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## Clinician's perceptions of the therapeutic alliance and treatment outcomes among juvenile offenders diagnosed with conduct disorder

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Nina Kramer-Feldman  
Clinician's Perceptions of the  
Therapeutic Alliance and Treatment  
Outcomes Among Juvenile  
Offenders Diagnosed with Conduct  
Disorder

### **ABSTRACT**

This qualitative study explored the ways clinicians navigate the therapeutic alliance, treatment approach, and have treatment success with juvenile offenders diagnosed with conduct disorder. Twelve Master's level or higher mental health clinicians were selected through purposive convenience snowball sampling. They were interviewed in person about their use of treatment modalities, techniques and strategies for developing a positive therapeutic alliance and how they have treatment success with these clients. Additionally, they were asked what client characteristics influence their sense of optimism for these clients, what factors contribute to a positive therapeutic alliance, what makes them hopeful/hopeless for these clients, and what hinders/creates a positive therapeutic alliance.

Study results indicated the importance of empathy, trust, developing mutual respect, being consistent and allowing the client to be the expert on their own life as the most important factors in developing a positive therapeutic alliance; while judgment, confrontation and anger hinder it. Additionally, despite the challenges of establishing a positive therapeutic alliance with these clients, the majority find this work to be enjoyable. Furthermore, clinicians have more hope that these clients will have brighter futures if they are able to form some sort of attachment with a caregiver, parent, older sibling, or other positive, influential person in their life. Finally, results indicated that the most useful treatment modalities for engaging and working with these clients are motivational interviewing and functional family therapy, however further research is needed.

**CLINICIAN'S PERCEPTIONS OF THE THERAPEUTIC ALLIANCE AND  
TREATMENT OUTCOMES AMONG JUVENILE OFFENDERS DIAGNOSED WITH  
CONDUCT DISORDER**

A project based upon independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2013

## **ACKNOWLEDGEMENTS**

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged. Firstly, I am deeply thankful to my thesis advisor, Krishna Samantrai, for her insight, helpful edits, calming words and constant reassurance.

I would like to thank the twelve participants who shared their precious time, stories, and unwavering dedication to this work with me.

To my friends and family for supporting me throughout this process by providing me with encouragement, love, comic relief and constant support.

And to Adam, your love, support, patience, and delicious dinners kept me sane and grounded.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	5
III METHODOLOGY.....	19
IV FINDINGS .....	25
V DISCUSSION.....	36
REFERENCES .....	41
APPENDICES	
Appendix A: Human Subjects Review Board Approval Letter .....	50
Appendix B: Screening Questions .....	51
Appendix C: Consent Form .....	52
Appendix D: Demographic Questionnaire.....	54
Appendix E: Interview Guide.....	56
Appendix F: Professional Transcriber's Assurance of Confidentiality .....	58

## **CHAPTER I**

### **Introduction**

Before the development of juvenile courts in the beginning of the 20<sup>th</sup> century, juvenile delinquency was considered primarily a criminal justice issue. Youth offenders were treated like adults who had committed a comparable infraction and punishment was often incarceration (Costin, 1991, p. 60). Recognition of the need for a separate legal process for youth under the age of 18 who commit crimes (juvenile delinquents), coincided with increasing understanding of the unique social characteristics and mental health needs of youth offenders by social work and mental health professionals.

Shortly after the establishment of the juvenile courts came the growth of professional social work with a focus on preventative social services, including the protection and safety of vulnerable, dependent children and families (as cited in Whitaker, 2012, p. 2). It wasn't until the 1960's that mental health professionals took a serious interest in the psychological dimensions and recognized importance of providing mental health services to youth who committed crimes (Knight and Stevens, 2009). Now, professionals from all three fields: criminal justice, social services and mental health are directly involved in the field of juvenile delinquency.

Over one million youth enter into the juvenile justice system in the United States each year (Bonham, 2006). Many have a significant trauma history and increased rates of post-traumatic stress disorder (SAMHSA, 2012). The most common diagnosis given to juvenile offenders is that of conduct disorder (Shufelt & Coccozza, 2006), an externalizing disorder

characterized by a “repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated...” (DSM IV). Many juvenile offenders diagnosed with conduct disorder are often referred for therapy as part of their sentence from juvenile court, but clinical work with these clients is challenging (Hammond, 2007). Therapeutic alliance, a critical factor in treatment success, is often difficult to establish with youth. It is more challenging with juvenile offenders, and even more so with juvenile offenders who have a diagnosis of conduct disorder. Several therapeutic models have been developed to work with this client population and their families. Significant ones include: motivational interviewing, the stages of change and functional family therapy. These models all concentrate on motivating and engaging difficult clients in therapy by increasing client's internal motivation to change.

The perception of juvenile justice professionals and clinicians towards youth with a conduct disorder diagnosis impacts their sense of optimism for their clients, their ability to form a therapeutic alliance and their choice of treatment modality. One study by Murrie et al, examined whether diagnostic labels of psychopathy and conduct disorder influenced juvenile probation officer service recommendations. The researchers presented probation officers with vignettes of juvenile offenders with varied diagnoses, backgrounds, and the presence of antisocial personality traits (Murrie et al, 2005) and asked what services, ranging from psychological services to incarceration, they would recommend for each juvenile offender. They found that diagnostic labels (such as conduct disorder) had little effect on probation officer recommendations but "diagnostic criteria of antisocial personality traits had a substantial effect on probation officer recommendations” (p. 323). Therefore, they were more influenced by reports of antisocial behaviors such as callousness, lack of empathy.

Reyes & Marsh (2007) looked at whether patient's contextual factors (such as socio-economic status, past trauma, family situation and educational experiences) influenced clinician's judgments of specific symptoms for conduct disorder. They found that contextual information highly influenced clinician's judgments. Another study conducted by Rocket et al (2011) found that while psychopathic personality features such as lack of empathy, manipulative behavior, egocentricity and an antisocial behavior history led clinicians to believe that there is a greater risk for criminality and violence, a psychopathy or conduct disorder label itself did not appear to have a consistent influence on clinicians' optimism for a healthy future for this client population.

While these studies contribute to our understanding of professionals' perceptions about treatment, contextual information and future risk for criminality and violence, they are limited by their reliance on hypothetical situations through the use of vignettes. Rocket, et al (2011) discussed this limitation:

We hope that future studies will move from vignette designs to studies of real world clinical practice. For example, studies should address...the ways in which psychopathy features and psychopathy labels interact with clinicians' expectations and perceptions to influence key outcomes such as therapeutic alliance, treatment response and treatment success (p. 119).

The current study addressed this gap through in-person interviews with clinicians who work with juvenile offenders. I explored the ways clinician's perceptions of the conduct disorder diagnosis impacts three areas in their therapeutic work with juvenile offenders: therapeutic alliance, treatment approach, and treatment success. I hope the findings of this study will contribute to a growing body of knowledge on how to best navigate the therapeutic alliance and have treatment success with juvenile offenders diagnosed with conduct disorder.



## **Organization of the Report**

This report is organized into five chapters: introduction, literature review, methodology, findings and discussion. The literature review presents a thorough overview of the findings from other studies and investigations that are pertinent to this research. The methodology chapter outlines the processes by which the research was conducted: including but not limited to a description of the general research strategy, the method used for sample selection, a description of the data collection instrument and the method of measurement. The findings chapter provides a detailed description of the major findings of this study. The final chapter, the discussion, describes the implications of this study's findings and presents possible new directions for related research.

## **CHAPTER II**

### **Literature Review**

The purpose of this study was to explore the ways clinicians navigate the therapeutic alliance, treatment approach, and have treatment success with juvenile offenders diagnosed with conduct disorder. This chapter presents a review of the salient literature.

