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**EVALUATING THE EFFECTIVENESS OF A TREATMENT PROGRAM  
WITH A LATENCY-AGED MALE CHILD**

by  
**Michael Calavetta**

**A Thesis**

**Submitted in partial fulfillment of the requirements of the  
Masters of Arts Degree  
of  
The Graduate School  
at  
Rowan University  
7-15-2002**

**Approved by** \_\_\_\_\_  
**Professor**

**Date Approved** 8/12/02

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**ABSTRACT**

**Michael Calavetta**  
**Evaluating the Effectiveness of a Treatment Program with a Latency-Aged Male**  
**Child**  
**2002**  
**Dr. Janet Cahill- Applied Psychology Master's Program**

The purpose of this study was to evaluate the outcomes of a therapeutic treatment program for a latency-aged male child. This eight-year old child presented with several problem areas. These included poor academic performance, attention difficulties, symptoms of depression and acting out behaviors. The client also had a long standing history of family dysfunction and instability. The client participated in a multimodal treatment program consisting of individual and family counseling, as well as a school based partial care intervention program. The client also received Adderall and Zoloft. The Connor's ADHD Scales, Children's Depression Inventory, and a Patient Satisfaction Survey were administered at different intervals through the course of treatment. The Connor's ADHD Scales were completed at intake by the biological mother and the intake coordinator. They were also administered tri-weekly by the group counselor. The Children's Depression Inventory was completed at the beginning of treatment three weeks later at discharge. Further, the Patient Satisfaction Survey was completed at the discharge meeting. Results indicated improvements in attending behaviors, but little improvement was noted in levels of depression. Results on the client satisfaction index indicated a high level of satisfaction with the treatment program. Lack of improvement

in the depression index may have been due to the difficulties in engaging the client's mother in substance abuse treatment.

The treatment protocol utilized by this agency was compared with best practice recommendations in the literature. Implications for normative practice are discussed.

**MINI-ABSTRACT**

**Michael Calavetta  
Evaluating the Effectiveness of a Treatment Program with a Latency-Aged Male  
Child  
2002**

**Dr. Janet Cahill- Applied Psychology Master's Program**

This study evaluated the effectiveness of a multimodal treatment program for an eight-year old child with multiple presenting problems. Treatment included individual therapy, classroom based partial care, and family therapy. Psychotropic medication was also utilized. Outcomes measures evaluated changes in attention behaviors, depression symptoms, and client satisfaction. Results were mixed with some improvements in attending behaviors but marginal changes in depression. Client satisfaction levels were high. The treatment program was compared with best practice recommendations from the empirical literature.

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## Chapter One- Psychosocial History

**Client:** Jay Clone

**Age:** 8

### **Presenting Problem:**

Jay is a school-aged child who was having significant difficulty functioning at school and at home. He had difficulty staying focused, was easily distracted, fought often at school, and was quite impulsive. Jay also felt sad often and has experienced abandonment various times throughout his lifetime. Jay also employed poor anger management skills when he was provoked or when he became enraged. For instance, when he became frustrated he would generally punch other kids and hit nearby objects. Jay was socially isolated and did not have many friends to interact with. As a result, he often isolated himself from others. For example, Jay did not ask other children to join him during free time.

Jay had experienced both physical and sexual abuse in the past, which affected his current relationship building skills. He lacked trust in others and has a fear of commitment. No other history was available during the intake assessment.

### **History of Complaint:**

Jay began having difficulties at age 5. Jay's mother, 29-year-old Sara Clone, reported that her son had been "tossed and turned" all over the place. Jay lived with his mother until he was two years of age at which time custody was awarded to his paternal aunt. Jay's custodial rights were transferred to his paternal aunt because of his mother's substance abuse. Ms. Clone abused cocaine and heroine throughout her pregnancy with

Jay. She was severely debilitated during Jay's early infancy due to her substance use. For example, she was unable to provide details regarding his early development because she stated she was "too into" her drugs.

Jay reported that he recalls being an angry little boy. Jay had three placements up to the intake appointment. He had experienced abandonment multiple times by his mother; his paternal aunt also abandoned him after a short stay with her. He also experienced abandonment from his biological father who handed him over to his maternal grandmother when he was five years old. He is currently residing with his maternal grandmother along with his mother and older cousin. Jay and Ms. Clone report that his behavioral problems have always manifested themselves at school and at home but have become increasingly worse during the past year. Jay was first evaluated at the request of his teacher by his school district at the age of 5.

Jay was also oppositional at home to his mother's directives and had a tendency to at times to become verbally abusive. He routinely refused to do daily chores when asked. Occasionally, his mother and grandmother were not successful in getting him to cooperate. Jay displayed oppositional and aggressive behaviors at school. He also fought at school but claimed this was the result of his peers provoking him. Jay reported that the fights did not result in injury to anyone. Jay stated the fights usually occurred after being coerced into things or being made fun of by his peers. The fights, which primarily consisted of pushing and shoving, did not usually involve punching with closed fists.



No other information was available. The lack of further information was primarily due to Ms. Clone's substance abuse history, which interfered with her ability to care for Jay as an infant, and the child's inability to recall due to his early development.

**Household Composition:**

At intake, Jay resided with his biological mother, 29-year-old Sara Clone, maternal grandmother, 53-year-old Maria Santiago, and older cousin, 28-year-old Yvette Santiago. Jay had no other children in his home to play or socialize with. Jay had an older brother whom resides with their mutual biological father. Jay's father had refused to assume parental custody for Jay. Jay did not have friends that lived in the immediate area where he resided.

**Developmental History:**

Jay's developmental history was unknown at the time of the intake due to Ms. Clone's substance abuse history that interfered with her ability to care for Jay as an infant. His grandmother, Ms. Santiago, knew more information but was unavailable at the time of the intake assessment. As Ms. Santiago replaced Ms. Clone in attending the family sessions, the focus became Jay's present behavior and his mother's disappearance, so his developmental history was not revisited.

At intake, Jay was in Special Education at his school district. He was classified as Learning Disabled by the Child Study Team at age 5. Jay was in third grade but was one grade level behind in reading. His math level was 2.8, relatively close to grade level. He had difficulty in reading but really enjoyed math class. The Child Study Team evaluation recommended that he begin taking a stimulant medication due to his

inattentiveness, distractibility, and impulsivity. Ms. Clone, however, did not consent to medication, even though she did not have current custody of Jay. In addition, the child's grandmother felt uncomfortable consenting to medication without his mother's support. Medications still have not been trialed as of present because of Ms. Clone's reservations. Ms. Clone's reservations are based around her own history of substance abuse and misperceptions about the factual targets and side effects of the medication. Ms. Clone was misinformed about the potential and positive outcomes of the available types of medication.

Jay experienced physical abuse and neglect as an infant by his mother. In addition to her use of heroine and cocaine during his fetal development, his mother would frequently leave Jay and his brother alone for extended periods of time with no supervision. According to the Child Study Team report, she would also use inappropriate physical discipline with Jay and his brother. Specifically, she would beat them with a speaker wire that often left bruises on their bodies. There was a report made to the Division of Youth & Family Services (DYFS) when Jay was 5-years-old by a family friend. A case was opened for two months at which time custody was transferred to Jay's paternal aunt. The case with DYFS was closed after Jay's placement with his aunt. There have been no additional referrals to DYFS. However, according to Jay and his mother, a 12-year-old family friend and Jay's 14-year-old cousin sexually abused him. The abuse took place in the perpetrator's homes. Jay reported that the male family friend fondled him in his genital area two times during a one-week period. He also reported that his male cousin rubbed his own genital area against Jay two times in about a week and a half. These episodes were never reported to the DYFS. Ms. Clone added that Jay is no

longer at risk for sexual abuse because she takes full precaution and supervises all interactions with any visitors. Ms. Clone also explained that she addressed these incidents with the perpetrators' parents on each separate occasion. Jay reported each incident to both his mother and his grandmother.

### **Family Relations:**

Jay reported that he had a good relationship with his mother, grandmother and cousin. He did, however, say that at times they got on his nerves. He also indicated that while he often complied with requests, he sometimes would not simply because he was just “lazy”. Jay reported that he does not know why his father will not see him, and reported that he misses his older brother. He felt rejected by his father. He really cared about his mother and his grandmother and said he would do anything for them. Ms. Clone confirmed the child’s feelings added that her and her mother have a strained relationship. Ms. Clone shared that her mom was unsupportive for herself as a child. As Jay’s grandmother began attending the sessions, she confirmed this as well. Both Ms. Clone and Jay’s grandmother had a difficult time following through with recommendations at home. Initially there was some medication non-compliance with Ms. Clone not distributing the medicine daily. As treatment progressed, a behavior plan was implemented at home which was not immediately effective due to inconsistencies by grandmother in applying rewards.

Jay appears to be emotionally connected to his mother and grandmother. He stated he loves them. However, he expressed concerns about future abandonment and

often worried that his mother will not return some day. Given Ms Clone's extensive history of substance abuse and abandonment, these fears were realistic.

**Drugs and Alcohol:**

Jay had no reported drug and alcohol history. Both Jay's mother and father have history of substance use including marijuana, crack-cocaine, alcohol, and heroin. As mentioned previously, Jay's mother reported being in recovery and no longer using any substances. No independent confirmation was available to substantiate this claim.

Jay's maternal grandmother, Ms. Santiago, also has a history of alcohol abuse. There was no independent validation of her current or past alcohol use. Jay's cousin, Yvette, has no reported past substance use or abuse. Ms. Clone has been in recovery for three and a half months and reports no relapse. However, Ms. Clone has relapsed multiple times before. Her relapses have been so numerous that she could not even give the number of times. She abused cocaine and heroine for approximately ten years and her longest period of recovery has been one year. She relied on her church involvement, volunteering, and isolating herself at home as her strengths to staying sober. There was no independent validation of this.

**Medical and Psychiatric History:**

Jay was reported to be in good health with some concerns about his weight. He is overweight for his age cohort and height-weight proportionate levels. Specifically, he is 4'9" and weighs 130 pounds. He has gained significant weight within the past two years. Jay had his last physical within the past year with no concerns by his doctor. He was born in good health, full term pregnancy and vaginal delivery. No complications were

reported. According to Ms. Clone, he did not experience substance withdrawal. As of date, no neurological examination has been completed.

Jay had feelings of sadness, hopelessness, and blunted affect at the intake appointment. He reported that he experienced these symptoms consistently for approximately the past two years. Jay had poor social supports to rely on as well. His sadness usually occurred when he was bored or yelled at for doing something inappropriate. It usually lasted for a few hours and he tended to rely on sleep as a coping mechanism.

Ms. Clone attended family counseling after the birth of her first son, which focused on her anger management skills. Her referral source was unknown. Treatment was brief and uncompleted. No other psychiatric history reported in the family.

**Education and Job History:**

Jay was currently in the 3<sup>rd</sup> grade at a public elementary school. His academic performance was mixed, consisting of B's, C's, and D's. As mentioned previously, Jay had very few friendships and often fought with peers at school when provoked. He had been suspended three times and had multiple detentions within the year. These disciplinary actions usually involved Jay's aggressive behavior while involved in fighting and not following directions.

**Other Agency Involvement:**

No other agencies were involved with Jay or his family. The court system was not presently involved with the family.

**Social Supports:**

Jay had limited social supports. He resided with three adult females (mother, grandmother, and cousin) and has no friends in the immediate area. He had an opportunity to interact with kids his own age at school of which few he has interest. He was unable to identify names of friends and denied having a best friend. He reported spending his recreation time playing video games and watching TV. He has no other specific identified interests.

**Situational Stressors:**

Jay's ongoing fear of abandonment by his mother was a significant source of stress. Additionally, Jay had recently been suspended from school for the third time due to oppositional and inappropriate behavior such as fighting in the classroom. He was referred by the school due to this inappropriate behavior and will not be permitted to return to school until successful completion of the program.

**Coping Mechanisms:**

Jay reported that he tries to keep himself occupied by playing video games and watching TV at home. He did not have any other identified coping skills that he utilizes productively. His coping skills were highly underdeveloped.

**Summary:**

Jay was an 8-year-old boy who attended the third grade at a public elementary school. He was having difficulties both academically and socially. He reported high

levels of inattentiveness, distractibility, impulsivity, and periods of sadness. In addition, Jay was socially isolated and had feelings of abandonment that effected his daily interactions. He had experienced extensive emotional turmoil in his few short years of life, and had poor coping skills to utilize in undesirable situations. Jay has been neglected and both physically and sexually abused. His mother and grandmother appeared to have had poor parenting skills and he has been abandoned on numerous occasions.

Jay has feelings of sadness, hopelessness, blunted affect, and overeats. He reports that these symptoms have remained consistent for the past two years. Jay had poor social supports to rely on as well.

Jay was evaluated for attention-deficit-hyperactivity-disorder, dysthymic disorder, and the possible presence of an oppositional- defiant-disorder. The assessment tools used were ADHD Connor's Scales, The Children's Depression Inventory, and behavior modification system based on rewards and consequences. Given Ms. Clone's substance abuse during Jay's prenatal development and his learning disabilities, a neurological evaluation is recommended.

