

**EARLY INTERVENTION FOR CHILDHOOD BEHAVIOURS:  
A LITERATURE REVIEW**

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A Final Project  
Submitted to the School of Graduate Studies  
Campus Alberta  
In Partial Fulfillment of the  
Requirements for the Degree

**MASTER OF COUNSELLING**

**FACULTY OF EDUCATION  
LETHBRIDGE, ALBERTA**

November 2008

## Abstract

This literature review focuses on the correlation between early childhood problematic behaviours and future health risks, such as substance use or abuse, juvenile delinquency and mental illness. It reviews common problematic behaviours from early childhood to adolescence. The author presents studies that indicate correlated findings and considers the relevance of these correlations, as well as recommendations for breaking the cycle of behaviour patterns. The literature review also explores alternative theories that explain behaviour development. The author summarizes the themes that emerge from the literature review and discusses possible research avenues for future intervention programs of youth in this population.

## Acknowledgments

To Dr. Noella Piquette-Tomei, my final project supervisor: thank you for your guidance and dedication. I appreciate your encouragement from the very beginning of this final project idea and your continuing to see me through this journey. Thank you!

To Dr. Reid Webster, my committee member: I am grateful for your willingness to participate in my final project and I value your feedback and expertise. Thank you!

To Judy O'Shea, my editor: I could not have put this project together without your guidance and partnership. Thank you!

To my special friends, colleagues and professionals that I look up to: Aruna Gore, Donna Buckley, Doug Broadfoot, Donna Piercy, and Jennifer Barrett. I value your professional wisdom, your open ears, and your shared interest in my project idea. Thank you!

Finally, to my family: I believe you deserve your Master's degree in Counselling yourselves. You allowed me to brainstorm and vent everything on you: my project idea, on-going thoughts, frustrations.... You always listened! You were the real and supportive drive behind my dedication to this project and throughout the whole Master's journey. Thank you, thank you!!!

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## Chapter 1. Introduction

### *The Drive Behind the Idea: Personal Experience*

“Another youth slipped through the crack.” This statement has been repeated for decades to describe children who never received the assistance they needed in order to develop and reach their full potential as healthy, happy, adjusted adolescents. When such children become juvenile delinquents, abuse substances and/or have mental illnesses, many individuals in society note that something should have been done when they were children. However, somehow they slipped away from the needed intervention through what many of us refer to as the “crack.”

My interest in this issue and motivation to perform this literature review began 15 years ago, when I was a support worker at an elementary school. One of my assignments at this school was to provide support to three boys, aged 11, who demonstrated problematic behaviours. My support to these boys mainly involved taking them to the library to work on their homework when they were kicked out of class because of their continuous disruptive behaviours. This occurred every day. After working with these boys for several months, I began to wonder why they always acted this way. I began to talk with them individually.

One boy eventually disclosed to me that he was pretty sure that his mother was dying and that no one in his family would tell him anything. He mentioned that his mother went away for long periods of time and that, when she came back, she looked thin and tired. The boy cried many times when he talked to me about this situation. I mentioned his comments to the principal, who told me that indeed the boy’s mother was

dying of cancer and that the family chose to hide this information from the boy. They did not want him to suffer during the anticipated two-year process.

The second boy disclosed to me his fears about his parents. He stated that his father came home most nights drunk and that his mother was becoming more upset each time. He confided with me the reason for his outburst in the previous week's math test: his mother had stabbed his father in the chest with a fork that morning. The boy stated that he feared one day his parents would actually kill each other.

The third boy always laughed and joked about his mother being a 'crack-head' and a 'hooker'. Observing his mother when she came to the school one day, I thought perhaps he was correct. I guess these boys did ultimately "fall through the crack," because all of them quit school in grade 8.

As a counsellor, I now work with youth who have been incarcerated and are on probation. Most of the youth I work with have addiction issues, and most have described some horrible event that they experienced as children. Many of these youth did not have a professional intervene in their lives until they were young teenagers and displaying angry and/or aggressive behaviours.

#### *Importance of Topic*

Research suggests that children who display problematic behaviours need early intervention so that a disruption in the problematic behaviour pattern may be obtained, leading to healthier outcomes. When early childhood behaviours are not explored or attended to, there is a higher probability of later juvenile delinquency, substance abuse, and/or mental health concerns (Rhule, 2005).



Studies demonstrate that such problems as cognitive development, social-emotional behaviours, and parent-family wellness tend to co-occur and accumulate without intervention (Nix, 2003). Problems in one area can lead to problems in others, demonstrating the cumulative effect. Because of these transactional relations among cognitive development, social-emotional behaviour, and parent-family wellness, it is fair to state that changes in each domain have a high probability of creating cascading effects and change in the other domains (Nix). For example, research has shown that early improvements in children's cognitive development can lead to better behaviour, and better child behaviour is easier for parents to manage; this demonstrates how one affects the other. Therefore, early intervention during childhood will usually have at least two components, one targeting the child's functioning and one targeting the parenting skills or home environment, in order to achieve long-term gains. Children's functioning is enhanced by prior successes or constrained by prior failure; therefore, the earlier children can receive help, the greater the opportunity for success and the upward spiral of better functioning.

Providing intervention at an early childhood level is important to prevent children's later maladjustment and to alleviate the high personal and societal costs of delinquency, addiction, and mental health concerns (Rhule, 2005). Early behaviour problems predict later behaviour patterns; in fact, the more apparent the behaviour problem is at an early age, the greater is its severity later on (Capara, Dodge, Pastorelli, & Zelli, 2006).

Criminal behaviour, substance abuse, and mental health concerns are serious problems that are associated with negative outcomes for the child or youth and for society

(Rhule, 2005). According to Rhule, intervention costs for a typical criminal are between \$1.3 and 1.5 million, and for a heavy drug user between \$370,000 and \$970,000.

Substance abuse or dependence is an issue for approximately nine percent of the youth population aged 12 to 17, and is associated with maladjustment in social behaviours, education, and physical and mental health issues. Garber and Horowitz (2006) state that depression related to problematic situations caused by or causing substance abuse affects between three and eight percent of adolescents.

Garber and Horowitz (2006) claim that one to two percent of pre-pubertal children experience depression because of external factors influencing their lives, and depression may lead to continuing patterns of negative behaviour in adolescence. Garber and Horowitz hypothesize that the earlier the onset of depression, the higher the risks for adolescents. Forth, Hare, Kosson and Neumann (2006) explain that the onset of psychopathic characteristics can also be traced back to earlier childhood behavioural patterns; for an adolescent or adult, behaviour problems can be extreme. The numbers of girls and boys who are at risk of or already experiencing complex, severe and chronic problems are large and growing (Anton, Durlak, Sandler, & Weisz, 2006). Research indicates the importance of preventing potential delinquency, substance abuse, and mental health concerns through intervention at the early childhood level. Postponing intervention or failing to intervene has high personal and societal costs (Rhule, 2005).

Since childhood experiences affect lifelong health, the earlier society can invest in and provide intervention, the greater the return for both children and the rest of society (Health Council of Canada, 2006). Early intervention is not only a responsibility that society has to children, it can also save millions of dollars by preventing long-term,

disastrous effects (Rhule, 2005). The Health Council of Canada states that, when intervention is provided sooner rather than later, children have the opportunity to grow up happy, healthy, confident, secure and able to reach their full potential. However, out of every seven Canadian children, one has a mental illness such as anxiety disorder, ADD, or depression (Health Council of Canada). Many of these illnesses emerge in early childhood and persist into adulthood. However, with the right treatment or intervention at an early age, most children are able to manage their health concerns. Children who grow up healthy and supported are more likely to become competent adults who will themselves raise healthy children.

Most would agree that all children deserve to be treated as individuals and to have their specific needs met. All children are entitled to grow in secure, protected, and nurturing surroundings; however, many children face stress and the obstacles of poverty, unstable home situations, and other issues that interfere with healthy functioning (Feldman, 2005). Professionals and caring adults need to do everything in their power to remove obstacles that prevent children from getting a good education, quality health care, and the opportunity to thrive as fulfilled, responsible individuals. Consequently, they need to find policy and practice approaches that help solve real problems. For children who demonstrate disruptive behaviour, school districts must provide a continuum of individualized service. Balancing the needs of the individual with the needs of the rest of the group is tricky. Teachers and students cannot learn in an atmosphere of disruptive misbehaviour. Services need to include individual assessment, treatment interventions and consultation. The purpose of such a program is not to shame and punish the child but to provide guidance and support and to help bring about remedial change.

