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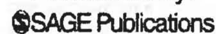
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A Trauma-Focused Individual Therapy Approach for Adolescents With Conduct Disorder

Ricky Greenwald

Abstract: *Trauma is proposed as a key to understanding the development and persistence of conduct disorder in conjunction with other contributing factors. Trauma history is virtually universal in this population, and trauma effects can help to account for many features of the disorder including lack of empathy, impulsivity, anger, acting out, and resistance to treatment. The current standard of care fails to fully address trauma, which may partially explain the low success rate. A trauma-focused individual therapy approach is presented as one example of how this population might be more effectively treated. This approach features motivational interviewing, self-control training, and trauma resolution and integrates eye movement desensitization and reprocessing (EMDR). Two illustrative case examples are presented and discussed.*

Conduct disorder represents a fairly common pattern of impulsive and antisocial behavior entailing enormous cost to afflicted individuals, their victims, and society (Robins, 1981). Researchers now know a lot about risk factors for the development of conduct disorder including temperament, gender, low intelligence, attention deficit/hyperactive disorder (ADHD), impulsivity, poor coping skills, social failure, parental psychopathology, inappropriate discipline, affiliation with deviant peers, and socioeconomic disadvantage (Kazdin, 1995; Moffitt, 1993; Patterson, DeBaryshe, & Ramsey, 1989). These factors are addressed with a variety of treatment approaches that do help some youth to be successful in socially acceptable ways. Unfortunately, there is as yet no really good treatment for adolescents with conduct disorder, with even preferred approaches yielding only modest results (Kazdin, 1997). This may be explained, at least in part, by the failure to address trauma's contribution to conduct disorder.

This article will briefly review child trauma prevalence and outcomes and propose a key role for trauma in the development and persistence of conduct disorder. Then, it will discuss current treatment approaches in that light and suggest an enhanced treatment approach reflecting recognition of the trauma component. To exemplify this approach, a trauma-focused individual therapy protocol that has been developed for this population and so far used primarily within residential treatment settings will be described. Finally, two illustrative case vignettes will be presented and discussed.

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TRAUMA AND CONDUCT DISORDER

For present purposes, *trauma* will be defined as an event in which the child or adolescent experiences intense horror, fear, or pain along with helplessness (Krystal, 1978). Typical examples include auto accident, physical or sexual assault, house fire, and witnessing violence. However, there is considerable empirical support for the notion that major loss experiences have a trauma-like impact on children and adolescents (Newcorn & Strain, 1992) except that the hyperarousal response may not be present following a loss. Therefore, although this discussion will focus strictly on trauma, many of the points probably apply to a wider range of adverse life experiences to which these children have been exposed.

Some of the data on the prevalence of traumatic events in childhood are indirect and suggestive yet persuasive and alarming (e.g., Pynoos, 1990). Recent research has found astonishingly high incidence rates for prior experience of at least one Criterion A stressor among young adults—most of which presumably occurred during childhood or adolescence. For example, Riise, Corrigan, Uddo, and Sutker (1994) found an 85% incidence among a military population (only a minority of which were military trauma), and Vrana and Lauterbach (1994) found an 84% incidence among college students (for more discussion, see Vrana & Lauterbach, 1994). Trauma during childhood and adolescence is now so common as to be normative, and with many risk factors for conduct disorder also constituting increased risk for trauma (e.g., exposure to negligent, coercive, pathological, and/or substance-abusing parents; and exposure to poverty-related violence and crime), trauma history must be nearly universal in this population.

The overwhelming nature of the traumatic experience often leads to a failure to integrate or "get over" the memory. The effects of unintegrated traumatic experiences can become permanently locked in, possibly leading to a variety of post-traumatic symptoms and, arguably, forming the basis of most psychopathology (Brom, 1991; Conaway & Hansen, 1989; Famularo, Kinscherff, & Fenton, 1992; Green, 1983; Kendall-Tackett, L. M. Williams, & Finkelhor, 1993; Terr, 1991; van der Kolk, 1987). Note that trauma may also lead to lasting symptoms in lieu of any formal diagnosis (Cuffe et al., 1998; Fletcher, 1996). The high rate of conduct-disorder-related comorbidity noted in the literature (Wierson, Forehand, & Frame, 1992)—mainly affective disorders and substance abuse—may partially reflect trauma effects. This confusing array of responses to traumatization may partially account for the field's general failure to address trauma effects in conduct disorder.