## Chapter Two- Differential Diagnosis

Axis I- Attention-Deficit Hyperactivity Disorder- Combined Type (314.01)

Dysthymic Disorder- Early Onset (300.4)

Reactive Attachment Disorder- Inhibited Type (313.89)

R/O- Oppositional Defiant Disorder (313.81)

Axis II- Deferred

Axis III- Overweight

Axis IV- Academic problems, sexual abuse, physical abuse, unsafe neighborhood,  
disruption of family by estrangement

Axis V- 45

### ADHD- Combined Type (314.01)

A) All of the following symptoms have persisted for more than six months to a degree that is maladaptive and inconsistent with his developmental level

1) Inattention-

a) Client has difficulty following directions to complete activities and tasks

b) Client is easily distracted by noises, people and changes from one task to another quickly

c) Client has often to be re-directed 2-3 times

d) Client forgets to complete homework and finish tasks given at school

e) Client loses things easily and does not recall location of items

f) Client unable to complete tasks in consecutive order



- g) Client loses focus easily
- h) Client forgets directions and past conversations in short periods of time

2) Hyperactivity/Impulsivity-

- a) Client squirms in his seat, bounces his legs, and is often fidgety
- b) Client is unable to sit in his sit correctly
- c) Client unable to participate in leisure activities without talking or making noises
- d) Client has difficulty raising his hand and waiting to be called on in the classroom
- e) Client cuts in line and does not wait patiently
- f) Client is intrusive into other people's business and conversations

- B) The symptoms were present before the age of seven years old
- C) The symptoms have caused impairment in both the school and home setting
- D) There is clear evidence of clinically significant impairment in social and academic functioning
- E) The symptoms occur outside of a Mood Disorder which the patient has also been diagnosed

**Dysthymic Disorder- Early Onset (300.4)**

- A) Client has suffered from a depressed mood for most of the day, for more days than not, as indicated by subjective account and observations by others for at least a year
- B) Present while depressed were:
  - 1) Overeating- client has gained significant weight over the past two years and outweighs expected height-weight proportionate levels for his age cohort
  - 2) Low self-esteem- Client suffers from poor self-image both physically and mentally
  - 3) Poor concentration and difficulty making decisions- client has poor attentive skills, is easily distracted, and often can not make decisions on his own
  - 4) Feelings of hopelessness- client has periods of time when he feels that nothing in his life will improve
- C) During the one year period of the disturbance, the client has never been without the symptoms in Criteria A and B for more than two months at a time
- D) No Major Depressive Episode has been present during the first year of the disturbance
- E) Client has never experienced a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and never met the criteria for Cyclothymic Disorder
- F) The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder

- G) The symptoms are not due to the direct physiological effects of a substance or a general medical condition
- H) The symptoms cause clinically significant distress or impairment in social, school, and home functioning

**Reactive Attachment Disorder- Inhibited Type (313.89)**

- A) Client has markedly disturbed and developmentally inappropriate social relatedness in most contexts, which began before age 5, and is evidenced by persistent failure to indicate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessive inhibition, ambivalence and contradictory responses. The client responds to caregivers with a mixture of approach, avoidance, and resistance to comforting
- B) The disturbance in Criterion A is not accounted for solely by developmental delay and does not meet criteria for a Pervasive Developmental Disorder
- C) Client's pathogenic care is evidenced by:
  - 1) Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
  - 2) Repeated changes of primary caregiver that prevent formation of stable attachments
- D) There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A

**R/O Oppositional Defiant Disorder (313.81)**

- A) Client has experienced a pattern of negativistic, hostile, and defiant behavior lasting at least six months but of which do not meet the criteria for the diagnosis
- 1) Client loses temper at home with his mom when she directs him to complete tasks. Client also fights at school when provoked. Client did not seem to be aggressive or short-tempered upon intake assessment. Client will be observed.
  - 2) Client often actively defies or refuses to comply with mom's requests. Client has experienced abandonment by his mother and father, which may lead to this non-compliance. Client to be further assessed.
- B) The disturbance in behavior causes clinically significant impairment in social and academic functioning
- C) The behaviors may occur exclusively during the course of a Mood Disorder
- D) Criteria are not presently met for Conduct Disorder

## **Chapter Three- Literature Review**

A review of the literature was conducted in order to evaluate the effectiveness of a treatment program for children with behavioral and emotional disorders. The focus of the literature included attention-deficit hyperactivity disorder, depressive disorders, family systems therapy, attachment disorders, and substance abuse affecting children.

### **Attention-Deficit Hyperactivity Disorder (ADHD)**

According to the American Academy of Pediatrics (2000) attention-deficit hyperactivity disorder, also known as ADHD, applies to a family of related chronic neurobiological disorders that interfere with an individual's capacity to regulate activity level (hyperactivity), inhibit behavior (impulsivity), and attend to tasks (inattention) in developmentally inappropriate ways. The core symptoms of ADHD include; an inability to sustain attention and concentration, developmentally inappropriate levels of activity, distractibility, and impulsivity. Children with ADHD have functional impairment across multiple settings including home, school, and peer relationships. Attention-deficit hyperactivity disorder has also been shown to have long-term, adverse effects on academic performance, vocational success, as well as social-emotional development. Children with ADHD experience an inability to remain seated and pay attention in class and as a result acquire the negative consequences of such behavior. They experience peer rejection and engage in a broad array of disruptive behaviors. Their academic and social difficulties suffer, therefore causing extensive long-term consequences. These children have higher injury rates. As children grow older untreated ADHD, in combination with conduct disorders, can lead to drug abuse, antisocial behavior, and

medical injuries. For many individuals, the impact ADHD continues throughout adulthood.

Achenbach (1993) found that the key elements in diagnosing ADHD include a thorough history covering the presenting symptoms, differential diagnosis, possible comorbid conditions, as well as medical, developmental, school, psychosocial, and family histories. It is helpful to determine what precipitated the request for evaluation and what approaches had been used in the past. As of yet there is no independent test aid for ADHD.

Attention-deficit hyperactivity disorder is one of the more common chronic conditions of childhood. According to the American Academy of Pediatrics (2000), “Studies using parent reports indicate persistence of ADHD of 60% to 80% into adolescence. Given the high prevalence of ADHD among school-aged children (4 to 12%) primary care clinicians will encounter children with ADHD in their practices regularly and should have a strategy for diagnosis and long-term management of this condition. It is estimated to affect (4 to 12%) of school-aged children, and occurring three times more often in boys than in girls. On average, about one child in every classroom in the United States needs help for this disorder (p. 1163).”

Research conducted by Barkley (1999) shows that ADHD tends to run in families; so there are likely to be genetic influences. Children who have ADHD usually have at least one close relative who also has ADHD. At least one-third of all fathers who had ADHD in their youth have children with ADHD. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychological Association, 1994) states that ADHD has been found to be more common in the first degree biological relatives of

children with Attention-Deficit Hyperactivity Disorder. The disorder is much more frequent in males than females, with males-to-female ratios ranging from 4:1 to 9:1, depending on the setting.

Neuroimaging research has shown that the brains of children with ADHD differ fairly consistently from those of children without the disorder in that several regions and structures (pre-frontal cortex, striatum, basal ganglia, and cerebellum) tend to be smaller. According to Barkley (1999), overall brain size is generally 5% smaller in affected children than children without ADHD. While this average difference is observed consistently, it is too small to be useful in making the diagnosis of ADHD in a particular individual. In addition, there appears to be a link between a person's ability to pay continued attention and measures that reflect brain activity. In people with ADHD, the brain areas that control attention appears to be less active, suggesting that a lower level of activity in some parts of the brain may be related to difficulties sustaining attention. Life can be hard for children with ADHD, they are the ones who are often in trouble at school, can not finish a game, and have trouble making friends. They may spend agonizing hours each night struggling to keep their mind on their homework, then forget to bring it to school. It is not easy coping with these frustrations day after day for children or their families. Family conflict can increase. In addition, problems with peers and friendships are often present in children with ADHD. In adolescence, these children are at increased risk for motor vehicle accidents, tobacco use, early pregnancy, and lower educational attainment. When a child receives a diagnosis of ADHD, parents need to think carefully about treatment choices. And when they pursue treatment for their children, families face high out-of-pocket expenses because treatment for ADHD and other mental illnesses is

not often covered by insurance policies. School programs to help children with problems often connected to ADHD (social skills and behavior training) are not available in many schools. In addition, not all children with ADHD qualify for special education services. All of this leads to children who do not receive proper adequate treatment. To overcome these barriers, parents may want to look for school-based programs that have a team approach involving parents, teachers, school psychologists, and other mental health specialists, and physicians. Primary care clinicians should educate parents and children about the ways in which ADHD can affect learning, behavior, self-esteem, social skills, and family function. This initial phase of patient education is critical to demystifying the diagnosis and providing parents and children with knowledge about the condition (Culbertson, 1993). Education enables parents to work with clinicians, educators, and, in some cases, mental health professionals to develop an effective treatment plan. Thorough family understanding of the problem is essential before discussing treatment options and side effects.

There are various forms of behavioral interventions used for children with ADHD, including psychotherapy, family systems therapy, social skills training, support groups, and parent and educator skills training. Behavior therapy then involves providing rewards for demonstrating the desired behavior (e.g., positive reinforcement) or consequences for failure to meet the goals (e.g., punishment). Repetitive application of the rewards and consequences gradually shapes behavior. Although these psychological interventions have great intuitive appeal, they have little documented efficacy in the treatment of children with ADHD, and gains achieved in the treatment setting usually do



not transfer into the classroom or home due to improper education on the part of the parent or teacher.

Classroom management often begins with increasing the structure of activities. Systematic rewards and consequences, including point systems or use of token economies are included to increase appropriate behavior and eliminate inappropriate behavior. Positive reinforcement would be providing rewards or privileges contingent on the child's performance. An example would be when a child completes an assignment and is permitted to play on the computer. Time-out would be removing access to positive reinforcement contingent on performance of unwanted or problem behavior. An example of that would be a child hits their sibling impulsively and is required to sit for 5 minutes in the corner of the room. A response cost is withdrawing rewards or privileges contingent on the performance of unwanted or problem behavior. An example would be a child loses free time privileges for not completing homework. Overall, a token economy is combining positive reinforcement and response cost. The child earns rewards and privileges contingent on performing desired behaviors and loses the rewards and privileges based on undesirable behavior. For example, a child earns stars for completing assignments and loses stars for getting out of their seat. The child cashes the sum of their stars at the end of the week for a prize.

Studies that compare the behavior of children during periods on and off behavior therapy demonstrate the effectiveness of behavior therapy; however, behavior therapy has been demonstrated to be effective only while it is implemented and maintained. A number of individual studies indicate positive effects of behavior therapy in addition to medications. Almost all studies comparing behavior therapy with stimulants indicate a

much stronger effect from stimulants than from behavior therapy. The MTA Study found that the combined treatment (medication management and behavior therapy), compared with medication alone, offered improved scores on academic measures, measures of conduct, and some specific ADHD symptoms. In addition, parents and teachers of children receiving combined therapy were significantly more satisfied with the treatment plan (Wells, 2000).

Programs that focus specifically on preventing or reducing inappropriate behaviors, usually through curriculum-based teaching of nonviolent conflict resolution or decision-making skills, have seen mixed results. The Second Step Program is a curriculum-based model that focuses specifically on skills to understand and prevent anger outbursts due to frustration from a lack of age appropriate skills. Second Step aims to reduce or prevent aggression by teaching anger management, empathy, and impulse control. Grossman and colleagues (Grossman et al, 1997) evaluated Second Step in a randomized controlled trial with approximately 800 primarily European-American elementary students from 12 schools in Washington State. Post-test data showed significant reductions in aggression and increases in neutral or prosocial behavior as measured by observations, though there were no significant effects found on parent or teacher ratings of behavior problems. Reductions in observer-rated physical aggression in the classroom were maintained at 6-month follow-up. Although these results are promising, there is a continued need for replication, as effects were not found in the current study on adult reports of child symptomatology.

Lochman, Burch, Curry, and Lampron, (1984) developed and refined a cognitive-behavioral school-based intervention that focuses on developing anger management skills

in aggressive elementary and middle-school-aged boys. The Anger Coping Program consisted of 18 sessions that teach affect identification, self-control, and problem-solving skills (Lochman, 1985). Children are given the opportunity to role-play and practice these skills in a small group setting and under conditions of affective arousal. Goal setting and reinforcement are incorporated to support skill acquisition. The program has shown that immediately following the intervention it lowers boys observed disruptive and aggressive behavior in the classroom, and in some cases, improves parent ratings of aggressive behavior (Lochman, 1985; Lochman et al., 1984; Lochman & Curry, 1986; Lochman, Lampron, Gemner, Harris, & Wyckoff, 1989). In a 7-month follow-up study, children who had participated the anger coping program were more on-task in their behavior compared to controls, but the differences in their disruptive-aggressive behavior evident at post-test were not maintained (Lochman & Lampron, 1988). Three years after the intervention, differences in parent-ratings of aggression and observations of disruptive-aggressive behavior were not maintained although improvements in children's on-task behavior were maintained for those who received a six session booster the following year (Lochman, 1992). These findings demonstrate the significance of continued long-term care to meet the child's needs and sustain improvements.

Another example of effective treatment for children with attention-deficit hyperactivity disorder is the Peer Coping Skills Training Program that targeted 94, first to third grade students with high teacher-rated aggression ratings (Prinz, Belchman, & Dumas, 1994). Students were randomly assigned to either a treatment group or control. In the treatment condition, integrated teams of children were taught prosocial-coping skills in 22 weekly fifty-minute sessions. The teams progressed through different skills

and levels of difficulty; new skills were not introduced until the team had demonstrated mastery of previous skills. This format encouraged and reinforced peer support. Outcomes measured at post-test and 6 months following the intervention supported its positive effects. The outcomes were based on observed teacher ratings reported. Significant improvements were also noted in the intervention children's prosocial coping and teacher-rated social skills.