#### **Juvenile Delinquency**

A delinquency offense is defined as "an act committed by a juvenile for which an adult could be prosecuted in a criminal court" (US Census Bureau, 2012, p. 214). Currently, a juvenile between the ages of 10-17 can be prosecuted in criminal court. There are a variety of possible outcomes for juvenile cases: the case can be waived to criminal court, the case can be dismissed, the youth can be placed on probation or in a facility for delinquents, or such actions as fines, restitution, and community service (US Census Bureau, 2012). The total number of delinquency offenses in the United States in 2008 was 1,653,000. Males committed 73% of the cases, while females committed only 27%. The most common offenses were robbery, aggravated assault, burglary, larceny-theft, obstruction of justice, disorderly conduct and drug-related violations (U.S. Census Bureau, 2012).

The overrepresentation of youth of color in the juvenile justice system is undisputed. This racial disparity is clearly seen in the 2008 U.S. Census Bureau statistics on the juvenile justice system. Juveniles who identified as white committed 63% of the cases, while juveniles who identified as black committed only 34%. However, only 4.4% of the juveniles who identified as

white were sentenced, while 11.3% of the juveniles who identified as black were sentenced. These statistics clearly demonstrate that youth of color are more than twice as likely to be sentenced for crimes than white youth. Juvenile delinquency continues to be a growing concern in the United States. Many believe it is directly related to the racial disparities illustrated above. There are a number of theories as to what contributes to juvenile delinquency. One such theory is explored below.

### **Factors Contributing to Juvenile Delinquency: General Strain Theory**

Recent contemporary theorists explain juvenile delinquency as a response to social-psychological stressors (Froggio, 2007). Many believe that multiple and often interacting factors contribute to juvenile delinquency (Froggio, 2007). These include: developmental issues, psychiatric mental health disorders, anger, criminal victimization, environmental and cultural factors, family dynamics, and verbal and/or physical abuse (Agnew, 2001; 2002; Bonham, 2006; Froggio, 2007). Agnew (1992) explored a number of these factors and their impact on juvenile crime. Through his 'general strain theory', he theorized that specific types of strains such as parental rejection, child abuse and neglect, negative experiences in the school setting and youth homelessness, in conjunction with underlying psychiatric disorders, may trigger aggressive and potentially criminal behavior.

Agnew (1992) hypothesized that disappointment, depression and fear are the emotions most connected to strain, however anger is the most critical emotion in relation to general strain theory. "Anger is a key emotion because the individual believes that others will feel their aggression is justified" (as cited in Froggio, 2007, p. 390). While one individual might feel anger towards a particular strain, others may feel depressed or anxious. The reaction to each strain is entirely subjective and is experienced differently by each individual (Froggio, 2007). Strain can

have an effect on anyone and because each reaction to strain is subjective, it is necessary to acknowledge that clinician's reactions to strain will be different and will likely influence his or her perceptions about how to best work therapeutically with juvenile offenders diagnosed with both conduct disorder and/or other mental health disorders. This is especially relevant today as more than half of juvenile offenders currently in the juvenile justice system are diagnosed with a mental health disorder.

### **Juvenile Offenders and Mental Health Disorders**

Over one million youth enter into the juvenile justice system each year (as cited in Bonham, 2006). When juvenile offenders initially enter into the juvenile justice system, they are evaluated for the purpose of placement (Holt, 2001). The outcome of the initial evaluation determines the type of treatment the juvenile will receive (Holt, 2001). It is reported that fewer than 1 in 5 juvenile offenders receive appropriate mental health services (U.S. Public Health Service, 2001). Thousands of these youth are being held in detention centers waiting for mental health services in the community, thus, making the juvenile justice system the default mental health system for youth who failed to receive mental health services in the community (as cited in Bonham, 2006).

Rates of mental illness among youth committed to the juvenile justice system are significantly higher than the general adolescent population: rates as high as 70% as compared to about 20% (as cited in Bonham, 2006). While the most common diagnosis is conduct disorder, other common diagnoses are substance use, anxiety disorders and mood disorders, such as depression. In addition to psychiatric disorders, many juvenile offenders often have a significant trauma history and increased rates of post-traumatic stress disorder (PTSD) (Ford et al, 2007; SAMHSA, 2012). Researchers at the Substance Abuse and Mental Health Services

Administration (SAMHSA) recently reported that 93% of males and 84% of females in juvenile detention reported exposure to childhood trauma. Furthermore, 11% of males and 15% of females met the diagnostic criteria for PTSD (SAMHSA, 2012).

### **Conduct Disorder**

The primary diagnostic features of conduct disorder include aggression to people and/or animals, destruction of property, deceitfulness or theft, and serious violation of rules (DSM IV-TR). Many boys and girls with CD often lie and/or steal to get what they want. While boys are more likely to engage in overtly illegal activities such as breaking and entering and stealing cars or other personal items, girls often engage in more covert activities such as "shoplifting, using someone else's credit card, or manipulating others into illegal activities" (Calles and Nazeer, 2010, p. 209).

Additionally, the behaviors cause serious impairment in social, academic or occupational functioning (DSM IV-TR). Youth with conduct disorder may "run away and/or skip school, as ways to avoid responsibilities or to just have fun" (Calles and Nazeer, 2010, p. 209). Due to the impulsive and risky nature of the activities that many youth with conduct disorder participate in, many become involved in dangerous activities such as drugs/alcohol, unprotected sex, crime, and may become victims of violence (Calles and Nazeer, 2010, p. 209). In more severe cases where more antisocial personality traits are present, "some youth with CD may lack remorse for harmful behaviors, and may even justify them in their own minds" (Calles and Nazeer, 2010, p. 209). A diagnosis of conduct disorder can be ruled out if the behavior can be explained by context: for example, dysfunctional parenting, association with deviant peers, rejection by others (peers, authority figures), and parental psychopathology (Burke, Loeber, & Birmaher, 2002).

There is considerable research about the comorbidity between conduct disorder (CD) and other psychiatric disorders among adolescents and children (Calles and Nazeer, 2010, p. 209). A longitudinal follow up study of children ages 9-13 found a high comorbidity between major depressive disorder (MDD) and conduct disorder. They found much higher rates for girls (10.6) than boys (0.7). Researchers found that 77.2% of the adults surveyed reported that conduct disorder developed prior to MDD (as cited in Calles and Nazeer, 2010, p. 209). There are similar trends comparing the comorbidity between CD and anxiety disorders and bipolar disorder. In both disorders, the majority of participants revealed that their CD symptoms preceded symptoms of anxiety disorders and bipolar disorders (as cited in Calles and Nazeer, 2010, p. 210). Finally, a previously cited study found that comorbidity with CD and substance use disorders were high for both boys and girls. Similar to anxiety disorders and bipolar disorder, researchers found that CD emerged before signs of substance use disorder (as cited in Calles and Nazeer, 2010, p. 210).

A final psychiatric disorder that often has comorbidity with conduct disorder is attention deficit/hyperactive disorder. Researchers suggest that children diagnosed with both Attention Deficit Hyperactive Disorder (ADHD) and Conduct Disorder are often more resistant to treatment, have poorer outcomes, experience more severe symptoms and have more peer rejection (Jones et al, 2008, p. 381).

Additionally, up to 70% of juvenile offenders meet criteria for ADHD (as cited in V.A De Sanctis et al, 2012, p. 783) and the relationship between childhood ADHD and later criminality is clear, as illustrated in the arrest rates between 39%-57% in ADHD youth (Barkley et al, 2004).

