WHAT DOES SCIENCE TELL US ABOUT PSYCHOLOGICAL TREATMENTS FOR CHILDREN AND ADOLESCENTS WITH CHALLENGING BEHAVIOURS?

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Around 10% to 15% of young people experience difficulties with aggression, impulsivity, following instructions and other challenging or disruptive behaviours – well beyond what the average child or young person of their same age experiences. What this looks like in their daily life varies considerably from child to child – but usually these kids and teens seem to get frustrated more easily than others, find it really tough to manage this frustration and often yell/scream/throw things. Some might also have low motivation to follow instructions from adults, and some might consistently act deceitfully or frequently break school and home rules.

These difficulties are likely to be caused by a combination of physical causes, genetic influences, temperament, and environmental, family, and social factors. Despite what some people might say or think – it is not a simple case of "poor parenting" – there are many complex difficulties these children face which are not easily changed by parents being "stricter".

Caring for a child with higher-than-average disruptive behaviours can be extremely tough for parents/caregivers and understandably they often seek help from health professionals. In fact, having a child or young person with higher than average challenging or disruptive behaviours is the most common reason for children attending a mental health service in Australia.

In this article, I'd like to discuss what research tells us about the psychological treatments for children and young people with challenging behaviours – what these treatments are, what they include and how effective they seem to be.

What kinds of psychological treatments exist for children or young people with challenging behaviours?

The psychological (sometimes called 'psychosocial') treatments for children with challenging behaviours which have been examined by researchers can be divided into two major categories – parent/caregiver-focused treatments and child/young person-focused treatments.

Parent-Focused Approaches

Parent/caregiver-focused treatment approaches for children and young people with challenging behaviours aim to assist parents and caregivers to interact effectively with and support their child in specific ways thought to be helpful in reducing challenging behaviours and improving child/young person well-being.

There are also different types of parent-focused treatments, and these can also be divided into two major categories.

The first category of parent focused treatments is that which is based on social/behavioural learning principles. Sometimes this is called "parent management training" or "behavioural parent training".

Some common "brand name" approaches include Parent Child Interaction Therapy (PCIT), Triple P and the Incredible Years.

These programs teach caregivers the following kind of topics: How to give children with challenging behaviours instructions, how to use praise/rewards more effectively with these children, how and when to ignore (certain) behaviours, how to use negative consequences for challenging behaviours, how to increase parent-child positive interactions and improve parent-child communication.

The *second category of parent-focused treatments* is that which is based on either something called an "attachment" or emotion coaching framework, or a family problem-solving/mediation framework. Some common "brand name" approaches for these treatments include the Circle of Security program, the Tuning Into Kids/Teens programs or Collaborative Problem Solving.

These attachment/emotion coaching/family problem solving approaches are more varied and slightly different from each other compared to the Parent Management training approaches above which are more homogenous. However, there are still some broad similarities between these approaches which tend to use less instruction giving, rewards and consequences, and focus more on emotions or problem solving. Common components included in these treatments are the following: helping parents to notice emotions in their children, to understand the underlying needs behind difficult behaviours, coach their children to talk about emotions, or teach parents how to communicate and problem solve more effectively with their young person. These approaches may also help parents to reflect on their own parenting related emotions and their own parenting experiences.

How are these parent-focused treatments program run?

In research trials, almost all parent treatment approaches usually include around 10-20 weekly (often 90-120 minute) sessions. They usually include an out of session/in between session tasks/homework – for instance 15-minute homework assignments daily or every second day. Sometimes these parent programs are run in a group format, and sometimes in individual parent/therapist sessions.

Sometimes these parent-focused treatment programs require the child to be present in sessions too – with the parent practicing using new behaviours with the child present and being given feedback by a therapist, or the therapist helping the parent/child learning skills together.

Are parent-focused programs effective for children and young people with challenging behaviours?

Usually – yes!

Research trials based on the format and intensity of the parent treatment programs as described above show that on average, children with challenging behaviours show a significant reduction in problem behaviours after their parents complete these 10–20-week programs – and the benefits for many families last for at least 12-24 months (usually the limit of the follow up studies).

In terms of which category of parent focused treatment works better - the parent treatments based on behavioural and social learning principles have been studied *more extensively* than the parent programs based on emotion coaching and family problem solving, *however* both types of parent programs appear to work well.

Some research suggests that either type of parent focused treatment might work especially well when they include the following components: a focus on ensuring parents complete weekly homework, coaching of parents/caregivers to help them know what to actually "do" with their child, role play and practice in session, involvement of *both* caregivers involved with parenting the child, and specific, "behavioural" (i.e., a parent knows exactly what to say/do) strategies to improve positive relationships with a child/young person.