Anger and violent acting out are common as symptoms of post-traumatic stress disorder (PTSD) (Chemtob, Novaco, Hamada, Gross, & Smith, 1997), and to observers, some adolescents with PTSD may be virtually indistinguishable from those with conduct disorder (Atlas, DiScipio, Schwartz, & Sessoms, 1991). There is a considerable body of literature documenting the relationship between trauma/maltreatment and subsequent aggressive/criminal acting out (Malinosky-Rummell &

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Hansen, 1993; Widom, 1989) including several studies specifically addressing adolescent delinquent behavior (Dembo, L. Williams, Wothke, Schmeidler, & Brown, 1992; Flisher et al., 1997; Hernandez, Lodico, & DiClemente, 1993; Herrenkohl, Egolf, & Herrenkohl, 1997; Paperny & Deisher, 1983; Rivera & Widom, 1990). Furthermore, many researchers have noted the prevalence of trauma histories in conduct disorder populations (Bowers, 1990; McMackin, Morrissey, Newman, Erwin, & Daley, 1998; Rivera & Widom, 1990; Steiner, Garcia, & Matthews, 1997), with some specifically finding post-traumatic symptomatology as well (Burton, Foy, Bwanausi, Johnson, & Moore, 1994; McMackin et al., 1998; Steiner et al., 1997; Watson, Kucala, Manifold, Juba, & Vassar, 1988).

Although trauma effects can manifest in many ways, when combined with the other risk factors noted earlier, trauma may be integral to the development and persistence of conduct disorder. Certain key features of the disorder can be explained much more completely by considering the trauma contribution. Trauma violates basic trust, disrupts attachment, and interferes with empathy (James, 1989), thus removing inhibitions regarding crimes against others. Trauma leaves the victim in a perpetual state of alert; this sensitivity to threat leads to a hostile attribution bias, leading in turn to impaired social competence and increased aggressive behaviors (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Hartman & Burgess, 1993). Trauma creates intolerable emotion such as intense fear, sadness, and anger, often leading to substance abuse (Clark, Lesnick, & Hegedus, 1997), distracting high-risk activities, and violent and destructive acting out (van der Kolk et al., 1996). Trauma diminishes the sense of future (Fletcher, 1996; Terr, 1991), fostering an instant gratification orientation and precluding investment in the long term. Trauma effects can last indefinitely and can become a primary focus around which personality and behavior are organized (Terr, 1991; van der Kolk et al., 1996).

TREATMENT ISSUES

Despite the prevalence of trauma history among adolescents with conduct disorder, treatment programs tend to address it only in a partial manner. Because trauma effects can be so powerful, this gap in treatment may leave the youth relatively impervious to the other elements of the treatment program. Until trauma effects are directly targeted and effectively addressed, success rates with this population may remain at the current low level.

Trauma treatment involves—to oversimplify—two phases: establishing a sense of safety and then working through the traumatic material (James, 1989; Peterson, Prout, & Schwarz, 1991; Pynoos & Eth, 1986). Safety can be effectively addressed in many ways within a treatment program for adolescents with conduct disorder. A range of physical and behavioral controls helps to maintain a sense of bodily safety. Positive relationships with individual staff members as well as daily routine help to foster a sense of emotional safety. Cognitive-behavioral training

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also contributes in that increased self-control allows for increased control over—and predictability of—the environment. For example, in a recent study of volatile veterans with PTSD, participation in an anger management group led to increased self-control as well as reduction of apparently unrelated trauma symptoms (e.g., intrusive thoughts and images), whereas standard trauma treatment did neither (Chemtob, Novaco, Hamada, & Gross, 1997). Consistent with this trauma-informed perspective, Greenwood (1994) observed that the more effective residential programs for juvenile delinquents do feature cognitive-behavioral treatment as well as small noninstitutional settings in which a relatively secure and supportive environment can be provided.

