Helping youth with conduct disorders: group therapy for parents

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Résumé : Les jeunes qui ont des troubles du comportement ont toutes sortes d'incapacités et proviennent de divers milieux familiaux. Pour bien les traiter, il faut disposer de tout un éventail de traitements dans toutes sortes de contextes pour répondre à leurs besoins particuliers. Dans ce numéro (voir pages 939 à 944), le Dr Harvey Armstrong et ses collègues décrivent une démarche suivie pour aider les jeunes qui ont des troubles du comportement par une thérapie de groupe à l'intention de leurs parents.

A key question in child psychiatry is how to help youth with disruptive behaviour disorders, the largest group of children seen in mental health clinics.[1] The Parents for Youth program, which Dr. Harvey Armstrong and his colleagues describe in this issue (see pages 939 to 944), is a significant contribution to the search for effective ways of helping these youth. However, for a proper perspective of this program, one must understand the general problem of antisocial behaviour in youth.

Most emotionally disturbed children can be divided into two categories: those who are troubled and those who are troublesome. Troubled children tend to internalize their problems; they, rather than others, are more likely to suffer from their problems. Examples of troubled children include those with depression, phobias and anxiety. Troublesome children, however, cause difficulties more to others than to themselves. They are labelled as having disruptive behaviour disorders, which include attention-deficit hyperactivity disorder, oppositional–defiant disorder and conduct disorder. Examples of their behaviours are running away from home, truancy, aggression, stealing and lying.

Children with disruptive behaviour disorders often come from families in which they have experienced neglect, or physical or emotional abuse,[2,3] or from broken homes in which there have been disruptions in parenting.[4] An early attachment to a parent, leading to a warm, close, confiding relationship, is central to a child's growing up without severe problems; the absence of such a relationship can lead to antisocial behaviour.[5] The importance of this relationship cannot be overemphasized: through it children learn prosocial behaviour. In most cases, children who have a close relationship with their parents tend to adopt their values and beliefs. When there are constant changes in parental figures or when parents are absent physically or emotionally a child has difficulty forming a close, warm relationship with a parent and thus learning to comply with adults, accept limits and control anger and hostility. Most children learn such behaviour during their preschool years, so that when they start kindergarten they have already learned to comply, to be respectful and not to be aggressive.

Thus, families play a key role in the socialization of children. This process is smooth for most children; more than 80% are compliant, respectful and perform well in school and at home.[6] However, some children are born with disorders, some with disabilities and others with difficult temperaments. The socialization of these children requires greater effort and much patience, although good parenting can overcome most disabilites.

Socialization becomes difficult when the family is unable to provide a stable and caring environment or when the child has more difficulties than the family can tolerate. Antisocial behaviour results. Most youth who are violent or have chronic conduct disorder have both strikes against them: they are born with severe disorders

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or disabilities, and they do not have a caring and understanding family.[7]

Clearly, any efforts toward preventing or treating youth with antisocial behaviour must be directed toward the family. In this way the Parents for Youth program is on target. Another asset of the program is its group approach. Many parents of antisocial youth experience guilt; they are ashamed of their child's behaviour and afraid to share their concerns. However, in a group of people with the same experiences parents can feel free to learn and share.

The helpfulness of the Parents for Youth approach is evident. Such a program should be duplicated in other communities to reduce the long waiting lists for family therapy at child psychiatrists' offices and to meet the needs of families quickly and economically.

However, can the group therapy approach for parents meet the needs of all antisocial youth? The answer is No, because the approach depends on parents being committed to meeting the cost and attending the long-term sessions. Most antisocial youth come from dysfunctional families in which there is much chaos and inconsistency.[8] Often the parents do not keep appointments for therapy, and in many cases, workers have resorted to visiting them at home.[9] In rare instances parents have refused therapeutic contact with professionals working with their children.

It is not surprising that families reach a point at which they are not willing to be involved in treatment. Most of the children in these cases have been difficult since early childhood. Parents have had to attend meetings with teachers, mental health workers and probation officers. The family of the adolescent with conduct disorder has been involved with about 15 agencies, on average, each demanding information and interviews, over 9 years since the onset of the disorder.[10] Understandably, such parents are reluctant to participate in treatment. In many cases, professionals have to be creative in initiating and sustaining family involvement.

The profile of the parents in the Parents for Youth program differs from that of parents of most antisocial youth: 45% of the parents Armstrong and his colleagues discuss have a university degree, 92% have three or fewer children, and 60% are married or remarried. The authors do not mention the parents' socioeconomic status, but the income level is assumed to be at least that of the average Canadian family, because the parents could afford to participate in the program for 1 year. The authors do not indicate the drop-out rate for the program, but it is probably below that of other programs because of the profile of the parents.

