Group therapy for parents of youths with a conduct disorder

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Résumé : Parents for Youth est un organisme de groupes de parents qui a pour but d'aider les parents dont les jeunes présentent des troubles du comportement et n'ont tiré aucun bénéfice des traitements classiques ou les ont refusés. Ce programme est novateur parce qu'il met d'abord l'accent sur les parents. Les groupes se rencontrent toutes les semaines lors de séances animées par des cliniciens d'expérience. À partir de l'évaluation initiale et pendant tout le traitement, l'habilitation, la validation et le soutien social des parents constituent les facteurs clés de cette approche. Les parents ont indiqué que leur participation leur avait permis d'avoir une meilleure estime de soi, ce qui a un effet particulièrement positif sur leur perception des moyens qu'ils peuvent prendre pour influencer le comportement de leurs enfants. Les parents notent aussi une amélioration du comportement de leurs enfants. L'organisme a mis en place des programmes ayant pour but de former des médecins et des thérapeutes à diriger ces groupes.

A conduct disorder is characterized by serious and persistent antisocial behaviour, such as verbal and physical abuse of others, lying, stealing and running away from home. Society incurs great financial and emotional costs as a result of this behaviour: these youths are involved with the criminal, correctional and social-service systems, and their behaviour wreaks havoc in their communities, schools and especially their families. In Ontario, an estimated 5% of all children have a conduct disorder.[1]

Children with a conduct disorder are difficult to treat: they do not usually respond to traditional therapies.[2-4] A myriad of approaches has been developed in an attempt to find an intervention that works and has lasting effects.[5-7] A confounding aspect of the development of an effective treatment strategy is that many of the most severely disturbed children and adolescents refuse or drop out of treatment.[8] In many jurisdictions, including Ontario, they have the legal right to refuse treatment.

Treatment strategies and research results often focus on the parents as the cause of the child's problems. This approach may actually worsen the problem by undermining parental confidence and authority.[9-11] The milestone study by Chess and Thomas[12] clearly showed that good parents can raise children with problems. Rey and Plapp[13] found that adolescents with a conduct disorder perceived their parents as more controlling but not more neglectful than adolescents in a control group perceived their parents.

Recent research has focused on the interaction between children and their parents.[14,15] Patterson[16] proposed that a coercive cycle of interaction between the parents and the child has an important role in the development or maintenance of conduct problems. Parent Management Training, which arose out of this social learning theory, is an attempt to intervene in the cycle by changing the behaviour of both the parents and the child. Subsequent research into this approach, mainly involving young children, has shown promising results,[17,18] even when the child does not participate in the treatment.[19] Moreover, a group treatment approach has been shown to be effective, and economical.[20]

We have been involved with an organization that

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provides Parent Management Training, called Parents for Youth. Even when it is not possible to treat youth with a conduct disorder we have found that it is possible to intervene effectively through the parents. Rather than undermine parents' confidence, this therapy strengthens the parents' roles. This approach goes further than merely teaching the parents behavioural methods: it recognizes that the parents have suffered and need support and healing. The group sessions aim to change the parenting style and attitudes of caring, committed parents. Empowerment of parents to deal with antisocial behaviour in their children may effectively decrease the incidence of negative behaviour in some youth.

Description

The experience of one of us (H.A.) with parent groups began 20 years ago at the Family Court Clinic of the Clarke Institute of Psychiatry, Toronto, Ont. The first parents' group was formed as a result of concern about the failure of traditional treatment to help some depressed and ineffectual parents of young offenders.[21] Since that time, the demand for parents' groups has increased. The program was continued at the Youthdale Psychiatric Crisis Service and the Hospital for Sick Children, Toronto. In 1988, after consultation with the Ontario College of Physicians and Surgeons, Parents for Youth was incorporated.

At present seven therapists lead 17 groups; these comprise approximately 180 parents of 130 youths with behaviour disorders. These youths account for nearly 9000 outpatient visits to clinicians each year. Each group comprises a maximum of 12 parents, who meet in the evenings for 1.5 hours each week. The average length of participation in a group is 1 year. Each group has a facilitator, who is either a professional therapist or a trained paraprofessional who has been involved in a group as a cotherapist for 2 years and continues to receive help and supervision from other group leaders through weekly meetings.

