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# Treatment of Antisocial Youth and Families

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The treatment of conduct disordered youth and their families is difficult work. The fundamental problem in most cases of conduct disorder revolves around the fact that the disorder is multiply determined. Of course, the basis for making a diagnosis (American Psychiatric Association, 2000) is specified by a youth violating other people's rights and major societal norms. However, problems are seldom limited to individual functioning of the youth. Multiple factors implicated include features of the individual child or adolescent, family, peer, school, neighborhood, and community. The symptoms of conduct disorder (e.g., physical aggression, property destruction, criminal behavior) more typically arise out of a developmental sequence with known features. The factors that are most often implicated also appear to underpin a lack of long-term effectiveness of many intervention programs. However, a number of programs over time have been capable of demonstrating short-term effectiveness. Additionally, more recently developed programs, particularly those that target multiple risk and protective factors, have been shown as capable of producing and sustaining long-term gains.

In following the literature on risk and protection combined with developments in treatment models and dissemination, the current contribution aims first to provide the reader with research and practice information about both of these areas. To illustrate, case studies are also presented. The first set of case studies focuses on risk and protective factors; the second set, on assessment and intervention practice. Finally, we summarize with recommendations, with a focus on evidence-based practice. However, even within an evidence-based model of practice, the research has documented problems with transporting these models into day-to-day practice settings (e.g., Curtis, Ronan, & Borduin, 2004; Henggeler, 2004). Consequently, consideration of real world issues, including resource and time limitations, high caseloads, early dropout, and the inability to mirror fully some of these practice models in many settings, needs to be undertaken by practitioners. One goal of this contribution is to help day-to-day practitioners gain the knowledge that will allow for informed choices about how to increase the effectiveness of their practice with highly disruptive youth and families. In fact, the entire premise of this contribution rests on the idea that day-to-day practitioners can make useful adjustments to their practice – even in the face of what appear to be significant obstacles – that can be translated into clinically significant changes for these youth and families. Thus, in that service, an organizing theme while reading this contribution might be to consider the questions, “How might the information presented here assist me, or my organization, to improve the delivery of services to this population?” and “How might I do this in the face of what others assert to be insurmountable obstacles?”

## RISK AND PROTECTIVE FACTORS: VULNERABILITY AND RESILIENCE

### Risk Factors: The Prominence of Peer and Family Factors

Table 1 (p. 7) presents a representative list of some of the major risk and protective factors for antisocial outcomes in youth initially adapted from Henggeler (1996) and more recently updated.

In terms of relative risk, the factor that has the most powerful influence on the functioning of many youths at risk for conduct disorder and antisocial outcomes is association with deviant peers. However, it is also the case that this influence has identifiable precursors that include the quality of the family environment. For example, conduct disordered youth more often come from family environments that are typically low in warmth and affection. These families tend also to use coercion and other ineffective discipline practices. As pointed out by Collins et al. (2000), the influence that family and parent-child relationships have on later associations with antisocial peers in adolescence has been characterized in the following way:

[deviant peer relationships] rightly should be viewed as the end of a long process of socialization that began early in childhood and most likely has its origins in the family. (p. 227)

### Peers as a Powerful Risk Factor: The Role of Socialization and Peer Contagion

Putting peers with problems together is a particularly powerful predictor of future problems. Dishion and Dodge (2005) recently edited a special issue of the *Journal of Abnormal Child Psychology* on this issue, referring to the problem of "peer contagion" in both naturalistic and treatment settings. For example, they concluded that "peer contagion may result from aggregation that occurs . . . ranging from preschool through college" (p. 396). Related more specifically to antisocial development in youth, there is ample evidence of the negative influence of deviant peer groups (see review by Granic & Patterson, 2006).

Underpinning these problems are findings supporting both a *selection* and a *socialization* effect (Prinstein & Wang, 2005). In simple terms, peers tend to choose, or select, like-minded peers. Once selected, peers then socialize each other to conform and act in certain ways. Related to antisocial behaviors, children rejected by prosocial peers because of aggressive and other behaviors tend to migrate in the direction of similar at-risk children. The overall idea here is that these children then begin to be subject to socialization effects through various mechanisms including deviancy training (Dishion, McCord, & Poulin, 1999), competition (Warren et al., 2005), and the use of aggressive and coercive problem-solving strategies (Granic & Patterson, 2006), including various forms of peer pressure. Various beliefs are also implicated, including perceived peer demand and false consensus (Prinstein & Wang, 2005), social contingency beliefs (Urberg, Cheng, & Shyu, 1991), and the hostile attributional bias (Dodge, Bates, & Pettit, 1990).

A particularly powerful influence identified by Dishion and colleagues is deviancy training, defined as "the process of contingent positive reactions to rule-breaking discussions" (Dishion et al., 1999, p. 756). Dishion et al. reviewed a number of studies (e.g., Dishion et al., 1995) that used a 25-minute videotaped problem-solving discussion format. It was found that in delinquent pairs of 13- to 14-year-old adolescent boys, the frequency and duration of antisocial solutions were strongly related to the rate of reinforcement – some form of positive affect

**TABLE 1: Risk Factors for Antisocial Outcomes**

INDIVIDUAL	FAMILY	PEER	SCHOOL	NEIGHBORHOOD AND COMMUNITY
<ul style="list-style-type: none"> <li>• Temperament</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of parental supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Association and influence of deviant peer groups, including deviance training</li> </ul>	<ul style="list-style-type: none"> <li>• Features of school (disorganized, chaotic)</li> </ul>	<ul style="list-style-type: none"> <li>• High levels of criminality and antisocial practices</li> </ul>
<ul style="list-style-type: none"> <li>• Alcohol and drug use</li> </ul>	<ul style="list-style-type: none"> <li>• Ineffective discipline:                             <ul style="list-style-type: none"> <li>- including coercive cycle</li> <li>- including child maltreatment</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Poor social skills</li> </ul>	<ul style="list-style-type: none"> <li>• Poor academic functioning</li> </ul>	<ul style="list-style-type: none"> <li>• Low levels of support available</li> </ul>
<ul style="list-style-type: none"> <li>• Attention-Deficit/Hyperactivity Disorder and aggression</li> </ul>	<ul style="list-style-type: none"> <li>• Poor parent-child relationship</li> </ul>	<ul style="list-style-type: none"> <li>• Low social conformity</li> </ul>		
<ul style="list-style-type: none"> <li>• Beliefs:                             <ul style="list-style-type: none"> <li>- hostile bias</li> <li>- false consensus</li> <li>- antisocial attitudes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- low warmth and affection</li> </ul>			
	<ul style="list-style-type: none"> <li>• Parental difficulties (e.g., substance abuse, psychiatric conditions, criminal activity, parent/marital conflict)</li> </ul>			

(e.g., laughter) - that each provided the other for engaging in and continuing rule-breaking talk. In these prospective studies, it was found that that 25-minute segment alone predicted problems (i.e., substance use, delinquency, violent behavior) at ages 15 to 16. More recently, deviancy training has been found to predict problems such as adult convictions and substance abuse 5 years later (Patterson, Dishion, & Yoerger, 2000). Another more recent study found this phenomenon in kindergarten children (Snyder et al., 2005). The point here is that from a young age, deviancy training appears to be a particularly powerful predictor of later problems.

