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***Commentary on A Strengths-Based, Skill-Building, Integrative Approach to Treating Conduct Problems in a 12-Year-Old Boy: Rafael's Story***

# Developmental Perspectives on the Treatment of Childhood Conduct Problems

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## ABSTRACT

Clement's (2011) case Rafael was a 12-year-old boy referred for reactive aggression in the school setting, whose developmental history was characterized by a serious birth defect and significant disruption early in life. He received individual cognitive-behavioral therapy, the aim of which was to enhance his capacity to self-regulate his behavior and emotions in social contexts using skills-training components that capitalized on his existing strengths. This case demonstrates the potential for older children and adolescents with conduct problems to actively participate in the change process. It also raises a number of important issues related to the planning and delivery of conduct problem interventions, which are explored in this commentary. Particular attention is given to the assessment and conceptualization of developmental trajectories of antisocial behavior, and the role of the family in the treatment of childhood conduct problems.

*Keywords*: conduct problems; developmental trajectories; callous-unemotional traits; parent training; clinical case studies; case studies

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Despite all that has been written about the treatment of child and adolescent conduct problems, detailed accounts of the therapeutic process remain relatively rare. Clement's (2011) case study of 12-year-old Rafael—drawn from a longstanding private-practice career devoted to evidence-based therapy—is a most welcome addition to this literature. It is apparent from the outset that this case is far from the text book example that Clement might have chosen to illustrate such treatment. Compared to the disruptions that often characterize the developmental histories of children with conduct problems, those experienced by Rafael were particularly severe. Abandoned soon after birth by his parents due to serious birth defects (involving physical deformity of limbs), much of his first year of life was spent in an orphanage before being adopted at 13 months of age. I was very pleased to be invited to comment on this interesting case study, and I have aimed here to address the issues it raises in light of my own research and clinical practice with the families of children with conduct problems.

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## RAFAEL'S PRESENTING PROBLEM

As described by Clement, Rafael's presenting problem related primarily to anger and aggression in the school setting. Specifically, he was reacting aggressively to provocation from peers when teased about the physical characteristics of his birth defect. Over time, the extent of this aggression had been sufficient to warrant three school suspensions. He had also engaged in minor vandalism – an isolated incident in which he had deflated the tires of a school staff member and thrown eggs on her driveway. This event precipitated his referral to Clement, with the school requiring Rafael to attend therapy as a condition of his return. Aside from a history of "talking out in class," Rafael was functioning very well in broader social and academic domains; achieving at grade level or above, and maintaining age-appropriate friendships and participation in organized sport. Some dysfunctional communication between Rafael and his mother is described (e.g., his tendency to withdraw when angry, some lying about his activities), though beyond these potentially age-appropriate issues, current externalizing problems were not apparent in the home setting. In addition to the developmental history already noted, his mother described him as somewhat impulsive, reported a history of temper outbursts commencing in the preschool years, and described some difficulty articulating his emotions. Other than this his development had proceeded typically. Based on these problem dimensions Clement arrived at an Axis 1 diagnosis of "Adjustment Disorder with Disturbance of Conduct."

## RAFAEL'S TREATMENT AND THE ISSUES IT RAISES

The cognitive-behavior therapy subsequently provided by Clement—Rafael's first contact with a mental health professional—was largely delivered to Rafael directly. The broad aim of this therapy was to enhance Rafael's capacity to self-regulate his behavior in social contexts, through skills-training components that capitalized on his existing strengths. The clinical decision-making detailed by Clement offers revealing insights into Rafael's progress, while highlighting issues of key importance to the planning and delivery of conduct problem interventions. Those that I have chosen to focus on here broadly relate to (1) the assessment and conceptualization of developmental trajectories of antisocial behavior, and (2) the role of the family in the treatment of childhood conduct problems.

