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.

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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

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:

1. Stop. Calm down. Think before you act (Impulse).

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 (Mpofu, 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

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 sever 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, &

Everhart, 1997). 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 countercontroling 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 produced 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 the 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.

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Figure 1

Treatment Program Outline

Name: Tom Age: 7 years	Date: 11/11/06
Diagnosis: Conduct Disorder	Practitioner: Nicole Ubinger

☒ **Comorbid Disorder(s)** ☒ ADHD ☐Depression ☐Dysthymia
                    ☐ Learning Disability ☐ Other (Specify)

Evaluation Tools:
☒ Conduct Disorder Scale
      ☒ Aggressive Conduct ☒ Hostility ☐ Deceitfulness and Theft
      ☐ 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	Treatment Guidelines
1. Violance towards Peers	☒Social Skills Training
2. Violance towards Adults	☐Anger Management Training
3. Accepting Feedback Appropriately	☐Problem Solving Training
4.	☒Family Intervention
	☒Attribution Retraining

Figure 2

Treatment Program Outline

Name: John Age: 13 years	Date: 11/14/06
Diagnosis: Conduct Disorder	Practitioner: Nicole Ubinger

☒ **Comorbid Disorder(s)** ☒ ADHD ☐Depression ☒Dysthymia
☐ Learning Disability ☐ Other (Specify)

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　　　　　　　　　Treatment Guidelines
1. Aggression towards Peers　　　　☒Social Skills Training
2. Truancy　　　　　　　　　　　　☒Anger Management Training
3. Accepting Feedback Appropriately☒Problem Solving Training
4.　　　　　　　　　　　　　　　　☒Family Intervention Training
　　　　　　　　　　　　　　　　　☒Attribution Retraining

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