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The Treatment of Conduct Problems in Children With Callous–Unemotional Traits

David J. Hawes and Mark R. Dadds
University of New South Wales

The aim of this study was to examine the impact of callous–unemotional (CU) traits on treatment outcomes and processes in a 10-week behavioral parent-training intervention with young boys referred for conduct problems ($N = 56$; mean age 6.29 years). CU traits were associated with greater conduct problems at pretreatment and with poor outcomes at 6-month follow-up. CU traits uniquely predicted clinical outcomes when analyzed in relation to conduct-problem severity, other predictors of antisocial behavior, and parents' implementation of treatment. Boys with high CU traits were less responsive to discipline with time-out than boys without CU traits and reacted to this discipline with less affect. These findings present important implications for the role of child temperament in intervention for conduct problems.

Keywords: Callous–unemotional traits, conduct problems, temperament, parent training, treatment

Parent training is considered highly effective in the treatment of conduct problems, especially when intervention is early and families are not overwhelmed by social adversity (Brestan & Eyberg, 1998). Relatively little is known however about child risk factors relevant to the poor treatment response typically seen in one third of treated cases (Beauchaine, Webster-Stratton, & Reid, 2005). In recent years, the construct of psychopathy has become influential in developmental models of antisocial behavior, with research showing that conduct-disordered children characterized by callous–unemotional (CU) traits (e.g., limited empathy and guilt, constricted emotionality) demonstrate a particularly severe and chronic pattern of antisocial behavior, as well as a number of characteristics consistent with adult psychopathy (Frick et al., 2003). The purpose of this study was to examine the impact of CU traits on the effectiveness of parent training and to identify the processes through which these traits may influence clinical outcomes.

The potential for CU traits to have an impact on the treatment of conduct problems is indicated in a range of evidence. Developmental research has found that CU traits moderate the relationship between parenting practices and conduct problems. In a clinical sample of conduct-problem boys (aged 6–13 years), Wootton, Frick, Shelton, and Silverthorn (1997) reported that poor parenting was associated with conduct problems only in boys without high CU traits, a finding since replicated in a mixed-sex sample (Oxford, Cavell, & Hughes, 2003). Recent evidence of heritability from twin research is consistent with this finding. In a representative sample of 7-year-old twins, Viding, Blair, Moffitt, and Plomin (2004) compared conduct-problem children exhibiting high versus low levels of CU traits. For those with high CU traits, genetic influence was found to be high relative to that of shared environment, whereas for conduct-problem children low in CU, only moderate influence was seen for both genetics and shared environment. Although childhood CU traits have not been evaluated directly in clinical trials, evidence that children with comorbid features of anxiety/depression benefit more from parent training than those without this comorbidity (Beauchaine, Gartner, & Hagen, 2000; Beauchaine et al., 2005) is consistent with the proposition that CU traits moderate the effectiveness of parent training. That is, children with features of anxiety/depression match the profile of emotional dysregulation associated with low-CU conduct-problem children, for whom aggression is not typically instrumental or proactive but rather impulsive and reactive (Frick & Morris, 2004). Finally, although findings from adult forensic research cannot be simply generalized to clinical child populations, evidence that psychopathic offenders benefit less from correctional treatments than do nonpsychopathic offenders (e.g., Ogloff, Wong, & Greenwood, 1990) is consistent with the notion that CU traits limit the responsiveness of antisocial behavior to intervention.

There is also reason to speculate that CU traits may influence treatment processes important to parent training. Children with conduct problems and high levels of CU traits exhibit temperamental correlates indicative of reward-driven and punishment-insensitive behavior patterns. Laboratory research has shown these children to exhibit reduced sensitivity to cues of punishment once a reward-orientated response set is primed and reduced reactivity to threatening and emotionally distressing stimuli (Blair, 1999; Frick et al., 2003). The high reward drive and low fearful inhibitions characteristic of these children suggest that, compared with conduct-problem children without these traits, they respond well to the reward-based components of parent training (e.g., praise, token reinforcement) yet are relatively insensitive to the disciplinary components (e.g., time-out, response cost).

David J. Hawes and Mark R. Dadds, School of Psychology, University of New South Wales, Sydney, New South Wales, Australia.

