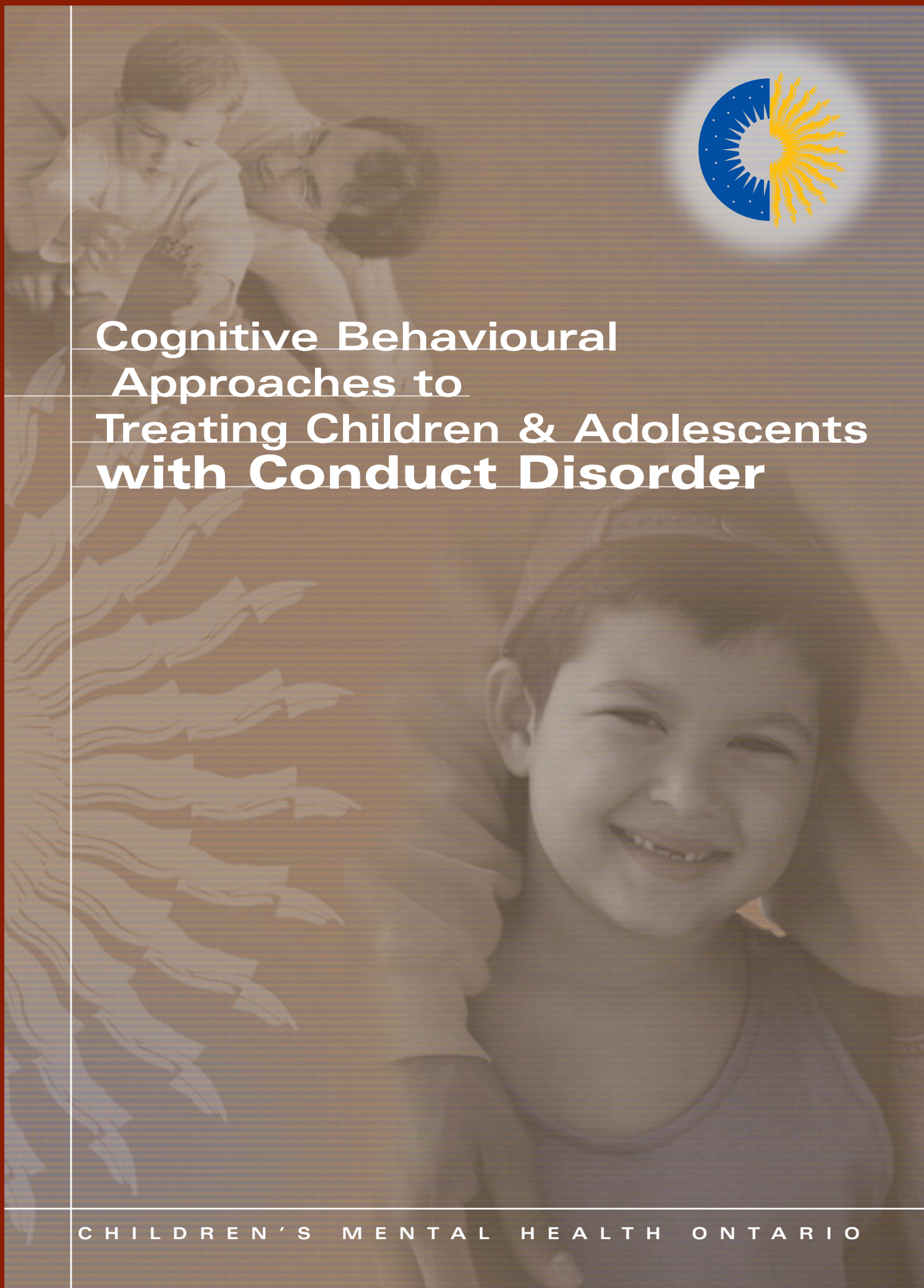


Cognitive Behavioural Approaches to Treating Children & Adolescents with Conduct Disorder

CHILDREN'S MENTAL HEALTH ONTARIO

Cognitive Behavioural Approaches to Treating Children & Adolescents with Conduct Disorder

Linda L.Baker, Ph.D., C.Psych.

Karen Scarth, Ph.D., C.Psych.

CHILDREN'S MENTAL HEALTH ONTARIO

Authors: Linda L. Baker, Ph.D., C.Psych.,
Centre for Children & Families in
the Justice System

Karen Scarth, Ph.D., C.Psych.,
Private Practice

Children's Mental Health Ontario

Table of Contents

INTRODUCTION

The goal of this manual is to help you understand Cognitive Behavioural (CB) therapy and how this treatment approach can be applied to children and youth diagnosed with Conduct Disorder (CD). We recognize the high level of complexity involved with treatment of these youth. Many present with multiple difficulties including neurological problems, histories of severe abuse and neglect, intellectual and academic challenges and other psychiatric disturbances.

Cognitive Behavioural therapy represents an important component of an overall treatment program. It is the part of treatment that assists children and youth with their thinking and problem solving skills and challenges them to acquire more positive, prosocial, and adaptive views and behaviours. These skills will be of value to young clients throughout their lifetime. The ability of children and youths to put these skills into practice depends on the many influences in their lives, including their family, peer groups, and the presence of other emotional and cognitive difficulties (e.g., Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder).

We have learned that treatment works best when the child or youth's network of contacts and influences become part of the treatment program. This means that parents, teachers, and peers are learning and using the same skills as the client. Treatment impact is maximized when the components of CB treatment are applied across time, situations and settings. Treatment does not need to be limited to hour long therapy or group sessions but can be integrated into day to day interactions with the client.

Section One – Background and Theory

Chapter one of this manual, entitled **Conduct Disorder**; will describe CD and provide some information regarding risk factors, prevalence, gender differences and comorbidity.

Chapter two, entitled **Effective Treatment Approaches for Conduct Disorder**; will outline the rationale for using CB therapy for treating CD. We will discuss the research basis that supports the use of this approach.

Chapter three, entitled **Theory of Cognitive Behaviourism**, will review the basic theory of CB therapy and how this approach is relevant to children and youth with CD.

Section Two – Treatment

Environmental Strategies:

Chapter four, entitled **Behaviour Management,** will review this treatment strategy.

Chapter five reviews **Modelling as a Teaching Device**.

Cognitive Strategies:

Chapter six reviews **Social Problem Solving**.

Chapter seven reviews **Cognitive Restructuring and Self-Management.**

Section Three – Application Issues

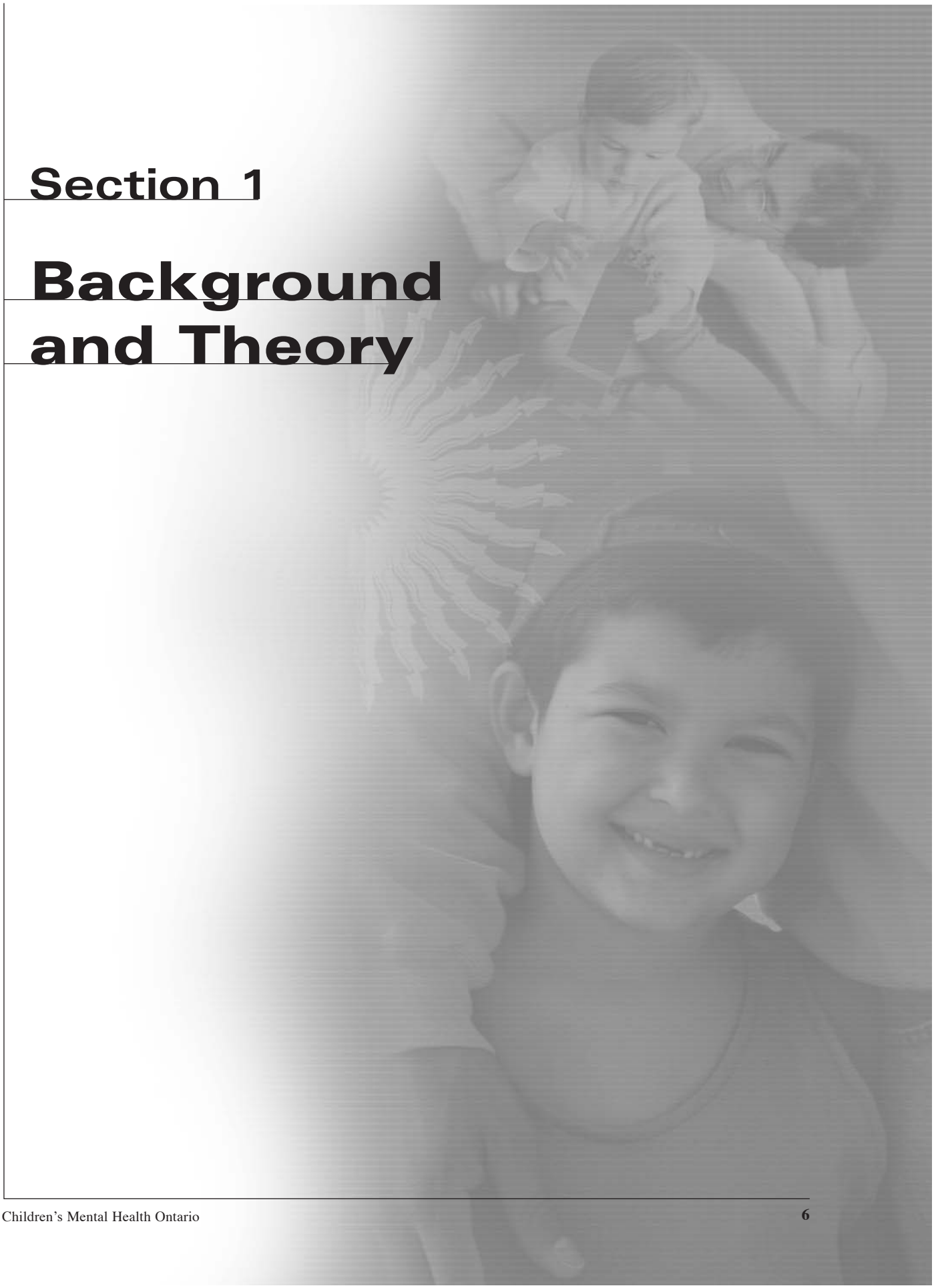
Chapter eight, entitled **Assessment of Barriers to Change**, will briefly examine how to determine the most productive focus of treatment.

Chapter nine, entitled **Homework,** reviews ways to help clients practice learned skills.

Section Four – Appendices

In Appendix I, the **Toolkit**, we have included paper and pencil tools to assist young clients, their parents, and the children's mental health practitioners working with them.

Finally, in Appendix II, **Frequently Asked Questions**, we will review common questions and concerns that will help you apply the techniques and understand the concepts discussed in the manual.



Section 1

Background and Theory

CHAPTER 1

CONDUCT DISORDER

CONDUCT DISORDER[1]

What is Conduct Disorder?

Conduct Disorder (CD) is a persistent pattern of antisocial behaviour in which the rights of others are violated or in which major social rules are broken.

BEHAVIOURS ASSOCIATED WITH CONDUCT DISORDER

- **bullying**
- **vandalism**
- **assault**
- **shoplifting**
- **running away**
- **fire setting**
- **break and enter**
- **rape**
- **con games**
- **truancy**

Behaviour problems often occur in various settings such as home, school, and community.

Onset of CD can be as early as 5-6 years of age, but is typically in late childhood or early adolescence. Onset after 16 years of age is unusual. Early onset is associated with a more negative outcome in adult adjustment.

Children and youth with CD may appear to have little concern for the feelings and well-being of others. They tend to perceive others as hostile and threatening and respond aggressively as a result. These children may tend to blame others for their misbehaviour. They often have a negative view of themselves. Problems with impulsivity, temper outbursts, recklessness, drug and alcohol use and early onset of sexual behaviour are common. Suicide risk is higher among this group than the general child/youth population.

The severity of the behaviour problems can vary. Some children demonstrate the minimum number of problems required to receive the diagnosis and their behaviour causes minor harm to others. Other children exhibit more behavioural problems than required to receive the diagnosis and their behaviour may cause considerable harm to others.

[1] This chapter is based on *Evidence Based Practices for Conduct Disorder in Children and Adolescents.* (Children's Mental Health Ontario, 2001). For a fuller discussion of this topic, it is recommended that you read this resource.

What contributes to the development of Conduct Disorder?

Our current understanding indicates that the development of CD is associated with a constellation of high risk factors (Dishian & Patterson, 1997; Farrington & Loeber, 1999; Huesmann, Moise & Podolski, 1997).

RISK FACTORS FOR CONDUCT DISORDER

- **single parent family**
- **poverty**
- **parental rejection/neglect**
- **difficult infant temperament**
- **inconsistent parenting with use of harsh discipline**
- **physical and sexual abuse**
- **lack of appropriate supervision**
- **early institutional living**
- **frequent changes of caregivers**
- **large family size**
- **association with delinquent peer group**
- **parent with antisocial personality disorder and/or substance abuse problems**
- **parent with history of violence, conflict with the law, arrests/imprisonment**

Initiatives aimed at reducing the risk for Conduct Disorder focus on preventing or minimizing risk factors. (See National Crime Prevention Council of Canada document, 1997.)

PROTECTIVE FACTORS FOR CONDUCT DISORDER

- **promoting healthy babies**
- **facilitating parent-child attachments**
- **preventing child abuse and family violence**
- **improving parenting skills and family cohesion**
- **encouraging cognitive and social development**
- **reducing aggressive behaviour and promoting prosocial behaviour**
- **improving school outcomes**
- **promoting community development and community identity**

How does Conduct Disorder get diagnosed?

To be diagnosed with CD, a child or youth needs to exhibit three or more categories (from the four listed below) of behaviour over the past 12 months. At least one category of behaviour needs to have been present in the last 6 months. (See DSM-IV-TR, 2000.)

Behaviour Categories

Aggression to People and Animals

Examples include:

- bullying
- threatening and intimidating others
- initiating physical fights
- use of a weapon
- physical cruelty to people or animals
- rape
- mugging

Destruction of Property

Examples include:

- fire setting
- vandalism

Deceitfulness or Theft

Examples include:

- breaking into someone else's home, building, or car
- shoplifting
- lying to obtain goods or favours (con games) or avoid obligations

Serious Rule Violations

Examples include:

- staying out at night despite parental objection beginning before age 13
- running away from home overnight
- truant from school

The behaviour problem must cause serious problems with social, school or work related functioning to be diagnosed. Childhood onset occurs prior to age 10 years and adolescent onset occurs when the characteristics of CD present only after the age of 10 years.

Other disorders which might account for similar behaviour patterns need to be eliminated before a child or adolescent is diagnosed with CD. For example, an adolescent who begins to engage in acting out behaviours in reaction to a trauma such as the death of a parent may run away, start taking drugs and become involved with an antisocial peer group. While such misconduct may indicate CD, it may also reflect the youth's attempt to cope with a traumatic loss. In this case, identifying and treating the underlying grief and trauma may be sufficient to restore the adolescent's preexisting prosocial behaviour patterns.

DIAGNOSIS OF CONDUCT DISORDER IS BASED ON FOUR TYPES OF BEHAVIOUR

1) Aggression to People and Animals
2) Destruction of Property
3) Deceitfulness or Theft
4) Serious Rule Violations

How common is Conduct Disorder?

The prevalence of CD is estimated to be between 1.5% and 3.4% of the general child and adolescent population (Bartol & Bartol, 1989; Feehan and others, 1993).

There are two distinct profile patterns of CD depending on the age of onset.

Childhood Onset CD

Those with childhood onset (before age 10) tend to be male, and they are often more aggressive and have more problems in their peer relationships than those in the adolescent onset group. By age 18, the majority of those with childhood onset CD meet the criteria for antisocial personality disorder.

Members of this subtype have often been imprisoned at some point. While this group represents a small portion (3-5%) of the total group with CD, they are thought to be responsible for about half of the offenses committed by young offenders.

Children in this category often exhibit disruptive behaviour in early childhood and the severity of behaviour problems escalates with age. These children are more likely to have other problems such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disabilities (LD), and poor academic performance. Individuals in this group have a high incidence of substance abuse, employment problems, marital problems, and abuse of their partners and children as they move into adulthood.

Adolescent Onset CD

Those diagnosed with adolescent onset CD may be affected by sociocultural factors such as poverty and negative peer groups to a greater extent than those with childhood onset CD. Adolescent onset CD is more likely to affect urban, poor, and minority youth. The male to female ratio is lower within this group compared with the childhood onset group. There are few serious problems evident prior to adolescence. Antisocial and illegal behaviours tend to occur in group situations. This group tends not to have severe learning, developmental, or neuropsychiatric problems as is the case with childhood onset CD. The behaviour patterns seen in this group tend to involve less aggression than those in the early onset group. The disruptive behaviours also tend to decrease as adulthood approaches.

Are there gender differences in Conduct Disorder?

Conduct Disorder is more common in boys (6-16%) compared with girls (2-9%) (APA, 1994). This gap between boys and girls narrows in adolescence (Offord, 1987). There are usually differences in the types of behaviours seen in adolescent boys versus girls with CD. Boys tend to exhibit aggressive behaviours while girls are more likely to break social rules through offenses such as truancy, lying, and prostitution. These gender differences tend to disappear with more severe levels of disturbance.

Do children and youth with Conduct Disorder have other problems too?

Comorbidity refers to the presence of two or more disorders at the same time in the same individual. For example, an individual can suffer from symptoms of both anxiety and depression at the same time. Some disorders are more likely to co-occur with others.

The majority of children with CD also suffer from other problems. Fifty to 75% of children who have CD also have Attention Deficit Hyperactivity Disorder. About 50% of children with CD also have depression or an anxiety disorder. Those children with both CD and depression are at greater risk for suicide than children with depression alone.

Children with CD often show a significant history of the following:

- **specific developmental disorders (e.g., Mental Retardation, Learning Disorders, Attention Deficit Hyperactivity Disorder)**
- **lower scores on intelligence tests**
- **head and facial injuries**
- **soft neurological signs**
- **psychomotor seizures**
- **febrile seizures**
- **nonspecific EEG abnormalities**
- **vague psychotic symptoms (e.g., paranoia, thought disorder, grandiose thoughts)**

(Bock & Goode, 1996; Carey &DiLalla, 1994; Plomin, 1994).

Self-Help Resources

Abuse

NiCarthy, G., (3rd ed., 1997). *Getting Free: You Can End Abuse and Take Back Your Life.* Seattle, WA: Seal Press.

Walker, L., (1979). *The Battered Woman.* New York: Harper & Row.

