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Our top story this month takes a look at whether there might be some unintended negative consequences from group treatment for delinquent youth.

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CABL

Aggression

Group treatment for aggressive and delinquent youth: Does peer interaction reinforce deviant behaviors?

By Stephanie L. Cardoos, Audrey L. Zakriski, Jack C. Wright & Harry W. Parad

Until relatively recently, there has been little debate regarding the efficacy of group treatment for aggressive and delinquent youth. Group treatment makes conceptual sense and is cost and time effective, but now a growing body of research showing negative or “atrogenic” (caused inadvertently by a treatment provider) effects from group treatment is raising concerns about this common practice.

Research has long noted the tendency of aggressive youth to affiliate with one another and has increasingly shown that association with deviant peers plays a causal role in the escalation of antisocial and violent behavior, substance abuse,

health-risking sexual behavior and police arrests. Evidence of such negative peer influence has been observed in kindergarten- through college-aged youth, with siblings, in natural peer groups, and most recently in group treatment.

One process that helps account for these effects has been termed “deviancy training” and was identified in an observational study of delinquent boys and their friends by Thomas Dishion and colleagues. In these interactions, delinquent youth reinforced each others' problem behaviors through deviant talk (conversations about past and future delinquent behavior) and social reinforcement of

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Angry, Sad, and Worried:

An emotional perspective on early disruptive behavior disorders

By Sarah Martin, Ph.D.

Case example: Jordan

Jordan was four years old when his mother called his pediatrician in tears, describing Jordan's increasing aggressiveness, explosive outbursts, and generally uncooperative behavior. While Jordan had always been a strong-willed and somewhat moody boy, his mother expressed her growing concern about Jordan's inability to comply with even basic behavioral expectations and family routines. It seemed that everyday was a battle of wills, with Jordan growing ever more angry and frustrated. Each day his mother found herself feeling more tired, discour-

aged, and defeated.

Young clients like Jordan are not uncommon to child mental health providers. Disruptive behavior problems represent the most common mental health referral concern for preschool aged children, with prevalence estimates between 4 and 16.8%. Early disruptive behavior problems may be characterized by a range of different symptoms, including aggressiveness, noncompliance, temper tantrums, and generally coercive and unpleasant interactions with others. Such problems can co-occur with poor attention and difficulties inhibiting

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**Keep your eye on...****...race complicates "common wisdom" about troubled youth**

A recent study suggests that more attention should be paid to the "intersection of race, gender and family" in dealing with troubled youth, said co-author Stephen Gavazzi with Ohio State University. Gavazzi and his fellow researchers used data from internet-based questionnaires administered to 2,549 Ohio youth, ages 13 to 17, scheduled to appear before a juvenile court. Their findings challenge the widely accepted notion that girls tend to internalize their problems while boys tend to externalize theirs. In the study African-American girls and boys showed the same levels of externalizing or internalizing behavior once family dysfunction was taken into account. African-American youth in dysfunctional families showed higher levels of outward aggression. This relationship was not found in white families. The results suggest "families matter in a different way for African-American youth than what we're finding for whites," said Gavazzi. He and his colleagues are now taking a closer look at African-American families in an attempt to understand some of their findings. [Gavazzi S, et al.: *J Marital Fam Ther* 2008; 34(3):353-368.]

...universal grade school behavioral intervention

In the longest yet follow-up study of the Good Behavior Game, a method of classroom behavior management implemented by teachers, GBG was tested in 19 Baltimore City Public Schools in five poor- to lower-middle class urban areas. Sheppard Kellam with the American Institutes for Research and colleagues wrote that GBG aims to stabilize first and second grade children to the student role and reduce aggressive, disruptive behaviors through a process of "interdependent team behavior-contingent reinforcement." As measured in young adulthood (ages 19-21), the GBG seemed to have a significant impact among males (particularly those who in the first grade were more aggressive and disruptive) in reducing drug/alcohol abuse/dependence disorders and antisocial personality disorders. The authors believe their results "underline the value of a first-grade universal prevention intervention." [Kellam S, et al.: *Drug Alcohol Depend* 2008; 95S: s5-s28.]