Another mechanism implicates the idea of competition (Warren et al., 2005). The basic idea here is that aggressive behavior can provoke a response in kind to prevent victimization. Thus, consistent with the idea of coercive problem-solving strategies (see next section), a number of studies have documented that reciprocating an aggressive act has been shown to terminate another's aggression (e.g., Granic & Patterson, 2006). Although this includes nonaggressive preschool children who have been found to reciprocate aggressive acts, findings to date appear to suggest this effect to be most characteristic of those children who have higher initial levels of aggression (see Warren et al., 2005). The main idea of this section for the practitioner is that clustering children at risk for antisocial outcomes can produce a cycle of aggressive and other antisocial behaviors: to prevent victimization, get approval, increase status, and so forth. Thus, to anticipate the discussion on treatment approaches, those that directly take into account the powerful influence of peers are more likely to have benefits for youth and their families.

## **Family Factors**

A main pathway to peer association – whether prosocial or deviant – is through the family context. In terms of deviant peer association, some main family risk factors appear central. Namely, three stand out particularly in the context of treatment targets (Eddy & Chamberlain, 2000). These three are:

- lack of warmth and affection (lack of positive parent-child interactions),
- lack of effective discipline strategies (lack of ability to be appropriately firm while at the same time being emotionally responsive), and
- lack of monitoring and supervision.

As seen in Table 1 (p. 7), other factors play a role and can include parental psychopathology, substance abuse and criminality, parental and marital discord, child maltreatment and neglect, and others. Although these factors can play quite an important role, the most important proximal factors are those that directly revolve around parenting practices: paying attention and being affectionate while at the same time being consistent and predictable in promoting prosocial and discouraging antisocial behavior. This latter feature of parenting of course includes effective discipline practice combined with appropriately supervising and monitoring the child and his or her interactions with others. In families at risk, problems in these areas can manifest in what has been referred to as a negative reinforcement and coercive cycle.

The first main idea here is that if coercive acts are reinforced, they will tend to happen more often (Patterson, Reid, & Dishion, 1992). In addition, aggressive behaviors tend to elicit aggressive behaviors in return, particularly in the face of reinforcing consequences for the aggressive reaction (Patterson, 1982). The main form of reward in this model is a reduction or termination of an aversive consequence. Thus, when a parent uses some form of coercion (e.g., verbal, physical) that is followed by child compliance (i.e., the child stops misbehaving), the parent is reinforced for his or her use of that coercive strategy. The child is also reinforced by the parent terminating the coercive act. Thus, owing to the mutually reinforcing quality of this interaction, there will be a tendency for it to be repeated in the future. In addition, findings

support the idea that various forms of coercive parenting (including corporal punishment) tend to produce immediate compliance (Gershoff, 2002).

However, one problem, among many, with this set of events is that there is a tendency for coercive acts to be reciprocated over time by the child and for a coercive cycle to be established. For example, a parent may begin to use coercive strategies increasingly, even for slight infractions. In fact, in families at risk (i.e., clinically referred), it was found by Patterson and colleagues (1992) that there was an intrusive interaction from a family member approximately every 3 minutes, typically coming in the form of a vague reprimand or command (see also Granic & Patterson, 2006). In the face of these occurrences, the child may then begin to resist. Patterson et al. (1992) documented that the resistance may come in the form of some aversive or coercive behavior (e.g., complaining, temper tantrum). In the event of a discipline attempt not being successful (e.g., in the face of a tantrum the parent becomes frustrated and withdraws or gives in; the parent is distracted by another event), the child's resistance (or misbehavior) may be reinforced. In this scenario, the parent may also be reinforced by giving in if the child then terminates the aversive behavior. Over time, the child begins to learn how to resist a parent's discipline attempts more often. In fact, the child may increasingly begin to use coercive strategies to try to get various needs met. Once a coercive cycle is in place, despite the parent or child getting some immediate need met, the child is then put at risk – both in the short and longer term – for problematic outcomes. For example, in research by Patterson (1982), in the shorter term, when parents used coercive strategies to punish acts of aggression in their children, it raised by half the chances that the child himself or herself would also engage in coercive behaviors. In the longer term, such parenting strategies have also been found to predict problems longitudinally, over 1 year (Pettit, Bates, & Dodge, 1993) and 2 years (Patterson et al., 1992).

When such a cycle is combined with a lack of positive attention paid to the child at other times, problems are likely to be exacerbated. Positive attention includes times for providing both “noncontingent reinforcement” (warmth, affection, positive interactions) and paying attention when he or she is behaving well and interacting well with others. Additionally, although coercive discipline has been shown to predict problems, it isn't to say that a child is not in need of limits set on behavior. In fact, as shown by Patterson and others (Patterson, 1982; see also Dishion et al., 1999), overly permissive parenting is also a predictor of later problems, including antisocial behaviors. Consequently, parenting that emphasizes being emotionally responsive but also being appropriately firm appears to be the balance that research supports as protective for children, including those at risk for conduct disorder (e.g., Collins et al., 2000).

In terms of propelling youth toward particular peer groups, these factors appear to influence the process of socialization (e.g., Dodge & Pettit, 2003). Socialization effects can be both direct and indirect (Parke & Bhavnagri, 1989). Direct effects include encouraging association with some children and prohibiting it with others; for example, through the management of social activities. Indirect effects would include the influence of parent and family factors that create certain attitudes, predilections, and personality factors that then influence the choice of peers with whom to associate (B. Brown et al., 1993). One of the risks is learning a style of interacting with others (e.g., aggression, coercive problem-solving style) that leads toward delinquent peers in adolescence as the preferred or, perhaps for some, the default socialization group. Youths who come from coercive families and who themselves engage in coercive problem-solving strategies also tend to interpret situations as more hostile and aggressive (Dodge et al., 1990). These youth tend also to be rejected more often by prosocial peers. In fact, as new peer groups form (e.g., in schools, at camps), it has been found that it can take one day or less for children to label an aggressive child as disliked (Coie & Kupersmidt, 1983; Erhardt & Hinshaw, 1994).

### **Other Risk Factors: Individual, Family, School, Neighborhood, And Community Contexts**

What appears to be a relatively straightforward sequence of events (i.e., overly coercive parenting leading to friendships that provide a context in which to practice coercion; Dishion et al., 1995) actually involves a more complex interplay of factors. These include additional family factors and a range of community, school, and cultural factors that can mitigate or exacerbate outcomes for a child. For example, certain parenting practices have been found to play a role in the selection of peers as described. However, additional influences on parenting practice may be at work. For example, Furstenberg et al. (1997) found that families who live in high-crime neighborhoods may make attempts to protect the child from danger. This can include restricting the range of access the child has to various neighborhood activities. Although this may protect the child from danger, it might also restrict the development of a sense of independence and autonomy and perhaps unintentionally propel the child in the direction of those very influences (for other examples of this type, see Collins et al., 2000). Of course, it is possible that deficits in parenting may be related to individual problems of the parents. A mother with solid parenting skills is likely to be less effective if depressed; a father may be unlikely to convince his adolescent son of the value of prosocial activities if he is engaging in criminal behavior and substance abuse. A main issue reiterated here is that parenting and peer influences tend to be related within a larger family, community, and cultural context (see also Table 1, p. 7).

### **The Role of Prominent Risk Factors: Case Examples**

The peer and family factors discussed – peer association, parental warmth and affection, discipline practice, and monitoring and supervision – appear to be particularly prominent in the development, as well as treatment (Eddy & Chamberlain, 2000), of conduct disorder. The following examples highlight the role of family factors as well as the role that these family factors played in creating pathways to problematic behaviors, including increased deviant peer association and influence, in two separate treated cases. Although the four main factors are emphasized in these case studies, other risk factors are also illustrated.\*

#### ***Case Example: Upping the Ante***

This case involved referral of a 15-year-old boy with a diagnosis of conduct disorder and a childhood history of Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and aggressive behavior. His primary caregivers were his mother and father. The mother and father were both employed in blue-collar professions. Both parents had a history of low-level criminal involvement and substance abuse. In addition, the father had a current pattern of regular substance use, including cocaine, barbiturates, and alcohol. Although both parents were involved in caregiving, the father was not around the home as much as the mother. When the family was referred, the youth was in frequent legal trouble and at risk for long-term placement.