Unfortunately, current treatment programs do not address the working-through phase very well. In some programs, there is at least an attempt to do this, whether individually or in group work, but it is unlikely to be helpful. (In lieu of directly applicable studies, see discussion of treatment difficulties in Solomon, Gerrity, & Muff, 1992). First of all, this population is extremely resistant to even engaging in this type of treatment. The trauma effects make them want to avoid close relationships, avoid reminders of the trauma, and avoid even temporary distress for a long-term gain that they do not believe they will see. Secondly, even those who are willing to address the trauma in treatment typically make only limited progress toward actual resolution and symptom reduction. In fact, many who attempt to face their traumatic memories only get upset, leading to acting out, negative consequences, and then increased resistance to treatment. The treatment methods used are sometimes harmful, generally inadequate, and at best, inconsistently effective.

THE TRAUMA-FOCUSED INDIVIDUAL TREATMENT APPROACH

The principle is simple: Effectively addressing the trauma effects associated with conduct disorder should enhance an otherwise comprehensive program's effectiveness and yield improved outcomes. The individual psychotherapy approach presented here incorporates the state of the art in trauma treatment in conjunction with several related techniques developed or adapted specifically for this population and systematically sequenced for maximum effect. This approach was developed and refined with about 50 adjudicated adolescent males in two different residential treatment settings, has been used in other settings, and is described in greater detail elsewhere (Greenwald, 1996a, 1999).

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Eye movement desensitization and reprocessing (EMDR) is central to this approach. EMDR is a fairly new, highly effective individual psychotherapy treatment for traumatic memories. To oversimplify, the client is asked to concentrate intensely on the most distressing segment of a traumatic memory while moving

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the eyes rapidly from side to side (by following the therapist's fingers moving across the visual field). Following the initial focus on the memory segment, after each set of eye movements (of about 30 seconds), the client is asked to report anything that "came up," whether an image, thought, emotion, or physical sensation (all are common). The focus of the next set is determined by the client's changing status. For example, if the client reports, "Now I'm feeling more anger," the therapist may suggest concentrating on the anger in the next set. The procedure is repeated until the client reports no further distress and can fully embrace a positive perspective. Although formal supervised training is required for safe and effective practice (Greenwald, 1996b), detailed procedural information is widely available (Shapiro, 1995).

The underlying mechanism of EMDR is not known. Shapiro (1995) suggested that the procedure somehow induces accelerated information processing whereby "stuck" traumatic material can be accessed, rapidly integrated, and thereby depotentiated. Along these lines, others have speculated that the purported accelerated information processing effect may be related to rapid eye movement (REM) dreaming (Greenwald, 1995; Stickgold, 1998). Taking a different tack and not addressing the possible effect of the eye movements, others (Hyer & Brandsma, 1997; Sweet, 1995) pointed out that the EMDR procedure is quite comprehensive in incorporating virtually every element believed to be effective in individual therapy for trauma. The question of how EMDR works is far from resolved, and in particular, the role of the eye movements remains a mystery.

EMDR treatment often allows the client to emerge with no further memory-related distress as well as a healthier perspective. A single traumatic memory can now be fully resolved in—typically—one to three sessions, and treatment time is also considerably shortened in cases involving multiple trauma. Although EMDR has been controversial (Greenwald, 1996b), it is now supported by more controlled studies than any other psychotherapy approach to trauma (Shapiro, 1996) and has gained mainstream recognition (Chambless et al., 1998).

EMDR's usefulness with adolescents with conduct disorder has not been directly evaluated, but results of a number of related studies indicate that this application holds promise. For example, Jameson (1998) anecdotally reported positive results with the trauma-focused EMDR treatment of 70 adult male prisoners. Also, several studies of EMDR with traumatized children and adolescents show positive outcomes essentially consistent with analogous adult studies (Greenwald, 1998). Three studies are more directly relevant to the adolescent conduct disorder population. Datta and Wallace (1996) provided three sessions of trauma-focused EMDR to 10 incarcerated adolescent male sex offenders who then showed significant improvements in behavior, academic performance, and empathy, many spontaneously initiating restitution attempts to their past victims. Scheck, Schaeffer, and Gillette (1998) provided two sessions of trauma-focused EMDR or active listening treatment to a randomized group of high-risk, acting-out adolescent girls (ages 16 to 19, $n = 18$) and young women (ages 20 to 25, $n = 42$). The EMDR group outcome was far superior, moving into the normative range

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on all five measures and with maintenance of gains at 90 days. Finally, Soberman, Greenwald, and Rule (in press) provided three sessions of trauma-focused EMDR as an adjunct to standard care to half of a randomized group of 24 acting-out boys ages 10 to 16 who were already in residential or day treatment. The EMDR group did far better than controls in reducing their primary identified problem behaviors at 3-month follow-up.