While working with juveniles with conduct disorder, it's important to understand that many often suffer from additional psychiatric disorders and it is necessary to account for that in

determining best course of treatment. Researchers have found that one of the most difficult aspects of treatment with juvenile offenders with conduct disorder is engagement. Despite this difficulty, it is also one of the most necessary aspects (as cited in DiGuiseppe, Linscotte & Jilton, 1996). As a result, many available therapeutic approaches/techniques have been developed to increase successful treatment. The following section will outline the available research on how clinicians have approached the therapeutic alliance, their treatment approach(s) and facilitated successful treatment with these challenging clients.

### **Clinical Work with Juvenile Offenders with Conduct Disorder**

Many juveniles enter into therapy as a result of external pressures from school, the legal system, family, or employers (as cited in Waldron, et al, 2007). While the juvenile justice system is the primary referral source for therapy, one study found that "as few as 20% of adolescents in need of treatment in the past year had been arrested" (as cited in Waldron, et al, 2007). Thus, therapeutic engagement through the juvenile system is remarkably unsuccessful. Furthermore, it has been documented that even when a juvenile is court-ordered to treatment, many still have a limited commitment to change or willingness to actively engage in treatment (as cited in Waldron, et al, 2007). As a result, there is a pervasive belief among clinicians that adolescents are among the most challenging clients to work with therapeutically. Given this belief, it is surprising that "little research investigating their perceptions of the counseling experience have been undertaken" (Everall et al, 2002, p. 79). Consequently, it is difficult to understand from the adolescent's perspective how clinicians might be more successful at therapeutic engagement with juveniles both in the community and in a juvenile justice setting.

There is substantial research that clinicians often have a considerable amount of "therapeutic frustration, confusion, and pessimism" (Salekin, 2002, p., 80) when working with

clients who carry a psychopathy label. There is a widely held belief that these individuals are highly difficult to treat and possibly "immune to treatment" (Salekin, 2002, p. 79). This belief is pervasive and likely undermines any motivation to find effective therapeutic models of treatment for these individuals. While there is considerable research on the impact of a psychopathy label on clinician's beliefs about treatment, there is little to no research on that of conduct disorder; that is, a disorder that is often seen as an early developmental stage to antisocial personality disorder (ASPD); a disorder that often presents with psychopathy symptoms (Olsson, 2009).

These above beliefs about treating psychopathic clients may also be true for clients diagnosed with conduct disorder because of the similarity in symptoms. The following sections will review the literature on how clinician's have established the therapeutic alliance, treatment approach and success with juvenile offenders, specifically with conduct disorder.

### **The Therapeutic Alliance**

Researchers have posited that the therapeutic alliance is an important determining factor in treatment success (Horvath & Symonds, 1991; Sanders, 1999). Two meta-analyses of the therapeutic alliance (Horvath & Luborsky, 1993; Horvath & Symonds, 1991) revealed that the therapeutic alliance begins to develop in the third or fourth session, the alliance is equally indicative of outcome in all theoretical orientations, and the alliance is unrelated to diagnosis. While there is an abundance of research on developing the therapeutic alliance with adults (Horvath & Symonds, 1991, Sanders 1999, Horvath & Luborsky, 1993), there is limited research on adolescents, and even less on juvenile offenders. DiGuiseppe, Linscott & Jilton (1996) define a positive therapeutic alliance with adolescents as:

A contractual, accepting, respectful and warm relationship between a child/adolescent and a therapist for the mutual exploration of, or agreement on, ways that the



child/adolescent may change his or her social, emotional or behavioral functioning for the better, and the mutual exploration of or agreement on procedures and tasks that can accomplish such changes (p. 87).

Other ways researchers and clinicians define the therapeutic alliance are "affective attachment to the therapist, affective bond, mutual positive regard, perceived supportiveness and/or helpfulness from the therapist, feeling allied with the therapist, trust of the therapist, comfort from the therapist, feelings of acceptance and respect by the therapist..." (As cited in Karver and Caporino, 2010, p. 223).

It is well documented that adolescents are often referred to therapy unwillingly; therefore they are difficult to engage in a positive therapeutic alliance (as cited in DiGuseppe, Linscott & Jilton, 1996). There is evidence to suggest that it may be beneficial for the therapist to develop a relationship with the juvenile's caregivers (as cited in Karver and Caporino, 2010, 223).

Additionally, one study found that training clinicians in communication skills in order to better develop the therapeutic relationship lead to improved retention rates and increased youth and parental participation in treatment (as cited in Karver and Caporino, 2010, p. 233).

Additionally, research suggests that therapists should "take time to understand the adolescent's experience and situation before launching into other therapy tasks" (Shirk, Caporino & Karver (2010). Additional factors that have been found to contribute to the development of a positive therapeutic alliance and thus positive treatment outcomes are therapist characteristics such as empathy, warmth, genuineness, and unconditional regard (Wright, Truax, Mitchell, 1972); while confrontation, anger and rejection impede change and a positive therapeutic alliance (as cited in Marshall & Burton, 2010).

## **Treatment Approach and Treatment Success**

Researchers have posited that youth with externalizing disorders such as oppositional defiance disorder and conduct disorder are among the most difficult and most resistant clients to engage in treatment (Steiner & Remsing, 2007). Various evidence-based strategies such as validating the client's feelings and behaviors, collaborating to set goals, orienting the client to treatment processes and his/her role and establishing credibility have been explored by researchers as a way of facilitating successful treatment with oppositional youth (Karver & Caporino, 2010). Additionally, the therapeutic model, motivational interviewing, was developed as a way of approaching clients who are often resistant to entering and engaging in treatment (Miller & Rollnick, 2002).

**Motivational interviewing and stages of change model.** Motivational interviewing is a collaborative therapeutic approach where clinicians help clients evoke their own motivations and resources for behavior change (Miller and Rollnick, 2002). Two key assumptions of motivational interviewing are that clients intrinsically have the motivation and resources within themselves to create change and that ambivalence about change is normal and expected. Clinicians using motivational interviewing work towards beginning client's change process and help clients to become "unstuck". (Miller and Rollnick, 2002).

While motivational interviewing is a way of being with clients, the stages-of-change model can be used in conjunction with motivational interviewing to identify specific clinical interventions that are likely to promote incremental behavior change through a series of stages that include: pre-contemplation, contemplation, preparation, action, maintenance and recurrence. According to Washton and Zweben (2006), it is important to "meet patients where they are" (p. 173) in order to best assist them through these stages. If the clinician uses an intervention in a

stage that is different from where the client is, they may be met with resistance, drop out of treatment, and oppositional behavior.

“Most systems of psychotherapies were designed for self-referred clients in the contemplative or action stages” (Digiuseppe, Linscott & Jilton, 1996, p. 86). As a result of many juvenile offenders not initially “choosing” to attend treatment, many are in the pre-contemplative stage. In this stage, the client “does not perceive their presenting concern as a “problem” and is not yet considering change or is unwilling to change” (Washton and Zweben, 2006, p. 171). As a result of this crucial aspect of psychotherapy with adolescent/juvenile offender, it is often difficult for the therapist to establish therapeutic alliance and to reach agreement on therapeutic goals (Digiuseppe, Linscott & Jilton, 1996, p. 88). Finally, it is well documented that in addition to overall reluctance to engage in treatment, many offenders have trauma histories, which contributes greatly to their resistance (Marshall & Burton, 2010).

