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PSYCHOTHERAPY OUTCOME MEASURES IN A
CLIENT WITH A CHILDHOOD DISORDER

by
Amy S. Lawrence

A Case Study

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
Rowan University
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Approved by

Date Approved May 7, 2004

ABSTRACT

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Psychotherapy Outcome Measures in a Client with a Childhood Disorder
2003/2004
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Masters of Arts in Mental Health Counseling

The purposes of this case study were to: (1) complete a thorough psychosocial assessment on a psychotherapy client, (2) to attribute the most accurate diagnosis, and (3) explain the most beneficial empirical treatment through research and review. The case study consisted of a single 17-year-old Hispanic male who resided in a group home. Data was obtained through individual therapy sessions and two self-report inventories. Findings indicated that client met criteria for Disruptive Behavioral Disorder, Not Otherwise Specified (DBD, NOS). Treatment research was done on Oppositional Defiant Disorder (ODD) for two reasons:(1) due to insufficient studies on DBD, NOS, and (2) client met the majority of criteria for ODD. In conclusion, Multidimensional Family Therapy along with supportive-expressive and cognitive behavioral techniques were deemed to be the most appropriate treatment for this client.

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I would like to thank Dr. Katherine Perez-Rivera and Dr. Roberta Dihoff, for their guidance and support in the preparation of this case study. At times, this paper became extremely anxiety-provoking, thank you both for your calm nature.

Thank you, Dr. Melisa Arrieta for providing me with this client, and taking the time to be such a dedicated supervisor. I wish you all the luck in the world with whatever you choose to do.

I would like to thank my family, friends, and boyfriend, Ernest Garcia for your support. You have all been so patient during my craziness.

Finally, I would like to thank my client. Always remember, “That which does not kill us, only makes us stronger”.

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Chapter 1 Psychosocial Assessment

Presenting Problem:

Client is a 17-year-old Hispanic male who was removed from his biological mother's home by the Division of Youth and Family Services (DYFS) due to unstable living conditions. DYFS placed him in a group home until his mother could find and maintain an apartment. Client stated that living in the group home made him agitated and depressed. He admitted to "cursing out" the staff at the group home, breaking the rules (e.g., smoking), and isolating himself when he became sad. He declared everything was fine in his life until DYFS got involved.

Client was not able to live with his biological father's family due to allegations of sexual abuse made against him by his half-sister. In February 2003, client's four-year-old half-sister accused him of touching her vagina. Client denied allegations and did not acknowledge this as a problem. In fact, he had repeatedly stated, "I did not do it". Charges were filed by client's stepmother; however, the prosecutor threw out the case after interviewing the alleged victim.

History of Presenting Problem:

Client has resided in the group home since June of 2003. Prior to the group home, client resided with his mother, sister, and half-brother in a studio apartment. When client first moved in with his mother in February of 2003, she refrained from using substances. Shortly after him moving in, she repeatedly began to use substances again. His mother's

addiction is not something new. Client had not lived with his mother since the age of 3 due to her incarceration, which was directly related to her substance dependence. He was well aware that his mother struggled with addiction. However, he was not aware of how powerless he would be in helping her.

Client lived with his father and stepmother prior to February of 2003. He reported always having problems with his stepmother. He indicated that when he was growing up she was verbally and physically abusive toward him and his two siblings. Client stated that she invented the sexual abuse allegations made against him. He specified that she was “crazy”, and she will say anything to get him out of the house. He reported that in the past she has made up things in order to call the police on him and his brother. However, this is the first time sexual abuse allegations have been brought against him.

Past Treatment History:

There has been no prior effort of client to address the problem of unstable living conditions. Client has tried to help his mother abstain from substance dependence by accompanying her to Narcotics Anonymous meetings. Also, He continuously reminded her to attend probation appointments, knowing her past drug charges made attendance mandatory.. Eventually, his mother stopped doing what she had to do and relapsed. Client continued to assist her with making probation appointments. Client also reported that he supported his mother by giving her money, which he would earn by working.

Family Relationships

Current Living Situation:

Client currently resides in a DYFS funded group home, which will prepare him for independent living. His decisions continue to fluctuate on future living arrangements.

Up until February of 2003, client lived with his biological father, stepmother, brother, sister, and two half-sisters. Client reported that his stepmother played the dominant role in the household. He stated that she was controlling with all of the family members and dominant in her marriage. He conveyed that she showed favoritism towards her two daughters, and was physically, mentally, and verbally abusive towards him, his biological brother, and biological sister. Client stated that, as a whole, the family did not get along. Client explained that there was constant arguing from the time he was three. He denied that this family unit had any strengths. He thought of his father as neglectful and his stepmother as abusive. Client reported that the family did nothing together except eat dinner.

The significant changes in the family began in February of 2003. Client's brother was court-ordered to inpatient treatment for substance abuse. Two weeks later, client was accused of sexually abusing his four-year old half-sister. He stated that the day of the accusation he was out with his father. His stepmother called and told them to come home. Client and his father returned home and found DYFS and the extended family all in the home. He was then informed of the allegations. Client reported that this day was not only devastating, but humiliating for him. Client moved out and went to stay with his biological mother. The county prosecutors' office investigated the case. The evidence from the victim, along with the medical report, was not enough to build a case.

Presently, the client's biological mother has custody of him. This family consists of the biological mother, her husband, client, client's half-brother from Puerto Rico, and his sister (who has since left the father's house and now stays with the mother). Currently, client's biological mother and her husband are separated. He does not live in the apartment. Client's sister is the head figure in the household. She and her boyfriend pay the rent and other utility bills. Of interest, the client's biological mother is a chronic heroin user. She has been in jail and in inpatient drug facilities for her addiction. She has had periods of abstinence throughout the past 20 years; however, she cannot abstain from drugs long enough to establish financial stability. This has affected the families' living conditions drastically.

Client reported that the family got along "good". They communicate well and understand each other. For instance, client stated that his mother acknowledges that he smokes marijuana possibly because she uses drugs too. In fact, he admitted to getting high with his mother on numerous occasions. The families' weaknesses, as stated earlier, are financial and housing instability, as well as the mother's drug addiction. The family likes to watch movies together and listen to Spanish music and dance. Client stated that he also loved his mother's cooking. Client conveyed genuine sincerity for his mother; he expressed concern about not being in the home. He wanted to be there to stop his mother from using drugs again.

Family History:

Client went to live with his father and stepmother at the age of 3. He stated he was not allowed to see his mother when he was growing up. Client did not have a

relationship with his mother until he was 15. At that time, he began to see his mother on weekends. He has always had the desire to live with her.

Client reported, while growing up, his stepmother was physically abusive. He stated that he, his brother, and sister were all “hit”. When asked for an example of a time when he was “hit”, he discussed an incident that occurred when he was 5. He was carving on a wall with a screwdriver. He said his stepmother caught him, grabbed the screwdriver, and began stabbing him with it. He also reported being hit with hangers and her bare hands. Client accused his father of emotional neglect. He stated that although his father worked hard and always put food on the table, he never had time to spend with him. He recalled now during his 10th birthday his father was outside working on the car and did not even come inside when it was time to sing “Happy Birthday” and cut the cake.

