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Counseling and therapy of patients with behavioural disorders using the cognitive-behavioural approach

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Abstract

Problem statement: The diagnosis of behavioural disorders and their treatment's success needs to be analyzed. The factors of its success should be specified and the future of CBT hypothesized. Research questions: What are the factors that increase the risk of behavioural disorder? What are the models and approaches currently used in their treatment and what is the effectiveness of CBT? Purpose of study: In the paper author will attempt to find answers to the research questions in terms of capabilities and effectiveness of cognitive-behavioural therapy. Research methods: Literature review, including APA, models and theories, research analysis. Theoretical study findings: Current Research analysis shows high effectiveness of cognitive-behavioural therapeutic interventions. Described therapeutic interventions in mainstream cognitive-behavioural, and research on their effectiveness allowed the researcher to assume that CBT has a high efficiency in the treatment of destructive, aggressive and rebellious behaviour by using cognitive-behavioural techniques and strategies. Conclusions: Future research on the treatment of patients with behavioural disorders should focus on important areas such as multi-component interventions, effective methods of individualization, identification and management of group processes. Considering CBT of patients with BD, as a successful one in a future, depends on whether the research results under controlled conditions will confirm it in a wide clinical practice.

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Keywords: Behavioural disorder, oppositional defiant disorder, cognitive-behavioural treatment, models and types of intervention

1. Introduction

Nowadays, the issue of antisocial, oppositional, rebellious and destructive behaviour among children and

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adolescents is of increasing interest of researchers and scientists from different research areas. Thus, diagnosis of the personality of the patient diagnosed behavioural disorder, along with prevention and intervention programs have ben of particular interest. The researches have focused particularly on the characteristics of individuals with behavioural disorder, their environment, diagnostic symptoms, and causes and consequences of conduct disorders occurring at different levels with varying severity. Antisocial, aggressive, and other types of behaviour are related to disorders in which dysfunction persists the longest hence, the lack of therapeutic intervention can have considerable negative consequences at personal, family and social life levels.

According to the literature review, behavioural disorders are interpreted as a complex set of emotional, cognitive and behavioural problems, which are characterised by lack of control and respect of the social and moral principles, and difficulties behaving in a desirable and socially acceptable manner.

However, the prevalence, diagnosis and prescriptive practices for behavioural disorders have received much attention over the last years (Culpepper & Fried, 2013; Stephen & Bailey, 2013; Monuteaux, Faraone, Gross, & Biederman, 2007; Frick & Dickens, 2006). The psychosocial problems among patients with these disorders, their experience and the consequences when their emotional and behavioural needs are unmet have been addressed less frequently. Children and adolescents with behavioural disorders struggle with some common issues that make them a vulnerable population. Socially, they are less popular among peers and have fewer friends with a positive attitude and socially desirable behaviour (Elkins, Malone, Keyes, Iacono, & McGue, 2011; Mannuzza et al., 2000). Some studies reported higher rates of depression, suicide attempts, and anxiety among youth with behavioural disorders (Zahn-Waxler et al., 2008), higher likelihood of engaging in risky behaviours such as substance abuse (Elkins et al., 2011; Farone et al., 2007; Torok, Darke, & Kaye, 2012) and negative involvement with the law (Pardini & Fite, 2010).

What is the difference between aggression, hooliganism and behavioural disorder? What factors t contribute to the occurrence of behavioural disorder and to what extent? What models and approaches are currently used in the treatment of behavioural disorders? Are cognitive-behavioural therapy and programs developed effective in the treatment of behavioural disorders? In the article the author will attempt to evaluate capabilities and effectiveness of cognitive-behavioural therapy and to find answers to these questions.