**Functional family therapy.** Another treatment model that was developed in the 1970's to work mainly with families with adolescents who exhibit externalizing behaviors such as acting out, stealing, fighting, truancy and assault is functional family therapy (FFT). Many of the families FFT works best with tend to have trauma histories, limited resources, histories of failure and a range of diagnoses ("The Clinical Model", 2012). FFT is widely used with juvenile offenders, specifically those who exhibit behaviors that might indicate a conduct disorder diagnosis. FFT is often a short-term intervention that offers approximately 12 sessions over 3-4 months ("The Clinical Model", 2012). It is a strengths-based model mainly based out of the home and at school that focuses on and assesses the client's risk factors (trauma, poverty, violence, poor communication, etc) and protective factors (good communication within the family, consistent attendance in school, an internal motivation to change, etc). FFT therapists

assess how these factors exist within the family and how they might influence the course of treatment.

There are five major components in FFT therapy: engagement in change, motivation to change, relational/interpersonal assessment, behavior change and generalization ("The Clinical Model", 2012). The components are addressed in the order listed and focus on different aspects of treatment. Until a component is completed, the FFT therapist will not move on. For example, without engagement in change and motivation to change, the FFT therapist would not move on to assessment or planning for change/behavior change ("The Clinical Model", 2012). FFT requires therapists to take a non-judgmental stance and to avoid taking sides with a particular family member. Finally, FFT holds a core belief or attitude of "respectful of difference, culture, ethnicity and family form" ("Since 1972..." 2012).

### **Treatment Success**

Because juvenile offenders with conduct disorder do not all have the same backgrounds, mental health histories or trauma experiences, no one standardized treatment approach is successful with every youthful offender. Despite this, there have been significant recent advances in understanding effective or successful interventions that will address the unique characteristics of each individual and their family. As outlined above, FFT, motivational interviewing and the stages of change have been found to be the main effective interventions with this client population; however, only FFT is an evidence-based model. Additional models, including motivational interviewing and stages of change, require further research about their abilities to specifically address mental health needs among youthful offenders. According to a study reported in a 2004 National Mental Health Association Report,

...Effective programs (for youthful offenders) are highly structured, intensive, emphasize social skill development and focus on behavior change, attitude adjustment and rethinking perceptions in order to reduce risk factors for juvenile justice involvement (p. 7).

Additionally, models are often considered to be effective with this population if they reduce recidivism rates and defer youthful offenders from further juvenile justice involvement (National Mental Health Association, 2004, p. 1).

FFT, as described earlier, is a short-term, family-centered, strengths based intervention for at-risk youth who's presenting concerns may include delinquency, violence, substance use, conduct disorder, and other externalizing disorders (FFT.inc, 2012). Researchers indicate that the FFT model is effective at reducing recidivism rates and reducing youth's further involvement in the juvenile justice system, as outlined below:

The one year re-arrest rate was about 25 percent for youth who participated in FFT; for youth who either had no treatment, eclectic treatment or were seen in juvenile court, the re-arrest rates ranged from 45%-70%. A five year follow-up study found that less than 10 percent of youth who participated in FFT had a subsequent arrest, as compared to almost 60 percent of youth who were seen in juvenile court (NMHA, 2004, p. 5).

Each model measures success in different ways and therefore not all are evidence based and/or diligent at measuring their success outcomes. However, in general, therapeutic models often define success for youthful offenders as reducing recidivism and re-arrest rates.

### **Summary**

More than half of the adolescents involved in the juvenile justice system today suffer from a mental health disorder (Grisso, 2008; Hammond, 2007; Shufelt & Cocozza, 2006).

Conduct disorder is the most common diagnosis given to these youth, followed by substance use, anxiety disorder and mood disorder (Shufelt & Cocozza, 2006). The primary diagnostic features of conduct disorder include aggression, destruction of property, deceitfulness or theft, and serious violation of rules (4<sup>th</sup> ed., text rev.; DSM-IV-TR; American Psychiatric Association). While many mental health disorders carry a concern about recidivism, further delinquency, adult criminality and adult mental illness, researchers have observed that this concern among clinicians is considerably increased for juvenile offenders diagnosed with conduct disorder (as cited in Rocket et al, 2007).

It is well documented that it is difficult to engage juvenile offenders in treatment. This is in part because of the forced nature of their participation (DiGuiseppe, Linscott & Jilton, 1996) and also their likely trauma history (Marshall & Burton, 2010). Evidence-based models such as motivational interviewing and the stages of change models were developed as ways of engaging resistant clients. Additional contributing factors include therapist traits such as empathy, warmth, genuineness and unconditional regard (Wright, Truax, Mitchell, 1972), while confrontation, anger and rejection impede engagement and change (As cited in Marshall & Burton. 2010). The above review of literature illustrated the importance of examining how clinicians navigate the therapeutic alliance, treatment approach, and treatment success with juvenile offenders diagnosed with conduct disorder.

## **CHAPTER III**

### **Methodology**

The purpose of this study was to explore the ways clinicians navigate the therapeutic alliance, treatment approach, and have treatment success with juvenile offenders diagnosed with conduct disorder. Data was collected through in person interviews with clinicians who work within a juvenile justice setting in Colorado. The qualitative design was chosen because previous studies on this topic all utilized a quantitative vignette format, therefore, a qualitative design would fill a necessary gap in order to allow participants to illustrate more freely and in more detail how they develop therapeutic alliance, their treatment approach, and have treatment success with these clients.

#### **Criteria for Selection of Participants**

The inclusion criteria for the participants I wanted in my sample were: 1) that they were mental health clinicians with at least a Master's degree in any clinical field working in Colorado; 2) that they have six or more months of experience working with juvenile offenders with a conduct disorder diagnosis; and 3) they all had to have a current or recent caseload of juvenile offenders diagnosed with conduct disorder (*See appendix A*). They did not have to have any specific affiliation with one agency or institution, only that they worked with juvenile offenders in the Boulder-Denver area in Colorado. In addition, there was no desired race or ethnic group, gender or age range. The sample size desired was 12 participants. As this project was exploratory and the focus was on obtaining a sufficient number of participants through snowball sampling

techniques, I did not have the opportunity to recruit for diversity. However, no participant was excluded based on race, gender or ethnicity.

### **The Recruitment Process**

The Human Subjects Review Board of Smith College School approved this study (*Appendix A*). The study utilized non-probability purposive convenience snowball sampling. The recruitment process began by contacting a clinician with whom this researcher spoke about the feasibility of reaching the desired number of participants for this study. She is a mental health clinician practicing in Boulder, Colorado who works with juvenile offenders; many of whom are diagnosed with conduct disorder. She met all inclusion criteria and was willing to give me names of potential participants to start the snowball sampling process. Once I obtained the names and contact information of the first three potential participants, I contacted them by email, explained who I was, why I was contacting them and asked three screening questions (*Appendix B*): were they practicing mental health clinicians with at least a Master's degree in any clinical field working in Colorado, have they had six or more months of experience working with juvenile offenders diagnosed with conduct disorder and whether they had a current or recent caseload of juvenile offenders diagnosed with conduct disorder. Finally, I asked if they would be willing to participate in my study. If they met inclusion criteria and were willing, I set up a time to interview them in person. If they did not meet inclusion criteria, I thanked them for their time and assured them that any identifiable information would be kept confidential. After every interview and until I reached the desired sample size, I asked each participant for a few names of other potential participants.



Before the sample size of 12 was reached, I contacted fifteen potential participants. Of the fifteen, thirteen met inclusion criteria, two did not. One potential participant who met criteria chose not to participate.

### **The Nature of Participation**

Participation involved reading and signing the consent form, filling out a brief five-minute demographic data questionnaire, and participating in an in-person interview for approximately one hour.

### **Informed Consent Procedure**

Informed consent was obtained before starting the interview. I brought the informed consent form (*Appendix C*) to the interview and gave participants time in the beginning to read it over, ask clarifying questions, and sign it if they were willing to participate in the study.

