Treatment of Conduct Disorder with a Multisystemic and Multimodal Approach

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Abstract

Conduct disorder is a childhood disorder that is often resistant to treatment. Current treatment methods often focus on separate interventions for each environment that the child or adolescent is exhibiting antisocial behavior. Additionally, the focus is on the behavior of the child and often does not focus on the family unit or the biology behind the behavior. This paper will look at a multimodal and multisystemic treatment that will combine treatment of several areas into one cohesive treatment plan, as well as addressing issues other than the antisocial behavior such as the family unit, attachment style, and follow-up to treatment to maintain gains on the reduction of antisocial behavior as important factors in the intervention and treatment of Conduct Disorder by providing examples through case studies to provide examples of application.
Treatment Program Conduct Disorder

Treatment of Conduct Disorder with a Multisystemic and Multimodal Approach

Conduct Disorder (CD) is a disorder that is characterized by aggressive behavior towards people and/or animals, theft, destruction or property, breaking into others property, lying to obtain good or favors, truancy, running away from home, and ignoring parental curfew (American Psychiatric Association, 2000).

The comorbid disorders most often associated with CD are Attention Deficit/Hyperactive Disorder (ADHD), depression, dysthymia, and learning disorders.

When considering attachment style it is important to remember that an individual’s attachment style will affect the likelihood of both seeking and accepting help. This is especially true with individuals who have an avoidant attachment style, which means that they view themselves in a positive light yet view others in a negative light and the world as a hostile place (Vogel & Wei, 2005). When these attachment styles come into contact with stressors they often reach a state of arousal and will react with the goal of eliminating the stressor and reinstating a sense of stability in their lives (Lyons-Ruth, 1996). For individuals with CD this avoidant attachment style, along with a hostile world view means that if they do realize they need help they will not seek it as they do not trust those
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around them. Additionally if they do receive help the avoidant attachment style is less likely to maintain a therapeutic relationship due to the negative perception of the world.

Case Studies

Tom is a child who was referred to a special education program that specialized in teaching social skills to students with emotional problems. Tom is the youngest of three children in his family. His parents are married and both have a high school education. There has been suspected abuse in Tom’s home, however there have never been charges brought against Tom’s parents. It has been recorded that discipline is either inconsistent or nonexistent. In the past instead of dealing with Tom his parents chose to leave him sitting alone in his playpen as a toddler for most of the day.

Tom has been hospitalized for evaluation in the past and resulted in an improvement in Tom’s antisocial behavior; however when he has returned home pharmacotherapy often ceases. There are currently no known medical problems. Tom’s comorbid condition is ADHD.

Tom was referred to a special education program as a result of his antisocial, argumentative, violent behavior in the classroom. He would attack other students when he did not get his way, attack teachers when reprimanded and became argumentative when asked to do things in the classroom. Tom has
been observed in the classroom on several occasions. His appearance is often disheveled, his clothing often too small for him with his shirt falling halfway down his midsection. Tom antisocial behavior often escalated when he was redirected by his teacher for not being on task and received negative consequences for not following instructions. At this point Tom would attempt to use countercontrol by tantruming, yelling and slamming his desk. When his teacher redirects him again for his tantrum behavior Tom will then become aggressive, sometimes charging at the teacher physically, other times throwing items across the room. On several occasions Tom has bit his teacher and thrown dirt and other objects at other staff members at his school. When interacting with his peers Tom will often take toys that they are playing with and become physically aggressive if they attempt to retrieve them from him.

John is an adolescent who was referred to special education program that specialized in teaching social skills to students with emotional problems. John is the only child in his home, however he has other siblings through his father that do not live with him and with whom he has little contact. John lives with his mother and stepfather and has contact with his father. John’s half-sister participated in the same special education program, however she has been placed into a group home because her adoptive mother could no longer control her.
John’s behavior began approximately at the age of 6 where he would be defiant and disrespectful towards his mother. It progressed into bullying his peers and eventually into theft and violence. He was placed in a juvenile facility before age 10 and has been expelled from several school districts due to his antisocial behavior.

John has had a psychiatric evaluation and has been diagnosed with CD, ADHD, and dysthmia. In the past John has taken medication for the ADHD, however he is currently not taking any medication. He is scheduled to start taking an antidepressant in the beginning of December. John reports having bruises from sports, but there are no known medical problems.