A series of questionnaires were drafted in 1985 and 1986 to provide evaluative data on the effectiveness of these groups. They were pretested with 82 parents, who were asked to fill them out and to provide input into the design. The revised questionnaires included queries about demographic factors, agency contacts, and emotional and physical health. Parents were asked to rate their youth's behaviour problems and their own responses to them on four- or five-point scales.

Questionnaires were completed by parents before they entered a group, when they left it and 6 months later. Parents were encouraged to comment on their group experience. In September 1993, Achenbach's Child Behavior Checklist[22] and Beck's Depression Inventory[23] were added to the initial assessment.

Parents of youths with a conduct disorder are referred to groups by physicians, social service agencies, schools and parents who have "graduated" from a group (Table 1 provides the referral criteria). Group leaders try to contact parents within 24 hours after referral to arrange an initial interview. This is a mutual assessment and screening interview designed to allow the parents and the group leader to determine whether the program would be of benefit. If they agree that it would, they enter into a contract regarding group entry, which covers such issues as length of involvement, notice of termination, involvement in evaluative research, prohibition of smoking, fees, use of a telephone list for after-hours support, liability, and agreement to discuss personal and marital issues outside of parenting as well as outside contacts with the group. The support of a parent-coach (a graduate or experienced member of the group) may also be offered.

A basic program has been established to train physicians and nonmedical caregivers as group leaders and to broaden the understanding and acceptance of this treatment. An advanced training program has also been set up to enhance the knowledge and skill level of experienced group therapists. The training model is based on Yalom's model of interactional group psychotherapy.[24]

Youth profile

Data were collected from intake questionnaires, completed by all parents as a condition for entry to the group. (Parents were also asked to complete questionnaires at completion of the group and 6 months later; some of them did not complete these follow-up questionnaires.) The following data were provided by 328 parents from 247 families who completed questionnaires from 1990 to 1994.

The data covered 262 youths who ranged in age from 10 to 25 (mean age 16.2, standard deviation 2.24) years. About two thirds (64.5%) were male and one third (35.5%) female. Their parents described them as bright (67.2%), charming (80.3%) and good-looking (75.1%), yet many of them (31.3%) had exhibited serious problems before the age of 12: they frequently lied to family members (95.2%) and stole from them (65.3%); many (60.2%) had threatened violence to family members; almost half were described as being violent to their siblings (43.3%) or to the parents (46.7%); many (55.3%) had run away from home; and almost all (90.9%) were

Table 1: Criteria for referral of parents of youths with a conduct disorder

The youth has been displaying serious antisocial behaviour for more than 2 years
The youth refuses to participate in therapy *or* other therapies were ineffective
The parents are caring and committed
The parents function adequately
The parents interact and communicate adequately

described as having withdrawn from the family.

Parents described their children as having had learning problems (47.7%) or behaviour problems (70.8%) at school. Most were truant (76.3%), disobeyed school rules (79.1%) and were inattentive and easily distracted (91.5%). Many exhibited disruptive behaviour (73.9%) and were rude and insulting to teachers (61.1%). Some were described as having assaulted their teachers (11.9%) or peers (35.1%). Almost half (47.8%) had been suspended or expelled from school.

Most of the youths (72.5%) had had contact with the police by the time their parents came to Parents for Youth, and most (83.6%) had been treated previously. The parents often reported being dissatisfied with the assistance offered (41.5%); many (46.2%) felt that the treatment agency or professional blamed them for their child's behaviour.

Parent profile

The parents ranged in age from 28 to 62 years (mean age 45); 70.1% were mothers and 29.9% fathers. Other characteristics are shown in Table 2.

When they joined the group these committed parents were under enormous pressure. They usually cared very deeply for their child and recognized the severity and seriousness of their child's difficulties. However, they were also in pain. At intake, they reported feeling helpless and impotent about their inability to understand or influence their child's behaviour. Many felt depressed and overwhelmed by guilt, anxiety and shame. Their sense of confidence and competence as parents had been severely shaken. They were exhausted by the constant vigilance and worry about the crises created by their child's behaviour. They often felt confused and lost in a maze of professionals and institutions; they felt that the professionals blamed and criticized them.