Client stated, he was, and still is, close to his brother and sister. He and his brother had the same friends and liked the same things while growing up. He reported watching soaps with his sister. Client stated that he loves his half-sisters. He was adamant about never doing anything to hurt them. Their mother, always favored them but client stated that he never held that against them.

Both the father and stepmother are recovering addicts. They have reportedly not used drugs or alcohol for over thirteen years. They met in a Christian drug and alcohol inpatient facility and have been together ever since. Client’s brother started smoking marijuana at the age of 9. Client considered his sister an alcoholic. He stated that in the past year she has begun to drink heavily.

Current Family Relationships:

Client reported getting along with his mother. He expressed concerned about her addiction. Client reported that his relationship with his mother was like that of two adults. She did not discipline him. Client admitted to playing the role of the “parent” with his mother. He thought of his mother as a weak, nervous, and shy person. He was protective of her and defended her mishaps. Client saw the strengths of their relationship as being understanding of one another. He denied any weaknesses in their relationship.

Client stated that he got along with his father although he did not feel he was his father’s favorite. He had continuously felt neglected by his father. He reported that his father constantly was busy with his job and working on his Camaro. Client stated that his father favored his brother. Client reported being kept in the house to do more feminine things. Client disclosed that being in the house meant more frequent abuse by his stepmother. He reported arguing with his father about his relationship with his stepmother. Client stated, “He always took her side, or did not do anything at all”. Client saw one of the strengths of his relationship with his father being that they were always physically there for each other.

Client has been in the group home for almost 4 months and his father has been a supportive parent. He has come to visit various times and even takes part in client’s outpatient sex-offender therapy. Client stated that his father believes he did not touch his sister. Client reported other strengths in their relationship such as the inclination to put family first. Although they do not have the best communication, they are still family and “you don’t abandon your blood”. Client has never gotten along with his stepmother. He stated she is crazy and just wanted his father for herself.

Drugs, Alcohol and Addictive Behaviors:

Client admitted to occasionally drinking beer since the age of 15. He also admitted to smoking marijuana on a weekly basis. Client has tried cocaine one time and did not like it. Client reported smoking PCP (wet) and not liking it. Client stated that in the past he has quit smoking marijuana for 6 months. He admitted when he quit it was because he had been feeling as if he was smoking too much. He wanted to stop. He reported he had not used to the point where people have annoyed him about his marijuana use. He also had not felt guilty about it. Client did not recall smoking or drinking to get over bad effects of using. Client smoked marijuana with his brother, mother, or in other social settings. He did not buy his own supply of drugs. He did not smoke marijuana by himself.

Client admitted to selling crack for a short time. He stated that he was not very good at selling; he would lose the crack or forget that it was in his pocket. He stated that he owes \$400 to a dealer whom he never paid, because he lost the drugs. When asked client how long he had been selling, he could not give an answer.

Early Development/Neurological History:

Client reported that he was the only child that was born “healthy”. Whether or not his other siblings were born unhealthy is unknown. He was not sure about developmental milestones, but he believed he began to crawl, walk, and talk on time. He does not recall neurological problems or any head injuries. It is worth noting that client’s mother and father were reportedly using drugs during the time when client was conceived; however,

client denied that his mother had any complications during her pregnancy with him.

Current or Past Medical and Psychiatric History:

Client currently has a cast on his right arm. He reported that he broke his hand after punching his dresser. He indicated that he is taking pain medication and antibiotics. Client was also prescribed Advair for his allergies. These health concerns have taken place since living in the group home (in the last 6 months). Client admitted to having intestinal problems. He stated that he has had this problem since he was young. Prior to the group home, client indicated that he had not been to the dentist since he was 6 or 7. His last appointment was 3 months ago. Client reported going to a physician when he had a hernia in 2001. He had surgery shortly after seeing the physician but went home the same day. Client also reported seeing the physician when he is sick, which is about once a year.

Client was prescribed Strattera 25mg after being diagnosed with Attention-Deficit/ Hyperactivity Disorder (ADHD), four months ago. Client took the medication for a month, but then refused to take it because he felt he did not need it. He reported, when taking the medication he felt tired and depressed. Since he has stopped taking the medication, client has not shown any significant social, educational, or occupational impairment. There is no history of psychiatric problems in his family, however, his biological mother and brother are both struggling with addiction. Client's father and stepmother are both in recovery. According to client, no one has been hospitalized for any emotional problems or psychiatric disorders besides substance abuse.

Client was the only one who has taken medication for a psychiatric disorder. Client

stated, that his father and brother also have “something wrong with them”, however, they have never been formally diagnosed.

Education and Job History:

Client reported that he failed most of his classes in school. He stated that he knew the material but gave up answering the teacher when he was constantly reprimanded for blurting out answers. Client reported that he would fall asleep in class and miss all the class notes. He found school boring and eventually stopped going. Eighth grade was the last grade he completed. He believed his strengths to be his intelligence. He stated that he did not have to pay attention given that he knew the answers. Client believed that if he was in a smaller classroom and there were less people, he could have done well. He reported he got in trouble for passing notes, being distracted by female students, falling asleep, and not doing his work. Client expressed a desire to get his General Equivalency Diploma (GED) and go to Lincoln Technical,, a mechanical school. He is currently enrolled in a work-study program. Overall, client is presently working. He is earning his wages and receiving guidance in preparation for his GED.

Client began working at the age of 14. He has since had five jobs. Client reported an unstable pattern of employment. Client has quit each of his jobs within 2 months of his date of hire. He admitted that he had trouble focusing at work. He “goofed off” a lot and ended up getting in trouble. Client stated that the one job he did well with was detailing cars. He did this for 2 months with his mother’s ex-boyfriend. This job ended due to the conflict between client and his mother’s ex boyfriend.

Social Supports and Patterns of Relationships:

Client reported having had a minimal amount of social support while growing up. He stated that he had no friends outside nuclear family and extended family. The social support he did acknowledge he had was his father. Although client reported emotional neglect in the past, he has realized that his father was one of the only people that was there for him. Further, he considered his brother a “friend”. This was one of his only peer relationships. However, his brother is currently not available to support client. Presently, client admitted to having social support from the group home. He stated that he has become close to one of the other male residents, and is able to confide in him when he is upset or angry. Ironically, this is the same resident who he argued with and ended up punching a dresser over. Shortly after that argument, they became friends again.

Client reported going on dates with girls, but never having a serious girlfriend. He stated that his first girlfriend was when he was living with his father. She was reportedly a deaf girl from his neighborhood. He stated that he learned sign language from her and was able to communicate with her fluently. He described her as a “very sweet girl”. He did not recall why they stopped seeing each other. In March of 2003, he lost his virginity to a 14-year-old girl who he shared a room with. The girl’s mother was a friend of his mother’s. At the time, they were all living together. He described the girl as seductive. He stated that he was not interested in having sex with her. He admitted that he was nervous because he was still a “virgin”, and she was already sexually active. He eventually gave in to her and continued to have a sexual relationship with her for a month. He never used protection. He expressed no concern of having a sexually transmitted infection. Client stated that he never considered this girl his “girlfriend”. He believed that sex is not that

important in a relationship. He was more interested in honesty and loyalty. He stated that girls do not like nice guys. He therefore, expects to be single until he is older.