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Correspondence concerning this article should be addressed to David J. Hawes, School of Psychology, University of New South Wales, Sydney, NSW Australia 2052. E-mail: D.Hawes@unsw.edu.au

The aim of this study was to assess the relationship of childhood CU traits to clinical outcomes and treatment processes in a sample of young boys with conduct problems in a parent-training intervention. It was hypothesized first that CU traits would be positively associated with the severity of presenting conduct problems in young boys referred to treatment. Participants high in CU traits were predicted to demonstrate fewer improvements at follow-up than those with low CU after controlling for pretreatment conduct problems, socioeconomic status, age, and treatment dose. On the basis of the known correlates of CU traits, it was hypothesized that boys with high CU traits would be more responsive to treatment components based on reward than those imposing discipline (e.g., time-out) and that boys with CU traits would exhibit reduced negative affect in reaction to this discipline.

Method

Participants

Treatment was conducted in the psychology clinics of two universities in Brisbane, Australia, and Sydney, Australia. Participants self-referred or were referred by community health services between April 2002 and October 2003. Participants were boys aged 4 to 8 years who met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) criteria for either oppositional defiant disorder (ODD) or conduct disorder. Children receiving concurrent psychological treatment were not eligible, nor were those with developmental disabilities. To focus on conduct problems most suited to behavioral (rather than pharmacological) intervention, we excluded cases with primary diagnoses of attention-deficit/hyperactivity disorder (ADHD). Secondary features of ADHD were permitted if currently medicated.[1]

Fifty-six families commenced treatment, with the target children having a mean age of 6.29 years ($SD = 1.55$). Total family income (in Australian dollars) ranged from less than $20,000 (7%), $20,000–$30,000 (12%), $30,000–$50,000 (26%), to over $50,000 (55%). Education in parents ranged from junior certificate (16%) through a mode of "finished high school" (40%), to university educated (31%). The majority of families (76%) consisted of two caregivers. Six families dropped out of treatment within the first three sessions, and the data from one further case were excluded because of marital stress requiring a significant deviation from the treatment protocol. The intention to treatment sample ($N = 56$) was split into completer ($n = 49$) and noncompleter ($n = 7$) groups and compared across demographic variables, child age, and pretreatment conduct-problem measures in a multivariate analysis of variance. As no between-groups differences were found, noncompleters were excluded from statistical analysis.

Measures

Diagnostic interviews. Diagnostic interviews were conducted using the Diagnostic Interview Schedule for Children, Adolescents, and Parents (DISCAP; Holland & Dadds, 1997). ODD diagnosis at follow-up was the primary treatment-outcome measure, and ODD symptom severity a secondary measure. Thirty percent of interviews were conducted by two independent interviewers to check interrater reliability.

Home observations. Each family was visited in its home on four occasions during treatment and observed in structured play interactions (0.5 hr) as well as during its typical dinner routine (0.5 hr) at each visit (i.e., a total of 4 hr across treatment). Observational data were collected using the Behavioral Observation Coding System: Family Observation Schedule (5th ed.; Dadds & McHugh, 1992). Variables calculated from the raw data included child deviant behavior, harsh/aversive parent behavior, and two treatment implementation variables, use of descriptive praise and correct implementation of discipline techniques. One third of all observations were recorded by two observers to examine interrater reliability.

Parent-report measures. Child CU traits and antisocial behavior were assessed using items from the Antisocial Process Screening Device (APSD; Frick & Hare, 2002), a measure of psychopathy-like features in childhood, and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), a measure of general child psychopathology established as valid and reliable in Australian children (Hawes & Dadds, 2004). CU traits were assessed using the pooled items of both measures, a method previously validated with children aged 4–9 years (Dadds, Fraser, Frost, & Hawes, 2005). In a representative sample of community children, Dadds et al. (2005) factor analyzed the pooled items from the APSD and SDQ, producing distinct CU and Antisocial factors. Consistent with the theoretical bases of these constructs, the CU factor demonstrated some overlap with the general Antisocial factor but predicted growth in conduct problems over a 12-month period independent of Time 1 Antisocial scores. The validity of this joint ASPD–SDQ measurement structure has also been supported in twin research showing substantial genetic risk for CU traits in 7-year-old children (Viding et al., 2004). The CU and Antisocial factors produced for the current sample were found to be more reliable than the corresponding original subscales of the APSD. Alphas for these factors were as follows: CU traits $\alpha = .79$, Antisocial $\alpha = .78$, compared with alphas of .57 and .66, respectively, for the original APSD subscales.