### **The Voluntary Nature of Participation**

All participation in this study was voluntary and participants were allowed to refuse to answer any question. All participants were able to withdraw from the study if they wished to do so. They were able to contact this researcher who removed and destroyed all materials related to them. They were not able to withdraw after March 1, 2013. This was explained in the informed consent and they were made aware of this fact prior to participating in the study. No participants decided to withdraw.

### **Data Collection**

Data was collected through a written demographic data questionnaire (*Appendix D*) and in person interviews using an interview guide (*Appendix E*) that was completed in the first five minutes of the interview. Interviews were held at either their private office or if they didn't have a private office, I reserved a private room at the local public library in Boulder, Colorado or a

private conference room at their place of employment. All interviews lasted about one hour and were tape recorded on an Olympus Digital Voice Recorder that allowed them to be inputted into the computer and subsequently transcribed for accuracy.

### **Instrument Used for Data Collection**

The instrument I used for data collection was an Interview Guide I developed based on my review of literature. Since this was a new, untested instrument, I did a pilot test to make sure that it worked correctly. In the pilot test, I met with a mental health clinician for forty-five minutes who met criteria for this study, but was not a participant. I asked her the questions off of the interview guide and recorded our conversation. This served two purposes: to see if any questions were unclear or unnecessary and to make sure the recording device worked properly. The device worked perfectly and no changes were made to the interview guide.

In the final form, this instrument consisted of five parts: The first part - a structured questionnaire to collect demographic data – asked participants to answer ten questions about their gender, age, race, education, employment and experience. Participants were asked to either: circle one, circle all that applied, or fill in the blank depending on the question. The follow four parts of the interview guide consisted of unstructured, open-ended questions. I first asked participants three warm up questions about their current caseload, the background of juvenile offenders diagnosed with conduct disorder on their caseload and in general, the range of offenses these clients often commit. Next, there were five questions that asked participants how they establish therapeutic alliance with juvenile offenders, how they define a positive therapeutic alliance, how they would describe the nature of their relationship with these clients and if they thought factors like age/gender/background/generation/societal attitudes impacted the development of a positive therapeutic alliance.

The last five questions asked participants what treatment models/skills/techniques they use to engage juvenile offenders with conduct disorder in treatment, how they define successful treatment for these clients, how often they see successful treatment with these clients, what gives them hope/makes them worry about these client's ability to have successes in their treatment and what the future holds for many of these clients. The very last question of the interview asked if participants had any final thoughts about working with these clients.

### **Data Analysis**

Before inputting the tape recorded interviews into the computer and subsequently transcribing them for accuracy, all names were removed from the participant's responses and replaced with code numbers that are kept separate from all data in a locked/secured location. I transcribed six interviews and a transcriber transcribed six interviews. The transcriber signed a confidentiality agreement (*Appendix F*). Since the demographic data form was structured into categories and there were only twelve participants, I counted the numbers in each category.

After all transcriptions were complete, the descriptive data from the four parts of the interview guide were analyzed manually through thematic coding and looking for patterns amongst responses. The responses in each of the transcripts were grouped in relation to each interview question and then placed in categories based on the occurrence of emerging themes and phrases. The themes came directly from the interview questions. The findings of this study are presented in the following chapter.

## **CHAPTER IV**

### **Findings**

The purpose of this study was to explore the ways clinicians navigate the therapeutic alliance, treatment approach, and have treatment success with juvenile offenders diagnosed with conduct disorder. This chapter provides a detailed description of the findings of this study.

#### **Characteristics of Participants**

There were twelve participants in this study (n=12), nine females and three males. Out of the twelve participants, four were between the ages of 23-33, six were between the ages of 34-41, one was between the ages of 42-49 and one was older than 49 years. All participants identified as Caucasian/White. Eight participants identified their highest degree to be a Master's of Social Work (MSW) and four identified their highest degree to be a Master's of Counseling and Psychology (MA). All twelve participants identified their current employer as a community mental health center. Out of the twelve participants: five were outpatient therapists, three were FFT therapists, one was a partnership assessment coordinator and three were intensive home-based therapists. The majority of participants (six) have worked at their current place of employment for six or more years. Three have worked there for six months-2 years and three have worked there for 2-5 years. The majority of participants (eight) have worked with juvenile offenders diagnosed with conduct disorder for six or more years. Three have worked with the population for 2-5 years and one has worked with the population for six months-2 years. The majority of participants (seven) have a current caseload of 0-10 clients at any time. Four have a

caseload of 11-20 clients and one has a caseload of 21-30 clients. No participants had caseloads larger than 30 participants.

In summary, the 12 participants (9 females, 3 males) identified as white/Caucasian, most were between the ages of 23 and 41, with Master's degree in either Social work or Counseling and Psychology, working in out-patient settings for 6 or more years, carrying a caseload of 10-20 clients at a time.

### **Characteristics of the Clients**

The majority of participants described having disproportionately more male than female juvenile offenders diagnosed with conduct disorder on their caseload. They also described the vast majority of these clients to identify as Caucasian and to come from lower socioeconomic status. Additionally, the majority mentioned that most of these clients come from impoverished, often divorce or single-family homes, and some live in foster care or with relatives. Finally, many clients have entrenched family histories of trauma, domestic violence, attachment difficulties, drug or gang involvement, and often come from environments where they are unable to establish trust in others and see the world as a dangerous place.

Participants presented a range of offenses that juvenile offenders diagnosed with conduct disorder often commit. These include: driving without a license, sexual assault, distribution, probation violations, minor in possession, truancy, first degree assaults, stealing cars, breaking and entering, gang involvement, drug involvement, physical fighting or other physical disruptions.

In summary, the clients (juvenile offenders diagnosed with conduct disorder) seen by my participants were Caucasian, mostly males between the ages of 12-17, who came from impoverished, sometimes single parent homes with significant history of entrenched family

histories of trauma, neglect, abuse, domestic violence, drug or gang involvement, and attachment difficulties. They had committed offenses such as driving without a license, sexual assault, distribution, probation violations, minor in possession, truancy, first degree assaults, stealing cars, breaking and entering, gang involvement, drug involvement, physical fighting or other physical disruptions.

### **Therapeutic Alliance**

There were many common themes when participants described the nature of their alliance or relationship with juvenile offenders. Most relayed that while it depends on the client and the situation, it is often very challenging to develop a relationship with these clients, mostly because many come from environments where they are not able to trust others, mainly adults, and often have a history of attachment difficulties. Despite it being difficult to develop relationships, most also said they have had many successes developing positive alliances with these clients, despite it often being quite superficial until some level of trust and attachment to the therapist is established. One participant stated: "In general, I find that I'm able to build pretty good alliances with these young people. Although I do have to say a lot of it tends to be pretty surface until you can spend a substantial amount of time with them..."

Additionally, many identified these clients to be stand off-ish, guarded and often experience a huge amount of "push-back" when the therapist attempts to develop a deeper relationship before they are ready or if the client senses the therapist is trying to force their own agenda on the relationship. Despite these challenges, many therapists also identified the therapeutic alliance to be playful and fun once you get past the tough guy or girl façade. When participants thought of a few clients with whom they felt they had a strong positive alliance with, there were a number of common themes. Many described the relationship having a

lot of trust, mutual respect, empathy, and one that is open, honest and where the therapist and client are able hold each other accountable. Many also identified strong relationships to be one where they allowed the client to be the expert on their own lives and when the client is willing to be vulnerable. In response to this question, one participant stated, "I think that trust is the biggest thing, that they trust me enough to be vulnerable..."