In following the emerging research literature (see next section on treatment), it was decided to carry out assessment and, subsequently, treatment, at the family home. At this point, it is worth mentioning to the reader that even if treatment cannot be carried out in a home setting, early home visits (or observing some structured office-based interactions; see treatment section) can be quite helpful. When visiting the family home in this case, it became apparent fairly early that there were coercive processes in place. For example, the mother or father would

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\*Case details have been altered to protect confidentiality.

variously threaten the children, including the 15-year-old, with some unspecified punishment for minor breaches but would not tend to follow through in any consistent manner. Both would tell the children to "go away" while the parents and therapist were meeting. However, the children would reappear at the living room door in fairly short order, only to have more threats, initial compliance, and reappearance within minutes. This proved to be a repetitive cycle. At one of the early visits, while the children were away from the living room, the 15-year-old apparently hit a younger sibling in a back bedroom. At this point, the mother – with the father's assistance – tried to intervene to discipline the child by trying to enforce a long timeout (as an aside here, another child came up to the therapist and told him quietly that "usually he gets hit").

However, in this instance, the adolescent resisted the parents' attempts by "back-talking," raising his voice, and starting to make threats. When the parents told him he had to stay in his room, he resisted and stated, "go ahead and make me." In this instance, the mother repeated the directive using a raised voice (with threatening tone), and the son again resisted, all in what might be referred to colloquially as an "escalating control battle." The son continued to resist and ultimately started to yell and scream and threaten property destruction. The end to this (coercive) cycle was initiated by the parents who told the young man to leave the house (e.g., "just go outside, will you"). At that point, the adolescent left the family home. When discussing with the parents the regularity of such occurrences, they both said that they had been dealing with this kind of behavior since an early age. When asked where he goes, both parents stated that they weren't always sure, but both expressed some relief about having some temporary "peace and quiet."

It turned out that this adolescent boy generally found his way to a group of other adolescent boys who regularly got into trouble (e.g., firesetting, breaking and entering, theft, stealing cars, bullying, and assault). This led to being picked up by police on several occasions and legal trouble, including the potential for removal from the family home.

#### ***Case Example: Warm But Not Firm***

This case involved a 13-year-old boy being raised by a single mother with a history of depression, employed as a night cleaner. The father was apparently no longer involved but was known to the children and, according to the mother, had several past reports made about him to the child protection agency for both neglect and abuse. The boy was the youngest in a family of four children. He had longstanding diagnoses of ODD and ADHD and more currently met the criteria for Conduct Disorder (CD).

These risk factors included starting to spend more unsupervised time away from home with a group of boys who were well known to the local community as "troublemakers." At the home itself, it was apparent in the first visit that discipline with the boy was lax. On the other hand, it was also apparent that this mother had the capacity to be quite warm and attentive with all of the children. Nevertheless, when the 13-year-old was acting up, the mother didn't set firm limits. Instead, she appeared to try to reason with him so as to convince him not to continue misbehaving. As she later described to the therapist, she had a belief that being both warm and firm were not particularly compatible. Such a belief was based on her own upbringing (i.e., coming from a harsh discipline background). This belief was combined with her strong feeling that she needed to provide balance to the father's formerly "firm" ways (i.e., punitive and, in some instances, reportedly abusive). Related to these beliefs, she felt being loving and attentive should naturally be reciprocated with "respect" and adherence to family rules. Compounding these beliefs were low levels of energy she reported that turned out to be secondary to depression.

During an early home visit, when still doing assessment, an incident related to "warm but not firm" occurred that was instructive to later intervention effectiveness. The therapist arrived and engaged in small talk with the children prior to a planned individual meeting with the



mother for information-gathering purposes. When the time came to sit down with the mother, she asked her children to occupy themselves. The other three children all complied, but the 13-year-old did not. Instead, he continued to stand at the periphery of the living room. After the other children left, the mother said, "Can you please go out and play?" The 13-year-old demonstrated his refusal to comply by not moving as well as starting to smile. The mother repeated the request several more times. He then mimicked her words and nonverbal gestures. After a few minutes, with the mother looking noticeably agitated (e.g., clenched hands, red neck, noticeable perspiration on her brow), the young adolescent said, "I am not going anywhere" while continuing to smile in the mother's and therapist's direction. At this point, the mother then – as she described it afterwards – "lost my cool." She said to the young person, in a noticeably different tone of voice with her finger pointing toward the door, "Now, you, go straight outside, right this minute, and I will tell you when you can come back inside. Do you understand me?" At this point, the boy stopped smiling and complied with his mother's request (i.e., left and remained in the backyard).

Immediately following this sequence of events, the mother apologized and said "sometimes that is the only way I can get him to listen." As the reader might have already discerned here, although the mother perceived herself to be losing her cool, what the therapist saw was a mother setting a necessary, and firm, limit in a manner that was not inappropriate. During our debriefing, the mother described giving in to her son's demands for a number of reasons. These included short-term relief, particularly during times of mood-related difficulties when her energy was lower, and to avoid the guilt she felt when she did lose her cool. As in the first case example, part of giving in to her son's demands was allowing him to leave the home and spend increasing amounts of unsupervised, unmonitored time with a peer group that put this child at increased risk. Also, owing to her ongoing depression, it was difficult for her to find the energy to engage in monitoring and supervision activities.

### **Concluding Comments: Family and Peer Factors**

As seen in the case examples, although prominent CD risk and protective factors were featured, it was also evident that each case had individual features unique to that family's particular situation. Consequently, in our practice, we emphasize a functional assessment (FA) framework. Part of doing a quality FA is being able to specify the causal chains of events that either do or do not lead to disruptive and CD outcomes. Of course, although FA is at its core highly specific to a particular situation or case, it is done here against the backdrop of what is known about the development and course of the disorder. Thus, the factors described should figure prominently when assessing the circumstances of a particular youth and family.

## **ASSESSMENT, MOTIVATION, AND TREATMENT**

Until the past decade, the main finding regarding a variety of modalities was that no intervention was capable of producing and maintaining clinically significant changes over the long term. A number of approaches – including Problem-Solving Skills Training (PSST/self-instructional problem-solving interventions; e.g., Kazdin et al., 1987; Kendall et al., 1990; Kendall, Ronan, & Epps, 1991; Ronan & Kendall, 1991), parent management training or behavioral parent training (PMT/BPT; Kazdin, 1998; Lundahl, Risser, & Lovejoy, 2006; Reyno & McGrath, 2006), residential, institutional-based forms of treatment (Hair, 2005), and others, including adventure programming and individualized wraparound care (see T. L. Brown,

Borduin, & Henggeler, 2001) – have generally been shown to be capable of producing some benefits on some indicators of functioning. However, these types of programs in general have not been shown to produce long-term significant change in major outcome indicators, including arrest, recidivism, and other factors (e.g., successful return to family and reduction in long-term institutionalization) (T. L. Brown et al., 2001; Curtis et al., 2002). On the other hand, some of these interventions, including PSST-related interventions and parent interventions, have been more successful than others. These approaches have been shown to be capable of producing clinically significant outcomes, particularly for families with younger and less disruptive children.