The article consists of several parts. The first describes the diagnostic features of behavioural disorder, distinguishing between conduct disorder (CD) and oppositional defiant disorder (ODD), as well as the risk factors of their occurrence. The next part describes the genesis of cognitive-behavioural therapy and presents the latest model for therapeutic intervention in the field of behavioural disorders. The last part of the article defines the cognitive behavioural therapy, and presents current research on the effectiveness of cognitive-behavioural therapy and programs aimed at adolescents with CD

1.1. Behavioural disorder and oppositional defiant disorder: definition and diagnostic criteria

Aggression, delinquency, and substance abuse have to be considered, when diagnosing behavioural disorder in terms of respect of social norms, authority and other people rights. An in-depth analysis of the "behavioural disorder" concept indicated a wide range of behaviours starting from the strong emotion of anger, rage and deliberate irritability of other people, highly conflicting relationships with adults, alcohol and drugs abuse and possibly injuring oneself or another person. These behaviours are characterised by high level of co-occurrence (Shubina, 2012). It should be noted that because of the diversity of those behaviours, it is possible to attribut a common psychological characteristic to all of them, which is antisocial behaviour.

The results of the current study allow us to conclude that children with behavioural disorders are a heterogeneous group, which accounts for a lack of agreement in the classification of behavioural disorders and their subtypes.

According to the DSM-IV, it makes sense to apply a two-dimensional approach to identify certain groups of symptoms of behavioural disorders. Based on the given classification, there are two major behavioural disorders: 1. conduct disorders (CD) - defined as symptoms of aggressive behaviour, that cause a physical threat to other people or animals and symptoms of non-aggressive behaviours, that can damage objects or can lead to property infringement, fraud and theft, as well as violation of rules; 2. oppositional defiant disorder (ODD), defined as a

recurring pattern of negativistic, stubborn, disobedient and hostile behaviour toward authority figures (APA, 1994). According to the DSM-IV an individual with behavioural disorder is characterized by aggression towards people and animals (bullying, threatening, or intimidating them, initiating fights, using a weapon, exhibiting physical cruelty, robbing, forcing sexual activity), destruction of property (damaging or destroying someone else's property), fraud or theft (breaking into someone else's apartment, house or car; stealing; not confronting the victim), a serious breach of the rules (staying out late into the night before 13 years of age, running away from home at least twice, missing school before 13 years of age) (Bloomquist, 2011). However, a pesron with oppositional defiant disorder loses his/her temper, argues with adults, actively defies or does not obey the command, deliberately annoys others, blames others, is touchy or easily annoyed, often gets angry or offended, and is malicious or vengeful. (Bloomquist, 2011)

Children and youth with behavioural disorders can be aggressive, provokative, and experience strong emotional distress with co-morbid health conditions, making the treatment more difficult (Guevara et al., 2007). Additionally, in a crisis, behaviours and distress can increase and may include self-harm. A recent study conducted in Israel reported that ADHD, adjustment disorder, and conduct disorder are the three most common behavioural disorders in children age ≤12 years admitted to a psychiatric hospital with suicidal ideation or attempt (Ben-Yehuda et al., 2012). That study showed that the most common diagnoses given to youth (>12 years) were depression, adjustment disorder, and conduct disorder.

Some studies stated that young patients with behavioural disorders manifest chronic, severe, and pervasive maladaptive behaviour and social responses (Gresham, 2005). Some studies identified several negative outcomes for children with behavioural disorders, which include school failure, dropping out, unemployment, substance abuse, and contact with mental health or criminal justice systems (Bradley, Doolittle, & Bartolotta, 2008). Some studies reported that difficulties in social, academic, behavioural, and emotional functioning strongly contributed to the negative outcomes experienced by children with behavioural disorders; however, they emphasized, that problems in each of these areas are related in ways that are not well understood yet (Tomblin, Zhang, Buckwalter, & Carts, 2000).

Although children and youth with a range of maladaptive behaviours are at risk of developing communication disorders and low language proficiency. These types of behaviours are often overlooked in children whose challenging behaviour is highly salient to adults (e.g., Donahue, Gole, & Hartas, 1994 Gohen, Davine, Horodezky, Lipsett & Isaacson, 1993). Researchers have also noted that those children's language deficits are wrongly perceived as inattention, low intelligence, noncompliance, or disrespect, deliberate dishonesty, and defiance (Donahue et al., 1994; Gohen et al., 1993). Such perception may cause additional frustration, stress, and blame that may contribute to negative or coercive interactions (Sutherland & Morgan, 2003).