Domestic Abuse
http://www.telalink.net/~police/abuse/index.html

Domestic Violence Resources
http://homepages.go.com/homepages/d/a/n/danielsonkin

Domestic Violence
http://www.zip.com.au/~korman/dv

Child Abuse FAQs
http://www.extension.ualberta.ca/legalfaqs/nat/v-chi-en.htm

Attention-Deficit / Hyperactivity Disorder

Alexander-Roberts, C., (1995). *ADHD and Teens.* Dallas, TX: Taylor.

Barkley, R.A., (1995). *Taking Charge of ADHD.* New York: Guilford Press.

Fowler, M. (3rd ed., 1999). *Maybe You Know My Kid: A Parent's Guide to Helping Your Child with Attention Deficit Hyperactivity Disorder.* Secaucus, NJ: Birch Lane Press.

Hallowell, E.M., & Ratey, J.J., (1994). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood.* New York: Simon & Schuster.

Nadeau, K.G., & Dixon, E.B., (2nd ed., 1997). *Learning to Slow Down and Pay Attention: A Book for Kids about ADD.* Washington, DC: Magination.

Boyles, N.S., & Contadino, D., (1996). *Parenting a Child with Attention Deficit/Hyperactivity Disorder.* Los Angeles, CA: Lowell House.

ADHD Assessment Services
http://www.svr.com/addhelp/index.htm

Attention Deficit/Hyperactivity Disorder
http://www.nimh.nih.gov/publicat/adhd.com

Divorce

Kalter, N., (1990). *Growing Up with Divorce.* New York: Free Press.

Neuman, G.M., & Romanski, P., (1998). *Helping Your Kids Cope with Divorce.* New York: Time Books.

Trattford, A., (1982). *Crazy Time: Surviving Divorce.* New York: Harper & Row.

Divorce Central
http://www.divorcecentral.com

Divorce Magazine
http://www.divorcemag.com

Divorce Support
http://www.divorcesupport.com

Focus on Kids: The Effects of Divorce on Children
http://muextension.missouri.edu/xplor/hesgide/humanrel/gh6600.htm

CHAPTER 2

EFFECTIVE TREATMENT APPROACHES FOR CONDUCT DISORDER

EFFECTIVE TREATMENT APPROACHES FOR CONDUCT DISORDER[2]

What is evidence-based practice?

Evidence-based practice refers to a set of approaches, questions, and strategies that have been shown through research to be effective in helping certain clients with certain problems. Research studies are designed so that different treatment approaches can be compared to determine which ones are most effective.

Consider the following description of a research study:

> *75 youths with similar severity levels of Conduct Disorder (CD) are randomly divided into three groups of 25. This ensures that there will be no systematic differences between the three groups prior to treatment and that any differences observed after treatment can be attributed to the intervention. Group one is given treatment A (e.g., cognitive behavioural therapy), group two is given treatment B (e.g., psychodynamic therapy), and group three is given a chance to talk with someone but no formal intervention is implemented. This last category allows the researchers to determine if simply talking with someone provides some benefit, even though no treatment protocol is followed. At the end of the allotted time period there would be an evaluation.*
>
> *Depending on the study, the evaluation might involve asking all youths to rate their symptoms, to demonstrate their knowledge of concepts taught in treatment, or to describe their views on various moral dilemmas. Alternatively, a clinician might perform an interview or examine misconduct rates to determine how much progress young clients have made.*
>
> *This assessment after treatment allows the researchers to determine if treatments A and B lead to better progress than simply talking to someone. It also allows the researchers to determine which treatment approach is most effective.*

[2] This chapter is based on *Evidence Based Practices for Conduct Disorder in Children and Adolescents.* (Children's Mental Health Ontario, 2001). For a fuller discussion of this topic, it is recommended that you read that resource, as well.

In summary, when outcome evaluations are conducted in ways that satisfy scientific requirements, conclusions can be drawn about the effectiveness of interventions. When we use approaches that have been shown through rigorous evaluations to be effective, we are engaging in evidence-based practice.

Why is evidence-based practice important?

Whenever we meet with a client, whether for the purpose of assessment or treatment, we are faced with some decisions about what kinds of questions to ask, what kind of information to share, and what feelings and themes to highlight. Part of our ability to be effective with clients depends on these decisions. Part of how we know what decisions to make depends on our theory of what is wrong and what will help. If we ask clients irrelevant questions like what colour their bedroom is painted, then we will gain little useful information regarding how to help them with their problems. Even when we have a theory that tells us what the problem is and how to solve it, we have no way of knowing the accuracy of the theory until research demonstrates the effectiveness of our approach.

Once our theory and therapeutic strategies are tested and proven effective, we can feel confident that we are asking appropriate questions, making helpful interventions, and providing the most effective treatment possible to our clients. Evidence-based practice helps us be accountable to our clients. It also necessitates that we keep up with the relevant research and modify our approaches over time depending on research results.

What does the research about treatment of Conduct Disorder show?

Systemic Approaches

Research studies suggest that effective treatment of CD usually involves working not only with individual children/youths but with their network of influences such as family, school, and peer group. Treatment also needs to be long and intensive enough to have the desired effect (Cowles and others, 1995; Kazdin, 1989; Mendel, 1995; Short, 1993; Webster-Stratton, 1993). More intensive and longer term treatment is needed when the onset of CD is early and the severity of the disorder is greater (Offord & Bennett, 1994; Sherman, 1999).

Cognitive Behavioural Interventions

Research studies support the use of Cognitive Behavioural (CB) approaches with children and youth diagnosed with CD (Kendall, 2000; Southam-Gerow & Kendall, 1997). CB interventions targeting communication and problem solving skills, impulse control, and anger management (Kazdin, 1995; Spivak and Shure, 1974, 1976, 1978; Tremblay and others, 1991) have been found to be helpful. This is not surprising, given that children with CD often have cognitive skill gaps and cognitive distortions which affect these areas of functioning.

Family Therapy

Treatment with the family is also important. Interventions which include parent (caregiver) education regarding the development of CD and parent training in behavioural management strategies are important (Kazdin, 1997; McCord and others, 1994; Mendel, 1995; Patterson and others, 1989; Wells, 1995). Parent training requires parental involvement and cooperation, and therefore this approach is limited if parents are unable or unwilling to participate.

Integrated Approaches

There is growing evidence to suggest that integrated approaches that include parent training and child-focussed CB treatment are more effective than either of these interventions on their own (Kazdin et al., 1992; Southam-Gerow & Kendall, 1997; Webster-Stratton & Hammond, 1997). Broader integrative approaches coordinate multimodal treatment efforts that involve the individual, family, peer/ social group, and the community. An example of such an approach is the *Earlscourt Under 12 Outreach Project* for 6 to 12 year old boys who commit mild to serious offenses (Day & Hrynkiw-Augimeri, 1996; Hrynkew-Augimeri and others, 1993). There are eight components in this integrated program:

- after-school structured group to teach self-control and problem-solving techniques
- 12 parent training sessions to teach effective parenting skills
- family counselling
- in-home academic tutoring

- school advocacy and teacher consultation
- victim restitution
- individual befriending to other boys with structured community based activities
- continuing groups

Developmental Considerations

Cognitive techniques require some degree of insight and verbal ability on the part of the client. Treatment outcomes suggest that older adolescents (age 13 to 18) benefit the most from these techniques as compared with younger children (age 5 to 11) (see Ronen, 1998). Interventions with younger children tend to rely more on environmental interventions such as behaviour management and modelling. Cognitive techniques can be used with younger children but need to be simple and specific. The younger the client, the more difficult it will be to implement cognitive techniques directly. The role of parents in treatment is greater with younger clients, and the children's mental health practitioner shifts focus from directly helping the youth to integrate these skills to helping the parents teach and model these skills for their child.

Gender Considerations

There are gender differences in the ways that boys and girls express problems and seek help. Girls are often more comfortable seeking help with problems and verbally expressing feelings compared with boys. Boys may be more receptive to techniques that are experiential (e.g., role playing) than to techniques that require verbal expression of cognitive insight (Ronen, 1998).

EFFECTIVE TREATMENT OF CONDUCT DISORDER INVOLVES:

- **Integrated approaches that involve child, family, school, and community**
- **Interventions of sufficient dosage**
- **Interventions that are developmentally and gender sensitive**

What does the research about Cognitive Behavioural therapy for Conduct Disorder show?

Current theories regarding antisocial behaviour in youth suggest that much of this behaviour is learned. The majority of our learning occurs through social interaction with others or by observing others. This is referred to as social learning. We learn through experiencing the consequences of our behaviour or by observing the consequences experienced by others. There are three primary arenas in which we learn the rules of our culture: family, friends, and school. These are the settings in which we learn the links between actions and consequences. The lessons learned within these arenas will influence whether we are likely to behave in a prosocial or an antisocial way.

Although we can not change someone's past experience, CB approaches help clients alter the lessons learned from those experiences and shape how those lessons are generalized and applied to future experiences. In addition, CB therapy enables us to change an individual's current experience by responding to them in ways which differ from the past. Current experience can also be altered by teaching individuals different ways of responding to events which then elicit different reactions from others (consequences).

Key Cognitive Behavioural Treatment Strategies

There are various treatment techniques used by CB therapists. We will focus on four key strategies.

The first two strategies aim to alter the client's current and future experiences by changing the social/behavioural environment:

i) behavioural management

ii) modelling

The third and fourth strategies are cognitive techniques that can be directly taught to the child or youth:

iii) social problem solving

iv) cognitive restructuring and self-management

These latter strategies enable the child or youth to shift how they respond to their environment.

Key Cognitive Behavioural Treatment Strategies

1) **Behavioural Management**
2) **Modelling**
3) **Social Problem Solving**
4) **Cognitive Restructuring and Self-Management**

CHAPTER 3

THEORY OF COGNITIVE BEHAVIOURISM

THEORY OF COGNITIVE BEHAVIOURISM

What is Cognitive Behaviourism?

Cognitive Behavioural (CB) treatment with children and youth aims to decrease problematic behaviours (e.g., aggression, impulsivity) while increasing behaviours which enhance functioning (e.g., social skills). This approach builds on behavioural approaches by adding a cognitive element. It ensures that the thoughts and feelings of young clients become the focus of treatment, along with their behaviours. CB therapy is based on the theory that our thoughts, feelings, and actions are linked. Therapy assists clients to monitor their thoughts and learn how they affect feelings and behaviours. It teaches clients how to identify dysfunctional thoughts and beliefs and substitute them with more realistic, adaptive ones.

CB therapy with children and youths focusses on problem solving and enlists the participation of the client in monitoring and changing his own behaviour. The relationship between the child and his environment is viewed as interactive. That is, the child is shaped by his experiences (environment) and the environment is also shaped by the child's unique set of behaviours and reactions. Treatment targets the child's social environment as well as internal learning processes.

As you read through the manual, you may discover that you already use many CB techniques. When we talk with young clients, the connections between their behaviour and their beliefs and feelings often become apparent. This therapy approach is a coping model. It is intuitively appealing since it fits closely with what many clients say about their own experiences. Clients learn a set of personal skills that they can draw upon to navigate situations throughout life.

How can thoughts, feelings, and behaviours be linked in different ways for different individuals?

Consider the following example to better understand how thought processes might affect our feelings and then our subsequent behaviour.

> *Lauren sees her primary worker walking down the hall with a scowl on her face. She interprets the scowl as anger towards her because she hasn't completed her chores. She feels anxious and guilty which then leads to ducking into the nearest room to avoid her. Mike, on the other hand was walking down the hall behind Lauren and saw the same scowl. He interprets the scowl as fatigue because he knows the worker has been off sick recently. He feels sympathetic and approaches her to see how she is doing.*

With this example, the different interpretations of the scowl affect the "feelings" (anxiety versus sympathy) and "behaviour" (avoidance versus approach) of Lauren and Mike.

In this next example, we see how a youth's particular interpretation of some information then influenced his feelings and actions and created a set of reactions which were not in his favour.

> *A youth named Derrick (age 13), just released from detention, had heard stories from his peers in detention that his particular probation officer was a "push over." He felt relieved when he heard this, and thought to himself "this is going to be a piece of cake." When he attended his first meeting with the P.O., he acted very confident and charming. His P.O. thought his light-hearted behaviour during the meeting suggested he was not taking his offending behaviour seriously enough. She felt angry and acted tougher than usual with this particular youth.*

The rumour affected how Derrick thought and felt about the meeting with his P.O., and this affected his behaviour during the meeting. In this particular example, his behaviour backfired. If he had heard a different rumour (e.g., that the P.O. was tough but fair), it might have led to different behaviour during the meeting (e.g., played it straight). We can also see how the probation officer's thoughts "Derrick is not taking this seriously," influenced her feelings (anger) and behaviour (acted tougher).

Thinking patterns are based on experience

Thinking helps us make sense of our experience. It helps us organize and interpret events and learn from our experience. It allows us to reason through new situations, to make judgements regarding the best course of action, and to make predictions regarding the possible outcomes of our actions.

Our thinking is greatly influenced by our past experience. This past experience helps to create the "filter" through which future events are often seen. The "filter" can be understood as the set of ideas and beliefs we have stored in memory. These beliefs influence how we make sense of new information.

Let's examine how an individual's past experience might influence the filter through which she interprets events.

Using our first example, consider why Lauren interpreted the scowl as anger directed at her, while Mike interpreted the scowl as fatigue. Remember that both were exposed to the same "experience" and environment, a children's mental health practitioner scowling in the hallway. The difference in their reactions came from their internal interpretation regarding the scowl.

Lauren may have already been feeling guilty about not doing her chores and anxious about the expected reprimand from staff. Also, she may have grown up in a household where she was often blamed for things she did not do and where parents' anger could flare up any time and be directed at her. Her filter may have been made up of the following beliefs:

- keep a close eye on the moods of others, especially those with power, because the only way to protect myself from harm is to see the arrows coming and get out before they strike
- I can't trust others to check things out first to see if their anger is justified
- the only defence is to hide or get away; I can't reason with someone who has power over me
- I seem to make people angry no matter what I do

Mike, on the other hand, may have grown up in a household where a full range of feelings were openly expressed and discussed. He may have developed a view of himself as likeable, competent and a good listener, based on feedback from his parents. He may have developed a filter containing the following beliefs:

- problems and conflicts between people can usually be identified and resolved
- I'm good at helping and supporting others when they are in distress
- when people get mad, it's usually for a reason
- I usually know when I've done something to upset someone else

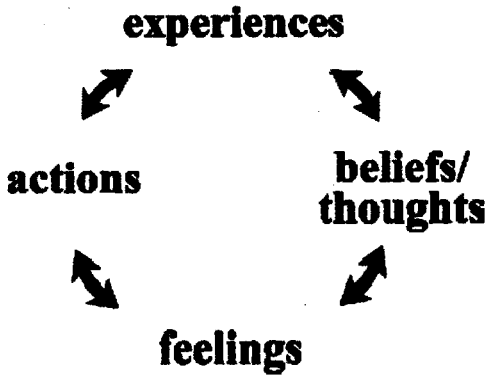
Lauren and Mike have different histories of experience which have shaped how they interpret and filter events. Ironically, the behaviour which stems from these beliefs may serve to confirm the beliefs. Imagine how the worker in this example might respond differently to Lauren and Mike's behaviour. How might you respond in a similar situation?

Let's look at our second example with Derrick to see how his beliefs affected his behaviour.

We may ask why Derrick was so quick to assume he could smooth talk his way out of trouble based on the belief that someone in authority was a "push over." Derrick's filter may look something like this:

- the world is made up of winners and losers, strong and weak
- only people who are weak can be bullied, fooled, and hurt
- I'm good at getting my way by fooling others

In summary, our experiences shape our beliefs about how the world works. These beliefs then influence how we feel and how we act. Our actions then create reactions and these become part of our experiences, which then influence our beliefs, feelings, and actions once again.



Beliefs create experiences

It is easy to see how a belief can be reinforced over and over. If you believe like Lauren that you cannot reason with others, then this might lead to avoidance of interpersonal conflict, since problems are not viewed as resolvable. As a result, you may have few experiences of successful problem solving. This reinforces your belief that conflicts cannot be resolved and provides no experience on which to base an alternative belief that problems can usually be sorted out between people.

Changing experiences through treatment

Since we know behaviour is linked to our thinking and beliefs, and these are based on our experiences, the focus of CB therapy is to alter experiences or the interpretation of experiences. Experiences can be altered by changing the consequences an individual experiences (behaviour management), by changing the behaviour and social interactions an individual witnesses (modelling), and by changing an individual's response to events such that a different set of consequences occurs (social problem solving). Although we cannot change an individual's past experiences we can help alter how she interprets past, current and future events (cognitive restructuring and self-management). By changing the individual's experiences and interpretations of experiences, his feelings about the event, himself and others may be altered. This shift in feeling may then lead to a different set of reactions or behaviours.

How would Cognitive Behavioural treatment be relevant to youths with Conduct Disorder?

Child and Youth Focussed Interventions

> Research shows that children and youth with various psychological problems often generate fewer alternative solutions to interpersonal problems, focus on ends or goals rather than on the intermediate steps towards attaining them, see fewer consequences associated with their behaviour, fail to recognize the cause of other people's behaviour, and exhibit less sensitivity to interpersonal conflict (summarized in Ronen, 1998).

For antisocial and more severely aggressive youth, research suggests that they generate fewer nonaggressive solutions to interpersonal problems and are more likely to misperceive the intentions of others compared with nonaggressive youth (Deluty, 1981; Dodge, 1985; Lochman & Dodge, 1998). In other words, they not only have difficulties figuring out how to solve problems, but are more likely to distort and misperceive situations which may create additional problems for them. Aggressive youth are more likely than nonaggressive youths to perceive others as hostile, and base their interpretations on less information (Dodge & Newman, 1981; Dodge and others, 1986; Gouze, 1987; Lochman, 1989; Milich & Dodge, 1984).

