CURRENT TOPIC

Intensive interventions in conduct disorders

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Conduct disorder in childhood includes excessive levels of fighting or bullying; cruelty to animals or other people; severe destructiveness to properties; fire setting, stealing, repeated lying; frequent and severe temper tantrums; defiant provocative behaviour and persistent severe disobedience; truanting from school; and running away from home. As the child grows, not only do problems escalate but the response to treatment is reduced.^{1 2} Several well conducted longitudinal studies indicate that conduct disorder is relatively stable over time and predicts antisocial behaviour in adult life. There are increased rates of delinquency and antisocial personality disorders. Follow up studies suggest high rates not only for alcoholism, substance abuse, physical illness, suicide and accidental death, but also for widespread social dysfunction with poor work records and difficulties in all relationships, including marital relationships.³

The prediction of antisocial behaviour is stronger for men than for women. For girls, conduct disorder in childhood predicts adult depression and anxiety disorders more strongly than antisocial behaviours and substance abuse.⁴

In addition to antisocial behaviours, there may be coexisting attention deficit and hyperactivity, frequently including cognitive deficits and academic failure.⁵ This is associated with particularly poor outcome.⁶

Disruptive and antisocial children are often unpopular with other children and are excluded from groups of normally functioning children, associating only with other antisocial children and becoming part of a deviant subculture.⁷ They, therefore, lack prosocial models and do not learn how to negotiate and fit in with the prosocial mainstream cultural group. Similarly, antiauthority attitudes and an inability to settle in class lead to a lack of satisfaction with the school and increasing alienation, disaffection, and disruptive behaviour.

Most parents of conduct disordered children engage in incompetent child management practices, which are associated with the inadvertent development and maintenance of aggressive and antisocial behaviour.⁸

Assessment for treatment

Assessment should be broadly based and needs to include not only the diagnosis of disorder in the child but should pay attention to an assessment of parenting competence. The possibility

of child abuse, treatable mental illness in the parent, and the presence or absence of support systems for parents in the community should all be considered. An assessment also needs to be made of the child's social functioning at school with adults and with peers and the nature and extent of academic difficulties.⁹ A psychometric assessment should be made to detect any cognitive deficit.

It is important to detect comorbid hyperkinetic disorder. The presence of severe antisocial symptoms with undoubted poor parenting and possibly abuse can dominate the picture. This may lead to a classic diagnostic pitfall, as hyperkinetic disorder if untreated is associated with a high risk of persisting antisocial behaviour.¹⁰

Another diagnostic difficulty is the child who is well engaged with an experienced clinician and symptom free at interview but impulsive and distractible in other situations. The use of standardised questionnaires may help in diagnosis.¹¹⁻¹³ A different problem occurs when the diagnosis of hyperkinetic disorder, manifest by inattention, overactivity, and impulsiveness is made correctly but because a broad based assessment is not carried out, conduct disorder may be missed.

A social assessment may be necessary in some cases, not only to provide a child protection risk assessment, but also to assess the need for respite provision and advice on housing and finances. Associated physical disorder such as visual or hearing deficits, epilepsy or dysmorphic appearance should be managed in consultation with a paediatrician.

Interventions: general considerations

While research papers may focus on comparing and contrasting the efficacy of different treatment approaches, in practice, a broad based combination of treatment procedures should be used. Combinations of approaches are likely to be complementary and maximally beneficial.^{14 15}

A combined treatment approach will need careful orchestration of the various elements involved and should include regular networking and consultation with other agencies, such as education and social services, to avoid conflict and confusion.

Occasionally children may 'need' admission to local authority care or to an inpatient unit. Satisfactory controlled studies of inpatient versus community care are limited. A somewhat

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flawed comparison showed that community placement produced at least as favourable results as inpatient treatment.¹⁶

Patent management training

The theoretical and practical basis for this work was developed by Patterson, Reid, and colleagues at the Oregon Social Learning Center (OSLC). They describe an escalating cycle of coercive interactions between parent and child – *the coercive hypothesis*. This postulates that children learn to escape or avoid parental criticism by escalating their negative behaviours (such as temper tantrums, defiance) which leads to increasingly negative parental behaviour (such as telling the child off, yelling or hitting the child). Over time the ‘coercive training’ in the family continues with an increasing rate and intensity of parent and child aggressive behaviour. Thus both parents and child are caught in the ‘negative reinforcement trap’ which effectively trains children to be conduct disordered.¹⁷

In addition to the negative reinforcement, the child also experiences effective modelling of antisocial behaviours from observation of parental aggression. Furthermore, parents may also positively reinforce children’s misbehaviour by paying attention to them only when they are shouting or behaving badly and ignoring them when they are playing quietly.

Five family management practices form the core components of the OSLC programme:

(1) Parents are taught how to pinpoint the problem behaviours and track them at home, for example recording compliance versus non-compliance.

(2) They are taught reinforcement techniques such as praise, points systems, treats, and rewards.

(3) When parents see their children behaving inappropriately they learn to apply a mild consequence or a short term deprivation of privileges, for example one hour loss of television time or bike use.