## DEVELOPMENTAL TRAJECTORIES OF ANTISOCIAL BEHAVIOR

Clement places considerable emphasize on the importance of determining the developmental trajectory that Rafael was following, describing this as a priority among the initial tasks involved in the clinical assessment of children referred for conduct problems. This is consistent with a developmental-systems model for assessment (see Mash & Hunsley, 2007), a core aim of which is to identify the extent to which the problem trajectory of a referred child deviates from a typical developmental trajectory, and is characterized by established risk markers for chronic problem trajectories of various kinds, such as antisocial behavior. Within such a framework, evidence-based models of problem trajectories guide the focus and scope of assessment by mapping out the behavioral, developmental, and contextual factors that are likely to be of most clinical importance based on a child's presenting problem. As indicated by Clement, much is now known about the developmental trajectory of chronic antisocial behavior, which is highly embedded in the ecology of family and peer systems. However, while the

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concept of the developmental trajectory is now commonplace in the clinical literature, research into developmental aspects of antisocial behavior has moved rapidly in recent years. Importantly, emerging evidence has challenged some of the longstanding assumptions of this field, presenting potentially important implications for clinical decision-making. These developments will be addressed shortly, following a brief review of the most established evidence-base that underlies current thinking about the development and treatment of childhood conduct problems.

Evidence from decades of research has described the various forms that antisocial behavior commonly assumes at different points in this trajectory, and the mechanisms through which distinct risk factors operate to amplify and transform these problems at across various periods of development (Dishion & Stormshak, 2007). It is now widely recognized that the most chronic and severe patterns of antisocial behavior have their origins in early childhood (Siever, 2008). Across early- to middle-childhood, children's oppositional behavior has been associated most proximally with parenting practices characterized by harsh and inconsistent discipline (see Hawes & Dadds, 2005a). This parenting context is believed to confer risk through the modeling of aggression, as well as escalating cycles of coercion based on escape-avoidance mechanisms. These cycles function as 'reinforcement traps' that reward both parents and children's use of aversive control tactics (e.g., whining, nagging, shouting, hitting), and extinguish positive family interactions (Dishion & Patterson, 2006). The participation of siblings in this coercion also contributes to family-based risk for conduct problems (e.g., Compton, Snyder, Schrepferman, Bank, & Shortt, 2003). With these ongoing exchanges children become increasingly skilled in the use of coercion and in turn more difficult to discipline, as the quality of parenting and family relationships is progressively eroded. Outside the family peers play an increasing role in shaping antisocial behavior, including delinquency and substance use across development – most notably in the adolescent years. This risk is conferred through peer relationship dynamics characterized by rejection, coercion, and the selective reinforcement of deviant talk in antisocial friendships. Parenting processes remain vital to externalizing trajectories across adolescence; however, the precise parent-child dynamics of proximal importance in this period shift from those related to setting limits on behavior in the home, to those related to the regulation of children's peer activities in external settings (Dishion & Tipsord, in press).

It is also widely recognized that the contextual factors that shape childhood problem trajectories are closely related to those that influence children's adaptation in a range of developmental domains (Mash & Hunsley, 2007). Such a perspective is apparent in the discussion of Rafael's growing capacity for self-regulation. Broadly speaking a healthy family environment allows a developing child to internalize the regulatory functions that are first provided externally by parents and other caregivers early in life, beginning in the domain of attachment. The environmental insults experienced by Rafael in infancy may have created attachment vulnerabilities that were to a large extent overcome by the high quality of caregiving that he appears to have received subsequently. Current perspectives on self-regulation assume that the neural attention networks that support a child's self-regulatory capacities are further shaped through repeated transactions between a child's biologically-based characteristics and family environment factors across development (Rothbart & Posner, 2006). From this perspective, the capacity to become self-directed with respect to regulating emotions, cognitions, and goal-directed behavior is seen to be highly embedded in relationship dynamics consisting of a set of behaviors such as turn taking and listening to others (Dishion & Patterson, 2006). It is

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also noteworthy that developmental aspects of self-regulation appear to moderate children's sensitivity to the stressful events, given that Rafael's presenting problem was conceptualized by Clement as an adjustment disorder (with disturbance of conduct), For example, a recent longitudinal study found that children who exhibited characteristics related to poor self-regulation – specifically, low effortful control – were particularly vulnerable to the effects of divorce (Bakker , Ormel, Verhulst, & Oldehinkel, 2011).