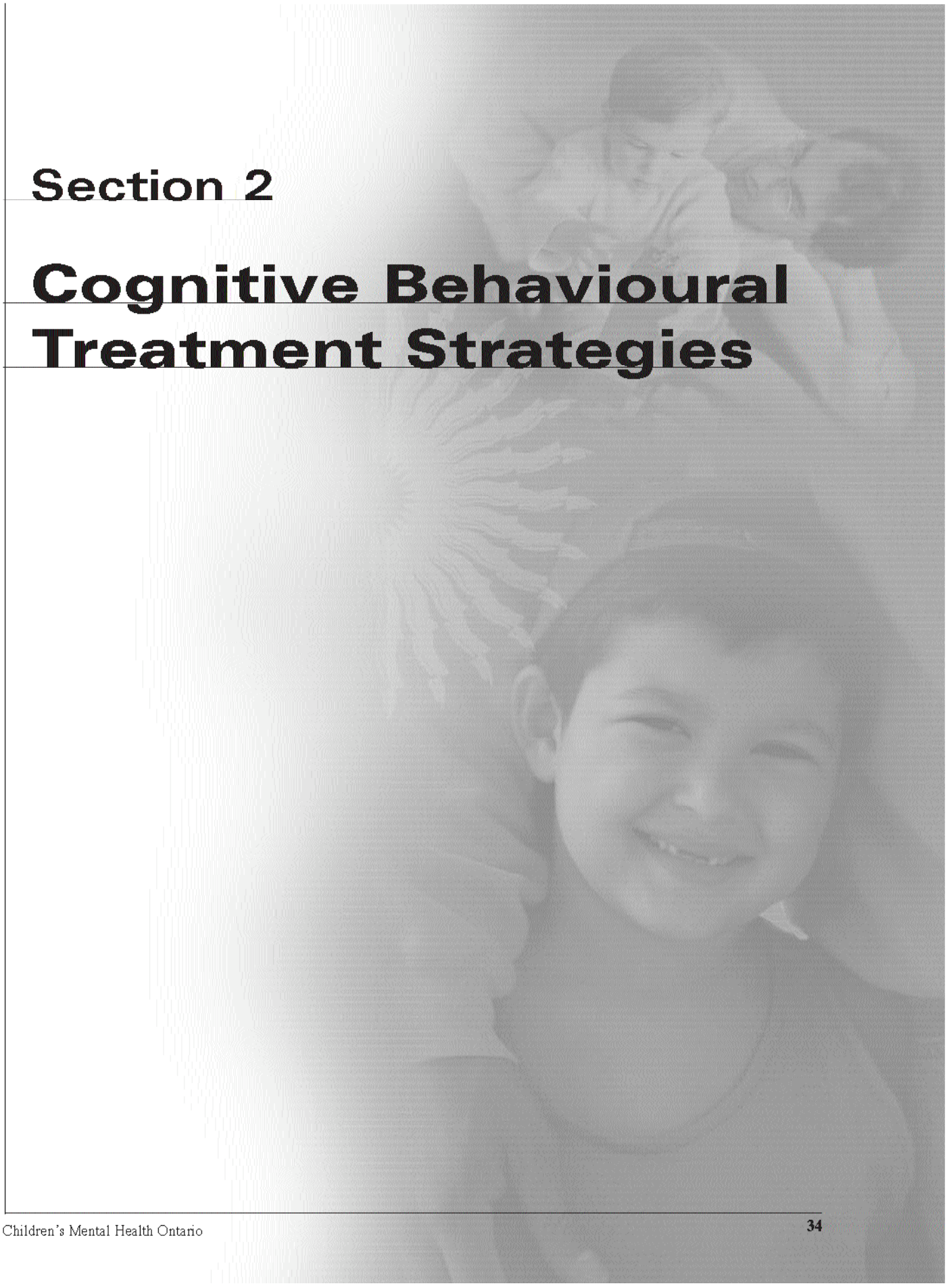
These cognitive deficits and distortions can lead to problems with anger and impulsivity. Treatment efforts which target these areas are most relevant to this client group. Cognitive behavioural interventions are specifically designed to address these thinking gaps and distortions.

Parent Training

Some of the risk factors for development of Conduct Disorder are related to parent functioning. The research supports treatment programs that include a parent training/family therapy component. In many cases, parents provide the "experiences" upon which many of the maladaptive belief sets adopted by antisocial and aggressive youths have been based. If the family environment is not altered in a positive direction, it will be more difficult for a youth to make use of skills learned in treatment.

Peer Interventions

The impact of peer behaviour and attitudes can be very significant, particularly as children approach early adolescence. Interventions which include peers, such as group training in anger management, social skills, problem solving, and self-management, provide powerful opportunities for positive peer influence and modelling (e.g., Goldstein, 1989). Group work also provides an opportunity for youth to develop new peer contacts which can support a shift from antisocial to prosocial behaviour.



Section 2

Cognitive Behavioural Treatment Strategies

Introduction

Treatment with children and youth experiencing conduct problems can occur in the context of individual treatment sessions, family therapy, intensive home-based treatment, residential milieu, and school programming. Your ability to apply treatment strategies will vary depending on whether your client is a youth living in the community and attending hourly therapy sessions or a youth living full time in a residential setting. Treatment impact will also vary depending on whether you are working with the youth individually or in a coordinated way with his family, school, and community.

Whatever the context, the goal is to make the most of your contact with your client. This includes integrating the treatment methods of behaviour management, social problem solving, modelling, cognitive restructuring, and self-management into as many **teachable moments** of contact as possible. If treatment interventions are limited to structured didactic group sessions, the youth's ability to generalize the concepts learned and to recognize his own skill gaps will be limited. For example, the youth may come away from a group session on social problem solving with the ability to list all the problem solving steps but have no idea how to use them when faced with a decision about joining some friends to go joyriding.

While we will attempt to show how these treatment strategies might look in day to day practice, it is important to recognize that several strategies may be applied in an overlapping manner. For example, you may be dealing with a youth who just blew up at her worker and trashed the worker's office. You are faced with impulsive, angry behaviour and will use a combination of consequences, problem solving, and cognitive restructuring in an effort to help this youth change her behaviour.

The following section is divided into four chapters as follows:

Environmental Strategies:
1) Behavioural Management
2) Modelling

Cognitive Strategies:
3) Social Problems Solving
4) Cognitive Restructuring and Self-Management

At the end of each treatment strategy, an **Applications** section with a case example is provided, along with how to apply the particular treatment strategy (e.g., modelling) to the case example.

ENVIRONMENTAL STRATEGIES

CHAPTER 4

BEHAVIOURAL MANAGEMENT

BEHAVIOURAL MANAGEMENT

Our ability to help a child or youth learn prosocial methods for coping with problems is directly related to our ability to ensure that her environment is safe, that basic needs are met, that she is treated with fairness, and that the links between behaviour and consequences are consistent and reasonable. Most importantly, the environment needs to be such that prosocial coping responses are more likely to work than antisocial coping responses.

One of the ways we help to create such environments is through the use of behaviour management strategies which can be applied by staff in residential programs, by school personnel in the school program and by parents in the home. These alterations to the child or youth's environment provide the necessary bedrock on which other more cognitive strategies are built. Imagine the futility of telling a youth that he needs to cooperatively resolve disagreements with his father if his father is an alcoholic who routinely abuses his son whenever his son disagrees with an unfair decision. A prosocial coping response involving conflict resolution is not going to be effective, or rewarded, in this environment.

Most children's mental health practitioners are well versed in the principles of behaviour management, so this treatment strategy will be reviewed very briefly.

ABC's of Behaviour

One of the methods by which we can better analyze and understand behaviour is to observe the events which precede (**A**ntecedents) and follow (**C**onsequences) the **B**ehaviour. This provides some clues regarding what may motivate or trigger the behaviour and why the behaviour is repeated. Consider the example of smoking. The immediate antecedent might be feelings of restlessness or agitation. These are the feelings which lead to the decision to have a cigarette. The immediate consequence of smoking might be a feeling of calm and well-being. Because the immediate consequence was positive, the behaviour is repeated. We can see from this example that longer term negative consequences (poor health) may not be powerful enough to override the more immediate positive consequence. This is important when analyzing behaviour, since in general, immediate consequences are more influential than delayed consequences.

For any given individual, the pattern of antecedents and consequences to a given behaviour will be unique. If we aim to change an individual's behaviour, we need

to understand her own unique patterns. By providing clients with ways to change antecedent events or with alternate options when these events occur, they may be able to reduce or eliminate the behaviour. Using our smoking example, this would mean teaching other ways to manage or tolerate feelings of restlessness and agitation, such as relaxation or distraction. In addition, by altering the consequences of the behaviour, we can help to increase or decrease the frequency of the behaviour. With the smoking example, this might mean using cognitive reminders regarding long term negative consequences of smoking (e.g., look at a picture of uncle Bill who died of lung cancer).

Information regarding behavioural antecedents and consequences is typically gathered by monitoring and charting observed behaviours. Depending on the nature of the behaviour, this charting might be done by an observer (parent, staff) or by clients themselves. (See page 109 of the Toolkit for a worksheet on behaviour analysis.)

ABC's OF BEHAVIOUR

Antecedents	→	**events preceeding the behaviour**
	→	**behaviour may be changed by modifying its antecedents or responses to the antecedents**
Behaviour		
Consequences	→	**events that follow the behaviour**
	→	**behaviour may be changed by modifying its consequences**

Positive and Negative Consequences

Rewarding behaviour increases the likelihood of that behaviour recurring. Negative consequences following a behaviour decrease the likelihood of that behaviour recurring. Rewards are individually defined so that what is reinforcing for one child may not be reinforcing for another. The same is true for negative consequences – one set of consequences may not be effective across different individuals.

CONSEQUENCES

- may be positive or negative
- positive consequences are rewarding or reinforcing to the youth
- negative consequences are unpleasant or undesirable to the youth (e.g., loss of desired privilege)
- positive consequences increase likelihood behaviour will reoccur
- negative consequences decrease likelihood behaviour will reoccur
- the youth's own perception ultimately determines whether a consequence is positive or negative

Timing of Consequences

Positive and negative consequences to behaviour are most effective when they are implemented soon after the target behaviour. Losing your chance to go out for ice cream on Saturday night because you did not make your bed on Monday is less effective than a more immediate consequence of losing play time that morning until the bed is made.

Nature of Effective Consequences

Consequences are most effective when they are fair and reasonable, linked logically to the nature and magnitude of the target behaviour, implemented quickly and consistently, and relatively short in duration. For example, being required to help pay for a broken window from allowance money represents a natural consequence that is linked to the behaviour in a fair and reasonable way. Grounding the youth for one month would be less effective because it is not logically linked to what he did and is difficult to implement because it requires heavy monitoring for a long period of time. In addition, grounding may lead to further problems when the youth tries to find ways to get out of the punishment because it is perceived as unfair and too lengthy. Consequences which are too lengthy are less effective because they lead children to stop trying (e.g., "why

behave, I'm already grounded, what more are they going to do to me?"). This can lead to an escalating set of consequences (e.g., grounding is extended each time the youth sneaks out).

In some treatment situations, tokens may be used to immediately reward desired behaviours. Tokens can be accumulated and then "cashed in" for a tangible reward, such as choosing the movie on Friday night. Parents and teachers sometimes make use of stickers or stars to acknowledge appropriate behaviour. Such systems tend to be more effective when they are used as incentives to increase positive behaviours, rather than punishment for inappropriate behaviour. When children start to lose their tokens for misbehaviour, they sometimes lose interest in the whole program. (See page 129 of the Toolkit for a parent planning sheet for use of consequences.)

Natural Consequences

Sometimes there are natural consequences to events which serve to increase or decrease the likelihood of the behaviour recurring. Examples include: being paid for completing a job, losing a friendship because of dishonest behaviour towards that friend, getting caught by the security guard for shoplifting, and receiving applause and praise for good performance at a school concert. Natural consequences are those events which typically follow behaviours. Whenever possible, it is important to allow children and youths to experience natural consequences since clients will need to cope with them as independent adults. When behaviour occurs in a family, school or treatment setting, it can be more effective to make use of natural consequences wherever possible or reasonable (e.g., call the police when a youth assaults someone) than setting up rules and consequences unique to that setting.

Development of Prosocial Behaviours and Values

Many children and youth with conduct problems have not experienced consistent links between rewards and prosocial behaviours or costs associated with antisocial behaviours. By altering their environment, we can alter their learning experiences and help them unlearn some of the maladaptive patterns that have led to problems.

This process can also lead to a shift in the youth's value system since he is now living in an environment where antisocial values are not supported and do not lead to positive outcomes.

Residential, school, and intensive home-based programs provide opportunities to alter the youth's experience using such behavioural programs. By living in and experiencing a predictable, fair and prosocial set of rules regarding behaviour, children with conduct problems can begin to associate appropriate behaviour with positive outcomes. By teaching behaviour management skills to parents, we can help ensure that children who are living at home are receiving learning experiences consistent with those provided in treatment.

Consequences are most effective when they are:

- **customized for the individual youth (e.g., developmental stage, preferences, strengths, needs)**
- **fair and reasonable**
- **linked logically to the nature and magnitude of the target behaviour**
- **implemented quickly and consistently**
- **relatively short in duration**
- **highlighted or consist of natural outcomes**

Application

Carry out the following activities in collaboration with the youth and his/her parents, and where appropriate, in consultation with other key resources (e.g., teacher):

- identify concerning behaviour
- determine antecedents and consequences for behaviour by monitoring and tracking
- identify strengths and needs that may be relevant (e.g., potential resources and challenges)
- make sense of information gathered
- identify consequences to decrease problematic behaviour and increase prosocial behaviour
- review, evaluate, and modify if necessary

Let's examine how behaviour management strategies could be applied to a specific case. Within each treatment strategy chapter, we will look at how our other treatment strategies of modelling, social problem solving, and cognitive restructuring and self-managment could be applied to this same case scenario.

Case Example

Case History

Jason is a twelve year old boy who lives with his mother and three siblings. Jason is the second youngest child in his family. His mother and father separated when Jason was two. His father was violent and an alcoholic. Between birth and age two, Jason was exposed to his father's verbal and physical violence against his mother. He was also treated roughly at times by his father. Jason's mother has struggled with depression for years and when she is depressed, her ability to manage basic daily parenting tasks is limited. At these times, she does not make regular meals for the kids, spends much of her time in bed, and is not aware of what her children are doing or where they are. When she is feeling better, Jason's mother takes the kids on outings to the park and tries to help them with school work. She tries to set rules at these times but finds it hard to gain compliance.

In the last year, Jason has started skipping school and his just-below-average grades have dropped so that he is now failing his grade seven year. He has been getting into fights at school and according to the school staff, he is bullying other kids around and receiving some degree of notoriety among his peers. School staff also suspect he is using drugs and drinking. He has just started getting involved with a rough group of kids and was caught damaging a car in a parking lot.

Jason was referred to treatment. He was assessed to have a conduct disorder along with significant family stressors. His aggressive behaviour was determined to be the priority concern, since he caused significant injury to apeer in a recent fight. Jason was referred to a family preservation program which allows for intensive in-home intervention. (See pages 104, 105, 108 of the Toolkit for assessment and treatment planning forms. See also pages 106, 107, 118, 119, 126 and 127 for pre- and post-treatment progress report forms. Page 128 of the Toolkit contains a form for parents to identify concerns and progress they observe between meetings.)

The child and youth worker was asked to develop a behavioural program to address the aggressive behaviour. The program was to be used by his mother, teacher, and other children's mental health practitioners who may be involved in Jason's treatment.

Monitoring and Tracking

The children's mental health practitioner asked Jason, his mother and his teacher to all keep track of the aggressive behaviour for a period of two weeks. Aggressive behaviour was defined as physical attacks on people or animals, verbal yelling and abusive comments, and behaviour leading to property damage. Everyone was asked to keep track of what happened before the aggression and what happened after the aggression. (See page 109 of the Toolkit for a behaviour analysis form.)

Making Sense of Information Gathered

An analysis of Jason's aggressive behaviour suggested that it was most likely to occur when he felt rejected by his mother due to her depressed withdrawal from her parenting role. It also occurred when other people made comments that Jason felt were insulting or critical. He tended to be taunted by peers who were hoping to provoke one of Jason's blow outs.

Even though his behaviour led to problems for him, Jason experienced a period of explosive release that made him feel more powerful and in control for a brief period of time and this is why he "liked" getting angry. In addition, whoever was bothering him before the blow up would often leave him alone afterwards and this is what Jason wanted. (See page 123 of the Toolkit for a client worksheet on analyzing thought-feeling-action patterns. See also page 131 for a parent worksheet on building self-esteem in their child.)

Identifying Strengths

The children's mental health practitioner decided that it would be difficult to change some of the antecedents (insults from peers) or the internal consequences of the aggression (release, feeling powerful). She decided instead to help Jason find other, prosocial ways to gain a sense of release when angry and feel powerful and in control with his life. She discovered that Jason liked playing basketball, and began focussing on this area of strength. Jason was encouraged to develop this skill and use the physical exercise as a regular form of release for built up emotional tension. As his skill in this sport developed, Jason's sense of competence and personal control grew. (See pages 120, 121, and 112 of the Toolkit for client goals worksheets and achildren's mental health practitioner worksheet for promoting cognitive skills.)

Collaboratively Determining Consequences and Other Strategies

While the behaviour monitoring was occurring, the children's mental health practitioner began working with Jason's mother and teacher to teach them ways to reinforce nonaggressive behaviour. (See page 129 of the Toolkit for a parent plan for use of consequences.) Jason was asked to make a list of activities that he enjoyed. His mother and teacher were asked to use these activities as incentives for nonaggressive behaviour. They were also asked to verbally notice and appreciate times when Jason's behaviour was appropriate. They were asked to use natural consequences for aggressive behaviour whenever possible. For example, if Jason physically attacked anyone or damaged property, the police were to be called.

If Jason was verbally aggressive with his mother, he was told that he needed to find another way to talk about his feelings or the problem and that until then, he needed to remove himself from the situation. If he refused to

leave, then his mother would leave, stating they would discuss things later when he could behave appropriately.

In the school setting, Jason's verbal aggression would lead to removal from the classroom. He would have a space to cool down. When ready, he would approach a resource teacher who would review what happened and help Jason think through how he could handle the situation differently the next time.

The children's mental health practitioner also worked with Jason's mother and teacher to develop ways to increase his sense of predictability and control in his personal world. Some of the changes made included:

1) having Jason make more choices regarding personal matters such as meals, clothes, and after school schedule
2) having Jason choose one outing per week with his mother and younger sibling
3) choosing some school assignments from a menu of options

Seeking Additional Resources

The connection between his mother's depression, Jason's feelings of rejection, and his aggressive behaviour suggested the need for individual treatment for Jason's mother. Jason's mother was referred for counselling for her own depression, and she began to understand the connection between her stability and Jason's sense of predictability and control in his life.

Self-Help Resources

Child Development and Parenting

Dreikurs, R., (1964). *Children: The Challenge.* New York: Hawthorn.

Faber, A., & Mazlish, E., (20th ed., 1999). *How to Talk So Kids Will Listen and Listen So Kids Will Talk.* New York: Avon.

Gordon, T., (1975). *Parent Effectiveness Training: The Tested New Way to Raise Responsible Children.* New York: Peter Wyden.

Leach, P., (rev. ed., 1997). *Your Baby and Child: From Birth to Age Five.* New York: Knopf.

