HOW TO MAKE A VIOLENT YOUTH: IMPLICATIONS for PREVENTION and TREATMENT

Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo,
Ontario, Canada

Research Director of the
Melissa Institute for Violence Prevention
Miami, Florida

www.melissainstitute.org
www.teachsafeschools.org
www.warfighterdiaries.com

Contact Information
dhmeich@aol.com

Mailing Address
Donald Meichenbaum
215 Sand Key Estates Drive
Clearwater, FL 33767

Book Order Information
Treatment of Individuals with Anger Control Problems and Aggressive Behavior (Cost $65 CDN Funds - - Make check Payable to Don Meichenbaum)
TABLE OF CONTENTS

A Dynamic Cascade Model of the Development of Aggressive Behavior: An Overview

A Developmental Trajectory of Early Onset of Aggressive Behavior in Boys: A Cascade Model of Influences

Implications for Prevention and Treatment Intervention

Overcoming Violence: The Potential Role of School Psychologists - - A TO DO List

Selling Preventative Programs: Factoids

Supplementary Tables

Table 1 Who Is Most at Risk For Engaging in Aggressive Behavior at School?

Table 2 A Functional Analysis of Student’s Aggressive Behavior

Table 3 Programs and Policies That Aggregate Deviant Peers and that Should be Avoided, if Possible

Table 4 Effective Programs That Represent Viable Alternatives To Aggregating Deviant Peers

Table 5 Checklist of What Trainers Should Do At The Outset, During and Following Training In Order to Increase the Likelihood of Generalization

Table 6 Some Lessons Learned from Prevention and Treatment Intervention Research For Children/Youth with Disruptive Behavior Disorders (DBD)

Table 7 Treating the Juvenile Offender: Lessons Learned

Table 8 Principal’s Checklist: Needs Assessment
A DYNAMIC CASCADE MODEL of the DEVELOPMENT of AGGRESSIVE BEHAVIOR

(As Dodge et al. 2008 observe, each domain in the developmental sequence operates in concert to lead to violent behavior)

Genetic Vulnerability Contributions

↓

Adverse Social Context

↓

Early Developmental Risk Factors

↓

Cumulative Exposure to Victimizing Experiences

↓

Lack of School Readiness

↓

Development of Early Behavior Problems

↓

Academic and Social Failures

↓

Conceivc Parenting: Lack of supervision, monitoring and academic support

↓

Deviant Peer Association

↓

School-Board Policies and Involvement with Juvenile Justice System That Aggregates Deviant Youth
PHYSIOLOGICAL CONSEQUENCES

(See DeBellis, 1994, 1999; Lipschitz et al., 1998; Ornitz & Pynoos, 1989; Perry, 1994, 1997; Pynoos et al., 1995; Yehuda, 1997; van der Kolk, 1997; Weiss et al., 1999)

EFFECTS OF TRAUMA ON THE DEVELOPING BRAIN:
ILLUSTRATIVE FINDINGS

Physical abuse and neglect, but not sexual abuse has been associated with the reduction in certain regions of the corpus callosum (total midsagittal area).

Among children who have been abused there is a greater likelihood of neuroendocrine abnormalities and cerebral lateralization differences. For example, abused children are seven times more likely to evidence left rather than right hemisphere deficits, which contribute to developmental difficulties in language development. That is, there appears to be impaired left hemisphere functioning in traumatized children.

Exaggerated startle response

Increased responsivity of the sympathetic nervous system evident under conditions of stress (e.g., increased heart rate and increased blood pressure)

Trauma experience results in elevated levels of circulating catecholamines; elevated growth hormone in abused boys

Trauma affect the hypothalamic-pituitary-adrenal axis (HPA Axis). (The persistent re-experiencing may serve as an ongoing source of stress that affects the HPA functions.) Early stressors produce long-term dysregulation of the HPA axis and can result in differential response to stress and an increased vulnerability to depression in adulthood.

Increase susceptibility to disease (e.g., vulnerability to sexually transmitted disease)

Trauma can influence early development
WHY THE MELISSA INSTITUTE FOR VIOLENCE PREVENTION IS CONCERNED ABOUT CHILDREN’S READING PERFORMANCE

Donald Meichenbaum, Ph. D.

Research indicates that:

➢ School performance, more than any other single factor, is a major contributor as to whether a youth becomes involved in drugs or violence.

