

THE RELATIONSHIP BETWEEN CONDUCT DISORDER AND ANTISOCIAL
PERSONALITY DISORDER: INTERVENTIONS AND IMPLICATIONS FOR
COUNSELING

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PERSONALITY DISORDER: INTERVENTIONS AND IMPLICATIONS FOR
COUNSELING

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Abstract

A review of literature that applies to children who are diagnosed with conduct disorder and the parents/caregivers who are raising them. Prisons are full of offenders, many of which have an antisocial personality disorder diagnosis. These prisoners would have had conduct disorder as a juvenile. Early interventions of conduct disorder can prevent a future of antisocial behaviors in a child. Effective treatment can help families work in a positive way.

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TABLE OF CONTENTS

	PAGE
APPROVAL PAGE.....	i
TITLE PAGE.....	ii
ABSTRACT.....	iii
TABLE OF CONTENTS.....	v
CHAPTER	
I. INTRODUCTION.....	6
Introduction	
Statement of the Problem	
Definitions of Terms	
Delimitations of Research	
II. REVIEW OF LITERATURE.....	9
Conduct Disorder	
Risk Factors	
Parenting Style	
Treatment and Counseling Approaches	
III. CONCLUSIONS AND RECOMMENDATIONS.....	18
IV. REFERENCES.....	20
V. APPENDIX A.....	23

Chapter One: Introduction

Adam, a 13-year old, was disruptive in school and disrespectful to any female teacher or staff member in the building. He was involved in a few physical fights during the school year, all of which he initiated. Adam's mom would often have a black eye, due to the fact that her husband (Adam's father) would often hit her. Both parents were violent towards each other and yelling and swearing was a normal occurrence through the house. Both parents had criminal records. Adam had disruptive behaviors as far back as 3 years old. His parents slapped him around when he didn't listen to or questioned them. The parents never sought out any help for Adam, as they felt they dealt with the issues the best way they knew how. The law got involved when Adam was caught stealing an expensive item from a neighbor's home. From there, a social worker became involved with Adam's case to guide the family through his consequences the court handed down. The court mandated therapy for Adam as a pattern of bad behaviors had been surfacing. This intervention would be the start of changes for this family.

Children with behavioral problems such as Adam's are often labeled as "bad kids" when the underlying problems reside within the family structure (Tufts, 2013). Throughout history "...a wide variety of terms [have been used] to describe bad children – out of control, incorrigible, delinquent, deviant, vagrant, wayward, dissocial – depending on the historical period and context" (Hill & Maughan, 2001, p.4) When a child is diagnosed with CD, it can cause some negative labeling of the child. Labeling theory is divided into two types: formal and informal. Formal labels are imposed on a child by the criminal justice system, whereas informal labeling is imposed by parents, teachers and a child's peers. When children in the system are adjudicated, they are referred to as criminals or as delinquents which negatively impacts children's' reputations within the communities they live. "As labels are continually reinforced,

they essentially become self-fulfilling prophecies: the juvenile comes to believe that the labels are accurate descriptors of him or her, and then proceeds to act in a way that comports with those very labels” (Tufts, 2013, p.342).

Parents and caregivers have the power to influence children in negative or positive ways. Parents often take their children to therapy and expect professionals to fix them. However, parents can learn to become a form of therapist in their own households by utilizing useful commands while simultaneously model positive behaviors (McNeil & Hembree-Kigin, 2010). Through early intervention and professional guidance, parents can strengthen their parenting skills, reduce risk factors contributing to CD, and decrease the likelihood of serious behavior problems continuing through their adulthood.

Statement of the Problem

What can be done to prevent Conduct Disorder from developing into Antisocial Personality Disorder?

Definition of Terms

Conduct Disorder is defined by the American Psychological Association as, “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (2000, p.68). There are four categories of symptoms for CD: a) aggression to people and animals, b) destruction to property, c) deceitfulness or theft, and d) serious violation of rules. Other symptomatic criteria include the behavior disturbance causes clinical impairment in social, academic or occupational functioning and that “if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder (ASPD)” (2000, p. 69).