Patterson, G., (3rd ed., 1987). *Living with Children.* Champaign, IL: Research Press.

Phelan, T.W., (2nd rev. ed., 1996). *1-2-3 Magic: Effective Discipline for Children 2-12.*

Ginott, H., (1965). *Between Parent and Child.* New York: Avon.

Ginott, H., (1969). *Between Parent and Teenager.* New York: Avon.

Renshaw Joslin, K., & Bunting Decher, M., (1997). *Positive Parenting Your Teens.* New York: Fawcett Columbine.

Steinburg, L., & Levine, A., (2nd ed., 1997). *You and Your Adolescent: A Parent's Guide for Ages 10-20.* New York: Harper Collins.

ABCs of Parenting
http://www.abcparenting.com

Common Sense: Strategies for Raising Alcohol- and Drug-Free Children
http://www.pta.org/commonsense

CHAPTER 5

MODELLING AS A TEACHING DEVICE

MODELLING AS A TEACHING DEVICE

What is modelling?

Modelling occurs when we learn by observing others. Sometimes there is no direct attempt to teach a concept, but we learn about it by watching someone else. We often underestimate the power of modelling for creating positive change, believing that if we have not set out to teach it, then it did not get learned. We sometimes fail to recognize that how we behave may have a greater influence than what we say ("do as I say, not as I do" doesn't work!). Parents may worry that their children are exposed to "negative influences," recognizing that children sometimes copy behaviours we do not like. It is important to remember that children can also copy positive behaviours if they are exposed to them. Modelling can be a powerful tool for teaching prosocial behaviours, coping responses, and problem solving.

Who are children and adolescents most likely to copy?

We are more likely to imitate and learn from models that are:

- **prestigious**
- **admired**
- **rewarded for their actions**
- **viewed as natural and realistic**

Children may imitate the behaviour of an older sibling and adolescents may imitate the behaviour of their peers or an idol for the reasons listed above.

An effective approach for teaching prosocial behaviour, coping responses and problem solving skills is referred to as a "coping model." Rather than demonstrate the perfect way to behave, this model demonstrates the individual's struggle with a problem and the process of figuring out a solution. The process of making the struggle observable to the youth makes it easier for him to identify with the model, and therefore more likely to make use of information learned from the model.

Models who do not make any mistakes or appear perfect are not as useful, since the youth may see such behaviour as beyond her reach and the internal process of problem solving remains hidden. The youth will also be more inclined to attribute the flawless model's coping response to personal qualities (large size, attractiveness), rather than to the cognitive strategy that could be used by the youth.

To illustrate the problem with perfect models, consider an example relevant to our own profession. As children's mental health practitioners, we often attend talks and read books by other mental health professionals. When we read about examples from other clinicians where they describe "curing" an adolescent's longstanding history of violent behaviour in one or two brilliant sessions, this is often most unhelpful for our own clinical practice. Instead of gaining expertise, we often come away feeling inadequate that our clients are not better after two sessions or less. We may even worry that we are the only ones who do not experience such outstanding successes, and that perhaps we are in the wrong profession.

What does a coping model look like?

The "key components" displayed by a coping model include:

- **behaviour that is a less desired response (e.g., interrupting a friend while they're talking)**
- **a clear display of self-catching and self-correcting that interrupts the less desired response (e.g., I keep butting in while you're talking, don't I?)**
- **labelling the error (e.g., "I'm too caught up with my own thoughts; I need to stop and listen more")**
- **display of more constructive behaviour (e.g., deep breathing and greater listening and attentiveness to friend)**

How can modelling as a teaching device be used in daily situations?

The power of modelling as a teaching strategy is that it can be done in the moment. Rather than having an abstract discussion about how to solve an invented problem, modelling allows us to capture the problem behaviour and the coping behaviour in action which is often more meaningful and memorable to the learner. Taking advantage of "teachable moments" as they occur is the key. Sometimes it involves identifying the coping behaviour of a peer and sometimes it involves demonstrating coping behaviour ourselves.

Many of the children and youth with conduct problems may not have had an opportunity to learn adaptive problem solving skills and therefore find it difficult to know how to reason through situations. They may have experienced significant family disruptions which have interfered with their chances to develop many positive coping skills. Treatment which targets these learning gaps can be most helpful.

Peer Modelling

We can highlight the behaviour of a peer as a way to teach another child or youth. This technique requires some skill and sensitivity so that the modelling peer does not feel embarrassed and the observing peer does not feel inadequate compared to his friend.

In a residential setting, a group of youths could discuss what went well for them during the day or week during a group meeting. The children's mental health practitioner might say "John, I noticed that you got through your chores this week really quickly and efficiently, even the ones I know you don't like too much. What made this week different from last week?"

Adult Modelling

We can also make our own internal problem solving visible and observable as a way to teach methods of reasoning and problem solving. Consider the following scenarios:

Imagine that a colleague approaches you in front of a client and inaccurately blames you for causing a problem with his computer. This is a perfect opportunity to model problem solving for the client. You might start responding defensively, then catch yourself and shift your response to assertively stating that you haven't caused the problem, but would be happy to help them sort out the problem later when you are free.

In this situation, the client sees that your first reaction was a defensive one, but that you realized this as it was happening and corrected your behaviour. This shows the client that you may have many of the same feelings as she does, but have learned to manage these feelings in a positive way.

A children's mental health practitioner is trying to do three things at once and one of the residents approaches her with a question. In her frustration she snaps at the resident. Realizing her behaviour wasn't ideal, she approaches the resident and says "Look, I'm sorry I snapped at you back there. I think I got a little overloaded with things to do and then when you approached me with your question I felt like it was more than I could handle and I snapped. I realize that I should have calmly let you know this wasn't a good time to talk and we could have set up another time together. Can we set that time up now?"

Feedback from children and adolescents indicates that when adults model acknowledgement and apology for errors, it creates a particularly meaningful learning situation, increases cooperative responses from youths and builds rapport. It also demonstrates that mistakes can be corrected.

Thinking Aloud

An effective component of modelling is "thinking aloud." This strategy exposes the private self instructions (self talk) that help us organize our thoughts and problem solve. Children often learn this skill by observing their parent, and this teaches them how to use the skill for enhancing their own abilities in these areas.

A child approaches his parent and asks her to come to his 7 p.m. ball game on Tuesday night. The parent says "Let me see, I've got a few things on that evening. I have a meeting at 6:30 and then I have to pick your brother up at swimming. Now maybe if I can reschedule my meeting and your dad picks up your brother from swimming, I could make it."

Overview

- **Modelling allows a demonstration of more helpful and prosocial ways of thinking and behaving.**
- **Youth learn from peer and adult models.**
- **Cognitive modelling requires thinking out loud.**
- **Models that demonstrate how they "cope" are more helpful than models that just appear to do everything perfectly.**
- **Children and adolescents are most likely to imitate admired or prestigious individuals who are rewarded for their actions.**

Role Playing

Among other functions, role playing provides a method for structuring and orchestrating modelling opportunities. It also provides a safe way to "try on" a newly learned approach. There are times when we want a youth to learn a better way to handle a situation, but chances to demonstrate these methods may not naturally occur with sufficient frequency. By setting up a role playing opportunity, a child or youth has more chances for practising new skills and for observing others using these skills. In addition, by reversing roles, you can create an opportunity for a youth to better understand the feelings and reactions of others. This ability to empathize with others is an important skill that will be used for social problem solving.

Stewart (a 15 year old youth) talks to you about his frustration with his math teacher. He is not doing well in the class and feels the teacher doesn't like him. In fact, he believes the teacher "has it in" for him. As evidence, Stewart explains that his teacher accused him of cheating on his last test. You and Stewart discuss how to problem solve the situation and work out what he would like to say to his teacher. You take on the role of Stewart and he takes on the role of the teacher and you practice the dialogue. You then switch roles and provide feedback to Stewart on how he might come across to the teacher and how that might affect the teacher's reaction.

Am I an effective model for my clients?

Effective use of modelling requires some self-examination. How do **we** solve problems, handle conflicts, organize our time, make fair decisions? Our credibility will be low with clients if we act in ways that are inconsistent with how we are asking them to behave. Our ability to influence clients' behaviour positively will be limited by perceived discrepancies in our words and actions. Alternatively, our confidence and sensitivity with clients will be enhanced when we feel sure of our own skill level in the areas we are modelling. We can appropriately make use of our own struggles and experiences with learning these skills to appreciate what our clients may be encountering and assist them to move through similar barriers to change.

Consider two examples of modelling, one involving a parent and a second involving a children's mental health practitioner.

> *A parent with two young boys, ages two and five, is shopping at the grocery store. The older boy is frustrated with his younger brother because the toddler keeps grabbing his toy. The older brother slaps his sibling. The parent is very upset with her older son and picks up her crying toddler to comfort him. She then slaps the older boy and says "do not hit your brother."*

In this situation, the five year old boy has received two conflicted messages. His mother's words say "don't hit" but her actions say "I can hit when I'm angry or when you've done something wrong." When children are faced with conflicted messages like this, they are more likely to dismiss or ignore the verbal message. While the well-intentioned mother is trying to teach her son a lesson that it's not OK to hurt others, she is in fact modelling the opposite lesson. At best, her son will feel confused. At worst he will feel angry and hurt and continue to believe hitting is OK.

> *A children's mental health practitioner has been working closely with an eleven year old boy who has many problems with anger. She has explained to him that his anger is just a feeling and that it's OK to have this feeling, but it's not OK to express anger through aggression. One day the boy comes home from school in a rage. His face is red, his teeth are clenched, and he is fuming. When the worker sees the boy she feels afraid that he is going to blow up at any minute. To prevent this, she sends him to his room and tells him to cool down.*

In this situation, the children's mental health practitioner has not seen any aggressive behaviour, but knows that the boy is angry. Her words tell the boy that the feeling of anger is OK, but her actions suggest that anger is unacceptable and that he must separate himself when he has this feeling. The unintended message to the boy might be, "Anger is too much for anyone else to handle so you need to deal with it by yourself. You are not acceptable to others while you are angry." If the boy learns that even adults cannot cope with his anger, he is likely to lose his confidence that he can learn to handle it and will continue to experience anger as overwhelming.

Effective modelling can occur when:

- **your actions match your words**
- **you behave in ways that are consistent with your expectations for clients (i.e., "do as I do")**
- **you make appropriate use of your experiences**
- **you are respectful towards clients**

Application

The following steps may assist you in increasing the use of modelling:

- Identify skills (cognitive and behavioural) that need to be modelled.
- Identify modelling of the skill that is already occuring:
  - scan environment for peers and adults who are already using the desired skills
  - determine which of these naturally occuring models would likely have the most impact on your client (e.g., prestige, rewarded for behaviour, admired)
  - determine how to expose the client to the "modelling" and/or highlight it in a natural manner
- Create teachable moments or structure situations that use "modelling" through:
  - highlighting behaviours and situations
  - demonstrating a skill yourself
  - introducing role playing (you and the client, or in peer group)
  - engaging a youth as a "model" for the desired skill/behaviour for another youth (e.g., modelling for a younger child)
- Identify existing modelling that may be influencing or maintaining undesirable behaviours:
  - minimize impact of this negative modelling by changing the model's behaviour, buffering exposure to the model (e.g., less contact, debriefing), changing the youth's response to the model

Case Example

How might we use modelling strategies in our treatment with Jason?

The children's mental health practitioner is very aware that how she deals with anger and how Jason's mother, teacher, and peers deal with anger needs to be examined as part of Jason's treatment.

Modelling by Children's Mental Health Practitioner

The children's mental health practitioner approaches Jason, his mother, and his teacher in a calm manner. She is not easily flustered, even when people seem to be irritated or annoyed with her. She listens closely to what people say, and if there is an area of disagreement, the children's mental health practitioner approaches the issue with a negotiating, solution-focussed style. (See page 110 of the Toolkit for planning how to use modelling with clients.)

Identifying Existing Modelling

Prior to treatment, Jason's mother would handle Jason's aggression in one of two ways and her responses were dependent on her mood. When she was depressed, she would give in to whatever Jason requested as soon as his behaviour started to escalate. His aggression was a very effective strategy for him to get what he wanted. When she was feeling stronger and less depressed, Jason's mother would become angry at his defiance and yell at him so that the two of them would continue to escalate. The interaction would typically end with Jason's mother making an unrealistic threat, "you're grounded for life," and Jason storming out of the house. (See page 130 of the Toolkit for a parent worksheet on modelling.)

Modifying Existing Behaviour

The children's mental health practitioner worked with Jason's mother to help her understand that howshe behaved when Jason was angry was important, and that she had the power to alter the interaction by altering her response. Jason's mother was taught the social problem solving steps and learned how these could be applied to conflicts between her and Jason. When Jason made a request, she was asked to sit down and listen and then discuss any concerns she might have with the request. She then would work with Jason to come up with a list of options that would work for both of them. In this way, Jason's mother would directly model how to solve interpersonal problems. While this approach may not always lead to the exact outcome Jason hoped for, it ensured that he did not have to escalate his behaviour to get his mother's attention. It also reduced the conflict

between Jason and his mom, which strengthened his attachment to her. Jason's mother was "modelling" the very skills Jason needed to learn.

In the school setting where Jason was getting into fights, the teacher was asked to use similar problem solving steps when conflicts arose. If the teacher noticed that a situation was developing, he would intervene early and work with the children involved **before** the situation became conflicted.

Whenever a problem arose, Jason's teacher and mother were asked to cue Jason by saying "Well, let's go through the problem solving steps and see what we can figure out." They were also asked to use this strategy in front of Jason when dealing with his peers and siblings.

Adult Models

Jason's mother and teacher were encouraged to openly express when they felt angry and use **think aloud** strategies to verbally walk themselves through how they should deal with their feelings. E.g., "I'm feeling really frustrated that this kitchen sink keeps leaking. I guess I'd better slow down, take few deep breaths and figure out what I can do to fix it."

Creating Opportunities for Modelling

As part of Jason's treatment, he participated in a group with other aggressive boys. Role playing was used to practice and observe others handling problems using the problem solving steps. Group members were asked during each session to describe a situation in which they handled a problem without using aggression, and to share the outcome of using this approach. This provided an opportunity for group members to hear real life examples of nonaggressive problem solving, and to hear about the consequences of these strategies. (See page 111 of the Toolkit for planning how to use role plays with clients.)

COGNITIVE STRATEGIES

CHAPTER 6

SOCIAL PROBLEM SOLVING

SOCIAL PROBLEM SOLVING

What is problem solving?

Problem solving refers to how we make decisions when we are faced with a choice. Effective problem solving is highly associated with positive adjustment and mental well-being. Problem solving is a key skill in cognitive behavioural interventions. Explicitly teaching the skill is associated with better maintenance of treatment gains for problem specific interventions (e.g., anxiety, aggressive behaviour).

For many of us, problem solving is an automatic skill that we engage in dozens of times per day. Any time we have a decision to make and we make it, we are problem solving. For example, we must decide each day what to wear, what to eat, what route to take to work, when to get up, how to get our daughter to do her homework, how we are going to make that deadline for a project, how we will afford to get the car fixed, etc. It is easy to see that if we do not successfully navigate these problems on any given day, our ability to function and cope would be severely impaired.

Social problem solving refers more specifically to problem solving "interpersonal" conflicts. Children and youth with Conduct Disorder (CD) often have learning gaps in this area and require specific instructions on how to solve interpersonal problems and make decisions. They also benefit from supportive encouragement and opportunities to practice problem solving.

Problem solving involves six basic steps:

1) **define or identify the problem**
2) **assertively communicate the problem**
3) **generate solutions**
4) **evaluate possible solutions and select one**
5) **implement the chosen solution**
6) **evaluate the outcome**

Problem solving skills can be taught in a formalized, structured way to individuals, groups, and families. They can also be taught in the moment as someone is faced with a specific decision. Using both methods to complement one another can be very effective, since the first method ensures an understanding of the procedure while the second method allows opportunities to apply and generalize the learned concepts.

Problem Solving Skills

Step 1 - Define the problem

This if often the most difficult step because it requires the youth to identify why something is a problem **for him**.

Gary might define his problem as "Joey is an idiot." This framework does not lead to a set of solutions that the youth has control over. With some searching ("okay, so you think Joey is an idiot, why is that a problem for you?") , you may discover that this youth is angry because Joey embarrassed him in front of some friends by telling everyone that Gary cried during a movie. The problem can then be reframed as "I felt embarrassed when Joey told everyone I cried because now they all think I'm some baby."

By reframing the problem in terms of Gary's "feelings" and how they were impacted by another person's behaviour, Gary can now consider his options for problem solving.

With interpersonal problems, how the problem is defined takes on special importance. Not only does it matter how the youth defines the problem in her own mind, but she must communicate her definition of the problem to another in such a way that they are able to hear it, understand it and not be so insulted or offended that the chance to resolve the problem is lost. This is a sophisticated skill which many adults struggle with.

Going through all the problem solving steps is not going to be effective if the problem has not been clearly or correctly identified in the first place. This is not as easy as it seems at first. Sometimes the young people that we are working with are unable to identify the problem clearly, or the real problem is masked by their displaced reaction.

Jake blew up at another youth, Angelo, when Angelo sat in Jake's favourite chair in front of the television. His reaction appeared to be far out of proportion to the apparent source of frustration. It becomes clear later on that Jake was angry with his best friend for yelling at him earlier that day, but took his anger out on Angelo rather than talk to his best friend about the problem.

If we ask Jake to identify the problem, he may not even realize that he is taking his anger regarding the argument with his best friend out on another peer. He may identify the problem only in terms of the argument over the chair.

The key to getting a clear picture of the problem is to identify and examine the **emotional response** to it. By helping the youth examine his own angry reaction and discussing why the chair argument led to such feelings, more clarity regarding the problem can be gained.

Another possible scenario is that Jake really was angry about the chair incident and there was no displaced anger regarding an incident with his best friend. Sometimes the emotional reaction has to do with the **meaning** a certain event has to that individual (remember the "filters" we discussed earlier).

Jake may have had few periods of stability in his life. While living in a given setting, he would become attached to certain things that made him feel comforted and at home. The chair he was arguing over represented a source of comfort and familiarity for him. His angry reaction was related to being afraid to lose, once again, something that he needed.

It is clear that depending on how the problem is identified, (e.g., a yelling incident with his best friend versus fear of losing a sense of stability and security), different solutions become appropriate.

Step 2 - Assertive communication of the problem

Once the problem is clearly identified, the next step (if it is an interpersonal problem), is to clearly and assertively communicate the problem.

One clear and assertive method of expressing a problem is to frame it in the following format:

"I feel _____ when _____."

"I want _____."