## SUBTYPING RISK PATHWAYS TO ANTISOCIAL BEHAVIOR

In addition to the models of antisocial behavior on which Clement explicitly focused, there is growing recognition that children and adolescents with conduct problems may comprise subgroups characterized by specific risk factors, whose problems follow distinct developmental pathways. In particular, there is considerable support for the subtyping of childhood conduct problems based on high versus low levels of callous-unemotional (CU) traits (i.e. reduced guilt and empathy), as seen in the proposed introduction of a specifier for CU traits for the diagnosis of conduct disorder in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–V) (Frick & Moffitt, 2010). CU traits at high levels appear to be a marker for a relatively small group of conduct problem children who are at risk for a particularly severe and chronic trajectory of antisocial behavior. Importantly, there is also growing evidence that among children with high versus low levels of CU traits, conduct problems develop through somewhat distinct causal processes (see Frick & Viding, 2009).

The most clinically important implications of this subtyping concern the differential role of parenting in these two pathways (see Hawes et al., 2009). The effects of negative (i.e., coercive) parenting on conduct problems are moderated by CU traits, such that negative parenting is less directly associated with conduct problems in children with high levels of CU traits (Oxford et al., 2003; Hipwell, et al., 2007; Wootton et al., 1997). Likewise, twin research has found that not only are high levels of CU traits highly heritable, but that the conduct problems exhibited by children with high levels of CU traits are under strong genetic control. Conversely, conduct problems among children with low levels of CU traits show moderate shared-environment influence and only modest heritability (Viding et al., 2005). That is, for this subgroup of children, the development of conduct problems appears to be somewhat independent of the parenting problems that have most often been associated with conduct problems in children. In line with this, intervention research conducted by myself and Mark Dadds (Hawes & Dadds, 2005b; 2007) has found that behavioral parent training that focuses on replacing harsh and inconsistent discipline with consistent, non-aggressive limit-setting, is associated with poorer long-term outcomes among children with high compared to low levels of CU traits.

Neurocognitive and longitudinal evidence is also emerging regarding the specific processes through which childhood CU traits interact with, and impact on, clinically important family dynamics. For example, data indicate that the emotion processing deficits exhibited by children with CU traits – including a failure to attend to the eye regions of faces – interfere with the quality of moment-to-moment parent-child interactions (Dadds, Jambrak, Pasalich, Hawes, & Brennan, 2011). Based on these findings, we postulated that a failure to attention to the eyes of attachment figures could drive cascading errors in the development of empathy and conscience in children with high levels of CU traits (Dadds et al., 2011). Additionally, CU traits have been

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found to uniquely account for deterioration in quality of parenting over time, including increases in corporal punishment and inconsistent limit-setting, and withdrawal of parental involvement (Hawes Dadds, Frost, & Hasking, 2011). Interestingly, there is some recent evidence to suggest that parental warmth may be particularly important to the behavioral outcomes of children with high levels of CU traits (Pasalich et al., in press), suggesting that this dimension of the parent-child relationship may represent a potential therapeutic target of unique importance to this subgroup. These findings add to growing evidence that CU traits interact (and transact) with parenting processes across development, and are beginning to provide specific indications for the delivery of family-based interventions for conduct problems. The clinical description of Rafael is not highly suggestive of such traits, which can be assessed using multi-informant reports on the Antisocial Process Screening Device (APSD; Frick & Hare, 2002). For example, while Rafael's aggressive appears to be exclusively reactive, the conduct problems of children high in CU traits are typically characterized by proactive or instrumental aggression also. At the same time, Rafael's mother is said to have expressed concerns regarding his lack of remorse and empathy. As such, the APSD might have served to clarify the dimensions of such traits in the clinical assessment of this case.