## **DEPRESSION**

Depression is a condition that affects between 2% and 21% of school-aged children (Reynolds & Stark, 1998). Depressive disorders involve a pervasive mood disturbance in which the child or adolescent may experience sadness or irritability, a lack of interest or energy, hopelessness, feelings of worthlessness or inappropriate guilt, psychomotor agitation or retardation, or disturbance in sleep, appetite, or concentration (DSM-IV; American Psychological Association, 1994). There has been controversy over whether young children are cognitively capable of depression. However, current thinking assumes that depression is a clearly identifiable disorder in children (DSM-IV; American Psychological Association, 1994; Kovacs, 1996, 1997). Typical intervention strategies focus on teaching students social skills necessary to receive reinforcement from others and restructuring irrational beliefs associated with depression. Although these approaches have generated some success, they are time and labor intensive (Reynolds & Stark, 1998).

Two protective factors that appear to modify the risk factors for internalizing disorders are social support and problem-focused coping strategies (Compas, 1987).

Positive coping skills are associated with decreased levels of anxiety and depression and the cognitive difficulties associated with both disorders have the potential to undermine effective coping. Adaptive coping is also modeled through parent-child interactions.

An example of a program that proves this approach effective for children with depression is the Penn Prevention Program. The Penn Protection Program is also directed towards altering the cognitive distortions and improving coping skills in at-risk youth (Gillham, Reivich, Jaycox, & Seligman, 1995; Jaycox, Reivich, Gillham, & Seligman, 1994). The participants in this program were considered at-risk for developing a depressive disorder due to elevated depressive symptoms (mean score on the Children's Depression Inventory was 9.1 at pretest) and elevated levels of child-perceived verbally reported family conflict. Students with elevated scores on both of these measures were eligible to participate in the program. Results from a quasi-experimental evaluation study suggested that the program resulted in clinically significant reductions in depressive symptoms immediately post-treatment and at a 6-month follow-up period. There was support that the reduction was mediated by changes in the explanatory styles. Although there were no group differences in externalizing behaviors post-treatment, at follow-up the parents of the intervention subjects reported significant improvements in children's home behavior compared to controls. The intervention appeared to be most effective for subjects from high conflict families and those with high levels of depressive symptoms.

The Primary Mental Health Project (Cowen et. al., 1996) has also demonstrated significant impact on children's internalizing symptoms of depression. The project seeks to prevent psychopathology by providing additional targeted support to early elementary aged children who have been identified as having social/emotional or learning

difficulties. The intervention focuses on the school domain and changing both the school ecology and the individual child. The core intervention component is the development of an ongoing interactive relationship with a therapist. The therapist meets with the child alone or in small groups in a structured playroom equipped with items designed to encourage interactions. The exploration and expression of emotions is encouraged through dialogue, with limits placed on inappropriate behavior. The therapist teaches life skills such as taking turns, following rules, and expressing feelings to others.

In an early non-randomized study of PMPH with approximately 200 subjects, children who had successfully completed one year of intervention were found to have significantly better adjustment on two separate teacher rated measures of acting out, moody, withdrawn behaviors, and learning difficulties at post test than a matched control group or a group of students who had not successfully completed the intervention (Lorion, Caldwell, & Cowen, 1976). With the exception of acting out behavior, these effects retained significance at 12-month follow-up.

Another non-randomized study of approximately 240 subjects found similar effects, with the greatest impact on students who began the program exhibiting more internalizing symptoms and less acting out behaviors (Cowen, Gesten, & Wilson, 1979). These findings were again based on observed teacher ratings reported. The cumulative findings of PMPH have strongly supported the effectiveness of such interventions.

Maag & Reid (1994) stated “symptoms of depression, such as reline sadness or hopelessness, are a common experience of everyday life. Yet the syndrome of depression (i.e., group of symptoms experienced together) represents such an insidious condition so adversely affecting individuals’ lives that suicide is often seen as the only solution

(p. 154).” It should be of particular concern to school personnel because between 2% and 21% of students experience symptoms of depression (Maag & Reid, 1994). Students with emotional/behavioral disorders and learning disabilities are at particularly high risk for displaying symptoms of depression (Maag & Forness, 1991).

Treating depression requires a concerted effort on the part of many professionals, especially educators. Students spend more time in school than most other structured settings outside the home, and their most consistent and extensive contact is with educators (Grob, Klein, & Eisen, 1983). Consequently, teachers may be the first professionals to notice developing problems and offer assistance. Unfortunately, many school personnel believe they neither have the time or the expertise to treat depression. This perception may be inaccurate. For example, many special education teachers have been trained to develop and implement such interventions as social skills training, self-control training (self-monitoring, self-evaluation, and self-reinforcement), activity scheduling, cognitive restructuring, attribution retraining, and relaxation training (Maag, 1989).

Pharmacological interventions for the treatment of depression in children have been proven effective as well. Several control-group treatment studies examining the efficacy of psychological treatments for depression in children have been conducted. Butler, Mietzitis, Friedman, and Cole (1997) compared moderately depressed fifth and sixth grade children who received either a treatment emphasizing social skills and social problem solving, a cognitive restructuring treatment, or assignment to an attention or waitlist control group. The two active treatments and attention condition consisted of ten 1-hour sessions conducted in small groups. A pretest-posttest design was used. At the

posttest, significant decreases in depression scores on the CDI were found for the active treatment group, as well as for the waitlist control. The attention group was unchanged.

Reynolds, Andersen, and Bartell (1999) conducted a small group treatment study, comparing cognitive-behavioral and behavioral problem solving treatment conditions to a waiting list control group. Participants were 345 moderately depressed children, age's 8-12 years. Assessment measures utilized the Children's Depression Inventory. Treatment took place in an elementary school and consisted of twelve 50-minute sessions administered in small groups over a five-week period.

The cognitive behavioral treatment relied on the self-control treatment for depression. Cognitive components consistent with Beck's (1976) cognitive therapy and components of attribution retraining were also included. The behavioral problem-solving therapy focused on procedures consistent with Lewinsohn's social learning theory (Lewinsohn & Arconad, 1981) which is designed to increase children's involvement in pleasant activities. In addition, modeling of the therapist presented problem-solving skills, an emphasis on increasing engagement in pleasant activities as well as improving social behavior was included.

The Children's Depression Inventory (CDI) (Kovacs, 1979) is a 27-item forced choice measurement tool of depressive symptomatology in children ages 7-17. Items have a three-choice format, where the child must select the symptom level that best characterizes how he or she is feeling in the past two weeks. There is a large amount of research on the CDI; all of which state that it should be used among other assessment tools and observations. Studies typically report internal consistency reliability coefficients in the mid to upper .80's (Nelson, Politano, Finch, Wendel, & Mayhall,



1997), and somewhat lower test-retest reliability coefficients depending on the interval between testings (Smucker, Craighead, Craighead, & Green, 1996). Although not designed as a diagnostic measure, the CDI is useful in assessing the severity of depressive symptomatology.

Outcomes on the CDI at posttest demonstrated both active treatments were a significant improvement in depressive symptomatology while the difference for the waiting list control group showed no improvements. An 8-week follow-up assessment showed a continuation of treatment effects, with some children in the self-control group continuing to improve from posttest to follow-up. Overall results indicated the treatments were effective, with 88% of the children in the self-control group and 67% of those in the behavioral group not depressed at the follow-up assessment (Reynolds, Andersen, & Bartell, 1999).

Another study conducted by Kaslow et al (1996) with moderately depressed middle school students investigated the efficacy of several treatments, including cognitive-behavioral, relaxation training, and a self-modeling condition, along with a waitlist control group. The cognitive-behavioral treatment focused primarily on pleasant activity scheduling and other behavioral components consistent with the approach of Lewinsohn (Reynolds, Andersen, & Bartell, 1999), with some cognitive, self-control, and social skills training added. Both treatments were group administered in twelve 50-minute sessions. The self-modeling group was individually administered with participants developing a three-minute videotape in which they modeled behaviors such as smiling, positive verbalizations, and appropriate eye contact, which were considered inconsistent with depressive symptoms. The Children's Depression Inventory was also

utilized to assess the effectiveness of treatment. All therapeutic groups demonstrated significant treatment gains at posttest and at a 4-week follow-up although the cognitive-behavioral and relaxation training groups tended to show the greatest outcomes

Seligman and Rosenhan state “Behavior is not displayed in a random or unorganized fashion, even for individuals experiencing severe psychiatric disorders such as depression or schizophrenia (p. 827).” Further Maag adds “...people behave purposely, and their behavior attains meaning as a function of the context, situation, or circumstances that exists in a particular environment (p. 147).” For example, the behaviors of running and yelling are considered inappropriate within the context of a math test but would be acceptable, or possibly valued, in the context of a soccer game. Context also serves as a cue for students engaging in certain behaviors.

Maag (1999) described how manipulating the context could have a profound effect on the performance of a behavior or symptom. It changes the meaning, purpose, and student’s desire to engage in it. Four general categories of context manipulations can be used to treat depression and include:

1. A student can engage in more of the behavior. For example, a student whose main expression of helplessness is passivity can be instructed to wait for people to open doors for them.
2. A student can engage in the behavior at a different time. For example, they may feel instructed to feel depressed from 2:30p.m. to 3:15 p.m.
3. A student can engage in the behavior at a different location. For example, they may be instructed to stand by a classroom window when feeling most depressed.

4. A student engages in the behavior using a different topography (i.e., appearance). For example, they may be instructed to cross their arms when feeling most depressed.

The rationale for these four approaches and their specific techniques is that they help students understand that what he or she perceived as an uncontrollable behavior or symptom is, in fact, controllable. A main reason that depression is so debilitating is because of the belief that it cannot be controlled. These approaches are also considered paradoxical because they convey to a student that she can change by remaining unchanged (Simon & Vetter-Zemitzsch, 1985). If a student complies with the direction, then she has proof that depression is under her control; whereas if she refuses to comply, she also has proof that depression is under her control because she was able to avoid experiencing it as instructed.

Contextually-based approaches require that teachers direct students to continue engaging in the troublesome behavior or symptom but engage in it more often or at a different time, location, or topography. These directives have the effect of changing the meaning, purpose, and desire for a student engaging in the troublesome behavior or symptom. Ironically, one of the most popular and well-researched approaches for treating childhood depression (i.e., cognitive therapy) also focuses on meaning; it is designed to help students identify, reality-test, and modify distorted or dysfunctional beliefs associated with depression (Reynolds & Stark, 1987). However, implementing cognitive therapy can be a time-consuming and intensive process that requires considerable training and expertise. Conversely, contextually based directives are simple and quick to implement and may accomplish the same goal. They have been intuitively

used successfully by teachers, therapists, and laypersons alike (Christian, 1999).

Therefore, ten directives for treating depression, based on the work of Yapko (1994), are described here for use with students. However, no outcome research was found on this approach to support or discount its effectiveness.

### Prescribing Depression

This directive relies on the use of symptom & paradoxical approaches. Symptom & prescription paradoxes communicate the message that in order to reduce a symptom of depression, a student may keep it. The idea is to make an uncontrollable behavior or symptom occur voluntarily. Because the behavior would occur anyway, a student would be in a better position to predict its occurrence. Therefore, the pattern that perpetuates depression is interrupted; a student cannot continue usual ways of trying to prevent it. Having a student express the symptom at a different time or location is an example of prescribing depression (Rohrbaugh, Tennen, Press, & White, 1981). Besides the altering pattern, a student discovers that instead of being a victim of depression, she can exert some degree of control over where and when episodes occur. Furthermore, carrying out the prescription changes a student's perceptions and feelings about depression because trying to deliberately experience depression makes it feel much less overwhelming (Yapko, 1994).

### Create an Ordeal for Relief

Creating an ordeal is a variation of prescribing a symptom. The idea here is for a teacher to construct a scenario in which a student is to display the symptomatic pattern in a way that will make it very inconvenient. This direction can create resistance in the student wanting to experience depression and, therefore, help him assume some control

over the experience instead of remaining its hopeless victim (Yapko, 1994). Haley (1984) described four characteristics of a good ordeal:

1. The ordeal should cause distress equal or greater than that caused by the troubling behavior. For example, a student who is distressed by compulsively sharpening pencils 25 times a day may be required to sharpen pencils 50 times a day at a pencil sharpener in a remote part of the school.
2. The ordeal should be good for the person. For example, requiring an adolescent who wants to quit smoking to keep a pack of cigarettes in a place that is only accessible by walking a 1 mile would provide him with exercise.
3. The ordeal should be something the person can do and to which he cannot legitimately object. For example, having a student who is depressed wait passively for adults to ask if he needs help is a behavior in which he could, and wants to, engage.
4. The ordeal should not physically harm the person or anyone else. For example, a student who kicks other students or cuts himself with a knife should not be required to engage in more of these behaviors.

#### Exaggerate Helplessness

Directing a student who is depressed to exaggerate helplessness may mobilize his recognition that he is, in fact, not helpless (Yapko, 1994). For example, a student can be instructed to stop and ask peers for directions to go places already known to him, such as the classroom, Cafeteria, principal's office, or bus stop. Yapko suggested that this recognition create power and autonomy; a valuable personal resource that can be called upon later.