This format makes the speaker's feelings and wants clear and minimizes the chances of a defensive reaction which can occur when we say "you _____." By stating our wants, we are suggesting how to solve the problem.

In the above example, we identified an interpersonal problem between Jake and his best friend. The problem could be framed as:

"**I feel** angry **when** you yell at me. When I get mad, it's hard for me to listen to what you are saying and then we both storm off mad. **I want** you to talk to me calmly and explain the problem.

Step 3 - Generate solutions

This step involves the youth volunteering solutions to the defined problem. At this stage, no solutions are censored, they are all listed equally, even the inappropriate ones. This is the stage in which you are trying to encourage broad and flexible thinking. It can be helpful to offer some suggested solutions, even silly or outrageous ones. It is important not to criticize the youth's suggestions at this stage, even for clearly antisocial solutions.

Gary may suggest that punching Joey in the face is a solution to his problem. The children's mental health practitioner nods and says neutrally "Yes, that would be one possible solution" and proceeds to write it down on the list along with the others.

With interpersonal problems, the generation of solutions is done with all the involved individuals. Each person contributes suggestions to the list.

Mark wants his girlfriend Alex to go with him to the mall to hang out with his friends. Alex doesn't like one of Mark's friends. Even though she wants to be with Mark, she does not want to be around this other friend.

Together Mark and Alex come up with several win-win solutions:

- *Alex goes with Mark to the mall and they agree that if this friend shows up, she will leave.*
- *Mark goes to the mall alone and meets up with Alex later.*
- *Mark and Alex go somewhere else together where they won't see this other friend.*
- *Alex decides to talk with this friend about his behaviour and why it bothers her to see if she can be more comfortable around him.*

Step 4 - Evaluate possible solutions and select one

During this step, all the listed solutions are judged to determine which is the best. The best solution is one in which everyone is treated fairly and respectfully and negative consequences to everyone involved are minimized. Examining the pros and cons of each solution requires that the youth predict consequences of each solution and consider the needs and rights of others.

This is the step in which Gary's suggestion for hitting Joey would be evaluated. Gary might say it is a good solution because:

- he would feel better
- now Joey would leave him alone
- no one would try to embarrass him again

The children's mental health practitioner might ask Gary for the "down side" to this solution. Prompts regarding the following will help Gary anticipate consequences and broaden his thinking to include the needs of others:

- how the solution might affect Joey
- whether the solution could lead to further problems for Gary
- whether other people in addition to Joey might stay away because they are now afraid of Gary

The best solutions for interpersonal problems are those which help to preserve a positive relationship. These are solutions in which each person walks away feeling she got at least some of the things she wanted: in other words, a win-win solution. These kinds of solutions often involve some compromises. There are some limits to the types of possible solutions: they must be **legal, do-able** and **acceptable to each person**.

Agreeing on the solution to interpersonal problems is sometimes difficult, and an impasse is sometimes reached. Having a third party (such as a children's mental health practitioner) mediate can sometimes be helpful. Another option is to go back and generate more solutions to see if there is another one that is agreeable to both people.

Step 5 - Implement the chosen solution

This step requires putting things into action. The youth will require some communication and negotiation skills to manage this step if it involves another person. The youth will also need to anticipate possible problems with implementing his plan and generate solutions for the potential problems.

If Gary's solution involves ignoring Joey, then he will need to think through how easy or hard this solution will be for him. It will help to identify what might make it tough to follow through on this plan. Gary may recognize that he can ignore Joey once or twice, but if Joey teases him continuously, it will be too hard to stick to the plan. By thinking through possible contingencies, you can help Gary develop a plan that he **can** *implement. In this case, a plan B may be needed if the teasing doesn't stop, such as letting Joey know that if he doesn't stop his behaviour then Gary will go to a teacher for help.*

Implementation of the solution for interpersonal problems requires that each person is clear about her part of the solution and what she will need to do to implement it.

If Mark and Alex agree that he will go to the mall alone and meet up with Alex later, then Mark needs to be clear that he can't continue to badger Alex to go with him to the mall and that he will later leave at an agreed upon time to meet Alex. Alex has agreed to meet Mark later, so she cannot berate Mark for going to the mall instead of coming with her right away.

Step 6 - Evaluate the outcome

This step is important because it involves assessing whether the solution worked. It is a chance to solidify the connection between behaviours and consequences. If a solution was not effective, then the youth has an opportunity to determine why that was the case and how he or she might choose to approach the problem in the future, having learned from this experience. It is also a chance to determine if another plan could be implemented with the same problem. (See page 122 of the Toolkit for a problem solving worksheet.)

Problem Solving Training:

- **helps the youth think about how to approach situations in constructive ways**
- **requires that the youth stop to think about the situation and solve the problem in manageable steps**
- **teaches the youth to generate options and to think through the advantages and disadvantages of the options**
- **is necessary but not sufficient; the youth must also acquire and strengthen prosocial values**
- **should focus on social problem solving**

Values Education

The goal of social problem solving is to help clients learn ways to resolve conflicts and find solutions to problems that balance their needs and rights along with those of others. A youth with antisocial values may learn how to problem solve very effectively but may not incorporate the needs and rights of others into his solutions. His behaviour would therefore continue to be antisocial. In these cases, the very beliefs and values of the client need to be identified and shifted for behavioural change to occur.

Application

Social problem solving can be taught individually or in group contexts. The benefits will be greatest when youths are exposed to problem solving in many forms throughout the day. In fact, your challenge is to create an "immersion" experience that enables your young clients to observe others, as well as practice problem solving themselves on an ongoing basis.

The following strategies are helpful tools for teaching problem solving:

Education	→	teaching youth how to approach problem solving
Modelling	→	showing how you approach problems, thinking aloud as you problem solve alone and with others
Self-Instructional Training	→	helping youth, especially young children, build an internal dialogue to guide problem solving
Coaching	→	helping youth through problem solving situations by encouraging, asking him to consider alternatives, making suggestions, etc.
Rehearsal	→	role-playing, writing out, or talking through an imaginary situation; practising what to do in real situations
Feedback	→	letting the child know when she is problem solving or what she may also want to consider (e.g., options)
Homework	→	creating opportunities to apply this skill in hypothetical or real situations

Case Example

How might we apply the social problem solving skills in our treatment with Jason?

Jason, his mother and his teacher were all taught the six social problem solving steps. Jason and his mother were asked to choose a situation that happens frequently in the home that they could problem solve, using this process.

Identifying the Problem

Jason wants to stay out with friends till 11:00 p.m.. In Jason's opinion, all his friends hang out until this time (regardless of what day of the week it is) and he thinks his mother is unfair for making him come in earlier.

Jason's mother thinks this hour is too late for a 12 year old boy, particularly on school nights. She also doesn't like the idea of him just hanging around since she knows he has gotten into trouble on these occasions. She also doesn't like his friends and prefers he not hang around them at all.

Generating Solutions

Both Jason and his mother are asked to generate possible solutions to the problem. (See page 122 of the Toolkit for a problem solving worksheet.) They come up with the following list:

1) Jason can stay out until 9:00 p.m. (Mom)
2) Jason cay stay out until 11:00 p.m. (Jason)
3) Jason can stay out until 9:00 p.m. on week nights and 10:00 p.m. on weekends. (Mom)
4) Jason can stay out until 11:00 p.m. for special events/occasions. (Jason)
5) Jason needs to tell mom where he is going for the evening and leave a phone number where he can be reached. (Mom)
6) Jason will call home if he can't be reached by phone (e.g., at movie theatre). (Jason)

7) If he's going to be late, Jason will call home and explain. (Mom)

8) If Jason is late getting home and did not call and does not have a reasonable explanation, then he will miss his chance to go out the next night and for one night on the weekend. (Mom)

9) If Jason misbehaves (drinks, does drugs, vandalizes) while out and mom discovers it, then his curfew changes to 6:00 p.m. and the police are contacted regarding any illegal behaviour.(Mom)

   A change in the 6:00 p.m. curfew would need to discussed at the time based on the specific situation.

10) Jason will choose who he goes out with but he will be responsible for his behaviour while with that person. (Jason)

11) Mom will have the right to veto certain relationships if she feels the friendship is not good for Jason. (Mom)

Selecting and Implementing the Solution

Based on this list, Jason and his mother agree to a plan based on points three to ten. Both feel the plan represents a compromise between their positions and takes into account Jason's wish for greater flexibility and mom's wish for safety and monitoring of Jason's activities.

Evaluating, Reviewing, Modifying

The plan is put into action and Jason and his mother sit down at the end of the first week to evaluate how things went. Jason's mom is annoyed because on the Saturday night, Jason did not call home and she had no way to contact him. Jason explained that he was not near a phone and he felt too embarrassed to call his "mommy" in front of some new friends. They decided that Jason could tell his friends he has to call in to collect messages and save embarrassment in front of his friends. They also decided that if Jason saves his allowance money, his mom will split the cost of a cell phone for him, something he wanted to get anyway.

Self-Help Resources

Assertiveness

Alberti, R., & Emmons, M., (7th ed., 1995). *Your Perfect Right: A Guide to Assertive Living.* San Luis Obispo, CA: Impact.

Kaufman, G., & Raphael, L., (1990). *Stick Up for Yourself: Every Kid's Guide to Personal Power and Positive Self-Esteem.* Minneapolis: Free Spirit.

Communication and People Skills

Bolton, R., (reissue ed., 1986). *People Skills.* New York: Touchstone.

Fisher, R., & Ury, W., (1981). *Getting to Yes: Negotiating Agreement without Giving In.* New York: Penguin.

Forehand, R., & Long, N., (1996). *Parenting the Strong-Willed Child.* Chicago, IL: Contemporary Books.

McKay, M., Davis, M. & Fanning, P (1997). *How to Communicate: The Ultimate Guide to Improving Your Personal and Professional Relationships.* NewYork: Fine.

Cooperative Communication Skills
http://www.coopcomm.org/fswcover.htm

CHAPTER 7

COGNITIVE RESTRUCTURING AND SELF-MANAGEMENT

COGNITIVE RESTRUCTURING AND SELF-MANAGEMENT

Cognitive therapy focusses on the individual's thought-feeling-behaviour patterns. The goal is to assist the client with understanding how the internal thoughts and feelings she experiences might be related to specific behaviour patterns. By understanding and then shifting these patterns, clients can gain a greater sense of control over their behaviour.

Automatic Thoughts

Even adults have difficulty identifying their thought patterns. This is because these patterns have become so automatic that we do not notice them anymore. Cognitive theorists have identified a number of thinking patterns that are associated with maladaptive functioning. David Burns (1993) describes 10 of these patterns:

All or nothing thinking: → If someone does one hurtful thing he or she is written off as "no good."

Over-generalization: → One failed test is interpreted to mean "I am stupid."

Mental filter: → Notice and dwell on negative events but ignore or don't notice positive ones.

Discounting the positive: → Accomplishments and positive qualities in oneself are dismissed or discounted.

Jumping to conclusions: → Conclude things are bad without definite evidence.

i) mind reading – assume people have negative feelings about you

ii) fortune telling – predict things will turn out badly

Magnification or minimization:	→	Events take on greater importance/ significance than they seem to warrant or less importance that they seem to warrant.
Emotional reasoning:	→	"I feel like a loser therefore I must be a loser."
Should statements:	→	Behaviour is judged in terms of how people "should," "must," or "ought" to behave.
Labelling:	→	Instead of saying "I made a mistake" you tell yourself "I'm such a jerk."
Blame:	→	Blame yourself for events outside your control, or blame others and overlook your role in the problem.

Antisocial thinking linked to antisocial behaviours

Some additional thinking patterns and beliefs "permit" an individual to engage in antisocial behaviours. You may have listened to your young clients "rationalize" and "justify" their misconduct in an effort to make their behaviour acceptable. Examples of thinking patterns or thinking gaps related to antisocial behaviour include:

Power thrusting:	→	A learned belief that you get what you want by verbally and/or physically opposing or bullying others.
Lack of perspective taking:	→	The failure to consider the feelings and position of others.
Victim stance:	→	Perceiving self as victim when held accountable for victimizing others and for disregarding rules/laws.
False view of self (false pride):	→	The belief that one is above the rules and laws that apply to others.
Failure to be straight:	→	The belief that it is okay to be dishonest in communication with others.

Although we all engage in these thinking patterns to some extent, people who repeatedly engage in serious misconduct often display pervasive cognitive distortions and fail to catch or correct such thoughts when they occur.

Using the described list of thinking patterns, we can sometimes help clients to identify which patterns may apply to them.

What is cognitive restructuring?

Cognitive restructuring helps clients consider any maladaptive patterns in their thinking-feeling-behaviour cycles. The client's goal is to rethink these patterns and consider more adaptive alternatives that will work better for him or her. Ultimately, the goal is to have the youth recognize that sometimes his thoughts lead to feelings and actions which are antisocial. By examining and changing his thoughts (beliefs), feelings and actions are altered in a prosocial direction. If she is successful, this shift in thinking can help the youth minimize her chances of future misconduct.

How do you identify someone's beliefs and their link to feelings and actions?

The first step in the process is to help young people identify the ways their thoughts and feelings and actions are linked. Illustrating the concept with examples will help the youth grasp the concept. However, relating this to his or her own thought-feeling-action patterns will not come automatically. To gain personal insight, the youth will need an opportunity to **rewind and replay** various events. The role of the children's mental health practitioner is to ask questions that allow the youth to identify the key components of the pattern. (See page 123 of the Toolkit for a client worksheet aimed at identifying these thinking patterns.)

Consider how we might help a youth named Maggie to rewind and replay an event to gain insight into her own thought-feeling-action pattern.

Maggie was walking down the school hallway when Tessa bumped into her. Maggie shouted at Tessa to "back off" and shoved her. Maggie was suspended for a day for her conduct.

Maggie's ability to avoid problem conduct in the future will depend on her ability to alter her reaction to similar future events.

When asked to think through what happened, Maggie may talk about how Tessa deliberately walked right into her and that if Maggie puts up with that, then she is a walking victim.

Maggie's **beliefs** are that:

1) Tessa purposely wanted to hurt or annoy Maggie.
2) If you don't come out punching then others will be free to push you around.

Maggie and the children's mental health practitioner discuss any distortions in the above thinking patterns. For example, belief one represents *mind reading* while belief two represents *magnification, all-or-nothing thinking* and *over-generalization.*

The children's mental health practitioner can then explore with Maggie how these two beliefs are the basis for Maggie's anger which led to her subsequent reaction of shoving Tessa.

Rational Analysis

Once the thoughts/beliefs have been identified and their link to feelings and actions explored, the children's mental health practitioner can assist the client with considering different, perhaps more realistic, perspectives on the same event.

In the example involving Maggie and Tessa, Maggie is asked to consider possible alternatives to her thoughts/beliefs. Some examples might include:

1) Tessa bumped me by accident, it was no big deal.
2) When people do things to purposely hurt or annoy me, I can take care of myself by talking things through with them. There's no need for me to get into trouble because of their behaviour.

These beliefs are less likely to create the same angry, defensive, and aggressive feelings that led to problem behaviour for Maggie.

Depending on which belief seems more accurate and realistic to Maggie, she then has to decide how to respond. She can use the problem solving skills outlined in chapter six to develop a plan.

How do you help a client change his/her thinking (or restructure cognitions)?

The next step in the process is to help the youth recognize that beliefs and their associated feelings and actions, can change. By helping the client identify his thoughts and beliefs, it becomes easier to pinpoint where these beliefs came from. The client can then consider if that source is the most accurate or valid one. Some beliefs are based on repeated messages from an important person, some are based on events, and some are based on the individual's reaction to events. The therapist can assist the individual with understanding how some beliefs interfere with the client's positive development. The therapist can also assist the client with exploring more positive, adaptive interpretations on events.

> *A youth who was beaten by his father believes "I am hateful and unlovable because even my own father couldn't stand me." In therapy, this belief would be examined and other possible explanations for the father's behaviour would be explored, such as "My father had serious problems and took them out on me because I couldn't defend myself and I was available. I didn't deserve to be hit and it is not a reflection on me that my father hit me." The original belief led to feelings of self-loathing, while the altered belief created feelings of sadness and anger for being the victim of maltreatment. These latter feelings were then explored and resolved in treatment.*

The youth can be taught that we are all entitled to choose our beliefs and that some beliefs will enhance our lives while others will limit it. Some beliefs lead to antisocial behaviours and others lead to prosocial behaviours.

Self Monitoring and Self-Talk

Once a client has identified her thought patterns and how they are linked to feelings and problem behaviours, she can then monitor her own "trouble spots." If anger leading to aggressive behaviour is an identified area of difficulty, then the youth will need to learn strategies for monitoring the build up of anger. This might include developing an awareness that clenched fists and tight shoulders are the early signs of trouble. When the youth notices these physical cues, then she can learn some self-statements or self-talk which help her to slow down and carefully assess the situation and her reaction to it. Examples of such statements might be "Ok, slow down, remember to stay in control. This isn't worth getting into trouble over." The client can then begin using the problem solving strategy to figure out how she wants to deal with the situation.

Self-talk is a simple technique that can be used effectively with younger children. Younger children can learn to monitor their body for clues that they are feeling angry, for example. When they notice the body clues, they can begin using their self-talk statements. This helps them slow down and put some time between the feeling of anger and their behaviour, and allows them to review some simple, preplanned options (e.g., I can walk away, I can get help, I can ignore it).

Why is it so hard for us to change our beliefs?

Asking someone to consider alternatives to his current beliefs is asking a lot. We know that many of our beliefs are based on our experiences. Some life lessons are painful and traumatic. Most people work hard to avoid getting hurt again. Changing some belief patterns is like removing a protective wall that might be lonely and isolating, but creates some sense of safety and protection. If you are asking someone to change a core belief from "nobody can be trusted" to "there are some people I can trust," you are asking him to risk getting hurt, rejected, and disappointed should his trust be broken. You are also asking him to take a chance that he will feel cared for, loved, and connected should his trust be well-placed. The client is faced with an enormous decision about whether the benefits of trusting someone outweigh the risks. Such decisions sometimes take years and are made in small increments, so patience is an essential asset in the children's mental health practitioner.

How do we make it less painful?

One way to make the task of change easier is to reduce the level of risk involved for the client. That means starting with decisions and situations where the client's ability to tolerate a negative outcome is greater because of less investment in the outcome.

> *Ben is terrified of rejection due to his experiences of abuse by his parents and their failure to fight for him when he was removed from their care. He believes that rejection is an inevitable part of any relationship at some point. He deals with his fear by hurting others first (through aggression, lying, stealing) before they have a chance to hurt him.*

Ben is very interested in a female classmate and wants her to be his girlfriend. He cannot bring himself to ask her out and risk rejection. He knows he would feel devastated by this outcome.