Oppositional defiant disorder (ODD) is characterised by a pattern consisting of disobedient, oppositional and hostile behaviours directed at authority figures (American Psychiatric Association, 2000). Along with this symptomatology, patients with ODD frequently display emotional instability; argue continually with adults; deliberately annoy others; get highly furious, irritable, and resentful; and show difficulty with a wide variety of emotional states, such as high emotional liability and low tolerance to frustration. Patients with ODD can present different levels of comorbidity, which signifies a greater or lesser degree of severity and personal adjustment (Loeber, Burke, Lahey, Winters, & Zera, 2000).

Patients with ODD have clinical symptoms similar to Borderline Personality Disorder, namely, explosions of rage, difficulties handling emotions, emotional instability, self-harm behaviours, impulsiveness, interpersonal problems and problems folowing rule (APA, 2000). Untreated emotional and behavioural disorders are usually strongly associated with negative outcomes such as poor personal relationships, poor grades, failure to complete high school, unemployment, substance abuse, and suicide (Smith et al. 2011). Young patients with emotional and behavioural disorders display highly variable externalizing and internalizing symptoms, that characterize many psychiatric disorders such as depression, anxiety, or posttraumatic stress disorder. Emotional and behavioural disorder symptoms manifest themselves within classrooms through extremely high levels of problem behaviours (e.g., fighting, aggression, disruption) and low levels of appropriate behaviours (e.g., positive social interactions, time on-task) (Jack et al. 2004; National Center for Special Education Research, 2006; Seidman 2005). Disruptive behaviour problems (e.g. fighting in class, impulsivity, aggression, disruptiveness) are the most highly related to Emotional and behavioural Disorders symptoms and correlate highly with academic failure (NCSER 2006; Wagner et al. 1991).

Patients with behavioural disorders display high comorbidity with ADHD (Hinshaw, 1994), major

depressive disorder (Angold & Costello, 1993) and, in case of adolescents, alcohol and substance abuse, aggravating the symptomatology (Whitmore et al., 1997). Comorbidity is more prevalent in families with negligent and incoherent educational practices and implies deterioration in the adaptation of such children to their school and family environment (Stormschak, Speltz, DeKlyen, & Greenberg, 1997).

In addition, the DSM-IV classification distinguishes the behaviour problems according to the age of their occurrence, that is, the childhood CD (occurs before 10 years old) and the CD in adolescence (occurs after 10 years of age) (APA, 1994).

Another important indicator of behaviour disorder is the level of the symptoms' severity. The DSM-IV classification distinguishes three levels of severity of behaviour disorders: mild, moderate, and severe. Mild behavioural disorders are recognised when the investigation of the child or young person leads to a slight violation of the law and does not cause severe health risks to others or the self. However, it is cumbersome, deviates from accepted standards and meets the diagnostic criteria included in the DSM-IV. In contrast, moderate CD is characterised by emotional and social dysfunction which is significantly harmful to the environment and poses a threat to the physical health of people or animals. Finally, severe behaviour disorder is recognised when the diagnostic criteria contained in the DSM-IV are met, and characterized by a particularly high intensity as well as severity (APA, 1994).

Regarding the distinction between CD and ODD, it is important to mention that the current studies provide some evidence that CD is an advanced form of the ODD and that there are similar correlates between them, namely, low socio-economic status, at least one of the parents suffered from antisocial personality disorder (Frick, Lahey, Loeber et al., 1992), the parents do not use effective methods of education (Frick, Lahey, Loeber et al., 1993).

Significant issue is the occurrence of some behavioural disorders among children and adolescents. According to DSM-IV, incidence of ODD ranges from 2 to 16%, and incidence of CD ranges from 6 to 16% for boys and 2 to 9% for girls. It has been empirically confirmed that the behavioural problems during childhood usually reflect aggressive behaviour while problems during adolescence – reflect the offensive behaviour (Zoccolillo, 1993).

Other resources indicates that the point prevalence of school aged children with Emotional and behavioural Disorders in the U.S. is 12–13 % and these children present with at least moderate impairment (Forness et al. 2011; Merikangas et al. 2010).