As well, the profile of the youth in the program differs from that of most other youth who are violent and antisocial: most antisocial youth are either poor responders or good responders.[11] The critical factor distinguishing the two groups is the age of onset of antisocial behaviour: onset between ages 4 and 10 years indicates a poor prognosis, and a later onset a good one.[12] Youth with a later onset seem to respond favourably to most treatments, including individual and family therapy. Although Armstrong and his colleages do not specify the age of onset of the antisocial behaviour in the youth in their study, 31.3% had serious problems before the age of 12 years; therefore, 68.7% would be good responders, for whom family therapy would be an ideal approach. Functional family therapy — a combination of systemic and behavioural approaches — produces excellent results.[13] Group therapy for parents has not been widely described in the literature but may have advantages over individual therapy for parents. The three main advantages of group therapy are that it is economical, parents can support each other rather than depend on the therapist, and more parents can be seen at one time.

As new research findings on youth with conduct disorder emerge it is clear that this group is large and varied, the only common denominator being antisocial behaviour for more than 6 months.[14] Some of these youth have attention-deficit hyperactivity disorder (which is biologically determined), some have major learning disabilities, and others without disorders or disabilities have disturbances that can be wholly explained by childhood experiences. The youth who are the most aggressive and the most resistant to treatment (those who have disorders and disabilities, have dysfunctional families and have exhibited antisocial behaviour since an early age) must be carefully assessed, their disorders and disabilities recognized and careful plans developed to help them overcome their disabilities. Their families can benefit from group therapy, but the youth need more: some should take medication, some need special classes, some will need cognitive behaviour therapy to learn to control their anger, and some may have to be removed from their families.

Adequate care for youth with all types of conduct disorder requires a spectrum of therapeutic options, from outpatient treatment providing individual, family and group therapy, to day programs and residential treatment, and, finally, secure treatment if the disorder is severe and unrelenting. Parents for Youth is one desirable program in the spectrum of services, but neither this program nor any other can serve all youth with conduct disorder. The challenge researchers face is to define clearly the criteria that determine which youth need which approach in which setting.

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Conferences
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Oct. 14–16, 1994: Diabetes, Obesity and Atherosclerosis (satellite symposium of the 10th International Symposium on Atherosclerosis)
Toronto
Dr. George Steiner, chairman, (Attention: Norah Rankin), Banting and Best Diabetes Centre, CCRW 3-845, Toronto Hospital — General Division, 200 Elizabeth St., Toronto, ON M5G 2C4; tel (416) 978-4656, fax (416) 978-4108

Oct. 14–16, 1994: The Molecular Basis of Antiatherogenicity (satellite symposium of the 10th International Symposium on Atherosclerosis)
Halifax
Drs. Yves L. Marcel and W. Carl Breckenridge, chairmen, Department of Biochemistry, Faculty of Medicine, Sir Charles Tupper Medical Building, Dalhousie University, Halifax, NS B3H 4H7; tel (902) 494-6636, fax (902) 494-1355

Oct. 15, 1994: Great Lakes Chapter of the Undersea and Hyperbaric Medical Society 15th Annual Scientific Meeting
Toronto
Ana Lopez, Hyperbaric Department, Toronto Hospital — General Division, Rm. ccrw g-821, 200 Elizabeth St., Toronto, ON M5G 2C4; tel (416) 340-4481, fax (416) 340-3657

Oct. 15–16, 1994: 20th International Tuberous Sclerosis Symposium
Arlington, Va.
Dr. Vicky H. Whittemore, medical director, National Tuberous Sclerosis Association, National Headquarters, 120–8000 Corporate Dr., Landover, MD 20785; tel (301) 459-9888 or 1-800-225-NTSA, fax (301) 459-0394

Oct. 16, 1994: Federation of Medical Women of Canada Annual General Meeting and Scientific Session: Care of the Mature Woman
Ottawa
Federation of Medical Women of Canada, 107–1815 Alta Vista Dr., Ottawa, ON K1G 3Y6; tel (613) 731-1026, fax (613) 731-8748

Oct. 16–20, 1994: Managing Change II: Management Skills Workshop II for Family Medicine
Chicago
Study credits available.
Program Department, Society of Teachers of Family Medicine, PO Box 8729, Kansas City, MO 64114; tel (800) 274-2237, (816) 333-9700, ext. 4510

Oct. 19, 1994: Clinical Day '94: Mid-Life Health Promotion/Advocacy and Substitute Decision Making Legislation
Toronto
Cindy Stolarchuk, conference coordinator, Sunnybrook Health Science Centre, 2075 Bayview Ave., North York, ON M4N 3M5; tel (416) 480-6100, ext. 5904

Oct. 20–21, 1994: Gairdner Foundation Lectures
Toronto
Sally-Ann Hrica, executive director, Gairdner Foundation, 220–255 Yorkland Blvd., Willowdale, ON M2J 1S3; tel (416) 493-3101, fax (416) 493-8158

Oct. 20–21, 1994: Long-Term Care in Transition: Preserving Patient Autonomy. . . in Changing Systems
London, Ont.
Dr. Gillian Kernaghan, ethics symposium task force chair, Parkwood Hospital, London, ON N6C 5J1; tel (519) 685-4023, fax (519) 685-4011

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