## THE ROLE OF THE FAMILY IN THE TREATMENT OF CONDUCT PROBLEMS

A defining aspect of Rafael's treatment was the active role he played in it. Indeed, the intervention was in large part delivered to him directly, with his mother playing a somewhat minimal role. Clement's rationale for this approach – conceptualized as a strengths-based skill-building intervention – is theory- and data-driven. Current best-practice recommendations for the treatment of disruptive behavior disorders recognize the potential benefits of engaging older children and adolescents directly in cognitive behavioral skills-training (Eyberg, Nelson, & Boggs, 2008). Likewise, growing evidence of child-driven effects in the parent-child dynamics associated with risk for antisocial behavior has prompted researchers to emphasize the potential value of including direct skills training in the treatment of antisocial youth (Burke, Pardini & Loeber, 2008).

At the same time however, this literature presents little support for the exclusive use of individual therapy with older children and adolescents referred for serious forms of conduct problems (Burke et al., 2008; Eyberg et al., 2008). It is important to acknowledge that Rafael himself was not such a child (his behavior neither met diagnostic criteria for CD or ODD). Notwithstanding this, the question arises as to whether treatment would have been more effective if it had been more family-centered? Based on the positive long-term (8-year follow-up) outcomes reported by Clement, this question is essentially moot. Could the gains associated with his therapy been achieved over a briefer duration, involving fewer sessions? This may be possible, given that there were numerous occasions on which Rafael failed to initiate homework tasks that involved his mother. Furthermore, the second course of treatment – in which Rafael's mother appears to have featured more prominently – was seemingly associated with greater gains than the first. It is relevant to note here that the same training components conducted with Rafael in relation to problems-solving and communication skills are also commonly implemented with adolescents and parents jointly in-session (see Barkley, Edwards, & Robin, 1999). However,

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rather than second-guess a treatment plan that ultimately led to impressive outcomes, it seems more useful to consider what approaches to treatment may have been indicated were Rafael to have presented with a different clinical profile. More specifically, what factors might have warranted a more family-centered intervention, and how can therapists negotiate the challenging process dynamics often encountered when initiating such an intervention with the families of children referred for conduct problems?

In discussing the development of Rafael's treatment plan, Clement presents a rationale for Rafael's individual therapy that emphasizes his apparent strengths and resources, as well as his age ("he would soon become a teenager"). Clement suggests that he may have considered training Rafael's mother in behavior management strategies if Rafael's conduct problems were more apparent in the home setting, rather than that of the school. This demonstrates classic formulation-driven treatment planning, wherein assessment data inform functional hypotheses about controlling variables in the contexts in which problem behaviors occur, and the selection of corresponding therapeutic targets.

While such an approach remains core to current evidence-based interventions for children with conduct problems, a growing emphasis on the delivery of intervention within a developmental-ecological framework has drawn attention to the unique importance of caregivers to the change process across all stages of child and adolescent development.

Dishion and Stormshak (2007) have argued that while factors outside of the family play an increasing role in antisocial risk pathways across development, parents are the adults who are most likely to be able to addressing the contextual influences that can undermine child adjustment in school and peer settings (e.g., Dishion, Nelson, & Kavanagh, 2003; Pettit, Bates, Dodge, & Meece, 1999). From this perspective it is possible that if Rafael had been following a higher-risk trajectory, characterized by early onset conduct problems of greater severity and stability, a return to a healthy developmental trajectory may relied on family-based intervention strategies (e.g., parenting practices associated with monitoring and supervision), despite problem behavior being based in contexts outside of the home (Dishion & Kavanagh, 2003). Further to this, individual therapy may be inappropriate for disorders that are comorbid with a child's disruptive behavior disorder. Most notably, cognitive behavioral "self-talk" and training in self-reinforcement is only likely to benefit clinical levels of attention-deficit/hyperactivity disorder (ADHD) if supplemented with intervention components that target conditions of external reinforcement in a child's environment (Hinshaw, 2006). As such, if Rafael's symptoms of hyperactivity/impulsivity were part of such a diagnostic profile, a family-based intervention may once again have been indicated.

