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The Interplay of Parenting Styles and Attachment Patterns in the Development of Conduct Disorder: A Case Study

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ABSTRACT

Background: Conduct disorder (CD) is a severe behavioral condition in adolescents, often arising from insecure attachment patterns and maladaptive parenting. Despite extensive literature on its etiology, limited research exists examining these factors in real-life clinical settings, particularly within non-Western cultural contexts. This study addresses this gap by exploring how parenting styles and attachment disruptions contribute to CD and how targeted intervention can mitigate its symptoms. **Objective:** The study aimed to evaluate the interplay between attachment patterns and parenting styles in the development of conduct disorder in a 14-year-old boy and assess the effectiveness of a multimodal intervention on executive functioning and behavioral regulation. **Methods:** A single-subject observational case study design was utilized (n = 1). The participant was selected based on DSM-5 diagnostic criteria for CD, excluding those with comorbid neurodevelopmental disorders. Data were collected using standardized tools including the BRIEF, SPM, BGT, and CARS-2. The 12-session intervention integrated CBT, REBT, Play Therapy, and parental training. Pre- and post-intervention data were analyzed using SPSS v27, with descriptive comparisons of raw and T-scores across executive functioning domains. Ethical procedures adhered to the Declaration of Helsinki, with informed consent obtained from the participant's guardian. **Results:** Post-intervention, the participant showed clinically significant improvements across BRIEF domains: Inhibit (↓7 points), Emotional Control (↓9), and Monitor (↓7), reflecting enhanced impulse control, emotional regulation, and self-awareness. Cognitive deficits persisted (SPM = 5th percentile), but behavioral outbursts and emotional reactivity notably declined, suggesting therapeutic effectiveness. **Conclusion:** This study demonstrates that attachment-informed, family-centered interventions can significantly improve emotional and behavioral functioning in adolescents with CD. The findings support integrating parenting support and cognitive-behavioral strategies into early treatment protocols, with implications for scalable healthcare models and cross-cultural applications. **Keywords:** Conduct Disorder, Insecure Attachment, Parenting Styles, Executive Function, Cognitive Behavioral Therapy, Emotional Dysregulation, Adolescent Mental Health.

INTRODUCTION

Adolescence is widely recognized as a pivotal developmental phase, characterized by profound biological, cognitive, emotional, and social transformations. This period is associated with an increased vulnerability to behavioral disorders, including conduct disorder (CD), which is particularly concerning due to its long-term impact on psychosocial functioning and risk for adult psychopathology (1). Conduct disorder is marked by a persistent pattern of behavior that violates societal norms and the rights of others, encompassing aggression, deceitfulness, and rule violations (2). Although various etiological models attempt to explain the origins of CD, attachment theory has emerged as a

particularly compelling framework, emphasizing the role of early caregiver-child interactions in shaping socioemotional development and behavioral regulation (3).

Despite extensive research on conduct disorder, there remains a notable gap in understanding the nuanced interplay between parenting styles and attachment patterns in the disorder's manifestation and maintenance. While it is acknowledged that children exposed to neglectful or inconsistent parenting are at elevated risk, few studies have explored this relationship in applied clinical contexts, especially in non-Western settings. Furthermore, although insecure attachment has been linked to

emotional dysregulation and antisocial behavior, the mechanisms by which these early relational patterns contribute to the emergence of conduct-related symptoms require deeper exploration (4). Prior meta-analyses have underscored the predictive role of attachment disorganization in externalizing behaviors, yet the clinical implications of these findings have not been sufficiently integrated into therapeutic strategies (5).

The study at hand attempts to bridge this knowledge gap by presenting a detailed psychological case study of a 14-year-old boy, U.H., diagnosed with conduct disorder. Drawing on principles from attachment theory and developmental psychopathology, the research investigates how early life experiences—specifically parental loss, maternal emotional unavailability, and inconsistent caregiving—may have contributed to U.H.'s behavioral issues. The case exemplifies how disorganized attachment and maladaptive parenting practices coalesce to impair emotional regulation and social adaptation, which are core deficits in CD. By integrating clinical assessment data with evidence-based therapeutic interventions, the study also offers valuable insight into the potential for behavioral change through targeted psychological and parental strategies (6).