John was referred to a special education program because of his behavior, which is reported to include bullying of other students, which required him to be escorted in the hallway between classes, throwing desks in the classroom, and truancy from school. There is one incident in which John threw a peer down a flight of stairs during an altercation. John has also had problems with the law and is currently on probation for theft.

John has been observed in the classroom and at home on several occasions. His appearance is often messy, his clothing is often slightly small for his build, however the clothing is usually always clean. However he often has dirt on his knees and elbows. When people talk to John, particularly someone in a
position of authority, John will often not look at the individual who is speaking to him or when he is responding to them. If John is being told something that he does not like, such as a reprimand for inappropriate behavior, John will often respond with a mocking sing-song voice imitating what the individual has said to him. When in the classroom John is often seen looking around the room or with his head on his desk. His teachers report that he completes less than 25% of his assignments and those that he does complete rate a grade in the D range. Additionally his teachers report that to get John to do any work it is often required that they stand next to his desk and repeatedly prompt him to keep working. He also requires the directions repeated to him on several occasions as he often says he does not understand how to do the assignment. In regards to his classmates they often avoid him. When he is interacting with them he will often use aggressive body language such as pretending to hit, throw things at, or charge at them. He uses verbal threats such as “I’m gonna kick your ass” or threatening to break their personal belongings.

Reports from his mother, as well as observations in the home, show that there is little consistent discipline. Both John’s mother and John report that he is often able to either bully or beg to get his way. An example of this is begging his way out of punishment for missing curfew so that he could go
play football with his friends. When John reports that he was able to avoid consequences for breaking the rules he often does so with a smile and a laugh.

**Multimodal and Multisystemic Approach**

The most important factor in successfully treating CD is ensuring that the treatments are both multimodal and multisystemic. Gertan (2000) stated that one problem with previous treatment models for CD is that interventions for school and for the home have taken place separately, meaning that different programs were being used by the parent and by the teacher. The multimodal approach is based on the idea that if the same treatment program is implemented across several settings it will be more likely to induce change. This means that for a child or adolescent who has CD, if the same treatment methods are applied, and goals are set, across the school and home setting a change in antisocial behavior is more likely to occur than if treatment was applied in school or home alone.

The multisystemic approach means that the intervention addresses the needs of several settings. This goes beyond addressing concerns in the child or adolescent’s home, it also means addressing issues such as economic status, any history of child abuse, and familial social supports (Gertan, 2000). One major factor of the multisystemic approach is based on the family systems theory (Gertan, 2000) which is based on the idea
that family functioning is a fully functioning system complete with a history and social structure where each member has a role to play. Since each family member is like an orbiting planet in the familial solar system who each have designated attributes and expectations on their behavior even minor therapeutic changes can have a wide reaching effect on the members of this family (Sadock & Sadock, 2003).

**Treatment Outline**

When creating a treatment plan there are several factors that must be considered:

1. Symptoms of CD manifested
2. Comorbid disorders
3. Countercontrol
4. Multisystemic treatment
5. Multimodalality

Factor number one outlines which symptoms of CD are manifesting as antisocial behavior. The behaviors that can manifest include A) aggression to people or animals, B) destruction of property, C) deceitfulness or theft, and D) serious violation of rules (American Psychiatric Association, 2000, pp. 98-99). To determine which behaviors are the strongest the practitioner can use observation or the CDS.

Factor two of the treatment plan is concerned with treatment of any comorbid conditions that may be present along with the
diagnosis of CD. Some disorders will receive more treatment in one setting than the other settings. For example, learning disorders will be more of a focus in the school setting than in the home setting, while the presence of depression or dysthymia will receive more focus from the practitioner and in the home setting than in the school setting.

Factor three of the treatment plan outlines how to cope with countercontrol that is likely to occur once the treatment plan is in place. When countercontrol occurs in an intervention with a child or adolescent with CD that individual will exhibit behaviors intended to systematically cause those implementing the treatment to exhibit the desired behavior of the individual with CD (Carey & Bourban, 2006). With a child or adolescent whom has strong levels of deceitfulness and theft this countercontroling behavior could be bargaining to reduce or eliminate consequences after they exhibit the antisocial behavior the treatment program is designed to eliminate. If the child or adolescent has high levels of aggression to people or animals countercontroling behavior may be for the violent behavior towards siblings or parents to escalate in an attempt to remove the unwanted treatment program.

