Effectively treating conduct disorder through therapy

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Abstract
This research paper examined four types of treatment. Functional Family Therapy, Multisystemic, Parent Management Training and Problem-Solving Skill Training, for youth with Conduct Disorder. It looked at the core of how each treatment was facilitated along with some of the strengths and weakness of the different therapies. This paper also explored the cost-effectiveness rate for the different therapies. It suggested that less severe cases might benefit from some form of Parent Management Training or Functional Family Therapy. Cases that are more difficult may require Multisystemic Therapy (Brosnan & Carr, 2000). Problem-Solving Skills Training should be used with Parent Management Training to improve its success rate (Kazdin, Siegel, & Bass, 1992).
EFFECTIVELY TREATING CONDUCT DISORDER THROUGH THERAPY

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This research paper examined four types of treatment, Functional Family Therapy, Multisystemic, Parent Management Training and Problem-Solving Skill Training, for youth with Conduct Disorder. It looked at the core of how each treatment was facilitated along with some of the strengths and weaknesses of the different therapies. This paper also explored the cost-effectiveness rate for the different therapies. It suggested that less severe cases might benefit from some form of Parent Management Training or Functional Family Therapy. Cases that are more difficult may require Multisystemic Therapy (Brosnan & Carr, 2006). Problem-Solving Skills Training should be used with Parent Management Training to improve its success rate (Kazdin, Siegel, & Bass, 1992).
Effectively Treating Conduct Disorder Through Therapy

Children with Conduct disorder can be challenging for adults. Although only 3-5% of children diagnosed with Conduct Disorder are diagnosed with early-onset Conduct Disorder, they commit at least half of the illegal juvenile crimes. These children are challenging for therapists to treat (Children’s Mental Health Ontario, 2001). Thus, it is beneficial for therapists to be aware of four of the common treatments, Functional Family Therapy, Multisystemic Therapy, Parent Management Treatment, and Problem-Solving Skills Training, all of which research suggests may be effective treatments for children with Conduct Disorder.

Conduct Disorders

The primary traits of Conduct Disorder are behaviors that violate basic rights of others or significant rules and age-appropriate societal norms. To be diagnosed with Conduct Disorder, a child’s behaviors must fall into three of the following four categories within the past six months: aggressive conduct, deceitfulness/theft, and serious violation of rules (American Psychiatric Association [APA], 1994).

People who are eighteen years of age or older can only be diagnosed with Conduct Disorder if they do not meet the criteria for Antisocial Personality Disorder. Usually the behaviors associated with Conduct Disorder are present in settings such as the community, home, and school (APA, 1994). In layman’s
terms, a person diagnosed with conduct disorder is aggressive and defiant (Barkley, 1999).

**Subtypes**

There are two subtypes of Conduct Disorder, Childhood-Onset Type and Adolescent-Onset Type. Children are diagnosed with Childhood-Onset Type of Conduct Disorder when they meet the criteria needed before the age of 10 years. Children with this diagnosis are typically male. These children have a higher chance of having enduring Conduct Disorder and of eventually being diagnosed, as an adult, with Antisocial Personality Disorder than individuals diagnosed with Adolescent-Onset Type (APA, 1994).

Adolescent-Onset Type is diagnosed in people who did not meet any of the criteria for Conduct Disorder before the age of ten years, but do after. People with this diagnosis are less likely to display aggressive behaviors, when compared to individuals with Childhood-Onset Type. They are more likely to have normal peer relationships than people with childhood onset are. This subtype has a lower ratio of males to females. In addition, a person can be diagnosed with “Unspecified-Onset” if the time of onset is unknown (APA, 1994).

