CHILD AND ADOLESCENT DISRUPTIVE BEHAVIOR DISORDERS

• Bio/Psycho/Social Pathways to Problem Behaviors

• Attention-Deficit Hyperactivity Disorder
  • Symptoms
  • Family/Social Support
  • Biological and Psychological Treatments

• Oppositional Defiant Disorder

• Conduct Disorder

• Elements of Effective Treatment
Are Parents Aware of Their Children’s Stress?

![Bar Chart]

Percentage of Respondents Who Say Child Experiences Stress

- General worries: 20% (3% parents, 3% child)
- School performance: 44% (34% parents, 30% child)
- Family finances: 30% (18% parents, 17% child)
- Getting into a good college: 17% (3% parents, 3% child)
- Physical appearance: 22% (17% parents, 17% child)

Areas of Childhood Stress
THEORETICAL FRAMEWORK FOR UNDERSTANDING DISRUPTIVE BEHAVIOUR DISORDERS

• Social Learning Theory – SLT
• Problem Behavior Theory – PBT
• Theory of Planned Behavior – TPB
• Social Norms Theory – SNT
• Theory of Transitional Teens - TTT
• Cognitive-Behavioral Theory - CBT
• Acquired Preparedness Model – APM
• Social-Community Responsibility Theory - SCRT
SOCIAL LEARNING THEORY

Adolescents adopt behaviors, cognitions (e.g., beliefs) and emotions - modeled by peers and adults related to substance use and criminal conduct.

CITY OF GOD TRAILER

https://www.youtube.com/watch?v=KrC73Kyft9A
PROBLEM BEHAVIOR THEORY

**Personality features** of poor self-control, impulsivity, risk taking, rebellion results in such **problem behaviors** as substance abuse and criminal conduct; risk increases with **exposure to environments** where these behaviors are role-modeled/normalized.
THEORY OF PLANNED BEHAVIOR (TPB)

Intention to use drugs and commit crimes combined with the expectation that others expect this are reinforced by the perception that one can successfully engage in the behavior.
SOCIAL NORMS THEORY (SNT)

Adolescent perceives, e.g. “everyone uses drugs” or “everyone in their neighborhood belongs to a sells drugs, commits crimes” – it’s the norm.
TRANSITIONAL TEEN THEORY (TTT)

Decrease in parental supervision and increase risk of involvement in drinking, risk taking behavior (e.g., sexual, criminal conduct); risk increases when affinity group has deviant norms.
COGNITIVE-BEHAVIORAL THEORY (CBT)

Lack of **cognitive skills** to manage and control thoughts and beliefs that lead to delinquency; deficits in **social skills; and community responsibility skills** to manage relationships that put the person at risk for substance abuse and crime.
When constitutional (genetic factors associated with behavioral under control) are combined with the expectation of positive outcomes of substance abuse and criminal conduct, delinquent / criminal acts are more likely to occur.
SOCIAL AND COMMUNITY RESPONSIBILITY THEORY (SRT)

Egocentric thinking and empathy deficits causing difficulty seeing how AOD abuse or property crime can cause harm to others and the community; deficits in moral reasoning and values that prevent engaging in responsible behavior in the community.
FROM THEORY TO PRACTICE

- **SLT:** Adolescents adopt behaviors, cognitions (e.g., beliefs) and emotions *modeled by* peers and adults related to substance use and criminal conduct.

- **PBT:** When *personality features* of poor self-control, impulsivity, risk taking, rebellion results in such *problem behaviors* as substance abuse and criminal conduct; risk increases with exposure to *environments* where these behaviors are role-modeled/normalized.

- **TPB:** *Intention* to use drugs and commit crimes combined with the expectation that others expect this are reinforced by the perception that one can successfully engage in the behavior.

- **SNT:** Adolescent *perceives*, e.g. “everyone uses drugs” or “everyone in their hood belongs to a gang, sells drugs, commits crimes” – it’s the norm.

- **TTT:** Decrease in *parental supervision* and increase risk of involvement in drinking, risk taking behavior (e.g., sexual, criminal conduct); risk increases when affinity group has deviant norms.

- **CB:** Lack of *cognitive skills* to manage and control thoughts and beliefs that lead to delinquency; and deficits in social skills to manage relationships that put the person at risk for substance abuse and crime.