### **Treatment and the Role of Risk Factors Including Family Motivation**

One theme tying various forms of treatment together – apart from the fact that they do not tend to show robust long-term effectiveness on ultimate outcome indicators – is that they are typically focused on a limited number of risk factors. A trend in the past 2 decades has been on combining intervention modalities and focusing on a larger set of risk factors in interventions. Another trend has seen the arrival of intervention approaches that explicitly address family motivation to engage in treatment (Nock & Kazdin, 2005). This trend is borne in part out of the fact that families regularly drop out of treatment prematurely (e.g., Kazdin, Holland, & Crowley, 1997).

### **Developments in Treatment: A Move to Multicomponent Models**

Treatments initially developed for nonself-controlled, disruptive youth, including those with CD, traditionally focused on one modality or one set of risk factors. For example, cognitive-behavioral programs focus on helping the child to “stop and think” before acting (e.g., self-instructional problem-solving training [Ronan & Kendall, 1991]; interpersonally focused problem-solving skills training [Kazdin et al., 1987]). Similarly, a number of parent management training interventions have also been developed and tested (Reyno & McGrath, 2006). However, although these programs are intended to teach parents effective parenting strategies, many have not focused on known obstacles to parenting practice discussed in the previous section (e.g., parental stress, psychopathology, substance abuse, criminality, parental and marital discord), nor have they traditionally focused directly on barriers to treatment attendance and participation (e.g., Kazdin et al., 1997). The lack of focus on dealing directly with these factors may be one quite important reason underpinning the fact that these programs have generally been found to be more effective for less disruptive children compared to more severely disruptive children and adolescents (Reyno & McGrath, 2006).

However, given the findings on effectiveness in the short term, a number of more recently developed intervention models have combined various approaches. Additionally, other intervention models have increasingly focused on explicitly targeting known risk and protective factors as well as barriers to engagement. *In more recent years, evidence has begun to accrue that longer term changes may be possible with an increased focus on multiple component interventions, targeting important risk factors, and explicitly addressing a family's motivation for attendance and participation in treatment.*

What follows is a review of some of the better-researched programs beginning with a more structured, in-office program that has discrete, relatively prescribed components and moving on to one that more explicitly targets important risk factors. Then, community-based interventions that are delivered outside of office settings are reviewed.

### **Exemplars of Multicomponent, Office-Based Interventions: Prescribed Components to Targeting Specific Risk**

A number of multicomponent models have been developed and tested. The review here focuses on representative programs that (a) have used at least two separate components, (b) have been developed and improved over time, and (c) have supportive evidence. One particularly well-supported intervention package developed by Alan Kazdin and colleagues combines individual child therapy with parent skills training (e.g., Kazdin et al., 1987). The individual component – problem-solving skills training (PSST) – is a cognitive-behaviorally based intervention focused on helping the child learn effective interpersonal problem-solving strategies. This and other similar intervention approaches (e.g., Ronan & Kendall, 1991) are designed to help the child internalize effective problem-solving strategies: defining interpersonal problems, generating alternative solutions, consequential and reflective thinking, making decisions, self-reinforcement, and coping with failure. The parenting skills component – parent management training (PMT) – is designed to focus on both discipline strategies and positive parent-child interaction. PMT also includes a school component emphasizing teacher contact and behavioral reinforcement programs managed at home (Kazdin & Whitley, 2003). In combining PSST and PMT approaches, there is also an interactive component. The child and parents are brought together to demonstrate skills learned, practice, and review homework together. Of course, in line with a cognitive behavioral therapy (CBT) focus, feedback from the therapist in the individual and interactive portions allows for additional learning and consolidation of skills.

PSST and PMT interventions have been identified as well-established interventions for children with disruptive and conduct-related problems (e.g., Sheldrick, Kendall, & Heimberg, 2001). More recently, additional components designed to (a) decrease parental stress (Kazdin & Whitley, 2003) and (b) increase treatment attendance, participation, and motivation of parents (Nock & Kazdin, 2005) have been developed and tested. In both cases, these additional features have been supported. Thus, an emphasis on helping parents to engage with treatment and to focus directly on factors that can impinge on treatment attendance and participation (e.g., negative life events/stressors, younger maternal age, single parent status, and factors related to low income and education; Reyno & McGrath, 2006), as well as the ability to parent, is likely to be beneficial. A few caveats are in order. First, although PSST and PMT have been found to produce reliable change, this approach has been less effective in returning children to within normative limits (Sheldrick et al., 2001). On the other hand, and encouragingly, an explicit focus on motivation and addressing barriers to attendance and participation does not need to use excessive therapy time (5–45 minutes across eight sessions; Nock & Kazdin, 2005). Such a focus in the Nock and Kazdin study was found to increase treatment completion rates by 21%. However, the completion rate for this “increasing participation” condition was still only a modest 56%. Finally, samples in studies using PMT and PSST have tended on average to be younger children (e.g., under 7 years in Nock & Kazdin, 2005; under 10 in Kazdin & Whitley, 2003). The point here is that additional strategies to engage families and produce clinically significant outcomes with older (and more disruptive) youth are probably necessary in light of such findings.

Rather than prescribing components, the Adolescent Transitions Program (ATP) developed by Dishion and Kavanagh (2003) is designed to identify and target those areas of particular concern within the family of a youth with antisocial problem behaviors, particularly those at risk for more serious problems. Consequently, ATP emphasizes the family ecology, and the parents in particular, as the centerpiece:

Put simply, parents do make a difference. Interventions that support parenting practices need to be tailored to the cultural background of the family and promote adaptive communication and collaboration with schools. (p. vii)

Once a young person is identified through referral and screening as at high risk, ATP explicitly focuses on strategies to increase family engagement while conducting what is referred to as an "ecological assessment strategy" (Dishion & Kavanagh, 2003). These two pieces underpin what ATP calls the Family Check-Up. The engagement strategies are designed to combat the problem of treatment attendance and early dropout. Engagement in the ATP program builds on motivational interviewing (MI) philosophy and techniques. A main idea in MI is helping a client "develop discrepancies" between a current status (e.g., young person at high risk) and a value or goal (e.g., young person on a prosocial path) (Miller & Rollnick, 2002). The idea here is to help move a parent from an externalizing frame of reference (e.g., the child needs to make the change; the therapist needs to focus on the child, not the parents; "What I do as a parent doesn't matter") to a more internalizing focus (e.g., "What I do can make a difference for my child"). One of the strategies here is to address parent concerns directly, including linking these concerns to the services on offer. The focus overall aligns with the view of ATP that working within the family ecology is preferred to "one size fits all" (Dishion & Kavanagh, 2003, p. 52) interventions. Thus, through the use of a comprehensive assessment battery designed to elicit specific information about a family's strengths and weaknesses (<http://cfc.uoregon.edu/atp.htm>\*; see also Dishion & Kavanagh, 2003), the resultant intervention is designed to target a particular family's unique circumstances.

One feature of the assessment protocol used by ATP to assess family context is through videotaping family interaction. Called the Family Assessment Task, the family is asked to do the following in a 1-hour videotaped session:

- Plan an activity together.
- Parents lead discussion on promoting positive behavior in child.
- Child discusses example of time not being supervised or monitored with family present.
- Parents lead discussion on recent examples of limit setting.
- Family problem solving.
- Parents lead family discussion on substance use and beliefs.
- Family plans a celebration that is not already planned (i.e., not a birthday or regular holiday).
- Finish with opportunity to praise the child.