Factor four outlines how the multisystemic approach should be taken. This looks at the idea of treatment not only covering multiple settings, but also addressing multiple issues that can
complicate the treatment of CD. Some of these issues include economic status, any history of child abuse, and familial social supports (Gertan, 2000). When these issues are addressed it will help in relieving stress on the family unit and allow more attention to be focused on ending the antisocial behavior of the child or adolescent. For example, if there is a single mother who is not able to be at home because she needs to work several jobs providing her with resources to help pay for heat, electricity, food and housing could result in her needing to work less hours and therefore be around to consistently implement the intervention program.

Factor five outlines how the multimodal approach should be taken. It is an important part of treatment because if treatment takes place across several different settings, such as both home and school, the likelihood that a change in behavior will occur increases (Gertan, 2000). When treatment of the targeted antisocial behaviors is consistent across both a school and home setting it will further reinforce the desired behavior and extinguish the undesired behavior. If it is possible to further widen the situational circumstances in which the behavior is reinforced, such as with a mentor, the treatment effects of the intervention can even further be solidified.

When looking at how the treatment program will play out we will look at the same treatment program in two different
locations, school and home as well as how the program differs for children and adolescents. We will show how the five necessary factors to treatment of CD should be implemented.

**Treatment Application.** The first factor of which symptoms of CD are manifesting is very important to treating CD, after all, if the child or adolescent is being violent towards people or animals you do not what to treat them for deceitfulness and theft. Once the antisocial behaviors which are most apparent have been determined, either by observation or through the use of the CDS, a treatment program to counteract these behaviors must be put into place. CD has shown that it responds well to cognitive-behavioral therapy (CBT) (Sadock et. al., 2003). This indicates that since there tend to be cognitive deficiencies and children and adolescents with CD also tend to view their world as a violent and potentially harmful place (Mpofu & Crystal, 2001) that changing how they process information and interpret the world around them may reduce antisocial behaviors.

When treating any of the symptoms of CD one of the most important parts of treatment is identifying which behaviors need to stop (Webster-Stratton, 1993). For example if the child is exhibiting symptoms from category “A” (aggression to people or animals) a behavior that could be identified would be bullying of peers or siblings. In the home the parent will work to condition the child or adolescent’s behavior through the use of
tangible and social reinforcement and consistent discipline techniques (Webster-Stratton, 1993). It is through the use of both reinforcement and discipline that the child or adolescent will begin to change not only their actions, but the impulsivity to complete the antisocial behavior.

In regards to changing how the child or adolescent views the world and interacts with it, this often requires attribution retraining. Attribution retraining encourages children and adolescents who view others intents as hostile and will react in an aggressive manner to stop, and when there is doubt if the action was hostile to assume that it was, in fact, not. Attribution training can be accomplished through the use of role-playing, watching a video demonstration, and using prosocial peers who do not have CD to analyze social situations (Mpofu & Crystal, 2001).

When treating symptoms of CD in a school setting it is to remember that while the goal is to reduce the targeted antisocial behaviors, the types of rewards and punishments will be different than those received within the home. However to maintain the consistency of treatment it is important that the same behaviors that are being treated at home are being treated within a school setting. In addition to attribution training a school can focus on problem solving skills which serves to teach self-regulation and impulse control. When teaching problem
solving skills it is important to teach children and adolescents with CD the following procedures:

2. Identify the problem and say how you feel.
3. Set positive goals (desired outcome).
4. Anticipate consequences.
5. Try the best plan of action (Mpfou, 2001).

When paired with attribution training, which will help the child or adolescent not to interpret others as hostile, the problem solving skills will help them to inhibit the initial reaction to lash out violently which will make it easier for them to form bonds with prosocial peers.

The second factor of treating comorbid disorders often becomes the tricky question of “does the comorbid condition compound the symptoms of CD or are the symptoms of CD compounding the comorbid condition?” The most common comorbid disorders are depression, dysthymia, ADHD and learning disorders (Sadock et. al., 2003).

In a school setting the comorbid conditions of ADHD and learning disorders will be more apparent and could potentially compound symptoms of CD more so than other comorbid disorders. Perhaps the best treatment option for comorbid disorders while maintaining multisystemic and multimodal treatment is the parallel treatment model. The parallel treatment model outlines
that comorbid conditions are treated concurrently by several different individuals in different settings (Miller, 1994). Therefore treatment of CD will occur with the practitioner, the school, and at home, as well as any other settings the child or adolescent participates in. Each setting may focus on a different comorbid disorder, however all comorbid disorders will receive treatment along side CD.

