Attachment and Conduct Disorder: The Response Program*

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An increasing number of youths are being identified as suffering from behavioral problems that cause difficulties in their family and peer relations which in turn reduces their chances of academic and vocational success. There is growing concern regarding their level of aggressiveness. The common diagnosis given to these dissatisfied youths is conduct disorder. To date, most treatment programs for conduct disorder have been unsuccessful. A review of recent studies indicates that the disruption of attachment may be an important feature that underlies the wide range of symptoms that are typically found in youths with conduct disorder. A community-oriented program designed to ensure long term care for these youths is described in this paper, and the findings of a six month follow-up evaluation are presented. Results indicated that communities, caregivers, and youths responded positively to the program; caregivers reported significant reductions in a broad range of psychiatric symptoms in youths, and youths reported a significant reduction in symptoms of conduct disorder.

Between 30% to 50% of mental health referrals for children and adolescents are the result of antisocial and aggressive behavior (1). Epidemiologic studies have estimated that the prevalence of conduct disorder in children and adolescents ranges between two percent and ten percent of the population, depending on age and gender (2,3). Overall, Offord et al (3) found that 5.5% of children between the ages of four and 16 suffer from conduct disorder. Based on these results, Offord et al (3) estimated that among Ontario youths alone, there were approximately 100,000 cases of conduct disorder. Research also shows that many more youths engage in specific behaviors included in the diagnosis of conduct disorder than are diagnosed with the disorder. For example,

Feldman et al (4) found that 60% of adolescents report engaging in more than one type of antisocial behavior such as vandalism, drug use, assault and theft.

Not only is conduct disorder a fairly common disorder of childhood and adolescence, it is also a highly stable and debilitating condition. Based on numerous follow-up studies, Olweus (5) estimated that the mean stability coefficient for aggressive behavior during childhood was 0.63. The range of behavior problems and age of onset are critical factors in predicting the course of the disorder. The greater the range of conduct disorder symptoms and the earlier the onset, the more likely it is that the course will be chronic (1,6,7).

Deficits associated with conduct disorder include poor peer and family relations, poor academic achievement, drug and alcohol use and low self-esteem (8-10). Unlike many conditions of childhood that remit with development, conduct disorder has a profound impact on adjustment in adulthood. Conduct disorder predicts an increased likelihood of antisocial personality disorder as well as internalizing disorders such as major depressive disorder, panic disorder, obsessive-compulsive disorder and substance abuse (11).

Efficacy of Current Treatment Approaches

Despite the long history of attempts to treat antisocial youths, little progress has been made (12-16). Reviews of the literature commonly conclude that the efficacy of treatments for antisocial problems is very limited. Indeed, the outcome of treatment programs prior to 1980 was generally so poor that some reviewers were forced to conclude that "nothing works" (17).

In Kazdin's (15) review of the literature, he noted that the majority of interventions for antisocial behavior have been individually based. In general, these interventions (for example, individual psychodynamic therapies) have not been shown to be successful (17-20). Kazdin (15) concluded that there are three modes of intervention that have demonstrated efficacy or, on the basis of preliminary findings, appear promising. These interventions are generally broadly focused programs that include parent management training, functional family therapy and community-based interventions.

Kazdin's (15) conclusions suggest that therapeutic strategies that are geared toward the alteration of a youth's immediate and wider social environment are among the most effective in responding to the needs of troubled adolescents. These programs often produce substantive changes in the quality of the adolescent's environment (for example, improved family functioning, reduced maternal psychopa-

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Table I
Organizational Structure of the Care Plan
Response Program Care Plan Format

<table>
<thead>
<tr>
<th>Issue</th>
<th>Personal and Family Dynamics</th>
<th>Management Strategies</th>
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<td>• social</td>
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<td>• health</td>
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<tr>
<td>Home life issues</td>
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<td>• relationship with caregivers</td>
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<td>• relationship with significant others</td>
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<td>• home responsibilities</td>
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<td>School issues</td>
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<td>• academic</td>
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<td>• relationship with peers</td>
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<td>• relationship with teachers</td>
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<td>• goals</td>
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<td>• attendance</td>
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</tbody>
</table>

With depression, youths appear to be at higher risk for impairment than when they have either disorder alone (35,36).

The fact that conduct disorder almost always occurs in conjunction with symptoms of other psychiatric conditions has important implications for understanding and responding to the needs of this population. An alternative perspective on conduct disorder is that it may be understood as one feature of a more general underlying problem related to the development and maintenance of attachment within interpersonal and social contexts, rather than as a distinct disorder per se. If one looks at the various approaches that appear to be somewhat successful with youth with conduct disorder it is clear that one common goal of these approaches is to build an affiliation between youths and others, whether it be within their family or community. The direct or indirect building or repairing of affiliation between adolescents and their social ecology appears to be central in responding effectively to the needs of these youths, suggesting that attachment disruption may be a critical underlying feature of the condition.