Spiritual/Cultural Identity:

Client identified himself first and foremost as a Puerto-Rican, then as an American. He was proud of his culture. He favored his culture's music and food over any other. However, he had no problem dating outside his ethnicity. He stated that he favors Caucasian girls and sees himself marrying a "White girl" some day.

Client considered himself a Christian. He did not feel he has to go to church to be a good Christian. He did feel that one must pray for forgiveness if they sin or else they will go to hell.

Situational Stressors:

In addition to client's presenting problem, it is worth noting the additional stress that he has encountered in the group home. Since coming to the group home, client has begun to take his life more seriously. He has struggled with the expectations of the group home because he was used to no expectations. He demonstrated ambivalence toward being in the group home. He was aware that being in the group home was best for him and he liked the idea that the counselors cared, but he also had displayed anger towards DYFS and wished he was still with his mother. This stress, along with an argument in the group home, caused him to punch a dresser and break his hand. He is now limited in the things he can do.

Coping Mechanisms and Strengths:

Client has coped with stress by isolating himself or sleeping. In the past, he has coped with stress by smoking cigarettes (ranging from a pack a week to a pack a day), and smoking marijuana. He stated that marijuana allowed him to forget about his stress for a short time.

Client was aware that he was good at communicating. He was also insightful as represented by the statement, "it hurts when my mom doesn't show up for visits". He was not ashamed to identify the feelings he had. Clear communication has allowed him to talk with people he trusts when he feels stressed. Client has the motivation to better himself in order to avoid certain stressors. In the group home, client has not appropriately been able to ask for help. However, when he is around certain staff or his therapist he will display symptoms of depression (e.g., not wanting to eat, agitated mood, and not talking as much). He has nevertheless, allowed others to approach him and thus been able to open up.

Other Agency Involvement:

Client has an open DYFS case. Client also attends outpatient group treatment for sex-offenders. He was referred to the group by DYFS. Client is not involved with the legal system.

Mental Status Exam

Client is a seventeen-year-old Hispanic male who was well-groomed and dressed in an age appropriate fashion during the initial intake. He was cooperative during the

assessment, and seemed eager to respond to the questions. His motor behavior was appropriate for the setting. His thought processes were clear and organized, and he demonstrated normal concerns and interests. Client was oriented to person, time, and place. He displayed good long and short -term memory. Client's judgment was age-appropriate. He confirmed his ability to manage everyday affairs. He had good insight concerning his problems, although the connection between his biological mother and his tribulations were difficult for him to identify. Client appeared to be of average intelligence. There were no overt suggestions of substance abuse during the interview.

Summary

Client is a 17 -year old male who is residing in a Division of Youth and Family Services group home due to his biological mother's unstable living conditions. He has experienced various problems with parental family members including his biological mother, biological father, and stepmother. Thus, his education, peer relationships, and employment experience have suffered. Client has learned to cope with feelings of disappointment, rejection, and inadequacy by oppositionally acting out. He also acknowledged marijuana use in order to cope with his problems. Client desires to get out of the group home and live with any member of his family, including his stepmother, whom he reported a history of physical abuse with. Unfortunately, all three parental figures are struggling with issues that need to be worked through. Client has become more aware of this and has considered focusing on his own goals in order to move on with his life.

Chapter 2 Differential Diagnosis

Based on the information obtained, the client met criteria for the diagnosis of Disruptive Behavior Disorder, Not Otherwise Specified. If the client had demonstrated this behavior over a 6- month period the diagnosis of Oppositional Defiant Disorder would have been justified.

Axis I 312.90 Disruptive Behavioral Disorder Not Otherwise Specified

314.01 History of Attention-Deficit /Hyperactivity Disorder, Predominantly
Hyperactive-Impulsive Type

Axis II V71.09 No Diagnosis

Axis III 493.90 Asthma, Unspecified

Axis IV Problems with Primary Support Group.

Problems related to the Social Environment.

Educational problems.

Housing problems.

Economic problems.

Axis V GAF= 61

Disruptive Behavioral Disorder, Not Otherwise Specified

Based on the information collected, it was determined that client displayed oppositional defiant behaviors. He lost his temper, argued with adults, actively defied or refused to comply with adults' requests or rules, was easily annoyed by others, and displayed anger and resentment. This behavior did not occur during the course of a Psychotic or Mood Disorder. Client did not meet criteria for Conduct Disorder, as he had no history of violating the basic rights of others or societal norms. Although there is a disturbance in behavior (as described by the symptoms above), the symptoms had not been observed as a pattern for the past 6 months because the client was not living in the group home for that length of time. Client did report exhibiting this behavior before the group home, however, the behaviors intensity and duration was unclear. This is why he did not meet criteria for Oppositional Defiant Disorder (ODD). Presently, symptoms have caused the client clinically significant impairment in the group home. Overall, if client continues to display symptoms listed, he would meet criteria for ODD. At the moment, he only meets the criteria for Disruptive Behavior Disorder, Not Otherwise Specified (NOS).

History of Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

Client has a history of Attention -Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type. From the ages of 7 through 14 client displayed the following symptoms of hyperactivity: squirmed in his seat, often left his seat in the classroom or in other situations in which remaining seated was expected, often had

difficulty playing or engaging in leisure activities quietly, and often talked excessively. He displayed symptoms of impulsivity as witnessed by: blurting out answers before the questions were completed, difficulty waiting his turn, and often interrupting and intruding on others. Client reported these behaviors were present from age 7 on (not before the age of 7). Social impairment was witnessed in the past by behaviors such as, interrupting conversations, verbal outbursts directed toward his teachers, and not waiting his turn when interacting with peers. Educational impairment was witnessed by failing grades. Client's highest grade level completed was eighth (he is presently 17). The symptoms at this time were not accounted for by another mental disorder. Client no longer meets criteria for ADHD.

Dysthymic Disorder

There was a possibility that client suffered from Dysthymic Disorder. The Behavior Assessment System for Children (BASC) is a self-report inventory designed to evaluate the personality and self-perceptions of children. Client completed the inventory the second session of treatment. Results displayed a clinically significant elevation on the Depression subscale. In other words, the client endorsed items suggestive of a diagnosis of depression. In therapy sessions, client reported his mood had been irritable on a daily basis. He admitted to having a poor appetite, low self-esteem, poor concentration and feelings of helplessness. However, these symptoms, besides the poor concentration and irritable mood, had not caused clinically significant impairment (as witnessed during counseling sessions, work study, and the group home). Client had not experienced an irritable mood or sadness daily for the past year. He admitted to feeling this way lately,

but he felt it was solely related to his current living situation. He related his feelings of helplessness to his mother's drug addiction. Furthermore, his poor self-esteem and poor concentration can be correlated to his failure to reach educational goals, family conflict, unstable living conditions, history of abuse, and lack of peer relationships, not Dysthymic Disorder. Overall, client's symptoms of Dysthymic Disorder can be better accounted for by Disruptive Behavior Disorder, NOS.