Behavior-monitoring scales. A number of parent-report scales were developed for the purpose of monitoring child behavior and affect in response to the behavioral strategies introduced during treatment (e.g., "Which of the following best describes your child when he is going into time-out? Calm, Angry, Scared, Sad"), as well as parent implementation of these strategies ("During the time spent with your child in the last week, how often have you used the reward strategies?").

Procedure

Following a telephone screening interview in which inclusion criteria were addressed and the ODD component of the DISCAP administered, eligible families attended an initial assessment session. During this session, a comprehensive diagnostic interview was conducted, including full administration of the DISCAP to confirm the screening diagnosis and identify additional psychopathology relevant to the inclusion criteria (e.g., developmental delay, ADHD). The parent-report measures were also completed at this time, as were the first set of the behavior- and treatment-process-monitoring scales and the first home observation assessment. Informed consent was also obtained. The subsequent home observations occurred following the introduction of reward strategies (Week 3) and discipline strategies (Week 5) and at posttreatment. The monitoring scales were administered at these same time points. Posttreatment assessment also included pretreatment parent-report measures and a diagnostic interview.

Diagnostic interviews were administered by phone by a clinician unfamiliar with the target child, as were the behavior-monitoring scales. Follow-up assessment was conducted at 6 months, with the entire assessment battery repeated minus the observational component. At all times, therapists and assessment staff were unaware of measures of participants' CU traits, as were participating families.

Treatment consisted of a fully manualized parent-training intervention based on the empirically validated intervention by Sanders and Dadds (1993). The intervention commenced with a 1.5-hr assessment session with parents, followed by nine weekly 1-hr sessions. Treatment was conducted

[1] This criterion applied to three participants in the sample. The results of the substantive analyses did not change when the data from these cases were excluded, indicating that medication status was not a confounding factor in the study.

by clinical psychologists with at least 1 year of clinical experience in child and family therapy.

Treatment integrity was monitored using therapist self-report scales previously developed and validated for use in controlled trials involving multiple therapists (e.g., Barrett, Dadds, & Rapee, 1996). These scales assessed adherence to each session plan, knowledge of session material, interpersonal effectiveness, and participant engagement and comprehension. Ratings were monitored by the project coordinator in supervision sessions, with any reports of deviation from the treatment protocol or related problems addressed directly with the clinician. Using this method, we excluded one case from the sample because of an excessive departure from the treatment protocol due to the parents' concurrent marital stress.

Results

Interrater reliability for the diagnostic interviews was high, with Cohen's kappa values of 1 at both posttreatment and follow-up indicating perfect agreement between interrater diagnoses. Strong correlations were also seen between interrater diagnostic severity ratings at posttreatment ($r = .90$) and follow-up ($r = .98$). Interrater reliability for the observational assessments was also high, with interrater data correlating $r = .71$ for observations of deviant child behavior, $r = .80$ for aversive parent behavior, $r = .78$ for correct implementation of discipline strategies, and $r = .79$ for correct implementation of descriptive praise (the primary reward strategy).

Antisocial factor scores from the joint APSD–SDQ measurement structure correlated significantly with both ODD severity as assessed by diagnostic interview ($r = .41$, $p < .01$) and severity of child deviant behavior assessed in observation of parent–child play ($r = .31$, $p < .05$). The convergence between these forms of assessment (self-report, diagnostic interview, direct observation) supports the validity of these measures of conduct problems.

Table 1 shows means and standard deviations for the joint APSD–SDQ factor scales across time. Because of the distinct developmental stages represented in the sample, we calculated internal reliability coefficients separately for boys aged 4–5 years and 6–8 years and found them to be satisfactory. These are shown in Table 1, as are means for ODD symptom severity across time. The rate of ODD diagnosis fell to 19% on completion of treatment, with subsequent relapse among the sample seeing 35% diagnosed at 6-month follow-up. This posttreatment rate of diagnosis is typical of research reports of immediate treatment effectiveness, as is the subsequent response rate of 65% at follow-up (e.g., Webster-Stratton & Hammond, 1997).