When the participants were asked about their general style/how they developed a positive therapeutic alliance, many themes emerged. Many participants described being strong advocates for their clients and being open, honest and gentle with them while also pointing out disparities in their thinking and pushing them to look at what is underneath their behaviors. Many also described being respectful, treating their clients with dignity, using humor, being curious, and developing a mutual understanding that they are going to work together in the therapy process. One participant stated that they try to be:

...a really strong advocate for the client. I'm very open and honest with the kids and so when I tell them I'm going to call them on their stuff I do. I expect them to do the same with me. So there's a reciprocal nature of the relationship. I see them as the experts on themselves, it's not me. So I think it's being respectful of them, treating them with dignity.

Additionally, most of the participants described being consistent, always showing up and being reliable as one of the main techniques to developing a positive therapeutic alliance. Finally, a salient theme was matching the clients where they are at: including language, speech, volume, emotions, and bringing up their differences and using it as a way of connecting with their clients and their families.

When participants were asked how they would define a positive therapeutic relationship, many themes became apparent. All participants mentioned empathy, trust and mutual respect as critical characteristics of a positive relationship. Many also discussed a relationship where there is a lot of consistency and the therapist continues to show up, both emotionally and physically, for the client. Most participants also mentioned clear, safe, and secure boundaries as a necessary aspect of the relationship. Finally, many participants also mentioned a positive relationship as one that feels open and honest with clear expectations of what is expected for both client and therapist.

Many themes emerged when participants were asked what themes hinder a positive therapeutic relationship. Most participants mentioned a lack of trust, lack of safety, no consistency, judgment, lack of clear boundaries and naming the client's experience as the most harmful factors to a positive therapeutic relationship. One participant stated what they think hinders a positive alliance is "taking a one up kind of position, assuming they're bad kids...not being respectful, having your own agenda and being punitive." An additional hindrance mentioned is when the therapist acts like they are the 'professional' on the client's life and doesn't work through or recognize his or her own counter transference. Finally, participants mentioned when the parents or caregivers are struggling with significant issues like: substance use, gang involvement, drug involvement or severe mental illness, it can interfere with the therapists' ability to create a positive therapeutic alliance.

The final aspect of therapeutic alliance that was explored with participants is if they believed factors such as age, gender, socioeconomic status, societal attitudes, or generation interfered with the therapeutic relationship. Most participants mentioned that they always bring up cultural differences with clients and take a 'one down' approach. For example, many



participant said they ask clients from different cultures a lot of questions about how their cultural differences might impact their work together and how can they be respectful if they went to their homes or their perspectives on healing and therapy. Many participants also mentioned stigma as another influential factor. In particular, adolescent boys were more likely to be influenced by the stigma of receiving therapy. The most common affect of the stigma is adolescent boys not being consistent in their attendance, therefore making it difficult to establish a positive therapeutic relationship. Finally, most participants believed that if there were two therapists from different cultures who had similar levels of cultural competency, a therapist from the client's same background might be a better match for the client.

### **Treatment Approach and Success**

When participants were asked about the models, skills, and techniques they find to be the most effective at engaging conduct disordered juvenile offenders in treatment, many salient themes emerged. All participants mentioned using motivational interviewing in the early stages of engagement. One participant said:

I think motivational interviewing is really, really helpful with the conduct disordered youth. It just, you know, takes away that judgment, it takes away my agenda. It really puts them in the position of being the expert of knowing what is best...it lowers all those defenses. I think that's probably the best that I've found.

Many also mentioned using functional family therapy with these clients. Most participants also mentioned that if clients have a trauma history and a positive working alliance has been established, they find trauma-focused cognitive behavioral therapy to be a helpful intervention. Many participants also mentioned using attachment-based therapy like attachment-focused family therapy because they identified many of these clients to struggle with attachment-based

issues. Additionally, some participants said they use dialectical behavior therapy with clients who have a hard time regulating their emotions and have poor interpersonal skills. Finally, skills they identified were empathy, curiosity, patience, acceptance and playfulness.

There were a number of ways that the participants defined successful treatments with juvenile offenders diagnosed with conduct disorder, but there were a few main themes throughout. All participants reported looking at the small successes in the day-to-day treatment rather than whether these clients fully completed their treatment goals. For example, if a client is able to have more awareness of what motivates, or is underneath their behaviors or have some self-efficacy around stopping themselves from doing a behavior that is considered success. One participant described how she defines success as:

I would say that to me, success in treatment means that kids have more awareness of what motivates their behaviors, what's *underneath* the behaviors. What kind of early attachment or early events have influenced this behavior today...so if there's some greater awareness.

Additionally, success includes a decrease in risk factors and disruptive behaviors, and an increase in protective factors. With their perspective definitions of success, most participants reported seeing these small successes all the time. In terms of the larger successes like graduating high school or completing treatment goals, many participants agreed that that was really rare. Finally, the participants who only used functional family therapy and not the other modalities with these clients, all reported seeing a lot of successful completion of treatment and that their drop out rate was really low. When one FFT participant was asked how often she sees successful completion of treatment with this population, she responded:

Very often. We have national standards that FFT should have less than 20% drop out. To be honest, if we can get kids in these services, it's successful. If we can, you know, not over service these kids, and to get the FFT upfront and they are the only service provider, we have incredibly successful outcomes. We are getting kids out of the juvenile justice system, we are reducing the frequency and intensity, duration of the referral behavior and we're also having an effect on siblings, families. So lot's of successful completion.

This was not a theme among participants who did not use the functional family therapy model.

When one participant who does not use FFT was asked the same question, he laughed and responded: "Not often."

When participants were asked what about the client gives them hope and what makes them worry, many salient themes emerged. Overall, what gave most participants hope is parents or caregivers who were supportive, loving, consistent and able to set clear boundaries with their children. Additional factors that gave most participants hope is the client's ability to be vulnerable, engaged in treatment, and willing to explore what is underneath their behaviors. Finally, most participants expressed the belief that all clients have something that will give the therapist hope and their job is to find it. What makes most participants worry is when these clients believe they are 'bad kids' and they are reinforced in these beliefs by school, their parents, and the juvenile justice system. Other worries that were common among participants were if there is no attachment between parent and client, if the client has poor impulse control, poor ability to tolerate distress, inability to regulate emotions or if there is the presence of anti-social personality traits like callousness or lack of empathy.

Many themes emerged when participants were asked what they thought the future holds for conduct disordered juvenile offenders, and what it depended on. Many participants believed

that the future is rather bleak, given the fact that the majority of these clients have quite severe attachment and/or trauma histories. As a result, they may have difficulties forming trusting relationships with others. Many also felt concerned about the overrepresentation of youth of color in the juvenile justice system and that they might not have enough opportunities for employment and education when they get out of the juvenile justice system.

Many participants noted feeling more hopeful if these clients are able to form some sort of attachment relationship with either parents or other important people in their lives. This could be a teacher, an older sibling, a mentor or a coach and if they and/or they're families are able to connect with some sort of services. Finally, many participants reported feeling more optimistic about these client's futures if they are able to get out of the juvenile justice system and become involved with peers who will be pro-social peers who will be able to reinforce positive behavior.

Most participants also believed that we have come a long way in our clinical work with these clients and have hope that it will continue. Many cited evidence based programs such as functional family therapy as the direction we should be headed in terms of developing more effective treatment for these clients. Most reported that in order for these clients to have hopeful and bright futures, it depends on collaboration between agencies and the county being willing to give these kids a chance and see them in a different light rather than just 'bad kids'. A final theme that emerged is the ability to provide early intervention, prevention, and the right services at the right time.