- **APM:** When *constitutional* (genetic factors associated with behavioral under control) are combined with the *expectation of positive outcomes* of substance abuse and criminal conduct, delinquent acts are more likely to occur.

- **SCRT:** Egocentric thinking and *empathy deficits* causing difficulty seeing how AOD abuse or property crime can cause harm to others and the community; deficits in moral reasoning and values that prevent engaging in responsible behavior in the community.
https://www.youtube.com/watch?v=hHHdovKHDNU

BANDURA – BOBO DOLL EXPERIMENT
GRAND THEFT AUTO; MORTAL COMBAT

https://www.youtube.com/watch?v=Z1rTOO1W2t0

COUNTERSTRIKE IN ICELAND
QUESTION 1:

Given what we know about modeling, observational learning, and desensitization, how should parents, psychologists, and health specialists design methods to control the harmful effects of violent media productions?
CHILD AND ADOLESCENT DISRUPTIVE BEHAVIOR DISORDERS

- Bio/Psycho/Social Pathways to Problem Behaviors
- Attention-Deficit Hyperactivity Disorder
  - Symptoms
  - Family/Social Support
  - Biological and Psychological Treatments
- Oppositional Defiant Disorder
- Conduct Disorder
- Elements of Effective Treatment
Attention-Deficit/Hyperactivity Disorder

• ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) -- Characterized by great difficulty attending to tasks, behave overactively and impulsively, or both
DSM-5 Checklist

Attention-Deficit/Hyperactivity Disorder

1. Either of the following groups of symptoms:

   A. At least six of the following symptoms of inattention, persisting for at least six months, to a degree that is maladaptive and inconsistent with development level: ● Frequent failure to give close attention to details, or making careless mistakes ● Frequent difficulty in sustaining attention ● Frequent failure to listen when spoken to directly ● Frequent failure to follow through on instructions and failure to finish work ● Difficulty organizing tasks and activities ● Avoidance of, dislike of, and reluctance to engage in tasks that require sustained mental effort ● Frequent loss of items necessary for tasks or activities ● Easy distraction by irrelevant stimuli ● Forgetfulness in daily activities.

   B. At least six of the following symptoms of hyperactivity and impulsivity, persisting for at least six months, to a degree that is maladaptive and inconsistent with developmental level: ● Fidgeting with or tapping of hands or feet or squirming in seat ● Frequent wandering from seat in classroom or similar situation ● Frequent running about or climbing excessively in situations in which it is inappropriate ● Frequent difficulty playing or engaging in leisure activities quietly ● Frequent “on the go” activity or acting as if “driven by a motor.” ● Frequent excessive talking ● Frequent blurtin out of answers before questions have been completed ● Frequent difficulty awaiting turn ● Frequent interrupting of or intruding on others.

2. Presence of some of the symptoms before the age of 12.

3. The symptoms occur in at least two settings.

4. Significant impairment.

Attention-Deficit/Hyperactivity Disorder

- About half the children with ADHD also have learning or communication problems
- Many more also have:
  - Poor school performance
  - Difficulty interacting with other children
  - Misbehavior, often serious
  - Mood or anxiety problems
Attention-Deficit/Hyperactivity Disorder

- **Onset and prevalence**
  - Disorder usually persists through childhood, but many children show a lessening of symptoms as they move into mid-adolescence
  - Around 4-9% of schoolchildren display ADHD, as many as 70% of them boys
  - Between 35% and 60% continue to have ADHD as adults
  - Race seems to come into play with regard to ADHD
What Are the Causes of ADHD?

• Several interacting causes
  • Abnormal dopamine activity
  • Abnormalities in frontal-striatal regions of the brain

• Sociocultural theorists
  • ADHD symptoms and a diagnosis of ADHD may themselves create interpersonal problems and produce additional symptoms in the child
How Is ADHD Treated?

- **Treatment**
  - About 80% of all children and adolescents with ADHD receive treatment
  - Heated disagreement about the most effective treatment for ADHD

- **Most commonly applied approaches**
  - Drug therapy (Ritalin, Adderall)
  - Behavioral therapy
  - Combination
  - Clinicians also commonly employ diagnostic interviews, rating scales, and psychological tests

https://www.youtube.com/watch?v=IgCL79Jv0lc
Oppositional Defiant Disorder and Conduct Disorder

- OPPOSITIONAL DEFIANT DISORDER -- Characterized by extreme hostility and defiance
- Those with oppositional defiant disorder are argumentative and defiant, angry and irritable, and, in some cases, vindictive
  - As many as 10% of children qualify for this diagnosis
  - The disorder is more common in boys than girls before puberty, but equal in both sexes after puberty
Oppositional Defiant Disorder and Conduct Disorder

• CONDUCT DISORDER – Characterized as a severe problem; children repeatedly violate the basic rights of others
  • Usually begins between 7 and 15 years of age
  • Involves as many as 10% of children, three-quarters of them boys
  • May be mild or severe
DSM-5 Checklist

Conduct Disorder

1. Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.