The third factor of dealing with countercontrol will become a strong, and often aggravating, factor for parents and teachers once a treatment program has been put in place. Since children and adolescents with CD do not believe there is a problem with their behavior they see no need to change their behavior (Mpofu et. al., 2001), however their behavior often alienates them from their peers and if not stopped can develop into an antisocial personality disorder (Loeber, Burke, & Lahey, 2002). When the child or adolescent attempt to countercontrol the parent it is an attempt to get the parents to exhibit the behavior they want (which is for the parents not to push to control the child’s behavior so they can see a decrease in the identified antisocial behavior being treated). It is imperative that the parents do not allow the child or adolescent to succeed with countercontrol. If the child is not allowed to use countercontrol they are forced to find new ways of handling the situation (Carey et. al., 2006). The key to effectively stopping
countercontrol so that the changes that occur are pro-social in nature is for the parents to be steadfast and consistent with their reinforcements for exhibiting the desired behavior and punishing the undesired behavior as well as the countercontroling behavior. By doing this the child or adolescent will be forced to learn more problem solving strategies and impulse control (Mpofu et. al., 2001).

In the school setting countercontrol will assume many of the same protocols. The teachers in the classroom will work to reduce the targeted antisocial behaviors through the use of a system of rewards for desired behavior and loss of privileges for the undesired target behavior and countercontrol. In turn the child or adolescent with CD will attempt to use countercontrol to change the teachers focus away from the targeted antisocial behaviors so that the treatment program will not be in place (Carey et. al., 2006).

The fourth factor of ensuring multisystemic treatment is where the family system theory will play the largest part (Gertan, 2000). It is important to look at the family dynamic to determine if there is any behavior which may be enabling the child or adolescent’s antisocial behavior. What is the family dynamic in the home, is the parent/child dynamic backwards so that the child or adolescent is in a position of authority? Is the reward and punishment system inconsistent and unpredictable?
Are the parental units reliable in their reactions to the child or adolescent’s behavior? When the problem within the family system has been identified then CBT and family therapy can be used to correct it. For example, in the home, if the role of parent and child has been reversed the family system theory would state that the roles must be reversed back to the intended state. Family therapy, where the use role playing, would be used to help ensure that this occurred.

In a different example, where the reward and punishment system has been inconsistent and unpredictable, these behavior not only reinforce antisocial behaviors associated with CD, but can also contribute to insecure attachment styles. In order to counteract this, the practitioner would suggest that the parents attending parenting classes to teach them consistency.

In addition to the family systems theory other factors to consider includes issues such as economic status, any history of child abuse, and familial social supports (Gertan, 2000) as all of these factors also will play a role in the child’s behavior during, and willingness to participate in, treatment. In situations where there is child abuse and low familial supports family therapy is highly suggested to improve the living situation of the child or adolescent with CD.

The fifth factor of ensuring that treatment is multimodal. This is most obviously applied by making sure that the behaviors
being targeted for treatment are the same in both the home and at school, and that the mode for treating them by means of rewards and punishment is also the same. This is supplemented by the practitioner helping with attribution training and CBT to help the child or adolescent with modifying their world view.

In regards of the child or adolescent’s attachment style, when there is insecure attachment it hinders their psychological adjustment and can create difficulties in creating successful interpersonal relationships (Brown & Wright, 2003). When working with an individual who have an insecure attachment style it is important that the practitioner working with them is able to create a complimentary response to the child or adolescent’s antisocial behavior. When this occurs there is a higher chance that the therapeutic relationship will be fostered. When this does not occur there is a high chance that the child or adolescent with CD will be resistant not only to the intervention, but particularly to the practitioner who is working to implement it (Dolan, Arnkoff, & Glass, 1993).

Application Examples

For application of intervention for CD, the approaches of using CBT would be different on a child than the approaches that would be used on an adolescent or an adult because of the age and developmental differences. When we look at Tom the problem is that he is aggressive and violent towards his peers as well
as towards authority figures when there are demands made on him. His physical appearance is often disheveled and his clothing often does not fit which indicates that he may not be receiving the proper care from his parents. This is further supported by allegations of abuse where he would be left in a playpen for hours on end without supervision or human interaction.