Adjustment Disorder, Acute, Unspecified

There was a possibility that client suffered from Adjustment Disorder, Acute, Unspecified. Upon arrival to the group home, client displayed behavioral symptoms including verbal outbursts toward staff, refusing to follow rules, smoking, and failure to listen to or talk to his therapist, which could have been in response to being removed from his mother's home. Disruptive Behavior Disorder, NOS can better account for the symptoms. This is because client was simultaneously able to adjust to the group home, make progress with his educational goals, and vocational goals. He was able to establish peer relationships and comply with rules; however, he still displayed oppositional defiant behaviors. Overall, client's symptoms can be better accounted for by Disruptive Behavior Disorder, NOS, not Adjustment Disorder, Acute, Unspecified.

Generalized Anxiety Disorder

Client displayed the following symptoms of anxiety and worry: restlessness or feeling keyed up or on edge, difficulty concentrating, irritability, and sleep disturbance.

Nevertheless, these symptoms were not excessive. Client denied that these symptoms

interfered with other aspects of his life. Client was able to control his feelings of worry. For this reason, client did not meet criteria for Generalized Anxiety Disorder.

Oppositional Defiant Disorder

Based on the information collected, client displayed oppositional defiant behaviors: lost his temper, argued with adults, actively defied or refused to comply with adults' requests or rules, was touchy or easily annoyed by others, and angry and resentful. This behavior did not occur during the course of a Psychotic or Mood Disorder and it did not meet criteria for Conduct Disorder.

Client did not meet criteria for Oppositional Defiant Disorder because the symptoms were not observed as a pattern for the past 6 months. Still, there is a disturbance in behavior (as described by the symptoms above) and it has caused clinically significant impairment in his social environment. The clinically significant social impairment is identified by his probation status at the group home. If his behavior does not change he will be negatively discharged from the program. Overall, client at this time does not meet criteria for Oppositional Defiant Disorder.

Chapter 3 Literature Review

Disruptive Behavior Disorder, Not Otherwise Specified is characterized by conduct or oppositional defiant behaviors that do not meet criteria for Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD). In other words, it includes clinical presentations that do not meet full criteria for either ODD or CD, but in which there is clinically significant impairment (American Psychiatric Association, 1994). In the present case study, the client's Axis I diagnosis is that of Disruptive Behavior Disorder, Not Otherwise Specified. Client met the majority of criteria for ODD however, his pattern of negativistic, hostile and defiant behavior was not witnessed over a 6-month period. If it had been, his diagnosis would have been ODD. Unfortunately, there has been no research done on empirical treatment for Disruptive Behavior Disorder, Not Otherwise Specified. Thus, the literature review will focus on treatment for ODD. This is deemed appropriate because client met criteria for ODD, with exception to the 6-month duration criteria. Initially, however, the controversy over the diagnosis of ODD will be discussed.

Controversy over the Diagnosis

There has been some controversy as to whether ODD is a milder form of CD, where as others question if ODD is a mental disorder at all and whether it can be distinguished from normal childhood behavior (Rey & Walter, 1999; Rey, 1993; Lahey,

1992). Although ODD includes some of the features witnessed in CD such as, disobedience and opposition to authority figures, it does not include the persistent pattern of the more severe forms of behavior such as aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules (American Psychiatric Association, 1994). Children and adolescents with ODD do not inherently devalue others as witnessed in CD (Hanish, Guerra and Tolan, 1996). Although there is a significant amount of youth with ODD who over time will meet criteria for CD, there are some who do not go on to develop CD (Rey & Walter, 1999). Research has explained the difference between normal developmental behavior and ODD. Rey (1993), supported the concept that symptoms of ODD are normative during preschool years; only their magnitude, inflexibility or persistence at later developmental periods indicate deviance. Another imperative difference between normal childhood and adolescent behavior, and children and adolescents with ODD, is the presence of considerable distress in their life (American Psychiatric Association, 1994).

Oppositional Defiant Disorder and Conduct Disorder: Sharing Empirical Treatment

While reviewing literature on treatment for ODD, it was evident that numerous researchers considered ODD to be a milder form of CD. This was witnessed by the identical treatment of the two disorders. (Alexander & Sexton, 2002; Kazdin, 2002; Shreeram, Srirangam and Kruesi, 1999; Waslick, Werry and Greenhill, 1999; Schoenwald and Henggeler, 1999; Ghuman, 1998). To some degree, it would make sense to unite treatment for both disorders since 75% of youth who struggle with ODD go on to develop CD, Antisocial Personality Disorder, or other adult psychopathologies where

aggression, violence, and lack of remorse are part of the diagnostic criteria (Milne, Edwards and Murchie, 2001; Long, 1996). Using the same treatment modalities could benefit in two ways: (1) treatment of ODD, and (2) prevention of CD.

Empirical treatments that are used for the two disorders are Parent Management Training (PMT), Problem-Solving Skills Training (PSST), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Family Therapy (MDFT). For the 25% of children and adolescents with ODD who do not go on to develop CD, these empirical treatments are still used in therapy. Evidence supports the importance of family involvement for effective treatment of youth with ODD (Northey, Wells, Silverman, & Baily, 2003; Rey & Walter, 1999). However, we cannot forget that ODD is its own disorder. There are some treatment approaches that will be more effective with these adolescents rather than adolescents with CD. This review will discuss several empirical treatments, which would work best for the present client.

Conceptualizing the Client's Diagnosis

This client was diagnosed with Disruptive Behavior Disorder, Not Otherwise Specified. He will most likely will progress to ODD and cease there. His defiant behavior does not include violating societal norms or deliberately hurting people. He is defiant in response to family interactions throughout his life. He viewed his stepmother as critical, verbally and physically abusive, and having inconsistent and unpredictable expectations. He felt his father neglected him emotionally. He witnessed marital discord between his stepmother and father and reported that they would argue on a daily basis. He perceived his biological mother's addiction as a continuous let down and, therefore, felt abandoned.

In response, he expressed opposition towards his parents and displayed defiance with certain authority figures. Studies have shown similar family conflict and interactions when looking at the etiology of ODD (Hanish, Guerra, and Tolan, 1996). In the interest of the most effective treatment for this client, it would make sense to focus on the client and his family. As mentioned before, ODD and CD share many of the same treatments. We will now summarize what these empirically validated treatments are and who is most likely to benefit for them. After summarizing the treatments, we will then discuss what treatment is most appropriate for the present client.

Parent Management Training

Parent Management Training (PMT) reflects the general view that oppositional and conduct problem behaviors are involuntarily developed and sustained in the home by maladaptive parent-child interactions. Thus, altering these interactions is expected to reduce these behaviors. The treatment focuses on increasing positive interactions and decreasing negative behavior in the child by teaching parents social learning principles and behavior-management skills (Kazdin, 2002). The parent attends training where they are taught effective management techniques through modeling and role-playing. They then implement new behaviors at home by using social praise and tokens or points for positive behavior. The idea is that if the parent learns to effectively communicate and discipline, the problem behaviors will go away. This treatment has proven extremely effective when treating younger children with ODD (Hanish, Guerra, and Tolan, 1996). As for adolescents, studies have suggested that they respond less well to PMT than

children. Therefore, the applicability of PMT to adolescents in comparison to the applicability of PMT with children is less clear (Dishion & Patterson, 1992).