2. At least three of the following features are present in the past 12 months (and at least one in the past 6 months): • Frequent bullying or threatening of others • Frequent provoking of physical fights • Using dangerous weapons • Physical cruelty to people • Physical cruelty to animals • Stealing while confronting a victim • Forcing someone into sexual activity • Fire-setting • Deliberately destroying others’ property • Breaking into a house, building, or car • Frequent lying • Stealing items of nontrivial value without confronting a victim • Frequent staying out beyond curfews, beginning before the age of 13 • Running away from home overnight at least twice • Frequent truancy from school, beginning before the age of 13.


Oppositional Defiant Disorder and Conduct Disorder

- **RELATIONAL AGGRESSION** – Another pattern of aggression found in certain cases of conduct disorder in which individuals are socially isolated and primarily display social misdeeds
  - Relational aggression is more common among girls than boys
    https://www.youtube.com/watch?v=xqXCjANyYRE

- **JUVENILE DELINQUENCY** – Occurs when children between the ages of 8 and 18 break the law
  - Boys are much more involved in juvenile crime than are girls
    Bullying Experiment
    https://www.youtube.com/watch?v=EisZTB4ZQxY
QUESTION 2:

What kinds of prevention programs might be effective for bullying?
WHAT ARE THE CAUSES OF CONDUCT DISORDER?

• Causes
  • Linked to genetic and biological factors, drug abuse, poverty, traumatic events, and exposure to violent peers or community violence
  • Often tied to troubled parent-child relationships, inadequate parenting, family conflict, marital conflict, and family hostility
PSYCHOPATHIC CHILD

• https://www.youtube.com/watch?v=VDVaiwzU8yc
QUESTION 3:

How should children who inflict harm on others be treated?
Teenage Crime

- **Total population**: 14%
- **Perpetrators of violent crime**: 30%
- **Murderers**: 34%
- **Victims of violent crime**: 33%
How Do Clinicians Treat Conduct Disorder?

• CHILD-FOCUSED TREATMENTS focus primarily on the child with conduct disorder, particularly cognitive-behavioral interventions,
  – Problem-solving skills training
  – *Anger Coping and Coping Power Program (ABC)*
  – Drug therapy

• Prevention
  – Early prevention programs
How Do Clinicians Treat Conduct Disorder?

• Sociocultural treatments
  • Family interventions
    • Parent-child interaction therapy
    • Video modeling
    • Parent management training
  • Residential treatment in community and programs at school
    • Treatment foster care
  • Institutionalization
    • Juvenile training centers
GUIDELINES FOR ADOLESCENT TREATMENT

• Take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.

• Treatment for adolescents should identify delays in cognitive, and social-emotional development and their connections to academic performance, self-esteem, or social interactions.

• Make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment.

• Using adult programs for treating youth is ill-advised. It should be done only with great caution and with alertness to inherent complications that may threaten effective treatment for these young people.

• Because many adolescents are coerced into treatment, providers should be sensitive to motivational barriers to change at the outset of intervention. Several strategies can be used for engaging reluctant clients to consider behavioral change.
FAMILY THERAPIES
MULTISYSTEMIC THERAPY (MST)

- MST is an intensive community based (outpatient) treatment that targets juvenile offenders (ages 12 to 17) and their families.
- The “typical” MST youth is 14-16 years of age; has multiple arrests; lives in a single parent home; has major problems at school or does not attend; has deep involvement with delinquent peers; and abuses substances (marijuana, alcohol, cocaine).
- There is daily contact with family members and therapy sessions are usually conducted directly in their home.
- MST addresses the multiple factors associated with heightened antisocial behavior patterns. These include characteristics of the:
  - Adolescent
  - Family
  - Peers
  - School
  - Neighborhood

Nine principles form the core of MST.
ENVISIONING A JUVENILE JUSTICE SYSTEM THAT SUPPORTS POSITIVE YOUTH DEVELOPMENT

Overarching Goal:

To create a juvenile justice system that seeks to uphold and protect community safety but also offers youth an opportunity for change, restitution, and rehabilitation.