The children's mental health practitioner recognizes that Ben has to start with something easier so he suggests that Ben invite another male classmate out to a movie. This task is less risky for Ben because he would not feel devastated if this person said no. This task is within Ben's comfort level for risk of rejection and is therefore do-able.

If the outcome of this process is positive and the classmate says yes, Ben now has a positive experience of acceptance (versus rejection) to build from. It will be the build up of similar experiences which allows Ben to shift his belief that he will always and eventually get rejected by everyone. As his beliefs regarding the inevitability of rejection become more balanced and realistic, then his feelings and reactions to rejection when it does happen will also become less overwhelmingly negative. (See page 112 of the Toolkit for planning strategies to develop clients' cognitive skills.)

Cognitive restructuring includes collaboratively working with older children and adolescents:

- **to become aware of their thinking patterns and associated feelings and behaviours**
- **to identify and change thinking patterns associated with antisocial behaviour**
- **to use self-monitoring, self-talk, and rational analysis**

Application

The following steps can be followed as part of the cognitive therapy process:

- identify thinking patterns associated with Conduct Disorder/antisocial behaviour, and prosocial behaviour
- identify possible distortions in thinking patterns
- invite youth to become more aware of his "thinking" and the links between experience, thoughts, feelings, and behaviours
- work collaboratively with youth to identify and strengthen patterns of thinking associated with prosocial behaviour, and to change patterns of thinking associated with antisocial behaviour using cognitive restructuring
- promote and create opportunities for behaving differently to strengthen changes in thinking patterns by:
  - using positive and negative consequences
  - creating associations with prosocial peers
  - introducing new situations, people, settings

Case Example

How can cognitive therapy be applied to our treatment with Jason? (See pages 112, 120, 121, and 123 of Toolkit.)

Identifying Thinking Patterns and Distortions

Jason's thoughts and beliefs regarding aggression are discussed. He is asked to **rewind and replay** various situations in which he physically attacked a peer, damaged property, or fought with his mother. In many cases, there is some comment or reaction from another person that Jason perceives as a criticism, insult or rejection. In some situations this is clearly the case, while in others it is more ambiguous. Either way, when Jason perceives these slights he thinks:

1) Everybody thinks they're better than me, I'll show them they can't mess with me (over-generalization, mind-reading, power thrusting).

2) If I can beat someone up or scare them, they'll stop bugging me and maybe respect me (power thrusting, lack of perspective taking).

3) I may not be as smart as other people but I'm stronger and that's what really counts (mental filter, power thrusting, all-or-nothing thinking).

4) The only way to make people listen and do what I want is to scare them (over-generalization, all-or-nothing thinking, lack of perspective taking).

5) I can't get people to like me (mind-reading, mental filter, over-generalization).

6) Most people don't really care about me or care what happens to me (over-generalization, mental filter, fortune-telling).

Establish LInk Between Beliefs and Experience

Jason's thoughts tell us that he really isn't sure how to deal with problems and get his needs met in nonaggressive ways. He also has some negative beliefs about himself that are highlighted when others reject, criticise or insult him.

Jason is asked where his beliefs come from. While he is not sure, he talks about how his dad must hate him because he left and has not even tried to see him. He talks about how his mom does not seem to care sometimes, while at other times she gets mad at him. Some therapy work is done with Jason regarding the behaviour of his parents. His father's failure to contact him is discussed in terms of his father's own limitations. Jason's mother joins some sessions to talk about his father and some of his strengths and limitations as a person (Mom needed some individual time with the children's mental health practitioner to discuss how to provide Jason with a balanced view of his father). As well, Jason's mother's behaviour is attributed to her own way of coping rather than a reflection of her feelings for Jason. The fact that she is working to change her behaviour highlights the fact that her behaviour is her responsibility and that Jason is not the cause of her behaviour.

Jason and the children's mental health practitioner also discuss what he has learned from interactions with peers and his sense that aggression is really his best option for getting his way since he has not had much success otherwise.

Cognitive Restructuring and Self-Talk

Jason explores some different perspectives on aggression based on what he has learned from experience so far:

1) Aggression sometimes gets me what I want but sometimes it just causes me a lot of problems.
2) While blowing up feels good for a few minutes, it can be embarrassing later.
3) Scaring people can get them to do certain things, but I've lost some friends that way.
4) Now that I'm learning about problem solving, there may be other things I can do instead of blowing up at people.
5) Things are working out OK with my mom and teacher now that they listen to me and we figure things out together, and we don't have to get into big fights anymore.

Jason and the children's mental health practitioner explore some self-statements he can use when he feels his anger building inside. He decides to remind himself "I don't need to lose it over this," "I can handle this," "Just remember my steps."

As Jason has some successes with peers and adults in his life using nonaggressive strategies, he begins to solidify the second, more realistic set of beliefs regarding use of aggression. This gives him some confidence to keep trying the nonaggressive problem solving steps he has learned.

Self-Help Resources

Mood Disorders

Beck, A., (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Burns, D., (rev. ed., 1999). *Feeling Good: The New Mood Therapy.* New York: Avon.

Burns, D., (rev. ed., 1999). *The Feel Good Handbook.* New York: Plume.

Greenburger, D., & Padesky, C.A., (1995). *Mind Over Mood: Change How You Feel by Changing the Way You Think.* New York: Guilford Press.

Lewinsohn, P., Munoz, R., Youngren, M.A., & Zeiss, A., (1996). *Control Your Depression.* Englewood Cliffs, NJ: Prentice Hall.

McGrath, E., (1994). *When Feeling Bad is Good.* New York: Bantam.

Depression
http://www.queendom.com/selfhelp/depression/depression.html

Stress Management and Relaxation

Benson, H., (1975). *The Relaxation Response.* New York: Morrow.

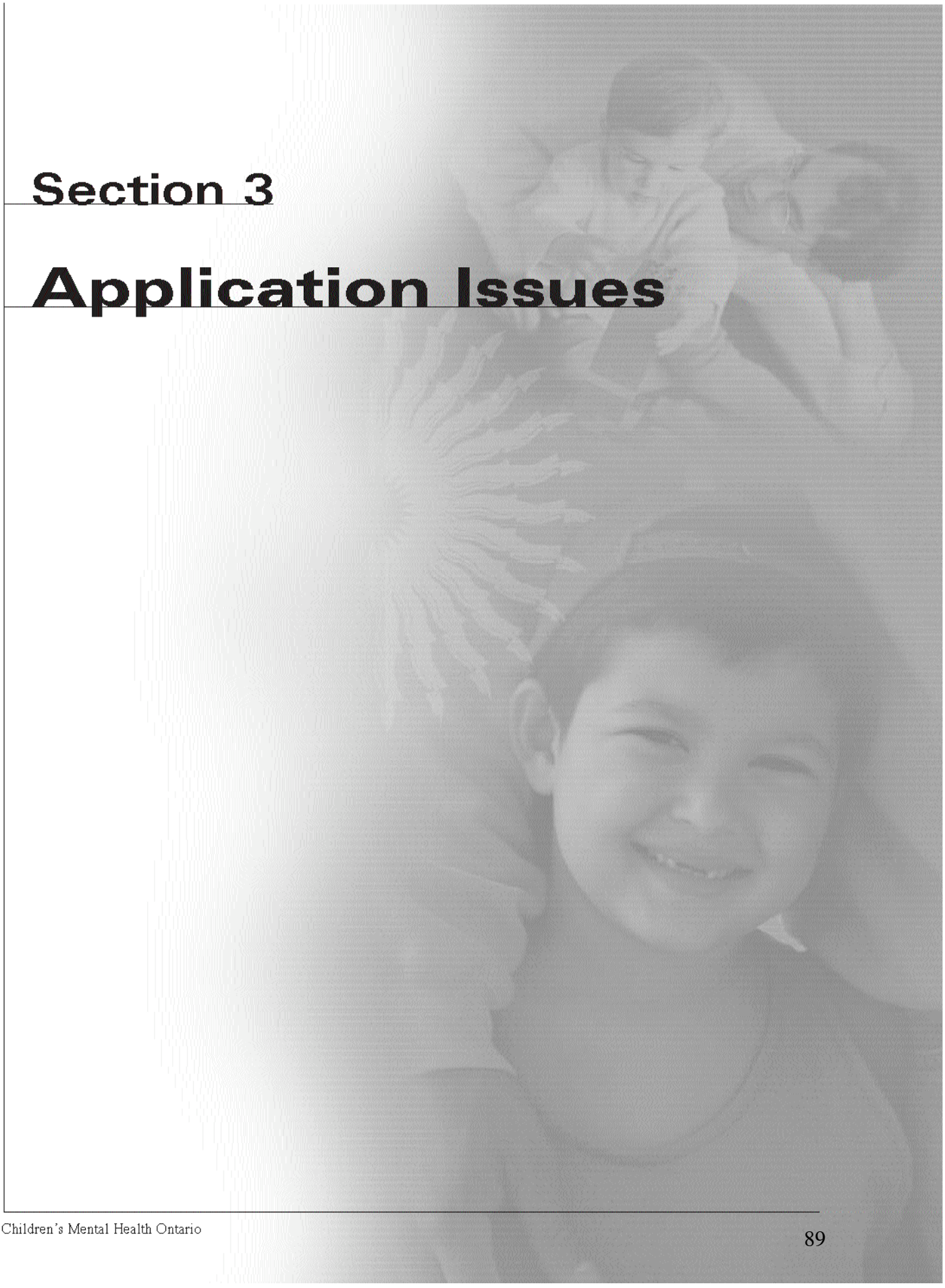
Benson, H., (1984). *Beyond the Relaxation Response.* New York: Time Books.

Davis, M., Robbins-Eschelman, E., & McKay, M., (1995). *The Relaxation and Stress Reduction Workbook.* Oakland, CA: New Harbinger.

Kabat-Zinn, J., (1994). *Wherever You Go, There You Are.* New York: Hyperion.

Madders, J., (1997). *The Stress and Relaxation Handbook: A Practical Guide to Self-Help Techniques.* London, UK: Vermilion.

Basis Guided Relaxation: Advanced Technique
http://www.dstress.com/guided.htm



Section 3

Application Issues

CHAPTER 8

ASSESSMENT OF BARRIERS TO CHANGE

ASSESSMENT OF BARRIERS TO CHANGE

In our roles as therapists and children's mental health practitioners, identifying the nature of someone else's difficulty is not always easy. Sometimes it can be helpful to go through a process of elimination to determine what is wrong and why things are not getting better. A familiar example of this process occurs when we have a crying newborn. We keep trying different things to remedy the most likely problems until the crying stops. First we check the diaper, then we try feeding, then we try burping. Finally after we are satisfied that the problem is not a dirty diaper, hunger or gas, we then consider other possibilities such as illness or boredom, etc.

We can use this process of elimination in a similar way with our clients. As treatment proceeds, we need to monitor behaviour change. If change is negligible, we need to assess why that might be so that we can determine if further, alternative interventions would be helpful. Once a skill set has been learned, we need to determine what is getting in the way of that client's ability to use those skills.

Common Trouble Spots

When working with children and youth with Conduct Disorder (CD), we can conceptualize their difficulties in terms of four common "trouble spots." These are common areas of difficulty for this group which often present barriers to change. We may view treatment as the process by which we eliminate these barriers so that the client can learn new, more adaptive skills and put these skills into action.

The four trouble spots are:

1) limited ability to process and solve problems
2) distorted perceptions regarding events
3) antisocial values
4) emotional disregulation

Limited Ability to Process and Solve Problems

Behaviour management, modelling, and problem solving techniques are all designed to address the first trouble spot, limited processing and problem solving ability. We have discussed how these techniques can assist the young client to learn links between prosocial behaviour and positive outcomes, anticipate consequences, consider the needs of others, and generate and execute solutions to social problems. If a client's difficulties with processing and solving problems are due to a developmental delay or an addiction problem, then treatment should emphasize environmental interventions (behaviour management and modelling) which do not require high levels of cognitive functioning, insight, or treatment readiness. Addictions should be treated as the first priority, before other treatment goals are pursued.

Distorted Perceptions Regarding Events

The second trouble spot can be resolved through the use of cognitive therapy techniques. Using rewind and replay techniques, rational analysis, cognitive restructuring, and self-monitoring allows the youth to rethink old response patterns and change the way he views future events.

Antisocial Values

The third trouble spot, antisocial values, are a product of the client's direct and witnessed experiences. All four of the treatment techniques which alter the client's experiences and interpretation of experiences contribute to changes in values. This type of change often takes time and occurs gradually, based on accumulated new experiences which reinforce prosocial values.

When we are satisfied that our client understands how to solve problems, can interpret events realistically and has prosocial goals and priorities, then look to see if her inability to regulate her emotional state is interfering with change.

Emotional Regulation

Our ability to think clearly and broadly is strongly affected by our emotional state. When our emotional state is heightened, our thinking processes are compromised. If you feel overwhelmed by fear, panic, grief or pain, then finding a quick way to make these feelings disappear or lessen becomes your first priority. It is important to understand that these are not emotions in the usual range of day to day experience. These are extreme, intense, and overwhelming emotions. Imagine how you might feel if your spouse announces he wants a divorce, your child is diagnosed with cancer, or you are threatened at knife point. This will give you some idea of the kinds of emotions we are talking about. They are debilitating.

This is why we sometimes have trouble seeing solutions to a crisis while we are in the middle of one. Someone outside the crisis can often see options and solutions more easily.

Imagine that you are in the mall and suddenly you loose sight of your two year old child. Your stomach drops, you feel nauseous, and your heart starts pounding. You start calling for your child and run around and around the same area looking for them. The longer it takes to locate your child, the more panicked you become, but your search efforts remain limited to the area you last saw her. It doesn't occur to you to go to the security desk, ask other shoppers for help or make your search efforts more systematic.

When we work with clients, we need to assess where to focus our treatment efforts. In the above scenario, it would not be helpful to say to this competent intellegent individual who has lost her child, "let's problem solve to see what your options were so that you can use similar skills when faced with future problems." In a calm state of mind, this same person can easily generate effective solutions. The barrier to effective problem solving in the crisis was her state of emotional arousal, not a cognitive skill deficit.

When working with young people, we need to determine if they have the cognitive skill set required to problem solve. If so, then we must ask, "what is getting in the way of their ability to use their skills?" If emotional arousal is the barrier, then they need to be taught ways to manage intense emotions and regulate them so they are less likely to interfere with problem solving.

When working with young people diagnosed with CD, there is an extremely high probability that their emotional needs have not been met in the past and that they have been exposed to significant losses and traumas. As a result, they may not have learned how to regulate their emotions and often experience them as intense, overwhelming, and unbearable. Even ordinary day to day events can trigger intense feelings of fear, panic, grief, or pain which may have originated with past traumatic events. Children with CD are more likely to experience the kind of emotional arousal which interferes with ability to implement cognitive skills.

When our emotions are heightened, we look for ways to neutralize them at least temporarily, because the experience is aversive. Examples include drug use, self-injury, thrill seeking, and aggressive outbursts. The problem with these strategies is obvious, and they create a whole new set of difficulties for the child or youth to deal with.

Helping Clients to Manage Intense Emotions

We need to assist our young clients to identify safer more adaptive methods for neutralizing painful emotions. These methods may not be as quick acting, but lead to fewer problems or "side effects." One of the most powerful ways of neutralizing painful emotions is contact with an attachment figure who can soothe and comfort reliably (e.g., who is the first person you want to talk to when you go into labour, lose your job, have your house broken into?). Developing a list of people the youth could contact when painful feelings arise and working with the people on that list to help him understand how they can help in such moments can be an important strategy. Other methods of neutralizing negative emotion involve deep breathing and relaxation while waiting for the feelings to attenuate. Strategies which allow for the release of built up energy (adrenaline) in safe ways can also lead to calmness and might include physical activities such as running, sports, or use of a punching bag.

Once the client's emotional state is managed, she can begin to use her problem solving skills once again. Clients need to learn which emotions lead to which maladaptive behaviours so they can begin to plan for change. Once they know which behaviours they want to change, they can plan how to handle the feelings which normally precede that target behaviour in ways that are safer and more adaptive. (See pages 113, 114, and 115 of the Toolkit for worksheets on identifying "trouble spots" to treatment progress.)

EMOTIONAL REGULATION

Helping youths identify and manage emotions that feel overwhelming, such as sadness or anger, can lead to an increased sense of control for themselves. Youths can better generate options when they are able to regulate emotions.

Youths benefit most when:

- **adults support them to learn to regulate their emotions (e.g., cueing, talking them through, debriefing)**
- **awareness education and preplanning occurs**
- **strategies focus on identifying and dealing with emotion before it builds to intense levels**
- **coping/regulating skills are taught that increase the youth's self-regulation (e.g., relaxation training)**

Self-Help Resources

Anger

Bilodeau, L., (1992). *The Anger Workbook.* Minneaplois: CompCare.

Ellis, A., & Chip Tafrate, R., (1997). *How to Control Your Anger Before it Controls You.* Secaucus, NJ: Birch Lane Press.

Potter-Efron, R., & Potter-Efron, P., (1995). *Letting Go of Anger: The Ten Most Common Anger Styles and What To Do About Them.* Oakland, CA: New Harbinger.

Whitehouse, E., & Pudney, W., (1996). *A Volcano in My Tummy – Helping Children to Handle Anger.* Gabriola Island, BC: New Society Publishing.

Controlling Anger
http://www.apa.org/pubinfo/anger.html

CHAPTER 9

HOMEWORK

Homework

A key factor in making cognitive behavioural techniques effective is to ensure that clients receive many opportunities to practice their skills. We need to see the lessons learned translated into behavioural change to know if therapy has been successful. Passively watching and verbally reciting knowledge may be part of the learning process, but if behavioural change is going to occur, a chance to put information into action is needed.

Consider the common experience of being the passenger in a car. Even if you have been through a particular route several times, you may not be sure how to get to the familiar destination if you were asked to drive. Once you have driven the route even once, you will likely feel much more confident about finding your way again than if you have only watched someone else drive the route. Clients are much more likely to use the skills they have learned if they have already had a chance to see how these skills feel when put to use and how these skills can lead to positive outcomes in their own lives.