Attachment Theory: An Alternative View of Conduct Disorder

What additional evidence is there to suggest that attachment issues are important in understanding conduct disorder? Loebel (37) has recently suggested that there is a critical period during infancy, when attachments are formed to adult caregivers, that ensure the learning of social skills. Studies indicate that deprivation during this period, through such events as an extended separation from the mother, multiple mothering, marital disruptions and poor quality care predict antisocial behavior. As Loebel (37) noted, these types of deprivation experiences are extremely common in the histories of youths with conduct disorder.

Research has shown that insecure-ambivalent attachment styles are related to harsh, punitive and abusive parenting styles (38,39). The presence of conduct disorder in youths has also been related to parent-child interactions that are characterized by high levels of defensiveness, low levels of warmth and negotiation and harsh and inconsistent discipline practices on the part of the parents (31,40-43). Moreover, there is direct evidence linking insecure attachment with conduct problems (44-49).

The relationship between conduct disorder and symptoms indicative of attachment disturbance has been supported by our own research within a clinical population (50). In this study, over 200 youths and approximately 100 of their caregivers completed the Ontario Child Health Study scales (51) to assess the comorbidity of conduct disorder with symptoms of separation anxiety disorder (SAD). Symptoms of SAD are similar to the characteristics one would expect to find in youths with insecure-ambivalent attachment styles (type C) (32), or fearful or preoccupied attachment styles (53). These forms of attachment are characterized by children's distrust of the ability of caregivers to respond reliably to their needs and by expectations of rejection and punishment rather than acceptance. The results indicated that...
youth's self-reports of conduct disorder correlated 0.83 with their reports of separation anxiety symptoms. Similarly, parent reports of conduct disorder and symptoms of separation anxiety disorder were correlated at 0.85. The majority of youths with conduct disorder were found to have moderate to high levels of separation anxiety. Additional analyses indicated that youths who scored at 0.3 or above the threshold set by Offord et al (51) for the identification of conduct disorder, and who also had high levels of symptoms of separation anxiety disorder, had significantly more impaired school and social relations, smoked more and reported more drug use than youths with conduct disorder alone or youths with a high level of symptoms of separation anxiety disorder alone. These differences were due to the unique combination of conduct disorder and SAD symptoms rather than to differences between the groups in their overall level of psychopathology.

In summary, there is a body of evidence that suggests that attachment problems are frequently found among youths with conduct disorder. If this is indeed the case, programs that respond to the attachment-related needs of conduct disorder youths may be of some value.

The Response Program

Several factors provided the impetus for the development of the response program. First, as previously noted there is growing evidence linking attachment disruption to conduct disorder. Second, the chronic course of the disorder and the wide range of symptoms found in these youths suggested that it was important to develop a broadly based program for long term care rather than short term treatment. Third, the high rate of conduct disorder in the population and the poor efficacy of residential treatment made it clear that, even if residential treatment were effective, we simply do not have the resources to provide it to the thousands of youths who may require it.

Thus, the task was to bring to the community some type of structure that would enable it to care for youth and assist the community in focusing their resources as effectively as possible. (A complete description of the program's philosophy and operation is available upon request from the authors.)

The Response Program is primarily based on the notion that a bonding injury or attachment failure of some sort has occurred in disaffiliated youths, and that this problem is chronic in nature and likely to require long term care. It is not a treatment program and, in fact, avoids conveying the expectation that there is a short term cure for these difficulties. Empirical research indicates that it is more realistic to view conduct disorder as a chronic condition (15). Rather, the program is designed to intervene with a youth's entire environment and to promote an understanding of the youth's needs from an attachment-based perspective. This goal is achieved through the development of a care plan, which details attachment issues involved in the current clinical situation for the youth and outlines a plan of care throughout adolescence. Outreach support and respite services are provided to assist the community in implementing the care plan. The extent to which this approach is expected to lead to behavioural change depends on both the nature and severity of attachment disruption and the flexibility and adaptability of the environment in responding to the youth's needs.

The Response Program differs from traditional treatment programs for youths with conduct disorder by focusing on the role of attachment and bonding insults in understanding the development and maintenance of behaviour problems; working to develop conditions within the youth's environment that are most likely to lead to the development of affiliation rather than providing treatment that is narrowly focused on behaviour change; and working to ensure the continuation of care for youths' behaviour.