➢ Reading is a gateway skill for success in school. For example, reading comprehension level by grade three is one of the best predictors as to who will finish high school. Children who acquire literacy skill in the earliest grades tend to remain the best readers throughout their school years. Prior to grade three students are taught how to read in order to learn, from grade three on students are expected to learn using their reading skills.

➢ Children with low reading achievement in early grades (by Grade 3) have a greater likelihood of school retention, dropout, drug abuse, early pregnancy, delinquency, and unemployment.

➢ Some 13% of 17-year olds are functionally illiterate and this rate jumps to 40% among minority youth.

➢ About 10 million children in the U.S. have difficulties learning to read. From 10% to 15% of these children eventually dropout of high school. Only 2% complete a four-year college program.

➢ Low bonding to school is an important predictor of dropping out, as well as engaging in antisocial behavior. (For example, ask students the following question to tap their sense of belonging – “If you were absent from school, who besides your friends would notice you were not present and miss you?”)

➢ Among youth who get into trouble with the law involving courts, some 85% evidence reading difficulties.

➢ About half of youths with a history of substance abuse have reading problems.

➢ Incarcerated adolescents are on average 5 years below their expected reading level for their expected grade level.

➢ Up to 80% of incarcerated youth are functionally illiterate.
Poor readers are more likely to be incarcerated for crimes of greater violence than better readers, and they are three times more likely to be injured in a fight requiring medical intervention and more likely to miss school.

6% to 9% of students account for 50% of school discipline referrals. The number of discipline contacts with the Principal during the school year predicts arrest status in 5th to 10th grades. If a student has 10+ disciplinary referrals to the Principal’s office in a year, he is at serious risk for school failure, delinquency, drug and alcohol use. Up to 40% of school suspensions are likely to be repeat reoffenders. School aggressive behavior and substance abuse predicts weapon possession, gang membership, and substance abuse. Poor academic performance (especially reading difficulties) underlies many discipline referrals, antisocial behavior with peers who are similarly academically deficient, as well as chronic unemployment.

About 75% of America’s unemployed adults have reading or writing difficulty.
II. Skills Training Phase

See the Model of Mastery on how to teach skills. Address issues of generalization.

HOW TO TEACH SKILLS

See Meichenbaum & Biemiller, 1998*

THREE GOALS

1. TO TEACH PARTICIPANTS HOW TO PERFORM MORE AND MORE DIFFICULT TASKS (MOVER ALONG THE X AXIS)

2. TO TEACH PARTICIPANTS HOW TO PERFORM TASKS WITH MASTERY, EVEN TO THE POINT THAT THEY COULD TEACH IT TO OTHERS AND / OR BE THEIR OWN "COACH" OR "TEACHER" (MOVE ALONG THE Y AXIS)

3. TO TEACH PARTICIPANTS HOW TO APPLY WHAT THEY LEARNED TO NEW TASKS AND IN NEW SETTINGS, AND EVEN, DISCOVER AND INVENT NEW APPLICATIONS (MOVE ALONG THE Z AXIS)

FIGURE 2

MODEL OF MASTERY

- Self-Directon Dimension
- Planning/Application Complexity Dimension
- Near Transfer (Simple)
- Far Transfer (Complex)
- Consultation Role
- Consolidation Role
- Acquisition Role
- Simple
- Complex
- X (OVER)
- Y (UP)
- Z (Out and Back)

SKILL (and vocabulary) DIMENSION
IMPLICATIONS FOR PREVENTION and TREATMENT INTERVENTION

What could you do to:
1. Avoid teenage pregnancy, in the first place
2. Provide services to pregnant teenagers
3. Provide home-visiting nursing programs to high-risk families
4. Offer services to reduce the likelihood of victimization and provide treatment to victimized families
5. Nurture school readiness, especially in the area of reading, provide empathy training early in development
6. Provide parent-child training programs
7. Implement school-based early screening procedures to identify high-risk students and high-risk families
8. Create safe, inviting schools designed to reduce bullying and cyber-bullying; improve academic performance and nurturing a future orientation - - offer career counselling
9. Bolster resilience, provide mentoring programs that will build on the youth's strengths that lead to contact with prosocial peers and a bond with prosocial activities and institutions
10. Work with parents to improve supervision, monitoring, conflict resolution, and positive affective bonds, address family dysfunction and familial psychopathology.
11. Provide school-based interventions that are designed to reduce high-risk deviant behaviors such as dating violence, offer school-based mental health programs with “high-risk” students, provide media literacy courses
12. Provide evidence-based skills intervention in the area of anger and impulse control, empathy training and social problem-solving. Incorporating generalization guidelines in order to promote skills maintenance. (See Table 5).
13. Eliminate or minimize practices that aggregate deviant youth.
14. Build in evaluation procedures
15. Convince others that implementing such interventions need to be prevention-oriented, administered early in the development cycle, comprehensive addressing multiple risk factors. Moreover, there is a need to convince supporters of these intervention program that doing so will not only be effective and have salutary consequences, but it will result in significant financial savings.
### TABLE 1