### *Structure of Project*

This project consists of a literature review that focuses on the correlation between problematic childhood behaviours and juvenile delinquency, substance abuse, and mental illness. Specifically, the review seeks to identify and discuss early disruptive behaviours in children at different developmental stages, comparing them to the behaviours in juvenile delinquents, addicts, and those with mental health concerns. The review explores what researchers suggest this correlation of behaviour may indicate, what they recommend as strategies for addressing the problem situation, and why they believe early intervention is crucial to support healthier future outcomes.

The search strategy for accessing the applicable research included several steps. PsycINFO was utilized to access the on-line library database systems of Calgary, Yorkville, and Lethbridge Universities. Most of the references gained through these searches were in peer-reviewed journals. Critically evaluated sites from the World Wide Web were utilized for the credibility of the research, using the analyzing strategies suggested by Barker (2005). The library at Thompson Rivers University and its computer database system were accessed to search for resources. Some of the key terms that were used to access all database systems were *juvenile delinquent, early addiction, mental health, early intervention, difficult behaviour, and disruptive behaviour*.

The later part of the literature review focuses on possible intervention strategies in order to provide education providers and communities with suggestions for implementing early intervention strategies, as well it demonstrates the use of the strategies by running them through a hypothetical case scenario. The review takes a health psychological approach in attempting to demonstrate two dimensions of assistance that help promote

healthier lifestyles and future outcomes for children. One health psychological approach involves direct help, providing therapy and other interventions to address the emotional and social adjustment problems and to reduce the prospects of the development of health hazards such as substance abuse and depression (Sarafino, 2006). The second approach is indirect; its focus is on the implementation and use of a program that promotes healthy lifestyles for children.

Finally, this project reviews both direct and indirect approaches used with children, attempting to deepen the understanding of health and health risks and to develop strategies that will contribute to the reduction in suffering and an improvement in quality of life (Ferris, Maticka-Tyndale, Murray, Nelson, & Poland, 2004). The health psychological approach is central to wellness; it is both reactive to present concerns that children demonstrate, such as acting-out behaviour, depression and/or anxiety, and proactive to future concerns by developing programs that address the prospects of later development of health problems, including substance abuse, criminal activity and mental illness (Prilleltensky & Prilleltensky, 2003).

This project addresses the following question: How can early intervention be incorporated into the school system to support children at-risk of later juvenile delinquency, substance abuse, and/or mental health concerns? Its conclusions are intended to identify best practices that support early intervention strategies to interfere with the escalating effects of early childhood problematic behaviours. Its ultimate goal is to generate awareness and knowledge that can be incorporated into educational practices.

### *Population Definitions*

*Early childhood* refers to children under the age of 8. *Juveniles* are aged 13 to 18 years (Youth Justice, 2006). The Canadian Mental Health Association (2006) defines difficult or abnormal behaviour patterns as including, but not limited to, aggression, violence, destroying property, lying, stealing, refusing to cooperate and using bad language. The term *delinquent* refers to a youth who is offending by neglect or in violation of duty or of law (Webster's Dictionary, 1992). For the purposes of this literature review, delinquency also includes substance abuse because, according to the Youth Justice Act, substance use is a violation of the law.

For the purpose of this project, the term *early intervention* is used not as a single entity rather a group process that involves many steps to ensure the child receives the optimum and needed services to effectively change the problematic situation.

## Chapter 2. Literature Review

### *Childhood Disruptive Behaviours*

#### *Early Childhood*

Children in this stage (aged 4 to 8) understand the world by perceiving it, being influenced by it, and acting on it. In turn, the surrounding world shapes the child (Cooper, DeHart, & Sroufe, 2000). This demonstrates the role of nurture within the child's environment, as well as its role in developing behaviour patterns (Corsini, 2005). Longitudinal studies have demonstrated that behaviour patterns and personality are established during the early formative years (Ball, 1962). Research suggests that, when children come from unhealthy backgrounds, such as dysfunctional, abusive homes, they are much less likely to develop adequately physically, academically, and emotionally (Hood, Lawrence, & Shamsie, 2006). Walters (1998) agrees that there is usually an initializing factor that aids in lifestyle behaviour. For example, a child from a family in extreme poverty may face ridicule from his/her peers. Therefore, the child's behaviour may appear blaming, angry or withdrawn.

Three levels of crisis can be used to describe the different influencing factors during child development. The first level is a normal development crisis, where a child may feel stress due to a change (Frank, 1982). For example, a child experiencing the birth of a sibling may feel normal stresses. The second form of crisis is situational, which creates stress because of feelings of loss or fear (Frank). This type of stress can occur with a death of a relative or the divorce of parents. Frank describes the last level as high risk, and claims that this level of stress can aid in the development of emotional disorders and cause greater than usual stress. Anders and Morrison (1999) demonstrate that, when a

child within this age range displays behaviours such as anxiety, impulsiveness, refusal to follow directions, and/or aggressive outbursts, compared to those of his or her healthy, developed counterparts, these are abnormal behaviours and require professional attention. Garrison (1946) hypothesized that behaviour should allow one to predict a child who is affected by his or her conditions.

*Summary of early childhood problematic behaviours.* The research indicates that young children behave according to their influencing environment. When a young child's environment is stressful or traumatic, he or she will display problematic behaviours that resemble his or her environment. The studies suggest that all children go through some type of crisis in life, but the high-risk crises are the ones that have the most effect on a child and can steer a child's life towards negative outcomes.

#### *Middle Childhood*

When children reach the next developmental stage of middle childhood (aged 9 to 11), they become more in tune with their own feelings, can appraise their own abilities and realize how others respond to them (Cooper, DeHart, & Scroufe, 2000). Research indicates that, when children at this age demonstrate difficult or disruptive behaviour, it can intensify into blaming, depression, withdrawal, and/or substance use (Anders and Morrison, 1999). Walter (1998) claims that the patterns of behaviour from early childhood will usually remain when environmental factors continue to be influenced. For instance, a child who displays problematic behaviours as a result from his or her disruptive home life will most likely continue the behaviour patterns unless the home situation changes. As a matter of fact, the pattern of behaviours that have continued from early childhood will most likely accumulate or snowball into later lifestyles. Franks'



(1982) similar hypothesis is that childhood behavioural signs, such as withdrawal and emotional outbursts, may result from unsuccessful development from high-risk environmental factors, and they may continue to affect successful normal development.

*Summary of middle childhood problematic behaviours.* Research has indicated that past behaviours become more intensified because children are beginning to understand the world around them and how they fit in. As studies demonstrate, behaviour patterns continue to escalate and will enter the adolescent stage of development when negative maintaining factors (i.e., disruptive home life or peer rejection) continue to influence the child's life.

#### *Juvenile Delinquent Behaviours*

Along with the cognitive changes of adolescence come changes in self-understanding and the ability to reflect on the nature of one's self, history, uniqueness, and complexity (Cooper, DeHart, & Scroufe, 2000). Morrison (1999) believes that, when juveniles aged 12-15 years display behaviours such as anxiety, impulsiveness, over aggression, poor school attendance, and/or rebellion against authority, they are identified as unhealthy and may demonstrate developmental disruption due to the effects of environmental influences. Corsini (2005) explained a Freudian hypothesis in which the unconscious mind that is derived from memories, learning, and situations from past experiences is the primary motivation and organization of behaviour. Freud's theory of the past dictating present behaviours demonstrates how some lifestyles can be traced back to the internalizing of rules, norms, and values in early experiences.

Research suggests that the long-term negative influences in a youth's life are the maintaining factors that could develop into the driving force behind unhealthy behaviour,

drug use, and/or crime (Walters, 1998). Walters explains that individuals who use drugs and/or commit crime most often continue the drug use and criminal behavioural patterns due to the growing influence of the maintaining factors. The continuous maintaining factors in one's life soon become the reinforcement for a particular lifestyle, and each lifestyle begins to develop its own set of rules, roles, rituals and relationships (Walters). For example, a child who had the influential maintaining factors of growing up with parents who disregard social norms or rules may develop social rule-breaking behaviours where they just do not apply or are there just to be broken. The child may take on the role of a rebel. The child's rituals may follow a dishonest pattern, and his or her relationships with others may be manipulative. Walters claims that negative conditions that influence a lifestyle often lead to the negative choices of lifestyle, which interact in a way to produce a behavioral style that leads to drug and/or criminal activity.