According to the American Psychological Association, Antisocial Personality Disorder is defined as “a pervasive pattern of disregard for and violation of the rights of others occurring since 15 years of age”. (2000, pg. 291) The symptoms include an unwillingness to respect the law, habitually committing unlawful acts, deceitfulness such as lying and conning, using aliases, the inability to plan ahead, impulsivity, irritability and aggressive behavior such as fighting and assaulting, a disregard for others’ safety, irresponsible behavior at work and with finances, and a lack of remorse to people the individual has wronged. Individuals diagnosed with ASPD must be at least 18 years old and must have met criteria for Conduct Disorder prior to age 15. (APA, 2000)

Delinquency involves behaviors associated with property crimes such as theft, burglary, and vandalism. In addition, delinquency includes acts of violence and drug use. Generally, delinquency is measured by arrest and conviction records or self-report (Murray & Farrington, 2010).

Parent-Child Interaction Therapy (PCIT) is a process of therapy where a therapist coaches parents or caregivers as they interact with a disturbed child (Bell & Eyberg, n.d.).

Comorbidity refers to “...the coexistence of more than one disorder” (Kazdin, 1997).

Delimitations of Research

Although there are many factors involved in the development of both CD and ASPD, the research presented focuses on the familial risk factors and effective interventions.

Chapter Two: Review of Related Literature

Conduct Disorder (CD)

CD is a complex childhood disorder and is often comorbid with other disorders such as Oppositional Defiance Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), and sometimes anxiety and depression. The defining feature of CD is the "...persistent pattern of behaviors in which the rights of others and age-appropriate social norms are violated" (Kazdin, 1997, p.162).

The DSM-IV (1994) states:

"Individuals with Conduct Disorder may have little empathy and little concern for the feelings, wishes, and well-being of others.....they may be callous and lack appropriate feeling of guilt or remorse. It can be difficult to evaluate whether displayed remorse is genuine because the individuals learn that expressing guilt may reduce or prevent punishment. (as cited in Hill & Maughan, 2001, p.20)

Conduct Disorder has been around as long as people have been trying to figure out what to do with their out of control children. Going back to biblical times, parents who had a defiant child could have that child stoned to death in the middle of the village. Children were thought of as evil if they could not obey their parents, and that way of thinking went on for centuries (Hill & Maughan, 2001). Society now holds parents with the responsibility for how the child turns out, and there are agencies that check on reports of child misconduct if reported by school, police, juvenile probation and parents. "Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and

carrying out special management and educational programs in the home and at school.

Treatment may also include medication in some youngsters, such as those with difficulty paying attention, impulse problems, or those with depression” (“Facts for Families”, 2013, p.2).

Kazdin states “...conduct-disordered adolescents attach to deviant peers because of weak attachment to their parents. By the time they are adolescent, however, conduct-disordered youth may have great difficulty maintaining relationships of any kind. Conduct-disordered adolescents’ friendships tend to be characterized by hostility, negative interchanges, and bossiness” (Keiley, 2002, p. 478).

CD is divided into two categories by the DSM-IV, childhood-onset and adolescent-onset. Childhood-onset usually involves temper tantrums and rude, argumentative, and annoying behaviors. This onset would occur prior to the age of 10 (Murry & Farrington, 2010). Adolescent-onset is when the criteria for CD symptoms were not evident before the age of 10. If it is unknown as to when the CD symptoms may have begun, then the CD is classified as unspecified-onset (APA, 2000).

Risk Factors

The family is a major risk factor in the development of children with evolving antisocial behaviors. Children who have ASPD parents biologically and have been adopted into a different family can still genetically develop the ASPD behaviors. This was found in a study of children adopted at birth. The children who had biological parents who had ASPD and substance abuse issues were more likely to have antisocial behaviors in childhood. So nature can play a part, but the nurturing or parenting also plays a part (Tufts, 2013).

Longitudinal studies have been done on conduct disorder, and poor family management (harsh discipline, inconsistent rules, poor parental supervision) lead to delinquent behaviors; according to the Seattle Social Development Project (Murray & Farrington, 2010). When it comes to childrearing, the way parents reinforce, reason with, punish, and respond to their children is important in the development of antisocial behaviors. The Cambridge studies were done on children who showed delinquent behaviors. In one of the Cambridge studies, authoritarian style parenting showed violent behaviors in children, where the law was involved and convictions were passed (Murray & Farrington, 2010).