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for youths regardless of the nature or persistence of their behaviour problems.

Several principles which are drawn from attachment theory, object-relations theory and self-psychology (54-59) underlie the operation of the program. First, we adopt the view that early experiences become solidified into representations of the self and other that then guide interpersonal functioning and give meaning to behaviour of the self and others. Two processes are central to the development of attachment: affiliation, the feeling of belonging and being connected with others; and mutuality, the understanding that the actions and feelings of one person affect others and vice versa. These processes ensure bonding to early caregivers and subsequently to others. Second, we adopt the perspective that all behaviour has meaning. The labels that are typically used to describe behaviour (for example, normal versus abnormal, good versus bad, healthy versus sick) often distract attention away from understanding the psychological meaning and interpersonal intent of behaviour for the individual and the observer.

Third, we see behaviour as reflecting a unifying act of intentions designed to maintain attachment and affiliation. Regardless of how behaviour may appear or how socially desirable it is, we tend to think of it as having a common goal of maintaining affiliation and ensuring security and survival. From this perspective, biological, familial, social and psychological factors contribute to the process of securing attachment, and all of these factors interact in determining success or failure in this regard. Fourth, we hypothesize that insults to attachment are expressed behaviourally and influence the capacity for affiliation and mutuality. Once an attachment representation develops, it can be added to, but it is impossible to subtract events once they have occurred. Change occurs through the assimilation of new self-other experiences and accommodation of attachment representations.

Structure and Operation of the Response Program

The Response Program serves the entire province of British Columbia. Youths are referred by local mental health centres to ensure that those agencies with the greatest knowledge of their communities' mental health needs have access to the program. These agencies identify youths that their community is having difficulty taking care of, usually because they are acting in such a way that a diagnosis of conduct disorder is likely. The program accepts all youth between the ages of 10 and 17 with the exception of children who have been identified as functioning within the intellectually deficient range. The Response Program is not an emergency placement and will not accept acute care cases or cases for which the community does not have an established and viable placement for youths to return to upon discharge. The following case vignette illustrates the typical case referral.

Tim is an attractive 15 year old who is living in his sixth placement away from his biological parents. He engages in behaviour that both adults and peers find problematic. He lies, steals, both from home and in the community, and is aggressive when he feels threatened. He uses drugs and alcohol whenever he can. He has no ongoing intimate relationships, only transient involvement with similar adolescents. He does not respond to, like, depend on, or care about adults. He appears to lack concern about the future, either in terms of intimacy in relationships or the consequences of his behaviour. He does not attend school. Tim has been diagnosed on a number of occasions. As a child a diagnosis of attention deficit disorder was suggested. At other times, a diagnosis of separation anxiety disorder was considered. Later, in early adolescence, after an episode of slashing his arm, a diagnosis of depression was suggested. Tim has difficulty expressing himself affectively. His WISC-R scores show that his overall level of cognitive functioning lies at the low end of the average range with higher non verbal than verbal functioning. Tim's biological parents have divorced and are in new relationships with new families. Both families have significant psychological and psychosocial difficulties, although they are managing instrumental tasks reasonably. The family's history shows a pattern of intergenerational problems in intimate relationships associated with physical and emotional abuse. There is an unresolved question of sexual abuse in one of Tim's placements. Tim's current diagnosis is conduct disorder.

Youths are in residence in the Response Program for four weeks. They are housed in two units, each with the capacity to care for 12 youths. Care is provided in the least restrictive, most normative environment as is clinically appropriate, and youths are encouraged to attend school within the complex and engage in recreational activities. The program begins with an intake meeting. At this time, the youth, all concerned caregivers and community support systems, and Response Program staff meet to form an agreement regarding the purpose of the admission and the development of the care plan. During the first three weeks, the multidisciplinary staff of the program gather information on the environment and functioning of the youth, focusing on attachment and affiliation issues. Social work completes an extensive social and family history in the home community with biological relatives and/ or alternate caregivers. This report traces patterns of attachment and interpersonal relations from the parents' relationships with their parents to the parents' relationships with the child. In addition, a detailed account of developmental milestones, the nature of the child care provided to the child and incidents of physical and sexual abuse are documented. The department of psychology completes an investigation of the youth's current level of intellectual and emotional functioning and comments on how this is related to the youth's history of attachment and interpersonal experiences. The education department documents the youth's academic and behavioural history, placement concerns, learning disabilities and vocational, instructional and special counselling needs. The psychiatry department completes a mental status examination and, again, examines developmental and bonding issues as they are currently expressed by the youth. All these investigations occur within the "living lab" of the facility.
Table III