### **Other Thoughts**

When participants were asked if they had any further thoughts or anything else they would like to share about their clinical work with conduct disordered juvenile offenders, several salient themes emerged. Many participants mentioned feeling uncertain about the actual Conduct

Disorder diagnosis because clients get labeled as 'bad kids' and therefore their community and society as a whole will likely treat them differently. Additional concerns about the diagnosis were that it isn't an accurate portrayal of what is going on with the client and that there is likely undiagnosed post-traumatic stress disorder, major depressive disorder or other serious diagnoses underneath the acting out behaviors associated with conduct disorder. Finally, most participants expressed that despite the common belief that conduct disorder turns into antisocial personality disorder, they have seen very few clients that they thought truly would develop an antisocial personality disorder.

### **Summary**

Many salient themes emerged among the twelve participants in this study. Most participants believed that while it is very challenging to establish a positive therapeutic alliance with conduct disordered juvenile offenders, often because of their often lack of trust, "tough guy/girl" attitudes, and often insecure attachment histories, they find the work to be very enjoyable. In terms of developing a positive therapeutic alliance, many participants mentioned using empathy, curiosity, trust, developing mutual respect, being consistent and setting clear, safe boundaries. Additionally, many participants reported finding it helpful to allow the client to be in control and be the expert on their own lives, rather than the therapist. Finally, participants identified a number of hindrances to developing a positive therapeutic alliance. These included: being judgmental, lack of trust, lack of mutual respect, telling the client what to do, not setting clear, safe boundaries and the therapist acting as the expert on the client's life.

Most participants agreed that in defining successful treatment for juvenile offenders, therapists have to look at the smaller, day-to-day successes rather than the larger picture successes like graduating high school or completing treatment goals. If they defined it as such,

most participants reported seeing success all the time. Additional definitions included reducing risk factors/increasing protective factors, decreasing the referral behavior and increasing the client's ability to see what is underneath their behaviors. Additionally, the therapists who practiced functional family therapy appeared to see more successful completion of treatment than therapists who practiced other models. While most participants believed that the future was rather bleak for these clients, they had more hope if the client was able to make some connections about why they do a particular behavior or had some attachment with a caregiver, parent, older sibling, or other positive, influential person in their lives. Additionally, many participants expressed more hope for these clients if they are able to get out of the juvenile justice system.

Finally, most participants expressed doubts about the actual diagnosis of conduct disorder. Many believed that often, there are many underlying issues for these clients that are presenting like conduct disorder so the concern was that we are treating the diagnosis rather than the behaviors. Despite these concerns, all participants believed that we are moving in the right direction in terms of researching best practices and have a lot of hope for future collaboration and early prevention to best support these challenging clients.

## **CHAPTER V**

### **Discussion**

This study explored clinicians' therapeutic alliance, treatment approach, and success with juvenile offenders diagnosed with conduct disorder. This chapter describes the implications of this study's findings and presents possible directions for ongoing and related research.

#### **Summary of Findings and Discussion**

The findings in this study primarily confirm those of previous ones that have examined how therapists develop positive therapeutic alliance with conduct disordered juvenile offenders. In particular, the current study found that: all participants discussed the struggle establishing a positive therapeutic alliance with conduct disordered juvenile offenders, and generally explained this challenge in light of their clients' lack of trust and insecure attachment histories. This confirms previous research on this subject (cited in DiGuiseppe, Linscott & Jilton, 1996). Secondly, participants in this study cited the importance of empathy, trust, developing mutual respect, being consistent, allowing the client to be the expert on their own lives and setting clear boundaries as important factors in developing a positive therapeutic alliance. Other researchers also confirmed these findings (Wright, Truax, Mitchell, 1972). Finally, this study confirmed prior research on clinicians' perceptions of barriers to a positive therapeutic alliance with these clients (cited in Marshall & Burton, 2010). These include: being too judgmental, lack of trust, unsafe boundaries, confrontation and anger.

In addition to corroborating prior research findings on developing a positive therapeutic alliance, this study primarily confirms previous findings on how to successfully engage these

clients in treatment and have treatment success. Four findings in particular confirmed previous research. First, participants reported mainly using motivational interviewing as a way of successfully engaging these clients. This confirms previous research on the effectiveness of motivational interviewing (Burke, Arowitz, Menchola, 2009). Secondly, participants in this study defined successful treatment as reducing risk factors, reducing re-arrest rates, emphasizing skill development and behavior change. Research conducted by the National Mental Health Association (2004) also defined treatment success in this way. Thirdly, this study confirms prior research (FFTinc.com, 2012) that Functional Family Therapy (FFT) therapists have high success rates and successful completion of treatment. Finally, this study confirms prior research (cited in Calles and Nazeer, 2010, p. 209; Jones et al, 2008, p. 381) that conduct disordered youth often have a number of other underlying psychiatric issues and could be given other diagnoses such as PTSD, anxiety, ADD and depression rather than Conduct Disorder.

One finding from this study that has not been previously reported is that despite the challenges in establishing a positive alliance with their clients, most of the clinicians in this current study find the work to be enjoyable. In fact, many describe clients with conduct disorder as among their favorite populations to work with. In contrast, most prior research found that clinicians working with this population often have a sense of "therapeutic frustration, confusion, and pessimism" (Salekin, 2002, p., 80). There are a few possible reasons why this finding contradicts previous literature. One might be because the county in which all participants work might focus more on support and better training for working with these difficult clients than other counties/states, and are therefore are better prepared for the difficult work. Another might be because the literature found on this topic is relatively old and times are different now than when most of the research on this subject was conducted. Therapists today may have better



training and support and greater understanding of and hope for clients with conduct disorder. If this is the case, more research needs to be done in this area to reflect these changes.

In addition to confirming previous findings on therapeutic alliance, treatment approach and success, there were four findings that, as far as I know, are not addressed in prior research. Participants in this study defined successful treatment as focusing on the day-to-day successes rather than "big picture" successes. In addition, participants who practiced FFT appeared to have more hope that these clients will have success in treatment than participants who did not. Moreover, most participants in this study were concerned that we are just treating the diagnosis rather than the behaviors or underlying issues that are often present, therefore using wrong interventions for these clients. Finally, participants in this study all felt that future collaboration and early prevention was necessary in order to best support these clients. These findings all reflect a shifting view for working with these clients that looks at the reasons underneath their behaviors as explanations for why they are acting out, rather than just seeing these clients as "bad kids" and can certainly explain the optimism of these study participants. It is possible these areas have not been previously reported because they are relatively new and the county all the study participants are practicing in is quite progressive. As far as I know, none of the above has been previously reported or discussed and as such, are all possible areas for further research.

### **Limitations of this Study**

The limitations in this study were: the sample was small, non-random, and self-selected. They all identified as Caucasian, the majority (nine) were women and only three were men, there were only twelve total participants, all participants identified their current place of employment to be a community mental health center in the same county. In addition, the instrument used for data collection, an Interview Guide developed by me, was not tested for validity and reliability.

The interviews were one-time only and the length of the interview with each participant was limited to about one hour. It is possible that with a different instrument and longer interviews, additional details might have emerged.

Due to the above limitations, it is not possible to generalize these findings to the greater clinician population in Colorado.

### **Implications for Social Work Practice**

The findings from this study present a number of implications for social work practice. In particular, they highlight the need for increased trainings for clinicians to promote more accurate diagnosis and more successful treatment for conduct-disordered youth. Most participants in this study reported that they enjoy their work with these difficult clients, have the skills and confidence to form positive therapeutic alliances and use therapeutic modalities that are known to be effective. However, comparing this study's findings to the literature on this subject, the participants in this study do not appear to agree with the overall negative perspective about working with these clients. It is possible that with more training on evidence based practices and awareness about how these client's difficult and often traumatic backgrounds are connected to their current acting out behaviors, there may be a shift towards a more positive or hopeful view about working with this difficult population. One could speculate that this optimism itself may lead to better outcomes.