Some research suggests that delinquency is basically a protest against past environmental circumstances or a protection against imposing hazards (Garrison, 1946). Garrison hypothesized that there is a real child hiding behind a shield of delinquency, a shield that was formed to protect the child from circumstances.

*Summary of juvenile delinquent behaviours.* The research demonstrates how past behaviour patterns grow into more severe behaviour problems, because adolescents have the ability to reflect on negative past events. Many researchers agree that juvenile delinquent behaviours are a coping mechanism for dealing with the past (Walters, 1998).

#### *Correlation of Behaviours*

The early onset of externalizing behavioral problems is a risk for juvenile delinquency, substance abuse, and/or mental illness (Calkins et al., 2006). Research

indicates that early behaviour problems predict later behaviour problems; in fact, the more apparent the behaviour problem at an early age, the greater its severity later on (Capara et al., 2006). Hood, Lawrence, and Shamsie (2006) state that the ability to predict later behaviour problems and health risks is due its having a cumulative effect. Calkins et al. explain that early problematic behavioral patterns remain stable and lead to more serious and maladaptive outcomes. Some studies have demonstrated that there is a clear pattern of chronic behaviours in childhood that act as significant signs of risk factors for latter problems. Hubbard et al. (2006) explain that early childhood risk factors, such as attention problems, coercive parents, peer rejection and school failure, result in criminal and violent behaviour in adolescence. Hood, Lawrence, and Shamsie (2006) state that, for young children, troubled backgrounds and behavioral difficulties result in learning problems, social ineptness and aggression that can lead to juvenile delinquency, substance abuse and/or mental health issues. Therefore, Hood et al. hypothesize that the onset of delinquent and antisocial, problematic behaviours occurs in the years of early childhood.

*Importance.* Children as young as 12 are continually being sentenced to prison and are viewed by society as deviant (Beyer, 2006). However, studies indicate that the majority of juvenile delinquents have experienced severe trauma in early childhood, with the higher percentages being physical and sexual assault (Beyer, 2006). Beyer claims that trauma in youth affects all aspects of children's development, and that traumatized children often abuse substances to numb the pain of memories. Corsini (2005) agreed with the Freudian theory that early childhood trauma becomes repressed memories, and that these create unhealthy, maladjusted behaviour later on.

Calkins, Degnan, and Keane (2006) claim that it is important to identify the early onset of behaviour problems in early childhood because these are the factors that contribute to the continuous, cumulative, and escalating behaviour problems of juvenile delinquency. The Canadian Mental Health Association (2006) explains that high-risk behaviour problems in childhood, such as aggression and refusing to cooperate, need serious attention, and when these behaviours create a repeated pattern over time, intervention is necessary.

*What needs to happen.* Hood, Lawrence, and Shamsie (2006) believe that children who display unhealthy or disruptive behaviours need to be assessed at the onset, and intervention needs to occur as soon as possible. There is an ethical responsibility to nurture young children and the investments in doing so will pay off for everyone (Health Council of Canada, 2006). Ignoring the problem or postponing addressing it leads to disaster for the youth and for society (Rhule, 2005). It is much easier to change behaviours and lifestyle patterns at an early age, opposed to allowing them to escalate to a lifestyle that has been entrenched for over a decade or so. Hood et al. hypothesizes that early intervention brings long-term positive outcomes.

Sheldon (2001) claims that intervention needs to stop focusing on children with disruptive behaviours as a problem or labeling them as bad, disturbed or aggressive. Sheldon states that labeling and identifying the child as the problem acts as punishment, when the focus needs to be on the actual source of the problem -- the maintaining factor or influence. Sheldon quoted a popular Vietnamese poem as a metaphor of how children who display difficult behaviours may be inappropriately viewed and consequently not provided with adequate intervention:

When you plant lettuce, if it does not grow well, you don't blame the lettuce. You look into the reasons it is not doing well. It may need fertilizer, or more water, or less sun. You never blame the lettuce. Yet if we have problems with friends or our family, we blame the other person. But if we know how to take care of them, they will grow well, like the lettuce. Blaming has no positive effect at all, nor does trying to persuade using reason and arguments. That is my experience. No blame, no reasoning, no argument, just understanding. If you understand, and you show that you understand, the situation can change. (p. 223)

Early intervention with children who display disruptive behaviours can be viewed as prevention of substance abuse, mental illness and criminal activity before it begins. It needs to include reducing the risk factors that are acting as maintaining influences, reducing vulnerabilities and increasing protective factors (Pagliaro & Pagliaro, 1996). For example, in a case where a child is faced with peer rejection, intervention may include applying an anti-bullying program in the school (maintaining influences) and providing peer relation skills and/or play monitoring to reduce the chances of peer rejection (reducing the vulnerabilities and increasing protective factors). Durlak (1997) claims that youth who have had negative maintaining influences in their past never develop a strong sense of psychological well-being, high self-esteem, or coping and social skills. However, much can be done early to reduce the chances of maladjustment and to promote mental health and stability in young people.

Research suggests that early intervention needs to focus on strengths and to empower youth by placing absolutely no blame on their behaviours (Walters, 1998). Intervention needs to be tailored to the child's needs, and effort needs to be placed on

restoring the child to normal or optimal state of mental health or behaviour adjustment. Rhule (2005) claims that intervention needs to focus on problem-solving and cognitive skills, so that children with behavioural problems learn to adjust to, deal with, or resolve conflicting and traumatic factors. Walters hypothesizes that skill development is an essential ingredient of lifestyle intervention.

#### *Intervention Strategies: Current*

Research suggests that the ideal situation to identify early disruptive behaviours is within the school system. However, it is difficult to find resources that suggest a process for identifying, assessing and providing treatment at an individual and tailored-to-need level. Hood, Lawrence, and Shamsie (2006) claim that schools are reluctant to release data on behavioural problems among their students because many school boards lack a uniform system for collecting and reporting this information. Hood et al. suggest that teachers are best placed to identify students' emotional and behavioural difficulties, which may act as indicators of future problems.

Some of the early prevention programs in schools lack appropriate goals and do not focus at an individual basis (Pagliaro & Pagliaro, 1996). The existing programs in some schools work on prevention as a whole through slogans such as "Zero Tolerance" or "Say No to Drugs. Such approaches may be effective for the normal developed and healthy child, but addressing the whole does not address individual needs (Pagliaro & Pagliaro). Some schools approach the problem through anti-bullying programs, which do serve to identify bullies and help their victims; however, they do little to stop a bully from being a bully, because they do not fully explore the reasons behind the bullying behaviour. Perhaps the bully has negative maintaining factors at home and feels like a

victim in his or her world; therefore, he or she reacts by expressing power over others at school.

Some of the literature ties into Freud's theory that repressed memories affect behaviours and well being later on. However, it is difficult to find research on methods of practice that demonstrate individual intervention and treatment for children in schools, or methods that address concerning issues before they become repressed and damage lives.

#### *Intervention Strategies: Potential*

As the literature review demonstrates, schools should consider the idea of a service that would provide individual, early intervention for children of elementary school age who display disruptive behaviour. This proposed service would identify children who may have future adjustment problems and provide intervention that focuses on the maintaining influences that contribute to their problematic behaviours. The service should include a caseworker that incorporates rapport building, continual assessment, intervention, family work, case management and be of long duration. The service should also refer children and their families to, and connect them, with community resources and other service providers.

#### *Rapport Building*

The caseworker needs to spend time with the child each week through 1-1 sessions. Spending continual and efficient time with the child enables a trusting rapport and a healthy working relationship to be established, which then facilitate more effective assessments and intervention needs (Barkley & Mash, 2006). The largest gains that children make while working with professionals occur when there is a healthy working relationship between the two (Barkley & Mash, 2006). Effective communication that is

built on trust is a key to understanding a child and his or her situation and/or concern (Department for Children, School, and Families, 2005).

Rapport building can be an essential ingredient in early intervention with children who display disruptive behaviours and can aid towards prevention of substance abuse, mental illness and criminal activity. When a case worker can provide on-going and consistent rapport with a child, it increases protective factors that are deemed an integral part of early intervention (Pagliaro & Pagliaro, 1996). Many children who have negative maintaining influences in their life become less likely to develop a strong sense of psychological welfare, high self-esteem, or coping and social skills (Durlak, 1997). Research suggests that early intervention needs to focus on strengthening and empowering the child; therefore, a strong rapport between caseworker and child can create opportunity for increase in skills and well-being (Walters, 1998).