**Prevalence**

The APA (1994) estimated that 6-16% of males under the age of eighteen and 2-9% of females have Conduct Disorders. In the United States, there are approximately 1.3-1.8 million cases of diagnosed conduct disorders in school age
Conduct Disorder

children (Kazdin, 1993) and it is the most frequently diagnosed condition in outpatient and inpatient mental health facilities for children (APA, 1994). Evidence suggests that Conduct Disorder has both environmental and genetic components. The risk of Conduct Disorder is higher in children with an adoptive or biological parent with Antisocial Personality Disorder or a sibling with Conduct Disorder (APA, 1994).

Why Treat It?

Conduct Disorder is associated with early onset smoking, drinking, use of illegal substances, sexual behavior, and reckless and risk-taking acts. The behaviors of people with Conduct Disorders may lead to unplanned pregnancy, sexually transmitted disease, school suspension or expulsion, legal difficulties, problems with work adjustment and physical injury. Less severe behaviors such as lying and shoplifting tend to occur before more severe behaviors such as rape and stealing something when someone is present. These individuals are also more prone to suicide ideation, attempts and completed suicides and are sometimes associated with lower than average intelligence (APA, 1994). Additionally, several longitudinal studies have suggested that conduct disorder can lead to alcoholism, poor work adjustment and criminal behavior in adulthood and often continues through generations (Kazdin, Siegel, & Bass, 1992). All of these can be a burden on society.
Effects on Society

Juvenile crime is a serious concern in many communities. Offenses range from minor offenses (trespassing and curfew violations) to serious crimes (violence, theft and drug abuse). Evidence suggests that exclusively punitive approaches, such as incarceration, are ineffective and costly. By taking adolescents out of their environment, these approaches create problems that are more difficult. Thus, communities need other interventions to help these juveniles. One of the interventions that communities can use is Functional Family Therapy (Sexton & Alexander, 2000).

Functional Family Therapy

Research suggests Functional Family Therapy [FFT] can prevent onset of delinquency and reduce recidivism at a lower cost than punitive programs. FFT is a family-based prevention and intervention program. Counselors have utilized this approach to successfully treat high-risk youth and their families. FFT has a flexible structure and is culturally sensitive (Sexton & Alexander, 2000).

FFT targets adolescents between the ages of 11-18 years from several cultural and ethnic groups. It also provides treatment to the family of the targeted client, including younger siblings. This therapy lasts from 8-12 sessions for mild cases and up to 30 hours of direct contact for difficult cases. Usually sessions occur through a three-month period. During this time, therapists motivate the
families to change by discovering and building on the family members’ strengths in a way that intensifies self-respect. The therapist also offers families suggestions on how to improve their child’s behavior (Sexton & Alexander, 2000).

FFT is a multisystemic and multilevel intervention. It centers on the treatment system, which includes the therapist, family and individual components. The therapist begins to assist the families by developing their inner strengths and building the families’ beliefs that they can improve their situation. The therapist leads the family to greater self-sufficiency at a lower cost than some other treatments (Sexton & Alexander, 2000). When using FFT the therapist has all members attend therapy together.

FFT emphasizes positive outcomes by eliminating problem behaviors. To achieve this using FFT five phases, engagement, assessment, motivation, behavior change and generalization, are completed. During the engagement phase the therapist encourages the family to have high expectations for positive change. The therapist’s central task is to appear credible and appropriate to family members (Alexander, Pugh, & Parsons, 1998).

During the next phase, assessment, the therapist comes to understand the family’s potential for change. The therapist provides structure and information. Counselors develop plans and then evaluate resistance and cooperative responses.
The therapist identifies and examines the function of problematic and adaptive patterns (Alexander, Pugh, & Parsons, 1998).

During the middle phase, motivation, the therapist assists the family in building the motivational context for long-term change. The therapist may do this by providing rationales for treatment techniques and by emphasizing the positive through such interventions as reframing and renaming (Alexander, Pugh, & Parsons, 1998).

The fourth phase is behavioral change. During this phase, the central task is to monitor behavior during sessions and outside of sessions. The therapist implements behavior change programs by describing and modeling appropriate interactive behaviors (Alexander, Pugh, & Parsons, 1998).