THE THREE-PHASE APPROACH

Although such reports are encouraging, merely offering an effective treatment for traumatic memories would frequently be insufficient for the resistant and volatile conduct disorder population. The present approach begins with a modified motivational interviewing technique because commitment to treatment is the first obstacle. The second phase involves cognitive-behavioral training and coping skill development that help the youth to trust the therapist and to gain the confidence, strength, and sense of control necessary to face the trauma directly. Finally, the working through is done.

Each phase of the protocol integrates EMDR. Although EMDR is best known as a treatment for traumatic memories, clinical observation supports the accelerated information processing hypothesis (Shapiro, 1995), which applies not only to resolution of disturbing memories but to other forms of information processing such as learning. Thus, EMDR has also been used for visualization, affirmations, and performance enhancement in a variety of applications (Foster & Lendl, 1996; Greenwald, 1993; Shapiro, 1995). The present approach uses EMDR's accelerated information processing effect to enhance a range of interventions. Here is a summary of treatment components.

The first phase, motivation, starts with the initial encounter. The systematic interview is designed both to obtain needed data and to enhance rapport. Then EMDR is used with the Future Movies technique to help the client identify and invest in positive short-term and long-term goals. This entails asking the client to fill in the details of a movie of the next 10 years of his life, including the positive actions he can take, leading to a happy ending. The movie is imaginarily viewed during eye movements. Then, an unhappy ending is identified and focused on during eye movements along with the statement, "It's not worth it." Once this is accomplished, the treatment plan can be offered in the service of the client's stated goals of choosing to work toward the positive outcome. Subsequent interventions build on this phase.

The second phase, skill building, includes a number of cognitive-behavioral techniques integrated with EMDR. For example, Early Warning System helps the client to become more aware of the various internal steps (e.g., angry thoughts or racing heartbeat) leading to escalation and loss of control. This entails interviewing the client to identify these steps and then having him imaginarily view them in sequence. Choices Have Consequences helps the client to develop a constant awareness, even during challenging moments, of the consequences of various

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behavioral options. This entails having the client imaginarily view a movie of a challenging situation in which a positive behavioral choice leads to a positive outcome and then again with a negative choice leading to a negative outcome. Tease-proofing includes a series of techniques that helps the client to become less reactive to provocation. First, the client is asked to imagine a fantasy scenario in which he is able to overpower his antagonist. Then, he is taught to erect an imaginary wall to keep his antagonist's barbs from getting through to him. Finally, he is asked to consider and then picture himself imitating a role model's effective coping. These exercises all include eye movements during the imagining portion.

The third phase, trauma resolution, includes some typical and some innovative uses of EMDR to address underlying trauma and loss issues and to further develop coping skills. For example, rather than plunging prematurely into work on a major traumatic memory, EMDR may first be applied to recent, relatively minor, upsetting experiences such as getting in trouble that day in school. This allows the client to develop a track record with EMDR under relatively low-stress circumstances while learning to talk about current issues, reduce stress, and problem solve.

The following two vignettes of actual (disguised) cases show this protocol in action. Selected methodological descriptions are included for illustrative purposes but are not sufficiently detailed to allow for replication (for detailed procedural information, see Greenwald, 1999).

CASE EXAMPLES

SHAWN

Shawn was a 15-year-old boy adjudicated to an open residential 4-month program following 2 months in medium-security placement on multiple charges including numerous car thefts, truancy, selling marijuana, and fighting. He had a chaotic family history including an alcoholic father and parental discord prior to divorce; prior to incarceration, he lived with his mother in a poor urban area. Reported major trauma history was limited to a house fire caused by his father's alcohol-related negligence. Shawn had a long history of progressively more serious acting-out behavior, with previous diagnoses—preceding the fire—including ADHD and oppositional defiant disorder (ODD). He had been offered counseling/therapy on numerous occasions previously but had "blown them off." Shawn was not enthusiastic about this treatment but agreed to give it a try.