**WHO IS MOST AT RISK FOR ENGAGING IN AGGRESSIVE BEHAVIOR AT SCHOOL?**

- Students with a past history of physical fights (either alone or with groups of students), been arrested (trouble with the law before age 12).
- Students who carry a weapon to school.
- Students who were injured and/or treated for aggressive acts.
- Students who use substances at school (alcohol, tobacco, cigarettes, marihuana, and/or sell drugs).
- Students who steal property at school and/or who damage school property.
- Students who are potential dropouts. Youths who are having frequent thoughts about quitting school (e.g., In one study, 34% of these students reported carrying a gun to school.)
- Students who are absent frequently (3 or more times without an excuse or without permission).
- Students who have been suspended 1 or more times.
- Students who feel unsafe going to and from school or at school; feel “threatened” and/or feel like a social outcast.
- Students who associated with like-minded peers and who are members of gangs. Peers carrying guns is one of the best predictors of students bringing guns to school.
TABLE 2

A FUNCTIONAL ANALYSIS OF STUDENT'S AGGRESSIVE BEHAVIOR

1. What form does the aggressive behavior taken? (Reactive-hostile, Instrumental proactive, Relational, or Some Combination of these)?
2. What is the frequency, severity and pervasiveness of the aggressive behavior?
3. Is the aggressive behavior evident in multiple settings? (Pervasiveness)
4. Is the aggressive behavior a long-standing problem or a recent development? (Chronicity - child or adolescent onset).
5. Is the aggressive behavior the only type of antisocial behavior being exhibited or is the aggression part of a mix that includes defiance of authorities, covert acts of aggression and oppositional behaviors (e.g., stealing, vandalism, fire-setting, teasing animals)?
6. Is aggressive behavior part of a form of deviant and high-risk behavior (substance abuse, risky-behaviors, sexual acting out, bullying behaviors, dating violence)?
7. Does the aggressive behavior occur alone or as part of a group activity (peer association with deviant peers)? Involvement in a gang - What role? Evidences poor resistance to peer influence?
8. What triggers the aggressive behaviors? Evidences poor impulse control?
9. What factors appear to maintain the aggression? Covert factors such as cognitive processing deficits and styles - hostile attribution bias, inadequate social problem-solving skills, cognitive distortions? Behavioral and emotional regulation deficits? Sequelae of neuropsychological impairment?
10. Does the child evidence callous, unremorseful reactions, or does he/she evidence prosocial emotions (empathy, regret, guilt, shame, anxiety about consequences)?
11. Are there additional comorbid features such as ADHD, learning disabilities, school failure, depression, peer rejection?
12. What signs of “strengths” and resilience does the child evidence? (Individual competencies, interests, talents, future orientation; Social connectedness, school and church affiliation, mentoring relationships, prosocial peer affiliation; Systematic supports - availability of supervisory services, health care).
13. Does the child have a sense of belongingness to anyone at school? (Ask the student “If you were absent from school, who besides his friends, would notice he was absent and would miss him?” “If he had a problem at school who would he go to for help?”)
14. Does the student have prosocial peers and/or a mentor (“Guardian Angel”) who he has access to?
15. How does the student see himself? Does he have an inflated self-esteem and is proud of aggressive behavior? Does the student see that he has a “problem” to work on?
16. How supportive is the family? Is the home safe and organized or prone to conflict and chaos?
17. Is there evidence of familial psychopathology (criminality, substance abuse, depression, family conflict and violence, intergenerational aggression)?
18. What is the nature of the stressors that the family experiences (e.g., low SES, minority status, living in “high-risk violent environment?”) Are the parents exposed to multiple stressors-current, ecological, familial, developmental?
19. Does the family have access to social supports and services?
20. How effective are the parents in performing disciplinary practices, establishing a warm affective bond, monitoring and supervising their child’s whereabouts and peer associates?
21. Are the parents involved and supportive of their child’s school performance?
22. What cultural supports and strengths does the family have that can be accessed in helping their child (e.g., extended family, church involvement, cultural beliefs)? (See list of risk and preventive factors in Table 7 on Lessons Learned from interventions).