### Control the Uncontrollable

A common basis for what seem to be uncontrollable behaviors or symptoms may actually be a student's ambivalence to the situation. Yapko (1994) believed that ambivalence is a tangible consequence of not controlling the controllable. Students who are depressed often know what to do and how to get what they want but believe they do not have the power or the right to have it. Therefore, an effective directive is to have a student attempt to control the uncontrollable.

In this strategy, a student is first asked to list a number of things that she knows are obviously outside the realm of her control, such as the weather, outcome of a baseball game, or number of parents that will call the school. The student is then directed to spend a certain amount of time each day attempting to control those things. The teacher should encourage the student to use whatever means she can bring to about a specific outcome. For example, the student may be instructed to plead, whine, tantrum, or use any other strategy the teacher has unidentified that the student has displayed in the past. The student should be instructed to pretend as if such maneuvers would actually attain the identified goal. Yapko (1994) suggested that this type of role-playing serve two purposes. First, it may help students identify feelings of resentment, frustration, and anger that can be dealt with openly and positively. Second, it may give other students a humorous look at the futility of trying to control situations in which no control is possible.

### Be Perfect

Perfectionism is a problem whose implications for school personnel have recently been addressed (Kottman & Ashby, 2000). Many students who are depressed experience

both the negative and positive aspects of this trait (Wicks-Nelson & Israel, 2000). One way to treat perfectionism is to direct students to be perfect in every dimension of their lives. No imperfections are allowable anywhere. For example, a student may be instructed to eat perfectly, breathe perfectly, walk perfectly, dress perfectly, and so forth. The frustration and resentment experienced by a student may be positively used to redefine perfection in a more realistic and self-directed fashion. Yapko (1994) pointed out another important reason to redefine perfection: A student's original concept of perfection is so often not her own but rather an interpretation to the expectations of a significant other (e.g., parent).

#### Make Deliberate Mistakes

Another directive for dealing with perfectionism is to direct a student to deliberately plan and execute a specified number of mistakes daily (Watzlawick, 1978). For example, a student may be instructed to bring the wrong book to class (assuming his teachers have been informed of the intervention and are willing to participate), turn the wrong way down the hallway, wear socks inside out, or any other harmless, trivial tasks. This technique, like many of the others presented, is paradoxical in nature.

The student is being compliant if he makes mistakes. The student is also being compliant if he makes the mistake of not making a mistake. The student would not feel responsible for complying and making mistakes because he would be following the teacher's instruction. Yapko (1994) suggested that this strategy give a student the opportunity to discover through direct experience that making mistakes does not lead to any catastrophic consequences that he may have previously feared.

### Buy it and Throw it Away

This strategy, involves directing a student to buy something inexpensive, hold on to it for a short time (perhaps as little as a few hours), and then destroy it and throw it away. For example, a student may be instructed to buy a candy bar, pencil, and piece of bubble gum and then throw it away an hour later. Yapko (1994) stated having a student buy something and throw it away illustrates certain important points. First, the student learns that something can be of importance for a very limited period of time and can then be discarded. Second, something need not last forever in order for it to have value. Third, a student need not get too personally invested in something because nothing lasts forever. In essence, a student learns that life goes on and what seemed important and necessary is nothing more than the normal process of developing new and deeper interests that go beyond material value.

### Self-Justification Shuffle

In some instances, students who are depressed try to justify everything they do. The justifications fall short of perfection and, consequently, exacerbate feelings of depression. In these instances, the teacher can direct a student to justify everything that he does. The directive is given that a student gives at least three reasons for all activities he performs. The exertion of mental energy required to justify what he does may soon become burdensome (Yapko, 1994). Most important, suggested Yapko, a student discovers that each of the justifications is essentially a rationalization for doing what he wants to and for possessing hidden feelings. It then becomes easier for a student to develop an awareness that the way he feels is simply a justification for doing or feeling as he desires because the justifications are nothing more than after-the-fact explanations.



### All Excuses

This strategy is designed to help students accept responsibility for their actions. A student would be instructed to carry out an assigned task incorrectly and then instantly furnish excuses for the outcomes of the task. Yapko (1994) suggested that the image created is one of a caricature of irresponsibility. The lightheartedness of such an interaction can paint a picture of the blaming style and its one-dimensional limitations. In a variation of this technique, a student may be asked to generate a list of personal accomplishments or personal experiences, however good or bad. The teacher then directs the student to deny having anything to do with any of them. This denying oneself may give a student a chance to see herself quite differently from the usual perspective (Yapko, 1994).

### Pretty Please Permission Seeking

Students who are depressed sometimes have a strong need for approval as a way to bolster a frail self-image. In this strategy the teacher instructs the student to ask others for permission to do whatever it is he wants to do (e.g., Can I sit here?). The student is required to get a positive reply from others before he can proceed with even simplest tasks (e.g., walking down the hall, taking a bite of a sandwich at lunch, and walking through a doorway). Yapko (1994) pointed out how the amplification associated with this strategy negatively frames the student's difficulties associated with having to have his needs validated by others. Yapko (1994) recommended that when using this strategy, the teacher should help the student learn to validate his own needs in order to transition away from an other-oriented to self-oriented focus.

## **Family Systems Therapy**

Systems intervention is founded upon the principle that psychological difficulties are inseparable from their interpersonal context. Nicholson argues (1987): “Attempting to do therapy without transforming the context may at best be slow, at worst futile (p.543).” Whitaker (1975) goes as far as to suggest that individual therapy only works to the extent that the client is able to change their family. Further, as Boddington (1993) reminds us, “There are inherent dangers in adopting a linear intrapsychic view of a client’s problems at the expense of giving attention to interpersonal relationships in their present life. Day to day reciprocal relationships may compare poorly with the special intensity of the therapeutic dyad and there is the risk that the practitioner can be drawn into an unhelpful alliance with the client, which reinforces an unhealthy family process (p. 34).”

Although past experiences are acknowledged, family systems thinking is primarily concerned with current relationships in the clients life and symptomatic behavior is understood as performing a function in relation to an unresolved family dilemma. To quote Bateson (1971): “The basic rule of systems theory is that, if you want to understand some phenomenon within the context of all completed circuits which are relevant to it. The emphasis is on the concept of the completed communicational circuit and implicit in the theory is the exception that all units containing completed circuits will show mental characteristics. The mind, in other words, is immanent in the circuitry. We are accustomed to thinking of the mind as somehow contained within the skin of the organism, but the circuitry is not contained within the skin (p. 244).” This enables Keeney (1979) to postulate the following generalizations: “Difficulties in any part of the

relationship system may give rise to symptomatic expression in other parts of the system. Symptomatic relief in one part of the system may result in the untransfer of symptomatic expression to another site. Significant change... in any part of the system result in changes in other parts of the system (p.120).”

Carter & McGoldrick (1999) state “All families must change fundamentally, given the developmental needs of family members and the lengthy period of contact between them as these are negotiated. Further, family inter-relatedness means that the achievement of each person in these tasks is dependent upon the contribution and success of other members. Of central importance is the hierarchical organization of the family which puts parents in charge of children and responsible for them and requires that children are treated in an age appropriate way. Symptoms exhibited in an individual are understood to be a function of a family system, which is operating poorly in one or more of these areas (p.354).” In family therapy intervention, when the family presents with a difficulty in one of its members, the therapist examines the family organization taking particular note of: boundaries (who is in or out of a particular activity); alignment (who is with who and against whom); and hierarchy (who has control over whom). Even in the absence of other family members and without having the opportunity of having the family demonstrate its process in the therapy room, the individual counselor or therapist can address the following questions: 1) What was the function of the client’s role in their family of origin at critical transitions in the family life-cycle? 2) How differentiated is the client from his or her family of origin? 3) How functional is the structure of the family of marriage? By applying the structural principles of boundaries, alignment and hierarchy, while keeping in mind cultural and ethnic variations (Jenkins, 1989; Bott &

Hodes, 1989), the practitioner will be in a position to formulate the systemic function of symptomatic behavior and begin the process of treatment planning.

In Minuchin's words (1974): "Unless the therapist can join the family and establish a therapeutic system, restructuring cannot occur, and any attempt to achieve the therapeutic goals will fail (p. 122)". He goes on to argue that, in joining a family, the therapist "should feel a family member's pain (p. 123)." Minuchin's notions of maintenance, tracking and mimesis, where he outlines behaviors by which a therapist joins with and accommodates a family, closely echo the active listening skills by which empathy is communicated in client centered work. Having established commonalities between family systems and humanistic/integrative approaches, it is important to clarify the place of empathy when working systemically with individuals. From a systems point of view, empathy directed towards a client by the therapist is essential for engagement and maintaining a therapeutic alliance but is not an end in itself. Given the systemic intervention is primarily concerned with real relationships in the present; empathetic understanding will not be restricted to the therapeutic relationship but extended to the significant relationships in the client's life. In that sense, the experience with the counselor or therapist can be viewed as providing the client with a model of how to engage with other family members in a non-threatening manner in order to change transactional patterns (Bott 1992).

The closing stages of family intervention with an individual are directed towards helping the client to control and change the part that they play in the system of their family of origin (Bott, 1992). Here intervention is informed by the approach of Murray Bowen (1978). The central principle of this work is Bowen's view that the relationship

between the self and the system is characterized by a variable degree of differentiation in relation to fusion which, in the absence of intervention, remains broadly constant throughout an individual's life. Therapeutic intervention is guided by two principles. The first is that of triangulation; the recognition that two person relationships are inherently unstable and that, when there is stress, a third person will be drawn in to divert anxiety leading to stability without resolution. Next, there is the notion of 'reactive distance'. This describes the tendency for an individual to react to a strong pull towards fusion by cutting off entirely from family contact. Therapeutic intervention aims at helping the client to re-enter the family system in order to establish a person-to-person relationship with each family member and thus to interrupt triangulation. With this, the practitioner supports the client in holding a differentiated position against the pressure to conform to previous patterns. Allen (1988) has taken up these ideas introducing also the notions of 'empathetic discussion' and 'metacommunication'. Empathetic discussion provides the client with a way of approaching family members, which is likely to reduce resistance on their part. The client is encouraged to understand their feelings and actions and to communicate that understanding as against attacking and blaming.

Metacommunication is a central principle in all systemic work describing the process of communicating about communication (Watzlawick, 1968). The practitioner helps the client introduce metacommunication moving from a discussion of past events to the current family predicament. Although child alone and parenting alone prevention models have shown limited effectiveness, a new generation of multi-component models provides the promise of greater impact. Following from developmental models of risk and protection, interventions that target multiple environments (e.g., child, school,

family, and neighborhood) and multiple socialization agents (e.g., parents, teachers, and peers) over extended developmental periods are probably necessary to alter the developmental trajectories of children who live in high-risk environments (Conduct Problems Prevention Research Group, 1992; Reid & Eddy, 1997).

Tremblay and his colleagues (McCord, Trembley, Vitaro, & Desmarais-Gervais, 1994; Trembley, Vitaro, et al., 1992; Trembley et al., 1996; Vitaro & Trembley, 1994) combined parent training and child social skills training in the Montreal Prevention Experiment. The program targeted 166 elementary school-age boys rated above the 70<sup>th</sup> percentile on a measure of aggressive and disruptive behavior. The subjects were randomly assigned to either an intervention or a placebo control condition that lasted two years. The child component consisted of group skill training sessions in which children worked with normative peers to develop more prosocial and adaptive social behavior. Parents worked with family consultants approximately twice a month for two years to learn positive discipline techniques and how to support their child's positive behavior. Initial results did not reveal many group differences although at post-test, intervention students were less likely to be classified as seriously maladjusted. Group differences began to emerge on the follow-up assessments. Intervention students were significantly more likely to be on grade level at one-year follow-up (fourth grade) compared to controls. When the boys were 11 and 12-years old there were a number of significant differences between the groups. At the three-year follow-up when the boys were age 12, treatment subjects were significantly less likely than control boys to engage in fighting according to teacher report or to be classified as having serious adjustment difficulties.

The results of the Montreal Prevention Experiment reflect the importance of extending assessments beyond the post-test point particularly when the behaviors being targeted by the intervention and more likely to occur later in development. In this program, group differences between the intervention and control group were apparent in multiple domains (i.e. academic, social, behavioral), emerged over time, and became increasingly significant.

The Earls court Social Skills Group Program (Pepler, King, & Byriad, 1991; Pepler, King, Craig, Byrd, & Bream, 1995) is a multi-component program that targets three domains: the child, the parents, and the classroom. Students ages 6 to 12, exhibiting aggressive and disruptive behavior (according to both teacher ratings and principal reports) are eligible to participate in the program. The primary intervention is social skills training provided in small groups, twice weekly over the course of 12 to 15 weeks. Training sessions are offered to parents but not required. Classroom presentations, teacher involvement, and homework assignments are all utilized to generalize the skills to the classroom setting. The evaluation included 74 boys and girls who were randomly assigned to the intervention or a wait-list control group. Findings revealed that teachers rated intervention students as exhibiting significantly less externalizing behavior than controls at post-test and that these were clinically significant changes in symptomatology.