#### *Assessment*

It would be most effective for the caseworker to utilize a biopsychosocial approach, which explores the biological, psychological, and social factors, to understand the child's situation or concern more fully from an interrelated system (Sarafino, 2006).

*The biological factor.* The biological aspect of the biopsychosocial approach explores factors such as possible health and physiological concerns that may have a negative impact on the child's well-being and contribution to his or her 'acting-out' behaviour. For example, studies demonstrate that the nutritional status of children has a direct impact on their growth rate, maturation, and overall physical and psychological well-being. These factors can negatively affect long-term outcomes of later health, psychological stress, and cognitive functioning (Panter-Brick & Worthman, 1999). The



lower nutritional status in early childhood that has been demonstrated to effect cognitive outcomes often results in negative behaviour patterns in school (Saracho & Spodek, 2006). Researchers have found that children who are disruptive in early childhood are more likely to be rejected by peers. Peer rejection or lack of friends in early childhood puts children at risk for adjustment problems, depression, and delinquency in adolescence (Barker, Pedersen, & Vitaro, 2007).

At the surface level, a malnourished child may easily be improperly assessed as a child who just acts inappropriately and, because of this, has no friends. Therefore, intervention may consist of behaviour modification for the inappropriate behaviour and even blaming the child for how he or she acts, both of which miss the true source of the problem --malnutrition. The biopsychosocial approach allows all the individuals who are involved in the child's life to have a fuller understanding of the child's situation from all the interrelated aspects that may be negatively impacting his or her development or health. These may involve biological factors, such as a possible allergy to certain foods that limit the nutritional intake throughout the day; therefore, intervention may include having a nutritionist discuss food supplements or vitamins with the child and parents, and ways to provide the nourishment that the child needs.

*The psychological factor.* Understanding the psychological factors, such as the child's experience and behaviour, allows those involved in the child's life a better understanding of the presenting or progressing concern. For example, body image can play a huge factor in behaviour patterns among children; children as young as six may be at risk for depression due to poor body image (Carlsen et al., 2006). When a child demonstrates a biological concern such as malnourishment, further psychological

exploration may indicate that the child is purposely not eating adequately in fear of gaining too much weight, in an attempt to gain approval from friends, or perhaps the child does not feel hunger due to symptoms of depression. Depressive disorder has been found to be a major characteristic of youth in the juvenile system (Fisher et al., 2003). Often such problems developed from situations in early childhood that could have been detected then with assessment and treated through intervention.

*The social factor.* Longitudinal studies have demonstrated that behaviour patterns and personality are established during the early formative years (Ball, 1962). Young children behave according to their influencing environment. When situations are stressful or traumatic, children will display problematic behaviours that resemble their environment (Walters, 1998). Thus it is important for all those involved in a child's life to explore the social factors in the biopsychosocial approach in order to understand the influencing external factors that play a role in the child's behaviour (Sarafino, 2006).

Equally important, patterns of behaviour from early childhood will usually remain when environmental factors continue to influence. Therefore, behaviours that have continued from early childhood actually cumulate or snowball into later lifestyles. Long-term negative influences in a youth's life are factors that could develop into unhealthy behaviour, drug use, and/or crime (Walters). The continued pattern of problem behaviours often causes youth to have low self-concept or self-worth, and in turn can increase the possibility of further criminal activity, school failure, and/or substance abuse (Healey et al., 2001). Numerous issues can negatively impact a child's life, which becomes the influencing factor leading to problematic behaviours. For instance, some children may experience fear and grief and can encounter mental health concerns when

parents are in high conflict. Such experiences may become sources of behaviour problems, such as, aggressiveness and/or demanding (Peterson & Zill, 1986). Severe sibling conflict can lead to poor adjustment outcomes in pre-school and elementary school-age children, which can progress to psychological maladjustment disorders, such as anxiety, depressed mood, and delinquency in adolescence (Briggs, Burwell, & Stocker, 2002).

Another issue relating to these outcomes is child maltreatment. Significant evidence demonstrates that histories of maltreatment in children account for the elevated symptoms of depression, anxiety, posttraumatic stress, suicidal ideation, other clinically significant mental health problems and delinquency in adolescence (Pittman et al., 2001). The Health Council of Canada (2006) states that one in seven Canadian children have mental illnesses, many of which emerged in early childhood and will persist with greater intensity into adulthood.

In the scenario of the malnourished child, a possible social factor could be that the parents are very busy and, therefore, rely on fast foods as the main source of meals for the family. Part of the intervention may involve the case worker making a referral to a nutritionist or health nurse so that the family may learn more about the importance of nutrition, especially in the early childhood years.

The biopsychological approach focuses on creating awareness of what is occurring for the child that makes him or her behave in a negative manner and possibly progress into later maladjustment of criminal activity, substance abuse and/or mental health issues. When all concerned become aware of the child's concern, either in the biological, psychological and/or social form, intervention can be implemented to create

possible change and a possible healthier future. Intervention may consist of a number of components. It may involve psychoeducation; for example, a child of a parent with a mental illness may need to learn about the signs and symptoms of mental illnesses so that he or she can have a better understanding of what the parent is going through. It may include skill enhancement; for example, a child may demonstrate inability to deal effectively with conflict. Another ingredient may be support; for example, the child of a parent with a mental illness may find he or she needs to develop coping skills, discuss emotions, or join a support group. Intervention will generally include counselling; for example, a child who demonstrates anxiety or phobias may benefit from cognitive behaviour therapy to understand his or her underlying thoughts. This approach may also involve referrals. A multi-agency approach may include working with different services, agencies, and teams of professionals to provide services that meet the needs of the children and their families. In addition, a team approach may involve schools, professionals and parents/guardians, all working together to meet the child's needs.

#### *Including the Family*

This proposed form of intervention must also include the family. Families are recognized as the primary care giving context for young children. Therefore, all early intervention policies and programs need to look to the family or caregivers as important mediators for developmental outcomes (Keilty, Phillips, & Shonkoff, 2000). Achieving efficient, long-lasting working outcomes with a child involves effective work with both the child and his or her caregiver(s). This work includes listening, understanding, and responding to the child's needs (individually and culturally), as well as involvement in

the design and delivery of services that incorporate their opinions and perspectives from the onset (Department for Education and Skills, 2005).

Professionals who work with children identify that the main goal of childhood is to become an effective person, which includes being able to get along with others and to work productively (Booth & Crouter, 2003). Children need to acquire a variety of skills, such as the ability to initiate and maintain appropriate interaction, to form and sustain relationships with a wide variety of people, and to access, understand and use social and academic knowledge in order to be productive as students. The research literature indicates that, when infants or children display difficult and challenging behaviours, these impact the parenting ability, behaviour, perceptions of their child, and the overall temperament of the family (Booth & Crouter). When children demonstrate significant difficulties in any of the component skills described above, they are often viewed as problematic due to the observable behaviours that often accompany these difficulties. Most often the intervention consists of behaviour modification alone, intended to reduce the negative behaviours and to promote more effective behaviours. However, including the role of the caregivers opens the door wider for a more multidimensional focus that will promote change in the additional domains that affect the child (Booth & Crouter).

Any problem is multidimensional, and it is important to examine each dimension in order to work out an appropriate intervention plan. In order to increase the probability of achieving a successful, long-term outcome for children with problematic behaviours, there needs to be improvement in the understanding of the multiple factors that have contributed to the influencing environment. These might include the history of parental nurturance, beliefs, parent-child interaction, competence, psychological, and biological

factors (Iwaniec, 2004). Studies demonstrate that, when caregivers are focused on and provided with intervention needs, there is a greater likelihood of attaining a meaningful, positive effect (Bierman, Coie, Greenberg, Lochman, & McMahon, 2007). Along with the need for intervention for the child, intervention for the family needs to be tailored to the many different issues using various methods and techniques (Iwaniec, 2004).

Caregivers may have individual needs, such as the need for parent training skills, support groups, or referrals to additional services. However, to fully understand and address the multiple factors aiding to the problem, meeting with the family as a whole can assist the caseworker in viewing and seeking solutions to the problem through a multidimensional lens, thus alleviating the problem as an independent variable (the child, or a particular caregiver).