When looking at Tom’s behavior we must consider, given his diagnosis of CD, that when he lashes out at his peers and at authority figures he is doing so because he interrupts their actions as hostile. In order to reduce this assumption Tom should receive attribution training. This training will teach Tom to not immediately assume that the other person’s intention of action is to harm him. One way for Tom to learn this is by practicing appropriate responses to situations in which he may feel unnecessarily threatened threw role-playing (Yasutake & Bryan, 1996).

We will assume that the CDS indicated that Tom scored high on aggressive conduct and hostility scales, therefore the target behaviors that treatment will work to improve and correct are (A) aggression towards people and animals as shown be his aggressive behavior towards his peers and teachers and (B) destruction of property as shown by his destruction of others property when he becomes angry (See Figure 1). Since Tom is young the methods of applying treatment will be slightly
different to account for lowered cognitive levels (Mpofu et. al., 2001).

When treating these targeted antisocial behaviors a behavior treatment program will be put in place (See Figure 1). The specific behaviors being targeted in Tom’s case include violence towards his peers and teachers and being unable to accept feedback from authority figures without reacting violently. One of the key ways to break this behavior pattern is to focus on teaching prosocial skills (Mpofu et. al., 2001). Some of these social skills may include things such as empathy, cooperating with others, sensitivity, behaviors such as being able to say please, thank you, waiting for their turn, walking away when angry, problem solving, anger management, and making friends (Sugai & Lewis, 1996). Tom’s violent behavior needs to be addressed by teaching basic skills such as saying please and thank you, as well as teaching emotional social skills such as sensitivity and anger management. When Tom shows he is using the social skills he is being taught he will receive a reward to reinforce the behavior, when Tom does use outline social skills he will receive a punishment and/or lose privileges.

The goal is to reduce Tom’s aggressive behavior towards his teachers and his peers as well as to be able to accept feedback without reacting violently (See Figure 1). Attribution training will allow Tom to reduce the number of instances in which he
perceives other’s actions as hostile, which should reduce some of the violent behavior. The attribution training will be paired with social skills training and the behavior treatment program which uses discussion, modeling, games, and role playing (Warren, 2002) to further encourage the appropriate social behavior.

When Tom is calm the practitioner should discuss with Tom that it is ok to express ones feelings as well as to recognize what feelings may be underlying anger. These discussions can take place through the use of role playing with puppets to show how to properly express feelings and when the Tom’s puppet models this behavior the puppet will receive a reward for correctly expressing an emotion (Warren, 2002).

In the school setting Tom’s teachers will continue the behavior treatment program rewarding appropriate emotional responses. Tom will also be punished through the loss of privileges for the inappropriate emotional response of reacting violently. When Tom is calm in school social skills will be taught to him giving him the chance to practice proper social skills through the use of modeling and role playing with other students in his classroom. At home the behavior treatment program will be in place where his parents will reward his appropriate behavior while inappropriate emotional responses will cause him to lose privileges. When Tom loses privileges he
Tom will need to complete a role play with his parents showing the correct way to react to the given situation. If Tom can do this calmly and correctly the time period he loses privileges will be reduced. This allows Tom to use his problem solving skills instead of countercontrol.

Tom’s treatment will avoid negative effects of countercontrol by maintaining consistent treatment across all of the settings that he is receiving treatment. If and when Tom attempts to use countercontrol to avoid the consequences of exhibiting the undesired behavior he will receive a punishment and/or lose privileges. This will encourage Tom to use his problem solving skills.

Tom’s comorbid condition is ADHD. While ADHD often responds best to pharmacological treatment research has also shown that results are the best when paired with social skills training (Sadock et. al., 2003), which Tom will be receiving.

Tom’s treatment will also be multisystemic and multimodal. To be multisystemic it is important that Tom’s parents receive parenting classes to help teach them appropriate parenting skills. A family intervention, as opposed to sole behavior treatment, appears to have the most promise in extinguishing antisocial behavior long term (Miller & Prinz, 1990). The family intervention is focused on improving old parenting skills and adding new parenting skills by teaching general principles of
behavior management as well as teaching the parents how to track behaviors and proper forms of discipline for undesired behaviors and rewards for desired behaviors. The new skills that Tom’s parents need to learn include conflict resolution, self-control, and goal setting (Miller et. al., 1990).