MOTIVATION (SESSIONS 1 AND 2)

Future Movies. The first session was spent on intake/history. At the second session, he was asked to imagine a movie of his own future: If things go well, what would be the ending picture 10 years from now? Following detailed questioning,

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he said, "I'd be making good money in construction with my uncle, I'd have an apartment with some friends, I'd be driving a Camaro." The feeling was good and the encouraging self-statement that went with this was, "I can do it." He then concentrated on a visual image representing this lifestyle—driving the Camaro—while doing eye movements (as in EMDR), noticing the good feeling, and saying to himself, "I can do it." Then he was asked, "What if the movie had a bad ending, what would that be?" It was a picture of himself in jail, with the associated feeling of "angry, bad," and the statement—which the therapist suggested—"It's not worth it." This was also a focus of eye movements. Then—back to the good movie again—he was asked what the steps would be along the way to get to the good end. These included staying out of trouble, not using hard drugs, and making passing grades in school. He then visualized during eye movements the entire movie from the present moment to the good end including all the steps along the way.

Commitment to treatment. Then, he was asked for a rating of how much he wanted the good ending as opposed to "doing the same old stuff" that would lead to the bad one. He said about 60% of him wanted the good end, the other 40% still felt like doing the same old stuff. He was asked if he wanted to do things to make himself stronger so the 60% would have a better chance of being in charge. He said, "Yes." He was told that he would not like it, that it would be boring, hard work, and so on. He said, "Let's go."

SKILL BUILDING (SESSIONS 3 AND 4)

Early Warning System. Shawn had a tendency to sudden explosive reactions. He was asked for a recent example and then asked to slow down the movie of this memory to gain awareness of the steps in the escalation of his strong reaction. With some prompting, he and the therapist made a list of the steps in order including cognitive awareness of an offense by a peer or teacher, increased heart rate, body tension, angry (covert) self-talk, and fists. Then, he visualized these steps in slow motion, repeatedly, during eye movements. The point, of course, is to learn to stop oneself before the escalation goes too far.

Choices Have Consequences. Shawn acknowledged that his reactivity and fighting was a problem for him because it got him in trouble and kept him from being able to play video games or go to the movies. He was asked to recall a recent event in which he had gotten himself in trouble. Then, he was asked to visualize a movie, during eye movements, including the following steps:

1. the provocation
2. the early warning system steps, in order
3. his poor behavioral choice (fighting)
4. the bad ending image (himself in jail) and the thought, "It's not worth it"

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Then, the movie was repeated but with a positive behavioral choice (walking away) leading to a good ending image (going to the movie or seeing himself in 10 years driving the Camaro) and the thought, "I can do it." Finally, the movie was repeated with an option: "I don't know how it will end this time. You make the choice by what you do. Remember, bad choice, bad ending; good choice, good ending." He chose the good ending.

This exercise was repeated with additional examples of recent events. Often, the Early Warning System was spontaneously used in making the positive behavioral choice more quickly and easily rather than waiting until the point of no return. In the next session, Choices Have Consequences was repeated with anticipated challenges both within the program and back home. For some targeted situations, the provocation was replaced with the temptation to skip school or steal a car. The rest of the format was the same. Choices Have Consequences was done for about 25 minutes in one session and 20 minutes in the other, and he said, "I've got it already, I don't want to do this anymore."

TRAUMA RESOLUTION (SESSION 5)

The standard EMDR protocol, slightly modified for use with impatient adolescents (Greenwald, 1999), was used to address the memory of the house fire. Shawn achieved resolution of this memory in one session, reporting no further memory-related distress. No other major trauma or loss memories were identified. If this memory had indeed contributed to any of Shawn's acting-out behavior, the pressure was off now.

OUTCOME

In the next session, Shawn reported that he was not getting in any trouble anymore, that the memory of the house fire still did not bother him, and that he did not have anything else to talk about or work on. The therapist suggested additional trauma work (regarding memories of parental discord) or more practice with Choices Have Consequences, but he was not interested. This final session lasted only 15 minutes. This course of treatment was quicker than usual and rather less focused on trauma resolution work.

Shawn was quite successful in the program and was released several weeks early. It was reported 6 months after he had returned home that he was attending school and making passing grades and that he had incurred no further legal trouble. He was supposed to see a therapist but did not keep his appointments.

CHRIS

Chris was a 15-year-old boy who was sentenced to 4 to 5 months in an open residential program following a month in a medium-security setting. He had been

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heavily involved in poly-substance abuse and random additional crimes with his friends. He also had an extensive history of assault charges, having targeted his stepfather as well as peers. Although he wanted to be friendly with peers and staff in the program, he clearly had a chip on his shoulder. His temper was so bad that in his first weeks he was constantly getting upset, yelling at someone, and storming off. His poor self-control made him a target of choice for his amused peers. This led to impaired social relations and many missed privileges.