Family counselling can be based on a number of theories; however, they all attempt to discover the multiple factors that aid to certain problems (Goldenberg & Goldenberg, 2008). Regardless of the type of theory, the therapy is guided by the need to build rapport with the family and to explore how the caseworker can help both the child and the family to function more healthily. Some assessment information during rapport building can be utilized to understand clients' emotional state, environmental factors that contribute to the problem, self-view, and relationships with others, in order that conclusions about their concerns may be considered in the development of intervention plans (Hackney & Cormier, 2001). At the same time, assessment can generate awareness about clients' skills, strengths and resources, which may help them to implement goals and decision-making to create healthy change (Hackney & Cormier).

Bohart and Tallman (1999) stress that the primary curative factor within the counselling process is the relationship between the clients and counsellor; this relationship can provide a safe space within which they may explore behaviours and receive reinforcement. Assessment procedures can be seen as the collection of information through observation, responses to questions, role-playing, and interviewing others that are relevant in the client's life (ERIC, 1999). A sound assessment procedure benefits both the family and the counselling process because it allows the caseworker's focus to remain on rapport building and working alliance, while through gentle questioning the caseworker gathers relevant information (Hiebert, 1996). The family may be hesitant about counselling and apprehensive about the process; however, client-centered conversations allow the members to think about their problems, possible learning outcomes and counselling expectations in an environment that enhances rapport building.

*Cognitive behavioural therapy.* If cognitive behavioural therapy (CBT) is utilized to work with a family of a young child with problematic behaviours, the therapist acknowledges that a type of family environment occurs because members are maintaining specific beliefs and expectations about their relationship; therefore, they feel negative about the family unit because they stay committed to the characteristic errors of thinking about themselves, the world around them and their future (Goldenberg & Goldenberg, 2008). The family's relationships, cognitions, emotions, and interactive behaviours all influence one another; therefore, the therapist's goal is to facilitate self-disclosure to reveal members' ideas, attitudes, beliefs and emotions to enhance a better understanding of one another (Alden, 1989). When the families can learn each other's

schemas around issues like the types of problems that occur within the family, or how the relationships should look, then the process of cognitive restructuring can help the members to restructure their thoughts and modify their perceptions to allow the production of healthier schemas, which will then alter behaviours (Goldenberg & Goldenberg).

The therapist may incorporate circular questioning during the assessment process in order to gather deeper information about the family's situation and to introduce active reflective thinking about belief systems and meaning (Goldenberg & Goldenberg, 2008). The therapist would most likely begin with 'future-oriented questioning' to help the members identify what the family looks like and their definition of how it is functioning. Using reflexive-type questioning helps to promote reflective thinking about individual perceptions, actions, and belief systems, encouraging the members to consider alternate constructive cognitions and behaviours (Goldenberg & Goldenberg).

During the initial session, the counsellor facilitates communication by utilizing a circular questioning technique with reflexive questions in order to gain more information about the family situation and to encourage active reflective thinking by the members. The dialogue may be similar to the following:

Counsellor: How do you know when your family is functioning in a positive manner?

Mom: When there is equal interest among all members and not just one person trying to pull us all together or deal with difficult situations.

Counsellor: Does another member have any thoughts to what mom just said?



Through this discussion, it may be learned that 'Dad' agrees that all the family members do not spend enough time with each other, but he also identifies that most mothers do not work and are home more to deal with family issues. The son (the one with the problematic behaviours) may think that the ideal family does not yell at each other so much and that children do not feel that they are the ones who are at fault for the family's misery. The daughter may agree that most families do not argue as much and that that most children do not feel ignored or that their sibling gets all the attention.

The cognitive behavioural therapist would recognize that each member has developed negative schemas that continue to organize their thoughts and perceptions. Therefore, when new situations arise within the family, the negative schemas become activated and continue to shape negative behavioural outcomes (Goldenberg & Goldenberg, 2008). The counsellor may identify that the mother believes she has the only invested interest in the family outcome and is frustrated that she has the sole responsibility to take care of everything (i.e., work, chores, family issues, and all of her son's behavioural issues at school and at home). It may be identified that Dad has personal schemas about what a family should look like based on his cultural upbringing; therefore, even though he encouraged his wife to work at the beginning of their relationship, he now believes that his wife should be at home. It would be important for the counsellor to explore culturally based beliefs between the mother and father, because doing so would allow them to identify these beliefs within themselves and to have a better understanding of each other's expectations.

The importance of gender differences in cultural intergenerational roles was highlighted in a recent study comparing men and women (Marriage & Family

Encyclopedia, 2008). For instance, many Asian cultural beliefs view women as primary family caregivers, and motherhood assumes a more central role in the lives of these women than fatherhood does in the lives of the men; that is, women are socialized to be more expressive than men and are more likely to assume the "kin-keeper" role in the family. On the other hand, westernized societies are considered to value autonomy, independence and the ability to get things done on one's own, and thus they encourage children to act autonomously and demonstrate initiative from an early age (da Silva & Wise, 2007). The term *parental ethnotheories* was developed to help explain cultural differences in parenting. It refers to the collective beliefs held by a cultural group about family, childrearing, and behaviour, beliefs that derive from parents' cultural experiences and beliefs (da Silva & Wise, 2007). The cognitive behavioural therapist may note that certain beliefs and expectations may have derived from individual cultural backgrounds and effect how the parents behave towards each other and their children. Therefore, their individual schemas about the family and relationships also influence how the members interact and behave.

Flannery-Schroeder et al. (2008) suggest that, when parents experience stress between themselves, it can promote stress and anxiety-type symptoms that they may then project onto their children, creating a family atmosphere of avoidance and turmoil. Therefore, a son may have negative schemas about himself that preclude that he is to blame for a lot of the family problems because of his continual pattern of acting-out behaviour, and a daughter's negative self-schemas may be that she is unimportant within the family unit. Family cognitive behavioural therapy attempts to modify beliefs and expectations so that the family can learn to communicate more effectively and support

with one another (Flannery-Schroeder et al.). This type of therapy attempts to restructure cognitions to help the members modify their perceptions, allowing them to produce new self-statements (Goldenberg & Goldenberg, 2008). A mother may learn to state, “It is tiring that I juggle a lot of things in my life, but these things are important to me and it does not mean that we cannot find time to enjoy each other.” A father may change his statement to this: “I do feel sad at times that my family does not follow my cultural norms, but it does not mean that my culture is not important and I can find ways to put some of my culture into my family.” Their son may state, “I feel sad when my family yells at each other, but it is not my fault when we do this.” Their daughter may say, “I do not like that I do not get as much attention as I wish, but I know I can always ask my Mom or Dad to do something and they would usually say yes.” Thus the focus of therapy is to provide the family members with experiences, both during sessions and outside of sessions through homework that disconfirm the negative conclusions and attempt to alter the members’ schemas (Goldenberg & Goldenberg).

A cognitive behavioural family perspective identifies that people’s ability to have a healthy functioning family is influenced by the processing of information, which then has an impact on behaviour (Beck & Weishaar, 2005). For example, when a mother identifies herself as “the one with all the responsibilities,” she continually directs herself towards this understanding by how much effort she puts in, how tired she is, and how she doesn’t receive help or empathy from others in the family; therefore, she does not allow herself to enjoy her family or acknowledge their efforts. Cognitive behavioural theory would describe this mother’s negative perceptions as cognitive distortions, where she applies inferences on failure that have to do with her efforts, magnification of how her

efforts direct the family success and happiness, and personalization of how her unsuccessful situations are her fault for not being able to juggle everything. Therefore, the mother's efforts to achieve goals, success and happiness are thwarted by her own internal thought processes of being a failure because she finds it difficult to maintain what she views as her responsibilities.

The treatment objectives for cognitive behavioural therapy would be to emphasize how each family member's thinking developed from past experiences that relates to their present thinking and processing abilities. It is believed that addressing the individual's "biased selection of information and distorted interpretations" (Beck & Weishaar, 2005, p. 241) during therapy creates a cognitive shift from dysfunctional beliefs and unbalanced cognitive processing to healthier cognitive processing and beliefs. To create these cognitive shifts for the family and in a short period of time, treatment needs to address their present processing so that they can identify its lack of effectiveness for healthy functioning. Cognitive behavioural therapy will test and explore the origins of the family members' beliefs and work towards correcting faulty schemas through problem solving, goal planning and client change. Therefore, the main objectives for treatment in cognitive behavioural therapy are to deactivate dysfunctional thinking, to modify unhealthy schemas, and to construct more adaptive modes of processing healthier schemas (Beck & Weishaar).