To help ensure that Tom’s parents are successful it is also important that they have a social support system. Spitzer, Webster-Stratton, and Hollinsworth (1991) stated that parents with children who have CD often feel isolated from other parents with normal children. They stated that when parents have a social support system where they can honestly discuss their difficulties with their children they begin the feel a sense of connection and that they are not alone. Getting parents in contact with other parents who are experiencing the same difficulties and can share their successes will most likely result in better parenting because they will not only be less stressed and isolated, but they will also have a larger set of tools with which to work with their child.

Tom’s has an avoidant attachment style. Like many individual’s with avoidant attachment he is overly aggressive, misreads social cues, and using his anger in an attempt to control those around him. His behavior alienates his peers and this further reinforces his negative world view (Penzerro & Lein, 1996). The negative antisocial behavior that Tom exhibits,
in part because of his avoidant attachment style, is an attempt on his part to minimize distress caused by his avoidant attachment style (Brown et. al., 2003). To help Tom improve his avoidant attachment, that is to move from insecure attachment to secure attachment he needs to be able to form social bonds with others. For that to occur the practitioner, and others working with Tom, need to adjust the level of empathy, physical activity, physical affect, pace of work, and emotional depth to one that matches his (Dolan et al., 1993). In this manner Tom will not feel as if he is being challenged and he can use his attribution training to work on improving his world view.

Application of intervention on an adolescent with CD will be more like that of an adult. The key factor to consider will be the onset of the disorder with the adolescent, as childhood onset tends to exhibit more severe antisocial behaviors (American Psychiatric Association, 2000) and has a higher rate of developing into an antisocial personality disorder than adolescent onset of CD (Loeber et al., 2002). To see how the treatment program would be applied to an adolescent we will look at John.

Like Tom, because of the diagnosis of CD we must take into consideration that John reads others actions towards him as hostile. To counteract this John should participate in attribution training. This training will be very similar to that
of Tom. When John is with the practitioner he will be able to work on role-plays that will prepare him for real life social situations.

We will assume the the CDS indicated that John scored high on the aggressive conduct, deceitfulness and theft, and rule violation scales therefore the target behaviors for treatment will be A) aggression towards people and animals as shown by bullying of his peers in school which resulted in his needing to be escorted between classes and throwing desks in the classroom, C) deceitfulness and theft as shown by his arrest and probation for breaking and entering, and D) serious violation of the rules as shown by his disregard for his parent set curfew and truancy from school.

When treating John’s targeted antisocial behaviors a behavior treatment program will be put in place (See Figure 2). The specific behaviors being targeting in John’s case include truancy from school, not following his mother’s rules, violence towards his peers, and reacting with violence when he receives feedback from teachers when his behavior is inappropriate.

To treat these targeted antisocial behaviors John, like Tom, would benefit from social skills training. However since John is older than Tom he can also benefit from treatment that requires a higher developmental level of cognitive processing. In addition to social skills training John should receive
training for coping with anger and problem solving (Mpofu et.
al., 2001). Additionally it is important for John to have
contact with a prosocial peer group so that he has a model for
what his behavior should be (Gertan, 2000).

The anger management training will include educating John on
how cognition and behavior both affect anger, cognitive and
behavioral techniques for managing anger such as relaxation
through techniques such as diaphragmatic breathing (Warren,
2002), assertiveness, anticipation of emotion and triggers of
anger, self-evaluation of emotions and triggers, and allowing
practice of newly learned anger management techniques through
the use of role-playing and using journals to log anger
triggering situations as well as when anger was successfully or
unsuccessfully managed (Kellner & Bry, 1999). The use of
journals to track his own behavior will help John become more
self aware of his own emotions as well as what can trigger his
anger so that he can use the anger management techniques, such
as relaxation, to avoid his behavior escalating into a violent
episode.

When adolescent’s with aggressive problems such as John come
across a problem they are able to identify the components of the
problem, however their solutions tend to be more aggressive than
the solutions of adolescents and children who do not have
aggression problems (Bloomquist, August, Cohen, Doyle, &
The key to John learning problem solving skills is to learn verbally assertive strategies to solve problems and to inhibit physically aggressive strategies. The use of role-playing seems to be the most effective means of learning these strategies for adolescents with CD (Dunn, Lochman, & Colder, 1997). The steps John needs to use to obtain verbally assertive strategies include:

1. Stop and stay calm, think before he acts.
2. State the problem and how he feels about the problem.
3. Setting positive goals for himself (how will he overcome the problem?)
4. Thinking ahead towards the consequences of using physically aggressive strategies and of using verbally assertive strategies.
5. Try the best plan with the most favorable consequences (Mpofu et. al., 2001).