...early intervention critical in first-episode childhood psychosis

In a letter to the editor in the *British Journal of Psychiatry*, Erin Carlton and colleagues write that the incidence of suicide attempts among first-episode psychotic patients is of great concern. Their retrospective review (submitted for publication) found that among 1,500 cases of first-episode psychotic patients admitted to a child and adolescent psychiatry unit, 32% had a recent history of self-harm (suicide attempt) just prior to their admission. They maintain this rate is double that seen in adult studies. Major depressive disorder and attention-deficit/hyperactivity disorder were the two most common comorbidities in the group who attempted suicide. Carlton and co-authors conclude that the quality of the initial treatment intervention for the first psychotic episode is "critical" and there should be a "low threshold for hospitalisation" for children with psychosis. The first intervention must emphasize the "consequences of inadequate or partial treatment." [Carlton E, et al.: *Br J Psychiatry* 2008; 193: 167.]

What's New in Research

Parents' perspectives on teen self-harm and help seeking

In the first study to examine parents' perspectives on a child's repetitive self-harm behavior, Anna Oldershaw, MSc and colleagues at Kings College London looked at a small group of parents and found they were "deeply affected" by their experience and benefited from support from outside sources. In particular, school staff and general practitioners (GPs) appeared to play an important role in motivating these parents to seek services for their children. While parents in this study tended to pick up on signs of their child's self-harm, they were generally slow to address the problem as they struggled to understand and cope with their child's behavior.

Oldershaw and colleagues believe there is a crucial need to find a way to identify undetected cases of self-harm among adolescents and encourage the use of services. They suggest that parents' experiences of adolescent self-harm — and their perspectives on their role in seeking or maintaining help — are "highly relevant" to developing appropriate interventions.

The current study involved interviews with 12 parents (nine mothers, two fathers, one grandmother) referred to a community child and adolescent mental health service (CAMHS) in Croydon, south London in reference to their child's chronic self-harm. Self-harm was defined as any non-fatal self-injurious act purposefully carried out, regardless of underlying intent. The specific acts were not defined in the study. In a couple of cases, cutting is implied.

At the time of the study, the adolescents were 13-to-18 years old and in different stages of services. Parents participated in hour-long semi-structured interviews with open-ended questions that covered the following broad topics: history of self-harm, personal experience, making sense of self-harm and self-help, and improvements and hopes for the future. Four general themes emerged from the parents' accounts:

The process of discovery

The authors write that the process of parents' discovery of their child's self-harming behavior was gradual. While most parents suspected something was amiss, often

spotting injuries on their child, few pressed the issue when their child either refused to engage in a conversation or offered an excuse. Most parents took a "wait and see" approach.

One father explained, "[We] decided that our best course of action was not to make a big dramatic fuss and just let it unfold and just see if this evaporated...we realized that there was a sort of element of risk in that, but we weren't sure whether this was something that was deeply rooted...or if this was something that was pretty temporary and would pass."

In most cases, parents' formal confirmation of their child's self-harm was mediated by an outside party, often the school or the GP. But even when the child was involved in this disclosure, many parents reacted by trying to "brush it under the carpet." As Oldershaw and colleagues write, "They shared their child's ambivalence towards seeking treatment." Most parents delayed the instigation or acceptance of help and in most cases this process was forced on the parent due to an 'accumulation' of problems, most often trouble at school or non-attendance. ("Things just gradually accumulated to the point where we realized we actually needed some external help.")

The majority of parents said that GPs or school staff were a key element in the timing of help seeking, either encouraging the process or hindering it. One mother said that the school's initial input was key to her accepting an immediate referral to a CAMHS. In contrast, another mother said that her daughter had been willing to see the GP to discuss her self-harm, but the GP's failure to engage on this topic led to the issue being ignored for several more months.

Making sense of self-harm

Once parents had confirmation of their child's self-harm, most looked for reasons to explain the behavior. Most said their child would not give any explanation for the self-harm. All parents had their own opinions as to potential causal factors. Themes were emotional ("Like any other person, if you're worried about something you look for a way to ease off your pain..."); situational ("The whole thing underlying self-harm was bullying."); or personality ("I think a sort of profound lack of self-esteem.").

Some parents implied a desire that their child had "chosen" some other deviant behavior. ("I kind of expect teenagers to sort of surprise me. Probably self-harming wasn't the thing that I'd thought that she'd do... maybe I would have been less surprised if she'd come home drunk or something.")