Along with other individualized measures, this task allows for assessing some important features of family functioning including relationship factors, discipline strategies, supervision and monitoring, family problem solving, family substance use beliefs, and the ability of the parents to pay positive attention to their child. Although videotaping may not be possible for the practitioner reading this contribution, the focus of this task can perhaps be instructive for structuring and guiding in-office assessment of features of family functioning.

Other assessment procedures used that can be transported quite easily into practice settings include daily report measures from the parent (and child) that target specific areas of concern (e.g., antisocial behaviors, substance use, peer association). These measures have been found to be reliable over time and sensitive to treatment effects. In ATP, the recommendation is to make brief phone calls to collect data; three 5- to 10-minute calls made by the same trained assistant (to enhance rapport) appear to provide a reasonably stable initial approximation (Chamberlain & Reid, 1987). Another easy-to-use measure is the House Rules Questionnaire (see Dishion & Kavanagh, 2003) that focuses on family rules with emphasis on parental monitoring. Home visits have also been found to be helpful to both assessment and engagement. For example, attendance at parenting sessions was seen to rise from about 30% up to 70% to 80% following a home visit (Dishion & Kavanagh, 2003).

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\*Although all websites in this contribution were correct at the time of publication, they are subject to change at any time.

Once assessment is complete, the Family Check-Up then concludes with feedback based on case formulation (Dishion & Kavanagh, 2003):

The primary goal is using data, expert advice, and a realistic menu of change options to support the parents' decision-making process regarding the need to change. (p. 77)

Other features of the feedback session include promoting parents as central to change, including their key role in monitoring and limiting deviant peer association. ATP also emphasizes a harm reduction approach: prioritizing areas of focus to ensure first that safety is maintained, families are kept together, youths are able to stay in school, and other similar situations are stabilized. With stabilization, additional interventions based on the case formulation can then target main treatment goals, including increases in positive parenting and decreases in youth misbehavior. To promote understanding of assessment results, feedback is tailored to a particular family's situation to help them understand the major issues and increase their buy-in to treatment.

Part of this tailoring involves emphasizing strengths, along with other strategies to be discussed later, to help the parents start to connect to therapy and view themselves as capable of making changes in the interests of their adolescent's functioning. Here, the recommendation is to provide a 4:1 ratio of strengths to problems. As a relevant aside here for the practitioner, this is also the "praise-to-correction" ratio recommended by ATP.

Intervention itself is focused on a model of stepped care (Ronan & Johnston, 2005). Designed to promote the idea of "least intrusive intervention," ATP uses a menu-based strategy that ranges from provision of self-help resources (e.g., handouts, brochures, books, audiovisual resources) through to parenting groups and then on to more individualized approaches including brief family interventions, school monitoring, and other strategies (e.g., helping parents to network effectively). The most intensive step is comprehensive family intervention.

Family intervention is recommended at least once a week, supplemented with frequent, brief assessments using measures like the daily reports described earlier. Promoting the idea of a flexible approach, ATP will do things like schedule more frequent meetings early as well as be willing to schedule visits to the home for sessions. In terms of their overall approach to therapy, Dishion and Kavanagh (2003) state, "Our approach to working with families is consistent with the multisystemic model" (p. 103). Given that the next main section focuses on the multisystemic model, and owing to space limitations, we will wrap up this section. However, first a brief word on two main sets of findings relevant to practitioners. First, the overall findings for ATP are that family-based intervention strategies have been found to be effective for reducing parent-child conflict and reducing youth antisocial behavior, including substance use:

We found that interventions focusing on family management were the most cost-effective strategy for reducing escalation in problem behavior among high-risk young adolescents. (Dishion & Kavanaugh, 2003, p. 173)

By contrast, an early attempt by ATP to increase efficiency through the use of group therapy for adolescents was found not only not to help, but also to increase problematic behaviors (Dishion & Andrews, 1995; see also Dishion & Kavanagh, 2003). Given this particular finding coupled with the fact that a number of intervention models continue to cluster youths together, we now turn to a discussion of group treatments before turning to community-based models.

### ***Group-Based Interventions With an Emphasis on Peer Influence***

This set of interventions has several youth with CD or antisocial behaviors clustered together. Taken together, the main findings for these approaches is that they too are capable of

producing short-term benefits (e.g., reductions in negative behavior; increases in prosocial behavior), but longer term benefits have generally not been supported (Frensch & Cameron, 2002).

As with the findings in early-generation ATP research just discussed, other research and reviews point to the potential for iatrogenic effects when clustering CD youths together in treatment (Dishion & Dodge, 2005; Dishion et al., 1999). As a contrast to what has become an increasingly mainstream viewpoint on the perils of deviant peer clustering, others have recently questioned the interpretation of findings in past studies and have offered up alternative reasons for negative, or reduced, effect sizes (Weiss et al., 2005). One of these, according to Weiss et al. (2005), is the fact that group therapies in general tend to produce lower effect sizes than individual or family-focused treatments, across a variety of problem areas (e.g., Weisz et al., 1995).

Nevertheless, although Weiss et al. (2005) make the overall claim that the risk for iatrogenic effects of group treatments is currently overstated, they conclude by saying, "We are not advocating the use of group treatments but simply that the evidence be evaluated more carefully" (p. 1043).

We also do not recommend the use of group-based treatments. The senior author has run a large state residential treatment facility for severely conduct-disordered youth in the U.S. in the 1990s, has worked in therapeutic camp settings for disruptive youth in the 1980s, and more recently has evaluated group-based conduct-disordered treatment programs. Both clinical experience and data suggest a role for iatrogenic effects. In more practical terms, managing highly disruptive youth in group settings (e.g., residential, camp, group settings) can on its own prove to be quite difficult. In support of clinical observations, Buehler, Patterson, and Furniss (1966) found in institutional settings a rate of reinforcement from peers to be greater than that provided by adult staff by a factor of 9. In other words, for each behavior being reinforced by adults, peers were reinforcing nine behaviors. Such a state of affairs can be difficult to manage, particularly in the face of peers reinforcing each other, including in subtle ways, for disruptive behavior.

In addition, group-based treatments as a primary modality may have difficulty being able to focus extensively on the main family-based risk and protective factors (e.g., parenting skills) or, alternatively, have a focus intensive enough to meet the needs of a severe CD youth (with or without his or her family). Finally, findings have underscored the fact that many treatment programs that do put youth together in fact are actually more expensive to run than alternatives discussed in this contribution and tend not to produce durable gains (e.g., Henggeler et al., 1998).

Having said all of this, we would also add that real-world considerations necessitate acknowledgment of the simple fact that youth in many areas of the U.S. and overseas continue to be treated in residential and peer group formats. However, we could not state more strongly that, even in the context of a secure residential treatment program, the role of the mental health professional is to ensure that the road is paved with the potential for long-term gains. Thus, we need to be mindful of the evidence around risk and protection within such settings. This certainly includes the potential role of peer influence and the resultant need to make sure staff is aware of the vital need for close monitoring and supervision. However, it is also the case that those residential and group-based programs that plan for long-term gains should find ways to focus on family factors and plan for long-term generalization early in treatment. In addition, with a recent summary of meta-analyses finding that residential treatment services tend to produce on average low effect sizes (average ES of around .19; Grietens & Hellinckx, 2004), along with the lack of long-term gain (Frensch & Cameron, 2002), other models need to be considered, particularly those that are "multi-modal, holistic and ecological in (their) approach" (Hair, 2005, p. 551). As one example, the senior author has had a role in assisting in the development of a government-funded program that originally was to have been a residential-

only treatment service for severely conduct-disordered youth. However, it is now a staged program that stresses short-term stabilization within a residential facility and longer term, more intensive care with a community-based and family focus in the final stage. One issue here worth emphasizing is that policymakers were willing to listen to arguments from an expert group that were based on evidence as well as on the idea that such a program would likely be seen as reflecting a real commitment on the part of the agency to follow a "best practice" model. We now turn our attention to one of the prominent community-based models.