A therapist using narrative therapy with a family would work towards identifying and labeling a problem, understanding how the problem affects life, detecting exceptions to the problem, and learning to create more exceptions to the problem so that the family members can develop specific strategies to improve their situation (Goldenberg &

Goldenberg, 2008). The therapist needs to keep in mind that this family has most likely been referred by a teacher. Consequently, there may be some initial resistance. Initial interventions need to have low levels of directiveness in order to reduce the resistance by decreasing the threat, the reminder of the referral source, and enhancing client control (Cormier & Nurius, 2003). Usually a non-directed approach allows clients to feel less resistance. The counsellor can then apply more-directive interventions such as structured assignments during the course of therapy (Cormier & Nurius).

*Narrative therapy.* Narrative therapy aligns with the progression from non-direct to direct intervention strategies. The therapist listens to the family's history and current experiences that would assist them to learn about themselves (e.g., "I want to feel close with my family"); to identify the problems (e.g., "We are so busy and we do not make time for each other"); and to recognize how they construct meaning and whether they help or hurt development of family identity (Egan, 1990). Narrative therapy allows the family to feel that they are in control of the process, which helps to lessen resistance to therapy and enhances the working alliance with the counsellor (Cormier & Nurius).

Narrative therapy can be utilized to encourage and assist each family member to share his or her story. The attentive listening, questioning, and guidance of a narrative therapist helps clients to discuss the different stages of their lives, their perceptions about themselves, their relationships, and the effects that concerning issues have on their situation and family (Combs & Freedman, 1994).

Narrative therapy can assist family members to see different perspectives by listening to what each has to say; for example, who they are (i.e., tired mom, worried dad, blaming son, and confused daughter), and what they want to be (i.e., a respected mom, a

dad whose culture is acknowledged, a good son, and an important daughter). The process of narrative therapy can help clients deconstruct their stories about themselves through questioning and reframing, so that they can see their situation from a different perspective (e.g., “I do not push my family away with my work; I am angry that I do not feel respected for wanting both a career and family”) (Combs & Freedman, 1994). This process may assist the family to label the problem (e.g., “We do not take the time to understand what is going on for the other members”). Therefore, they are able to externalize the problem and understand that it is affecting their behaviour and choices (e.g., “When we do not understand another member’s perspective, we only see our own ‘side’ of the story; therefore, we ‘push’ the members further away”) (Combs & Freedman). This process encourages family members to identify alternate choices in their lives and possible goals that support their preferred outcome and ideal selves (e.g., “If I ask for help from the rest of the family members, I would not feel as bogged down with responsibility and it would free me from some stress and time that I could spend doing family things”).

Egan (1990) stressed that the essential starting point in therapy is to focus on the individuals first and then the problem. Narrative therapy allows each family member to discuss information that they consider important in life. This enables them to consider how they live, what they believe, and what skills and strengths they possess, all of which aid in identifying the problem (Egan). Many clients enter counseling with reluctantly and with resistance, not seeing any ‘problem’ in their lives. Narrative therapy provides them an opportunity to be the expert and to be in charge of the therapy process, so they feel less threatened or judged (Selekman, 1993). It encourages clients to identify, explore, and

clarify their problem situations and unused opportunities so that they can learn to grow and change (Egan).

Narrative therapy involves three main steps that a therapist may take with a family to ensure that the process is working for them. The therapist progresses from one step to the next in the different stages in the intervention, observing and evaluating the changes in the clients' behaviours and abilities.

The first step is to help the family members tell their story. This is important because it is difficult for the counsellor to be of service and guide the process towards goal achievement if they fail to develop an understanding of the difficulties and possibilities in their life. In addition, they cannot grow or change the problem without understanding it first (Egan, 1990). The counsellor may need to use enabling communication skills for the more involuntary client (such as the daughter described above) to help provide support and to help her tell her story (Cormier & Nurius, 2003). The counsellor listens and assesses the information (nature and severity of the problem, hints about further problems, impacts on the family environment, interpersonal and environmental resources that they can access, and opportunities) to guide further discussion and exploration of the family's situation (Egan).

The second step is to identify and challenge individual members on their "blinded perceptions" in order to develop new perspectives of themselves and their problem situation so that they can move beyond their subjective understanding of the problem situation. For example, the mother may discuss that she feels tired and unsupported because she learned this pattern from her parents; therefore, she feels she is expected to resume the "wonder-woman" role. Applying the second step of narrative therapy

intervention, the counsellor may challenge the mother's perception of her problem by asking her an open-ended question about what "doing it all" means for her. With this new perspective, the mother may begin to explore alternate reasons for her need to "do it all" (e.g., wanting to escape from feeling as inadequate as she did when she grew up, or feeling disappointment when comparing herself to her husband's mother). In this step, the counsellor can assign out-of-session homework for the mother, where she can take note of times when she feels unsupported and identify what emotions, feelings, or thoughts are occurring. Egan (1990) notes that it is difficult to move out of the problem if one cannot view it from a different perspective and away from self-defeating patterns of thinking and behaving. A circular questioning technique could be incorporated during this step to allow the other members to reflect on each other's narrative perspective and gain insight into how their own behaviour influences others (Goldenberg & Goldenberg, 2008). For example, the counsellor may inquire further during the daughter's narrative about what she is experiencing when her mother is busy. The daughter may discuss that she often does things on her own, but through hearing her mother's and her own narratives, she may begin to restructure her story by acknowledging that she does not offer to help her mother with chores.

The third step of narrative therapy is to identify and work on a problem, issue, or concern that will make a difference in the family's life. It takes some time for the therapist to determine and address the different problems that may arise during the discussion. The family members need to decide which one will be dealt with first, which one is the priority, or which one, if managed properly, will contribute best to addressing the family's problems. For example, through the discussion, the father may identify that



the problem in his life is that he does not feel a sense of culture connectedness and wishes that his family took more interest in his Japanese heritage. With further exploration, he may discover that his personal lack of cultural ties is a main problem and is a contributing factor to the other problems in his life (e.g., feeling grumpy and resentful towards family members) and that working on this problem needs to be the priority. Again, circular questioning could be incorporated to involve other members' views and how they contribute to the problem. Therefore, the mother may learn through listening to her husband's and her own narratives that she considers the family to be westernized because they live in North America and have closer ties to her side of the family.

Regardless of the therapeutic approach used, the purpose of incorporating the family in session is to allow them to gain awareness about how each member affects the others with his or her beliefs and behaviours. They can then learn how to create a healthier functioning atmosphere that supports and nurtures growth. Treating the family coincides with the multidimensional approach to helping a child with problematic behaviours. It creates an opportunity for the therapist to diagnose and provide referral information for the additional risk factors that can negatively impact the child and his or her family, such as extreme economic deprivation, family conflict or disruption, parental psychopathology or drug use, or severe sibling conflict. According to Liddle (2002), risk factors do not exist or operate in isolation. Multiple risk factors interact over time and have a cumulative impact and synergistic effects that yield higher levels of risk, deteriorating functioning, and fewer developmental enhancing opportunities (Liddle, 2002). Therefore, the earlier the identification of a child with problematic behaviours and

the application of intervention to him and his family, the better the chances for prevention of later child maladjustment and for a healthier outcome.

### *Case Management*

Case management provides a wraparound service that enables the child and the family to receive solid, practical support while they learn to function differently. It involves caseworkers, who take on a number of tasks to address the multiple factors that may be adding to a child's and family's issues. The first task involves obtaining an initial assessment of the child and family, which provides a baseline of their behaviours, skills, and knowledge. In addition, caseworkers must continually monitor the child's school attendance, services obtained, and progress, in order to understand the changes and/or further services that are required (Liddle, 2002). They must maintain active contact with the school and team to ensure that intervention plans are being met and that any needed changes are being implemented. In addition to the individual support and/or therapy provided to the child and family, caseworkers may need to provide further referrals or advocacy for alternate services. Consequently, they need to have a thorough understanding of all the resources in the geographic area that would be useful in treatment (Liddle). For example, caseworkers may need to be aware of different schooling options for the child, such as alternate schools or tutoring programs. They need to be aware of job prospects, pro-social support, economics, and medical services in order to provide additional successful opportunities for the child and family. In addition caseworkers need to know about available job training programs, vocational education programs, mentoring programs, parent groups, Alcoholics or Narcotics Anonymous,

after-school activities, food banks, income assistance, housing, shelters, medical and dental programs, and family planning or counselling services.