Parent and Youth Reports of Psychiatric Symptoms at Intake for all Admissions versus Admissions Included in the Program Evaluation Study

<table>
<thead>
<tr>
<th>OCHS Scale</th>
<th>All Admissions*</th>
<th>Evaluation Cases Only</th>
<th>Mean Difference†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Parent or caregiver report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct</td>
<td>41</td>
<td>10.07</td>
<td>6.07</td>
</tr>
<tr>
<td>Oppositional</td>
<td>45</td>
<td>13.78</td>
<td>3.42</td>
</tr>
<tr>
<td>Attention deficit hyperactivity</td>
<td>43</td>
<td>17.02</td>
<td>5.77</td>
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<tr>
<td>Overanxious</td>
<td>43</td>
<td>7.40</td>
<td>3.51</td>
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<tr>
<td>Separation anxiety</td>
<td>42</td>
<td>6.67</td>
<td>3.38</td>
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<tr>
<td>Depression</td>
<td>42</td>
<td>13.90</td>
<td>4.52</td>
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<tr>
<td>Total symptom severity</td>
<td>34</td>
<td>68.00</td>
<td>18.56</td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Conduct</td>
<td>149</td>
<td>7.12</td>
<td>4.60</td>
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<tr>
<td>Oppositional</td>
<td>147</td>
<td>9.18</td>
<td>3.69</td>
</tr>
<tr>
<td>Attention deficit hyperactivity</td>
<td>139</td>
<td>10.54</td>
<td>5.18</td>
</tr>
<tr>
<td>Overanxious</td>
<td>139</td>
<td>7.15</td>
<td>3.98</td>
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<tr>
<td>Separation anxiety</td>
<td>152</td>
<td>7.83</td>
<td>3.73</td>
</tr>
<tr>
<td>Depression</td>
<td>134</td>
<td>11.06</td>
<td>5.71</td>
</tr>
<tr>
<td>Total symptom severity</td>
<td>110</td>
<td>32.48</td>
<td>20.41</td>
</tr>
</tbody>
</table>

*All admissions minus the sample included in the program; †All comparisons not significant.

Child care and nursing staff are with the youths throughout their stay and examine the characteristic ways in which the youth establishes relationships with others as well as his or her emotional and behavioural strengths and weaknesses.

The Care Plan

Outreach and Respite Services

The most focused "intervention" is the development and formulation of the care plan, which takes place in a meeting 21 days after admission to the program. All individuals who have a legitimate interest in the youth are urged to attend. This includes parents, alternative caregivers, the youth, social service and school representatives as well as representatives from each discipline in the program. This is an open meeting at which all professionals present their reports and the contributions of all members of the community are encouraged. The open format of the care plan conference is often experienced as unique and challenging to professionals, families and adolescents. Often it is the first time that information is shared completely and openly with all members of the youth's environment. The discussion of the information focuses on patterns of attachment and affiliation between the youth and his or her environment, as well as among members of the environment in general. The types of care situations and strategies that would be most beneficial from this perspective are also discussed. We believe that it is critical to include all members of the youth's environment in this meeting to ensure that they are exposed to this understanding of the youth and his or her environment, and to concretize their participation and commitment to the process.

The information that is discussed in this meeting is summarized in the care plan document (see Table I). The information is organized into three sections: lifestyle issues, home life issues and school issues. Within each domain, personal and family dynamics and management strategies are addressed. Again, attachment and affiliation issues are emphasized within each section. The broad range of the care plan ensures that attention is directed to the numerous domains in which these youths typically have difficulty (60). The care plan is also written in such a way as to ensure that it can be understood by most members of the environment.

A discharge meeting is held one week after the care plan meeting, when the care plan document is reviewed. This meeting also provides an opportunity for members of the community to respond to the process and to solve problems around issues related to the implementation of the care plan. The discharge meeting also marks the beginning of the relationship between outreach workers and the community. The Response Program makes a commitment to assist the community in interpreting the care plan throughout adolescence. In addition, the program commits to respite care of up to two weeks at any particular time during the youth's adolescence to ensure the preservation of a placement. This is a preventative aspect of the program, rather than an emergency placement to house an adolescent after his or her placement in the community has broken down.
In summary, the Response Program is designed to focus members of the youth’s environment on the attachment and affiliation issues related to his or her current functioning and needs for long-term care. In this way, the care plan attempts to move attention away from the behavioural problems presented by the youth to the underlying interpersonal meaning of these behaviours. A program evaluation was completed to assess the impact of the program on the community, the perceived usefulness of the care plan in caring for youths, and the impact of the program on adolescent self-reports of symptoms and caregiver or parent reports of symptoms. The impact of the program on both internalizing and externalizing symptoms of psychopathology was specifically examined.