Notre Dame Journal of Law, Ethics & Public Policy [Vol.22], 2008 Frabutt, J., Diluca, K., Graves, K.
Exemplary Treatment Practices
SCRAM: GENERIC TREATMENT MODELS

• S tages of Change

• C ognitive-Behavioral Treatment

• R elapse Prevention

• A ssessment / Hypothesis Testing

• M otivational Enhancement
STAGES OF CHANGE

Entry

Permanent Exit

Pre-Contemplation

WHAT: CHALLENGE

Contemplation

NOW: OWNERSHIP

Maintenance

Relapse

Action

Determination

HOW: COMMITMENT

Prochaska & DiClemente “six stages of change”/Wanberg & Milkman “three stages of change.”
SCRAM: GENERIC TREATMENT MODELS

- Stages of Change
- Cognitive-Behavioral Treatment *(Client and Family)*
- Relapse Prevention
- Assessment / Hypothesis Testing
- Motivational Enhancement
The greatest discovery of my life is that a human being can alter his life by altering his attitude

- William James
Thinking makes it so. The greatest weapon against stress is our ability to choose one thought over another.

- William James
ESSENCE OF COGNITIVE -BEHAVIORAL TREATMENT

Your thoughts and attitudes and not external events create your moods.

Emotions are experienced as a result of the way in which events are interpreted or appraised. It is the meaning of the event that triggers emotions rather than the events themselves….

The role of the cognitive therapist is to help the individual see the alternative ways of thinking about and appraising a situation… and then help the individual identify any obstacles to thinking and acting in this new, more helpful way.
Beck identifies two primary levels of cognitive processing:

1. The highest level of functioning is **Consciousness** – CBT therapists encourage the development and application of rational thinking and problem solving.

2. The therapist helps patients recognize and change pathological thinking on two levels:

   • **Automatic Thoughts** – cognitions that stream rapidly through our minds when we are in the midst of situations (or recalling events). “This talk is boring; get me out; I can’t take it anymore.”

   • **Schemas** – core beliefs that give meaning to information from the environment. “Academics no nothing about the real world.”

There is an emphasis on techniques designed to help clients detect and modify their inner thoughts, especially those that are associated with emotional symptoms such as depression, anxiety or anger.

One of the most important clues that automatic thoughts might be occurring is the presence of strong emotions.
Model of cognitive structures and processes. Stress may activate dysfunctional core beliefs that energize automatic thoughts which are filtered through characteristic errors in logic.
INTERACTION OF DISTAL, INTERMEDIATE AND PROXIMAL STRUCTURES

PROXIMAL STRUCTURES – AUTOMATIC THOUGHTS
Decision – GET HIGH
Expectation – If I have a drink/drug, I’ll feel better; can’t cope
Appraisal – Breaking up is the worst thing that can happen
Attribution – It’s all my fault; It will affect everything that I do

INTERMEDIATE STRUCTURES
Rules – Do whatever you can to get over
Values – Peace of mind
Attitudes – Who cares anyway; life sucks

DISTAL STRUCTURES
CORE BELIEFS; SCHEMAS
I’m damaged; life isn’t fair; I fall apart under pressure

STRESS
Breakup with girlfriend
Automatic Thought Exercise

1. Draw three columns on a sheet of paper and label them:
   - **Event**
   - **Automatic Thoughts**
   - **Emotions**

2. Recall a recent situation or memory of an event that seemed to stir up emotions such as anxiety, anger, sadness, physical tension, or happiness.

3. Try to imagine being back in this situation, just as it happened.

4. What automatic thoughts were occurring in this situation? Write down the event, the automatic thoughts, and the emotions in each column of your record.

5. Try to identify the underlying beliefs that energize these thoughts.

6. What kind of errors in logic might you be using?

7. What alternative cognitive process can you use to alter your emotional states?
Pathways of Learning and Change
THE TREATMENT CURRICULUM

PATHWAYS TO SELF-DISCOVERY AND CHANGE: A GUIDE TO RESPONSIBLE LIVING
THE PARTICIPANT’S WORKBOOK
Mike's Story

I've thought about changing. I really have. I started drinking when I was young. I can't even remember when. I never really thought my drinking was a problem, or something that needed to be changed. But then one night, I was at a party with some friends. We had all ditched school to start drinking early, and by 9 o'clock we were all hammered.