While most of the parents came to an intellectual understanding of self-harm, most had difficulty coming to terms with their child's behavior or empathizing. And many understated the significance of their child's behavior. ("First of all, my immediate reaction was 'She's just copying. She's just copying her friend.'")

Psychological impact of self-harm

Upon confirmation of their child's behavior, parents described reactions of shock, disappointment, guilt and fear. More persistent feelings, most still fresh during the interview process, were described as sadness, a sense of loss or 'bereavement'. ("She was the loveliest little girl. It's like a bereavement really because that person's not there anymore.") Many described feelings of helplessness. ("As a mother, you always know how to help your child and make things better and I can't. I just feel out of my depth really.")

Parents who accepted the offer of support following referral to a CAMHS reported that the support was beneficial in their continued struggle with the emotional impact of self-harm. One parent did not have access to support and felt this lack of specialist advice added to her distress. ("It's very distressing when you feel very much on your own and you don't know what to do for the best.")

All parents in this study said that if advising other parents in their situation, they would advise seeking help sooner.

Effect of self-harm on parenting and family

Parents felt that knowledge of their child's self-harm behaviors significantly impacted their behavior as a parent, such as a feeling of "walking on eggshells" around their child and a fear of doing anything that might lead to a self-harm episode. Some reported having difficulties in setting limits for their child. Several parents reported feeling constantly aware of what their child was doing and having difficulty not checking up on their child. This anxiety plus balancing the needs of their self-harming adolescent with the

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needs of their other children caused significant stress.

Discussion and implications

This study is very small and therefore may not be representative of the majority of parents' experiences. The authors write that future research should investigate whether "good advice and support" from a community resource would help parents to cope with knowledge of their child's self-harm and might encourage them to seek appropriate service contact sooner. Also, the authors believe their findings make it clear that even when the child is receiving professional help, parents require separate support and advice to cope and to provide appropriate care.

The authors believe that the implications of this study are that teachers and healthcare practitioners should be aware of the needs of parents of adolescents who self-harm. Parents with an improved understanding of self-harm and with appropriate guidance from schools and GPs might seek help for their child sooner.



Oldershaw A, Richards C, Simic M and Schmidt U: Parents' perspectives on adolescent self-harm: qualitative study. *Br J Psychiatry* 2008; 193: 140–144. E-mail: anna.oldershaw@iop.kcl.ac.uk.

PATS survey suggests stress may be number one reason adolescents use drugs

The 2007 Partnership Attitude Tracking Study (PATS) released in August by the Partnership for a Drug-Free America found that 73% of teens reported that school stress is the number one reason for their drug use. Other top reasons that teens reported using drugs:

- To help them feel better about themselves (65%)
- To look cool (65%)
- To help them deal with problems at home (55%)
- To improve their athletic performance (54%)

Only 26% of teens in 2007 reported using drugs because "drugs are fun." This reflects a major shift from a decade ago, when the PATS survey found that "fun" was the primary reason given for using drugs.

The current survey suggested striking disconnect between parents and teens: only 7% of parents reported the belief that their children might use drugs to deal with stress or to "regulate" their lives. Meanwhile, recent studies by the

Partnership have explored reasons for adolescent drug use and found that "regulating their lives" is an increasingly important theme for adolescents when they discuss drug use.

"There are a lot of priorities and pressures on kids today, and that creates stress, so it's reasonable to think that kids are using drugs to try to handle it," said Kevin P. Conway, Ph.D., deputy director of the division of epidemiology services and prevention research at the National Institutes on Drug Abuse (NIDA). He explained that while positive reinforcement is one model for drug use motivation, another is negative reinforcement. Negative reinforcement occurs when you do something to alleviate something negative — for example, use drugs to alleviate stress.

Conway also suggested that the parents and teens who agreed to participate in the PATS telephone survey may not be representative of all teens. "They might be sampling for a population that's very high functioning," he said. "And high functioning kids very well may cope with the pressures by using chemicals for handling stress."

To read the PATS study, go to www.drugfree.org/Files/2007_Teen_Survey.

Group Treatment

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deviant behavior (laughter, positive affect).