Method

Participants

The subjects in this study were drawn from 257 youths who were consecutively admitted to the program between January 1989 and July 1992. Youths admitted between March 1991 and January 1992 were included in the six-month follow-up survey. For each case, attempts were made to collect information from case managers, caregivers, and the youths. Case managers included mental health professionals in the community (for example, social workers, psychiatrists, psychologists, counsellors) who were responsible for overseeing the care through their work with the caregiver and the community. Specifically, they were responsible for coordinating and/or providing services to youths and their caregivers within their communities. Caregivers included natural and/or adoptive parents, foster parents, and child care workers in group homes. Of a potential 89 cases, 74 case managers (83%), 65 caregivers (73%) and 53 youths (60%) completed the follow-up survey that assessed their response to the program.

Of the potential 89 cases, 44 caregivers (49%) and 36 youths (40%) also completed additional follow-up questionnaires that assessed psychiatric symptoms. In 29 cases (33%), the participants failed to return the questionnaires, even though they had agreed to do so, and in 11 cases (12%), they refused to be included in the evaluation. In addition, we were unable to locate 12 cases (13%), and two cases (two percent) had moved out of the province. Finally, in one case (one percent), the youth was deceased.

Measures

The purposes of the program evaluation were twofold. First, the evaluation was designed to assess the impact of the program on the community in terms of the distribution of the care plan within the community, the perceived usefulness of the care plan in caring for youths, the compatibility of the care plan with community resources and the frequency of use and value of the respite service. A 32-item survey was developed to assess these aspects of the program. It also asked respondents to provide information on the number of placements that had occurred since discharge. In addition, the youth version of the questionnaire asked respondents to rate the extent to which they believed the program was of benefit to them.

The second purpose of the evaluation was to assess the impact of the program on adolescent self-reports of psychopathology and caregiver or parent reports of psychopathology. The Ontario Child Health Study scales (61) were used to evaluate and monitor the presence and severity of symptoms in the sample from the time of admission to follow-up at six months after discharge. Respondents were asked to indicate whether symptoms were “never or not true” (0), “sometimes or somewhat true” (1), or “often or very true” (2). These scales were developed by revising and adding items to the Child Behavior Checklist (62) to ensure that symptoms of six disorders according to the DSM-III-R could be assessed. The OCHS scales assess the presence and severity of three externalizing disorders (conduct disorder, ODD, and ADHD) and three internalizing disorders (overanxious disorder (OAD), separation anxiety disorder and depression). The prevalence of symptoms of these disorders has been investigated in a non-
Table V

<table>
<thead>
<tr>
<th>OCHS Scale</th>
<th>Intake</th>
<th></th>
<th>Six Month Follow-up</th>
<th></th>
<th>N*</th>
<th>Difference</th>
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<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
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<td>SD</td>
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<tr>
<td>Parent or caregiver report</td>
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<td>6.05</td>
<td>31</td>
<td>3.23*</td>
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<td>4.73</td>
<td>11.07</td>
<td>5.14</td>
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<td>55.10</td>
<td>21.63</td>
<td>19</td>
<td>13.55*</td>
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<td>Youth report</td>
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<tr>
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<td>0.03</td>
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<tr>
<td>total symptom severity</td>
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<td>4.83</td>
</tr>
</tbody>
</table>

*Cases were deleted if missing values were found for any scale item. Ns are for paired comparisons. *p < 0.05; **p < 0.01; ***p < 0.001.

clinical and clinical sample, and recent psychometric evaluation of the scales has indicated that they generally possess adequate homogeneity and test-retest reliability and can effectively discriminate between youths using outpatient mental health services and those not using such services (63).

Procedure

At the time of admission, the OCHS scales were completed by youths as well as by their parents or caregivers who had knowledge of the youths' functioning within the past six months. When the adolescents had difficulty reading or understanding questions, they were assisted by child care staff. The respondents were sometimes unable to complete all questionnaire items. Thus, the number of subjects fluctuates slightly in various analyses.

Six months after discharge, the case managers and caregivers were contacted by an outreach worker and completed the follow-up survey over the phone. Outreach workers completed these surveys as part of their regular contact with communities in which they assist in problem solving around case management. It is possible that the respondents may have restricted or moderated their responses because of their ongoing relationship with outreach workers. This was not felt to be the case, however, because even prior to the evaluation the community was consistently encouraged to provide direct, open and often critical feedback to the program regarding their experiences.