Additionally, I found that the majority of participants agreed that increased collaboration and coordination between clinicians and other providers such as: schools, social services and the juvenile justice system are necessary to provide the best possible care for these clients. This might include advocating for increased funding on the policy level to bring in trainings or bring

more social workers into the schools or the juvenile justice system. This may also contribute to reducing the "bad kid" stigma and negative perspective about working with these clients.

### **Recommendations for Further Research**

There are a number of areas for further research. In order to generalize the findings from this study, it would be important to conduct a similar study on a larger scale with mixed methods: both survey format and interviews. It would be important to have a greater sample size and more diversity among participants in order to have a better idea of how these findings translate nationally.

Additionally, an intriguing finding that should be explored further is whether therapists who use the FFT model have higher job satisfaction, more optimism for their client's treatment success and have lower burn out rates when compared to therapists who use other models with juvenile offenders diagnosed with conduct disorder. Since the sample size for this study was so small, it is difficult to generalize this interesting finding. Therefore, a larger, mixed methods approach would be more successful at obtaining these findings.

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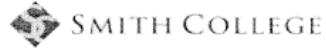


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## Appendix A

### Human Subjects Review Board Approval Letter



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 2, 2013

Nina Kramer-Feldman

Dear Nina,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett' followed by a flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Vice Chair, Human Subjects Review Committee

CC: Krishna Samantrai, Research Advisor

## **Appendix B**

### **Screening Questions**

1. Are you a practicing mental health clinician in the Boulder-Denver area in Colorado?
2. Have you worked clinically with juvenile offenders for more than six months?
3. Do juvenile offenders diagnosed with conduct disorder make up a significant portion of your caseload?

## Appendix C

### Consent Form

Dear Participant,

My name is Nina Kramer-Feldman and I am a second year graduate student at Smith College School for Social Work. I am conducting research to investigate the ways clinicians navigate the therapeutic alliance, treatment approach and treatment success with juvenile offenders diagnosed with conduct disorder. This study will be presented as a thesis and may be used in future presentations, publications or dissertations.

I am asking you to participate in an approximately forty-five minute in-person interview to discuss the ways you navigate the therapeutic alliance, treatment approach and success with juvenile offenders diagnosed with conduct disorder. Clinicians currently practicing in Colorado who have six or more months of clinical experience working with juvenile offenders with conduct disorder will be included in this study. Following your participation, I will transcribe your interview, and look for salient themes.

There are minimal risks associated with this study, although it may bring up some feelings positive and/or negative about your current or past treatment successes and failures with juvenile offenders with conduct disorder. The benefit of participating in this study is that your comments will contribute to the limited knowledge about best practices and successful treatment for juvenile offenders diagnosed with conduct disorder. Additionally, your participation in this study will hopefully inform clinical trainings and practical skills for clinicians on how to best engage and successfully work with this difficult population. Compensation will not be provided for participating in this study.

Your confidentiality will be carefully maintained to the extent possible in this study. You will be assigned a number that will stay with your responses. The list of names and numbers will be kept separate from all data. Should a transcriber other than myself transcribe the tapes, they will sign a confidentiality pledge. In publications or presentations, the data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised. All data (notes, tapes, transcripts, surveys) will be kept in a secure location for a period of three years as required by Federal guidelines. Should I need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed. Finally, I strongly caution you to not identify any of your clients in the interview process.

Participation in this study is voluntary. You may withdraw from the study anytime during the data collection process and you may refuse to answer any question. If you would like to withdraw, you can contact this researcher by email at \_\_\_\_\_ up till March 1, 2013. All materials pertaining to you will be immediately destroyed should you choose to withdraw. If you have any concerns about your rights or about any aspect of this study, I encourage you to call Nina Kramer-Feldman at (\_\_\_\_) \_\_\_\_\_ or by email at [xxxxx@smith.edu](mailto:xxxxx@smith.edu) or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your participation.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher

**\*\*Please keep a copy of this form for your records\*\***

## Appendix D

### Demographic Questionnaire

Thank you again for agreeing to participate in this study. Please fill out this survey prior to the in-person interview.

**1. Gender (circle one)**

- a. Male
- b. Female
- c. Other \_\_\_\_\_

**2. Age range (circle one)**

- a. 23-33
- b. 34-41
- c. 42-49
- d. 49 and above

**3. Race (Circle all that apply)**

- a. White/Caucasian
- b. Black/African American
- c. Asian
- d. Latino/Hispanic
- e. American Indian/Native American
- f. Pacific Islander
- g. Other: \_\_\_\_\_

**4. Circle your highest degree completed:**

- a. Graduate degree
  - i. Please indicate your degree/area/year of graduation:
  
- b. Post-Graduate Degree
  - i. Please indicate your degree/area/year of graduation:

**5. Where are you currently employed?**

**6. What is your current position title?**

**7. Number of years worked at current employment?**

- a. 6 months - 2 years
- b. 2-5 years
- c. 6 or more years

**8. Number of years clinically working with juvenile offenders?**

- a. 6 months – 2 years
- b. 2-5 years
- c. 6 or more years

**9. Number of years working with juvenile offenders with conduct disorder?**

- a. 6 months-2 years
- b. 2-5
- c. 6 or more years

**10. Approximately, how many total clients do you have on your caseload at any time?**

- a. 0-10
- b. 11-20
- c. 21-30
- d. 31 or more

**Thank you.**



## Appendix E

### Interview Guide

#### **Warm-up Questions:**

1. About how many of the juvenile offenders that you currently work with have a diagnosis of conduct disorder?
2. Please briefly describe the background of the juvenile offenders diagnosed with conduct disorder on your caseload (age, race/ethnic background, living situation).
3. In general, what is the range of offenses that the juveniles diagnosed w/conduct disorder have generally committed?

#### **Questions about Therapeutic Alliance:**

**Lead Question:** Given that it is generally difficult to establish a therapeutic alliance with kids this age, it must be harder with juvenile offenders, and even more difficult with juvenile offenders who have a diagnosis of conduct disorder. So my question is:

1. How do you do it? What is your general style?
2. How do you define a positive relationship?
3. In your work with these clients, what factors do you think create or hinder a positive working relationship?
4. **Last question about alliance:** In general, how would you describe the nature of your relationship/alliance with these clients?
5. **Follow up question if needed:** Do you think factors like age/gender/background/generation and societal attitudes such as stigma influence your therapeutic relationship? If so, how?

#### **Questions about Treatment Approach and Success:**

**Lead Question:** Given this nature of your relationship:

1. What is your treatment approach?
2. Why this approach, rather than any other?

3. What is your goal, using this approach?

***Other questions:***

4. What treatment models/strategies/skills/techniques have you found to be most effective at engaging juvenile offenders with conduct disorder in treatment?

5. What are the ways you define successful treatment for juvenile offenders with conduct disorder?

6. How often do juvenile offenders with conduct disorder successfully complete treatment?

7. What have you noticed create your own feelings of hope/hopelessness for a successful treatment completion with juveniles with conduct disorder?

8. In your opinion, what does the future hold for many juveniles with a CD diagnosis? What does it depend on?

9. ***Last Question (ending the interview):*** Is there anything else you can tell me about working with juvenile offenders in general, and juvenile offenders with a diagnosis of Conduct Disorder?

## Appendix F

### Professional Transcriber's Assurance of Research Confidentiality

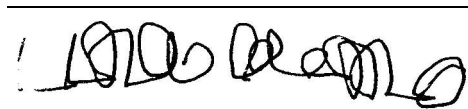
This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Nina Kramer-Feldman, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

#### PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Nina Kramer-Feldman, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

---



Linda Adams

Signature

Transcriber

Date

March 15, 2013

Nina Kramer-Feldman

Researcher

March 15, 2013

Date