MOTIVATION (SESSIONS 1 AND 2)

Chris was not convinced that talking to someone would help but he was willing to play along until he felt otherwise inclined. The first session was devoted to a developmental history, trauma/loss history, and a history of his legal difficulties. In the second session, he participated in the Future Movies exercise and visualized positive and negative futures (during eye movements) including the likely steps along each way. He saw himself running his own business and perceived that he would have to do well in school and work and stay out of jail to achieve this. Following this activity, he was able to identify his attitude and his temper as obstacles that he was willing to try to overcome to achieve his goals.

SKILL BUILDING (SESSION 3)

Teaseproofing. Because Chris's reactivity was so debilitating for him, in the third session the therapist chose to go directly to teaseproofing. This set of interventions, all of which include eye movements during the imagining portions, proceeded as follows. Chris was easily able to identify the peer who made him most angry. The first intervention, Play Therapy, entailed Chris imagining himself as a comic book artist who could create any imaginable outcome to the story. The story, of course, began with a provocation by his most prominent antagonist. Over the course of several repetitions, Chris proceeded to (imaginarily) turn the peer into a roach, to erase him from the page, and to make him explode. Similar to the traditional play therapy, this rather humorous intervention seems to enhance the client's sense of power and ability to face the "monster."

The next intervention, Walls, may be preceded by a brief discussion to orient the client to a constructive reframe of provocation. For example, the therapist may say, "When he calls you a name, is it because you're really a bad person or because he has bad feelings he wants to take out on someone?" Then, the wall makes sense as a way to keep someone else's bad feelings from getting inside the client. The intervention entails imagining instantaneously erecting a wall to prevent the antagonist's communications—or bad feelings—from getting through. Chris performed this exercise only a couple of times—imagining a brick wall—and said he "got it," so the therapist accepted that and moved on.

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The last intervention required Chris to select a role model to emulate, someone who would handle the target situation very well. Curiously enough, when asked earlier how one ought to handle provocation, Chris had said, "ignore, walk away." However, here Chris identified a peer role model who "just makes a joke, laughs it off, and then it's over." Chris was first asked to imaginarily observe the peer handling the target provoking situation. Next, he was asked to imagine becoming this person and handling the situation. Finally, he was asked to imagine being himself handling the situation in the way the role model might.

The Teaseproofing interventions took a full session. In Chris's case, results were instantaneous: He simply ceased to overreact to provocation. At the next session, he reported that he was making friends and that he had been able to attend nearly all available activities during the past week, having virtually eliminated the outbursts that led to lost privileges.

TRAUMA RESOLUTION (SESSIONS 4 THROUGH 11)

At this point, with the crisis passed, the importance of addressing Chris's extensive trauma/loss history was discussed because he traced much of his behavioral deterioration to the suicide of his best friend 2 years before. Although he was naturally skeptical of EMDR at first, he was willing to experiment with it regarding a minor upsetting event involving a recent argument with a peer. Once he experienced the relief following the first EMDR session, he was willing to continue through the rest of the material. For the next 8 sessions, Chris worked through a number of trauma/loss memories using EMDR including the suicide, the deaths of a grandfather and two uncles, and a car accident.

SKILL BUILDING (SESSIONS 12 THROUGH 15)

At this point, Chris was functioning very well within the program and seemed to have resolved many of his past issues. With home visits beginning, treatment began to address anticipated challenges including potentially conflictual contact with his stepfather as well as exposure to drug-involved friends. (Chris was attending a 12-step program and he and the therapist did not focus much on substance abuse issues within the individual treatment.) He was able to describe potentially challenging situations that were addressed as follows.

Choices Have Consequences. Chris was asked to imagine a movie including: (a) a challenging situation (e.g., being offered cocaine by a friend); (b) making the bad choice (e.g., using the cocaine); and (c) the bad ending that might eventually ensue (e.g., ending up in jail again). Next, he was asked to imagine a movie that started with the same challenging situation but this time to make a good choice leading to a good ending. Finally, he was asked to imagine a movie with the same beginning but to make his own choice. The rest of the instruction is also the lesson: "Remember, if you make a bad choice, go to the bad ending. Good choice, good

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ending." This exercise was repeated a number of times over several sessions addressing concerns regarding substance abuse, reintegrating himself with his troublemaking friends, and dealing with his stepfather.