The justification for this case study lies in its relevance to both clinical practice and academic discourse. In particular, it highlights the critical need for early identification of attachment disturbances and the implementation of family-centered interventions that address both child behavior and parenting dynamics. Moreover, the study contextualizes its findings within the broader literature on executive dysfunction and neurodevelopmental vulnerabilities in CD, providing a comprehensive account of the disorder's biopsychosocial underpinnings (7). Through this investigation, the study aims to refine our understanding of the pathways leading to conduct disorder and to inform the design of more effective, relationship-focused therapeutic approaches.

Accordingly, the central research question guiding this inquiry is: How do attachment patterns and parenting styles interact to contribute to the development and maintenance of conduct disorder in adolescents? By addressing this question through a rich, longitudinal case study, the research seeks to enhance both theoretical frameworks and practical approaches for treating conduct disorder in complex clinical presentations.

MATERIALS AND METHODS

This study employed a single-subject case study design to explore the influence of attachment patterns and parenting styles on the development and management of conduct disorder in a 14-year-old adolescent boy, identified as U.H. The design facilitated an in-depth analysis of behavioral symptoms, familial dynamics, and therapeutic interventions over a defined treatment period. The participant, U.H., was referred by his mother to the Department of Clinical Psychology at a private university in Islamabad, following repeated episodes of aggression, defiance, and emotional dysregulation. Inclusion criteria for the study included: (1) formal diagnosis of conduct disorder as per DSM-5 criteria; (2) aged between 12–16 years; and (3) the availability of a primary caregiver for involvement in the intervention. Exclusion criteria included the presence of any neurodevelopmental disorders such as Autism

Spectrum Disorder, confirmed through the Childhood Autism Rating Scale – Second Edition (CARS-2), and any significant medical or neurological conditions that could affect cognition or behavior. Informed consent was obtained from U.H.'s mother prior to the initiation of the study, ensuring her understanding of the nature and scope of the intervention, and confidentiality of data was assured throughout the process.

Data collection encompassed both qualitative and quantitative approaches to comprehensively assess U.H.'s cognitive, emotional, and behavioral functioning. Pre- and post-intervention assessments were conducted to evaluate treatment outcomes. The primary outcome was a change in executive functioning and impulse control, measured using the Behavior Rating Inventory of Executive Function (BRIEF). Secondary outcomes included emotional regulation and behavioral adjustment, assessed through clinical interviews, behavioral observation, and standardized psychometric instruments. These included the Standard Progressive Matrices (SPM) to evaluate non-verbal intelligence, the Bender-Gestalt Test (BGT) for visual-motor integration, and the Human Figure Drawing (HFD) technique for emotional assessment. The BRIEF scores were tracked across eight subscales including Inhibit, Shift, Emotional Control, Initiate, Working Memory, Plan/Organize, Monitor, and Organization of Materials, administered before and after a 12-session therapeutic intervention.

The intervention spanned 12 in-person sessions with U.H. and included two structured parental training sessions. Therapeutic approaches integrated Cognitive Behavioral Therapy (CBT), Rational Emotive Behavior Therapy (REBT), Play Therapy techniques such as the Sandtray and Safety Hands activities, and mindfulness-based strategies including progressive muscle relaxation. Psychoeducation was delivered to the mother to support consistent application of therapeutic practices at home, including reinforcement strategies, structured routines, and emotion-labeling techniques. Behavioral modeling and positive reinforcement were employed to shape desired behaviors, and physical redirection exercises were used to channel excess energy productively. Therapeutic progress was continuously monitored through clinical observations and feedback from the mother and school staff.

The study adhered to the ethical principles outlined in the Declaration of Helsinki. Confidentiality of participant data was maintained through anonymization, and all records were securely stored. Informed consent was obtained from the caregiver, with clear communication regarding the voluntary nature of participation and the right to withdraw from the intervention at any point.

Statistical analysis was limited to descriptive comparisons of pre- and post-intervention scores, as is typical in single-subject case studies. Data were analyzed using SPSS version 27. BRIEF scores were interpreted using T-score ranges to evaluate clinical significance, with reductions indicating therapeutic gains. No imputation was required for missing data, as all assessments were completed in full. Given the design, confounding variables were controlled through detailed clinical profiling, consistent session

delivery, and inclusion of contextual factors in the interpretation of results (6).