23. Where indicated, take a weapon’s history of at-risk students (see Pittel, 1998).
### TABLE 3

PROGRAMS AND POLICIES THAT AGGREGATE DEVIANT PEERS AND THAT SHOULD BE AVOIDED, IF POSSIBLE

*(From Dodge et al. 2006 and www.teachsafeschools.org)*

#### Education
1. Tracking of low-performing students
2. Forced grade retention for disruptive youth
3. Self-contained classrooms for unruly students in special education
4. Group counselling of homogeneously deviant youth
5. Zero tolerance policies for deviant behavior
6. Aggregation of deviant youth through in-school suspension
7. Expulsion practices
8. Alternative schools that aggregate deviant youth
9. Individuals with Disabilities Education Act (IDEA) reforms that allow disruptive special education students to be excluded from mainstream classrooms
10. School-choice policies that leave low-performing students in homogeneous low-performing schools

#### Juvenile Justice and child welfare
1. Group incarceration
2. Military-style boot camps and wilderness challenges ("brat camps")
3. Incarceration placement with other offenders who committed the same crime
4. Custodial residential placement in training schools
5. Three strikes-mandated long prison terms
6. Scared Straight
7. Group counselling by probation officer
8. Guided group interaction
9. Positive peer culture
10. Institutional or group foster care
11. Bringing younger delinquents together in groups
12. Vocational training

#### Mental Health
1. Any group therapy in which the ratio of deviant to non-deviant youth is high
2. Group therapies with poorly trained leaders and lack of supervision
3. Group therapies offering opportunities for unstructured time with deviant peers
4. Group homes or residential facilities that provide inadequate staff training and supervision

#### Community programming
1. Midnight basketball
2. Unstructured settings that are unsupervised by authority figures (e.g., youth recreation centers designed as places for teens to “hang out”)
3. Group programs at community and recreation centers that are restricted to deviant youth
4. After-school programs that serve only or primarily high-risk youth
5. 21st Century Community Learning Centers
6. Interventions that increase the cohesiveness of gangs
7. Gang Resistance Education and Training programs
8. Comprehensive Gang Intervention program
9. Safe Futures program
10. Urban enterprise zones
11. Federal housing programs that bring together high-risk families
TABLE 4
EFFECTIVE PROGRAMS THAT REPRESENT Viable Alternatives TO AGGREGATING DEViant PEERS
(From Dodge et al. 2006)

Education
1. Universal, environment-centered programs that focus on school-wide reform, including:
   a. clearly explicated expectations for student and staff behavior
   b. consistent use of proactive school discipline strategies
   c. active monitoring of “hot spots” for behavior problems
   d. improved systems to monitor student achievement and behavior
2. Universal classroom programs to build social competence (e.g., Responding in Peaceful and Positive Ways, PATHS, school-wide bullying prevention programs)
3. School-wide positive behavior support
4. Individual behavior support plan for each student
5. Improved training in behavior management practices for classroom teachers, especially:
   a. group contingencies
   b. self-management techniques
   c. differential reinforcement
6. Incredible Years Teacher Training
7. Good Behavior Game
8. Consultation and support for classroom teachers
9. Family-based Adolescent Transitions Program
10. Matching deviant youth with well-adjusted peers (e.g., Coaching, BrainPower, Peer Coping Skills Training, the Montreal Longitudinal Project)
11. Multimodal programs (e.g., LIFT-Linking Interest of Families and Teachers, Fast Track, Seattle Social Development Project
12. Proactive prevention programs that shape student “morals” and encourage responsible decision making
13. Cognitive-behavioral Intervention for Trauma in Schools (CBITS)

Juvenile Justice and Child Welfare
1. Functional family therapy
2. Intensive protective supervision
3. Teaching Family Home Model
4. Sending delinquent youth to programs that serve the general population of youth in their neighborhoods (e.g., Boys and Girls Clubs)
5. Community rather than custodial settings
6. Interpersonal skills training
7. Individual counseling
8. Treatment administered by mental health professionals
9. Early diversion programs
10. Victim-offender mediation
11. Teen court programs
12. Therapeutic jurisprudence programs
13. Community commitment orders
14. Psychiatric consultation
Mental Health
1. Individually administered treatment
2. Family-based interventions
3. Adolescent Transitions Program
4. Linking the Interests of Families and Teachers (LIFT)
5. Iowa Strengthening Families Program
6. Family Unidas Program
7. Mentoring programs such as Big Brothers/Big Sisters