I had never felt sicker than I had the next morning. As I was sitting in the bathroom, pulling my guts out, I started wondering what had happened. How I had gotten home, where the hell my car was and why my fist was all bruised and bloody.

I called the friend who I thought had gotten me home. I guess I had gotten a little too wild at the party, making a fool of myself, and as I was walking past the garage of the house, I guess I punched it. A cop had stopped us and I had a court date for MUI and public intoxication.

But I didn't think anything of it. So I kept drinking. And it kept happening. Almost every weekend was a blur or some non-existent action of my body.

My girlfriend broke up with me. She said she couldn't be with a guy who drank so much and made an ass out of himself and her. My friends avoided me.

I didn't want to drink anymore. My mom was actually kind of helpful. It was really cool to think that other people were willing to share and help me if I asked.

So I think I want to stop drinking. In fact, I know I want to stop drinking. Besides, pretty soon, they're going to put me on probation, then I'll have to take tests every couple of days. I don't get the warm and numb feelings anymore, and it's just not fun.
Ikera's Story

I want to stop using, really I do, but it's scary. When I'm high, though, I'm suddenly mellow. A month ago, I think I hit my bottom.

I hadn't had a fix for a day and was shaking bad. I must've looked totally schizo sitting on that corner with my sign and empty coffee can. I was starting to get desperate and ready to sell myself to anyone who would have me when this lady sat down and just started talking to me.

I followed her right to the teen rescue center, just across the street from my chosen corner. That same woman sat my angry butt in a chair and began talking to me about changing my life, about getting sober. Something was different this time. I think mostly, I was tired and ready to give up, but I haven't yet.

I know those things never should have happened to a little kid. I never solved any problems by using, but I sure did create some. I've done more damage to my life than anyone.

Sometimes the pain and the memories are just too much to bear and I think about using. But at the end of the day, I feel so proud that I didn't give in, and I dealt with all this shit without checking out.

I just started going to group counseling and have even tried some of those 12-step meetings. It just helps to talk to other people who understand what I am going through. They keep reminding me that sobriety is the key to really living. I don't think I was really doing that before. I was just surviving. I want more than that now.
STEP MODEL FOR “HOT” SITUATIONS

S
Situation Event

T
Thinking Change

E
Emotions Feelings

P
Positive Actions and Outcome
Pathways of Learning and Change
KARL WALENDA

https://www.youtube.com/watch?v=S90DnKM_j4Q
SCRAM: GENERIC TREATMENT MODELS

- Stages of Change
- Cognitive-Behavioral Treatment
- Relapse/Recidivism Prevention
- Assessment / Hypothesis Testing
- Motivational Enhancement
Relapse / Recidivism Prevention

The Relapse/Recidivism Model

High-Risk Situations & Thinking

Weak Coping Response

Strong Coping Response

Greater Self-Confidence & Control

Less Chances of Return to Drug Use or Criminal Acts

Relapse or Re-offend

Greater chances of return to AOD use or criminal acts

Rule violation effect & perceived benefits of AOD use & crime

See cause as "weakness" & conflict over who you are

Initial AOD use or criminal planning

Expect Positive results from AOD use and/or crime

Relapse/Recidivism thinking = less self-confidence

Adapted from Market and Denson, 2000.
SCRAM: GENERIC TREATMENT MODELS

- Stages of Change
- Cognitive-Behavioral Treatment
- Relapse Prevention
- Assessment / Hypothesis Testing
- Motivational Enhancement
COLLABORATIVE EMPIRICISM

“That the therapist engages the client in a highly collaborative process in which there is a shared responsibility for setting goals and agendas, giving and receiving feedback and putting CBT methods into action in everyday life.”

Wright et al., 2006
DIMENSIONS OF ASSESSMENT

• Motivation and readiness to change;

• AOD use and abuse;

• Criminal conduct patterns;

• Current life situation problems;

• Capacity to engage in a therapeutic alliance;

• Ability to access automatic thoughts and accompanying emotions.
CONVERGENT VALIDATION AND THE PROCESS MODEL OF ASSESSMENT

Vector representations of the client's "true" condition (A); the other-report (B); and self-report (C)

Estimating Drug Use Involvement Veridical "True" Condition

A

B self-report
C other-report
D other report
E self-report

B-C Angle is discrepancy between self-report and other-report and represents a measure of defensiveness - considered to be low discrepancy and thus low defensiveness

B+C Average represents the estimate of A or "true condition" and is a good estimate of the "true condition."