RESULTS

This study assessed executive functioning in U.H., a 14-year-old adolescent with conduct disorder, using the Behavior Rating Inventory of Executive Function (BRIEF) before and after a 12-session therapeutic intervention. The assessment focused on impulse control, emotional regulation, and cognitive flexibility. Subscale raw scores and corresponding T-scores were used to evaluate clinical change. In addition, cognitive and visual-motor integration abilities were assessed using the Standard Progressive Matrices (SPM) and Bender-Gestalt Test (BGT).

Table 1. Pre- and Post-Intervention BRIEF Raw Scores and T-Scores

BRIEF Subscale	Pre Score	Pre T-Score	Post Score	Post T-Score	Change	Clinical Interpretation
Inhibit	27	78	20	65	↓7	Improved impulse control
Shift	22	74	17	60	↓5	Enhanced cognitive flexibility
Emotional Control	30	80	21	70	↓9	Improved emotional regulation
Initiate	18	70	14	55	↓4	Better task initiation
Working Memory	25	72	20	68	↓5	Moderate improvement in memory retention
Plan/Organize	23	75	18	65	↓5	Better organizational thinking
Monitor	26	77	19	68	↓7	Improved self-monitoring and awareness

Reductions in raw scores ranging from 4 to 9 points across domains are indicative of clinically significant changes, particularly in Emotional Control, Inhibit, and Monitor, where post-intervention scores moved from the clinical to borderline range. These gains reflect enhanced capacity for behavioral regulation and executive functioning.

Substantial improvements were observed across all BRIEF subscales post-intervention. Notably, the raw score for Inhibit decreased from 27 to 20, with a corresponding reduction in T-score from 78 to 65, reflecting enhanced impulse control. Emotional Control dropped from 30 to 21 (T-score 80 to 70), indicating improved affective regulation. Initiate improved from 18 to 14, suggesting better task engagement, while Shift declined from 22 to 17, showing improved cognitive flexibility. Working Memory, Plan/Organize, and Monitor all showed similar trends of clinically meaningful improvement, reflecting gains in attentional regulation and organizational capacity.

U.H.'s cognitive assessment showed continued below-average intellectual functioning, as reflected in his SPM score of 12, placing him in the 5th percentile. His BGT score of 6 indicated mild visual-motor integration deficits. These findings highlight persistent cognitive vulnerabilities that may moderate the pace of therapeutic gains.

Table 2. Cognitive and Visual-Motor Assessments

Measure	Raw Score	Percentile/Range	Interpretation
Standard Progressive Matrices	12	5th percentile	Below-average intellectual functioning
Bender-Gestalt Test	6	N/A	Mild visual-motor integration issues
CARS-2	14	Below ASD threshold	No indication of Autism Spectrum Disorder

Behavioral observations and caregiver feedback aligned with the psychometric improvements. U.H. showed reduced aggression, increased delay in response to provocation, and improved verbal emotional expression. The STOP technique, emotion labeling, and physical activity redirection strategies were successfully integrated into daily functioning. School and home reports noted a decline in disruptive behaviors and enhanced adaptability in structured settings.

DISCUSSION

The current case study presents a nuanced understanding of conduct disorder (CD) through the lens of attachment theory and executive functioning, offering clinical insights that resonate with established developmental psychopathology frameworks. The observed improvements in behavioral regulation, emotional control, and executive functioning following a structured multimodal intervention reinforce the conceptualization of CD as a disorder with both environmental and neurocognitive underpinnings. This finding aligns with the work of Fearon et al., who highlighted the role of insecure attachment in fostering

externalizing behaviors through disrupted emotional regulation pathways (1). The trajectory observed in U.H.'s case – marked by early relational trauma, inconsistent caregiving, and resultant executive deficits – provides a practical validation of these theoretical assertions.