OUTCOME

The entire treatment lasted 15 sessions over 4 months. Chris was able to keep some of his preexisting friendships alive, whereas he found himself distancing from friends whose only interests were substance abuse and other illegal activities. He was able to defuse a number of potential conflicts with his stepfather and found himself beginning to like the man as well as get along with him. He was looking forward to going back to school and seemed well on track for the positive future he had envisioned. At 3-month follow-up, he was doing well in school and developing some new friendships as well.

This story has an interesting footnote. Three weeks before Chris graduated the residential program, a new boy named Scott entered who quickly became the group's scapegoat. Naturally, early in Scott's treatment the teaseproofing protocol was implemented. When he got to the role model intervention, Scott was asked who he could think of who might handle such a situation well. He said, "Chris."

DISCUSSION

These cases being real, it should not be surprising that the protocol was not meticulously followed. With Shawn, Teaseproofing was skipped, and EMDR was used directly with a major traumatic memory without first trying it with a recent minor event. With Chris, Teaseproofing preceded Choices Have Consequences, and the Early Warning System was omitted as is common with clients who are already aware of their pattern of escalation. Also, Choices Have Consequences is normally applied first with current rather than future challenges, but that step was not needed here. There is considerable variation in focus and emphasis from case to case, according to clinical judgment.

The protocol seems to be sufficiently flexible to tolerate some changes, and rigid adherence is probably less important than responding to client needs. Still, many basic principles were followed that are particularly important in the conduct disorder/trauma treatment context. For example, the client's own goals formed the basis of the treatment contract, and his most immediate concerns were most quickly addressed. This makes therapy seem relevant and beneficial and enhances the therapist's credibility, all prerequisites for later trauma resolution work. Also, safety issues related to self-control were addressed prior to facing the trauma/loss memories.

The Future Movies intervention serves many functions. First of all, teens with conduct disorder may not be accustomed to exposing a positive side of themselves

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to adult authority figures. Sharing their hopes and dreams allows them to be seen in a positive light, perhaps a rare experience and not a bad basis for a working relationship. This intervention also helps to sidestep the tendency of many conduct-disordered teens to rebel by refusing to engage in treatment. Because treatment is offered in the service of the client's own goals, most do sign on. Motivational interviewing has been applied successfully to engaging clients in addictions treatment (Miller, 1996), and the present application is not such a great leap. Trauma effects often interfere with belief in a positive future; this exercise can help to counter that by fostering an active emotional investment in that future. Without the hope and emotional investment in the positive future, there would be little reason to engage in treatment. Finally, research has shown that imagining doing the specific activities that are required to achieve a desired outcome can lead to increased implementation of the required activities (Taylor, Pham, Rivkin, & Armor, 1998).

It is generally essential to provide some cognitive-behavioral training early on in the treatment whether it entails using the Teaseproofing, Choices Have Consequences, or anything else that may be effective. This phase of therapy is face valid, nonthreatening, and can provide some measure of immediate relief, sense of control, and success. Self-control training is also one of the few interventions with any documented effectiveness for this population (Kazdin, 1997). Although such training may generally be viewed as addressing a skill deficit, here it is also conceptualized as an element of trauma treatment consistent with a similar application with volatile adults with PTSD (Chemtob, Novaco, Hamada, & Gross, 1997).

Using Choices Have Consequences to anticipate future challenges also fortifies the client to cope effectively (for an interesting variant targeting adolescent sexual offenders, see Hunter & Santos, 1990). This application has similarities to the relapse prevention approach that has been used in addictions treatment (Marlatt & Gordon, 1985) as well as with sex-offending adolescents (Marshall, 1996). This intervention also serves multiple functions. Imaginary rehearsal of the set-up for problem situations along with problem-solving strategies leads to improved problem situation avoidance as well as more effective resolution. Pairing the negative behavior with the negative outcome leads to sensitization, interfering with thoughtless impulsivity. Pairing the positive behavior with the positive outcome provides an opportunity both for imaginary rehearsal and imaginary reinforcement. Meanwhile, there may be incidental desensitization to the emotional impact of the challenging situation so that it simply becomes less of a challenge. In terms of trauma treatment, this intervention not only enhances coping skills, sense of safety, and sense of control but it also mitigates the power of contemporary situations to function as triggers to traumatic material.