This pattern of deviancy training was found to predict future delinquent behavior, and later linked to iatrogenic effects of peer-based treatment. Specifically, increased cigarette smoking and externalizing behavior were seen after peer-based treatment for at-risk youth, but not following family-based or combined treatment. This could be explained by differences in deviancy training within the treatment sessions.

Since this work, increased scrutiny of group interventions for aggressive and delinquent youth has revealed that they can lead to increased tobacco use, anger, high-risk peer affiliation, delinquency and externalizing behavior, especially for those at highest risk.

However, abandonment of group treatment for such youth may be premature. In their treatment review, Bahr Weiss and colleagues conclude that risk of harm for antisocial youth in group treatment has been overstated and argued that iatrogenic effects may only occur under special circumstances.

Individual and group factors, as well as staff and program characteristics (e.g., structure and supervision), may play a role in the extent to which peer aggregation undermines treatment effects. Both Dishion and Weiss acknowledge that group treatments may both help and harm at the same time, and urge careful attention to both when determining treatment efficacy.

Here we report ongoing research designed to increase our understanding of peer influence and risk for iatrogenic effects within the context of

a highly structured, highly supervised group-based residential treatment program.

Negative peer influence

Wediko Children's Services is a Boston-based nonprofit organization that each year serves an ethnically and socioeconomically diverse group of youth ages 6–18 in its 45-day residential New Hampshire Summer Program. Youth attending the program struggle with a range of chronic behavioral, social and academic problems. Pre-admission Child Behavior Checklist (CBCL) ratings indicate clinically elevated aggression (T=70.3), and borderline clinical elevations for attention problems (T=68.9), social problems (T=67.9), rule-breaking (T=65.8), and thought problems (T=65.3).

Youth live in same-age, same-sex clinical groups of 8–12 children. They attend two activity blocks, group therapy, general swim, meals, and spend

less structured cabin time with their clinical group each day. For two activities each day, and during two hours of daily educational instruction, youth spend structured time with other peers in their program. A 3:1 child:staff ratio ensures consistent supervision.

As part of the assessment program, a peer sociometric measure (the Peer Inventory) is completed by all children twice during the program. Items include "liking and disliking" nominations, evaluations of aggression, withdrawal, and prosocial behavior, and assessments of deviant talk ("Who likes to talk about breaking the rules?" and "Who laughs and thinks it is cool when other kids break the rules?"). Staff complete detailed behavioral observations about children's behaviors in context several times per day throughout the summer. They also provide summary ratings at four assessment points on measures including the Teacher Report Form (TRF). At the end of the summer, they assess overall treatment response.

Peer social support for antisocial behavior?

An initial study of peer influence at Wediko examined possible peer support for antisocial behavior, and effects on treatment outcome using peer social status variables. Specifically, high levels of peer acceptance for youth who engage in rule-breaking would indicate peer support and could undermine treatments designed to reduce those behaviors. Overall, rule-breaking as measured by CBCL staff report was not associated with peer acceptance as measured in the Peer Inventory.

However, evidence suggested that rule-breaking girls may experience more social rewards via high peer status than their male counterparts. Rule-breaking was more strongly associated with peer acceptance for girls than for boys in this setting. In addition, girls who scored high for rule-breaking tended to improve less than their male counterparts. They also improved less than other girls in the setting. This indirect connection between social reinforcement for rule-breaking and reduced improvement led to a deeper examination of peer influence within this treatment program.

Deviancy training

In a second study, deviancy training was directly measured through peer reports of deviant talk on the Peer Inventory. Deviant talk was reported at both time points, and increased over time for preadolescents. There were no gender differences. Youth with externalizing problems engaged in this behavior most often.

Interestingly, deviant talk was related to peer *rejection*, not acceptance. Youth who engaged in deviant talk also experienced fewer positive and more corrective interactions with staff. There was no evidence of overall iatrogenic effects related to deviant talk; in fact, deviant talk at the beginning of the summer was significantly related to improvement in

While deviancy training and other negative peer influences may dampen treatment effects for some, we found little evidence of harm from group-based treatment of this type.

aggression, rule-breaking, externalizing, and total behavior problems on the TRF.

Follow-up analyses showed that the influence of deviant talk on treatment outcome was related to person-group fit. For example, youth who engaged in deviant talk showed dampened treatment responses if they were in clinical groups that engaged in high (versus low) levels of deviant talk. These effects were seen for overall behavior change, as well as change in aggression, and relations with adults.