Significant reductions in BRIEF subscale scores post-intervention demonstrate the therapeutic potential of integrative cognitive-behavioral approaches tailored to executive dysfunction. The clinical gains seen in impulse control, emotional regulation, and self-monitoring are consistent with past evidence supporting CBT and REBT for managing behavioral dysregulation in adolescents (2). Notably, the marked improvement in the Inhibit and Emotional Control domains post-treatment suggests that therapeutic strategies emphasizing impulse management, such as the STOP technique and cognitive restructuring, can produce meaningful neuropsychological changes in children with CD. These results substantiate earlier findings by Kendall and Braswell, who demonstrated that structured interventions targeting

maladaptive cognitions significantly reduce aggressive outbursts and improve prosocial functioning in similar populations (3).

The integration of parental training within the intervention model also mirrors conclusions from previous work indicating that caregiver involvement is essential in sustaining behavioral improvements (4). Freeze *et al.* emphasized the moderating role of parenting style, particularly emotional availability and consistency, in influencing treatment outcomes for youth with conduct problems (5). In the current study, the mother's increased use of positive reinforcement and emotional labeling techniques likely contributed to the child's improved behavioral regulation, highlighting the reciprocal relationship between parenting behavior and child psychopathology. This underscores the theoretical model proposed by Patterson *et al.*, wherein coercive family interactions act as a sustaining mechanism for externalizing disorders (6).

Nonetheless, certain limitations warrant consideration. As a single-subject design, the findings may not be generalizable across broader populations, and the absence of a control condition precludes causal inferences. Moreover, U.H.'s below-average cognitive profile, as indicated by SPM and BGT scores, likely moderated the pace and magnitude of improvement, necessitating longer-term and more cognitively accessible interventions for sustained change. This finding reflects the complexity described by Moffitt, who delineated neurocognitive deficits as key differentiators in life-course persistent versus adolescence-limited antisocial trajectories (7). Additionally, the time constraints imposed by the family's relocation, as well as the lack of involvement from the stepfather, limited the scope of family-based intervention strategies — an essential component in holistic CD management.

Despite these limitations, the study's strengths include its comprehensive assessment protocol, multimodal treatment integration, and clear pre-post outcome metrics. The use of standardized tools such as the BRIEF and SPM allows for clinically meaningful interpretation and reproducibility, enhancing the study's validity. Moreover, the therapeutic approach's adaptability to a culturally specific context — in this case, a South Asian family structure — extends the applicability of Western-based models of intervention to non-Western populations, contributing to the growing discourse on cultural sensitivity in clinical child psychology.

Future research should prioritize longitudinal follow-ups to assess the stability of therapeutic gains and the long-term impact of early interventions on conduct trajectories. There is also a need for studies involving larger, diverse cohorts to further elucidate the interaction between attachment insecurity, parenting behavior, and neurocognitive functioning in the etiology of conduct disorder. Multisite clinical trials evaluating tailored interventions for low-IQ or neurodevelopmentally at-risk populations may enhance our understanding of therapeutic thresholds and cognitive accessibility. Further exploration of paternal roles, especially in collectivist cultures, may offer additional insights into family-systemic influences on behavioral disorders.

In conclusion, this case contributes to a growing body of evidence that positions early, integrative, and family-centered intervention

as a critical component in addressing the complex presentation of conduct disorder. By demonstrating how targeted therapy can mitigate executive dysfunction and behavioral pathology, this study reinforces the clinical value of addressing both relational and neurocognitive factors in the treatment of externalizing disorders (8).

CONCLUSION

This case study underscores the pivotal role of parenting styles and attachment patterns in the development and maintenance of conduct disorder, highlighting how early relational disruptions and inconsistent caregiving contribute to emotional dysregulation and behavioral dysfunction. The observed improvements in U.H.'s executive functioning and behavioral regulation following a structured, multimodal intervention affirm the efficacy of integrated therapeutic approaches that incorporate cognitive-behavioral strategies and parental training. Clinically, these findings advocate for early identification of attachment disturbances and tailored interventions that engage caregivers to promote emotional sensitivity and secure attachment. For human healthcare, this reinforces the need for systemic, family-centered care models in managing conduct disorder. Future research should aim to generalize these findings through larger-scale, longitudinal studies, particularly in culturally diverse settings, to enhance the translational impact of attachment-based interventions in youth psychopathology.

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