Involving the child in these parent-focused approaches (helping the parents actually practice skills in interacting with the child in the session itself) may also help these parent -focused approaches be more helpful in some cases.

Are these treatments helpful for everyone? Probably not.

Like most psychological treatments – these parent programs do not work for all children. Research suggests a quarter or more of parents/caregivers "drop out" of treatment (suggesting it is hard work) and even for those who do complete, about a third of children still might not experience much benefit of their parents undertaking the program.

Nevertheless, the fact that around two thirds of children do experience significant reductions in challenging behaviours means that the parent treatments listed above are generally considered by national and international health authorities as the "gold standard" when it comes to psychological treatments for children with challenging behaviours.

Child-Focused Approaches:

In contrast to *parent-focused treatments* in which the treatment is primarily focused on helping the parent use and learn new skills (even if the child is present some of the time), *child-focused* approaches are those where a therapist works directly with the child rather than the parent.

The child-focused approaches for children with challenging behaviours which have been evaluated in the research have been further divided by some researchers into a) programs which aim to improve social skills (social skills programs), b) those which aim to help children manage their emotions and behaviours (cognitive-behavioural programs/CBT), and c) programs which use play in a non-directed way to help the child express and understand their emotions (play based therapy).

Although these categories can be used in research settings, in practice, however, most social skills and cognitive behaviour programs have many common elements and may be very similar to each other. In addition, most social skills and cognitive behavioural programs use play as a way of teaching skills to young children.

Are child-focused treatment programs effective?

Sometimes – yes.

The research suggests that for most primary-aged children with challenging behaviours, *social skills and cognitive behavioural programs* can be effective for many children, with the evidence of effectiveness is less certain about *purely child directed and play-based approaches*.

However, and this is a crucial point, although research suggests that child-focused therapies are usually more effective than no treatment at all, most reviews of the research conclude that *parent-focused treatments (either those which involve children but still focus primarily on parents or those not involving children at all) are significantly more effective compared to child-focused ones*. This is why, as stated above, parent focused treatments are rated as "gold standard" for supporting children with challenging behaviours.

What about the research on treatments for adolescents with challenging behaviours?

Much (i.e., not all – but most) of the research described above for children with challenging behaviours has been conducted with primary-aged children.

The research for treatments for adolescents with challenging behaviours is slightly different but has a similar underlying theme.

It's important to note firstly that most of the research on psychological treatments for adolescents with challenging behaviours has been conducted with adolescents with very severe forms of challenging behaviours (sometimes diagnosed with "conduct disorder") who are in juvenile justice systems. This research has typically evaluated very intensive forms of psychological treatments – when I say very intensive – they are usually 3-4 weekly sessions with both adolescents, and parents/caregivers, and often also teachers – and often also include daily phone check-ins. This research has shown that these extremely intensive treatments are generally found to be very effective. Unfortunately, these are not offered in Australia in my experience.

There has been a smaller number of studies evaluating other types of treatment for less severe forms of challenging behaviours.

First, there have been some studies evaluating *youth focused treatments* for adolescents with challenging behaviours. These treatments include individual (usually "cognitive behaviour") therapies. As with the child focused treatments described above, these usually include supporting teens to learn skills related to being aware of emotions, communicating emotions, being aware of triggers, increasing skills related to managing emotions, and social problem solving. These programs generally include 12-24 weekly sessions with a focus on homework completion in between sessions. These individual programs for adolescents with challenging behaviours have been rated by some reviewers as slightly more effective than individual therapy for children in primary school with challenging behaviours, although some reviewers think they are of similar effectiveness to individual programs for younger children.

Again, similar to the research above on children with disruptive behaviours, there have been some studies on *parent-focused treatments* for parents/caregivers of adolescents with challenging behaviours, which also contain much of the same content as programs for younger children with challenging behaviours – but with the content modified to include developmentally appropriate topics. These programs have been rated as effective. Importantly – once again, some reviewers and classification systems conclude that involving parents/caregivers (and if possible, teachers and other key figures in an adolescent's life) is likely to be more effective than providing therapy to individual adolescents.

Problems with applying this research to Australian treatment settings:

The conclusions I've described above are based on studies of treatment trials conducted in university or research settings, and many of them have been conducted in non-Australian settings.

One of the challenges for families and mental health providers is translating that research to real world therapy settings – and there are many problems in trying to do this.

For instance, if we consider therapy for primary school aged children with very challenging behaviours – as you can see above, what the research suggests is that 12-24 weekly (group or individual) 90–120-minute sessions with parents/caregivers (possibly with their child present for some of those sessions) is likely to be most helpful.