Case management needs to follow a multidimensional framework so that caseworkers may learn about how the child developed and where and when the problematic issues interfered. This framework allows for a thorough understanding of the risk factors that add to the problem for the child and/or family. For example, childhood problems can be due to several domains in history, such as school, neighborhood, peers, community, and society. At the systemic level, risk factors may be due to extreme economic deprivation, while proximate and individual ones may be due to family conflict, disruption in family management, parental psychopathology or drug use, child's failure to bond in school, problems with emotional regulation, poor interpersonal skills, and/or peer rejection (Liddle, 2002). Avoidance of such conflictual topics and negative interactions are common coping behaviours in families; however, these can set the stage for further issues, such as inconsistent parenting, increased frustration and increased problematic behaviours in children.

The purpose of case management is to ensure the increase of protective factors by ensuring that the proper intervention plan is developed, implemented, monitored, and assessed. By incorporating case management into the situation of a child with problematic behaviours, it will help to ensure that he or she is getting and maintaining the services needed that facilitate the steps towards the possible prevention of substance abuse, criminal activity and mental health concerns.

### *Multi-Disciplinary Team*

The early intervention strategies that are identified in this literature review demonstrate the need for other service providers to be involved directly with the child and/or with the child's family members. A multi-disciplinary approach works to include all possible services needed to benefit the child and his or her family in terms of their medical, developmental, family and environmental needs. As discussed earlier, a child's needs are affected by the surrounding environment; therefore, the focus for change must not emphasize only one domain (the child), but rather change in all the surrounding domains (family, school, and so on). In determining a child's interrelated system, it is imperative to identify the multi-factual system that relates to the individual system (Iwaniec, 2004).

While the caseworker would arrange for and coordinate the management of all the services, all the additional service providers need to have continual dialogue pertaining to the child and his or her family's progress and needs. When the team has a full and continual understanding of the child's progression and possible further needs, it will most likely lessen the possibility of later maladjustment. With the family's permission, the team of service providers (including the family) would keep one another informed with relevant information pertaining to the case, so that each member of the team understands the others' intentions and services. The team approach would help eliminate duplication of services so that the child and the family can receive the maximum benefit from each.

### *Duration of Intervention*

This project demonstrates the need for intervention to begin as early as possible in a child's life in order to disrupt the escalation of problematic behaviour patterns to later

maladjustment. It has been identified that behaviour patterns develop over the duration of the child's lifespan; therefore, it is not expected that intervention be of short duration. In fact, there has been less reliance on short-term treatments for the prevention of long-term mental health concerns (Walker, 1999). Research demonstrates that short-term treatments for early childhood problems are not effective in many cases (Walker).

As Nix (2003) indicates, all factors influencing a child's life, such as cognitive development, social-emotional behaviour and parent-family wellness, co-occur; therefore, if there is a problem in one area, it will create a problem in another. The benefit of incorporating long-term intervention for early childhood problems is that it provides the opportunity for assessment and monitoring of the child's influencing factors. As well, the child's progression in behaviour and skill development can be monitored and/or future services that may need to be put in place can be identified and implemented. The advantage of a longer intervention strategy for children with problematic behaviours is that it will remain with the child until he or she demonstrates a significant change in behaviour and situation, that is, until the child is identified to be functioning in a healthy manner and will most likely develop into a well-balanced adolescent.

### Chapter 3. A Case Scenario

As discussed, early intervention with children who display problematic behaviours can prevent the later development of further maladjustment. In order to demonstrate the process for early intervention with such children, a brief hypothetical case scenario is described, followed by the suggested steps and strategies to be followed.

#### *Case Scenario: Alex*

Alex is a 6 year old male in a grade one class at X Elementary School. He entered X school at the end of kindergarten because he changed schools after his mother and father divorced. Both parents agree that the divorce was long overdue; however, they had tried to remain together as a couple and family for the children's sake. Last year Alex's mother moved to the X community. Alex lives with his mother and older brother by five years, and he visits his father on weekends. Alex's current grade one teacher identifies Alex as a challenging student; she stated that he continually disrupts the class with his angry outbursts of not wanting to do his schoolwork. Alex's kindergarten teacher from X school stated that for the short time that she had him in class, he appeared uninterested in learning and would often complain about the other children; for example, he did not like the games the other children played during centre time or the partner he was with for project work.

Alex's kindergarten teacher from his previous school (prior to the divorce) stated that Alex was often sent to the principal's office or given yellow slips for his aggressive behaviour towards other students, both in class and on the playground. Alex's parents appear concerned about his behaviour; they have limited time to come to the school due to their employment situations and schedules. Both parents believe that Alex's problems

are due to the divorce, as they both have less time to spend with him now that they are separated in two homes. The parents stated that Alex's older brother has appeared to adjust well to the new family situation. He is doing well in school and with peers; however, he picks on Alex frequently (i.e., punches him and verbally puts him down). Since the brother's behaviour towards Alex has been an on-going issue, the parents do not see it as resulting from their divorce.

#### *Alex's Developmental Stage*

Alex is in the childhood developmental stage (age 4 to 8) where his actions are based on how he perceives the world, and he is influenced by his surrounding environment (Cooper, DeHart & Sroufe, 2000). According to developmental theory, nurture played a definite role in Alex's behaviour patterns and helps to develop and sustain his behaviour patterns (Corsini, 2005).

Alex's home situation represents some stress and disruption patterns that may directly impact his functioning and behaviour at school. Alex is experiencing a family break up, and in addition he may have experienced parental conflict prior to the actual divorce. Research demonstrates that some children may experience fear and grief and can encounter mental health concerns when parents are in high conflict; therefore, these experiences may become sources of behaviour problems, such as aggressive or demanding behaviour (Peterson & Zill, 1986). It was also indicated that Alex's brother has picked on him for some time. Other research indicates that severe and ongoing sibling conflict can lead to poor adjustment outcomes in pre-school and elementary school-age children, outcomes which can progress to psychological maladjustment disorders such as anxiety and depressed mood (Briggs, Burwell, & Stocker, 2002).

Sheldon (2001) claims that intervention should not focus on the child's disruptive behaviours as a problem, or label the child as bad, disturbed or aggressive. Sheldon states that labeling and identifying the child as the problem acts as punishment, when the focus needs to be on the actual source of the problem -- the maintaining factor or influence. Young children such as Alex are less likely to fully develop physical, academic and emotional functions when their home life is unhealthy or dysfunctional, compared to children whose home life is not disruptive (Shamsie, 2006). Research demonstrates that when young children are subject to high levels of stress, as Alex is, they may develop emotional disorders that result in anxiety, impulsiveness, refusal to follow directions, and/or aggressive outbursts (Frank, 1982).

The Canadian Mental Health Association (2006) explains that high-risk behaviour problems in childhood, such as aggression and refusing to cooperate, need serious attention. When these behaviours form a repeated pattern over time, intervention is necessary. Intervention for children with such issues at this developmental stage must be tailored to their needs. According to Rhule (2005), the focus must be on restoring them to a normal or optimal state of mental health or on behaviour adjustment; that is, a focus on problem-solving and cognitive skills may help children like Alex learn to adjust to, deal with, or resolve conflicting and traumatic factors. Intervention needs to include reducing the risk factors that are acting as maintaining influences, reducing vulnerabilities and increasing protective factors (Pagliaro & Pagliaro, 1996). In Alex's case, exploration is needed into factors in his environment that may be negatively influencing his emotions understanding, and ultimately behaviours.



### *Rapport Building*

Based on the information presented by the parents and teachers, it appears that Alex has been labeled as a disruptive and challenging child. The attachment of labels to children often teaches them to view themselves accordingly (Sheldon, 2001). Therefore, it may be fair to assume that Alex identifies himself as bad, a problem, and/or worthless.

Through establishing a good rapport with Alex by listening to him and accepting him, the case worker can create a positive and safe working relationship where Alex may learn to identify himself in more positive terms. Spending consistent time to establish a trusting rapport and healthy working relationship with a child enables a worker to make large gains in allowing the child to open up and is key to understanding the child's concerns and situation (Barkley and Mash, 2006). Making considerable effort to empower the child and focus on his or her strengths will create a situation where the child will respond to the environment, enabling awareness and learning (Cooper, DeHart & Scoufe, 2000).

### *Assessment*

The literature review suggests that a biopsychosocial approach will be effective for understanding Alex's situation from an interrelated system. The next three steps in demonstrating early intervention for Alex will focus on his biological, psychological and social factors.

*The biological factor.* The assessment of Alex's biological factors would explore his historical perspectives pertaining to information provided by his teachers, parents and Alex himself. Based on the input from the teachers, Alex has had a continual pattern of disruptive, angry and non-compliant behaviour throughout his school involvement.