The last phase is generalization and termination. During this phase, the goal is to finally maintain the changes that the family has made. The therapist assists the family in generalizing the changes so that they can use what they have learned in the future. Then the therapist terminates his or her relationship with the family (Alexander, Pugh, & Parsons, 1998).

Functional family therapists assume that if they can assist the family in changing their problematic communication patterns and if the child is more closely supervised, then the child's behavior will be more appropriate. They assume this partially because in 1973 Alexander completed research that suggested there were higher levels of defensive communication and lower levels
of supportive communication in the families of delinquent youth (Brosan & Carr, 2000).

**Strengths**

Therapists have used Functional Family Therapy for over 25 years as a form of treatment with problem youth and their families. Controlled comparison studies with follow up periods of up to five years have shown long-term significant decreases in re-offending and of siblings entering into high-risk behaviors (Alexander, Pugh, & Parsons, 1998) In one study, only 26% of delinquent youth assigned to FFT were arrested within 18 months of treatment, compared with 59% of the youth who received no treatment. In nine different studies FFT showed at least 25% improvement in out-of-home-placement, recidivism and recidivism by siblings of treated youth Mendel (2000). These results can be achieved at a reasonable price.

**Cost Effectiveness**

Mendel (2000) estimated FFT costs $2,000 per youth. However, it is a one-year process for a site to become certified and the training costs $24,500 per site for the entire training plus travel expenses. Sites are required to be certified if they want to implement FFT as a clinical model (www.open.org/westcapt/bp15.htm). After the first year, a “small yearly fee” is required for certification. (Alexander, 1999).
Like FFT, Multisystemic Therapy [MST] works with the youth in their homes and focuses on both the youth and the family (Mendel, 2000). The MST therapist empowers the family. In fact, the family members assist in designing the treatment plan (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

Henggeler and Borduin developed Multisystemic Therapy (Cavell, 2000) in a university research setting. Early clinical trials supported its short-term effectiveness with maltreating families and delinquent inner-city adolescents. MST then moved into community mental health settings where it worked as effectively as it did in university settings (Henggeler, Schoenwald, & Pickrel, 1995).

The main objective of MST is to understand the behaviors in their systemic context. When using this form of therapy both indirect and direct factors that contribute to behavior problems are considered. For example, the therapist may consider the child’s behavior with neighbors, peers, family, and in school (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

The services provided target the individual client and the problems of the family of the client. For example, the therapist might begin by teaching parenting skills and then eventually the parent would begin to implement interventions that would help change the child’s systems. Therapists provide the services in the natural environment (such as at school or at home) (Henggeler, Schoenwald, &
Pickrel, 1995). The therapist determines how the child’s problem behaviors are affected by certain individual areas and in the combined systems (Henggeler, et al., 1998).

When completing the assessment the therapist examines the strengths and needs of each system and how they relate to the known problems. The therapist examines these systems by looking at several perspectives, such as the family members perspectives, neighbors, family friends, school personnel, probation officers, peers, and anyone else whose perspective may be of interest to the therapist. Sometimes they may encounter different perspectives and inconsistencies. In these cases, the therapist will decide which evidence comes from more credible people (Henggeler, et al., 1998).

MST therapists rarely depend on psychological testing. Instead, they try to understand the problems in their real-world situations. However, they do acknowledge that biological behaviors may contribute to behavior in a social-ecological way (Henggeler, et al., 1998).

Therapists acknowledge this by developing and utilizing a hypothesis. “Generally, hypothesis development takes the form of one element $A$, contributes to a second element $B$, for a person, $C$, under $X$ conditions.” (Henggeler, et al., 1998, p.26). For example, a hypothesis might state that fights with teachers ($A$) contribute to not wanting to go to school ($b$) by Matt ($c$) without his parents. The therapist would then develop a baseline rate of fights with teachers. The
hypotheses are tested by implementing interventions that are based on the child’s strengths and needs in the context (Henggeler, et al., 1998, p.26).