In Australia, we have a Medicare system which only funds TWO parent-only sessions with a psychologist per year, and a total of 10 (child-only or child and parent) sessions per year. In addition, demand for services in

Australia means most psychologists can't offer longer than 50-minute sessions and often can't fit families in more than fortnightly.

We also have to (and want to in most cases) get young people's permission (once they are aged over about 14 – depending on their maturity level) to work with parents/caregivers.

So, as you can see, there are many challenges in getting evidence-based practice treatment for children and young people with challenging behaviours in Australia.

What should I do if I want to get a treatment for my child/adolescent with challenging behaviours from a psychologist in Australia?

If you have a *primary-aged child* with challenging behaviours and are looking for psychological treatment options, here are some points to consider:

1) The best results for most children will *probably* come from you (and even more effectively, both legal guardians) being the primary receiver of a parent-focused treatment (group or individual might both be helpful) which teaches you how to respond and relate to your child (possibly with your child there in the room too to assist with practice of your skills), rather than your child being the focus of sessions.

   This is a real mind shift for many caregivers. Understandably – due to how our Medicare system is funded, and how adult therapy is portrayed in the media – parents come to therapy with an idea that their child will be the person mostly in a therapy session with a therapist and the child will learn to manage their emotions better. Many parents we see do believe they themselves may need to "help" or get some ideas from the therapist themselves, but still assume that their child will be the main focus of the therapist's attention. And finally, due to difficulties with funding and parent expectations, many child therapists themselves often suggest they work predominantly with a child (and remembering that this approach still *can* be effective – just usually less effective than working directly with a parent/caregiver). However, this is in contrast to what research cited above suggests is most effective for children with challenging behaviours.

Before we go any further, there are three important points to make to ensure parents don't feel any blame or shame about getting this parent focused treatment:

a) It is important to understand that the likely best practice of doing parent work with a therapist does not mean as a parent that your behaviour has *caused* the child to have challenges with behaviour.

An analogy might be helpful. Imagine you sprain your ankle. Best practice physiotherapy-based rehabilitation treatment for this sprain might include (after a period of rest) daily strengthening and stretching work. This strengthening work does not imply that it was just a lack of strength that *caused* the sprain to occur. It may have occurred for all kinds of reasons including a poorly positioned curb – but the treatment involves strengthening just the same.

Similarly, the cause of children's challenging behaviours may involve multiple factors – physiological/biological, environmental, trauma, sleep/nutrition, psychological disorders, neurodevelopmental differences, etc. But the treatment – parent focused therapy – can be effective regardless of the cause.

b) It is also important to understand that caregiving for a child with disruptive behaviours is much more difficult and different than doing this for a child without these behaviours. There is plenty of evidence to suggest that some children with challenges simply do not respond to usual parenting strategies in the same way as other children. Parent directed treatment with a therapist is not about telling you "How to be a parent" but instead specifically working with you on how to respond to, coach and support your unique child with their particular challenges.

c) A final point to ensure there is no blame and shame – most parents/caregivers are *already* doing and providing many excellent and important parenting behaviours. These are probably keeping things better than they might be in extreme cases. Parent focused treatment is also aimed at extending all of these important things *you are already doing* to try to make them have a more powerful impact on your child/young person.

Hopefully this removes any misconceptions about parent focused treatment being about "blaming" a parent. Let's go on to address more of the issues in seeking this treatment.

2) Obtaining *the needed number* of sessions for treatment under Australian-based medical funding. The research-based programs are usually 12 to 20 sessions in length. One of the big problems we have here in Australia is that while children/adolescents can get a referral for 10 rebatable sessions each year under Medicare Better Access funding, the most common funding source for children/adolescents with mental health concerns - only 2 of these rebatable sessions are allowed to be parent only. The rest have to be with the child in the room (If your child has NDIS funding on the other hand, then often more of parent-only sessions are covered).

This means if you want to get the "gold standard" treatment approach for your child with challenging behaviours, you will need to talk with your therapist about two options: a) using private funding for another minimum of 10 sessions, or having all 10 sessions where you and your child are receiving treatment together, rather than the focus just being on your child.

It might also mean that you access group-based therapy programs or online programs to receive this type of treatment – again, your GP or therapist might be able to direct you to some (there are not many, but a few).

3) Obtaining the *regularity of sessions* needed for evidence-based treatment. The evidence-based treatments are based on weekly sessions. Therefore, it might be wise to try to work with your psychologist to attend weekly. However, many therapists cannot schedule weekly sessions, so fortnightly is the next best option. Attending on a monthly basis is not really in line with our current evidence base – and may be likely to increase problems with loss of momentum (i.e., lack of homework being completed, the therapist needing to do more "top up" assessment and information giving to account for increased time in between sessions).