Child abuse can have an effect on antisocial behaviors. A longitudinal survey of abused children in Indianapolis showed that physical abuse can cause permanent brain injury, a desensitization to pain, poor coping and problem solving skills, low self-esteem, and push them to associate with delinquent peers (Murray & Farrington, 2010). Parental conflict is also a key factor in the development of CD. According to the Christchurch Health and Development Study in New Zealand ...”children who witness violence between their parents were more likely to commit both violent and property offences according to self-reports.” (Murray & Farrington, 2010; pg. 636) In the Christchurch study, being separated from one or both parents before age 5, predicted CD at age 15 years. In the Dunedin study of marital interruption (divorce or separation)...”children who were exposed to parental discord and many changes of the primary caretaker tended to become antisocial or delinquent” (Murray & Farrington, 2010, p.637). In the Ontario Child Health study, “coming from a single-parent family predicted CD, but this was highly related to poverty and dependence on welfare benefits” (Murray & Farrington, 2010, p.637).

Antisocial parents have a strong chance of having antisocial children. Parents who commit criminal acts and have alcoholism tend to have increased associations with having CD children (Kazdin, 1997). People choosing their mates who are antisocial, as themselves, transfer the behaviors to the next generation, according to Farrington (Murray & Farrington, 2010).

“An individual’s exposure to more than one risk factor ‘significantly increases the risk of maladaptive outcomes’ and the risk factors may influence one another, resulting in even greater detriment to the individual” (Tufts, 2013, p. 340). Adults who receive an ASPD diagnosis show more behavior risks besides just going against the society norms. These individuals tend to be low functioning with work and education, have poor parenting skills, and have unhealthy relationships (Hill, 2003). By the time a client has reached an ASPD diagnosis, the person has had years of disruptive behaviors and the personality traits are ingrained in the individual (Tufts, 2013). There are many different explanations but no single factor can predict what children will develop ASPD.

Parenting Style

In 1939, Lewin developed his three Participatory Leadership Styles-autocratic, laissez-faire, and democratic which was for the business world. Autocratic leadership is where a leader makes decisions without consulting others. . Laissez-faire leadership is a hands-off approach, where the leader makes minimal decisions and the people decide what is best. Democratic leadership is where joint decisions are made, but the leader may still have the final say. Lewin discovered that the democratic form of leadership received the best results. Laissez-faire leadership resulted in less energy put into the work, and autocratic leadership often led to

rebellion (IAAP, 2009). In the 1960's Baumrind applied Lewin's leadership model and applied it to parenting. Baumrind developed three models of parental control-authoritarian, permissive, and authoritative (Baumrind, 1966).

According to Baumrind, authoritarian parents usually set high standards for their children and are not willing to bend their ideals. Authoritarian parents value obedience and do not believe children should question parents' beliefs. Authoritarians value structure and order in the household and will assign household chores to get an appreciation for work (Baumrind, 1966). For example, a child must complete all homework without error before dinner time.

Permissive parents set few or no boundaries for their children. Children are left to make their own choices without interference from the parents. This parent may manipulate a child to get what they want, but will not demand it. Children often view the no reaction of the parents as approval, even if it is not (Baumrind, 1966) For example, a child can do homework at will, without any repercussions for not completing it.

Authoritative parents give reasons with the household rules and what they expect. There is a balance "... between pleasure and duty, and between freedom and responsibility" (Baumrind, 1966, p.891). This parenting style allows children to think for themselves, while still having clear boundaries. For example, the child is free to work on homework at leisure; however it must be completed by bedtime.

Treatment and Counseling Approaches

Many different forms of treatment have been used on conduct-disordered youths. Treatments have dealt in psychotherapy, pharmacotherapy, psychosurgery, home, school, and

community based programs, residential and hospital treatments, and social services (Kazdin, 1997).

Parent Child Interaction Therapy

According to the Child Welfare Information Gateway, Parent Child Interaction Therapy (PCIT) is "...a family-centered treatment approach proven effective for abused and at-risk children ages 2-8 and their caregivers- birth parents, adoptive parents, foster parents, or kin caregivers" (Child Welfare Information Gateway, 2013, p.1). Weekly 1-hour sessions are the typical way PCIT is handled, with an average length of 13 sessions. The parent puts a hearing device in their ear, called a "bug in the ear". The therapist usually stands behind a two-sided mirror and coaches the parent through the hearing device, as the parent is interacting with the child. This treatment is the first of its kind to treat both child and parent or caregiver simultaneously. It helps parents or caregivers become more efficient with the way they parent, decrease the negative behaviors of the child, and strengthen the bond between the parent and child. Parents are taught consistent discipline methods as well as how to set boundaries. PCIT differs from other treatment modalities because it focuses on the responsiveness of the parent and emphasizes the relationship of the child and parent (Bell & Eyberg, n.d.).