Table 2: Characteristics of parents (at entry into group)*

Age, yr	
Range	28–62
Mean	45
Marital status, % of parents	
Single (never married)	2.5
Separated	13.9
Divorced	17.6
Widowed	2.8
Married	54.6
Remarried	5.6
Living with partner	3.1
Sex, % of parents	
Male	29.9
Female	70.1
Highest educational level achieved, % of parents	
Grade 8 or less	2.3
Some high school (not completed)	6.8
High school graduation	19.7
Postsecondary training or education	26.3
University, bachelor's degree	29.8
Postgraduate degree or training	15.2
Number of children (including youth with a conduct disorder), % of parents	
1	24.4
2	43.9
3	23.6
4	6.5
5 or more	1.6

*n = 328 parents from 247 families.

These parents often believed they had no allies. Other people, including their own extended family, did not understand how lonely and difficult it was to parent a powerful, angry and manipulative child. Many parents concealed the extent of the difficulties from extended family and friends. Their relationship with their partner had frequently undergone considerable stress. Problems with such a child often divide couples. The youth may manipulate this division to his or her advantage.

Group process

Group leaders are initially active. They encourage parents to recognize their own expertise with regard to themselves, their children and their families, rather than see the group leader as the "expert." Empowerment, validation and support are key factors in this approach, from the intake process and throughout the entire treatment. As the group matures, the leader becomes less active, and the parents discover that they can help themselves and each other.

At first the parents focus on their children and discuss themselves solely in the parental role. As the group progresses, relational processes, other roles and past experiences become central. Members begin to focus on the emotional effect of their children's behaviour and on the sources of these emotions in their own childhoods.

These parents have faced and continue to face many losses. These may include the loss of the idealized child and family, their idealization of parenthood, their dreams and hopes, intimacy with the child, the emotional support of the child and the other parent, the positive public image of self and family, contact with extended family and friends and, for some who confront their own childhood trauma, even their idealizaton of their family of origin. Mourning is a central and continuing theme of group discussions.

The experience of being in a group of caring, hard-working, conscientious parents who love their children fosters a positive self-image. The validation of their pain and of their needs in relation to the child enhances their self-esteem.

Before joining the group, parents often surrendered control to the youth. The group process enables them to regain control of their interactions with their children, emotional expression, actions and even property. They learn to recognize, however, that they cannot control

their children in the sense of defining success and failure for them. Separation and individuation become the main themes after the first few months of therapy.

The parents begin to recognize their previous inability to set boundaries for their child's behaviour. The development of these boundaries is a slow and painful process. Parents often equate setting limits with hostility, but they come to realize that it can be an act of love that fosters a sense of responsibility in the youth. They strive to set limits calmly, supportively, immediately and concisely.

These boundaries are often physical ones. Parents assert control over access to the television, stereo and telephone. They learn to walk away from a youth who is trying to provoke helpless fury while continuing to manipulate through charm or terror. Occasionally, some of these parents need to protect their own valuables and those of other children in the home.

The parents assert their right to personal safety and the security of their home. They refuse to tolerate threats, property damage, screaming and endless nights of disturbed sleep. They no longer feel they have to justify their feelings, perceptions and actions to their child. As group members' self-esteem improves, and as they observe each other's successes, they develop and reinforce boundaries. Their interactions with their child improve.

Evaluation

The predominant observed effect of treatment was a heightened sense of strength and confidence in the parents. They learned new and more effective behaviour-control skills and became better able to set limits and boundaries. They evaluated their contribution to their children's problems more constructively and coped with them more realistically. They began to accept the limitations of their children and give up unrealistic expectations. Parents reported significant positive changes in many areas of their functioning as a result of their participation in the group (Table 3).

Although group therapy for parents does not directly affect the youth, preliminary analysis of the data revealed that parents perceived their child's behaviour to have improved (Table 4): the overall rating of its severity decreased significantly during parental involvement with the group (Student's t-test, $p \leq 0.001$). The parents also reported that the extent of specific negative behaviour in the home, the school and the community had decreased.