In the school setting, as with treatment in the home, treatment will be multimodal. Treating the targeted behaviors, as well as encouraging John to use problem solving skills and anger management, will continue in the academic setting. In school John will receive rewards for responding appropriately when he receives feedback from his teachers on his academics as well as on his behavior as well as for following school rules and interacting appropriately with his peers. John will
experience a loss of privileges if he does not use his verbally assertive strategies, such as discussing a social issue with a peer, and instead opts to use physical aggressive strategies, such as bullying to get his way, to problem solve or uses countercontroling behavior. In the home John’s mother will reward him for obeying the rules, going to school, and using his verbally assertive problem solving skills; while he will lose privileges for truancy, not following the rules, aggressive problem solving and countercontroling behavior. Like Tom, loss of privileges for countercontroling behavior will encourage him to use his problem solving skills to come up with more appropriate means of getting what he wants, which is to do what is asked of him.

John’s comorbid conditions include ADHD and dysthymia. Both of these conditions often respond well to pharmacotherapy, for ADHD stimulants of the central nervous system and for dysthymia antidepressants, so it is important that John see his family physician or a psychiatrist for this form of treatment. For treatment along side of pharmacotherapy ADHD often responds well to social skills training. It is also important that that John learns that he is capable of meeting reasonable expectations despite the difficulties his ADHD presents (Sadock et. al., 2003), which means that it is important that John does not develop a sense of helplessness. Dysthymic disorder can be
treated with antidepressants; however there is a common belief that this disorder is mainly psychological and not biological. As a result psychotherapy is the most common treatment for dysthymia (Sadock et. al., 2003). These treatments should occur parallel with the other interventions John is receiving for CD.

To ensure that John’s treatment is multisystemic the treatment outline will be very similar to that of Tom’s, meaning that the family systems theory will play a large role (Gertan, 2000). When looking at John’s family dynamic he lives with his mother and stepfather and has contact with his biological father on a regular basis. His mother is often inconsistent with both setting boundaries and doling out consequences for John. As a result John has stated that he is often able to get his way by repeatedly asking his mother for what he wants and wearing her down until he gets the desired result. John also ignores curfew and will stay away from home if he does not get what he wants. This is a good example of how John uses countercontrol to get his way with his mother. As with many CD cases, a family intervention is also appropriate for John’s family as part of his treatment to improve his mother’s parenting skills and teach her how to be consistent with discipline and rewards (Miller et. al., 1990). Key behaviors that his mother will need to learn is not giving into John’s countercontrolling behavior by not accepting his disregard for the rules as well as making him
accountable for his behavior by being consistent with punishment for the undesired behavior.

John’s parents have a larger social support system than the parent’s of Tom, as John has several siblings who have many of the same problems as he does. However John’s parents would benefit in much the same way from having a peer group to learn how other parents have experienced success in using the new skills for treating their child with CD (Spitzer et al., 1991).

In regards to John’s attachment style, he too has an avoidant attachment style. Like Tom John’s is overly aggressive, misreads social cues, and using his anger in an attempt to control those around him. John’s aggressive behavior is now to the point where it is extremely dangerous as exemplified by his incident of throwing a peer down a flight of stairs. His behavior alienates his peers and this further reinforces his negative world view, which is a catalyst for his antisocial behavior (Penzerro & Lein, 1996). The negative antisocial behavior that John exhibits, in part because of his avoidant attachment style, is, like Tom, an attempt on his part to minimize distress caused by his avoidant attachment style (Brown et. al., 2003). To help John improve his avoidant attachment, that is to move from insecure attachment to secure attachment he needs to be able to form social bonds with others. For that to occur the practitioner, and others working with John, need to
adjust the level of empathy, physical activity, physical affect, pace of work, and emotional depth to one that matches his (Dolan et al., 1993).

Discussion

Conclusion

Current singular programs do not produce sustained results for treatment of CD. The merging of multimodal, multisystemic, CBT, attribution training, social skills training, and aftercare programs use the strongest points of each singular program to increase the chances of success.

While both the onset of the condition and the age in which treatment is put in place both have the possibility of an effect on the treatment outcome (Loeber et al., 2002), meaning whether the child or adolescent will decrease their antisocial behavior or the disorder possibly progresses to APD, they are not necessarily a determinate of the outcome.