PCIT is divided into two main phases: Child-directed interaction (CDI), and Parent-directed interaction (PDI). (McNeil & Hembree-Kigin, 2010) During phase 1, the concentration is on the parent-child relationship and during phase 2, parents are taught to lead the child with consistent and structured discipline (Child Welfare Information Gateway, 2013).

Prior to beginning the actual therapy, parents meet with a therapist to discuss their personal parenting styles and are introduced to the principals of coaching. In phase I (CDI) parents use positive reinforcement and encouragement; they applaud good behaviors and ignore

the bad ones (Child Welfare Information Gateway, 2013). The child leads the play sessions, with the parent using what is called nondirective PRIDE skills: PRAISE the child, REFLECT on what the child is saying, IMITATE the child's play, DESCRIBE the child's behavior, and use ENTHUSIASM when playing (See Appendix A). A 5-minute session is held at the beginning where the parent is on their own with only being watched and not coached, once a therapist feels that a parent is proficient with the new skills (Bell & Eyberg, n.d.). Some may achieve this in a short period of time, and some may take longer to understand the connection of their parenting skills and their child's current behaviors (McNeil & Hembree-Kigin, 2010).

In Phase II (PDI) a therapist coaches the parent during play (Child Welfare Information Gateway, 2013). This is the discipline part of therapy, where again, the parent and therapist will meet alone to go over the information of the concepts, have discussions, and role-play. The sessions are first held at the clinic, then at a public place such as a playground (McNeil & Hembree-Kigin, 2010). The PRIDE skills are still used, but the parent is to use productive commands and consistent consequences for the child's behaviors (Bell & Eyberg, n.d.). Parents are also given homework to use the skills they have learned at home (Child Welfare Information Gateway, 2013). When all the current problems are resolved or significantly improved, there is a graduation session. The parents will then receive a certificate and the child will receive a prize for their successes. Most families meet their goals of treatment after 6 sessions of the PDI phase (McNeil & Hembree-Kigin, 2010).

PCIT does have some limitations. Parents who spend little time with their kids will not be able to hold the daily consistency that is needed. Parents with serious AXIS I disorders, that involve hallucinations or delusions, would have a difficult time following the reality needed to do the therapy. Parents who are hearing disabled or who have problems with their expressive or

receptive language skills would cause a barrier to treatment. Lastly, parents who are abusive physically or sexually, or the parent (s) have issues with chemical dependence are going to hinder the experience. With these populations, PCIT may not be effective, or an altered form of this treatment may have to be used. (Child Welfare Information Gateway, 2013)

Problem-Solving Skills Treatment

Problem-Solving Skills Treatment (PSST) has been applied for the treatment of conduct disorder. This treatment looks at how the child handles situations and how they can learn to handle these situations more effectively. The children talk firmly to themselves to get through an assigned task. Modeling and direct reinforcement are used as part of the problem-solving process. As treatment continues, cognitive problem-solving skills are applied more often. The therapist plays an active role in treatment by modeling cognitive processes by making verbal self-statements, apply those statements to problems, prompt the child when to use the skills that have been taught, and give feedback and praise to ensure the skills are used correctly (Kazdin, 1997). “Cognitively based treatments have significantly reduced aggressive and antisocial behavior at home, at school, and in the community” (Kazdin, 1997, p.164)

Functional Family Therapy

Functional Family Therapy (FFT) “...views a child’s symptoms as serving a function within the family, such as regulating emotional distance or avoiding conflict between the parents, and therapy is aimed at reorganizing family relationships to include more constructive ways to fulfill these functions” (Keiley, 2002,p.482). The belief of FFT is that families of conduct-disordered children show poor communication between parent and child, and parent and parent. FFT emphasizes the importance of not blaming others and giving mutual support to each other.

The therapist points out problems with family members in their daily functions, and addresses the problems for which therapy was sought in the first place. When the family realizes a different way to look at the problem, they can begin to interact more constructively (Kazdin, 1997).