Another multi-component program that combines parent and child focused interventions is the First Steps program (Walker, Kavanagh, et al, 1998; Walker, Stiller, Severson, Feil, & Golly, 1998). This program intervenes with children and teaches them more adaptive behavior that is likely to foster social and academic success. The initial

phase consists of a comprehensive screening process (Early Screening Project) which identified kindergarten children exhibiting elevated levels of maladaptive behavior. Families with an at-risk child receive a 6-week home intervention in which program consultants help them develop ways of supporting the child's adaptive behavior. In school, target children participate in a classroom based, skill building and reinforcement program that lasts about 8 weeks. The program was evaluated with two cohorts of 42 subjects. Teachers in this study reported significantly less aggressive and maladaptive behavior for intervention students compared to those in the control group at post-test. Immediately following the intervention, the teachers also rated the intervention students as significantly more adaptive and indicated that program students showed more time engaged in academic activity. Both cohorts were assessed again at follow-up a year later and treatment effects were maintained for both groups.

Aponte (1976) created a team approach to working with school problems and recommended an initial family-school meeting to include the child, family, and school personnel (e.g., teacher, counselor, and principal). The purpose of such an approach is to learn about the presenting problems and the relationships among the people who contribute to the problem in the school context, as well as to develop ways in which these people can support the child in bringing about change. Morrison and Olivos (1998) conducted a study utilizing the paradigm that was previously mentioned, referred to as the mini-SARB.

To be referred for the mini-SARB, the student's problem behavior must have been chronic for six months or longer that a systemic intervention is necessary to keep the child from being expelled from school. The purpose of every meeting with all



included representatives is to transform the current relationships into a collaborative relationship in which there are clear boundaries between the home and the school and reciprocal transactions based on mutual trust and respect (Power & Bartholomew, 1998).

The parent's role is to provide relevant information pertaining to the student and family situation that will be useful in resolving the student's problems. The parent assumes their proper place in the family's hierarchy relevant to the child and collaborates with school personnel to develop and implement a plan for change. The student is given an opportunity to set goals, define problems, and if possible, to develop the plans for change. The student is encouraged to be an active participant and is responsible for changing the inappropriate behavior. The mini-SARB process brings together the significant problems in the child's life at the interface between family and school systems to form a therapeutic suprasystem or mesosystem (Andersen, 1998). The team approach also emphasizes the seriousness of the situation for the parents and the student; however, the team is perceived as being supportive by both teachers and parents. Finally, mini-SARB team members model effective communication and intervention techniques for both school personnel and family members that can be used with other problems and with other children in the school and family.

The study conducted by Morrison & Olivos (1998) focused on a predominantly minority community made up of mostly Hispanic and African-American children. The participants included 848 students from an inner-city community located in Hawaiian Gardens, California. The types of behavioral problems the children were presenting included not completing homework, fighting, disrespectful behaviors toward adults and peers, defiance, withdrawn behavior, provocativeness, and elopement among others. The

sessions ranged in number from 1 to 7 depending on the family's compliance. Each session lasted from 30- 40 minutes. The data indicates that 67% of the students totally met their objectives, which was measured by successful achievement of goal outlines during the mini-SARB meetings. Follow-up data over a 1-2 year period indicated that the behavioral changes were maintained as indicated by teacher report and a 7% re-referral rate was reported. In sum, 77% of the students either completely met their objectives or made observable progress toward meeting their objectives.

The study also assessed the social validity of the process. To assess the social validity, there were two post-study surveys requested to be filled out by parent and school personnel. Parents and staff were asked a series of questions about the effectiveness of the mini-SARB process. Their responses were scored on a Likert-type scale of 1 to 5, 1= completely ineffective and 5= maximally effective. The respondents were also asked to make comments and suggestions for improvement. As the data showed, both parents and teachers perceived the mini-SARB as a valuable tool to improve student behavior and the relationship between the school and family. In addition, it seems to be most effective when the intervention is implemented before the crisis stage and before a chronic behavior problem develops.

The outcome to these studies mentioned demonstrate the importance that the family systems approach takes in the treatment process. The improvements made by those children that participated in the studies were far more significant with the involvement of their families. Further, those improvements stayed consistent over a period of time when continued treatment was followed through with along with the support of the family.

## **Attachment Disorder**

Bowlby's theory conceptualized attachment as a biological drive toward species survival (Bowlby, 1969). He theorized that selective attachment provided protection from predators. Bowlby divided the attachment cycle into four phases occurring during the first few years of life. He suggested that these represent a biological repertoire of signaling behaviors to induce individuals to approach, thus increasing proximity and physical contact. During the first phase of the attachment cycle, crying is the dominant signaling behavior. The cry of the infant signals the caregiver to provide relief for the child. In addition, Bowlby felt that the infant is equipped with additional behaviors (e.g., rooting, sucking, and grasping) in order to prolong the physical contact. These behaviors are the basis of attachment formation in that they seek to minimize distance between infant and caregiver.

Within this framework, attachment is conceptualized as an intense and enduring bond biologically rooted in the function of protection from danger (Bowlby, 1969). This is the evolutionary basis of attachment; however, it remains that attachment is a subjective experience of the infant based on a consistent alleviation of infant needs (Lieberman & Zeanah, 1995). The infant's biological needs and behavioral requests (in the form of crying or reaching) must be consistently answered by the caregiver in order to foster the sense of trust and security imperative for attachment to occur (Lieberman & Zeanah). If these needs are appropriately met, the caregiver becomes a conditioned source of comfort (James, 1994). Bowlby (1969) believed that the infant uses these early experiences to develop an internal working model, later influencing interpersonal perceptions, attitudes, and expectation. If an infant is cared for consistently, the internal

model will reflect that consistency, and trust will begin to form (Carmen & Huffman, 1996). The implication of this is that the infant will maintain normative social development given that the environment satisfies these biological needs consistently (Ainsworth et al., 1978). The concept of caregiver sensitivity addressed the problem of individual variation in attachment formation by declaring that a responsive, sensitive caregiver was of critical importance to the development of a secure, versus an insecure, attachment pattern (Goldberg et al., 1995).

Boris et al. (1997) delineated numerous behaviors that should be assessed to determine whether a particular pattern of attachment is clinically significant. Primarily, the style of showing affection and seeking comfort from the caregiver should be observed. A lack of affectionate interchange between child and caregiver and/or indiscriminate affection with strangers is cause for concern. Another clinical area of behavior is the degree of cooperation between child and caregiver. Specifically, expressive dependence on the caregiver or an inability to seek the support of the attachment figure is problematic (Boris et al., 1997). He also concluded that the clinical assessment of attachment disturbances should be based on a focused history and a systematic observation of parent/infant interaction (1997). Therefore, the quality of the caregiver's emotional availability early in life is critical in the development of a healthy internal representation of the self, the attachment figure, and the external world (Rosenstein & Horowitz, 1996). A child who has not experienced sensitive care and thus does not believe in the responsiveness of the caregiver is said to have an insecure attachment (Lieberman & Zeanah, 1995). This insecure attachment forms a major risk

factor in the development of ambivalent relationships, negative mood states, and psychopathology (Noshpitz, Flaherty, & Sarles, 1997).

For example, Rosenstein and Horowitz (1996) examined the relationship among attachment classification, psychopathology, and personality traits in 60 adolescents (13 to 20 years of age) admitted to a psychiatric hospital. An overwhelming majority (97%) of adolescents reported feelings congruent with insecure attachment as described by the Adult Attachment Inventory (George, Kaplan, & Main, 1985). Rosenstein & Horowitz compared the adolescents' psychological assessments. Adolescents labeled as dismissing (i.e., derogatory and cut off from attachment experiences) were associated with conduct and substance abuse disorders as well as denial of psychiatric symptomatology. Those labeled preoccupied (i.e., passive, angry, and entangled by past experiences) were more likely to suffer from affective disorders, and manifested overt disclosure of symptomatic distress. Thus, the findings were consistent with the internal working models of attachment theory and the vulnerability of early insecure attachments to later psychiatric diagnoses. Researchers concluded that attachment patterns during infancy could serve as an indicator of later psychological problems (Rosenstein & Horowitz, 1996).

Boris et al. (1997) demonstrated a link between attachment classification during infancy and a diagnosis of anxiety disorders during adolescence. The insecure/resistant pattern of attachment was the only classification predictive of future anxiety disorders. Twenty-eight percent of the infants labeled as insecure/resistant developed anxiety disorders during adolescence. Those classified as insecure/avoidant were more likely to resent other clinical disorders, although the authors did not specify which disorders (Main

& Solomon, 1986). These two studies support the significance of attachment measurements as predictors of clinical behavior problems.

Attachment disorder parental support and information groups have begun to develop throughout different communities. These groups provide information, advice, personal experiences, and a network which group members can interact and be supportive to one another (Trenberth, 2000). Parents who share horror stories about their children who have been diagnosed as unattached are discovering that many other parents experience these difficulties. Treatment centers to specifically address attachment disorder issues, such as The Attachment Center and Forest Heights Lodge have been created to support those parents that have experienced the outcomes to attachment disordered children (Fahlberg, 1999).

According to attachment theory, children's failure to develop an attachment causes a number of symptoms (Curtis, 2001). Some of these symptoms include a lack of ability to give and receive affection, exaggerating stories to the point of lying, lack of long-term consistent relationships, extreme control problems, and conduct behaviors such as stealing. When choosing among treatment options, the most important factor to consider is the severity of the attachment disorder. Through testing and evaluations, therapists can determine the severity and place the child into the appropriate environment to address the attachment issues at hand.

The greatest challenge is building a relationship with the mildly unattached child. Therapists should be able to provide security and safety and still push the child to explore his/her relationships. The relationship between therapist and child should be perceived as an attached relationship to pursue the emotional and cognitive components of the child.

Access to this part is a necessary element in building a trusting relationship. However, the therapist's role with the more severely unattached child, for instance a child of abuse and neglect, is more of a complicated situation. According to Fahlberg (1999), the severely unattached child needs to be treated for the disorder by someone who possesses in-depth knowledge and training in dealing with these types of cases. It would be mandatory that the therapist be specialized in dealing with victims of abuse and neglect to reach the core of those unattached issues.

The Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed.; DSM-IV; American Psychiatric Association, 1994) recognizes Reactive Attachment Disorder (RAD) as one of the most severe forms of infant psychopathology in terms of attachment disturbances. This disorder is characterized by an inability to form normal relationships with others and impairment in social development, marked by sociopathic behaviors during early childhood (Carmen & Huffman, 1996).

Psychologists recognize that the risk for RAD is increased by factors that contribute to neglect and abuse, as in infants who are handicapped or unwanted and/or parent characteristics that interfere with the normative attachment cycle (DeAngelis, 1997). In terms of caregiver characteristics, such risk factors include parental depression, isolation, and lack of social support, as well as extreme deprivation and abuse during parents' own upbringing (Culbertson & Willis, 1993).

Although epidemiological data are limited, the DSM-IV describes RAD as a fairly uncommon behavioral disorder marked by developmentally inappropriate social relatedness in most contexts appearing before the age of 5 (American Psychiatric Association, 1994). However, increases in social problems (i.e., family separation,

abuse, and neglect, and foreign adoptions) may augment the frequency of this disturbance (DeAngelis, 1997). Lieberman & Zeanah (1995) suggested that this disorder is fairly common, citing a study that claims 1 million children with RAD live in New York City alone.

The DSM-IV delineates two subtypes of RAD, the inhibited type and the disinhibited type. The inhibited type is characterized by a persistent failure to initiate and respond to social interactions in a developmentally appropriate manner. There is a resistance to comfort along with a mixed pattern of approach and avoidance behaviors. The disinhibited type is characterized by social promiscuity; the child fails to discriminate attachment behaviors. For example, a child diagnosed with RAD-disinhibited type may be overtly charming, telling strangers that he or she loves them, asking them to come home with him or her. Other features not identified in the current diagnostic criteria of RAD but that appear to be shared by most of these children include lack of empathy, limited eye contact, cruelty to animals, poor impulse control, lack of casual thinking and conscience, abnormal speech patterns, and inappropriate affection with strangers (Carmen & Huffman, 1996). Because the behavior associated with RAD often appears similar to (and is often misdiagnosed as) a conduct disorder, oppositional-defiant disorder, or attention-deficit hyperactivity disorder, it is important to distinguish those children who show attachment disturbances from those who have other disorders (Carmen & Huffman, 1996).

A system proposed by James (1994) identifies three major types of attachment disturbances: nonattached, disordered, and disrupted. Children classified as nonattached are those over the cognitive age of 10 months who have shown no preferred attachment



to anyone. Two subtypes of this group would coincide with the subtypes of the DSM-IV: nonattachment with indiscriminate sociability (disinhibited) and nonattachment with emotional withdrawal (inhibited).

Disordered attachments would characterize those children who do not use the caregiver as a secure base for exploration. Three subtypes of disordered attachment are described: (a) a child who is excessively clingy and inhibited in exploration (disordered attachment with inhibition), (b) a child who fails to check back with the caregiver in times of danger (disordered attachment with self-endangerment), and (c) a child who tends to worry excessively about the emotional well-being of the caregiver (disordered attachment with role-reversal). Because of the importance of the attachment figure during the first three years of life, James (1994) suggested that the loss of the attachment figure at this time would be qualitatively different than at other developmental stages, predisposing a child to problems in attachment.

Additional barriers to traditional therapies include an ability to profit from experience, a minimal desire to change little or no regard for authority, and poor impulse control. Regardless of orientation, therapies for those suffering from RAD have similar goals: developing self-control and self-identity, understanding natural consequences, and reinforcing reciprocity and nurturing (Attachment Center, 1997). These therapies are directed to the individual child, the parent(s), and the family support structure as a whole.