Community programming
1. Public or private organizations that are open to all youth, regardless of risk status, and that provide structure and adult involvement (e.g., religious groups, service clubs, Scouts, Boys and Girls Clubs)
2. School-based extracurricular activities that include pro-social peers
3. Encouragement of commitments outside of gangs (e.g., to jobs, family roles, military service, mentors)
4. Early childhood interventions such as the Perry Preschool Program, school readiness programs like Head Start, and programs that highlight reading comprehension skills
5. Job Corps
6. Policing programs that target high-crime neighborhoods where high-risk youth congregate
7. Community efforts to reduce marginalization of specific groups of youth
REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS
FOSTER GENERALIZATION

How many of these 23 features are included in your training program?
What grade would you give to your Intervention Program to foster generalization?

In order to foster transfer at the OUTSET OF TRAINING, my program:

1. Uses explicit collaborative goal-setting when discussing the reasons and value of transfer and relates training tasks to treatment goals.

2. Explicitly instructs, challenges and conveys an “expectant attitude” about transfer.

3. Uses discovery learning, labeling transfer skills and strategies.

4. Solicits participants’ public commitment and uses behavioral contracts.

5. Anticipates and discusses possible barriers to transfer.

6. Chooses training and transfer tasks carefully (build in similarities and use ecologically-valued training tasks).

7. Develops a “community of learners” (e.g., Alumni Club).

In order to foster transfer DURING TRAINING, my training program:

8. Keeps training simple – uses acronyms and reminders.

9. Uses performance-based training to the point of mastery.

10. Teaches metacognitive skills – involving self-monitoring, planning, etc.

11. Accesses prior knowledge and skills, uses advance organizers and scaffolds (individually tailors) instruction.

12. Conducts training across settings, using multiple trainers and environmental supports.


Meichenbaum

In order to foster transfer at the CONCLUSION of training, my program:

15. Puts trainees in a consultative role (uses reflection, opportunity to teach others, puts trainees in a position of responsibility).

16. Ensures participants directly benefit and receive reinforcement for using and describing transfer skills.

17. Provides between sessions coaching.

18. Provides active aftercare supervision – fade supports and “scaffolds” assistance.

19. Ensures participants take credit and ownership for change (self-attributions). Nurtures personal agency.

20. Ensures that participants collaborate in designing personal transfer activities.

21. Involves significant others.

22. Provides booster sessions.

23. Conducts a graduation ceremony.
TABLE 6

SOME LESSONS LEARNED FROM PREVENTION and TREATMENT INTERVENTION RESEARCH FOR CHILDREN/YOUTH WITH DISRUPTIVE BEHAVIOR DISORDERS (DBD)

When government asks scientists what to do, scientists tend to respond with assurances far beyond the state of science and out-of-keeping with the tentative nature of scientific knowledge. Science requires a “disputatious community of truth-seekers” to keep researchers from falling into the “over-advocacy” trap and “sleight of hand” marketing (Campbell, 1988; Litell, 2006; Mendel, 2000).

1. Any definition of aggression and conduct problems in children and youth need to recognize the heterogeneous nature of the population and tailor assessment prevention and treatment interventions accordingly. Need to draw a distinction between early starters and late-onset aggressive behavioral patterns (see Moffitt, 2003).

2. There are substantial gender differences in the form, pattern and developmental course of boys versus girls, (See Levene et al. 2001; Moffitt et al. 2002; Pepler et al. 2006; Undwerwood, 2003 and Website addresses of Aggression in Girls.) Interventions should be gender-sensitive (OJJDP, 1988; Patton & Morgan, 2002; Levene, 1997; Levene et al. 2001; Walsh et al. 2002). See www.melissainstitute.org for Handout materials on a conference on Gender differences in aggression.