Discussion

Parents for Youth differs from more traditional treatments in its focus on parents. Self-help and psychoeducational groups share this focus, but there are important differences. Self-help groups, although they offer support, may concentrate on issues of power and control rather than on other problems. The groups are self-selected, can have a high turnover and are usually run by a parent who has experienced similar problems. Parents for Youth screens parents to ensure appropriate group membership, the members stay for an average of 1 year, and the groups are conducted by a trained leader.

Psychoeducational groups tend to have "experts"

Table 3: Parents' reports of their abilities and feelings at the start (n = 419) and finish (n = 126) of group involvement

Ability or feeling	Score* at start (and finish†), % of parents		
	Poor abilities and negative feelings	Average abilities and feelings	Strong abilities and positive feelings
Ability to influence positively their child's negative behaviour	74.2 (9.0)	18.3 (25.4)	7.5 (65.6)
Ability to set limits for their child's behaviour	62.1 (3.3)	25.8 (10.0)	12.2 (86.7)
Ability to follow through after setting limits	56.8 (1.7)	25.4 (12.6)	17.7 (85.7)
Relationship with their child	48.2 (11.5)	30.8 (35.2)	21.1 (53.3)
Optimism about their child's improvement	39.3 (12.0)	25.0 (35.2)	35.7 (52.8)
Feelings of guilt as a parent	45.1 (3.2)	27.4 (22.6)	27.4 (74.2)
Feelings of responsibility for the child's behaviour	36.2 (4.0)	35.3 (20.2)	28.5 (75.8)
Sense of confidence as a parent	40.5 (1.6)	36.5 (15.3)	23.0 (83.1)
Sense of competence as a parent	23.4 (2.4)	43.2 (18.5)	33.4 (79.0)
Feeling of clarity about what can and cannot be done about the youth's behaviour	68.3 (3.2)	16.5 (6.4)	15.3 (90.4)

*A five-point scale was used, ranging from poor or negative (score of 1) to strong or positive (score of 5). For analysis, negative responses of 1 and 2 were combined and positive responses of 4 and 5 were combined.
†The differences in scores from start to finish were all statistically significant (χ^2 test, $p < 0.001$).

teaching large numbers of people. They are topic-focused, with less opportunity for problem solving or dealing with personal distress. This approach may be better for parents of youths with less severe problems. Parents for Youth maintains a small-group approach, offering a high level of support for members and a more direct opportunity for problem solving. Because the members set the agenda, a broad range of problems and issues are addressed.

The main limitation of the program is that it is not always available to all of the parents who need it. Although parents can join the program quickly in Toronto (there are no waiting lists), it is not a funded service; thus, it is limited to those parents who can afford the nominal fee. Furthermore, the program is not directed at parents who are themselves seriously disturbed or otherwise unable to function in an interactional setting.

A clear strength of this program is that it can respond to families of youths with conduct disorders when the youths themselves do not participate in treatment. In addition, it is self-supporting and therefore not vulnerable to government funding cuts.

In this context we believe the program has succeeded. As parents graduate from the group they feel that they have more power and control over their lives. The healing and the learning processes fostered by the group help them cope more constructively with their children, and this behaviour is generalized to other areas of their lives. In addition, parents perceive that the severity of their child's conduct disorder is reduced or, at least, not increased. Written evaluations by the parents indicate that they regard the program as highly successful.

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Table 4: Parents' reports of their child's behaviour at the start (n = 320) and finish (n = 78) of group involvement

Behaviour	Rating* at start (and finish†), % of parents							
	None		Mild		Moderate		Severe	
At home								
Lying	4.8	(28.8)	18.4	(30.8)	30.0	(21.2)	46.8	(19.2)
Theft of articles and money	34.7	(63.5)	22.1	(11.5)	25.6	(21.2)	17.5	(3.8)
Threats of violence	39.8	(78.0)	18.8	(14.0)	21.4	(4.0)	20.1	(4.0)
Violence against parents	53.3	(88.0)	21.2	(10.0)	15.0	(0.0)	10.5	(2.0)
Running away	44.7	(88.2)	22.4	(5.9)	16.8	(5.9)	16.1	(0.0)
Withdrawal from family	9.1	(29.4)	18.2	(31.4)	39.7	(17.6)	32.9	(21.6)
Difficulty accepting limits	0.6	(15.7)	14.1	(35.3)	36.9	(31.4)	48.4	(17.6)
At school								
Erratic attendance or truancy	23.7	(59.2)	22.4	(24.5)	25.1	(2.0)	28.8	(14.3)
Disobedience	20.9	(55.3)	29.1	(21.3)	30.1	(19.1)	19.9	(4.3)
Lack of attention, tendency to be easily distracted	8.5	(31.9)	14.3	(27.7)	34.5	(21.3)	42.7	(19.1)
Disruptive behaviour	26.1	(56.5)	21.7	(26.1)	24.7	(13.0)	27.4	(4.3)
Rude and insulting behaviour toward teachers	38.9	(67.4)	24.0	(21.7)	21.3	(6.5)	15.9	(4.3)
Assault of peers	64.9	(93.5)	19.1	(6.5)	12.5	(0.0)	3.5	(0.0)
Suspension or expulsion	52.2	(82.6)	18.0	(8.7)	14.9	(2.2)	14.9	(6.5)