Homework is a chance for clients to practice what they have learned. It can take many forms, including:

- asking a client to list some of his thoughts and analyze if they are accurate, distorted or unrealistic
- asking a client and a family member to pick an area of disagreement and use the social problem solving steps to work out a solution
- asking a client or parent to monitor behaviour and keep track of antecedents and consequences to that behaviour
- asking a client to practice role playing a discussion she plans to have the next day
- asking a parent to come up with possible incentives and consequences that could be used in the home to manage difficult behaviour and encourage positive behaviour
- asking a client to take the next step towards a goal, e.g., asking someone to go out for a coffee as part of dealing with social anxiety
- asking a parent to think about what kind of model he wants to be and what he could do towards that goal

Homework gives clients a chance to reflect on how the new concepts they are learning might apply to their own life and experience. It takes time to absorb and integrate new information and particularly to incorporate it into one's daily routines.

It is important for homework to be framed as a chance to practice learned skills and work out any "glitches." If it becomes a battle of control or power, then it is no longer a productive exercise.

Clients need to choose what, when, and how they will use homework to enhance their learning. Explaining to clients that homework can help to speed up the learning process and help them reach their goal faster, allows them to choose if this is what they want. Failure to complete an assigned task may reflect that for this client, the pace is too fast. Slowing down and asking the client to decide what she is ready to try and what she feels she can do, may be helpful in determining more appropriate assignments. Additionally, using incentives and rewards for completion of homework or achievement of a specific treatment goal can keep clients positively motivated. For example, a client who completes homework could be given extra priviledges such as a later curfew.

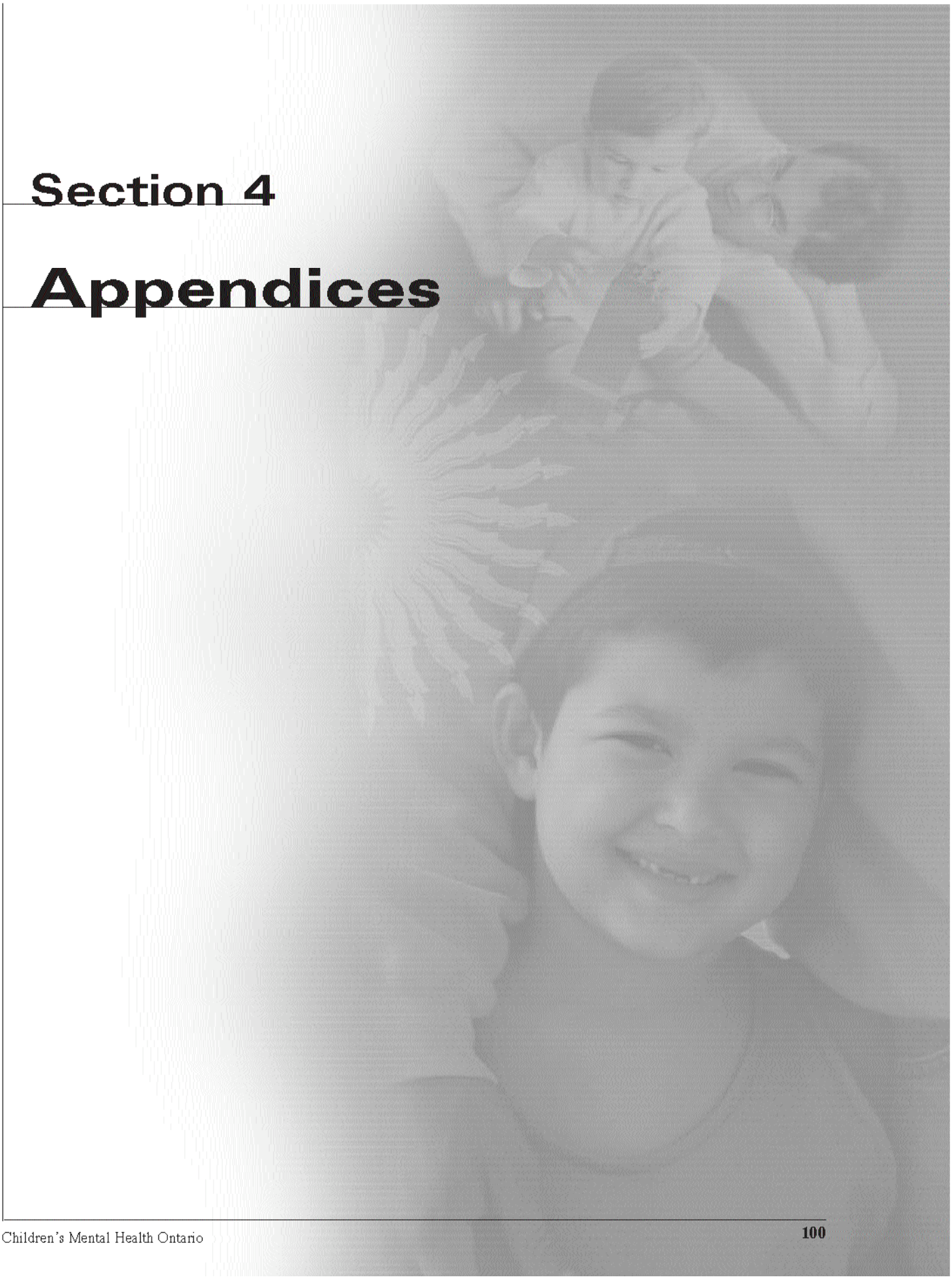
There will always be some clients who do not want to do homework and who do not complete tasks between sessions. For these clients, the sessions can be used as opportunities to practice and do tasks that might normally be completed by the client alone. It is important that clients do not feel reprimanded under these circumstances, since this will only break down the therapeutic relationship and the children's mental health practitioner will lose his ability to positively influence the client's growth. Whenever we work with clients, we need to be careful to go at their pace and recognize small increments of change.

THE EFFECTIVE USE OF HOMEWORK

- **Have the client identify goals for change and keep homework relevant to these goals.**
- **Reward completion of homework tasks with extra priviledges.**
- **Avoid power battles over homework completion.**
- **Present homework as a chance to practice and achieve goals faster.**

Section 4

Appendices



APPENDIX 1

TOOLKIT

FORMS FOR CHILDREN'S MENTAL HEALTH PRACTITIONER

Assessment Form

Name:

D.O.B: DD / MM / YYYY ☐☐☐☐ **Age Category (5-12)** ☐ **(13-18)** ☐

Diagnosis: _____

_____

Behavioural Difficulties: (check all that apply)

Aggression ☐
Severity of Behaviour: **Low** ☐ **Moderate** ☐ **High** ☐

Property ☐
Severity of Behaviour: **Low** ☐ **Moderate** ☐ **High** ☐

Deceit/Theft ☐
Severity of Behaviour: **Low** ☐ **Moderate** ☐ **High** ☐

Rule Violations ☐
Severity of Behaviour: **Low** ☐ **Moderate** ☐ **High** ☐

Other (please specify) _____
Severity of Behaviour: **Low** ☐ **Moderate** ☐ **High** ☐

Medical/Developmental Issues: _____

_____

_____

Verbal Skills: **Low** ☐ **Moderate** ☐ **High** ☐

Insight: **Low** ☐ **Moderate** ☐ **High** ☐

Treatment Readiness: **Low** ☐ **Moderate** ☐ **High** ☐
(recognizes need for personal change, recognizes how his/her choices are leading to at least some of his/her problems).

(See chapters one, two and four to seven for background information.)

Family Factors:

Parental Mental Health Issues: (e.g., antisocial personality, depression) _____

_____

Parental Behavioural Issues: (e.g., violence, substance abuse, child abuse) _____

_____

Resource Issues: (e.g., poverty, lack of supervision)_____

_____

Client Strengths: (check all that apply)

Behavioural ☐ **Academic** ☐ **Social** ☐ **Family** ☐

Parental Strengths: (check all that apply)

Behavioural ☐ **Emotional Attachment** ☐

Personal Competency ☐ **Vocational** ☐ **Health** ☐

Recommendations and plans regarding treatment emphasis.

(Consider age, gender, verbal skills, insight, parental and client readiness for treatment.)

1) Environmental Approaches – behavioural management, modelling: (greater emphasis with younger, less verbal, less insightful clients who have a lower readiness for treatment) _____

_____

2) Problem Solving: (can be learned by broad range of clients – emphasize role playing and practice for younger, male, less verbal clients) _____

_____

3) Cognitive Therapy: (greater emphasis with older, more verbal/insightful clients who are ready for change) _____

_____

4) Parent and School Interventions: (emphasize role of these individuals when working with younger clients)_____

_____

Staff Progress Report (pre-treatment)

Name: _____

Date: DD / MM / YYYY

1) Identify the behaviours your client currrently exhibits that you would like to see improve with treatment. (For each of the behaviours listed below, rate the severity of the behaviour such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

2) Identify the emotional issues your client currently exhibits that you would like to see improve with treatment. (For each of the emotional issues listed below, rate the severity of the problem such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

3) Identify the kinds of supports and resources that you would like your client to have more of as your client undergoes treatment. (For each resource, rate the degree to which you feel your client receives support such that 1=no support and 10=excellent support.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

4) List the ways in which you would like to see the relationship between your client and his/her caregiver improve with treatment. (For each area of improvement, rate the severity of the problem in the relationship such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

Staff Progress Report (post-treatment)

Name: _____

Date: DD / MM / YYYY

1) Using the list of behaviours you identified prior to treatment, rate the current severity of each behaviour such that 1=very severe/serious and 10=very mild.

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

2) Using the list of emotional issues you identified prior to treatment, rate the current severity of each issue such that 1=very severe/serious and 10=very mild.

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

3) Using the list of supports and resources you identified prior to treatment, rate the degree to which you feel your client currently receives such support for each item such that 1=no support and 10=excellent support.

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

4) Using the list of ways you wanted to see the relationship between your client and his/her caregiver improve with treatment, rate the current severity of each problem in the relationship such that 1=very severe/serious and 10=very mild.

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

Treatment Planner

Name: _____

Goals of treatment: (e.g., client resolves conflicts verbally and without aggression)

Short term: (please list) _____

_____

_____

_____

Long term: (please list) _____

_____

_____

_____

Indicators of Success: (easy to observe/measure, e.g., fewer suspensions for fighting at school)

Short term: (please list) _____

_____

_____

_____

Long term: (please list) _____

_____

_____

_____

Treatment Approaches to be Used: (list according to emphasis)

Identify which goal to be targeted by which treatment approach.

1) _____

2) _____

3) _____

4) _____

Date for progress review: DD / MM / YYYY

(See section two for background.)

Behaviour Analysis

Date: DD / MM / YYYY

Name of Observer: _____

Name of Client: _____

Behaviour Monitored: _____

	ANTECEDENT	CONSEQUENCES
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		
Day 6		
Day 7		

Your assessment of what seems to motivate or trigger the target behaviour: _____

_____

Your assessment of what seems to maintain or reinforce the target behaviour: _____

_____

(See chapter four for background.)

Strategy Plan for Use of Modelling

Counsellor: _____

Client: _____

Date: DD / MM / YYYY

Describe behaviour to be modelled: _____

List situations/opportunities where desired behaviour could be modelled for this client: _____

Plan for modelling coping response: (include what you will say, how you will respond to possible questions).

1) **Less desired response:** _____
2) **Self-correction:** _____
3) **Labelling error:** _____
4) **Constructive (corrected) new response:** _____

Other plans for modelling: _____

(See chapter five for background.)

Strategy Plan for Use of Role Plays
(Children's Mental Health Practitioner Worksheet)

Counsellor: _____

Client: _____

Date: DD / MM / YYYY

Teaching goal of role play: _____

Describe Scenario: _____

List "roles" to be played: _____

Possible problems that could arise: _____

Plan for responding to problems: _____

Key themes to be emphasized: _____

(See chapter five for background.)

Planning Work Sheet for Development of Cognitive Skills

Cognitive skill to be developed: (e.g., considering consequences to actions)

_____

_____

Check off which treatment strategies you will use to help client develop identified skill. Outline your plan for how you will use the treatment strategies to develop the skill.

Modelling:

☐ **Peer modelling:** _____ ☐ **Adult modelling:** _____

☐ **Think Aloud:** _____ ☐ **Role Playing:** _____

Problem Solving:

☐ **Issue with staff:** _____ ☐ **Issue with peer:** _____

☐ **Issue with parent/caregiver:** ☐ **Issue with teacher:** _____

Cognitive Restructuring:

☐ **Analysis of automatic thoughts:** _____

☐ **Rational analysis to more reasonable belief:** _____

☐ **Self-monitoring:** _____ ☐ **Self-talk:** _____

(See chapter seven for background.)

Troublespots (when change isn't happening)

1) Does client have cognitive limitations that interfere with his/her ability to "read" social situations, remember new information, apply new learning to real life situations, etc.?

Yes ☐ **No** ☐

If so, focus on lots of practice, role playing, modelling, exposure to wide variety of possible scenarios, consistent feedback from parents/teachers to expand generalizability. These clients benefit most from "experiencing" rather than "talking."

Plan: _____

_____

_____

2) Does client have emotional issues that interfere with his/her ability to "read" social situations, resist destructive behaviour?

Yes ☐ **No** ☐

If so, plan strategies to neutralize intense emotion.

a. Attachment figures: _____

_____

What response is helpful? _____

_____

b. Relaxation/breathing training: _____

_____

c. Physical release (exercise plan): _____

_____

A referral for individual psychotherapy may be needed to assist clients with resolution of trauma, depression, or anxiety for example. Such treatment can be concomitant with treatment for the behavioural problems of CD.

Plan: _____

_____

_____

(See chapter eight for background.)

Troublespots (cont'd.)

3) Is readiness for treatment an issue? Client may feel that his/her current lifestyle and way of coping is fine and have no desire for change?

Yes ☐ **No** ☐

If so, focus on environmental change through behaviour management and modelling. If possible, wait out and maintain contact with the client until he/she is ready. Focus treatment efforts on those affected by the youth (e.g., parents, school, community). Changes in the youth's environment can lead to increased motivation for change since consequences tomisconduct may become more aversive (e.g., parent starts using consequences to misbehaviour where before it succeeded in getting the youth what he/she wanted).

Plan: _____

_____

_____

4) Are treatment goals being undermined by contradictory messages/behaviours from other players in the child's life (parents, school, community, other treating professionals)?

Yes ☐ **No** ☐

If so, include these players in treatment in an effort to coordinate treatment. If cooperation is a problem, then consider more intensive approaches such as residential treatment or family preservation. (If the client is older and more intensive approaches are not an option, help the client understand how to take care of his/her own needs and future by avoiding choices which may be reinforced by others but are ultimately self-destructive.)

Plan: _____

_____

_____

Troublespots (cont'd.)

5) Is the pace of change too fast or are the goals too big?

Yes ☐ **No** ☐

Clients who say they want to change but act in ways which seem inconsistent with this may be feeling that things are going too fast. By having the client identify goals and focussing on his/her priorities, we can help ensure that we don't move too fast. Clients may also need help breaking down goals into smaller steps because they may not yet have the skills to achieve the larger goal.

Plan: _____

_____

_____

CLIENT FORMS

Client Progress Report (pre-treatment)

Name: _____

Date: DD / MM / YYYY

1) **Identify the behaviours you think cause you problems and that you would like to change with treatment.** (For each of the behaviours listed below, rate the severity of the behaviour such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

2) **Identify the emotional issues that you would like to see improve with treatment.** (For each of the emotional issues listed below, rate the severity of the problem such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

3) **Identify the kinds of supports and resources that you would like to have more of as you undergo treatment.** (For each resource, rate the degree to which you feel you already receive support such that 1=no support and 10=excellent support.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

4) **List the ways in which you would like to see your relationship with your parent/caregiver improve with treatment.** (For each area of improvement, rate the severity of the problem in the relationship such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

Client Progress Report (post-treatment)

Name: _____

Date: DD / MM / YYYY [ ][ ][ ]

1) **Below are listed the behaviours you identified as needing change, prior to treatment.** (For each of these behaviours, rate the current severity of the behaviour such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

2) **Below are listed the emotional issues that you wanted to improve with treatment.** (For each of these emotional issues, rate the current severity of the problem such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

3) **Below are listed the supports and resources that you wanted more of prior to treatment.** (For each resource, rate the degree to which you feel you currently receive support such that 1=no support and 10=excellent support.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

4) **Below are listed the ways in which you wanted to see your relationship with your parent/caregiver improve with treatment.** (For each area of improvement, rate the current severity of the problem in the relationship such that 1=very severe/serious and 10=very mild.)

   i) _____ **Rating:** _____

   ii) _____ **Rating:** _____

   iii) _____ **Rating:** _____

Client Goals – Part I

List what changes you would like to make in your life. Try and list at least three small, easier-to-make changes and three bigger and tougher-to-make changes.

(A) Easier-to-make changes:

1)_____

2)_____

3)_____

(B) Tougher-to-make changes:

1)_____

2)_____

3)_____

For each goal(change), describe what you could do to help make the change.

(A) Easier-to-make changes:

1)_____

2)_____

3)_____

(B) Tougher-to-make changes:

1)_____

2)_____

3)_____

For each goal(change), describe what you need from other people to help make the change.

(A) Easier-to-make changes:

1)_____

2)_____

3)_____

(B) Tougher-to-make changes:

1)_____

2)_____

3)_____

Client Goals – Part II

Pick the easiest goal from your list. _____

How much time do you need to reach this goal? _____

Do you think you can succeed? Yes ☐ No ☐

(If no, why?) _____

List anything that you think is getting in the way (roadblocks) of reaching this goal right now. _____

_____

_____

With your counsellor's help, make a list of steps you can take to reach this goal and include the things you will need to do to get past the roadblocks. _____

_____

_____

_____

Is there anything else you can think of that will make it hard for you to reach your goal or get started? _____

_____

How will you feel when you've reached this goal? _____

_____

What are some ways you would like to reward yourself when you've reached your goal? (What could your counsellor do to help celebrate your success?) _____

_____

_____

_____

Problem Solving Worksheet

1) Definition of the problem: _____

_____

2) My plan for communicating the problem

"I feel _____ **when**

_____**."**

3) Possible solutions:

My ideas _____

_____

Other person's ideas _____

_____

4) My favourite solutions: _____

Other person's favourites: _____

Common favourites: _____

We agree and choose this solution: _____

_____

5) To put the solution into action:

I agree to _____

timeline _____

Other person agrees to _____

timeline _____

6) Outcome:

Acceptable to me _____ **to other person** _____

Not acceptable to me _____ **to other person** _____

What changes would we make for next time? _____

_____

(See chapter six for background.)

Client Worksheet for Analyzing Thoughts-Feelings-Actions

Event: _____

Your actions during the event which led to trouble: _____

What were you thinking just before you acted? _____

What were you feeling just before you acted? _____

What thoughts and feelings were linked to the problem-behaviour?