Problem Solving Skills Training

Problem Solving Skills Training (PSST) is a cognitive behavioral therapy that consists of developing interpersonal problem solving skills and applying it to real life situations. Studies indicate that children and adolescents are taught to engage in a step-by-step approach to solve interpersonal problems (Kazdin, 2002; Rey and Walter, 1999). Prosocial behaviors such as communication, dealing with anger or rejection, and interacting with authority figures are encouraged through modeling and practice, direct reinforcement, role-playing, and mild punishment. Evidence suggests that older adolescents gain more from this treatment (Kazdin, 2002; Rey and Walter, 1999). This might be related to more extensive cognitive development. Overall, studies do suggest that PSST leads to therapeutic change (Kazdin, 2002).

Functional Family Therapy

Functional Family Therapy (FFT) is a family based intervention which has been noted to be “particularly effective” when working with at-risk adolescents. It is a short-term, multiracial, multiethnic, intervention ranging from 8 to 12 one-hour sessions. Target populations vary from at-risk adolescents to adolescents with severe CD ranging from ages 11-18 (Alexander and Sexton, 2002). The idea of FFT is that the problem is not isolated within the adolescent. Instead, the problem is rooted in a network of risk factors that include the family as the primary psychosocial system of the adolescent. Thus, FFT focuses first and foremost on developing positive family functioning by altering

dysfunctional interactions and miscommunications. (Alexander and Sexton, 2002; Bastien, 1999). The family then begins to focus on the adolescent who is acting out. Their goal is to increase prosocial behaviors and positive reinforcement with this individual. This is done through clear communication, tasks and directions, positive relabeling, more consistency, less defensiveness, non-blaming and non-confronting relationship skills and alleviating tension with humor. In turn, FFT is capable of reducing defiance and increasing prosocial behavior within the family and the individual (Bastien, 1999; Friedman, 1989).

Multisystemic Therapy

Several studies support the effectiveness of Multisystemic Therapy (MST) when working with adolescents who have been diagnosed with ODD or CD (Kazdin, 2002; Ray and Gary, 1999; Schoenwald and Henggeler, 1999; Henggeler, Melton, Brondine, Scherer, and Hanley, 1997). This therapy views adolescents as being intertwined in a network of interconnected maladaptive systems that include the individual, family and extra-familial factors (e.g., peers, neighborhood, and school). Thus, in all of these systems behavior problems manifest and are maintained. Various interventions such as cognitive-behavioral, behavioral, and family systems are used to intervene within every system. MST is considered intense. The focus of treatment is to emphasize the positive in the adolescent and use the systematic strengths as levers for change. Sessions are active, highly focused, and sometimes daily (in early treatment). Occasionally, a team of therapists representing each system is needed to reduce defiance and noncompliance and increase positive reinforcement among the systems. Several studies have supported the

effectiveness MST has had when working with juvenile sex offenders and serious juvenile criminal offenders. Adolescents with severe emotional disturbances and abuse drugs and alcohol have also responded well to this type of treatment (Cardin, 2002; Ray and Gary, 1999; Schoenwald and Henggeler, 1999; Henggeler, Melton, Bromine, Scherer, and Hanley, 1997).

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) is an empirically supported family therapy, which is used for the treatment of adolescents who display behavioral and drug problems. Studies indicate that MDFT was effective with a multicultural population and problem severity may vary from high-risk early adolescents to multi-problem juvenile justice-involved, dually-diagnosed, female and male adolescent substance abusers (Liddle & Dakof, 1995). Like other family therapies, MDFT agrees change in the behavior of the adolescent is cyclical with change in the family system. The goal of treatment is to relieve symptoms and improve functioning by altering unhealthy interactions in the family. Schoenwald and Henggeler (1999), identify the four domains of MDFT- the adolescents intrapersonal and interpersonal functioning, the parents intrapersonal and interpersonal functioning, parent-adolescent interactions, and family interactions with extrafamilial sources of influence (Schmidt, Liddle, & Dakof, 1996; Schoenwald and Henggeler, 1999). A considerable amount of time is spent with the adolescent alone in order to understand this unique individual and gain access to his/her peer network. The importance of this understanding is demonstrated in MDFT and the effectiveness is

witnessed by the success in reducing drug use in adolescents (Schoenwald and Henggeler, 1999; Liddle & Dakof, 1995). In 1999, Liddle wrote:

Adolescents are generally not willing to discuss the details of their antisocial activities with peers in the presence of their parents. Hence, access to the adolescent's conception of and activities within the peer world, are achieved by spending time with the teenager alone (page. 523).

This simple outlook could predict MDFT's success with the present client.

Client's "Best Fit" for Treatment

Although there are various types of empirical treatments used for adolescents with ODD, finding one that would fit this client wholly was difficult. The fact that the client was 17-years-old and temporarily residing in a group home made the treatment modality more complex. First, he was too old for a treatment such as PMT. Although this treatment has proven successful with children, its use with adolescents is less apparent (Hanish, Guerra, and Tolan, 1996). Nevertheless, even if it was successful with adolescents, it is unclear whether a particular parental figure in his family would "step up" and take the responsibility of therapy and parent training. Thus, this treatment would not have been effective with this client.

PSST could have been beneficial for this client. He has the cognitive ability to identify problems in his relationships and work on change. Client admitted that many of the interpersonal problems he has is with his family are due to communication, dealing with his anger, and his feelings of rejection. These conflicts have led him to oppositionally act out. Changing these problems to prosocial behaviors could facilitate

improvement in the client's family relationships. Thus, PSST could be utilized in the client's treatment; however, at the time of this paper, treatment was not yet complete due to the lack of family involvement. For this client, family involvement is essential. As supported by Northey, Wells, Silverman, and Bailey (2003), family involvement is crucial for treatment of ODD. Although this client was not diagnosed with ODD, he mirrored the symptoms of ODD. In individual counseling, he was able to verbalize his anger and resentment, which he felt towards his mother, father, and stepmother. His testimony, along with maladaptive familial relationships witnessed by the therapist, confirmed the need for family therapy.

MST is an intense treatment for adolescents with an array of severe problems. MST would be unnecessary. Besides the client's occasional substance abuse, he did not demonstrate any other delinquent/conduct behavior. There is not a need for intense therapy on a daily basis.

At first glance, FFT would appear flawless when working with this family. As stated earlier, FFT sees the problem as rooted in a network of risk factors that include the family as the primary psychosocial system of the adolescent. Thus, FFT focuses first and foremost on developing positive family functioning by altering dysfunctional interactions and miscommunications (Alexander and Sexton, 2002; Bastien, 1999). The family then begins to focus on the adolescent who is acting out. Unfortunately, this client's situation was not as adaptable for this scenario. The fact that he is presently placed out of the home makes it difficult to concentrate first on the family. It would make sense to establish rapport with the client, learn about his intrapersonal and interpersonal relationships, engage the family into treatment, and then begin family therapy. The reality of the

client's living situation identifies the importance of the need to have individual therapy with the client and the importance of family involvement.

MDFT would allow this client to have both individual and familial needs met. During individual sessions, the therapist could begin to understand more clearly this client's experience and perception. In turn, the client and therapist can work on problem solving skills training to use in everyday life situations and in family therapy. MDFT is also noted for its success with different ethnic groups. The unique cultural/familial dynamics of the Hispanic household would also be considered in the treatment plan.