Alex's parents may have stated that there were no indications of problems during and since his birth; however, he has had troubles sleeping, frequent angry outbursts, and moments of complete withdrawal from family and peers for the last several years.

The parents may also report that on the father's side of the family (including Alex's father) there has been a history of depression and mood disorders. Research demonstrates that children of depressed parents are at high risk for depression themselves (O'Connor, 1997). Often parents feel that a child's behaviour is the source of their distress; however, more often the child is reacting or matching to the parents' moods (O'Connor). Some symptoms of depression in children include feelings of sadness, loss of interest in activities, irritability, poor performance in school, tantrums, and change in sleep habits (Health.com, 2008). In many cases, the source of childhood depression can be found in family dynamics (Health.com). Some of Alex's behaviours and his family's biological history make him predisposed to a high risk of developing depression; therefore, it would make sense to conduct a more in-depth screening for childhood depression.

*The psychological factor.* Understanding Alex's psychological factors, such as his experience and behaviour, allows those involved in his life to have a better understanding of the presenting or progressing concern. Malle (2004) noted that one's behaviour can be identified as either intentional or unintentional; it is then differentiated between reason and cause. Cooper, DeHart, and Scroufe (2000) stress that a child behaves according to his or her influencing environment; therefore, Alex's behaviours of anger, non-compliance, and withdrawal are in response to what he is internalizing from his environment. To explore the cause of Alex's behaviour, one would need to look at his

historical situations. Based on what is known about Alex's history, it is recognized that his parents have had conflict for some time, the divorce created abrupt living changes, his brother picks on him, and he has had a pattern of problems at school. As Peterson and Zill (1986) note, parental conflict, family break down, and abrupt changes can create fear and grief for a young child. Continual and severe sibling conflict has been demonstrated to create the progression of children developing psychological maladjustment (Burwell & Stocker, 2002). The continued patterns of Alex's problems in school make it highly probable that he has developed feelings of low self-worth or self-concept (Healey et al., 2001). Research shows that these types of experiences and influences will impact Alex psychologically and increase the possibility that he will behave in aggressive, non-compliant and demanding ways.

*The social factors.* Social factors will help provide a better understanding of the external influencing factors that play a role in Alex's behaviour. Based on discussions with Alex and his parents, it is clear that in Alex's environment he experiences conflict (i.e., parental, sibling and at school). Walters (1998) stressed that when a child's environment is stressful and traumatic, he or she will display problematic behaviours that resemble that environment. Equally important, patterns of behaviour from early childhood will usually remain when environmental factors continue to exert their influence. Therefore, behaviours that have continued from early childhood actually cumulate or snowball into later lifestyles. Long-term negative influences in a youth's life are factors that could develop into unhealthy behaviour, drug use, and/or crime (Walters). The continued patterns of problem behaviours often cause youth to have low self-concept or self-worth, and in turn can increase the possibility of further criminal activity, school

failure, and/or substance abuse (Healey et al., 2001).

### *Including the Family*

It is vital for the caseworker to include the family in order to discover the multiple factors that may contribute to the specified problems (Goldenberg & Goldenberg, 2008). The family's relationships, cognitions, emotions, and interactive behaviours all influence one another; therefore, the worker's goal is to facilitate their awareness, to work towards a better understanding of one another, and to identify how they can create better outcomes (Alden, 1989). It may be useful to identify for the family additional services that individual members may find to address their particular need. For instance, it may be beneficial for Alex and his brother to participate in a program for children dealing with divorce or separation. The mother may learn that she would benefit from learning time management skills or joining a support group for women dealing with divorce. The father may want to seek individual counselling or speak to his physician about his symptoms of depression. Meanwhile, bringing the family members together provides them the opportunity to let each other know what they are doing, and they can learn to work together and to support each other.

### *Case Management*

Aware of all the incoming and outgoing services for Alex and his family, the caseworker is able to continually monitor progress and/or additions and changes to the intervention plan. The caseworker conducts the initial assessment of the Alex and his family in order to provide the baseline of behaviours, skills, risks and knowledge. The caseworker must maintain active contact with the school and team to ensure that intervention plans are being met and that any needed changes are being implemented. In

addition to the individual support and/or therapy provided to the Alex and family, the caseworker may need to provide further referrals or advocacy for alternate services.

#### *Multi-Disciplinary Team*

The caseworker is responsible for management of all the services. However, all the additional service providers need to have continual dialogue pertaining to Alex and his family's progress and needs. With the family's permission, the team of service providers (including the family) will keep one another informed with relevant information pertaining to the case, so that each member of the team understands the others' intentions and service provided. The team approach helps to avoid duplication of services so that Alex and the family can receive the maximum benefit from each.

#### *Duration of Intervention*

Alex's behaviour patterns demonstrate the need for intervention to commence right away in order to create a higher probability of establishing circumstances in which Alex can grow into a happy and healthy youth. The history profile reveals that there are several outside influences impacting Alex's behaviour. In addition, he demonstrates the need for skill building and behaviour development. Clearly Alex and his family need to participate in different services. It will take some time for the caseworker to make the referrals, provide therapy, monitor on-going progress, and make any adjustments in the services provided. It will also take time to evaluate the effectiveness and sustainability of all the interventions. Therefore, the ideal duration of intervention for Alex will be the point at which it is identified that his problematic behaviours have ceased and he is dealing effectively with stress and conflict.

#### Chapter 4. Conclusion

It costs society millions of dollars to deal with such problems such as mental illness, drug abuse and criminal activity. As the literature review demonstrates, problematic behaviours in early childhood, regardless of how they developed, cumulate in a pattern of identifiable behaviours that may very well lead to such problems. Theorists appear to concur that the more dramatic the behaviour demonstrated at an earlier age, the worse the predicted outcome.

It is generally agreed that the maintaining factors in a young child's life are the influences that create behaviour, and that the continuation of maintaining factors will create the pattern of behaviours. Conversely, interrupting negative maintaining factors means interrupting the problematic behaviour pattern, which is the necessary change for a child in a problematic situation. This is similar to a health psychology approach in that it promotes healthy change in the present and maintaining or promoting the change in the future.

The need for this type of intervention is often identified at school, because children spend most of their waking moments in school. Furthermore, for many children, school is the first public setting in which they are viewed by professionals. It is generally believed that professionals who work with children have the responsibility to promote their well-being. Professionals need to be able to recognize when a child may not be achieving his or her developmental potential or when a child's health may be impaired, and to be able to identify and link appropriate resources to create the best opportunity for the child. It is important that concerns be identified as early as possible, so that children

and their families can get the help they need to ensure that the children have a higher probability of reaching their full potential as healthy, happy, and educated citizens.

A possible limitation to the proposed ideas of this literature review however, is the notion of change. Change is often difficult to implement especially into such a large system, such as the school system. Past research suggests that one of the biggest challenges is reforming a school system because change is not usually welcome (Kirkpatrick, 2008). However, it is also noted that there is a price to pay for not changing a system to meet the changing needs of the environment and the children within it (Kirkpatrick).

The positive notion about this literature review's proposed idea is that it is not expressing the need for an extreme and drastic change within the school system, rather an added ingredient that will enhance a better understanding of student needs and issues that promote long-term, effective growth and well-being. A suggested idea for early identification of children who are at-risk could be to conduct an automatic assessment to all children when they first enter school. A possible screening tool could be developed based on the identified risk factors (i.e., child in poverty, health factors...) that teachers could use to identify children whom they suspect need a more in-depth assessment and possible intervention. Research demonstrates that children before the age of 8 require specialized instruction and learning environments in order to properly set the tone for future learning capabilities (Gullo, 2005). An early, initial assessment would serve for many purposes that could create an optimum environment for a child who could be at risk for later maladjustment. The benefits of the early assessment is that it would create an earlier understanding of the child's overall development so the areas that may need

specific help are identified and can be implemented at the onset (Gullo). When childhood problems can be identified within the early schooling years, the intervention guidelines that were discussed in this project can be incorporated to provide the full-range of services that would significantly increase the possibility of interrupting the escalating probability of later criminal activity, substance abuse and/or mental health concerns.

Intervention at an early age means the possibility of change for a child who may be experiencing trauma in his or her life, and change would most likely lead to greater happiness, better development, and improved health. If this opportunity is ignored, the child may 'slip through the cracks.' It is time to fix the crack!



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