Items for the six diagnostic scales of the OCHS were mailed to caregivers and youths. Again, only parents or caregivers who had at least six months experience with the youth completed the OCHS scales. Typically, the questionnaire was completed by the mother or foster mother. In the few cases where more than one parent or caregiver wished to complete the questionnaire, it was requested that only one questionnaire be completed through consultation between the caregivers. The respondents were asked to complete and return the survey as soon as possible. If a survey was not received from a respondent within two to three weeks from the time of mailing, he or she was contacted by phone and offered assistance in completing the questionnaire over the phone or encouraged to complete it and mail it back.

Results

Demographic and Psychiatric Characteristics of the Sample

Table II summarizes demographic information on all youths admitted to the response program (N = 257). These results indicated that approximately 31% of this group reside with their natural parents and 33% are in the care of their guardian. The demographic profiles of youths who were included in the current study (n = 89) were also examined to determine whether or not this sample was representative of typical cases admitted to the program. A comparison between the profiles of the two groups revealed that they were very similar with the exception that youths included in the current study were more likely to reside with their natural parents (45%) than was typical for all youths admitted to the program. In addition, youths included in the current study were also more likely to be in the care of their guardian (47%) than was typical for the young.
typical for all youths admitted to the program. These differences most likely reflect the greater stability of the living arrangements of respondents whom we were successful in contacting for the program evaluation.

Several analyses were conducted to confirm the representativeness of the sample included in the evaluation study. Table III summarizes the mean parent report and youth report OCHS scale scores at intake for all youths admitted to the program versus cases included in the evaluation study. No significant differences were noted in the mean levels of symptoms for these two groups on any of the scales, indicating that the group included in the evaluation study was representative of typical referrals to the program.

As noted earlier, six month follow-up data of symptom levels was available from 45% of the caregivers and 40% of the youths in the sample. To assess the extent to which the youths who completed the six-month follow-up were representative of those included in the evaluation, symptom levels at intake for the two groups were compared. Results indicated that, at intake, parent or caregiver reports of symptoms on all OCHS scales and the total level of symptom severity were not significantly different for those who completed versus those who did not complete the six-month follow-up survey. Similarly, at intake, youth reports of symptoms on the OCHS scales and the total level of symptom severity were not significantly different for cases who completed the survey versus those that did not.

The general level of psychopathology in the sample included in the program evaluation study can be estimated by comparing the mean level on each of the OCHS scales to the means reported for the general population (63). For parent report information, elevations were noted on all OCHS scales and ranged from one standard deviation (ADHD, OAD, SAD) to two standard deviations (conduct disorder, ODD, depression) above the mean level for the general population. For youth report information, elevations were noted on all OCHS scales and ranged from less than one standard deviation (ADHD, OAD, SAD) to one standard deviation (ODD, depression) and two standard deviations (conduct disorder) above the mean level for the general population.

Impact of the Response Program on the Community

Table IV provides a summary of the survey responses from the case managers, caregivers and youths. In order for the care plan to be effective in influencing the care of youths, it must be efficiently distributed within the community and it must maintain visibility within this context. The results indicated that the care plan appears to remain highly visible within the community. The majority of case managers and caregivers indicated that they possessed a copy of the document or were familiar with its contents. Although less than 40% of youths reported that they had a copy of their care plan, 67.9% reported that they had read it.

The results also indicated that the majority of case managers and caregivers perceived the care plan to be useful in ensuring care for the youths. Only ten percent of case managers and 9.8% of caregivers did not find the recommendations helpful. Over 75% of the youths reported that they found the response program beneficial, while 17% reported that this was not the case. Overall, these results indicate that the participants and their communities generally responded favorably to the program and found the care plan helpful in providing care for youths.

Care plan recommendations describe the general characteristics of caregiving, vocational or other care experiences that may be helpful rather than specific resources per se. For example, a care plan may note that a youth would benefit from an adult role-model and from developing vocational interests and skills. It is left to the community to determine how these recommendations can best be realized. In one community, this may be met by providing a youth with a child-care worker and enrolment in vocational training. In another community, this may be met by engaging the interest of an appropriate adult who is willing to take the youth on in a semi-apprentice role. It is critical that the participants and their communities perceive the care plan recommendations to be feasible within the context of the resources available within their communities. As Table IV indicates, this is one area in which the community may require more support in interpreting and implementing recommendations for community and school resources. The perception that resources are limited is particularly strong in the area of school functioning, where approximately 40% of case managers and 33% of caregivers reported that resources were insufficient to implement the recommendations. These findings underscore the importance of outreach workers in assisting communities to use existing resources in new and flexible ways.