Attending weekly or fortnightly sessions for 12 weeks is not always something caregivers expect and is often very inconvenient for caregivers. I sometimes suggest to clients, as a compromise, if they don't want to attend fortnightly for 10 sessions that instead of attending monthly (again usually less helpful in my view and not in line with evidence-based approaches) that they have several weekly or fortnightly sessions, then take a 6-week break – and then attend weekly/fortnightly again. This pattern at least 'approximates' an evidence-based treatment more closely than a monthly schedule in my experience.

4) Homework/out of session practice. All of the evidence-based parent treatment approaches above – and even the child treatments – rely upon parents/caregivers practicing skills outside of session. Therefore, you should expect your therapist to provide you with specific, easy to understand and achievable tasks to practice in between sessions – and expect these to take between 5 and 15 minutes daily, between 3 and 7 days per week. If you are receiving parent-focused treatment, this is homework that you will need to do (sometimes with your child). If your child is receiving treatment as well, this is homework that your child will need to do.

This is another part of evidence-based therapy which is quite difficult for many families who usually have more than one child and many commitments, and children who are reluctant or not interested in doing it. However, in this way, treatment is very much like reading or music or driving lessons – the lesson itself with no practice outside the lesson is unlikely to be helpful.

If you are going to find it impossible to do this kind of (nearly) daily in-between-session work and/or impossible to have your child do, it might be worth talking with your therapist about this, so they are aware from the outset of treatment. Don't worry about being judged for this – therapists have busy lives too and understand the difficulties in trying to find time. They might talk with you about adjusting your expectations for the speed or extent of treatment effects, or brainstorm with you about homework tasks which might be able to be fitted in with your usual daily routines. They might also talk with you about whether you might want to delay treatment until you have the time/space to be able to implement in the way that the evidence above suggests will be necessary for most families to get effects.

If you have an adolescent with challenging behaviours:

If you have an adolescent with challenging behaviours, the main messages listed above are similar, but here are some additional points to consider:

1) Individual therapy for your adolescent with challenging behaviours on their own is likely to be more helpful at their age than it would have been if they were younger. In fact, your adolescent is likely to benefit from having sessions on their own. This kind of therapy will probably involve practical strategies around being aware of and managing/expressing emotions, improving social and conflict management skills, improving peer relationships, and increasing problem solving,

2) *However*, and this is probably true if your adolescent has significantly challenging behaviours (e.g., law breaking or important social rule breaking – lying/stealing/physical aggression) as with what the research on younger children suggests, it is very likely that therapy will be *more effective* if, as a parent, you are also receiving treatment focused on what to do, how to relate and how to respond to them.

Before we go on – it is important to note that if you have a child older than around 13 or 14, therapists in Australia have to manage ethical guidelines such that once children are considered to be "mature minors" (able to understand the implications of therapy) they need a young person's consent to involve parents/caregivers, and additionally to tell parents/caregivers any information that a young person provides to them (unless there is a clear safety risk of not doing so). This means that parent-directed work may or may not be possible, depending on how the adolescent feels about it and whether the therapist can help the adolescent understand its possible importance.

If parent directed treatment is possible and appropriate, given the evidence, as stated above, it is likely to be more effective than working with the adolescent on their own. Parent treatment might look like different things, including attending a parent-only group program, attending a series of sessions on your own without the adolescent, attending sessions with your adolescent in the room but have the therapist be working with your adolescent in front of you in order to help you know how you then can relate to your young person at home, or have your adolescent there with you in the room for the purposes of assessment and providing practice opportunities with you.

The same points above which relate to parent work with children also apply – please (if you haven't already) go back and read that section of the article – about understanding that parent work does not mean parents have caused or are responsible for adolescent challenging behaviour, about the number of sessions, the regularity of sessions and the need for out of session practice.

One extra point about the value parent directed treatment which may be particularly relevant for parents of adolescents – it can be particularly helpful for families of adolescents when the adolescent themselves refuses to attend therapy.

In conclusion:

If you have a child/adolescent with particularly challenging behaviours, please be compassionate towards yourself. It is a really tough life challenge to manage, and unfortunately seeking appropriate treatment is not easy in the Australian health care system (we haven't even addressed the wait lists). However, it is worth knowing that there are some evidence-based treatments which are very effective for the majority of families – it is just that these might look a bit different than what the media portrayal of therapy leads us to believe. As always, every family's situation is different and if you are in or starting therapy, it is important to talk with your therapist about these issues, and to see what they might recommend for your particular situation.