### **Community-Based Interventions: Focus on Multisystemic Therapy**

Multisystemic Therapy (MST) is an intensive intervention model that is designed to be carried out directly in community settings – primarily the home – by a therapist who is capable of addressing all known risk and protective factors for antisocial behavior and outcomes (Henggeler et al., 1998). The main factors initially targeted, based on a functional assessment, are the following factors linked most often directly to antisocial outcomes:

- peer association
- features of the family (low warmth, poor discipline practice, lack of supervision and monitoring; conflict and coercive problem solving; parent and marital problems)
- individual, school, neighborhood, and community factors

Like ATP, MST focuses on a two-step strategy. The first step is engagement with the family, along with comprehensive assessment. Then, as family "buy-in" occurs and an initial formulation is arrived at, active treatment takes place. One of the ideas in MST being carried out in the natural environment is that it is thought to improve engagement. Given both concrete and philosophical barriers experienced by families (e.g., transport and babysitter problems, mistrust of social service professionals; Kazdin et al., 1997), one of the means for overcoming these is thought to be through providing the service at the family home (Henggeler et al., 1998).

As seen in Table 2 (p. 19), the overall model itself is predicated on nine guiding principles (Henggeler et al., 1998). As can be seen in the table, the idea in assessment is "finding the fit." In other words, the model employs a functional assessment framework to situate the problem behaviors of interest within a systemic, and sequential, context.

Once the fit has been identified, and the family engaged, more active treatment then begins (Henggeler et al., 1998). However, given that MST considers the idea of ongoing engagement and "buy-in" to be a fundamental issue, the model works from the platform of "strengths as levers for change." That is, the identification of strengths, along with needs, is part of an overall assessment approach. Each need and strength is assessed across different levels: individual, family, peer, school, neighborhood, and community. The strengths that are identified are then used in the service of targeting needs (i.e., the problematic sequences that are identified during assessment). Examples of these ideas in practice are provided later in the case examples.

As can also be seen in Table 2, the intervention itself is designed to promote higher levels of specific activities by family members, with the main aim of promoting responsible behavior in the youth and family members. Specific interventions used draw from evidence-based approaches, including parent and family interventions, school interventions, interventions for the youth, and, when necessary, interventions for parents themselves (e.g., substance abuse, depression). The overall aim during the 4- to 6-month intervention is that continuous efforts by family members – with 24-hour, 7-day support from therapists – are thought necessary to ensure clinically significant change and long-term generalization. The foundation for generalization is through parents inculcating the skills necessary to help their child regulate his or her

**TABLE 2: Treatment Principles of Multisystemic Therapy\***

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Principle 1:	The primary goal of assessment is to understand the fit between the identified problems and their multiple systemic contexts.
Principle 2:	Therapeutic contacts emphasize the idea of “strengths as levers” for change.
Principle 3:	Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.
Principle 4:	Interventions are present focused and action oriented, targeting specific and well-defined problems.
Principle 5:	Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
Principle 6:	Interventions are developmentally appropriate and fit the developmental needs of the youth.
Principle 7:	Interventions are designed to require daily or weekly effort by family members.
Principle 8:	Interventions’ effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
Principle 9:	Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members’ needs across multiple systemic contexts.

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\* From *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*, by S. W. Henggeler, S. K. Schoenwald, C. M. Borduin, M. D. Rowland, and P. B. Cunningham, 1998, New York: Guilford. Copyright © 1998 by Guilford Publications, Inc. Adapted with permission.

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behavior and associations more in line with a prosocial trajectory. To help ensure that this process remains on track, the intervention itself is monitored through continuous evaluation. When progress is stalled, rather than giving up on clients, the MST supervision process is instead designed to help identify barriers to effective outcomes and help therapists get the treatment back on track.

Thus, in addition to being carried out in an intensive fashion and in the natural environment, MST stands out as a model with some built-in quality-assurance mechanisms. These include an intensive training and supervision process along with ongoing evaluation. Just as importantly, there are additional organizational controls that require the direct involvement of MST developers in setting up, licensing, and supporting local delivery. Current sites that do have licenses can be found at the MST website ([http://www.mstservices.com/text/licensed\\_agencies.htm](http://www.mstservices.com/text/licensed_agencies.htm)). Currently, sites in 32 states, the District of Columbia, and 9 other countries hold MST licenses. Thus, if agencies wish to pursue MST specifically, they would be advised to visit the website (<http://www.mstservices.com/>) and make direct contact with MST Services in Charleston, South Carolina.

On the other hand, for the everyday practitioner without direct access to MST services, there is much to be learned from practice as promoted by MST. This includes the following:

- home-based and intensive service delivery
- emphasizing family buy-in to treatment
- emphasizing strengths directly in the intervention
- increased levels of training, supervision, support, and overall accountability for engaging families and producing outcomes
- targeting all known risk and protective factors, including ones that might be deemed to be secondary (e.g., parental psychopathology; marital conflict)
- use of a functional, and ongoing, assessment framework to identify and monitor observable sequences that culminate in problematic behaviors
- use of available evidence-based interventions
- small caseloads



### **Research Effectiveness and Dissemination of the Approach**

A recent meta-analysis (Curtis et al., 2004) confirmed the overall effectiveness of MST. When compared with a number of alternative treatments, and across different outcome evaluations, MST was found to have an effect size (ES) of .55. Thus, in translating this to more practical terminology, an ES of .55 tells us that the average family in the MST condition surpassed 70% of those in the alternative conditions on outcome indicators.

Although the ES of .55 is lower than that traditionally found for a range of other psychotherapies (typically between .7-.8), it is the case that the standard comparison group in most meta-analyses is a no- or minimal-treatment group. By contrast, every comparison group in this meta-analysis was some actual intervention for the population of interest (chronic juvenile offenders; juvenile sex offenders; substance-abusing juvenile offenders; youth in psychiatric crisis; abusive/neglectful parents). In addition, the average age of the youth across all studies was just under 15 years of age; the overall treatment completion rate across all 708 of these youth (and their families) was an impressive 86%.

On the other hand, it was found that studies that employed graduate students training in clinical psychology (and participating in training activities emphasized in MST practice) and intensive, ongoing supervision by one of the original MST developers (e.g., Henggeler, 2004) had an overall ES of .81. By contrast, those that employed therapists in a more conventional manner, and who received ongoing supervision from those not involved in MST development, produced an ES of .26. Thus, although the ES in the latter case is reduced, it is worth remembering that MST in those studies still fared better than the "usual services" intervention that served as the comparison group here. Nevertheless, one of the main points to be taken here is that there are various factors that can impinge on maximizing effectiveness of an intervention, even one like MST that has a solid evidence base. Some of the findings that are now emerging from MST (Henggeler, 2004) implicate the following factors: "organizational climate and structure, therapist fidelity, and key aspects of the MST quality assurance protocol" (p. 422).

As a consequence of these findings, and combined with clinical and administrative experiences in this area, one implication is that services for this population require the full support of the organization (with the first year perhaps being the most difficult according to Henggeler, 2004); motivated and accountable therapists who are ready, willing, and able to do the hard work necessary to ensure intervention success; and quality assurance mechanisms in place (e.g., not giving up on families, ongoing evaluation, fidelity monitoring, competent and ongoing training, supervision, and support for therapists).