Although the skill-building component has real value, it is important not to stop there. Apparent success in self-control is only half of the equation. To fully master an impulse control problem, one must also do something about the strength of the impulses. Otherwise, coping skills that are effective within a controlled environment may not withstand the more powerful stressors to which the

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client may be exposed subsequently. Trauma resolution work can help to reduce the burden of reactivity and negative emotions while increasing a sense of strength, security, and confidence. This puts the client in a better position to face subsequent challenges.

The integration of eye movements with many elements of the treatment also serves multiple functions. First of all, it is intended to enhance the impact of the various imaginary activities via the accelerated information processing effect (this is only speculative as the accelerated information processing effect per se has not been formally tested). Secondly, as noted earlier, eye movements may contribute to an incidental desensitizing effect for the targeted material. Finally, it prepares the client procedurally for progressively more challenging eye-movement-related activities, eventually leading to work on traumatic memories.

Of course, not every case proceeds as smoothly or successfully as these. However, anecdotal reports do indicate that using this protocol increases the odds for both engaging conduct-disordered teens in treatment and in obtaining positive outcomes (Greenwald, 1996a; Stewart, 1998). This approach may also facilitate response to other treatment components that may further contribute to positive outcome.

Preliminary results of a more systematic evaluation are also encouraging. In one facility in which all clinicians were trained in this approach, by 2 months later, all critical incident (assault, property destruction, etc.) counts were down by 50% or more on all units (male, female, conduct disorder, and sex offender) compared to any of the 6 months pretraining (D. Lundberg, personal communication, June 30, 1998). Because the clinicians were previously trained in EMDR and because cognitive-behavioral treatment was also already in effect, those components in isolation cannot account for the findings. However, additional concurrent trauma-focused staff training and consultation may have led to a more generally safe and supportive milieu. Further study of the protocol is under way.

When the youth is not driven by anger and reactivity, not compelled to block himself or herself off from friendship and from hope, there is a much better chance that the rest of the treatment program will get through. Although this protocol is far from the only possibly effective approach to working with this population, it can serve as an example of a treatment approach that systematically addresses generic trauma treatment needs as well as considerations specific to this population.

CONCLUSION

Further ascertaining the role of trauma in conduct disorder can be accomplished in several ways. Short of longitudinal studies, trauma history and symptoms can be assessed at intake or at other points when youth with conduct disorder are identified and accessible. In this context, it would be important not merely to assess for Criterion A events and PTSD but for the full range of adverse life events

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and post-traumatic symptomatology as the issue here is trauma effects regardless of diagnosis. Because conduct disorder itself probably encompasses subtypes (Christian, Frick, Hill, Tyler, & Frazer, 1997; Moffitt, 1993; Sorensen & Johnson, 1996), these should also be addressed as they may prove variably trauma related.

Trauma-focused treatment approaches can also be tested. Because conduct disorder seems to be so complex and multidetermined, a comprehensive approach including trauma treatment is likely to be more consistently effective than a stand-alone trauma treatment. In treatment outcome studies, both trauma symptoms and conduct disorder symptoms should be tracked to ascertain whether reduction in conduct disorder symptoms is indeed related to the trauma effects.

Considering trauma may prove to be key to a more complete understanding of conduct disorder, leading finally to more consistently effective treatment. The individual therapy approach presented here, when implemented within the context of an otherwise appropriate treatment program, potentially represents such an advance in treatment. This approach has many strengths. It addresses treatment challenges specific to this population by combining established clinical principles and interventions with empirically supported state-of-the-art trauma treatment in an innovative, carefully targeted, and sequenced manner. It is also flexible enough to adapt to individual clients and situations and specific enough to be manualized. Of course, there is as yet only preliminary evidence for effectiveness.

Given the ubiquity of trauma and loss in the histories of conduct-disordered youth, with potentially profound and lasting effects, trauma may play a central role in the development and persistence of conduct disorder for a large subset—even a majority—of this population. Without negating other important components of treatment, it may be useful to consider trauma as an organizing, principle-informing treatment approach. Effectively addressing trauma means that other potentially effective treatment components may stand a better chance of success.

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