The Response Program is committed to providing respite to youths throughout adolescence to preserve placements. The survey responses indicated that to date approximately one-third of the sample has used this service, and it was typically perceived as helpful in preserving placements. These results were consistent with the finding that 58.9% of the youths were still in their first placement six months after their discharge. Approximately 18% had experienced one placement breakdown, 9.6% had experienced two placement breakdowns, and ten percent had experienced three or more placement breakdowns.

Impact of the Response Program on Symptom Profile

Changes in youth self-reports and parent reports of psychiatric symptoms on the OCHS Scales are summarized in Table V. Repeated measures t-tests indicated that the parents or caregivers reported significant reductions in conduct disorder, ODD, ADHD and depression symptoms at six months follow-up when compared with intake. In contrast, the youths reported a significant reduction only in conduct disorder symptoms at six months follow-up when compared with intake.

To further investigate the nature of these changes, planned t-tests were completed to evaluate change on specific symp-
toms within each of these diagnostic scales. With respect to the externalizing disorders, caregivers reported significant or marginally significant reductions on nine of the 13 conduct disorder scale items. Specifically, they reported reductions in theft at home (p < 0.0001), theft outside of the home (p < 0.0001), running away (p < 0.001), lying or cheating (p < 0.0001), vandalism (p < 0.01), setting fires (p < 0.10), truancy (p < 0.10), use of weapons (p < 0.10), and break and entering (p < 0.10). In contrast, although youths consistently reported less frequent problems on 12 of the 13 items tapping conduct disorder, these differences were significant or marginally significant only for lying or cheating (p < 0.08), setting fires (p < 0.09) and physically attacking others (p < 0.05).

Similar results were noted for ODD. The parents reported significant reductions in all nine ODD scale items, including temper tantrums (p < 0.01), arguing with adults (p < 0.01), defiance (p < 0.0001), annoying others (p < 0.0002), blaming others (p < 0.000), being annoyed by others (p < 0.01), feeling angry and resentful (p < 0.01), getting back at others (p < 0.05) and swearing (p < 0.0001). In contrast, the youths reported only a marginally significant reduction in annoying others (p < 0.10). With respect to ADHD, the parents reported significant reductions for six of the 14 scale items, including distractibility (p < 0.001), difficulty waiting turn (p < 0.004), problems with attention (p < 0.01), difficulty playing quietly (p < 0.05) and interrupting others (p < 0.05). In contrast, the youths reported significant reductions only in problems with attention (p < 0.05) and difficulty playing quietly (p < 0.08).

In summary, these results indicate that parents perceive pervasive and significant reductions in a wide range of externalizing symptoms, while youths report reductions in only a handful of these symptoms.

With respect to the internalizing disorders, the results indicated that the only significant reduction occurred in the parent reports of depression. Parents reported reductions in the youths’ feelings of irritability (p < 0.10), lack of interest in activities (p < 0.001), anhedonia (p < 0.0001), feelings of worthlessness (p < 0.05) and problems with concentration (p < 0.01). In contrast, youths reported fewer problems only with concentration (p < 0.05) and weight gain (p < 0.10).

Small increases in scale scores were noted for SAD in the reports of both parents and youths, and for OAD in the reports of youths. These changes reflected significant increases in parent reports of the youth’s worries about being separated (p < 0.05) and small increases in several additional features of SAD and OAD (for example, being worried that something bad will happen to people to whom he or she is close; being overly upset while away from others he or she is close to). Youths also reported non significant increases in several features of SAD (for example, avoiding being alone, having nightmares of being abandoned) and significant increases in symptoms of OAD, including worrying about past behaviour (p < 0.05), worrying about doing better at things (p < 0.05) and more frequent aches and pains (p < 0.005).

Overall, these findings indicate that, although parents perceived some reduction in depression symptoms over the six month period, both the parents and youths perceived increases in anxiety symptoms.

**Discussion**

The results of this study are important in several respects. First, the findings indicate that communities, caregivers and youths generally responded well to a program aimed at maintaining youths in their communities. The care plan remained visible within the community. Community members found it helpful in planning and providing care for the youth, and caregivers reported significant reductions in symptoms of almost all externalizing disorders. The parents and youths also reported small increases in the frequency of anxiety-related symptoms. Of course, it is important to determine whether these effects are reliable and durable or, as is more commonly found, short-lived. Preliminary findings from the 12 month follow-up in progress are promising in this regard. These results indicated that parents and caregivers continue to report significantly fewer symptoms of conduct disorder 12 months after discharge than at intake. The reliability of these changes was over 12 months and 18 months after discharge is being monitored.