3. There is a need to take into consideration cultural and racial differences in identifying risk and protective factors and in conducting assessment and treatment interventions. The nature of risk and protective factors (role of hopelessness, attitude toward academic achievement, parenting style, responsiveness to different disciplinary efforts, form of treatment and risk factors for dropping out of treatment have been found to vary by ethnic groups. de Arellano (2008) and de Arellano and Danielson (2008) have described an assessment strategy with ethnic minority child populations (Cognitive and Behavioral Practice, 15, 53-66 and Behavior Modification, 29, 130-155.) Kazdin et al. (1995) have discussed risk factors for dropping out of treatment among different racial and ethnic groups. See Gay (2000), Goldston et al. (2008), Hammond and Yung (1993, 1994), Paniagua (1994) for a discussion of cultural considerations.

4. Aggression behavior problems in the elementary school years are significant predictors of later severe problems with antisocial behavior adolescence. There is a critical need for early intervention. The earlier the intervention, the more likely they are to be effective. Intervention efforts are more successful with children between ages 4 to 10 than with older children. Overall, corrective interventions after 10 are not very effective. Aggressive behavior is relatively stable by grade 3, but can be altered. (Frick, 2001, Guerra & Smith, 2006; Kazdin & Weisz, 2003).

5. Identifying “high-risk” children based on a single marker such as externalizing behavior often misidentifies many children and underestimates females. In order to identify the 5% to 10% of school-aged students who evidence clinically significant aggressive behaviors (with boys outnumbering girls 3:1), there is a need to use a multi-gating assessment procedure that uses a variety of indicators and sources. Keep in mind the 50% Rule. Roughly half of children diagnosed
with Conduct disorder will improve over time, no longer showing signs of aggression or antisocial behavior at adolescence. 50% to 70% of hard-to-manage preschoolers do not persist in problem behaviors past the ages of 6 to 9 (Cavell, 2000). There is a need not to prematurely label a child. When at risk students are identified there is a need to build upon those protective factors that contribute to desistance from aggressive behavior. There is a need to maintain and convey HOPE. (Eron et al., 1994; Green, 1998; Knesting & Waldron, 2006; Smith et al., 2000; Trembley et al., 1995).

6. The factors that place children at risk are multifaceted and are unlikely to be modified by relatively, brief, time-limited interventions. Moreover, single factor-focused interventions are not likely to be successful. There is a need to target multiple risk factors and protective resources. There is no simple “magic-bullet” solution to violence reduction. (Chamberlain, 2003; Kazdin, 1994; Sherman et al., 1997).

7. Programs that segregate and that aggregate antisocial youth do not work and can exacerbate the incidence of aggression and violent behaviors (see Tables 3 and 4 and Dishion et al., 2006).

8. One cannot conduct a training program and hope for transfer or generalization or skills maintenance. Trainers need to follow research-based guidelines on how to increase the likelihood of generalization. See Table 5 for a detailed set of guidelines to be followed before, during and after training to increase the likelihood of skills maintenance across settings, across response domains, and over time. Interventions that are conducted across multiple settings and systems (school, home community) are more effective than single setting interactions (Walker et al., 2004).

9. There is a need to involve prosocial peers as part of the intervention. Interventions that only engage “high-risk” youth may do more harm, and inadvertently increase the rate of antisocial behavior. A prosocial mentor (“Guardian Angel”) who can foster “bondedness” with prosocial peers and institutions is critical to sustainable positive changes. (Dubois and Karcher, 2005). If a training program is going to be effective there is a need to assess and then alter the youth’s peer network. This can be challenging since prosocial peer’s may be responding to the youth’s former social reputation, rather than to the youth’s current level of social functioning. There may be a need to “shop around” for a new peer group tied to the youth’s talents and interests.

10. While parent management training is one of the most effective interventions with children and youth with Disruptive Behavior Disorders, parents of such children have high drop-out and no show rates. There is a need to focus on engagement procedures using Motivational Interviewing procedures and to systematically assess for possible barriers to participating in treatment at the outset and throughout training (see Brooks & Goldstein, 2001; Cavell, 2000; Kazdin et al., 1998; 2005).