Multisystemic Therapy

Multisystemic Therapy (MST) is a family-systems based treatment (Kazdin, 1997). MST uses an individualized treatment plan for each family involved in therapy. Assessments are done on each member of the family to establish each person's strengths and weaknesses. In this treatment, alliances are broken, family issues are handled as they come up, and individual problems are dealt with that contribute to problem behaviors (Keiley, 2002).

The therapy is conducted in the family household, by the therapist making home visits. This is an advantage because fewer families drop out of treatment and a more accurate assessment is done when witnessing clients in their natural environment. MST family therapists focus on ways to increase engagement between members, and work on the disconnection of the family structure (Keiley, 2002).

Chapter Three: Conclusions and Recommendations

The use of medication may be used to help some of the symptoms of CD, typically aggression. But the American Academy of Child and Adolescent Psychiatry (AACAP) states that medication solely is not enough to treat conduct disorder. (Eyberg, Nelson, & Boggs, 2008) Although there is no cure for CD (Tufts, 2013), PCIT removes some of the risks. Controlling the risks helps to manage CD from developing into ASPD. Through the use of PCIT, the therapist provides the parent with a proactive approach to coping with their children's behavioral problems (Tufts, 2013). Parent satisfaction is typically high with PCIT, and parents/caregivers report feeling better about their listening, talking, and interacting skills concerning their children. They also report less stress, and are less physical with their children when trying to control the child's bad behaviors. The live coaching helps parents to practice the new skills they have learned, as well as receive immediate feedback, support, and guidance. (Child Welfare Information Gateway, 2013)

Not only is Parent-Child Interactive Therapy effective in treating CD, it can also be used to treat Oppositional Defiant Disorder (ODD), Attention Deficit Hyper Disorder (ADHD), families where trauma has taken place, Fetal Alcohol Syndrome children, children with developmental delays, and children who have issues due to premature birth (Child Welfare Information Gateway, 2013).

It is a common belief that children outgrow behavior problems. While this may be the case with children whose behaviors fall within the developmental norms, children who display persistent aggressive and oppositional behaviors are at risk for developing more serious conduct problems throughout their childhood and adolescent development. Studies have shown that early intervention is critical. Continuous and untreated symptoms can worsen over time and interfere

with the development of the child's socialization, problem solving and self-help skills (McNeil & Hembree-Kigin, 2010). Although PCIT does have limitations, it can be used to treat children as early as the age of 3. For this reason, PCIT may have a high success rate in the prevention of CD developing into ASPD. Since a diagnosis of ASPD cannot be made without a prior history of CD symptoms prior to the age of 18, it is evident that the symptoms of CD are progressive.

Children from at risk families such as those with authoritarian parents are restricted in some ways from developing with social norms. By applying PCIT techniques, a parent learns to re-parent and the child develops self-control, reducing the impulsivity that is one of the key components in both CD and ASPD.

I would recommend that a family dealing with antisocial behaviors seeks treatment. Though a small percentage of families dealing with these issues see them disappear, it is not a given. The risk of letting the behaviors go on is tremendous, and the chances of having the law involved will increase as the behaviors do. Getting a grasp on the behaviors can allow a family to function in a successful manner, and possibly stop antisocial behaviors from being passed down to the next generation of the family.

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APPENDIX A

Child-Directed Interaction Rules Handout* Parent-Child Interaction Therapy

<i>Rules</i>	<i>Reason</i>	<i>Examples</i>
PRAISE your child's appropriate behavior	<ul style="list-style-type: none"> • Causes your child's good behavior to increase • Lets your child know what you like • Increases your child's self-esteem • Makes you and your child feel good 	<ul style="list-style-type: none"> • Good job of putting the toys away! • I like the way you're playing so gently with the toys. • Great idea to make a fence for the horses. • Thank you for sharing with me.
REFLECT appropriate talk	<ul style="list-style-type: none"> • Lets your child lead the conversation • Shows your child that you are listening • Demonstrates that you accept and understand your child • Improves your child's speech • Increases verbal communication between the two of you 	<ul style="list-style-type: none"> • <u>Child:</u> I drew a tree. • <u>Parent:</u> Yes, you made a tree. • <u>Child:</u> The doggy has a black nose. • <u>Parent:</u> The dog's nose is black. • <u>Child:</u> I like to play with the blocks. • <u>Parent:</u> These blocks are fun.
IMITATE appropriate play	<ul style="list-style-type: none"> • Lets your child lead • Shows your child that you approve of the activity • Shows that you're involved • Teaches your child how to play with others and take turns • Increases the child's imitation of the things that you do 	<ul style="list-style-type: none"> • <u>Child:</u> I put a nose on the potato head. • <u>Parent:</u> I'm putting a nose on Mr. Potato Head too. • <u>Child:</u> (Drawing circles on a piece of paper) • <u>Parent:</u> I'm going to draw circles on my paper just like you.
DESCRIBE appropriate behavior	<ul style="list-style-type: none"> • Lets your child lead • Shows your child that you are interested • Teaches your child concepts • Models speech for your child • Holds your child's attention on the task • Organizes your child's thoughts about the activity 	<ul style="list-style-type: none"> • You're making a tower. • You drew a square. • You are putting together Mr. Potato Head. • You put the girl inside the fire truck.