Summary

Research indicated multiple treatments, which have been successful in treating Oppositional Defiant Disorder such as; Parent Management Training, Problem Solving Skills Training, Functional Family Therapy, Multisystemic Therapy, and Multidimensional Family Therapy. The controversy of Oppositional Defiant Disorder being a milder form of Conduct Disorder has suggested that these treatments can be beneficial for both disorders. In the present study the client was diagnosed Disruptive Behavior Disorder, Not Otherwise Specified, because he did not meet full criteria for Oppositional Defiant Disorder. There was no research specifically for treatment of Disruptive Behavior Disorder, Not Otherwise Specified. Thus, considering the client's likelihood of developing ODD, this suited the treatment focus. When working with youth diagnosed with ODD it is initially imperative to assess the uniqueness of the youth and his/her family dynamics. In doing so, the appropriate treatment can be identified.

Chapter 4

Normative Practice and Treatment Outcomes

“Home Base” is a group home for adolescents who are involved with the Division of Youth and Family Services (DYFS). It is one of sixty placements operated by Center for Family Services in Camden, NJ. This twelve-bed group home harbored adolescents between the ages of 16 to 20, who prepared for independent living. The proposed length of stay is eighteen months. Adolescents were expected to attend either school or work while residing in home. The group home also provided individual and group therapy for these youth. A clinical psychologist was readily available in the group home, throughout the week.

Individual therapy was provided for each of the 12 adolescents for the length of the program. A combination of, Supportive-Expressive and Cognitive-Behavioral based techniques were the desired treatment modalities in this facility. Throughout the duration of therapy, the therapist was responsible for creating a trusting environment in which the client would be encouraged to express himself. The fact that all twelve adolescents were involved with DYFS and placed out of their normal environment brought upon daily stressors. The art of learning how to identify and cope with these stressors was a significant focus of treatment. Cognitive-Behavioral techniques such as, constructing “pro and con lists”, and role- playing were also implicated in therapy. Scaling was used weekly to measure the client’s feelings and emotions. At the end of each session the client was assigned homework. The assignment consisted of, keeping track of thoughts and feelings by journaling throughout the week.

Therapy focused on the client's emotional, cognitive, and behavioral problems. During the initial session the client disclosed a history of problems related to himself, his family and his school environment. He reported having an array of symptoms related to depression and anxiety such as hopelessness, trouble concentrating, fatigue, and worry throughout his life. Therefore, initial measures were used to assess possible impairment related to identifiable symptoms. The Behavior Youth Inventories (BYI) was chosen for this client. Also, scaling was used each week, throughout the duration of therapy in order to measure client's mood on a weekly basis.

The BASC, SRP-A is a self-report inventory used to evaluate the personality and self-perceptions of the adolescent. It consisted of 186 true/false questions which, address how the client perceives himself, the client's thoughts, and the client's feelings on certain things. All of the questions address one of the 3 validity indexes or 14 scales (clinical or adaptive) measured in this inventory. The indexes and scales measured in the BASC, SRP-A are listed below:

Validity Index

1. F index – infrequency index or “fake bad” index
2. L index- social desirability or “fake good” index
3. V index- indicates a adolescent who is uncooperative, illiterate, mentally retarded, confused or psychotic.

Clinical and Adaptive Scales

4. Anxiety
5. Attitude to School
6. Attitude to Teachers

7. Atypicality
8. Depression
9. Interpersonal Relations
10. Locus of Control
11. Relations with Parents
12. Self -Esteem
13. Self-Reliance
14. Sensation Seeking
15. Sense of Inadequacy
16. Locus of Control
17. Somatization

This self-report inventory was computer scored. T-scores were identified for each index and scale. The computer print out consisted of a clear interpretation of the results. The results of the client's self-report inventory indicated three T scores which were at a clinically significant level: Locus of Control, Depression and Interpersonal Relations.

The Locus of Control scale assessed the client's perception of who or what controlled the various events in one's life. High scores signify an external locus of control, that is success or failure is determined by forces outside one's control. High scorers have a why bother attitude and a sense of helplessness (Reynolds & Kamphaus, 1999). The client's T score for the Locus of Control scale was 68, which put him in the "At-Risk" bracket. Thus, the client had clearly established an external locus of control, however, the score was not high enough to be considered "pathological" (T >70).

The Depression scale assessed the client's symptoms of depression such as, feelings of loneliness and sadness, hopelessness, and pessimism. High scores ($T > 70$) on the Depression scale often indicate adolescents who are introverted and reserved. There is also evidence of anxiety and emotional lability in these individuals (Reynolds & Kamphaus, 1999). The client's T score for Depression scale was 64, which put him in the "At-Risk" bracket. The "At-Risk" bracket was considered a significant level of depression.

Unfortunately, the client did not take the BASC, SRP-A a second time. This is partially due to the fact that the client started a work-study program and was not available to attend therapy consistently, at the time initially scheduled. Furthermore, shortly after the client began attending the work-study program, the present therapist discontinued therapy at the group home. Therefore, the significant results to the self-report inventory had nothing to compare too.

The BYI was the second assessment tool administered to the client. The inventory consists of a combination of five individual inventories; The Beck Depression Inventory for Youth, the Beck Anxiety Inventory for Youth, the Beck Disruptive Behavior Inventory for Youth, the Beck Self Concept Inventory for Youth and the Beck Anger Inventory for Youth. The combined inventory is considered a valuable aid in diagnosis and treatment of mental disorders. The inventory consists of 100 questions, related to how the adolescent thought or felt. The adolescent was to circle one of four answers which best fits him: Never, Sometimes, Often, or Always. The questions fit into one of the five measures.

1. Self Concept

2. Anxiety
3. Depression
4. Anger
5. Disruptive Behavior

The client's inventory results reported "average" T scores (< 55) for Anxiety (46) and Depression (47). The client self-reported elevated scores for both externalizing behavior measures, Disruptive Behavior, and Anger. A "mildly elevated" T score (55-59) was reported for Disruptive Behavior. A "moderately elevated" T score (60-69) was reported for Anger. The use of both externalizing behavior measures allows the interpreter to differentiate feelings and cognitions associated with anger and the symptoms associated with DSM-IV criteria for Oppositional Defiant Disorder and Conduct Disorder. Thus, the client reported more difficulty with feelings and cognitions associated with his anger than the latter. Finally, the client reported a "much lower than average" T score (< 40) on the Self Concept measure (34). This indicates less of a positive self concept, than someone with a higher score.

Unfortunately, the BYI was not a valid measure for this client because he was 17 years old. The norming for this test was done on 7-10 and 11-14 year olds. This information was not known until after the inventory was completed. Due to the discontinuation of therapy, with the present therapist, a more suitable inventory was never administered.

The assessment tool most consistently used for measuring the client's mood on a weekly basis was "scaling". Starting with the initial session of therapy, the client was asked in the beginning of each session, "On a scale of 1 to 10, 1 being the lowest and 10

being the highest, how do you feel today? The focus of therapy shifted depending on how the client reported feeling. The client was seen on a consistent basis for 5 consecutive weeks. After the 5th week his attendance was sporadic due to other priorities. Thus, only three more sessions were provided. However, evidenced by his behavior and the scaling measure, the client's feelings and mood became more positive.