An additional component of intervention at many such facilities is an unconventional and controversial technique involving physical holding to elicit the child's inner "rage" (Magid & McKelvey, 1987). The goal is to recreate the bonding cycle that an infant experiences with the parent. Therefore, holding therapy is designed

to provide a safe and protected space in which to express overwhelming emotions. Fahlberg (1990) cited significant progress in reducing destructive behaviors, strengthening attachments, and increasing emotional expressions following holding therapy.

Randolph and Myeroff (1998) reported findings of two studies concerning the aforementioned intervention provided at the Attachment Center at Evergreen. One study assessed the behavioral change in 12 children following the intervention compared with a control group of 11 children. Controls were individuals who had expressed interest in treatment but for various reasons were unable to receive it. Both groups completed the Child Behavior Checklist (CBCL; Achenbach, 1993) 1 week before and 1-week following the 2-week intensive intervention. Those in the treatment group showed significant decreases in aggression and delinquency as measured by the CBCL, whereas the controls showed no change. Thus, researchers concluded that holding therapy combined with intensive parent counseling was effective in reducing problem behavior (Randolph & Myeroff, 1998).

The second study assessed 25 children between the ages of 4 and 14 receiving long-term treatment (from 6 months to 2 years) at the same facility. Using the CBCL as a measure of problem behaviors both before and after intervention, Randolph & Myeroff (1998) reported significant improvements of behavior for 76% of the sample. About 16% remained unchanged, and 8% showed mixed changes (improved on some subscales and worsened on others). Thus, researchers concluded that treatment with these children was more complicated and necessitated additional time to show change (Randolph &

Myeroff). Follow-up evaluations continued to show maintenance of the initial improvements.

### **Substance Abuse & Families**

The issues of substance abuse and its effect on the individual, family, and community remain a major challenge to the social work profession. When the substance abuser is a parent and has responsibilities for raising and supporting children, the challenge can be even greater. Not only must the issues of substance use and relapse prevention be addressed, but the demands of parenting and family must be considered as well. Many substance-affected parents are faced with hard choices in managing their recovery efforts and meeting their family responsibilities. Because of their addiction, they lack the ability to assume an effective parenting role or to be a supportive member of their family. Too often this results in a disengagement from the family, which has detrimental effects for the parent and the family. To help prevent this outcome, a source of support to help with the transition back to parent responsibility and family involvement is needed. Gruber (2001) states that this support can be provided through continuing care substance abuse recovery services, which can help these individuals work on their recovery and develop the education and skills they need for effective parenting, supportive family involvement, and avoidance of drugs and alcohol.

Studies show that individuals are more likely to relapse when families fail to maintain involvement in treatment activities (educational, counseling, and self-help programs) than individuals from families who do stay involved (Daley & Marlatt, 1992; Daley & Raskin, 1992; Gorski & Miller, 1988; Hawkins & Catalano, 1985). When families participate in the recovery process, they are more likely to be supportive and less

likely to “sabotage” the addict’s recovery. They are also more likely to encourage the addict to seek support from a self-help network and to recognize factors that may interfere with recovery (Daley & Marlatt, 1992).

Involvement in the recovery activities is beneficial to the family in more than just providing support to the substance-affected family member. Other members of the family benefit when they have the opportunity to learn about addiction and its physical, psychological, and emotional effect. Family participation in the recovery plan helps them identify relapse warning signs, support efforts to remain abstinent, and achieve some control over the recovery process (Daley & Raskin, 1991). Participation in the process gives family members the opportunity to heal any emotional pain they may have experienced as a result of the addict’s substance abuse history (Daley & Marlatt, 1992). Research shows a strong link between parental substance abuse and child maltreatment (Child Welfare League of America, 1990; Famularo, Kinscheroff, & Fenton, 1992; Sheridan, 1995). According to the Child Welfare of America, substance abuse may be involved in as many as 80 percent of all substantiated cases of abuse and neglect. Substance abuse is one of the most common reasons children enter into the care of social service agencies (Children Defense Fund, 1992). In a study conducted by the Child Welfare League of America (1992), referral of over 40 percent of children to public and private child welfare agencies was related to substance abuse. The study also noted that substance abuse is a major factor in cases involving child protection, family disruption, and placement into foster care.

Psychological, cognitive-behavioral, and behavioral risks to children of substance-abusing parents are well established (Aktan, Kumpfer, & Turner, 1996; Curtis

& McCullough, 1993; Dore, Doris & Wright, 1995; Julianna & Goodman, 1992; Sheridan, 1995). Dore, Doris, and Wright (1995), in a review of how substance abuse effects children, reported that studies of psychosocial functioning have found that children from substance-abusing families are prone to behavior problems involving hyperactivity and conduct disorder, drug and alcohol use, impaired intellectual and academic functioning, clinical levels of anxiety and depression, low levels of self-esteem, and perceived lack of environmental control. Aktan, Kumpfer, and Turner (1996) reported that children in families of substance abusers are inclined to have ability deficits that impair their ability to solve problems, cope with stress, tolerate drugs, communicate effectively, consistently apply good standards, hold reasonable expectations, and be sufficiently interactive and supportive with others.

In families which parents abuse substances, parental control and protection factor are less evident and youths are more likely to exhibit behavior problems at home and school, be involved in delinquent activities, and use drugs and alcohol than youths from families in which parents do not abuse drugs (Julianna & Goodman, 1992). Drug abusing families are likely to exhibit poor family management skills that lead to disruption, conflict, loss of parental control, low frustration tolerance, unrealistic expectations of children, weak child-parent bonds, low family cohesion, and undefined family boundaries (Julianna & Goodman; Sheridan, 1995). Also, there is evidence that when parents stop using drugs they become better parents (Murphy et al., 1991).

Few programs have the comprehensive range of services to address the diverse needs of substance-affected parents, which include special and developmental needs of children, child care and parenting skills, housing and vocational assistance, and

counseling directed a emotional consequences (for example, guilt and shame) of substance abuse.

According to the Child Welfare League of America, “Chemically dependent families need intensive immediate and ongoing assistance to resolve AOD dependency, improve family functioning, and remedy the problems that chemical dependency creates for children (p. 20).” The report asserts that services must be provided to help parents improve their ability to perceive, understand, and respond appropriately to their children’s needs. Also, it is important to consider the larger context of alcohol and drug use and how it might affect family needs such as housing, employment, medical care, sufficiency of social network, and contact and integration with the community.

An example is a program named Project Connect, operated by the Rhode Island Center for Children-at-Risk, which provides therapeutic home-based and case management services that include substance abuse assessment and counseling, individual and family counseling, parent education, pediatric nursing services, and linkage with formal substance abuse treatment programs and other community resources. The program provides services for a six- to 12-month period. In a recent assessment of the project, the majority of a 66-case sample of mostly single-parent (single mothers) families with young children who received services made positive progress on their service goals (Olsen, 1995).

Preservation of the family is a primary goal of intervention with substance-affected families with dependent children in the home. In Olsen’s evaluation of Project Connect, which provided some home-based substance abuse treatment services, she

(1995) found that when parents were successfully involved in the services, 83 percent of those families' children remained in the home. By contrast, only 17 percent of children in families of unsuccessfully involved parents avoided out-of-home placement. Olsen concluded that "these data tell us that a project designed to offer supportive services to families struggling with problems of addiction can be successful in helping to maintain family ties and reducing the risk of child maltreatment in those cases where the parent is able to successfully engage in the recovery process (p. 191)."

Recovering from a chemical dependency involves gaining information, increasing self-awareness, developing coping skills, and following a program of change. The goal of the recovery process is to have the recovering individual assume increasing levels of responsibility for dealing with problems and issues of a chemically free lifestyle. In addition to the recovering adult, children in these families often need special attention. Intervention must include helping children understand and cope with the dynamics of substance abuse and providing opportunities to develop positive supportive relationships that can help them understand the effects of substance abuse and develop appropriate coping mechanisms (Julianna & Goodman, 1992). In a study of successful completers of a family rehabilitation program, a sample of 20 recovering mothers achieved their success because of the program's ability to increase parental strengths, provide environmental support, and focus on educational and vocational achievement (Carten, 1996).

Another example of a recovery program aimed at helping families is The Bridges Program. It is based on an integrated model of relapse prevention and family preservation. Services address three basic primary goals: (1) to help the substance abuser

in maintaining the recovery process, (2) to help the family with the abuser's recovery, and (3) to provide family preservation or family reunification services. The program connects clients and their families with self-help groups (such as Alcoholics Anonymous, Narcotics Anonymous, or Al-Anon), teaches problem-solving skills, and helps obtain treatment and special assistance services. Intervention domains consist of four focuses. The core domains were selected to achieve the service focus of linking parental recovery with family support. The domains and their respective components were included on the basis of their relationship to family and parent functioning and to their identified significance in contributing to relapse prevention. The four domains are individual actions and cognitions, individual recovery actions, family actions and cognitions, and family recovery actions. Individual actions and cognitions consist of behaviors and thinking patterns of the substance abuser that represent facets of functioning that are essential to engaging in a lifestyle not dependent on alcohol or drug use. Individual recovery actions are behavioral changes that substance abusers must integrate into their daily lives to achieve and maintain sobriety. Family actions and cognitions are behaviors and thinking patterns of the substance abuser's family that represent facets of family functioning that are essential to providing support and the structure the abuser needs to be able to engage in a lifestyle not dependent on alcohol or drug use. And, family recovery actions are actions that the families of substance abusers need to take to understand substance abuse and help the substance abuser achieve and maintain sobriety. The level of functioning within each domain is addressed so that the focus on the work with the family is to establish a strong link between family behavior and support actions and the substance-affected parent's functioning and recovery actions.



## **Conclusions**

The following conclusions can be made regarding validated programs targeting children with emotional and behavioral problems. Short-term therapeutic interventions produce time-limited benefits, at best, with at-risk groups whereas multi-year programs are more likely to foster enduring benefits. Treatment interventions are best directed at risk and protective factors rather than at categorical problem behaviors. With this perspective, it is both feasible and cost-effective to target multiple negative outcomes in the context of a coordinated set of programs. Interventions should be aimed at multiple domains, changing institutions and environments as well as individuals. Prevention programs that focus independently on the child are not as effective as those that simultaneously educate the child and instill positive changes across both the school and home environments. The success of such treatment is enhanced by focusing not only on the child's behavior, but also the teacher and family's behavior, the relationship between the home and school, and the needs of schools and neighborhoods to support healthy norms and competent behavior.

## **Chapter Four- Treatment & Outcome Measures**

The client's treatment was coordinated by a Treatment Team comprised of the primary therapist, Clinical Nurse Specialist, Child Psychiatrist, and mental health counselors. Throughout the treatment process, all the treatment team members observed the client. Problem behaviors were identified during the first two weeks of observation. A specific treatment plan was developed with focus on appropriate goals and objectives. Specific treatment goals were: decreasing oppositional behaviors, increasing direction following behaviors, learning ways to express feelings to peers and adults, taking responsibility for behavior, anger management skills, and developing strategies to ignore distractions and stay focused on tasks at hand.

The treatment program also used several assessment measures to obtain a baseline level of Jay's attention deficit hyperactivity disorder and depressive symptoms. Specifically, Jay was given the Connor's ADHD Scales and The Children's Depression Inventory, at intake. Jay was also given a Patient Satisfaction Survey at discharge.

There were fourteen individual and eight family sessions. He also received appropriate education and psychopharmacological interventions. These intervention components will be discussed in more detail below. Jay made progress while in treatment, developing many new coping skills.

Individual sessions focused on the development of positive social skills related to anger, insight development, and abandonment issues by both biological parents. A behavior modification approach was used to address appropriate classroom behaviors. The behavior modification protocol was developed in the individual session, but implemented in the classroom. Jay's behavior during the sessions varied. The client had

sessions marked by expression of emotions and identifying needs, while he also presented guarded at times. Jay would come into sessions sometimes focused and cooperative. At other times he would be withdrawn and non-compliant. During the individual sessions he was easy to build rapport with and related well to his Primary Therapist. Jay was successful at exploring abandonment issues and the impact of this experience on his behavior. He participated in feeling identification in addition to some artistic therapeutic interventions.

A number of issues regarding Jay's biological family were raised during these sessions. Specifically, the impact of his biological father's absence from Jay's life and past and current abandonment by his mother were discussed. None of these issues were resolved while he was in treatment but rather reinforced in a negative fashion due to his mother's re-abandonment and the child's unwillingness to explore his father's absence. The therapeutic goals of the individual sessions included developing appropriate de-escalation strategies when frustrated, social skills that were age appropriate, and feeling identification. The specific techniques that were utilized included feeling identification and processing thoughts through artistic creations, processing feelings and thoughts through one-to-one verbal interaction, developing a checklist of daily responsibilities including hygiene maintenance and daily household chores, and silence. The client was successful in achieving his treatment plan through practice and therapeutic support. The most effective technique utilized was silence, which caused some anxiety in the client. This anxiety was therapeutic, however, in that it motivated the client to continue the interaction.