11. Parents alone or even with a partnership with teachers, cannot provide adequate supervision to high-risk children and youth. As the adage goes, “It takes a village”, in the form of involvement and supervision by caring adults outside the family to work and reducing aggressive, antisocial and violent behavior. (See the Website prevnet.ca for an example of how they organized 42 non-governmental community agencies). Consider Pepler and Craig’s (2008) estimate that worldwide “an estimated 200 million children and youth around the world are being abused by their peers” (p. xix). In fact, an international effort is now underway to stop bullying and violence by youth called the Kandersteg Declaration.
12. Treatment programs should attend to the presence of comorbid disorders like hyperactivity, anxiety, depression, suicidal ideation, PTSD, learning disabilities and physical disorders. Psychosocial interventions should be synergistically combined with pharmacological interventions, where indicated. If medication is being prescribed, there is a critical need to monitor and address the issue of treatment nonadherence. When improvement occurs it is important to have the youth and family attribute improvement not only to the medication per se, but what the medication allowed the youth to “do”, namely, “notice, catch, plan, interrupt, choose, control behavior, in spite of provocations, peer pressure, bad moods, etc.” Ensure that the youth “takes credit” and “ownership” for behavior changes. Comprehensive intervention programs that combine teacher classroom management training, small group social-cognitive training, and family-based parent-training interventions like those conducted by the Conduct Problem Prevention Research Group and the Parent Training Programs have proven most effective. (Dodge et al., 2005; Everston & Weinstein, 2006; Kazdin, 2008).

13. There is a need to engage and train primary health care professionals to identify and screen for the mental health needs of the youth they treat. It is estimated that 25% of 150 million child visits per year for primary health care have psychological or behavioral problems associated with the presenting medical complaints. There is a need to train these gatekeepers to become front-line screeners. (See Melissa Institute Website for Meichenbaum’s discussion on how to train Primary doctors to screen for suicidal ideation in adolescents).

14. Most successful programs are those that prevent youth from engaging in delinquent behaviors in the first place. Thus, preventative efforts that reduce risk factors and that bolster protective factors are most effective. There is a need to adopt a strengths-based intervention approach and work to bolster student’s and families’ resilience (see Meichenbaum, 2009 and Melissa Institute Website for examples of successful preventative programs). For example, home-based nurse visiting programs that provide prenatal care and ongoing education and support following delivery; parent management training programs; Preschool school readiness intervention programs; school-based cognitive and emotional training programs; bully prevention programs; mentoring programs; community-wide programs that include wrap-around services from multiple agencies such as Communities that Care, Youth Prevention Council and Community Blueprints for Action Programs; and programs that relocate high-risk families to more supportive affluent and less distressed neighborhoods have each been found to reduce the level of aggressive behaviors and violence. Illustrative promising programs with high-risk children and families have been offered by Dubois and Karcher, 2006; Hawkins and Catalano, 1992; Jaycox et al., 2006; LaGreca et al., 2002, and Stein et al., 2003. Such programs should work to reduce risk factors and bolster protective factors, as enumerated in the following list.

LIST OF RISK AND PROTECTIVE FACTORS

RISK FACTORS

Child Risk factors: Disabilities, low IQ and poor verbal-analytic skills, low self-esteem, poor social skills, impulsive behavior, poor emotional self-regulation skills, impulsive behavior, information-processing deficits and a sense of alienation, lack of empathy, difficult temperament, insecure attachment.
**Family risk factors:** Teenage mother, father absence, large family size, family violence and disharmony, long-term parental unemployment, low involvement in child’s academic and social activities, psychiatric/criminal activities, violent models, harsh and coercive discipline practices, presence of neglect and abuse.

**Life event stressors:** Divorce, family breakup, death of family member, dislocation, exposure to ongoing neighborhood violence.

**School risk factors:** Academic failure, aggregation of deviant peer group, bullying, peer rejection, poor attachment to school, unsupportive and undisciplined school environment (large class size, inexperienced teachers, poor principal leadership), poor emotional climate, high ratio of reprimands to praise, low teacher morale, high turnover, in both students and teachers.

---

**PROTECTIVE FACTORS**

**Child protective factors:** Social skills and competencies, attachment to family and school, empathy, problem-solving skills, a sense of optimism and future orientation, above average intelligence, easy temperament, school achievement, Internal Locus of Control, good style, bicultural competence, and a sense of humor.

**Family protective factors:** Supportive caring parents, family harmony, small family size and more than two years between siblings, secure, supportive and stable family, sense of belonging and bonding, family rituals, strong family norms and morality, responsibilities at home (chores).

**School protective factors:** A positive school climate, prosocial peer group, opportunities for success and recognition of achievement, prosocial norms concerning violence, sense of belonging, high staff morale, adequate staffing, staff development and consultation, Principal leadership and commitment (see Table 8).

**Community and cultural protective factors:** Access to support services, community prosocial networking, commitment to and participation in community identity and prosocial cultural norms, participation in church or other community groups, ethnic pride, community cultural norms against violence.