Given the primary role of the peer context in trajectories of antisocial behavior across early- to late-adolescence (see Patterson, Dishion, & Yoerger, 2000), the use of group-based interventions with such youth has received considerable attention. Importantly, research in this area suggests that—depending on their design and delivery—group-based interventions can lead to either positive or negative outcomes. For example, prevention programs that create intense group interactions among large numbers of antisocial youth have been found to produce lasting iatrogenic effects - increasing the problem behaviors they aim to prevent. Such negative outcomes are understood to operate through the process of deviancy-training (described earlier),

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and as such seem most likely to occur when group leaders do not effectively control the expression and rewarding of antisocial talk (Dishion, McCord, & Poulin, 1999). In contrast, effective group-based interventions are generally conducted with small groups of children (e.g., five), are carefully structured, and incorporate parallel groups for their parents. The Coping Power Program (Lochman & Wells, 1996) is one such example, in which young adolescents train in and rehearse social-cognitive skills for managing anger and externalizing problems, while their parents are trained in skills related to the management of child behavior and parenting stress. A case study of a pre-adolescent girl treated in the program published by Lochman, Boxmeyer, Powell, Wojnaroski, and Yaros (2007) might be considered a companion case-study to that of Rafael.

In addition to the various developmental and diagnostic child characteristics that may indicate the need for a family-based intervention, it can be assumed that such an approach is indicated when a child's family system is characterized by multiple problems and stressors. Risk for child conduct problems may stem from a range of factors in the family environment, including those related to social adversity (e.g., socioeconomic disadvantage, lack of social support, exposure to community violence), parental psychopathology and substance abuse, marital conflict, and dysfunctional parental attributions concerning the intent and causes of a child's behavior (Hawes & Dadds, 2005a). These same risk factors are known to disrupt parent-child relationship dynamics critical to the socialization of children in the family; that is, parents' attention, effort, and skills in managing the minutiae of daily parent-child interactions, including behavior management practices and the structuring of children's participation in broader social contexts outside of the family (e.g., Leung & Slep, 2006; Slep & O'Leary, 2007). It is this disruption to the parent-child relationship that appears to often function as the proximal source of risk through which other distal factors influence child outcomes. Keller Cummings, Davies, and Mitchell (2008), for example, showed that paternal drinking problems accounted for increases in marital conflict over time in the families of preschoolers, which was consequently related to decreased parental warmth and increased parental psychological control; these parenting problems were in turn uniquely associated with the longitudinal development of internalizing and externalizing problems in these children. It is on the basis of such evidence that parenting practices are often conceptualized as the proximal controlling variables in the problems of clinic-referred children, and prioritized among the clinical targets of effective interventions. Clinical research has also demonstrated that the effects of interventions that train parents in effective behavior management strategies can be enhanced with the inclusion of adjunctive treatment components that target issues in the family context, such as marital discord and parental psychopathology (Dadds & Hawes, 2006).

## CONSULTATION STRATEGIES FOR INITIATING INTERVENTIONS FOR CONDUCT PROBLEMS

Accurate data on the controlling variables that maintain problem behaviors in various contexts are an essential, but not sufficient pre-requisite for a therapist to target problem mechanisms effectively. The process of therapeutic change is also driven by the process of consultation, the most important of which concerns the initial assessment of the family. Clement presents a sophisticated perspective on Rafael's readiness to change, and the process strategies