(4) Parents are taught to ‘monitor’ (or supervise) their children at all times, even when they are away from home. This involves parents knowing where their children are at all times, what they are doing, and when they will be returning home.

(5) Finally, the parents are taught problem solving and negotiating strategies. They also become increasingly responsible for designing their own programmes.

This programme typically requires 20 hours of direct contact with individual families and includes home visits in order to improve the generalisation of parenting strategies.

A parent training programme designed to treat non-compliance in young children aged 3 to 8 years was developed by Forehand and McMahon.¹⁸ This incorporated the idea of *alpha* and *beta* commands based on the observation that parents with reasonably obedient children give more so-called alpha commands and parents with conduct disordered children give more negative beta commands. Alpha commands are characterised by being clear,

specific and direct, being given one at a time, and being followed by a wait for five seconds for compliance. Beta commands are vaguely phrased chains of instruction and comment, often delivered as a question and frequently followed by a rationalisation. An example of a beta command is ‘How many times have I told you, if you don’t come away from there, Darren, I don’t know how I’m going to keep my hands off you – you know I’ve had a bad day, what with that letter from the welfare people and now the TV’s on the blink – Darren what have I told you!’ As an alternative, parents are taught to give alpha commands where clear, specific, direct instructions are used with the parent waiting five seconds for compliance.

The child is also named and eye contact achieved. Parents are encouraged to use a firm but not cold voice and are encouraged to refrain from telling their children what to stop doing. Parents are also taught how to play with their children in a non-directive way and how to identify and reward children’s prosocial behaviours through praise and attention. Treatment is carried out in a clinic playroom, equipped with one way mirror and can use an ‘ear bug’ through which the therapist can directly coach or prompt the parent while playing with the child. This is called the *parent-child game*.

The group discussion videotape modelling programme (GDVM) was developed by Webster-Stratton as a parent training programme for young conduct disordered children. It includes components of the Forehand, McMahon, and Patterson programmes as well as problem solving and communication skills.^{19 20}

The basic parent training programme consists of a series of 10 video tape programmes, modelling parenting skills. There are 250 vignettes, each of which lasts approximately one to two minutes. These are shown by a therapist to groups of eight to 12 parents per group. After each vignette, the therapist leads the group discussion of the relevant interactions and encourages parents’ ideas and problem solving as well as role play and rehearsal. Parents are given homework exercises to practice a range of skills at home but the children do not attend. Great efforts were made to use models of different sexes, ages, cultures, socioeconomic backgrounds and temperament in order to enhance the power of the modelling by the ability of parents to identify with models.

The programme has also been used by parents of conduct disordered children as a self administered intervention, viewing the video vignettes and completing the homework assignment without therapist feedback or group support. A recent development has been a further six video tape programmes called ADVANCE to focus on family issues other than parenting skills. This includes anger management, coping with depression, marital communication skills, problem solving strategies, and how to teach children to problem solve and manage their anger more effectively. For

mild behavioural problems the provision of a brochure alone is often sufficient to produce behavioural change.^{21 22}

Family therapy techniques have emphasised general principles rather than the contingency management of antecedents and consequences of specific target behaviours. The emphasis has been on altering maladaptive patterns of interaction and communication through broad principles of child management, the setting of limits (boundaries), the interpersonal interactions of family members, marital relationships, and improving the self esteem of carers.

Individual behavioural programmes for conduct disordered children using parents as cotherapists have been shown to be most successful when attention is paid both to the antecedents and the consequences of the desired behaviour. This makes use of the ABC model, a helpful mnemonic for parents as well as therapists.

A: stands for Antecedent events – what happens immediately before the targeted behaviour

B: stands for targeted Behaviour.

C: the Consequences – what happens after the targeted behaviour.

Paying attention to the antecedents and consequences of targeted behaviours ('catch the child doing something good') leads to intervention programmes which aim to increase prosocial behaviours by giving clearer instructions and positive reinforcement.

Antisocial behaviour can be decreased by a range of techniques such as extinction, over correction, time out from positive reinforcement and most importantly teaching and reinforcing prosocial behaviour that is incompatible with the antisocial behaviour.

Working with the child

Social skills training approaches have been increasingly used with young conduct disordered children. Initially *operant techniques* were developed, rewarding prosocial behaviour and discouraging antisocial behaviours. *Modelling strategies* were also used, teaching by allowing children to observe appropriate social behaviour modelled by adult or child models. *Coaching* was used where principles of competent social behaviour were taught, often using role play of problem situations such as what to do when hit by another child or punished unfairly by a teacher. *Impersonal cognitive problem solving training* emphasised the paramount importance of interpersonal communication and negotiating skills, seeing the others' point of view and achieving compromise within the social situation. The training developed thinking processes; *how* to think rather than *what* to think. Further developments in problem solving skills training incorporate both behavioural and cognitive techniques.²³

Conduct disordered children have been shown to have a range of cognitive deficits and distortions. They recall high rates of hostile cues in social situations, attend to few cues when interpreting the meaning of others' behaviour, and attribute the behaviour of

others in ambiguous situations to hostile intentions.^{24–26} When in conflict with others, conduct disordered children underestimate their own level of aggression and responsibility in the early stages of a disagreement.²⁷