During treatment, the family sessions focused on relationship issues between Jay's mother and the child and how her history of abandonment affects their present relationship. Jay at times was able to express appropriate concerns and feelings, but Ms. Clone was unable to accept responsibility. Interactions with Jay's mother included one-to-one support during the beginning of each family session, during which time she explored her own history of sexual and physical abuse and how this impacted her relationship with her child. An attempt was made at the onset of treatment to refer her for outpatient drug and alcohol counseling. This suggestion to attend a drug treatment program may have precipitated her abandonment of the family. She left the day of her outpatient intake appointment. She did not return to the home nor contact the family for the remainder of treatment. At this point, Jay's grandmother, Ms. Maria Santiago, took responsibility to attend the sessions. The focus of the sessions shifted to Ms. Clone's absence and in developing strategies to enhance the relationship between Jay and his grandmother. Techniques used to enhance the relationship were feeling identification, empathy, and communication. Jay and his grandmother also were engaged in an interactional game during one session to further enhance their communication skills. She was cooperative and compliant to treatment recommendations and attended sessions regularly and promptly. She was also cooperative with follow-up in implementing a behavior plan at home. The plan included appropriate rewards and consequences for behavior. The family created a behavior plan with the support of the primary therapist. A happy face symbolized the successful achievement of his goals, which included completing his daily chores, listening to his guardians, and not talking back. A sad face symbolized the unsuccessful attempt for that day. Jay was provided with rewards such as

thirty minutes extra before bedtime, thirty minutes of television privileges of his own choice, and a choice of a family game to play. Consequences included early bedtime and loss of personal privileges such as video games. For more severe infractions the consequences included the lack of outside privileges. Jay was also motivated by working towards a weekly reward with successful achievement of his goals each week, which was an agreement made by the family and him. The family reported positive feedback regarding this program.

In group therapy, Jay was successful at accomplishing goals and was a role model at some points. He was competent at ignoring negative behavior, providing positive support and feedback to peers, and following directions. He was guarded and withdrawn at times, but responded well to staff intervention. The interventions utilized included one-to-one staff support, time away from peers, verbal re-direction, and behavior modification. He did not require therapeutic holds, which is considered a passive restraint intervention, during treatment and was successful at de-escalating peers as well. The staff would engage the client by re-directing him to his daily goals and points for the day. Jay was reminded about his accomplished achievements with such goals as expressing feelings, controlling his frustration, and being a positive role model and how to incorporate these successes into the present moment. Jay responded well to the behavior modification system utilized at the program and advanced up the level system quickly. He received rewards for positive behavior and very rarely required consequences for negative behavior.

## **Intake Assessment Measures Results**

Upon intake, Jay was evaluated with The Connor's ADHD Scale. His mother, teacher, and the program intake coordinator completed the scales. Higher scores indicate more severe symptoms and behavior. Eighteen behaviors were evaluated with a choice of one through three representing the level of severity. Initial scores were as follows: Mother- 35, Teacher- 54 and intake coordinator- 32. These scores fall into the High Range regarding behaviors disruptive to the client's daily functioning. According to Barkley (1999), the norms for this scale demonstrate that a score above ten is significant and may require therapeutic intervention. Jay was assessed tri-weekly over an eight week period of attending treatment. His scores remained consistently high. Jay scored high in such areas as having difficulty remaining seated, is easily distracted, often interrupts or intrudes on others, mood changes quickly and drastically, often blurts out answers to questions, among others.

Additionally, Jay completed The Children's Depression Inventory (CDI) three times throughout his treatment at the program. Higher scores demonstrate more severe depressive symptoms. Twenty-seven sets of feelings and ideas are chosen by the child, which represents how the child has been feeling in the past two weeks. Initially, the child scored an 18 with follow-up two weeks later that resulted in a score of 13. These scores indicate that the client was presenting with depressive symptoms over the past two weeks. The initial score of eighteen is considered to be in the high range and second interpretation considered in the moderate range. Jay completed the CDI discharge as

well, which will be discussed shortly. He had high scores in negative mood, anhedonia, and ineffectiveness.

### **Medications**

Jay also received some psychotropic medications during his treatment. Jay 's medications consisted of Adderall 5 mg in the morning, with subsequent addition of Zoloft 12.5 mg in the morning. Adderall is a central nervous system stimulant that has been shown to be useful in helping children improve behaviors commonly associated with ADHD. It has such effects as improved motor activity, decreased disruptiveness, decreased distractibility, and more goal-directed behavior. Additionally, Zoloft is an anti-depressant used in the treatment of depression. Zoloft has the effect of elevating mood, improving concentration and psychomotor functioning. It inhibits the reuptake of serotonin, a central nervous system neurotransmitter. Subsequently, Adderall was increased to 10 mg in the morning and 5 mg at noontime and Zoloft to 25 mg in the morning, which he was able to tolerate well. He required an increase in medication due to de-stabilization and continued high ADHD scales. Additionally, his depressive symptoms remained present with no change, which lead to the increase in the anti-depressant regimen. As mentioned before, initially Jay's ADHD scales were high, as well as his CDI.

### **Outcomes**

As treatment progressed, Jay's ADHD scores decreased, but his CDI score remained the same. His ADHD scales decreased to the single digits (6, 8, 4) with improvements in such areas as remaining seated, ignoring distractions, and not blurting out answers to questions. However, his CDI remained consistent with no significant

improvements and a score of 16 upon discharge. His mother's current inability to participate in treatment and her re-abandonment of the family may have influenced these results, which demonstrates how important the family system approach is in addressing the client's needs. According to Corey, "The one central principle agreed upon by family therapy practitioners is that the client is connected to living systems and that change in one part of the unit reverberates throughout other parts. Therefore, a treatment approach that comprehensively addresses the other family members and the larger context as well as an 'identified' client is required (p. 367)." While Jay's mother was involved in the treatment program Jay's depressive symptoms were decreasing. However, his depressive symptoms re-appeared when his mother abandoned the home. He became withdrawn and his mood changed drastically and quickly over the next two weeks. For example, Jay was increasingly irritable and unable to accept feedback or support from the staff. While Jay's grandmother replaced his mother by attending the family sessions, this was not sufficient to improve his depressive symptomatology given his extensive history of abandonment and his renewed fears on this issue. Jay's depressive symptoms showed some moderate improvements with the anti-depressant regimen and continued multi-modal therapy. His response to the medication was to continue to be monitored in aftercare.

### **Client Satisfaction Scale**

This survey utilized a Likert-type scale with numbers one through five representing one, "very much satisfied" to five, "very much dissatisfied." It was completed by Jay's grandmother at the end of treatment. She rated all items with 1's "very much satisfied" along with positive comments. She recorded satisfaction in such



areas as the family's beliefs and customs were respected, "my child is improved as a result of the services we received", "there was good communication between the program staff and my family", "staff were courteous and helpful", and overall "I was satisfied with the services."

Jay's prognosis was fair due to abandonment issues, drug and alcohol issues in the family, and concerns about future compliance. He was referred to an evening partial program for aftercare to follow-up and reinforce the tools learned while providing support to the child and family. He will also receive continued psychopharmacological treatment focusing on medication management. Jay was sent back to his school with a behavior plan given to his teacher aimed at identifying successes with implementation of rewards and consequences. Hopefully, his teacher will be effective in the implementation of this successful strategy. The family was to continue with the behavior plan at home as well. The discharge plan created by both the family and Primary Therapist should meet the client's needs while reinforcing continued success. It was also recommended that the follow-up therapeutic aftercare supported by Jay's grandmother, Ms. Santiago and the preparation of Jay's mom returning to the home be addressed while in treatment including individual, family and group therapy.

## **Chapter Five- Best Practice**

A review of the literature indicated there are a variety of strategies and modalities suggested to be effective practice. These strategies and modalities are targeted to improve the associated symptoms and behaviors of the designated diagnoses. As we look at the available treatment options suggested it is important we keep in mind that there may be other treatment approaches that have not been empirically assessed.

The research shows that effective treatment for children with attention-deficit hyperactivity disorder should include a school-based program incorporating a team approach. The approach should include parents, teachers, Child Study Team members, principal if available, and other mental health professionals involved in the treatment plan. The implementation of all these factors will allow for the creation of a detailed and descriptive treatment plan.. Behavioral interventions outlined on the treatment plan should include social skills training aimed at problem-solving, controlling impulsive behavior, peer relationship enhancement, and psychopharmacology if appropriate. According to Wells (2000), behavior therapy along with psychopharmacology seems to show the best results. Behavior therapy requires a descriptive modification plan outlined by rewards and consequences applied to associated behaviors presented by the client. If the child reaches a goal, he/she earns a reward; in contrast, if he/she presents an undesirable behavior, the child earns a negative consequence.

The MTA Study (Wells, 2000) and the Second Step Program (Grossman et al, 1997) are two examples of studies demonstrating these effective treatment options. The MTA Study showed psychopharmacology and behavior therapy combined, resulted in

improved scores on academic measures of conduct, and some specific ADHD symptoms. Furthermore, parents and teachers were more satisfied with the outcomes to the treatment plan (Wells, 2000). These results were in comparison to children whose treatment included psychopharmacology only. Another example is the Second Step Program, which teaches skills to control frustration and anger behaviors, which often are associated with ADHD children. The skills targeted are anger management, empathy, and impulse control. Grossman et. al. (1997) conducted a study, which showed a significant reduction in aggression and an increase in appropriate classroom and peer interactions.

Effective treatment for children with depression should include social support, problem-solving focused coping strategies, cognitive-behavioral therapy, social skills training, relaxation strategies, and psychopharmacology if appropriate. Research demonstrates that positive coping skills lead to lower levels of depression. An example is the Penn Protection Program (Gillham, Rieivich, Jaycox, & Seligman, 1995; Jaycox, Reivich, Gillham, & Seligman, 1994) which focused on the implementation of cognitive-behavioral therapy and the induction of coping skills. Results proved to be positive especially for severely depressed children whom were at risk of suicide. Another example of teaching social skills was the Primary Mental Health Project (Cowen et. Al., 1996) which was mostly aimed at developing a socially supportive relationship with a therapist. The relationship was detailed by the ability to explore multiple facets of the child's life and maintain a supportive one-to-one relationship. Results indicated less moody, withdrawn behavior in addition to reduced depressive symptoms.

Other proven effective treatment includes psychopharmacology and cognitive-behavioral therapy. The two approaches combined seem to show the best results.

According to Butler, Mietzitis, Friedman, and Cold (1997), “the outcomes to combined treatment shows lowered scores on the Children’s Depression Inventory, demonstrating less depressive symptomatology. Also, the outcomes to such treatment seem to have long lasting effects (p.756).” However, it is necessary to be cautious about the duration of treatment and cognitive levels.

The most vital component of treatment seems to be the inclusion of family therapy. Family systems focuses primarily on current relationships and how to enhance the already existing network no matter how loosely it is combined. It is important to include as many members of a specific network and evaluate each connecting piece and how it relates to the client’s current functioning. Further, family systems aims to reduce troublesome triangulation and enhance dyadic relationships. The client’s treatment is strongly influenced by the successful implementation of this result.

An example would be Tremblay and his colleagues (McCord, Trembley, Vitaro, & Desmarais-Gervais, 1994; Tremblay, Vitaro, et al, 1992; Tremblay et al, 1996; Tremblay & Vitaro, 1994) study involved parent raining and social skills training for children in the Montreal Prevention Experiment. Children who participated in this study were significantly more likely to be on grade level and reduce the amount of conduct behaviors. Positive outcomes and long-lasting effects are seen due to the additional involvement of family members learning appropriate self-motivating rewards and consequences. Another example is the Earls court Social Skills Group Program (Pepler, King, & Byriad, 1991; Pepler, King, Craig, Byrd, & Bream, 1995) which targeted children, parents, and the classroom. Results showed the children to be exhibiting significantly less externalizing behaviors based on teacher report.

The literature also shows that attachment between a parent and a child is a key component to that child's other relationships. If a child is unable to secure a reasonable attachment to his/her parent, other secondary relationships will suffer as a result. Effective treatment warrants that a therapist observe a parent/child interaction, paying close attention to affection and comfortability between the two (Boris et. al., 1997). Educational groups describing strategies to improve already underdeveloped attachment patterns are available for parents whom are interested. A therapist needs to attempt to implement a variety of techniques to connect to the child. These efforts should permit the child to feel comfortable to explore their emotional and cognitive deficits within a relationship based on trust.

Parents who are addicted to substances are one of the most damaging influences on children and their present relationship patterns. Children often feel abandoned and are targets for different types of abuse due to their parent's addiction. Research indicates that the most powerful influence on the parent's recovery is the support of the family. According to Gruber (2001), this point underscores the importance of family therapy. He stated, "Support services should be based on continuing care substance abuse recovery services focusing on the development of skills through education (Gruber, 2001, p. 756)." An example is the Project Connect (Olsen, 1995), which provided the above-mentioned focus of treatment and results in success when parents and families remain in treatment throughout as a system. An additional component should be supporting children to develop coping skills and understand the effects of substance abuse and addiction.

## **Chapter Six- Summary and Conclusions**

The effectiveness of this designated treatment program was progressive in some areas and unsuccessful in others. There are a variety of explanations for these results. According to the assessment tools utilized, the clients' attention symptoms improved; however, depressive symptoms did not. The client initially presented with significantly high Connor's ADHD Scales (30's) which through the course of treatment were decreased to the single digits (6, 8, 4). The behavior plan created was helpful in the child's ability to become responsible for his behavior both at the program and at home. The child showed improvements in goals such as staying focused, controlling his impulses, following directions, completing expected daily chores at home, and utilizing supports from adults as needed. However, the child's depressive symptoms did not show equivalent results. The client initially scored significantly high for his age cohort (18) on the Children's Depression Inventory. Through the course of treatment his symptoms did not improve as demonstrated by a score of (13) three weeks later into treatment and (16) upon discharge.