Client's Feeling and Mood Scale

Session One (Initial Session)- "5", reported nervousness, sadness, and having a low self-esteem

Session Two- "2", reported feeling angry and sad about living in the group home. He missed his family. He stated, he hated the system, and he wanted to run away.

Session Three- "6" Client stated he wanted to get a job. He also reported being in a good mood.

Session Four- "8", reported feeling excited about returning to school, however, nervous because he was not sure he would pass the test to get in.

Session Five- "8", reported feeling good about himself, he stated he liked a girl at his school. He admitted to being disappointed with his biological mother, however, he stated he was not going to let her affect his life anymore.

Session Six- "6" Client stated everything was good, but he had not talked to his family in a week.

Session Seven- "7" Client expressed mixed feelings about the holidays. He was happy about his role in the holiday concert at school.

Session Eight- "7" Client reported being busy with school. He stated he wanted to find a job so he could get his own apartment.

Using the information gathered from assessment tools and individual sessions, the client's treatment plan was devised. The goals associated with the client's diagnosis of Disruptive Behavior Disorder, Not Otherwise Specified, will be discussed in the following section.

Treatment Goals

The Center for Family Services is required by the state of New Jersey to produce a "30, 60, and 90" day treatment plan on every adolescent residing in the group home. The treatment plan is broken up into five specific sections to identify goal. The following is a glimpse at some of the client's goals in each section.

Medical

- a. Learn to maintain dental care and health independently.
- b. Client's hand will heal, through frequent doctor visits and physical therapy.

Behavioral

- a. Develop appropriate social skills toward authority figures.
- b. Resolve the conflict that underlies the anger, hostility and defiance.
- c. Reach a level of reduced tension, increased satisfaction, and improved communication with family and other authority figures.

Academic

- a. Obtain GED
- b. Go to mechanical school

Social

- a. Establish healthy relationships with peers and adults.
- b. Client will see that he is a “likeable” person.

Family

- a. Client will gain skills that model respect, kindness, and nurturance with his mother and father.

Treatment Interventions

The following were the solution-focused, cognitive-behavioral based, interventions used for the client’s behavioral, academic, social and family goals, during the first 90 days at the group home.

1. Journaling

The client was asked to keep a journal in order to keep track of his feelings, thoughts and behaviors. Each day, he would write about any significant events that took place in the group home, at school, or while interacting with his peers or adults. After a few weeks he was able to correlate certain behaviors with thoughts and feelings. For example, the client thought the staff in the group home was “talking down to him”. For this reason, the client became disrespectful toward the staff and refused to do his chores. His noncompliance resulted in him losing certain privileges. When the client came to his next session, he brought his journal and read over the scenario. He then went on to identify the feeling of “being talked down to”, as humiliating. He stated this was the same way his step-mother made him feel throughout his life. In later sessions the client was able to go back through his journal and make a list of all his “anger” triggers.

Journaling allowed the client to gain insight into his behavior. It also became a healthy way of expressing his anger. The client was encouraged to read his hostile and negative feelings with his therapist. In doing so, the client was able to establish trust and a positive relationship with his therapist. This intervention was used for the client's behavioral and social goals in the treatment plan.

2. The Ungame

The Ungame was designed for children and adolescents who have a difficult time recognizing and verbalizing feelings in a constructive way. During the second session of therapy, the game was used in order for the client to open up without feeling defensive. The client and therapist took turns rolling the dice and answering questions that related to feelings and thoughts about oneself, others, and the world. The client demonstrated his ability to play by the rules in a cooperative fashion. It also provided an opportunity for the therapist to model, respect, attentiveness and good listening skills for the client. Thus, the client felt comfortable talking about hurtful feelings. This intervention assisted the therapist with a better understanding of the client's feelings toward himself and his family. The intervention also worked toward meeting behavioral and social goals.

3. Creating Pro/Con Lists

The client and therapist created "pro/con" lists in order to assist client in arriving at the best decision. Client was able to see the benefits (pros) and consequences (cons) of every situation while working on these lists. One particular incident, the client was contemplating whether or not he should run away from the group home. He diligently identified all the "pros" he would get from running away (e.g. could smoke cigarettes, would not have a curfew, could see his mother). He then identified all

the “cons” of running away (e.g. would not have a dependable source of transportation, would probably stop going to school, and would not have a stable place to live). Client then identified the “pros” and “cons” of staying in the group home. When he was finished, he prioritized his list by numbering his wants and needs in a hierarchal order (#1 most important, #10 least important). This exercise helped the client sharpen his problem solving skills, by allowing him to think things through, without making oppositional decisions. He was encouraged by his therapist to do this on his own. He later stated, working on this exercise, was beneficial because he did not feel like he was being told what to do by an adult. The therapist used a collaborative approach with this intervention. Thus, the client felt empowered, and motivated to make the most beneficial decision for himself. This intervention was used for academic, behavioral and social goals.

The Miracle Question

“If you could wake up tomorrow and have the perfect day, how would you spend it?”.

When the client was feeling sad or not in the mood to talk, the therapist would ask questions like these. Miracle questions challenge the client to identify situations and things that make the client happy. These type of questions are used to instill hope and to find something positive when everything seems negative. This intervention was used for the client’s behavioral goals.

Homework Buddy

The group home developed a homework buddy system. The client was expected to work on their homework with their buddy during a specific time. This intervention was used to meet client’s academic goals.

Engagement Interventions

Throughout the course of therapy, the therapist used various engagement interventions in order to establish trust with the client. The goal was, once the client felt comfortable enough with the therapist, he would allow himself to open up about hurtful memories and feelings toward his family. The therapist concentrated on validating the client's feelings, showing interest and encouragement in his goals, accepting him for who he was, and providing him with genuine feedback. The client allowed himself to trust the therapist and eventually began to discuss his family dynamics. This intervention was useful in working toward all of the client's goals.

Role-playing

The client and therapist role-played future situations in which the client felt anxious about. During one session, the client discussed how it made him feel when his mom did not show up to visit him, when she said she would. Client wanted to confront her on the phone but knew he would become hostile and she would hang up on him. The client and therapist role-played the phone call. This intervention allowed the client to practice expressing hurtful feelings toward his mother, in a respectful way. After the role-play, the client and therapist processed what it was like to do the activity and how the client felt while doing it. The therapist encouraged the client to continue role-playing in other conflict areas with his family.

Treatment Outcomes

In a short amount of time, the client made considerable progress in individual therapy. Initially, the client began therapy with a slew of complaints about the program, (e.g. I hate the system, they destroy peoples' lives"), and hopeless expectations regarding his

future, (e.g. “ I will stay a loser for the rest of my life”). His behavior was disruptive, witnessed by his probation status at the group home. He continuously was arguing with the staff and at times, refused to do required chores. He reported, being treated unfair. His emotions consisted of anger and sadness (e.g. hate her, I hate everybody”). Client also demonstrated mixed feelings and thoughts about treatment. He even reported not wanting to come to therapy; however, he eagerly participated in all of his sessions.