D-E Angle represents degree of defensiveness of client and represents measure of defensiveness - considered to be high discrepancy and thus high defensiveness

D-E Angle represents estimate of A and is not a good estimate of the "true condition."
ADOLESCENT SELF ASSESSMENT PROFILE II - (ASAP II)

Client Information/ASAP II Information

- Name: STEVE MCMASTER
- ASAP II ID: 000001
- Prior Alcohol/Drug: Inpatient TX 1 or 2
- Prior Alcohol/Drug Outpatient TX 1 or 2
- Prior Mental Health: Inpatient TX 1 or 2
- Prior Mental Health Outpatient TX 1 or 2

Drug Use History

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<th>Drug Category</th>
<th>Times Used Lifetime</th>
<th>Days Used in Last 90 Days</th>
<th>Drug Category</th>
<th>Times Used Lifetime</th>
<th>Days Used in Last 90 Days</th>
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<td>Alcohol Intoxication</td>
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<td>1 - 14</td>
<td>Inhalants</td>
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<td>6 - 14</td>
<td>Ketoxin</td>
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<td>2 - 3 days</td>
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<td>Tranquilizers/Sedatives</td>
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<td>Hallucinogens</td>
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<td>2 - 3 days</td>
<td>Cigarettes (Tobacco)</td>
<td>Do not use</td>
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ASAP Basic Profile

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Percentile:

- 10
- 20
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- 40
- 50
- 60
- 70
- 80
- 90
- 100
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</table>

**Critical Items**

**LIVING ARRANGEMENT AND FAMILY**

Current living at home. Both of my birth parents are living in my home. My birth or adopted mother is living in my home. My birth or adopted father is living in my home. My stepmother is living in my home. My stepfather is living in my home. Birth or adopted parents are (been) separated or divorced. Have a sibling living at home. Have never been placed out of the home. My birth mother may have an alcohol or other drug problem. My birth father may have an alcohol or other drug problem. My birth grandmother or grandfather may have an alcohol or other drug problem. I have an aunt or uncle that may have an alcohol or other drug problem. My mother has been in jail or prison. My father has been in jail or prison. My stepfather has been in jail or prison. I have a sibling that has been in jail or prison. I have an aunt or uncle that has been in jail or prison. I plan to continue living at (or return to) home. My childhood was very happy. Have lost three or more close family members through death.

**PSYCHOLOGICAL CONCERNS**

Reports having been physically abused. Have had personal and emotional problems all the time.

**SCHOOL ADJUSTMENT**

Have been suspended from school one to five times. Have been expelled from school from three to four times.

**DEVIANCY AND CRIMINAL BEHAVIOR**

Hit or threatened to hit a school teacher, parent, or another adult three to five times. Have broken into someone’s home or building more than five times. Have stolen a motor vehicle three to five times. Have carried a concealed weapon other than a small pocket knife more than five times. Have been involved in gangs or part in gang activities three to five times. More than five times, have hurt another person on purpose so they had to see a doctor or go to a hospital. Have sold drugs or have been involved in selling drugs or dealing drugs from three to five times.

**DRUG USE PATTERN**

Would use alcohol or other drugs four to ten days in a row before stopping. Longest time gone without using alcohol or other drugs in the past year was about one to two months.

**DISRUPTIONS AND SYMPTOMS WHEN USING OR COMING OFF THE USE OF ALCOHOL OR OTHER DRUGS**

Backed out four to six times. Passed out or became unconscious four to six times. Saw or heard things not there one to three times. Became mentally confused four to six times. Had physical shakes or tremors one to three times. Had a seizure or convulsion four to six times. Had a rapid or fast heart beat four to six times. Felt feverish, hot, sweaty one to three times. Did not eat or sleep four to six times. Became very upset/anxious one to three times. Unable to go to school or work four to six times. Broke the law committed a crime one to three times.