Effects were larger for preadolescents. Observational assessments of aggression in context revealed one narrow iatrogenic effect for this group: an increase in aggression to peer provocation. This increase, however, was offset by sharp decreases in aggression to instruction and talk from adults. Parent reports of overall symptom change from spring to fall also showed dampening effects for youth who engaged in deviant talk if their treatment groups were

also high in deviant talk.

Thus, deviant talk emerged as a dynamic variable that can dampen treatment effects and even produce narrow increases in aggression towards peers, if individual and group tendencies towards deviant talk align. However, such effects occur in the context of overall improvement and contrasting reductions in aggression to specific interactions with adults.

Clinical implications

This research suggests that peer support for aggressive and delinquent behavior, and deviancy training in particular, can exist even in the most highly structured and supervised treatment settings, such as the Wediko program. It also suggests that these behaviors and the potential for iatrogenic effects *can be managed*.

While deviancy training and other negative peer influences may dampen treatment effects for some, we found little evidence of harm from group-based treatment of this type. As Dishion and Weiss' arguments anticipated, the one narrow iatrogenic effect we detected was offset by gains in other areas.

Constant supervision and monitoring, as well as group/individual behavior management are specific strategies that may reduce risk for iatrogenic effects in group treatment. It is notable that most negative effects have been found in outpatient treatment programs with fewer staff and more opportunities for youth to associate with one another in unsupervised interactions outside of treatment.

We also recommend regular assessment of peer group influences through sociometric interview as a specific strategy for managing risk. Peer support for antisocial behavior can be subtle and even in supervised peer interactions can go undetected without sensitive assessment tools.

Additionally, our work suggests that constructing heterogeneous treatment groups may serve to reduce risk in this type of setting. Group assignment at Wediko is guided by a desire for heterogeneity and balance, but some groups have more aggressive members than others. It is these less heterogeneous

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groups that appear to be responsible for the treatment dampening effects we observed.

Interestingly, heterogeneity has been shown to be problematic in non-clinical, at-risk populations. A key difference may be that in these studies of at-risk youth, heterogeneity often comes from differences in severity level on the same behavioral dimension. In our case, heterogeneity comes from mixing youth with different types

of clinical presentations (e.g., aggression, depression, attention/social problems). It is this latter form of heterogeneity that appears most protective.

In conclusion, the evidence supporting risk from deviancy training is sufficient to motivate careful monitoring within existing group-based treatment programs. In addition to providing prudent risk management and treatment monitoring, these efforts can help further identify indi-

vidual, group, and treatment setting characteristics that influence deviancy training and the effectiveness of group-based treatment for antisocial youth.



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Delinquent Behavior

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impulses and activity level.

Development of early disruptive behavior

Theories to explain the emergence of disruptive behavior problems have historically focused on learning and socialization mechanisms that lead to increasingly coercive and negative interactions between children and their caregivers. That is, children learn that aggressive and uncooperative behaviors are effective in achieving their immediate goals, such as the gain of a desired object, the removal of a limit, or the termination of an unpleasant interaction. There is clear evidence to support these perspectives, which has laid the groundwork for the development of effective treatments for disruptive behavior symptoms in young children.

What has been less evident in many theories focusing on the development of disruptive behavior problems is emphasis on the emotional facets of these problems. When emotions are considered, focus is typically placed on anger; specifically, on disruptive children's inability to safely express and regulate their angry, hostile, and frustrated feelings. And perhaps because these anger expressions are so impairing to the child's social functioning, interventions often focus specifically on teaching children (and caregivers) skills for anger regulation and self-control.

And yet for some children, a focus on anger and behavioral control may overlook a vastly more complicated

emotional picture. In our own research and clinical work with severely disruptive preschoolers, we have been struck by the extent to which these aggressive and "angry" children struggle with intense feelings of sadness and anxiety, and perhaps more importantly, the extent to which expressions of anger serve to keep these other feelings at bay.

The example of Jordan

Jordan was referred to Bradley Hospital's early childhood partial hospital treatment program, and indeed, he fit well his mother's description of an angry, frustrated, and highly uncooperative little boy. He was quick to lash out at both staff and peers, often in response to seemingly minor frustrations or provocations. Conversely, Jordan was slow to calm after his behavioral outbursts, often becoming "stuck" in prolonged periods of agitation and conflict with others, which would eventually give way to tearful exhaustion.