**Strengths**

MST is one of the few treatment approaches shown to be effective with older children and adolescents diagnosed with severe conduct disorder. It uses a design that is flexible and thus can fit many child and family needs. Instead of being a set of very specific interventions, MST is an orientation to treatment. It expands beyond a family system perspective to include the child’s behavior at school, with peers and in the neighborhood (Frick, 1998). Studies suggest that MST is an effective treatment.

In rural South Carolina, violent and habitual offenders who were treated with MST had 43% fewer arrests, 66% fewer self-reported committed offenses, and spent 64% fewer weeks in treatment centers or youth prisons than youth who were randomly assigned to routine court sanctions and treatments (court-ordered school attendance and curfews and referral to other community agencies). In Missouri, youth treated with MST showed a rearrested rate of less than a third when compared with youth who had completed individual therapy, 22.1% and 71.4%, respectively (Mendle, 2000).

**Weaknesses**

Home-based therapy services can be costly and are not always mandatory to help the family of a youth with a Conduct Disorder (Henggeler, et al., 1998).
Thus it may not be the best choice of therapy to use with less severe cases of Conduct Disorder.

Cost Effectiveness

Studies suggest MST reduces days spent in out of home placement by 47-50% when compared with peers treated in traditional programs. MST is estimated to cost $4,500 per a youth, which is less than it would cost to place the youth in a group home or to incarcerate them (Mendle, 2000).

Parent Management Training

Parent Management Training [PMT] refers to therapy where therapists teach patents how to interact differently with their child (Kazdin, 1990). It focuses on interactions in the home, especially coercive exchanges. The therapist trains the parents to develop pro-social behavior in their children (Kazdin, 1995).

PMT involves teaching parents techniques to change their child’s behavior at home. The techniques the counselors teach encourage pro-social behavior and decrease deviant behavior. The therapist typically uses little or no direct interventions with the child. This treatment form assumes that the youth sustain their behaviors by maladaptive parent-child interactions. For example, the parents may be reinforcing deviant behavior, ignoring appropriate behavior and using harsh forms of punishment (Kazdin, 1995).

However, this training method does not assume that the parents are completely responsible for the child’s behaviors. Instead, it assumes they effect
each other. For example, if the parents are inconsistent and unpredictable the
child, who has Conduct Disorder, may participate in deviant behavior as a way of
prompting parents to react in a predictable way. This is because the child wants
her/his parents to be predictable (Kazdin, 1995).

PMT addresses family participation by shaping parenting skills through
reinforcement. As much time as needed is spent shaping these skills. Then PMT is
supplemented by giving parents time during treatment to discuss their stressors
and thus decrease drop out rates (Kazdin, 1997b).

Parent Management Training requires the parent to establish rules for the
child, use contingency contracting, provide positive reinforcement for suitable
behavior and punish the child for other behaviors through a mild form of
punishment. The parents are taught social learning principles and how to use
timeouts. They use the sessions to practice the techniques and to discuss the
behavior change programs. As they become more skilled at using the necessary
techniques, the training can begin addressing areas outside the home, such as
behaviors at the child’s school (Kazdin, 1995).

**Strengths**

PMT is a well-researched therapy technique for treating
children/adolescents with Conduct Disorder. Research suggest that Parent
Management Training enables improvements in children’s’ behaviors in various
areas of their lives, including home, school and community. This treatment helps
the children bring their problematic behaviors to an area of normative behavior. One study suggested that children maintain their gains for ten to fourteen years later (Kazdin, 1995).

PMT has a broad effect; it effects areas that the therapist and family do not focus on during the treatment. For example, siblings also improved, even though they were not the direct focus of treatment. This is important because the siblings of people with Conduct Disorder are at a greater risk for antisocial behavior (Kazdin, 1995).