Another fundamental issue is the level of parent and youth motivation and engagement with services. We have recently found that a child's motivation over the course of MST treatment is mediated by the level of motivation of the parents (Curtis & Ronan, 2007). In other words, ensuring that parents are engaged is very likely fundamental to the success of interventions, particularly in light of high dropout rates seen in child and family therapy settings (see Nock & Kazdin, 2005). As indicated earlier, compared to a 40% to 60% completion rate in traditional child and family therapy, MST has a much higher rate of completion (i.e., 86% completion rate). What makes this completion rate particularly impressive is that it included a majority of disadvantaged families (e.g., low socioeconomic status) as well as highly disruptive, emotionally disturbed adolescents (e.g., 84% of 708 youths had been previously arrested; Curtis et al., 2004). Given these encouraging findings, but also mindful that some therapists are not able to do things like carry out intervention as intensively as MST or carry out an entire course of therapy in the client's home, the issue of how to increase parent motivation, attendance, and participation is an important one for practitioners in this area. Thus, we return to it again shortly in the context of prevention. However, in the meantime, the practitioner is encouraged to consider how he or she might start addressing these issues within his or her practice and organization.

Another question, given the flexibility of the MST model, is exactly what strategies produce the beneficial impact. Although MST has been shown to impact both instrumental (e.g., family relations) and ultimate (e.g., arrests, recidivism) outcomes, including over long-term intervals (e.g., Borduin et al., 1995), what "ingredients" within this approach actually produce the family buy-in and the intended outcome is less well known. However, in a recent study looking at mediators of treatment impact in Multidimensional Treatment Foster Care, an approach with similar values to MST (e.g., home-based service delivery, targeting risk and protective factors, limiting peer influence), Eddy and Chamberlain (2000) were able to identify some important features worthy of attention. In this study, the factors identified as mediating outcomes were the prominent factors emphasized in this contribution: (a) family management skills (discipline practice, increased supervision/monitoring, and increased positive youth-adult interactions) and (b) a focus on decreased association with deviant peers.

### **Prevention and Tiered Approaches: Focus on Parenting, Resources, and Barriers to Engagement**

Owing to space limitations, this section is brief. However, we would be remiss not to touch on the topic of prevention of conduct disorder. Prevention programs are quite likely to get more attention over the next couple of decades, with rising rates of conduct disorder in many Western countries (e.g., Curtis et al., 2002) and with more attention in the literature to early intervention. A number of different programs have been found to be successful in preventing problems, including those by Carolyn Webster-Stratton and colleagues (e.g., Webster-Stratton, Reid, & Hammond, 2004), Matthew Sanders and colleagues (e.g., Sanders et al., 2000), and others. Although some programs, like Webster-Stratton's Incredible Years series (Webster-Stratton et al., 2004), emphasize parenting (and teacher) programs, others, like Sander's Triple P Program (Sanders et al., 2000) and Dishion's ATP (Dishion & Kavanagh, 2003), promote the idea of tiered, or stepped, care. Many prevention programs are first aimed at helping parents improve parenting practices and the family environment.

With respect to these programs, a variety of parenting programs have been found to work successfully in ameliorating current concerns that predict longer term problems (e.g., Sanders et al., 2000; Webster-Stratton et al., 2004). Additionally, practitioners might consider the value of the resources available through some of these programs. For example, Webster-Stratton's Incredible Years series of videotapes is available and might be considered as a resource for assisting parents become more effective parents through the use of both basic and advanced strategies. Resources include videos, books, CDs, and materials not only for parents but also for teachers and children (<http://www.incredibleyears.com/index.htm>). The Triple P Program has resources available for practitioners and organizations as well as some being planned for parents (<http://www1.triplep.net/>).

It is important to consider factors that can have an effect on parenting intervention outcomes (Reyno & McGrath, 2006). These include socioeconomic status, maternal mental health, perceived barriers to treatment, severity of child behavior, life events and stressors, and referral from a school or agency versus self-referral. Of these factors, another meta-analysis found socioeconomic status to be the biggest obstacle to favorable outcomes (Lundahl et al., 2006). For these families, parent education delivered individually, versus in a group format, was most effective (Lundahl et al., 2006). One main conclusion that might be drawn from such research is that prevention programs that do account for multiple risk factors increase their potential for maximizing outcomes (see also Lees & Ronan, 2007).

As emphasized in this contribution, other problems in child and family interventions, including parent education and prevention programs, are poor attendance and premature drop-out. Reyno and McGrath (2006) identified the following factors as significant predictors of drop-out in parent education programs: single parent status, low socioeconomic status, low

levels of education, younger maternal age, minority group status, and negative life events. Severity of child behavior was a near significant predictor ( $p$  value of .07). More generally, Kazdin and colleagues (e.g., Kazdin et al., 1997; Kazdin & Whitley, 2003) have also identified a variety of barriers to engagement including concrete barriers (e.g., transportation, babysitter funds) and those that are more emotional or conceptual (e.g., parent stress, mistrust of social services, belief that treatment lacks relevance, poor relationship with the therapist). For the practitioner, the implications of findings to date are quite clear: Those that do not deal directly with attendance and participation factors are at risk of failing, particularly in the face of an accumulation of barriers to engagement and early indicators of potential dropout.

### **Return to Case Examples: Assessment and Treatment Principles in Practice**

As seen in the two case examples introduced earlier, the relationship between antisocial behavior and its family, peer, and other contexts varied in some ways but also shared commonalities. One of these was the prominence of deviant peers and favorable attitudes to antisocial behavior in the young persons and other family members. Another was a lack of parental monitoring and supervision and a lack of a firm limit setting done in appropriate ways and at appropriate times. Additionally, for different reasons in the two families, a lack of discipline tended to link to a lack of attention or lax periods without supervision. Thus, discipline attempts in both families were almost exclusively reactive to misbehavior.

Thus, although there were different factors that needed attention in the families, the relationship between problematic behavior and family and peer contexts could be conceptualized in the following sequence derived through a functional assessment combining interview, psychometric assessment, and observation of family process:

Lack of attention/lax periods with a lack of supervision → misbehavior → inappropriate discipline (i.e., overly punitive or too lax) → parent and/or child upping the ante (coercive cycle). → Either 1. parent “wins,” child disciplined in punitive fashion but has immediate compliance (in former case) or child disciplined more effectively (in latter case where the mother felt she lost her “cool”) OR → 2. child “wins,” parent gives in to the child’s coercive behavior; → following 2., one manner of giving in to the child’s demands was by allowing the child to leave the home (for relief); when away from home, the youths in both cases spent unsupervised/unmonitored time with deviant peers → child engages in antisocial behaviors.

### ***Treatment Approach and Outcome Evaluation Strategies and Recommendations***

The intervention in both cases revolved around the idea of targeting the main risk factors identified in the sequence. Thus, in each of the cases, parents were educated about the role of deviant peers, monitoring and supervision, discipline practice, and positive parent-child interaction. Like MST, with both needs and strengths assessed for the child and family, and considering school, peer, neighborhood, and community factors, one initial focus was to encourage the family to use strengths as a means for solving problems. Thus, in the “Upping the Ante” case, the mother had the strength of being able to be firm; the father, being affectionate and playing with the children. Although the mother was at times inappropriately firm (i.e., punitive and “heavy handed”), she also demonstrated an ability to be firm in an appropriate fashion, particularly with coaching and encouragement. It was more difficult for her to be affectionate or use positive reinforcement strategies. In the “Warm But Not Firm” case, the mother could be very warm and affectionate with her children and was able to use positive reinforcement strategies well. She also did demonstrate, albeit initially only when under duress, the ability to

set firm limits. However, owing to her depression, she sometimes isolated herself from the children and was not consistent with the use of positive discipline strategies.