Between episodes of noncompliance and hostility, Jordan appeared quiet and unhappy, mostly watching others from a distance. He was easily distracted by other children's distress and disruption, although he would never make efforts to approach or comfort an upset peer. With encouragement, Jordan was willing to play with program staff, although the content of his play was emotionally impoverished and lacking in spontaneity. When prompted, he was readily able to recognize facial expressions of joy, anger, sadness and fear, yet Jordan struggled to apply this understanding to his own experiences; he was frequently unable to articulate his own feelings, and often confused feelings of sadness, anger, and fear.

Emotional facets of early behavior disruption

From an emotional perspective, Jordan's profile is not unlike those of many of the disruptive young children who receive treatment at Bradley's early childhood partial hospital program. While episodes of anger and frustration are prominent, equally striking is the extent to which these children often struggle to initiate and maintain positive feelings, such as joy or interest.

This lack of positive engagement com-

Treatments to address disruptive behavior problems in preschool-aged children can be enhanced by appreciating the emotional complexity of such problems, and by directly targeting the development of early emotional competencies, as well as behavior control.

promises their ability to be good interaction partners; it is hard for these children to achieve any positive emotional momentum in their relationships, and they typically struggle with peers and adults alike. While some basic social-emotional competencies appear intact (i.e., in Jordan's case, the ability to label happy, sad, angry, and scared feelings), children struggle to enact these competencies when the emotional stakes are high.

We also find that, as in the case of Jordan, behavioral disruption often over-

lies a vulnerability to sadness and deep concerns for their emotional wellbeing; expressions of anger and acts of aggression may function to prevent children's experience of sadness, helplessness, or uncertainty. Children like Jordan may use anger to forcefully engage their environment, thereby guarding against potential loss of interpersonal connection or control.

An emotion-focused treatment approach

There is growing awareness that for disruptive preschoolers like Jordan, treatment must not only target disruptive behavior symptoms, but also the range of emotion processes that exacerbate these symptoms. Evidence to support this approach comes from prevention programs that promote emotional competencies in young children at risk for poor academic or mental health outcomes, with findings to suggest that emotion-focused interventions can foster children's behavioral adjustment and social wellbeing.

While there exists no empirically validated "formula" for addressing the emotional facets of early disruptive behavior disorders, available clinical, theoretical, and research literatures offer clinicians potentially helpful guidelines:

- **Move beyond anger**

Anger management and problem-solving skills are core to many existing approaches to interventions for disruptive behavior problems in children. Yet young children with behavior problems additionally benefit from interventions that support their capacities to tolerate and express the *full range* of emotions, including feelings of anger, as well as sadness, anxiety, loneliness, jealousy, and shame — all of which serve adaptive functions in development. To this end, parents and other caregivers can act as "emotion coaches" by labeling and normalizing difficult emotions for their children, thereby expanding their emotional repertoire and increasing tolerance for such feelings as sadness and anxiety.

Treatments are also most effective when they can support the function of anger (i.e., to engage others and mobilize resources),

while simultaneously replacing its maladaptive expressions with more competent means of self-assertion. For example, young children can be coached in steps for flexible problem-solving during episodes of mild frustration or upset.

- **Increase positive emotions**

Positive emotions — such as joy, excitement, and interest — create the foundation for smooth and successful social interactions. In early childhood, the sharing of positive emotional states between children and their caregivers pave the way for compliance and cooperation. Positive interaction is also among the most important factors in maintaining family treatment gains. As such, interventions that provide opportunities for shared positive emotion (e.g., child-focused play activities) are likely to increase the effectiveness and durability of treatments targeting children's disruptive behavior symptoms.

- **Emphasize flexible regulation, not rigid control**

Over the last decade, there has been a burgeoning of conceptual and empirical interest in the concept of *emotion regulation*. This framework emphasizes the temporal dynamics of emotion, for example, the ability to shift between emotion states or to adjust the intensity of an experienced emotion to fit the demands of a given situation. As such, the goal of some interventions may be to simply help children to make emotional shifts (e.g., to "move on" from negative interactions or to settle into a less intense emotion state) that permit better adaptation and coping.