Weaknesses

The duration of treatment appears to predict its effectiveness. Time-limited treatments, which may last less than 10 hours, are less likely to show favorable results time-unlimited programs lasting up to 60 hours (Kazdin, 1995).

Although research does not suggest that PMT dropout rates are higher than other treatment, some parents may drop out because of the demands PMT places on them. For example, parents must learn key concepts and implement treatment procedures at home. In addition, conduct problems are often associated with parental history of antisocial behavior, high levels of stress, younger mothers, socioeconomic disadvantage and low social support, which are risk factors for dropping out of treatment (Kazdin, 1997a).
Problem-Solving Skills Training

Shure and Spivack have identified different cognitive processes for solving problems that underlie social behaviors. Disturbed children usually tend to produce fewer alternative solutions, to realize fewer consequences associated with behavior, to focus more on the goal than the steps needed to obtain the goal, to not perceive why others act as they do, and to be less sensitive to conflict with others (Kazdin, Siegal, & Bass, 1992).

Problem skills training is a type of treatment focused directly on the child or adolescent. It assumes that youth with Conduct Disorders do not utilize their potential cognitive abilities. This form of therapy teaches children to identify problems, recognize causation, be aware of consequences and consider different ways of responding to difficult situations (Lewis, 1991).

Weaknesses

Problem solving skills training interventions generate modest symptom improvement (Dodge, 1993). Studies suggest that parents of children who have Conduct Disorder participate in unsuitable child-rearing practices that escalate child dysfunction. Thus, even if the counselor could effectively treat the child using a form of treatment that is child focused there might be inept parental skills that contribute to the youth's dysfunction that would not be treated. Thus, Problem-solving Skills Training is more effective when combined with Parent Management Training (Kazdin, Siegel, & Bass, 1992).
Conduct Disorder

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Problem-solving Skills Training [PSST] and Parent Management Therapy

A study by Kazdin, Siegel and Bass (1992) suggested that in families where both problem-solving skills training and Parent Management Training are implemented, the children experience more durable changes in their functioning and their parents showed greater changes in parent functioning. These treatments are complementary. While PSST focuses on the individual child and his or her cognitive-behavioral experiences that he or she brings to situations, PMT focuses on child rearing practices which includes parent-child interactions and circumstances at home that promoted-social behavior (Kazdin, Siegel, & Bass, 1992).

In this study, the parents of the children in the problem-solving skills training group were actively involved in the child’s treatment so that they could assist the therapist and consequently could use the problem solving skills at home. Parents were instructed on how to prompt and assist the child through written guidelines and by watching the therapist and child role-play the situation. In addition, there was phone contact between sessions. The therapist also interviewed the parents and the children so that they could reenact the previous weeks assigned tasks (Kazdin, Siegel, & Bass, 1992).

Choosing Services

Conduct Disorder is a widespread problem. It affects families and society as a whole. When trying to decide what treatment to use with a client, cost-
effectiveness is often an issue. It may be helpful to treat less severe cases with some form of parent training. In addition, Functional Family Therapy may be utilized for less severe cases, (Brosnan & Carr, 2000), which costs approximately $2000 per a child (Mendle, 2000). Cases that are more difficult may require multisystemic therapy (Brosnan & Carr, 2000), which was estimated to cost $4,500 per a youth (Mendle, 2000). Because problem-solving skills training interventions have generated only modest symptom improvement (Dodge, 1993) this author would recommend that PSST not be by itself as a treatment. However, this author would encourage the use of PSST combined with PMT for less severe cases of Conduct Disorder.

Evidence suggests that exclusively punitive approaches, such as incarceration, are ineffective and costly. In fact, these approaches may create more problems (Sexton & Alexander, 2000). As counselors, we need to play an active role in treating these children with the effective therapies, such as Parent Management Training, Multisystemic, Functional Family Therapy, and Problem-Solving Skills Training combined with Parent Management Training. By treating these children effectively, we may be able to reduce juvenile crime, and thus create a better, law abiding, society.
References


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