Any ideas about why this event made you feel and think the way you did? _____

What could have happened that would have made you feel or think differently? _____

Are there any other ways to make sense of what happened? _____

Are any of these other interpretations likely? _____

What way of thinking and feeling about the event would have helped you keep your behaviour in check and out of trouble?

What statements can you use to keep calm and thinking clearly?

What feelings or thoughts do you need to watch for (clues that you're heading for trouble)? _____

(See chapter seven for background.)

PARENT FORMS

Parent Progress Report (pre-treatment)

Name: _____

Date: DD / MM / YYYY

1) Identify the behaviours your child currrently exhibits that you would like to see improve with treatment. (For each of the behaviours listed below, rate the severity of the behaviour such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

2) Identify the emotional issues your child currently exhibits that you would like to see improve with treatment. (For each of the emotional issues listed below, rate the severity of the problem such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

3) Identify the kinds of supports and resources that you would like more of as your child undergoes treatment. (For each resource, rate the degree to which you feel you already receive support such that 1=no support and 10=excellent support.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

4) List the ways in which you would like to see your relationship with your child improve with treatment. (For each area of improvement, rate the severity of the problem in the relationship such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

Parent Progress Report (post-treatment)

Name: _____

Date: DD / MM / YYYY

1) Below are listed those behaviours exhibited by your child that you identified (prior to treatment) as needing improvement. (For each of these behaviours, rate the current severity of the behaviour such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

2) Below are listed those emotional issues exhibited by your child that you identified (prior to treatment) as needing improvement. (For each of these emotional issues, rate the current severity of the problem such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

3) Below are listed the supports and resources that you wanted more of prior to treatment. (For each resource, rate the degree to which you feel you currently receive support such that 1=no support and 10=excellent support.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

4) Below are listed the ways in which you wanted your relationship with your child to improve with treatment. (For each area of improvement, rate the current severity of the problem in the relationship such that 1=very severe/serious and 10=very mild.)

i) _____ **Rating:** _____

ii) _____ **Rating:** _____

iii) _____ **Rating:** _____

Parent Notes

Date and Time of Next Meeting(s) DD / MM / YYYY _____

List one (or more) success(es) you and your child have experienced since the last meeting. _____

List major challenges you and your child have experienced since the last meeting. _____

Questions you want to ask: _____

Things you want to discuss: _____

Parent Plan for Use of Consequences

Behaviours I would like to encourage: _____

_____

_____

What typically happens before and after these behaviours?

_____

_____

Strategies for encouraging these behaviours: _____

_____

_____

Behaviours I would like to discourage: _____

_____

_____

What typically happens before and after these behaviours?

_____

_____

Strategies for discouraging these behaviours: _____

_____

_____

Strategies I think are best and most likely to work.

_____

_____

_____

(See chapter four for background.)

Parent Worksheet (Modelling)

1) List the kinds of values and attitudes you would like your child to have (e.g., I'm a capable person).

i) _____

ii) _____

iii) _____

2) How did you decide what to put on the above list? Were these values/attitudes chosen because they reflect how you think and feel? Were they chosen because they are the opposite of how you think and feel?

i) _____

ii) _____

iii) _____

3) Were there any items from your list in #1 that you think you could teach your child by modelling it yourself?

i) _____

ii) _____

iii) _____

4) Were there any items from your list in #1 that you would like to model for your child but would find that difficult? If so, why?

i) _____

ii) _____

iii) _____

5) Are there ways you would like to change the way you think and feel about yourself? About your child?

i) _____

ii) _____

iii) _____

(See chapter five for background.)

Parent Worksheet (Self-Esteem)

1) List the qualities in your child that you find most positive and appealing.

i) _____

ii) _____

iii) _____

2) Would your child be able to guess what you've put down on this list? If not, what makes it hard for you to share these feelings with your child?

i) _____

ii) _____

iii) _____

3) What would make it easier for you to tell your child about his/her strengths?

i) _____

ii) _____

iii) _____

4) List three things you feel you could honestly say to your child about him/herself that are positive and that you have not yet said to him/her.

i) _____

ii) _____

iii) _____

5) Make a plan for how and when you could give your child the positive feedback you described in #4.

i) _____

ii) _____

iii) _____

(See chapter five and seven for background.)

APPENDIX 2

FREQUENTLY ASKED QUESTIONS

FREQUENTLY ASKED QUESTIONS

1. How do cognitive behavioural (CB) approaches differ from behavioural therapy?

CB therapy builds on behavioural interventions. Both approaches bring about changes by altering the child's environment (scheduling positive and negative consequences, removing reinforcement, etc.). CB interventions, however, go beyond behavioural approaches. CB therapy also targets the way in which young people process information and make sense of their world (teaching problem solving, identifying and replacing cognitive distortions, etc.). Thus, CB interventions preserve the best of behavioural therapy while incorporating a cognitive component.

2. Do CB interventions ignore the youth's feelings?

Nothing could be farther from the truth!

The name, cognitive behaviourism, is misleading. Unfortunately, this has caused many caring, frontline children's mental health practitioners to regard this approach with caution or outright avoidance.

CB theory and practice are founded on the assumption that thoughts, feelings, and behaviours are interrelated and causally linked to one another. In fact, CB interventions are frequently the intervention of choice to assist young clients in self-regulating emotions that are so intense that they interfere with the youth's ability to cope with daily routines (e.g., anger, depression, fear, anxiety).

3. When we use this approach, aren't kids just telling us what we want to hear?

This is possible. In fact, it is a possibility no matter what approach is used!

Other explanations are also possible. Consider the following. Because CB approaches are focussed on acquiring coping strategies (e.g., social problem solving), young people will need to learn related skills (e.g., problem

solving steps). Most often, mastery of the information (procedural steps) comes before the youth develops the ability and/or the confidence to apply the steps. Learning to apply the skills can be further complicated by competing demands or the emotional arousal that may accompany a real life situation. For example, a youth may be very capable of social problem solving in group, but really struggle when he has to use these skills when feeling shamed or angry on the playground.

Other young people may learn a skill set but are not able or willing at this time to see the value in using the skill. Sometimes this is because previously learned ways are more reinforcing in the short term (e.g., the power surge that may come from punching the person who is teasing you). Old learning is also easier to call upon than new skill sets in challenging situations. Finally, it may also be that the youth has learned the skill but continues to buy into a value system that promotes antisocial behaviour.

We strongly suggest that any indicator that knowledge has been learned is an important first step. Understanding the individual needs and make up of each client can help create opportunities for the youth to **buy into** using the skill and to practice using the skill over and over again. This often requires value education. Because some of the natural rewards for using some new skills may take longer to be experienced, it may be very important to provide tangible rewards to encourage the use of the skills in the beginning stages of intervention. Remember, what you value about the use of the skill may have little meaning to the eight year old child struggling to navigate her way on the playground.

4. I like the idea of teachable moments, but how do we find the time or staffing resources to focus on attitudes and beliefs in teachable moments?

The very definition of a teachable moment, indicates that most, if not all, programs at children's mental health agencies can create and respond to teachable moments. We are defining a teachable moment as the ongoing opportunities to encourage change that arise as we go about our daily routines and activities with young clients. They are not a substitute for other forms of programs (e.g., groups, individual counselling). Many of the CB strategies described in this handbook were chosen because of their suitability for enhancing or creating teachable moments.

It is important to remember that a teachable moment ceases to be such when

the learning consumes an hour. We've all known very skilled children's mental health practitioners with great intentions who decrease their potential impact by exceeding the limits of the youth's attention span and capacity to process.

In training, children's mental health practitioners estimated that role-played, teachable moments took 1 to 4 minutes on average. Moreover, children's mental health practitioners using teachable moments reported that their job was easier in the long run because fewer situations escalated to a level that required longer interventions by staff.

Some children's mental health practitioners have reported that they only began to use skills in teachable moments after they had been leading groups that focussed on these skills for clients. When asked why, many indicated that the process had to become so familiar to them that they could use it in an informal fashion while still attending to other important pieces of information.

We would be surprised if you are not already using teachable moments. We would like to challenge you to look for increased opportunities to create teachable moments in which you can use some of the skills described in this book.

Even if we use CB approaches and do a great job, the kids are still going right back into the families and peers that caused these difficulties in the first place. Are we really helping?

We learn the basic rules of the culture from our family, peers, school experiences and the media. It follows that unlearning or relearning is going to be most effective when it is multi-systemic; that is, when it involves all of the primary influences that contribute to our social learning.

This means that it is important for clients to experience rewards across settings for learning and using prosocial behaviours. Antisocial behaviours need to result in negative consequences in as many settings as possible.

Accordingly, we have to creatively look for ways to connect with and enhance efforts in the youth's primary social settings. Family-based-in-home interventions, wrap-around service models, creative partnerships between children's mental health settings and other resources (e.g., community schools, recreation programs, youth justice system), are all being used to build multi-level and multi-faceted interventions for young people with conduct disorder. Continued efforts in these directions are essential for developing effective programs.

References

American Psychiatric Association, (2000). *Diagnostic and Statistical Manual of Mental Disorders*™. 4th Edition, Text Revision (DSM-IV-TR). American Psychiatric Association, Washington, D.C.

Bartol, C., & Bartol, A., (1989). *Juvenile Delinquency: A Systems Approach.* Englewood Cliffs, N.J.: Prentice Hall

Bock, G., & Goode, J., (1996). *Genetics of Criminal and Antisocial Behaviour.* CIBA Foundation Symposium 194. Chichester: Wiley.

Burns, D., (1993). *Ten Days to Self-Esteem.* William Morrow & Co., NY.

Carey, G., & DiLalla, D., (1994). Personality and Psychopathology: Genetic Perspectives. *Journal of Abnormal Psychology,* 103:32-43.

Children's Mental Health Ontario, (2001). *Evidence Based Practices for Conduct Disorder in Children and Adolescents.* Toronto, Ontario : Children's Mental Health Ontario.

Cowles, E., Castellano, T., & Gransky, L., (1995). *"Boot Camp" Drug Treatment and Aftercare Interventions an Evaluation Review.* Research in Brief, National Institute of Justice, Washington, D.C.

Day, D.M., & Hrynkiw-Augimeri, L., (1996). *Serving Children at Risk for Juvenile Delinquency: An Evaluation of the Earlscourt Under 12 Outreach Project.* Final Report. Department of Justice, Canada.

Deluty, R.H., (1981). Alternative-thinking ability of aggressive, assertive and submissive children. *Cognitive Therapy and Research,* 5:309–312.

Dishion, T.J., & Patterson, G.R., (1997). The Timing and Severity of Antisocial Behaviour: Three Hypotheses within an Ecological Framework. In D.M. Stoff, J. Breiling and J.D. Maser (Eds.), *Handbook of Antisocial Behaviour.* Toronto, Ontario: John Wiley & Sons, Inc.

Dodge, K., (1985). Attributional bias in aggressive children. In P.C. Kendall (Ed.), *Advances in cognitive-behavioral research and therapy* (Vol.4). New York: Academic Press.

Dodge, K.A., & Newman, J.P., (1981). Biased decision-making processes in aggressive boys. *Journal of Abnormal Psychology,* 90:375–379.

Dodge, K.A., Petit, G.S., McClaskey, C.L., & Brown, M.M., (1986). Social competence in children. *Monographs of the Society for Research in Child Development, 51*(2, Serial No. 213).

Farrington, D.P., & Loeber, R., (1999). Transalantic Replicability of Risk Factors in the Development of Delinquency. In P. Cohen, C. Siomkowski, & L.N. Robbins, (Eds.). *Historical and Geographical Influences on Psychopathology,* Mahwah, NJ: Lawrence Erlbaum.

Feehan, M., McGee, R., & Williams, S. (1993). Mental Health Disorders From Age 15 to Age 18 Years. *Journal of American Academy of Child & Adolescent Psychiatry,* 32:1118-1126.

Goldstein, A.P., Glick, B., & Carthan, W. (1989). *The Prosocial Gang: Implementing Aggression Replacement Training.* Thousand Oaks, CA : Sage.

Gouze, K.R., (1987). Attention and social problem solving as correlates of aggression in preschool males. *Journal of Abnormal Child Psychology,* 15:181–197.

Henggeler, S. & Borduin, C.M., (1990). *Family Therapy and Beyond: A Multisystemic Approach to Treating the Behaviour Problems of Children and Adolescents.* Pacific Grove, CA: Brooks/ Cole.

Hrynkiw-Augimeri, L., Repler, D., & Goldbery, K., (1993). An Outreach Program for Children Having Police Contact. *Canada's Mental Health,* 41:7-12.

Huesmann, L.R., Moise, J.F., & Podolski, C.L., (1997). The Effects of Media Violence on the Development of Antisocial Behaviour. In D.M. Stoff, J. Breiling and J.D. Maser (Eds.). *Handbook of Antisocial Behaviour*. Toronto, Ontario: John Wiley & Sons, Inc.

Kazdin, A., (1989). Hospitalization of Antisocial Children: Clinical Course, Follow-up Status, and Predictors of Outcome. *Advances in Behavior Research and Therapy,* 11:1-67.

Kazdin, A.E., (1997). Parent Management Training: Evidence, Outcomes, and Issues. *Journal of American Academy of Child & Adolescent Psychiatry,* 36:1349-1356.

Kazdin, A.E., (2nd ed.,1995). *Conduct Disorder in Childhood and Adolescence*. Thousand Oaks, CA: Sage.

Kazdin, A.E., Siegel, T.C., & Bass, D., (1992). Cognitive Problem-Solving Skills Training and Parent Management Training in the Treatment of Antisocial Behaviour in Children. *Journal of Consulting and Clinical Psychology,* 60:733-740.

Kendall, P.C., & MacDonald, J.P., (1993). Cognition in the Psychopathology of Youth and Implications for Treatment. In K.S. Dobson & P.C. Kendall (Eds.). *Psychopathology and Cognition*. San Diego: Academic Press.

Kendall, P.C., (Ed.) (2nd ed., 2000). *Child and Adolescent Therapy: Cognitive – Behavioral Procedures*. New York: Guilford Press.

Lochman, J., & Dodge, K., (1998). Distorted perceptions in dyadic interactions of aggressive and nonaggressive boys: Effects of prior expectations, context, and boy's age. *Development and Psychopathology*, 10:495–512.

Lochman, J.E., (1989, Februrary). Hardware versus software: Land of deficiency in social-cognitive processes of aggressive boys. Paper presented at the first annual meeting of the Society for Research in Child and Adolescent Psychotherapy, Miami, FL.

Loeber, R. (1990). Development of Risk Factors of Juvenile Antisocial Behaviour and Delinquency. *Clinical Psychology Review,* 10:1-41.

McCord, J., Tremblay, R., Vitaro, F., & Desmardis-Gervais, L., (1994). Boys Disruptive Behaviour, School Adjustment, and Delinquency: The Montreal Prevention Experiment. *International Journal of Behavioural Development,* 17:739-752.

Mendel, R., (1995). *Prevention or Pork? A Hard-Headed Look at Youth-Oriented Anti-Crime Programs*. Washington, D.C.: American Youth Policy Forum.

Milich, R., & Dodge, K.A., (1984). Social information processing in child psychiatric populations. *Journal of Abnormal Child Psychology,* 12:471–490.

National Crime Prevention Council of Canada, (1997). *Preventing Crime by Investing in Families Promoting Postive Outcomes in Children Six to Twelve Years Old*. Ottawa, ON : National Crime Prevention Council of Canada.

Offord, D., & Bennett, K., (1994). Conduct Disorder: Long-Term Outcomes and Intervention Effectiveness. *Journal of American Academy of Child & Adolescent Psychiatry,* 33:1069-1078.

Offord, D., (1987). Prevention of Behavioural and Emotional Disorders in Children. *Journal of Child Psychology & Psychiatry,* 28:9-19.

Patterson, G., DeBaryshe, B., & Ramsey, E., (1989). A Developmental Perspective on Antisocial Behavior. *American Psychology,* 44:329-335.

Plomin, R., (1994). The Emanual Miller Memorial Lecture 1993: Genetic Research and Identification of Environmental Influences. *Journal of Child Psychology & Psychiatry,* 35:817-834.

Ronen, T., (1998). Linking developmental and emotional elements into child and family cognitive-behavioural therapy. In P. Graham (Ed.). *Behaviour Therapy for Children and Families.* Cambridge: Cambridge University Press.

Sherman, L.W., Gottfredson, D., MacKenzie, D., Eck, J., Reuter, P., & Bushway, S., (1997). *Preventing Crime: What Works, What Doesn't, What's Promising.* Washington, DC: US Department of Justice, Office of Justice Programs.

Short, R., (1993). Conduct Disorders: A Framework for Understanding and Intervention in Schools and Communities. *School Psychology Review,* 22:362-375.

Southam-Gerow, M.A., & Kendall, P.C., (1997). Parent-Focused and Cognitive-Behavioural Treatments of Antisocial Youth. In D.M. Stoff, J. Breiling and J.D. Maser (Eds.), *Handbook of Antisocial Behaviour.* Toronto, Ontario: John Wiley & Sons, Inc.

Spivak, G., & Shure, M.B., (1974). *Social Adjustment of Young Children: A Cognitive Approach to Solving Real-Life Problems.* San Francisco, CA:Jossey-Bass.

Spivak, G., & Shure, M.B., (1976). *The Problem-Solving Approach to Adjustment.* San Francisco, CA:Jossey-Bass.

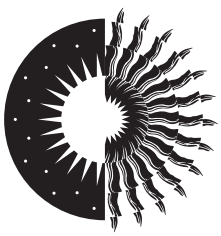
Spivak, G., & Shure, M.B., (1978). *Problem-Solving Techniques in Child-Rearing.* San Francisco, CA:Jossey-Bass.

Tremblay, R., McCord, J., Boileau, H., & Charlebois, P., (1991). Can Disruptive Boys be Helped to Become Competent? *Psychiatry,* 54:148-161.

Webster-Stratton, C., & Hammond, M. (1997). Treating Children with Early-Onset Conduct Problems: A Comparison of Child and Parent Training Interventions. *Journal of Consulting and Clinical Psychology,* 65:93-109.

Webster-Stratton, C., (1993). Strategies for Helping Early School-Aged Children with Oppositional Defiant and Conduct Disorders: The Importance of Home-School Partnerships. *School Psychology Review,* 22:437-457.

Wells, K., (1995). Parent Management Training. In P. Sholevar (Ed.), *Conduct Disorders in Children and Adolescents.* Washington, DC: American Psychiatric Press.



C H I L D R E N ' S M E N T A L H E A L T H O N T A R I O

40 St. Clair Avenue East, Suite 309, Toronto, Ontario M4T 1M9

Tel: 416-921-2109 • Fax: 416-921-7600 • E-mail: info@cmho.org • Website: www.cmho.org