**MOTIVATION AND NEED FOR HELP**

Maybe I need help with an alcohol problem at this time. Do not need help with problems having to do with the use of drugs other than alcohol. I have not been forced to see the answers check these conditions.
SCRAM: GENERIC TREATMENT MODELS

• Stages of Change
• Cognitive-Behavioral Treatment
• Relapse Prevention
• Assessment / Hypothesis Testing
• Motivational Enhancement
MOTIVATIONAL ENHANCEMENT
ROLE MODELS

DESCRIBE CHARACTERISTICS OF PEOPLE WHO TRIED TO INFLUENCE YOU

SUCCESSFUL

UNSUCCESSFUL
MOTIVATIONAL INTERVIEWING WITH ADOLESCENTS

As a supportive, flexible, idiographic, brief, and autonomy-based intervention, MI overlaps well with adolescents' individual needs, competing attentional demands, developing identities, and desire to assert independence possibly catalyzing maturation and development.

MI STRATEGIES

• Simple Reflection
• Shifting Focus
• Reframing
• Rolling with Resistance
• Siding with the Negative
• Self-Efficacy

• Avoiding Arguments
• Open-ended Questions
• Listen Reflectively
• Expressing Empathy
• Develop Discrepancy
• Affirm
MOTIVATIONAL STYLE

• **O**pen-Ended Questions
• **A**ffirmations
• **R**eflective Feedback
• **S**ummarizations
• **R**einforcement of Change Talk
MOTIVATIONAL ENHANCEMENT

D - Develop discrepancy

A – Avoid argumentation

R – Roll with resistance

E – Empathy

S – Support Self Efficacy
So why *DO* people change?

What does it take?
Theory X

- **Offenders** are liars, antisocial personalities, cheat, con, and evade in order to escape the consequences of their behavior, and are unmotivated to change.

- **Employees** are ultimately lazy and unmotivated, dislike work, and will always get away with doing as little as possible.

- **Alcoholics/addicts** are deeply in denial, unmotivated to change, and will resist every effort to help them.
Logical Consequence of Theory X

You have to *make* them change by demanding compliance
Natural Consequences of Theory X for the “Managed”

- Evade and “look good”
- Power struggles
- Defensiveness, frustration and anger
- Commitment to “get away” ASAP
- Recidivism
Theory Y

- **Offenders** have their own personal motivations for change that need to be drawn out, are resourceful, often want to change, and will make their own choices.

- **Addicts** already have their own reasons for change, often want to change, and are capable of positive choice.

- **Workers** have underutilized talents and creativity, often enjoy their work, and are capable of self-direction.
Logical Consequences of Theory Y

- *Listen* to those you work with
- Regard them as capable, resourceful
- See the world through their eyes
- Respect their ability to choose (even though you may not like their choices)
- Evoke their own positive motivation
- Reinforce all steps in the right direction
A Client is Not a Potted Plant

• Try to actively engage clients in developing their own plan for change vs. passively accepting service plans

• This is often difficult in CJ culture that values conformity and passivity

• Empathy

• Programs of all sorts, not just those in correctional institutions tend to have standardized goals, objectives and interventions. Sometimes, its just a matter of changing the name on the plan.

• It is not uncommon that we do a comprehensive assessment of risks and needs, assign a client to an evidence-based program to address these issues, yet are met with resistance or lack of engagement by the client and/or their family.

• The missing step is the process of engagement or addressing motivation among other responsivity factors.
ENGAGEMENT

• It's like "cart before the horse" to tell a client how to change *before* the client is engaged with us.

• You can't mandate and coerce someone to attend and then think it will have an effect regardless of their attitude.

• For instance, it doesn't matter if you resist a laxative, or feel "unwilling" to cooperate with a laxative, it's going to have its effect on you.

• You MUST have (1) engagement and (2) motivation for experimenting with new functional behaviors.
Empathy is similar to gas in your car – it does not define where you will go, which route you take, when you will take off or stop.

But you certainly are not going anywhere without it.
THERAPEUTIC EMPATHY

• Empathy *is not*:
  – Having had the same experience or problem
  – *Identification* with your client
  – Let me tell you my story

• Empathy *is*:
  – The ability to accurately understand your client’s meaning
  – The ability to reflect that accurate understanding back to your client
EMPATHY IN ADDICTION COUNSELING

• Counselors who show high levels of empathic skill have clients who are:
  – Less resistant
  – More likely to stay in treatment
  – More likely to change
  – Less likely to relapse

• Empathy is the single best predictor of a higher success rate in addiction counseling.