After eight sessions with the client, there was a marked difference in his thinking, behavior and moods. First, client’s interactions with peers and staff in the group home demonstrated improvement. Through journaling and creating “pro and con lists” the client grew insight into his own thoughts and feelings. He grew more discipline into thinking before he behaved. He was able to cognitively weigh the benefits and consequences of his “acting out” behavior. Second, the client became more motivated to obtain the goals that he wanted for himself. He went back to school to obtain his GED. He demonstrated a serious desire to excel in his school work, witnessed by his diligence in completing homework. Third, the client began to express his true feelings in therapy. He disclosed with his therapist the anger he felt toward his family. He gained insight into his displacement of anger onto other people and things. He openly discussed his anger toward his family with his therapist , and participated in role plays in order to safely express his anger. Finally, the client’s mood grew more positive. He was able to focus more on the things he had going for him (e.g, school, friendships, job), and less on the things he could not solely change (family dynamics, mother’s addiction, stepmother’s behavior). The client still felt a considerable amount of stress, however, he now demonstrated the ability to enjoy himself (e.g. acting silly, laughing).

During the eight sessions, the client and therapist did not fully meet the client's family goals. This was partially due to lack of family involvement. The client did have a chance to process his feelings about his family, to his therapist. However, he did not get the opportunity to discuss his feelings with his family, as he desired. Continued treatment should consider this.

The client's treatment with the present therapist was discontinued after three months. This was due to changes in the client's daily schedule and the therapist moving on to another internship. The client continued therapy with (the therapist's supervisor) the clinical psychologist at the group home.

Chapter 5

Comparison of Best and Normative Practice

The literature review in chapter three discusses various treatment modalities, which have been successful in treating Oppositional Defiant Disorder (ODD). Studies indicate that several treatments have been effective such as, Parent Management Training (PMT), Problem-Solving Skills Training (PSST), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Family Therapy (MDFT). The assumption made from the research is that, the best treatment for this disorder depends on the individual. Thus, an older adolescent with ODD who does not live with his family may not benefit from the same type of treatment as a child with ODD who does reside with family.

The present client resided in a group home. He had numerous problems that stemmed from his family dynamics. Unfortunately, his family was not willing to be a part of therapy on a consistent basis. The 17-year old client was aware that with or without his family, he needed to work through issues that were disrupting his life. The studies on Multidimensional Family Therapy (MDFT), introduced a type of treatment, which would allow the client to have both individual and familial needs met. The assumption made from the studies on MDFT is, that this would have been the best practice for this particular client.

The agency did not have a specific normative practice. The clinical psychologist encouraged using supportive-expressive and cognitive-behavioral techniques.

The focus of treatment was to be a positive support for the client. Ideally the more support the client received, the more they would learn to trust and express themselves. The agency took into account that these adolescents had numerous stressors, one that they all shared, being in the system. The majority of the adolescents prioritized their number one problem as, what took place in the group home. Thus, many hours in therapy were spent on discussing that issue. This could be seen as a weakness of their normative practice, however, it was the client's concern. At that time, the fact that the client had somebody he was comfortable confiding in was more efficient than any technique. Thus, the client felt safe to express himself with the therapist. The more the therapist supported and aligned with the client the more he was willing to work on his individual issues.

The present therapist was able to integrate the normative practice and the chosen best practice. This is due to the similarities between the two practices. Both practices orient their techniques to support the client to express himself. The goal of the therapist is to empathize with the client, thus, creating a trusting relationship for the client and therapist to work through problems. Both practices acknowledged the importance of the client's family with his treatment and the need for them to participate. Unfortunately, they were not willing to commit to treatment at the time. Positively, individual treatment continued and the client was able to work through some of his hurtful thoughts and feelings regarding his family.

Chapter 6 Summary and Conclusions

The purpose of this study was to apply the appropriate therapy techniques to an individual with Disruptive Behavior Disorder, Not Otherwise Specified, using a case study format. A client of this study was a 17-year old Hispanic male who exhibited symptoms of Oppositional Defiant Disorder (ODD) witnessed by; lost his temper, argued with adults, actively defied or refused to comply with adults' requests or rules, was easily annoyed by others, and displayed anger and resentment. The client did not meet the full criteria for this disorder, because, the therapist did not see the client over a 6 month period. If this were the case, full criteria for ODD would have been met for the diagnosis. The client did report similar behaviors before coming to the group home, however, he was never diagnosed ODD.

The client resided in a group home funded by the Division of Youth and Family Services. He came to the group home because his biological mother could not provide stable housing due to her own struggle with addiction. His biological father and stepmother did not want him living in their home due to unresolved conflict between the stepmother and the client. The group home setting was very anxiety provoking for the client. The client expressed his anxiety and hurt through acting out behaviors. He had difficulty dealing with the staff and other residents in the home. He had difficulty accepting the fact that he was ordered to live in the home by the state. The client's first thought was to run away, when things became too difficult to deal with at the group home.

The major emphasis of this study was to support the client in coping with every day stressors within the group home and reduce his symptoms of ODD. Individual therapy took place once a week for five consecutive weeks. During the five weeks, the therapist and client developed a strong therapeutic relationship. This relationship allowed the client to feel safe and work through some of his problems. He did this through journaling, identifying feeling and thoughts, role-playing, and developing “pro and con” lists for pertinent decisions. The client and therapist made considerable progress in a short amount of time by collaboratively devising specific goals for therapy. His disruptive behavior decreased, witnessed by a decline in verbal outbursts and acts of noncompliance. His irritable mood and feelings of hopelessness decreased, witnessed by the “scaling” measure taken once a week. The client’s overall functioning was measured by observation and communication with the group home’s direct care.

By the end of the 5th week, the client had met his goal of returning to school to obtain his GED. Since this was one of his goals for therapy, school was prioritized first. As a result, the client’s attendance to therapy became sporadic. Due to limited staff at the group home, there was no guarantee when the client would return home from school. The therapist and client did meet occasionally. The client reported feeling good and doing well in school, evidenced by good grades on assignments.

There were several limitations in this study. First, the assessment tools and measurements to distinguish client’s thoughts, feelings, symptoms and functioning were not completely reliable or valid. Two assessment tools were administered, however, there was no follow-up done. The “scaling” measure was useful; although, this was the client’s self-report, therefore, this measure is not completely valid for obvious reasons.

Observation could conclude that the client had made considerable progress, however, due to the limited amount of time that the client was seen in therapy this progress cannot be generalized over a long -time period. Second, the best treatment for this client cannot be clearly distinguished. The relationship of the client and therapist was genuine. The client was comfortable enough to express himself due to the therapist's support. He was able to achieve goals and feel better about himself in a short amount of time. He learned techniques to effectively problem solve and make sound decisions. Overall, supportive-expressive and cognitive-behavioral techniques were effective; however, there was a lack of structure in the treatment. Research for adolescents with symptoms of Oppositional Defiant Disorder was not concrete. In addition, it was not obtained until later in therapy sessions. Third, the client had unresolved issues with his immediate family. This was only touched upon in the three-month period. Further treatment should combine individual and family sessions in their treatment modality. It was evident that the client's family dynamics had a strong impact on how this client identified with himself.

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