The explanations for his lack of improvement may have to do with the holistic approach. The highlighted areas that may have effected these setbacks are the duration of treatment, inability to access the individual components of his treatment, and re-occurrence of attachment problems. The duration of treatment was approximately six weeks and may not have permitted enough time to explore the roots of his depression. As treatment progressed, client's mother re-abandoned the child and confirmed the child's initial anxiety about re-separation. The medication regimen did not seem to be helpful in targeting the client's biological needs. Additionally, the inability to include the

Child Study Team and individual's teacher into the treatment process may lead to a lack of continued classroom success as he demonstrated here at the program.

In reviewing the literature, the family therapy component appeared to be vital. The studies provided showed that the consistent and supportive stance of a family systems approach leads to success in improving children's lives. Unfortunately, this child's mother was dealing with her own set of conditions which she was unwilling to accept help for. The client's mother continued to experience her own emotional setbacks from childhood and ongoing addiction. As a result, the client's mother disappeared from the home and refrained from attending the treatment sessions, which led to grandmother's involvement in the program. These factors reinforced the child's ongoing attachment problems and symptoms remained.

It is possible that, with the extensive discharge plan implemented by his grandmother, the child will have continued supportive services to address his ongoing needs and symptoms. The case study provided a variety of useful interventions in creating and applying successful treatment approaches to assist latency-aged children that have been diagnosed with behavioral and emotional disorders. This case study points to the need for continued research to demonstrate effective, supportive strategies in providing the best treatment possible.

## Bibliography

- Achenbach, T.M. (1993). *Manual for the Child Behavior Checklist*. Burlington, VT: Author.
- Ainsworth, M.D., Blehar, M.C., Waters, E., Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum
- Aktan, G.B., Kumpfer, K.L., & Turner, C.W. (1996). *Effectiveness of family skills Training program for substance use prevention with inner city African-American Families*. *Substance Use & Misuse*, 31, 157-175.
- Allen, D. (1988) *Unifying Individual and Family Therapies* (San Francisco, CA, Jossey-Bass).
- American Academy of Pediatrics, Committee on Quality Improvement and Subcommittee on Attention-Deficit/ Hyperactivity Disorder. *Diagnosis and evaluation of the child with attention-deficit/ hyperactivity disorder*. *Pediatrics*. 2000; 105:1158-1170
- American Psychiatric Association. *Diagnostic and Statistic Manual of Mental Disorders*. 4<sup>th</sup> Ed. Washington, DC: American Psychiatric Association; 1994
- American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3<sup>rd</sup> ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3<sup>rd</sup> ed., rev.). Washington, DC: Author
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed.). Washington, DC: Author



- Attachment Center. (1997). *Attachment Disorder: A portrait*. [Brochure]. Evergreen, CO: Author.
- Barkley RA, Fischer M, Edelbrock CS, Smallish L. *The adolescent outcome of hyperactive children by research criteria: I: an 8-year prospective follow-up study*. *Journal of Child Adolescent Psychiatry*. 1990; 29:546-557
- Bateson, G. (1971) *A systems approach*, *International Journal of Psychiatry*, 9, pp. 242-244.
- Boddington, D. (1993) *Limitations of personal counseling: the case for couple therapy*, *Journal of the British Association for Counseling*, 4, pp. 33-35.
- Bott, D. (1988b). *The relevance of systemic thinking to students counseling*, *Counseling Psychology Quarterly*, 1, pp. 367-375.
- Bott, D & Hodes, M. (1989) *Structural therapy with a West African family*, *Journal of Family Therapy*, 11, pp. 169-179.
- Bott, D. (1992) *'Can I help you help me change?' Systemic intervention in an integrated model of counseling*, *Journal of the British Association for Counseling*, 3, pp. 31-33.
- Bowen, M. (1978) *Family Therapy in Clinical Practice* (New York, Jason Aronson).
- Bowlby, J. (1969). *Attachment and loss* (Vol. 1). New York: Basic Books.
- Carmen, R., & Huffman, L. (1996). *Epilogue: Bridging the gap between research on attachment and psychopathology*. *Journal of Consulting and Clinical Psychology*, 64(2), 291-294.
- Carten, A. J. (1996). *Mothers in recovery: Rebuilding families in the aftermath of addiction*. *Social Work*, 41, 214-223.

- Child Welfare of America. (1990). *Crack and other addictions: Old realities and new challenges*. Washington, DC: Author.
- Child Welfare of America. (1992). *Children at the front: A different view of the war on alcohol and drugs*. Washington, DC: Author.
- Children's Defense Fund. (1992). *The state of America's children 1992*. Washington, DC: Author.
- Conners CK, Epstein JN, Hinshaw SP, et al. *Multimodal treatment of ADHD (MTA): an alternative outcome analysis*. *Journal of Child Adolescent Psychiatry*. 2000; 40: pp. 159-167.
- Culbertson, J. L., & Willis, D.J. (Eds.) (1993). *Testing young children: A reference guide for developmental, psychoeducational, and psychosocial assessments*. Austin, TX: Pro-Ed.
- Curtis, P.A., & McCullough, C. (1993). *The impact of alcohol and other drugs on the child welfare system*. *Child Welfare*, 72, 533-542.
- Daley, D.C., & Marlatt, A.G. (1992). *Relapse prevention: Cognitive and behavioral interventions*. In J.H. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (pp. 533-542). Baltimore: Williams & Wilkins.
- Daley, D.C., & Raskin, M.S. (1991). *Relapse prevention and treatment effectiveness studies*. In D. C. Daley & M.S. Raskin (Eds.), *Treating the chemically dependent and their families* (pp. 183-196). Newbury Park, CA: Sage Publications.

- DeAngelis, T. (1997). Psychologists are providing a controversial treatment for reactive attachment disorder. APA Monitor [On-Line]. Available: [www.apa.org/monitor/jun97/disorder.html](http://www.apa.org/monitor/jun97/disorder.html)
- Dore, M.M., Doris, J.M., & Wright, P. (1995). *Identifying substance abuse in maltreating families: A child welfare challenge*. Child Abuse & Neglect, 19, pp. 531-543.
- Fahlberg, V. (1990). *Residential treatment: A tapestry of many therapies*. Indianapolis, IN: Perspectives Press.
- Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Matton, G., Target, M., & Gerber, A. (1996). *The relation of attachment status, psychiatric classification, and response to psychotherapy*. Journal of Consulting and Clinical Psychology, 64, 22-31.
- George, C., Kaplan, N., & Main, M. (1985). *An adult attachment interview: Interview protocol*. Unpublished manuscript, Department of Psychology, University of California, Berkley.
- Goldberg, S., Muir, R., & Kerr J. (Eds.). (1995). *Attachment theory: Social, developmental, and clinical perspectives*. Hillsdale, NJ: Analytic Press.
- Gorski, T., & Miller, M. (1988). *Staying sober workbook*. Independence, MO: Independence Press.
- Grob, M.C., Klein, A. A., & Eisen, S. V. (1983). *The role of the high school professional in identifying and managing adolescent suicidal behavior*. Journal of Youth and Adolescence, 12, pp. 163-173.

- Haley, J. (1984). *Ordeal therapy*. San Francisco, CA: Jossey-Bass.
- Hawkins, J.D., & Catalano, R.F., Jr. (1985). *Continuing care in drug abuse treatment*.  
International Journal of Addictions, 20, 917-945.
- Heinl, P. (1985). *The image and visual analysis of the genogram*, Journal of Family  
Therapy, 7, pp. 213-229.
- Hinshaw, S.P., March, J.S., Abikoff, H., et al. *Comprehensive assessment of childhood,  
attention-deficit/ hyperactivity disorder in the context of a multisite, multi-modal  
clinical trial*. Attention Disorders. 1997; pp. 217-234.
- Hinshaw, S.P., Owens, E.B., Wells, K.C., et al. *Family processes and treatment  
outcomes in the MTA: negative/ ineffective parenting practices in relation to  
multi-modal treatment*. Abnormal Child Psychiatry. 2000; 28: pp. 555-568.
- James, B. (1994). *Handbook for treatment of attachment trauma problems in children*  
New York: Lexington Books.
- Jenkins, H. (1989). *Family therapy with one person: a systemic framework for treating  
individuals*. Psychotherapy, 19, pp. 61-73.
- Juliann, P., & Goodman, C. (1992). *Children of substance abusing parents*. In J.H.  
Lowinson, P.Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A  
comprehensive textbook* (pp. 808-815). Baltimore: Williams & Wilkins.
- Keeney, B. (1979). *Ecosystemic epistemology: an alternative paradigm for diagnosis*,  
Family Process, 18, pp. 117-127.
- Kottman, T., & Ashby, J. (2000). *Perfectionistic children and adolescents: Implications  
for school counselors*. Professional School Counseling, 3, pp. 182-188.
- Lieberman, A.F., & Zeanah, C.H. (1995). *Disorders of attachment in infancy*. Child and  
Adolescent Psychiatric Clinics of North America, 4(3), pp. 571-587.

- Lieberman, S. (1979). *Transgenerational Family Therapy* (London, Croom-Helm).
- Maag, J.W. (1989). *Use of cognitive mediation strategies for social skills training. Theoretical and conceptual issues*. Monograph in Behavioral Disorders, 12, pp.87-100.
- Maag, J.W. (1999). *Why they say no: Foundational precises and techniques for managing resistance*. Focus on Exceptional Children, 32(1), pp. 1-16.
- Maag, J.W., & Forness, S.R. (1991). *Depression in children and adolescents: Identification, assessment, and treatment*. Focus on exceptional children, 24(1), pp. 1-19.
- Maag, J.W., & Reid, R. (1994). *The phenomenology of depression among students with and without learning disabilities: More similar than different*. Learning Disabilities Research and Practice, 9, pp. 91-103.
- Maag, J.W., Rutherford, R.B., Jr., & Parks, B.T. (1988). *Secondary school professionals ability to identify depression in adolescents*. Adolescence, 23, pp.73-82.
- Magid, K., & McKelvey, C.A. (1987). *High risk: Children without a conscience*. New York: Bantam Books.
- Main, M., & Solomon, J. (1986). *Discovery of an insecure-disorganized/ disoriented attachment pattern*. In T.B. Brazelton & M. Yogman (Eds.). (1997). *Handbook of child and adolescent psychiatry* (Vol. 3). New York: Wiley.
- Minuchin, S. (1974). *Families and Family Therapy* (London, Harvard University Press).
- MTA Cooperative Group. *Moderators and mediators of treatment response for children with attention-deficit/ hyperactivity disorder: the multimodal treatment study of children with ADHD*. Arch Gen Psychiatry. 1999; 56: pp. 1088-1096.

- Murphy, J.M., Jellineck, M., Quinn, D., Smith, G., Poitras, F.G., & Goshko, M. (1991). *Substance abuse and serious child maltreatment: Prevalence, risk and outcome in a court sample*. *Child Abuse & Neglect*, *15*, pp. 197-211.
- Nichols, M. (1984). *Family Therapy Concepts and Methods* (Gardner Press).
- Noshpitz, J.D., Flaherty, L.T., & Sarles, R.M. (Eds.). (1997). *Handbook of child and adolescent psychiatry* (Vol. 3). New York: Wiley.
- Olsen, L. (1995). *Services for substance abuse-affected families: The Project Connect experience*. *Child and Adolescent Social Work Journal*, *12*, pp. 183-196.
- Randolph, L. (1998). *Randolph Attachment Disorders Questionnaire*. Evergreen, CO: Attachment Center at Evergreen, Inc.
- Reynolds, W.M., & Stark, K.D. (1987). *School-based intervention strategies for the treatment of depression in children and adolescents*. In S.G. Forman (Ed.), *School-based affective and social interventions* (pp. 69-88). New York: Haworth.
- Rohrbaugh, M., Tennen, H., Press, S., & White, L. (1981). *Compliance, defiance and therapeutic paradox: Guidelines for strategic use of paradoxical interventions*. *American Journal of Orthopsychiatry*, *51*, pp. 454-467.
- Seligman, M.E.P., & Rosenhan, D.L. (1998). *Abnormality*. New York: Norton.
- Sheridan, M.J. (1995). *A proposed intergenerational, model of substance abuse, family functioning, and abuse/ neglect*. *Child Abuse & Neglect*, *19*, pp. 519-530.
- Simon, D.J., & Vetter-Zemitzsch, A. (1985). *Paradoxical interventions: Strategies for the resistant adolescent*. In M.K. Zabel (Ed.). *Teaching: Behaviorally disordered youth* (Vol. 1, pp. 17-22). Reston: VA: Council for Children with Behavioral Disorders.
- Watzlawick, P. (1978). *The language of change*. New York: Basic Books.

- Wells, K.C., Epstein, J.N., Hinshaw, S.P., et al. *Parenting and family stress treatment outcomes in attention-deficit/hyperactivity disorder (ADHD): an empirical analysis in the MTA study*. *Journal of Abnormal Child Psychiatry* 2000; 28: pp. 548-553.
- Wells, K.C., Peham, W.E.Jr., Kotkin, R.A., et al. *Psychosocial treatment strategies in the MTA Study. Rationale, methods, and critical issues in design and implementation*. *Journal of Abnormal Child Psychiatry* 2000; 28: pp. 483-505.
- Wicks-Nelson, R., & Israel, A.C. (2000). *Behavior disorders of childhood* (4<sup>th</sup> ed.). Upper Saddle River, NJ: Prentice Hall.
- Yapko, M.D. (1994). *When living hurts: Directives for treating depression*. New York: Brunner/Mazel.