Personalising evidence based treatments for conduct disorder

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http://www.national.slam.nhs.uk/services/camhs/camhs-adoptionfostering/
Based on Social Learning Theory principles
To improve family relationships
Parents identify own treatment goals
Include Role Play & Homework
Sufficient sessions, e.g., 8-12
Trained & supervised therapists
Adhere to evidence based manual
NICE Guidance

(TA102) parent training/education programmes in the management of children with conduct disorders

• Based on Social Learning Theory principles
• To improve family relationships
• Parents identify own treatment goals
• Include Role Play & Homework
• Sufficient sessions, e.g., 8-12
• Trained & supervised therapists
• Adhere to evidence based manual
Parent Training programmes

- Good PT programs have similar theoretical base – **Social Learning Theory**
- Differ in tone, but also in degree of
  - Evidence base
  - Materials / Manualisation
  - Training requirements
  - Supervision structures, etc.
- Different potential for ‘personalisation’ of approach
  - In **Group** programmes possibility of mid-week calls and/or top ups
  - In **Individual** programmes formulation based approach possible
Social Learning Theory

2 rules for most occasions:

1. **Reinforcement rule:** Behaviour that is reinforced immediately more likely to occur.

2. **Attention rule:** Children’s behaviour oriented to gaining attention from others, especially parents.

Not always so simple, so need to be aware of other processes involved

But given this - reinforce positive behaviour & withhold reinforcement for negative behaviour
Patterson’s coercion hypothesis:

*Escalation - a process*

- Parental command
  - Whining / screaming
  - Parent shouts angrily
    - Increased screaming
    - Escalation
  - Child complies
  - Parent capitulates

Negative reinforcement for Parent’s Hostile Discipline

Negative reinforcement for Child’s Escalated B-
Clip
Group or Individual?

• Group-based parent-training/education programmes **are recommended** in the management of children with conduct disorders

• Individual-based parent-training/education programmes are recommended in the management of children with conduct disorders **only in situations** where
  – There are particular **difficulties in engaging** with the parents or
  – A **family’s needs are too** complex to be met by group-based parent-training/education programme
Comorbidity

• NICE Guidance also talks of the high comorbidity with other disorders
• Comorbidity especially high with ADHD, but also emotional disorders, CUT & neurodevelopmental features and school attainment
• A potential barrier to effective treatment
• Parenting practitioners need to know about comorbidity and how to **personalise** a treatment plan for the child’s needs

• **But do parenting practitioners have these skills??**
Identifying CD

• “2.3 Conduct disorders need to be professionally assessed by a child and adolescent psychiatrist, a paediatrician, a child clinical psychologist specialising in the area of behaviour disorders or another professional who has the appropriate competencies. This professional will make an assessment based on observations and interviews with the parents, teachers and children.”
  — TA102, p6

• Do parenting practitioners, inside & increasingly outside of CAMHS, have these skills or access?
Also for the challenges parents bring

• “It is clear that many variables that influence response to parent training for child externalizing behaviour problems do not directly involve the child, with maternal mental health being a particularly salient factor” [Reyno & McGrath, 2006, p108]

• Also format [open-ended/flexible] & setting [community vs clinic] reduce barriers
A simple case – intrinsic factors

• Sensitive parenting is **differential parenting** according to child’s intrinsic factors, e.g., temperament, IQ etc.,
  • Sib A: 9 yrs - High IQ; reserved, seen for depression & anxiety
  • Sib B: 5 yrs - High IQ; feisty and lively, seen for ODD

• A needs quiet, gentle interaction & disciplining, while B needs exciting, high stimulation interaction & forceful, immediate discipline
• Otherwise loving parents report feeling incompetent with B; tired & depressed. Mother says “You can see why I hate him”.
• Not bad parenting per se, but a different parenting style needed to accommodate second child’s intrinsic differences
Parenting in ‘simple’ cases

• Child is very dysregulated, but **low risk**
  – Child; parents; social factors & treatment history
• Calibration issue re. sensitive responding
• Once recalibrated the mutual benefits drove the maintenance of treatment gains
• Even low risk cases can have complex interpersonal factors, influencing the process
Mechanism of Change

• Age appropriate ‘Sensitive Responding’ at the heart of all SLT approaches
  – Sensitive Responding is differential responding – property of the dyad, *personalised*
• ‘Affect Regulation’ (quality of attachment) parents contain his rage...
• Parental schemas & attachment beliefs, e.g., efficacy, agency... and love
Outcomes

Measured in reduced oppositionality & defiance

But also in the increase in warmth, enjoyment, sensitivity, mutuality and love

Can’t easily measure the growth or rediscovery of love but it is how carers will often talk about it [and as you saw, children too]

However, you can measure increases in sensitive responding and we know this is the basis for developing good, secure attachments
Developing Secure Attachments
“Less is More”

The evidence for developing secure attachments in early childhood indicates that **sensitive responding** is a primary mechanism & that **less is more** (van IJzendoorn et al 2005)

**Sensitive Responding:**

Not specific about the precise form, but it should be **developmentally appropriate** for the child’s age
Treating attachment problems within an evidence-based framework with a personalised SLT approach
(Woolgar, Bengo & Scott, 2014)

9 year-old child in pre-adoptive placement with a lone carer

Birth family:
- Marked neglect, domestic violence & sexual abuse
- Parentified child caring for 2 younger siblings.

Removed to single 3 year foster placement @ 5 years:
- All 3 siblings mimicking sexual acts
- C deemed ‘unmanageable & unadoptable’ @ initial placement because controlling
Presenting problems

• Extremely oppositional and aggressive

• Tantrums – daily, and long-lasting [e.g., ‘2 ½ days’ – noticing onsets/offsets?]