The hypothesis that CU traits would be positively associated with severity of presenting conduct problems was tested with bivariate correlations between CU, Antisocial, and ODD severity ratings. A positive relationship between pretreatment CU and conduct problems was seen for both measures, with CU correlating significantly with both Antisocial scores ($r = .43$, $p < .01$) and ODD severity ($r = .31$, $p < .05$).

To examine the effects of CU traits on treatment outcomes, we conducted a logistic regression. Contributions to the prediction of diagnostic status at follow-up were tested for a set of background predictor variables (mother's education, child age, pretreatment severity of ODD, number of sessions attended), along with pretreatment CU scores. For each predictor variable, the logit coefficient (B), its standard error, the Wald statistic, and the odds ratio (Exp B) are reported in Table 2. Higher CU scores increased the likelihood of an ODD diagnosis at follow-up ($B = 0.46$, $p < .05$), as did being older ($B = 0.07$, $p < .01$) and receiving more treatment sessions ($B = 1.05$, $p < .05$). This effect for treatment dose is consistent with the assigning of additional sessions (limited to three) on the basis of poor parent functioning.

To test whether variance in clinical outcomes could be explained by parents' implementation of the child management strategies, we added a further step to the same regression model. This step consisted of implementation variables based on observational data across treatment. These three variables were the total amount of correctly implemented descriptive praise, the total amount of correctly implemented time-out, and the total amount of harsh/aversive parenting. None of these variables added significant contributions to the prediction of follow-up outcomes beyond those predicted by the original set. With the addition of this block, CU traits and number of sessions remained significant, with only child age becoming nonsignificant (see Table 2). CU traits therefore predicted treatment outcomes independently of these previously established predictor variables and parent's implementation of treatment.

The relative effectiveness of the reward versus time-out treatment components in relation to CU traits was examined next. Partial correlations were calculated between CU traits and parents' ratings of the overall effectiveness of the reward strategies and time-out, controlling for ODD severity at pre- and posttreatment, as well as implementation variables based on observations of parents' correct use of descriptive praise and time-out. CU traits correlated with parent ratings of ineffectiveness for time-out ($r =$

Table 1
Means and Standard Deviations for Joint Factor Scales in the Treatment and Community Samples and Severity of ODD Symptoms Across Time

	Pretreatment		Posttreatment		Follow-up			
New factor scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	4–5 years ($n = 22$) coefficient alpha	6–8 years ($n = 27$) coefficient alpha
Antisocial	10.60	4.53	8.71	4.89	7.77	4.58	.82	.76
Anxiety	2.54	2.10	1.89	1.63	1.57	1.96	.59	.71
CU traits	9.42	3.31	7.78	3.36	7.39	3.79	.71	.83
Hyperactivity	11.83	3.40	10.71	3.18	10.11	4.14	.70	.79
Peer problems	2.67	2.07	2.67	1.81	2.16	1.92	.67	.53
ODD severity	3.92	0.84	0.81	1.63	1.41	1.88		

Note. CU = callous–unemotional; ODD = oppositional defiant disorder.

Table 2
Logistic Regression Predicting Diagnostic Status at Follow-Up From Pretreatment Variables

	Block 1				Block 2			
Variable	B	*SE*	Wald	Exp B	B	*SE*	Wald	Exp B
Mother education	−0.72	0.40	3.14	0.48	−0.68	0.51	1.79	0.50
Pretreatment ODD severity	0.30	0.61	0.24	1.35	0.28	0.81	0.12	1.08
Number of sessions	1.05	0.37	7.72	2.86**	1.30	0.48	7.23	3.69**
Child age	0.07	0.03	6.45	1.08*	0.07	0.04	3.50	1.08
CU factor	0.46	2.05	5.10	1.59*	0.51	0.24	4.31	1.67*
Correct praise					−0.27	0.16	2.77	0.75
Correct time-out					−0.02	0.03	0.88	0.97
Harsh/aversive parenting					0.02	0.09	0.07	1.02

Note. Wald = the Wald statistic; Exp B = odds ratio; ODD = oppositional defiant disorder; CU = callous–unemotional.
* $p < .05$. ** $p < .01$.

