2008.0314>
- Paris: Institut national de la santé et de la recherche médicale. (2005). *Conduct: Disorder in children and adolescents*. INSERM Collective Expertise Centre. <https://www.ncbi.nlm.nih.gov/books/NBK7133/?report=reader>
- Patel, R., Amaravadi, N., Bhullar, H., Lekireddy, J., & Win, H. (2018). Understanding the Demographic Predictors and Associated Comorbidities in Children Hospitalized with Conduct Disorder. *Behavioral Sciences*, 8(9), 80. <https://doi.org/10.3390/bs8090080>
- Paula Weerkamp-Bartholomeus. (2018). *Autism: is there a place for ReAttach therapy? A promotion of natural self-healing through emotions rewiring (978th-88th-98991st-71st-6 ed. ed.)*. Giovanni Fioriti Editore s.r.l.
- Raine, A. (1993). *The psychopathology of crime: criminal behavior as a clinical disorder*. Academic Press;
- Saddok, V. A. (2009). *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. Kaplan & Sadock's Comprehensive Textbook of Psychiatry.
- Sagar, R., Patra, B. N., & Patil, V. (2019). Clinical Practice Guidelines for the management of conduct disorder. *Indian journal of psychiatry*, 61(Suppl 2), 270–276. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_539_18

- Scott, S. (2008). An update on interventions for conduct disorder. *Advances in Psychiatric Treatment, 14*(1), 61–70.
<https://doi.org/10.1192/apt.bp.106.002626>
- Suddendorf, T., & Corballis, M. C. (2007). The evolution of foresight: What is mental time travel, and is it unique to humans? *Behavioral and Brain Sciences, 30*(3), 299–313.
<https://doi.org/10.1017/s0140525x07001975>
- Taylor, S. E., Pham, L. B., Rivkin, I. D., & Armor, D. A. (1998). Harnessing the imagination: Mental simulation, self-regulation, and coping. *American Psychologist, 53*(4), 429–439.
<https://doi.org/10.1037/0003-066x.53.4.429>
- Waschbusch, D. A., & Elgar, F. J. (2007). Development and Validation of the Conduct Disorder Rating Scale. *Assessment, 14*(1), 65–74.
<https://doi.org/10.1177/1073191106289908>
- Zuckerman, M., & Neeb, M. (1979). Sensation seeking and psychopathology. *Psychiatry Research, 1*(3), 255–264.
[https://doi.org/10.1016/0165-1781\(79\)90007-6](https://doi.org/10.1016/0165-1781(79)90007-6)