- **Appreciate the relationship context**

Emotions are social processes.

Emotion-focused interventions necessarily involve children's significant interaction partners, including parents, preschool teachers, and peers. Interventions should directly target the impact of emotions (experienced or expressed) on these relationships and interactions. For example, parents can be coached to be mindful of their own emotional reactions to their child's expressions of anger, sadness, and fear, and to use their experienced emotions to organize more helpful responses to child distress and disruption.

Conclusions

For many young children, behavioral disruption goes hand in hand with problems in the experience, expression, and regulation of emotion. Moreover, early behavioral disruption and its associated social experiences (e.g., interpersonal conflicts and rejection, preschool expulsion) undermine the achievement of other critical tasks of emotional development. Treatments to address disruptive behavior problems in preschool-aged children can be enhanced by appreciating the emotional complexity of such problems, and by directly targeting the development of early emotional competencies, as well as behavior control.



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Guest Commentary

Statewide assessment and psychiatric disabilities: Mutually exclusive?

By Anne Walters, Ph.D.

During the last decade, a yearly educational ritual has taken root in our culture, with increasingly high stakes: statewide assessment. This Department of Education-mandated administration of standardized measures is designed to assess the proficiency of students in specified subject areas. And while it is intended to measure progress toward achievement of the No Child Left Behind mandate (and in fact may actually do that for some children in some states) it is a travesty for those children and adolescents struggling with severe mental illness.

Students for whom getting up in the morning to get to school can be a struggle — such as those diagnosed with bipolar disorder, severe attention deficit/hyperactivity disorder (ADHD), psychosis, or Asperger's disorder — must complete hours of educational assessment with none of the accommodations they have been granted for everyday school work as part of their educational plans. Most recently, there is a push toward requiring a specified level of performance on these assessments in order for students to receive high school diplomas, a decision that is guaranteed to increase drop out rates for our most vulnerable high school students.

As an example, let's consider a student named John who has bipolar disorder. John has already been determined to be unable to function in a public school setting. He is attending a substantially separate or "out-of-district" private therapeutic placement that is funded by his local special education department. His Individual Education Plan (IEP) notes difficulties with self management, particularly in the face of frustration; difficulty attending to academics for extended periods of time; and lower than expected levels of academic achievement in math, reading, and written language. He has goals developed as part of his IEP to improve functioning in these areas.

On his IEP, accommodations are noted to be required for him to be successful in completing his academics, examples of which might be: having written material read to him, using a calculator for math, using a computer or word processor for written language.

John is also given accommodations for statewide assessment — but these may be part of a standard list and limited to allowances like extended time, taking the test in a quiet room over a longer period of days, and taking breaks as needed. His "everyday" learning accommodations are not permitted to be utilized for statewide assessment.

Contrast John with Bill, a boy in public school who has severe intellectual or cognitive limitations and instead of the statewide assessment is given the option for alternative assessment. (This option is based on some form of portfolio assessment, tied to

his IEP and his classroom performance and completed over the entire school year.) One has to wonder how a child with a severe psychiatric disorder like John is any more likely to be able to sit for hours and complete an assessment with no help from the adult in the room, than would be a child with a cognitive disability like Bill? And how is this any less discriminatory than it would be for the child with the cognitive disability?

Further, the result of statewide assessment is the yardstick by which districts are measured in terms of their ability to educate special populations. This assumes that this particular form of assessment is a good measure for children with psychiatric disorders. It also assumes that improvement in educating children with disabilities will result in improvement in assessment scores. We must begin by examining the validity of these assumptions for special populations.

To this end, I believe we must gather educators and mental health professionals to engage in a dialogue about effective

Educational programs for hard-to-reach children are necessarily creative. We must likewise think creatively to devise a way to measure the success of these programs. Most importantly, our solution must protect these students from yet another "failure" experience at school.

ways to measure John's progress toward achieving state standards of learning. Let's engage in dialogue about a portfolio reflecting his improvement in classroom work, including both informal classroom assessment and standard scores on widely used individualized reading assessment.

Educational programs for hard-to-reach children are necessarily creative. We must likewise think creatively to devise a way to measure the success of these programs. Most importantly, our solution must protect these students from yet another "failure" experience at school.



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