.31, $p < .02$, $n = 38$) but not with reward strategies ($r = .08$, $p < .29$, $n = 38$). Thus, parents found time-out to be less effective for boys with high CU traits regardless of how correctly the strategies were implemented or the severity of the child's conduct problems.

The relationship between CU traits and children's affective reactions to being placed in time-out was examined using partial correlations between CU traits and parents' ratings of child affect at midtreatment, posttreatment, and follow-up. The three negative-affect categories (anger, sadness, fear) were collapsed into a dichotomous negative/neutral-affect variable. As parents reported child affect only when time-out had been recently implemented, the number of cases represented at each time point varied. When we controlled for ODD severity at both pre- and posttreatment, parent-reported frequency of time-out implementation, and observed correctness of implementation, CU traits correlated negatively with displays of negative affect in children being placed in time-out at both posttreatment ($r = -.41$, $p < .03$, $n = 19$) and follow-up ($r = -.49$, $p < .001$, $n = 34$), but not at midtreatment ($r = -.03$, $p < .43$, $n = 21$).

Discussion

The aim of this study was to examine the impact of CU traits on treatment outcomes and processes in a parent-training intervention with young conduct-problem boys. As predicted, high levels of CU traits were associated with greater conduct-problem severity on presentation. In relation to treatment outcomes, it was hypothesized that participants high in CU traits would demonstrate poorer outcomes at follow-up than those low in CU traits. This prediction was supported, with diagnostic status at follow-up predicted from CU scores, independent of established predictors of antisocial behavior (e.g., parent education, child age) and parents' implementation of treatment.

Consistent with the predictions based on evidence of reward dominance in conduct-problem children with CU traits, parents found the disciplinary component of treatment (i.e., the time-out) to be more effective with low-CU boys than high-CU boys, whereas the effectiveness of the reward strategies (e.g., descriptive praise) was not contingent on CU traits. There was partial support for the prediction that CU traits would be associated with reduced affect in reaction to the implementation of time-out. Higher CU scores were associated with fewer displays of negative affect at two of three relevant time points (posttreatment and follow-up). It appears then that the risk for poor treatment outcomes associated with CU traits may be partly due to this relationship between CU traits and reduced responsiveness to time-out.

The findings of this study support the clinical utility of assessing CU traits in children presenting for conduct problems. Among clinic-referred conduct-problem children, those with high levels of CU traits appear to be at increased risk for poor outcomes. The assessment of CU traits in addition to other established risk factors may allow such children to be targeted with more individualized intervention. It should be noted however that among the children exhibiting high levels of CU traits at pretreatment, some exhibited a drop in CU scores across treatment. The monitoring of CU scores during treatment may therefore be clinically informative also, as the poorest outcomes were seen for participants whose CU scores were not only high but also stable.

Although the current findings should be considered tentative until replicated with other samples, they raise the question of how parent training might be adapted to target children with CU traits more effectively. One paradigm that may inform such developments is attachment, with recent research emphasizing the importance of positive attachment experiences to the development of conscience and pro-social behavior in children characterized by a fearless temperament (e.g., Dadds & Salmon, 2003; Fowles & Kochanska, 2000). It could be speculated that approaches focusing on rewarding experiences in the context of a positive parent–child relationship may hold the most promise for maximizing treatment gains for children with CU traits.

A number of limitations should be recognized when interpreting the findings of this study. First, the measurement of CU traits, as well as child responsiveness to the various treatment components, relied exclusively on parent report. Future research may benefit from additional measures (e.g., direct observation) of child affect and behavior in response to various parenting strategies, in addition to specific measures of the correlates of CU traits (e.g., punishment insensitivity) theorized to underlie the differential responsiveness to discipline strategies found. Participant factors that may limit the generalization of the current findings to broader clinical samples include the exclusion of cases with untreated ADHD comorbidity and the use of an exclusively male sample. Finally, although care was taken to evaluate the effects of CU traits

in relation to established predictors of antisocial behavior and treatment response, it is possible that CU traits were a proxy for some unmeasured variable.

In conclusion, CU traits were associated with a particularly severe pattern of presenting conduct problems but were uniquely related to poor treatment outcomes at follow-up. These findings indicate that the conduct problems of children high in CU traits may be less responsive to parenting practices than those with low CU traits and support a model of treatment in which child temperament is integrated with social learning principles.

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