Attribution training early in treatment plays a key role in helping the child or adolescent understand that the intentions of others are not necessarily hostile, which could be the root of many of the antisocial behavior and violent reactions (Mpofu et al., 2001). Later on, CBT and social skills training, paired with a multimodal and multisystemic treatment model ensures that the child is able to practice their appropriate skills across several different social environments, giving them
the opportunity they need to see from experience that when they apply the attribution training the outcomes of their behavior will not be negative when their responses are not antisocial.

In regards to countercontrol, this is a response that the child or adolescent will use when they do not like what the parent, practitioner, or teacher is asking and expecting from them (Carey et. al., 2006). It is a means of getting the individual with expectations to change their expectations to more closely match what the child or adolescent wants to do. Countercontrol needs to be treated in the same manner as the antisocial behavior, which will make the child or adolescent use their problem solving skills to come up with better verbally assertive strategies when confronted with a problem.

Insecure attachment style contributes to the antisocial behavior patterns associated with CD. While an avoidant attachment style cannot be held solely responsible for the antisocial behaviors, transition towards secure attachment holds the possibility of reducing, at least in part, some of the antisocial behaviors and the child or adolescent’s perception of the world around them.

Finally, follow-up treatment to maintain the gains in reducing antisocial behavior is the last integral part to treating CD as most research finds that there is a reversal of gains, and the child or adolescent falls back into antisocial
behavior after one year (Gertan, 2000). Continuing to offer supports such parental support and a prosocial peer group for the child or adolescent may help to maintain behavioral gains.
References


Treatment Program Outline

<table>
<thead>
<tr>
<th>Name: Tom</th>
<th>Age: 7 years</th>
<th>Date: 11/11/06</th>
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<tbody>
<tr>
<td>Diagnosis: Conduct Disorder</td>
<td>Practitioner: Nicole Ubinger</td>
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</tbody>
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- Comorbid Disorder(s)  
  - ADHD
  - Depression
  - Dysthymia
  - Learning Disability
  - Other (Specify)

Evaluation Tools:
- Conduct Disorder Scale
  - Aggressive Conduct
  - Hostility
  - Rule violation
- Children’s Interview for Psychiatric Symptoms
- Results: CD, ADHD
- Wide Range Achievement Test 3
- Problems with:  
  - Reading
  - Spelling
  - Arithmetic

Multisystemic Treatment:
- Issues that need to be addressed in treatment:  
  - Economic
  - Family Social Supports
  - Child Abuse
  - Parenting Skills

Multimodal Treatment:
- Treatment will be administered in the following locations:  
  - Home
  - School
  - After School Program
  - Counselor

Treatment Outline:
- Targeted Behaviors
  1. Violence towards Peers  
     - Social Skills Training
  2. Violence towards Adults  
     - Anger Management Training
  3. Accepting Feedback Appropriately  
     - Problem Solving Training
  4.  
     - Family Intervention
     - Attribution Retraining
Figure 2

Treatment Program Outline

<table>
<thead>
<tr>
<th>Name: John</th>
<th>Age: 13 years</th>
<th>Date: 11/14/06</th>
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<tbody>
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<tr>
<td>Comorbid Disorder(s)</td>
<td>ADHD</td>
<td>Depression</td>
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</table>

Evaluation Tools:
- Conduct Disorder Scale
  - Aggressive Conduct
  - Hostility
  - Deceitfulness and Theft
  - Rule violation
- Children’s Interview for Psychiatric Symptoms
- Results: CD, ADHD, Dysthymia
- Wide Range Achievement Test 3
- Problems with: Reading, Spelling, Arithmetic

Multisystemic Treatment:
Issues that need to be addressed in treatment:
- Economic
- Family Social Supports
- Child Abuse
- Parenting Skills

Multimodal Treatment:
Treatment will be administered in the following locations:
- Home
- School
- After School Program
- Counselor
- Mentoring Program

Treatment Outline:
Targeted Behaviors
1. Aggression towards Peers
2. Truancy
3. Accepting Feedback Appropriately
4. 

Treatment Guidelines
- Social Skills Training
- Anger Management Training
- Problem Solving Training
- Family Intervention Training
- Attribution Retraining

Program Outline
- Home
- School
- After School Program
- Follow-up Treatment/Support
- Counseling
- Mentoring Program