• Counselors who are in recovery themselves are neither more nor less effective than others.
EMPATHIC SKILL AND CLIENT RELAPSE

Goal Setting
You are the “GPS” for Your Client
EVOKING AMBIVALENCE IS A PRIMARY KEY TO CHANGE
MINING FOR AMBIVENCE
THE FLOW OF CHANGE TALK

MI

Desire

Ability

Reasons

Need

Commitment

Change
LISTENING FOR CHANGE TALK

I don’t want to be in this stupid substance program program! I don’t have a drug problem. The Parole Agent told me I had to do this program to go home. I really want to go home and be good. I can stop drinking and smoking weed when I want to; it’s not a problem for me. I have not done any drugs since I have been locked up.
BEGIN PRESENTATION
1. Draw three columns on a sheet of paper and label them:

<table>
<thead>
<tr>
<th>Event</th>
<th>Automatic Thoughts</th>
<th>Emotions</th>
</tr>
</thead>
</table>

2. Recall a recent situation or memory of an event that seemed to stir up emotions such as anxiety, anger, sadness, physical tension, or happiness.

3. Try to imagine being back in this situation, just as it happened.

4. What automatic thoughts were occurring in this situation? Write down the event, the automatic thoughts, and the emotions in each column of your record.

5. Try to identify the underlying beliefs that energize these thoughts.

6. What kind of errors in logic might you be using?

7. What alternative cognitive process can you use to alter your emotional states?
Pathways of Learning and Change

Event → Thoughts → Emotions → Choice

Positive Behavior → Good Outcome

Negative Thoughts → Poor Behavior → Bad Outcome
STEP MODEL FOR “HOT” SITUATIONS

- S: Situation Event
- T: Thinking Change
- E: Emotions Feelings
- P: Positive Actions and Outcome
SCRAM: GENERIC TREATMENT MODELS

• Stages of Change

• Cognitive-Behavioral Treatment

• Relapse/Recidivism Prevention

• Assessment / Hypothesis Testing

• Motivational Enhancement
Relapse / Recidivism Prevention

**THE RELAPSE/RECIDIVISM MODEL**

**HIGH-RISK SITUATIONS & THINKING**

**WEAK COPING RESPONSE**

- Relapse/Recidivism thinking = less self-confidence
- Expect positive results from AOD use and/or crime
- Initial AOD use or criminal planning
- Rule violation effect + perceived benefits of AOD use & crime
- See cause as "weakness" & conflict over who you are
- Greater chances of return to AOD use or criminal acts
- Risk of relapse or re-offend

**STRENGTH COPING RESPONSE**

- Greater self-confidence & control
- Less chance of return to AOD use or criminal acts

Adapted from Mallett and Burton, 2003.
SCRAM: GENERIC TREATMENT MODELS

- **S**tages of Change
- **C**ognitive-Behavioral Treatment
- **R**elapse Prevention
- **A**ssessment / Hypothesis Testing
- **M**otivational Enhancement
“The therapist engages the client in a highly collaborative process in which there is a shared responsibility for setting goals and agendas, giving and receiving feedback and putting CBT methods into action in everyday life.”

Wright et al., 2006
ADOLESCENT SELF ASSESSMENT PROFILE II - (ASAP II)

Client Information/ASAP II Information

- Name: STEVE MCMASTERS
- ASAP II ID: 000001
- Prior Alcohol/Drug Outpatient TX: 1 or 2

Drug Use History

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<td>Marijuana</td>
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<td>Ketamin</td>
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<td>Cocaine</td>
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<td>Pain Killers</td>
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ASAP Basic Profile

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- Open-Ended Questions
- Affirmations
- Reflective Feedback
- Summarizations
- Reinforcement of Change Talk
So why do people change?
What does it take?
Theory X

- **Offenders** are liars, antisocial personalities, cheat, con, and evade in order to escape the consequences of their behavior, and are unmotivated to change.

- **Employees** are ultimately lazy and unmotivated, dislike work, and will always get away with doing as little as possible.

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- *Listen* to those you work with
- Regard them as capable, resourceful
- See the world through their eyes
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EVOKING AMBIVALENCE IS A PRIMARY KEY TO CHANGE
MINING FOR AMBIVENCE
THE FLOW OF CHANGE TALK

Desire
Ability
Reasons
Need
Commitment
Change
LISTENING FOR CHANGE TALK

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