*This is a reproduction version of material from a forthcoming work tentatively titled *Comprehensive Handbook of Psychotherapy* Volume 2

Child-Directed Interaction Rules Handout
Parent-Child Interaction Therapy (Cont'd)

<i>Rules</i>	<i>Reason</i>	<i>Examples</i>
Be ENTHUSIASTIC	<ul style="list-style-type: none"> • Lets your child know that you are enjoying the time you are spending together • Increases the warmth of the play 	<ul style="list-style-type: none"> • <u>Child</u>: (Carefully placing a blue Lego on a tower) • <u>Parent</u>: (Gently touching the child's back) You are REALLY being gentle with the toys.
Avoid COMMANDS	<ul style="list-style-type: none"> • Takes the lead away from your child • Can cause unpleasantness 	<p>Indirect Commands:</p> <ul style="list-style-type: none"> • Let's play with the farm next. • Could you tell me what animal this is? <p>Direct Commands:</p> <ul style="list-style-type: none"> • Give me the pigs. • Please sit down next to me. • Look at this.
Avoid QUESTIONS	<ul style="list-style-type: none"> • Leads the conversation • Many questions are commands and require an answer • May seem like you aren't listening to your child or that you disagree 	<ul style="list-style-type: none"> • We're building a tall tower, aren't we? • What sound does the cow make? • What are you building? • Do you want to play with the train? • You're putting the girl in the red car?
Avoid CRITICAL STATEMENTS	<ul style="list-style-type: none"> • Often increases the criticized behavior • May lower your child's self-esteem • Creates an unpleasant interaction 	<ul style="list-style-type: none"> • That wasn't nice. • I don't like it when you make that face. • Do not play like that. • No, sweetie, you shouldn't do that. • That animal doesn't go there.

Child-Directed Interaction Rules Handout

Parent-Child Interaction Therapy (Cont'd)

<i>Rules</i>	<i>Reason</i>	<i>Examples</i>
<p>IGNORE negative behavior (unless it is dangerous or destructive)</p> <ol style="list-style-type: none"> a. avoid looking at the child, smiling, frowning, and so on b. be silent c. ignore every time d. expect the ignored behavior to increase at first e. continue ignoring until your child is doing something appropriate f. praise your child immediately for appropriate behavior 	<ul style="list-style-type: none"> • Helps your child to notice the difference between your responses to good and bad behavior • Although the ignored behavior may increase at first, <i>consistent</i> ignoring decreases many behaviors 	<ul style="list-style-type: none"> • <u>Child:</u> (Sasses parent and picks up toy) • <u>Parent:</u> (Ignores sass; praises picking up)
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content; margin: 0 auto;"> <p>Behaviors to ignore include:</p> <ul style="list-style-type: none"> • crying for no good reason • whining • playing roughly </div>		
<p>STOP THE PLAYTIME for aggressive and destructive behavior</p>	<ul style="list-style-type: none"> • Teaches your child that good behavior is required during the CDI special time • Shows your child that you are beginning to set limits 	<ul style="list-style-type: none"> • <u>Child:</u> (Hits parent) • <u>Parent:</u> (CDI STOPS. This can't be ignored.) On special time is stopping because you hit me. • <u>Child:</u> Oh, oh, oh mom. I'm sorry. Please, I'll be good. • <u>Parent:</u> Special time is over now. Maybe next time you will be able to play nicely during our special time.
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content; margin: 0 auto;"> <p>Aggressive and destructive behaviors include:</p> <ul style="list-style-type: none"> • hitting • biting </div>		