When problem solving, conduct disordered children generate fewer verbal assertive solutions and many more action oriented and aggressive solutions to interpersonal problems.²⁵ When upset, or in situations that might cause upset feelings, conduct disordered children show an unusual pattern of affect labelling; they anticipate fewer feelings of fear or sadness. When highly aroused, the feeling is interpreted as anger and increasingly action oriented responses result. However, when aggressive children use deliberate rather than quick automatic responses, they can produce higher rates of competent and assertive solutions.²⁸

A positive view of aggression and its use to solve social problems appears to be incorporated into the belief system of conduct disordered children. They expect their aggressive actions to reduce negative consequences; they think aggressive behaviour enhances their self esteem; and they value social goals of dominance and revenge more than affiliation.

The aim of therapy for these children is to remedy the deficits and distortions in behaviour and cognitions. Several programmes and models have been developed and most have several elements in common. *Emotional education* enables the child to identify and label different emotions and the situations in which they occur. The therapist may model expression of feelings and empathising with others in addition to using pictures and games to increase the repertoire. Self monitoring of behaviour and of feelings whose intensity can be rated enables the child to feel empowered to manage their own behaviour and feelings. *Self instruction* may use a 'stop! think! what can I do?' approach to inhibit or slow automatic responses while *self reinforcement* techniques teach the child to use positive self talk, for example 'well done, I didn't answer back' to enhance the development of prosocial skills. *Social perspective taking* uses vignettes, modelling, role play, and feedback in order to help children become aware of the intentions of others' in social situations. *Social problem solving* such as in the 'think aloud programme' uses a cartoon of Ralph the bear to teach a self instructional approach to problem solving 'What is the problem? What can I do about it? Is it working? How did I do?'²⁹

An approach used by the Hahnemann programmes emphasise deficits in *alternative thinking*, the ability to generate multiple solutions to interpersonal problems; *consequential thinking*, the ability to foresee the immediate and long term consequences of the solution; and *means end thinking*, the ability to plan a series of actions to attain the goal devising ways around obstacles within a realistic time frame.³⁰ They use simple word concepts as a foundation for problem solving, for example *or* and *different* to help generate alternatives 'I can hit him *or* I can tell him I am upset'; 'Hitting is *different* from telling'. *Cognitive restructuring* can

be introduced in parallel where problem solving includes consideration of concepts of fairness, safety, and what the other person would feel, the aim being to change basic beliefs and attitudes.

All these elements must be incorporated into a matrix of enjoyable activities in order that treatment itself is enjoyable for the child. When working with groups, the therapist must pay attention to group composition and be able to manage and control the behaviour of the group using behavioural methods such as positive reinforcement for participation. In order to encourage the generalisation of prosocial behaviours learned in therapy to home and to school, goal setting and operant techniques should be used. Goals should always be specific and attainable and must be carefully monitored. The contingent use of social reinforcement (for example praise, particularly the approval of a valued person), activity reinforcements (treats), and tangible reinforcements (rewards) can be tailored to a particular child's needs. Pairing social reinforcement by parents, teachers, or therapists with other reinforcements may be particularly important for the conduct disordered child as these children often have poor relationships with authority figures and are minimally motivated by adults' reinforcement. Other techniques may focus particularly on anxiety³¹ or anger management^{31 32} and may use group feedback with whiteboards, flipcharts, video feedback, and group discussion.

Liaison with schools

Teacher liaison is necessary in order to reinforce developing prosocial behaviours and to change inappropriate beliefs or behaviours by the teacher. Teachers may also be helped by advice on management and structuring of the classroom.^{33 34} and in training in positive teaching methods.³⁵ It may also be necessary to integrate specific educational remediation for a child whose educational attainments are retarded. School approaches to bullying are useful in reducing a school culture of antisocial behaviour.³⁶

Outcome

Unfortunately, the characteristics of parents that lead to parenting difficulties are those that are also associated with poorer outcomes.^{8 37} These factors include multiple social problems, marital problems, single parents of low socioeconomic status, and a strong punishment ideology in the parents. Components can therefore be added to address these difficulties. Close liaison with social services will be helpful where there are multiple social problems, perhaps using family aide support or respite care to reduce stress, while couple therapy to address problems in the parents' relationship may reduce marital difficulties interfering with the parenting.

The underlying behaviour principles of parent management training have a face validity which parents appreciate and which may

increase their compliance. Programmes generally have high parental rating of acceptability and consumer satisfaction.³⁸ However, while teaching parenting skills empowers parents it also makes demands on them with consequent difficulties in engaging in therapy and high drop out rates.¹⁵

Although programmes treating conduct disordered children are steadily developing and the therapeutic elements are being evaluated in randomised controlled trials, the central problems of working with families who are difficult to engage remain. Overall it appears helpful to recognise that conduct disorder is a chronic condition and that 'booster sessions' may be necessary.

While public anxiety about delinquency and violence is high it is important to recognise the cost benefit and potential health gain of early intervention with conduct disordered children^{39 40} as well as the opportunities for creative therapeutic interventions.

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