*If more than one parent reported on the same youth, the responses of one parent only were chosen at random for inclusion in this analysis.
†The differences in ratings from start to finish were all statistically significant (χ^2 test, $p < 0.001$).

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Oct. 21–23, 1994: 3rd World Biomedical Conference of the Hellenic Diaspora
Athens, Greece
Conference Secretariat, 84 Hippocratous St., GR-106 80 Athens, Greece; tel 011-30-1-36-26-972, 011-30-61-424-273, 011-30-1-72-11-845; fax 011-30-1-36-26-972, 011-30-1-72-15-082

Oct. 23–25, 1994: Biomaterials and Medical Devices: an Industry in Transition (sponsored by Gorham Advanced Materials Institute and Intertech Corporation)
Washington
Keynote speaker: Jerry L. Marlar, president, Intermedics Orthopedics Inc.
Deedra A. King, conference coordinator, Gorham/Intertech Conferences, PO Box 250, Gorham, ME 04038; tel (207) 892-5445, fax (207) 892-2210

Oct. 24–25, 1994: 6th Annual Palliative Care Conference, Education and Research Days (sponsored by Caritas Health Group)
Edmonton
Linda Aubrey, tel (403) 930-5852, fax (403) 930-5970

Oct 24–26, 1994: Bioethics: 2nd World Congress (sponsored by the International Association of Bioethics)
Buenos Aires, Argentina
Escuela Latinoamericana de Bioética, Fundación Dr. J.M. Mainetti, Calle 508 e. 16 y 18, (1897) M.B.Gonnet, Argentina; tel 011-54-21-71-1160, ext. 63; fax 011-54-21-71-2222; or Secretaría en Buenos Aires, Fundación Favaloro — Comité de Etica, Solis 453 (1093) Buenos Aires, Argentina; tel 011-54-1-383-1110, -0098, -1327, -1371, -1468 or -5080, ext. 3105; fax 011-54-1-383-9077, -1474 or -0323

Oct. 24–28, 1994: Cirugía/Surgery '94 (includes the Cuban Society of Surgery 5th Congress, the Iberian–Latin-American Society of Surgeons 2nd Congress, 1st International Meeting on Laser in Surgery, 2nd International Meeting on Endoscopic Surgery and 1st International Meeting on Trauma Surgery)
Havana, Cuba
Official languages: Spanish and English
Cirugía '94, Palacio de las Convenciones, Apartado Postal 16046, Havana, Cuba; tel 011-537-20-4653 or -22-6011 to -6019, ext. 2391; fax 011-537-22-8382 or -33-1657; or Iberian–Latin-American Society of Surgeons, Apartado Postal 6996, Havana, Cuba

Oct. 24–28, 1994: Prevention in Practice: Workplace Health in the 21st Century — 1994 State-of-the-Art Conference
Denver
American College of Occupational and Environmental Medicine, 55 W Seegers Rd., Arlington Heights, IL 60005-3919; tel (708) 228-6850, fax (708) 228-1856

Oct. 30–31, 1994: 15th Annual Conference for Generalists in Medical Education — Medical Education in an Age of Reform
Boston
Dr. Phillip K. Fulkerson, Department of Family and Community Medicine, Medical College of Wisconsin, 8701 Watertown Plank Rd., Milwaukee, WI 53226; tel (414) 257-8664, fax (414) 257-8575

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