The effectiveness of the Response Program may be due to the impact of the program on how parents and communities understand youths, how they interact with them and how youths experience and respond in these relationships. It may be that the general impact of the program is to “reframe” or redirect the attention of parents or caregivers toward internalized features of their child’s distress and to interpersonal or attachment issues. In this, in turn, may increase how effectively parents respond to their youths’ behavioural problems because they see these difficulties as arising from underlying feelings of distress and anxiety over attachment rather than only as expressions of hostility and disrespect. As a result, parents and communities may be less likely to respond harshly to youths, which has been shown to exacerbate behaviour problems (harsh, punitive and controlling styles).

For youths, the experience of greater understanding, acceptance and less criticism within parental relationships, and within community relationships (for example, school), may be crucial to altering their internal working models of attachment. This process can be likened to the curative experiences of psychotherapy, but on a community- based level. These experiences may assist youths in reconstructing their understanding of their relationships with others and finding a place for themselves within their social context. Unlike psychotherapy, the Response Program is a community-based model that promotes change through experiences in a wide range of relationships (for example, parental, school, vocational). In addition, these changes are not assumed to occur only in youths. The relationships of parents and communities to youths, and more specifically the cognitive models that guide parents and community members in understanding and relating to youths, are equally the target of this intervention.
The values of bringing the care of youths back into the communities are two-fold. First, the removal of youths from their communities may exacerbate their already fragile affiliations with others, not only caregivers. More often than not, removal from the community is followed by placement in an environment where the only affiliations to be made are predominantly with an antisocial subculture, resulting in further contamination. As Steinhauser (64) has pointed out, if and when affiliation with adult caregivers occurs in residential programs, it is often cut short by premature discharge. In the end, youths are left to return to their original communities or to new ones, where they must find a way of establishing themselves. From an attachment perspective, this process seems very counterproductive for the youths and their families.

The second reason for maintaining youths in their communities is more pragmatic. With the soaring costs of residential treatment, and the high number of youths with conduct problems, it is simply impossible to provide residential care to all those in need. Grizekno and Papineau (65) recently compared the costs of treating children in a residential treatment unit versus a day treatment program. Their results indicated that similar treatment outcomes were achieved with the two programs, although these were achieved within a shorter treatment period in the day treatment program. The daily cost ranged from $79 to $90 for the day treatment program and $141 to $143 for the residential program. Overall, the total cost of treatment was $9,213 for day treatment, compared with $61,412 for residential treatment. Clearly, we have a responsibility to seek out the most cost-effective way of responding to the growing number of youths in need of assistance.

There are several limitations of the current study that point to the need for further research. Kazdin (15) has noted that community-based programs are among the more effective programs for treating antisocial behavior. Certainly, the response program falls within this category. Nonetheless, the lack of a control group in this study makes it difficult to determine whether or not the program itself was responsible for the reduction in the severity of the youths' symptoms. Comparative evaluations with other programs that have demonstrated efficacy (for example, parent management training, functional family therapy, other community-based interventions) may be helpful in identifying which types of programs are most helpful to youths with particular types of needs.

Further research is also needed to identify the aspects of the program which may account for its effectiveness. It is quite possible that the care plan is implemented differently in different communities and for different types of cases. A more in-depth understanding of how care plans are implemented in the community will be helpful in identifying whether some components of the program are more critical than others in producing change. These issues are the focus of the current program evaluation.

Finally, subsequent studies are required to determine the specific relationship between attachment and conduct disorder. These issues would be best examined by directly measuring attachment in these youth with a structured interview or similar measure.

References


Résumé

Un nombre croissant de jeunes semblent souffrir de problèmes de comportement qui leur posent des difficultés au sein de la famille et dans les relations avec leurs pairs, et laissent leurs chances de réussite scolaire et professionnelle. On s'intéresse aussi de plus en plus à leur degré d'agressivité. Le diagnostic courant pour expliquer ce détachement des jeunes est un trouble du comportement. Jusqu'à présent, la plupart des traitements mis au point pour traiter ce problème se sont soldés par un échec. L'examen des études récentes révèle qu'une rupture des liens affectifs peut jouer un rôle important dans la vaste gamme de symptômes qu'on observe couramment chez les jeunes atteints d'un tel trouble. Suit la description d'un programme axé sur la communauté, conçu pour assurer le traitement à long terme de ces jeunes. L'auteur présente aussi les résultats d'une évaluation effectuée au bout de six mois. Ceux-ci montrent que la collectivité, les pourvoyeurs de soins et les jeunes réagissent positivement au programme; les pourvoyeurs de soins signalent une réduction significative de nombreux symptômes psychiatriques chez les jeunes, tandis que ces derniers rapportent une diminution sensible des symptômes d'une conduite désordonnée.