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with which he established an effective therapeutic alliance with him. Likewise, when dealing with distressed, multi-problem families, the effective management of this process in relation to the broader family system is crucial (Scott & Dadds, 2009). Mark Dadds and I (Dadds & Hawes, 2006) have described a family-based intervention model for child conduct problems in which the consultation process is conceptualized in terms of stages that lay the foundation for treatment. Like currently established parent training interventions, the content of our program is designed to target the social-learning-based mechanisms through which family interactions maintain and amplify child conduct problems. However, the process through which the intervention is initiated and delivered draws in large part on Minuchin's (1974) structural model of the family. According to this model, a healthy family is characterized by overlapping but independent parent, child and extended family subsystems, that are organized hierarchically. Most importantly, parents act as an executive subsystem wherein they maintain a positive relationship independent of the parenting role and can function cooperatively to solve family problems. While there is little data to show that problematic structural dynamics are a direct causal variable for child psychopathology, evidence suggests that these dynamics may confer broad risk for conduct problems. In the families of children with conduct problems, for example, it has been found that the boundaries between parent and child subsystems often become unclear; the parents' relationship becomes conflicted; and extended family get drawn into failed attempts to manage the child's behavior (Green, Loeber, & Lahey, 1992, Shaw Criss, Schonberg, & Beck, 2004).

In our model the first critical process aim is to join with the parental subsystem of the family to form a therapeutic team (Dadds & Hawes, 2006). We assume that it is through this parent-centered partnership that a therapist is best placed to impact on the broader family system of the referred child. In my work supervising psychologists in a range of child and family settings, I have found that the process difficulties encountered by therapists when attempting to engage the families of children with conduct problems often stem from a failure to structure initial contacts that are compatible with this aim. The effective management of the consultation process begins with the first telephone contact, at which point it is important to clarify who is involved in the parenting of the child, and to take the necessary steps to ensure that the relevant members of the parenting subsystem attend the initial assessment session whenever possible.

Many therapists trained in family-systems approaches believe that the first session should involve all family members so that the system as a whole can be observed. This opportunity for observation can however come at a significant cost. A therapist's attempts to explore issues beyond those directly associated with the child are in many cases rejected by parents whose experience and perception of the problem has not first been sufficiently validated. This relies on parents being free to express and explore their experiences in the family, no matter how distressing or controversial. Complaints about the effect of the child's behavior on the parents' lives and marriage, catastrophic fears about the child's future, and hostile feelings toward the child, are common themes. Parents may withhold such disclosures in the presence of children, while therapists may be forced to similarly restrict the scope of the interview when such expressions intensify. As described here, the way that we typically proceed with child and adolescent conduct problem referrals therefore varies somewhat from the approach described by Clement. Rather, my recommendation is to schedule the initial assessment interview with parents alone, in order to allow for the full expression and exploration of the issues impacting on the

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family, and the planning of future contacts as an adult team. There can be important benefits to including older children and adolescents in the initial assessment session. However, in my experience this can often be most advantageous within a session structure that permits the therapist to build relationships with the adolescent and his/her parents separately (e.g., dividing the session to accommodate one-on-one time with respective subsystems).

## CONCLUDING COMMENTS

Clement's case study of Rafael is an impressive demonstration of the potential for older children and adolescents with conduct problems to actively participate in the change process. I am sure that readers will appreciate the thoughtful attention with which Clement has reported this case, as have I. Despite the serious disruptions that characterized Rafael's early developmental history, he presented as a resilient child with personal strengths and protective factors in a range of domains. Clement's intervention capitalized on these strengths, helping him to enhance practical self-regulatory skills within the context of a supportive therapeutic relationship. While Rafael's developmental trajectory suggested some deviations in relation to early behavioral deregulation, the conduct problems he exhibited did not suggest markers of a chronic, high risk trajectory (or indeed diagnostic features of an externalizing disorder above a clinical threshold). Clement hints at some of the alternative routes that treatment may have taken had this not been the case, and I would be curious to learn how he typically proceeds with more severe presentations of conduct problems in the context of serious family dysfunction. I echo Clement's recommendation regarding the importance of characterizing the developmental trajectories of children's clinic-referred conduct problems. I would further propose that emerging models for subtyping risk pathways to antisocial outcomes are providing an increasingly precise basis for treatment planning in this area, and I encourage clinicians to explore such applications.

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