In both cases, discussions during the assessment phase also focused on motivation to engage in therapy. This was done through the development of a relationship combined with the use of various strategies including reinforcing their willingness to be involved in therapy and sharing research about such things as positive outcome indicators, the role of active participation in producing outcomes, and treatment outcomes themselves. It also involved other strategies including motivational interviewing techniques like rolling with resistance and identifying and resolving discrepancies (Miller & Rollnick, 2002). Early on, parents in both cases assumed that the focus would be on working with the child. A discussion was held about the merits of that approach (i.e., we could do that), what the research said about a focus on the child (i.e., gains are quite possible; however, they tend not to maintain), and what the research says about active parent involvement (i.e., a much better chance of long-term gains). Ultimately, through discussions of this sort, the parents in both cases made a public statement of commitment to the theme of "doing what is necessary to try and assist my child."

The intervention itself was delivered in the home, and therapist contact initially occurred one to three times a week (titrating downward in both cases), focusing first on helping parents with family management strategies. Parenting interventions were not just limited to the more traditional behavioral management strategies (i.e., strategies to increase desirable and reduce undesirable behavior at home and elsewhere) seen in most parent education programs. Although assisting parents to learn and carry out behavior management strategies was given a prominent focus, an additional emphasis was also placed on other features of family functioning. For example, educating the parents about the value of warmth and affection and assisting them to learn, role play, and carry out strategies for increasing positive interactions with their child was undertaken alongside the learning and practicing of behavior management. Additionally, within the context of enhancing parenting and family management skills, helping parents understand their role in assisting the adolescent to internalize prosocial values was also emphasized (see Lundahl et al., 2006). For example, helping parents learn how to provide rationales to their child when limits needed to be set, in the context of more general communication and problem-solving training, was additionally undertaken. Within a problem-solving framework, a prominent focus was given to helping the parents develop strategies to help their child reduce antisocial, and increase prosocial, peer involvement. This included an early emphasis in both cases on helping parents to increase monitoring and supervision practices. The specific targets for these interventions were the problems and patterns identified during functional assessment. In between sessions, parents were provided with homework to assist them in generalizing skills (e.g., Kazantzis et al., 2005). Across intervention, there continued to be a focus on strengths as well as ongoing motivation and engagement (e.g., Dishion & Kavanagh, 2003; Henggeler et al., 1998; Nock & Kazdin, 2005). An additional child focus consisted of CBT-focused intervention (Ronan & Kendall, 1991) to help the youth internalize an increased sense of self-control including consequential and reflective thinking and emotional and behavioral regulation strategies, particularly in interpersonal situations. Finally, rather than referring parents elsewhere for assistance, a necessary treatment focus included attention to other risk factors related to parent functioning (e.g., substance abuse, antisocial attitudes, maternal depression, parenting conflict). For example, paternal substance abuse in the first case and maternal depression in the second were addressed through brief CBT/motivational interviewing and emotion-focused interventions, respectively. The rationale for a focus on such factors is first related to "the child's best interests." Such a focus may help to reduce stigma for some parents. It may also encourage agencies to broaden their focus of what constitutes a child's best interests as well as what constitutes evidence-based practice in such cases (e.g., Henggeler et al., 1998; Kazdin & Whitley, 2003).

To monitor outcomes, pre- and postassessment used parent, teacher, and child measures. To supplement prepost assessment, ongoing ratings on adaptations of the parent and child versions of the Coping Questionnaire (CQ) were also carried out. This measure, like target complaints measures for adults, allows for individualizing assessment based on specific areas that are problematic for the youth and was developed initially for our evaluation of interventions for childhood anxiety (Ronan & Deane, 1998; see also Kendall et al., 1992). It is rated on a 7-point scale. Alternatives to the CQ include global ratings like ATP's daily ratings that also can focus on individual, and targeted, problems for the child, parents, or family (e.g., amount of police contact; frequency/intensity/duration of disruptive behavior; antisocial versus prosocial peer influence; effectiveness of parent monitoring and discipline; quality of positive parent-child interaction). A main point here is that ongoing assessment is strongly recommended, is not difficult to do with a few simple indices, and is often appreciated by families, particularly once change begins to be demonstrated. For the clinician, it allows him or her to monitor the effectiveness of intervention efforts and to take on a mantle of increased accountability.

In both cases and in following recommendations of effective interventions in this area (Henggeler et al., 1998), treatment continued in both cases until it was determined that "clinically significant" change had occurred as indicated by psychometric evaluation as well as ongoing discussions with the parents and youth. Follow-up phone calls over time, and the availability of booster sessions, were designed to support initial gains.

## PUTTING IT ALL TOGETHER: PRACTICE PRINCIPLES AND RECOMMENDATIONS

When tying together elements of effective interventions, the following recommendations can help practitioners reflect evidence-based practice with conduct-disordered youth and families:

1. Early attention to *motivational factors*, including risk factors for drop out.
2. A willingness to *address obstacles* directly, including advocating for home visits or sessions (particularly early if home visits need to be limited), increasing session frequency when necessary, and brief calls during the week from the practitioner or an assistant to get easy-to-gather data and to enhance motivation (Lees & Ronan, 2007).
3. *Functional assessment and formulation* that link prominent risk and protective factors apparent in the family. Based on the case formulation, offer feedback that emphasizes strengths while pointing out key areas of treatment focus.
4. An emphasis on *parents as central* to treatment effectiveness.
5. *Assessment that is ongoing* and capitalizes on easy-to-use measures that provide feedback to therapists and families on goals and treatment targets.
6. The *use of a range of evidence-based interventions* that target central, and secondary, risk factors.
7. The *use of additional resources* for families (e.g., handouts, books, videos).
8. The *use of homework* to supplement in-session work.
9. The *availability of follow-up or booster sessions*. Although some programs, like MST, do not advocate for this strategy, we have experienced its utility in helping families get back on track relatively quickly.
10. *Advocacy at a policy level* for incorporating evidence-based practice in treatment settings. A focus on the best interests of youth and families can – not surprisingly – converge quite nicely with the best interests of administrators and policymakers. In

the case of the latter, incorporating best practice principles, while committing to programmatic evaluation, can assist organizational heads and politicians to advertise programs as committed to a progressive and research-based agenda.

## **CONCLUDING COMMENTS: THE ROLE OF COMMITMENT, ADHERENCE, AND ALLEGIANCE**

As indicated by research in the CD literature (Henggeler et al., 1998) and more generally in the treatment literature (Wampold, 2001), a key feature underpinning success of interventions relates to key therapist factors: adherence and allegiance. Adherence is the ability to carry out treatment as intended (Henggeler et al., 1998); allegiance, belief in one's approach (Wampold, 2001). Thus, the practitioner having a flexible, but clear, agenda while conveying to a family a belief in the approach can help "sell" the merits of intervention to families even in the face of initial frustrations and lack of progress.

As we have argued in this contribution, the research as well as our experience indicates that there is real hope for those youth and families who might formerly have been labeled as "treatment resistant." However, as indicated at the outset of this contribution, working with CD youth and families can be difficult. With a focus on engaging families, providing hope and motivation to change, empowering parents to help themselves help their child across known areas of risk, and simply "hanging in there" and not giving up (i.e., continuing to provide a beacon of "evidence-based hope"), families, and their therapist, can begin to experience the real pleasure of seeing their child or adolescent, and themselves, achieve clinically significant outcomes.

## **CONTRIBUTORS**

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