• Relationships with carer and peers ‘intensely controlling’

• ‘Anxiety’ – widespread, easily distressed by small changes
  Most problematic expression refusal to leave carer’s side e.g., cooking a meal, going to the loo, showering, company, etc
  Aggressive distress when carer tries to separate – carer locks herself in bathroom while C screams, kicks door & ‘worries’ carer is dead until carer comes out.

**BUT** specific to home, C goes to school & to 3 day camps without distress

Carer reported placement in crisis & danger of breakdown – hated clinginess and felt her own efforts unappreciated and ineffective. Hopeless about their future.
Formulation

Meets criteria for conduct problems but more than this.

- Extreme distress on separation, but can separate on own terms, so not a straightforward Separation Anxiety disorder

- Is ‘anxiety’ really controlling behaviour: a remnant from parentified early years - a disorganised attachment?

- The degree of distress & punitive anger suggests emotional dysregulation – directed especially towards her carer.

An attachment issue, but not RAD/DAD, as she has a clear preference for the carer [of poor quality – enmeshed but clearly comforted by it] and no evidence before 5
Treatment approach - 1

No current evidence based treatments for ‘attachment difficulties’ at this age – so target the conduct problems, which does have excellent evidence

Carer’s understandable irritation with C’s clinginess leads to her noticing it, hence reinforcing the negative behaviour and ignoring C’s good, calmer, nicer behaviour – it’s hard to notice when you are still upset

Work on sensitive responding with live coaching – to catch C being good, to help the carer ignore the irritating bids for claustrophobic closeness & to praise C’s appropriate behaviour - challenge her negative beliefs

Coach carer to use clear, calm commands with C – keep them simple, without extensive explanations, or talk of disappointment, or how she feels, or her beliefs about the origin of C’s behaviour
C looks a bit like she has Separation Anxiety disorder, and the best treatment for that would be gradually increasing the length of separation.

Introduce graded separation after increase in Sensitive Responding & calm, clear instructions from a personalised SLT Parent Training

Separation would allow C to gradually get used to her strong & overpowering feelings when she is unable to control being close to her carer

Separating from the carer could allow some talking [cognitive work] about:
  C’s strong beliefs about the danger of being separated from her carer & to explore her emotional response to it
  Help give C a vocabulary to understand and describe why she feels so upset and out of control

Successful separation a primary treatment goal for the carer.
Quality & Duration of Pre-Separation
Parental Instructions

Pre-Separation

Minutes

Duration
Protest
Aggression
Controlling
M Betas

Session Number

Count

0 2 4 6 8 10 12 14 16 18

1 2 3 4 5 6
Reduction in behavioural problems

![Graph showing reduction in behavioural problems over time.](image_url)
Improvement in prosocial behaviour at school

![Graph showing improvement in prosocial behaviour at school](image-url)
Outcomes

Evidence to show this modified parenting program worked:

• Observed increased calmness over extended periods of separation
• C began to briefly reflect upon her arousal with a clinician
• C shared her feelings & explained the cause of her tantrums in letters to her carer, initially written down but torn up before shared, but later given to her carer
• No major tantrums between 1st August & December – sporadic since triggered by big events, e.g., birthdays, contact with birth siblings
• The growth of love & stabilisation of the placement

Immediately post treatment - reasonable outcomes, e.g., placement stability, and then the real work started...
Conclusions

• Can modify an evidence-based parenting programme to address issues beyond CD
• But need to measure it – but what?
  – CYP-IAPT give some tools but need formulation specific ones for a personalised treatment...

• And which CAMHS are really treating CD nowadays with all its complex comorbidity?
Parenting in complex cases

- Affect regulation poor in child BUT also poor in carer [stress, SA, mental health etc.]
  - Missed out on effective affect regulation in toddler years, in age-appropriate stage [cf. SLT]?
  - ? Disorganised attachment in infancy often becomes controlling by pre-school, but still oppositional & defiant
Case details - complexity

• High levels of child; parental & social risk, & history of variable parental engagement

• Mum’s severe mental health problems:
  – Serious self-harm incidents
  – Poor affect regulation & chronic low mood
  – Complex grief – unresolved wrt loss/trauma?
  – Drugs?
  – Repeated DV

• Other child & social risks too...
Complex case example

• Controlling elements
• Restraint – modelling calm but safe management of extreme behaviour cf. ignoring then punching
  – Is this safe for parenting practitioners to do?
• Cool down & return to sensitive, age appropriate & caring interaction
• A melodrama in 3 acts...
Realistic Outcomes

• Not just questionnaires & self report...
• Change observed in sessions, reliably scored with valid system that:
  a) Specifies SLT mechanisms of change
     • The elements now present
  b) Predicts attachment classification
     • Sensitive responding & concomitant affect regulation evident

• Excellent - behaviour & attachment outcomes in clinic
Realistic Outcomes

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     • Sensitive responding & concomitant affect regulation evident
• Excellent - behaviour & attachment
• **BUT** when we look into it a bit further ...
Real Outcomes

• Considering outcomes beyond clinic data; FU 1 month post-treatment
  – Home visit: no toys - no generalisation
  – School network: violence persists & exclusion
  – Social services – on-going safeguarding concerns

• Ultimately a treatment failure – despite all the excellent, multiple, detailed short-term outcomes
Final thoughts

• Evidence based SLT parenting allows a formulation-led tailoring of treatments
• Need to measure the right things, based on the formulation goals
• But
  – Recognise that there are limits to the sustainability of treatments; especially with issues extending beyond specialist CAMHS involvement
  – Can these approaches be used effectively by generic parenting practitioners in SSD / voluntary sector etc?
  – How many services nowadays are really committed to working with CD as a CAMHS issue?