Speaking about the behavioural disorders among children and adolescents, it is necessary to mention their co-occurrence with other disorders, namely 75-90% of children with behavioural disorder have co-morbid ADHD (Abikoff & Klein 1992), 60-75% of children referred to the hospitals have comorbid anxiety disorder, and 15-31% of them - have comorbid depression (Zoccolillo, 1993).

Behavioural disorders prevalence oscillates between 2 and 16% of adolescents (APA, 2000). Furthermore, adolescents suffering from behavioural problems, alcohol abuse, drug dependency and problems of emotional instability, including ODD, are at a greater risk of committing suicidal and parasuicidal acts (Miller & Taylor, 2005). The joint presence of three factors - emotional instability, behavioural disorder and impulsiveness - is related to suicidal behaviour in children and adolescents (Miller, Rathus, & Lineham, 2007). Many suicide attempts which adolescents make are impulsive acts, with only a quarter being planned (Hoberman & Garfinkel, 1998).

Some sources suggest that behavioural disorders hav an important diagnostic cause, which is neuropsychiatric disease, a low level of intelligence, ADHD, aggression and mental illness in the family. Among other important distinguishing characteristics of BD are: lack of empathy, poor understanding of the intentions of others, lack of a sense of guilty and low self-esteem. Additionally, the intentions and suicide attempts should be seriously considered in treatment of young people with diagnosed conduct disorder and depression (McMains , Maynard & Conlan , 2003).

Many studies have provided data that show that behavioural disorders are the result of a complex interaction among certain specific groups of factors (Lochman, 2003; Frick, 1994). Lochman, Magee and Pardini distinguished four groups of factors: biological factors, family context, social ecology and relationship with peers, social cognitive content (Lochman, 2005). Biological factors are associated with the possibility of inheritance of diseases and disorders, and occurrence of other diseases with biological background that predict behavioural disorder. Group of family factors includes: poor mental adaptation, low level of parents' socialization, and marriage instability (Frick, 1994). Ecological indicators refer to low socio-economic status, low level of education, neighbourhood and related environmental stressors, and lack of acceptance among peers in early childhood (Miller-Johnson, Lochman, Coie, Terry & Hyman, 1998). Some studies have shown the relationship between the rejection

by peers and the substance abuse, truancy and violence (Lochman, Wayland, 1994). The cognitive factors should include social deficits in cognitive content and processing of information. Those factors are basic in planning and implementing of cognitive-behavioural interventions.

Other approaches have been used to classify risk factors for behavioural disorders, which, however, is difficult to generalize. Some cases correlate with genetic factors, exposure to psychoactive substances in early life, brain damage, behavioural disorders in the family, the specificity of temperament, maternal smoking during pregnancy, negative parent duties, child abuse, and inadequate peer relationships. However, it should be not analysed as a single factor that conditions the behavioural disorder, but as a group factors, that would yield a cumulative total. On the other hand, some healing factors, such as parental competence, specific features of the child's personality and appropriate social environment can have a positive effect and increase the resilience of the child. Modern studies consider the general assumption that approximately 40% of the behavioural disorder results in antisocial personality disorder in the future (McMains, Maynard & Conlan, 2003).

Another classification distinguishes biological, psychological and social risk factors. Biological determinants are defined as occurrence of some specific problem in a family, such as ADHD, addiction or affective disorder. Irresponsible parenting, social deficits and problem solving deficits, the tendency to non-accent the social aspects, attributing negative motives and hostile actions to others, the difficulties in developing solutions to the problems, and attitude of aggressive behaviour strengthening are among the most prevalent psychological facors. Social factors are classified as poverty, violence in the community, dysfunctional environment, lack of control and support from parents, severe punishment, child molestation, behaviour deviant peer groups, the tendency to experience weak therapeutic effects (Opositional Defiant Disorder and Conduct Disorder. n.d.).

1.2. Models of cognitive-behavioural therapy

Contemporary cognitive-behavioural and socio-cognitive theories and models have their roots in the theories of social learning and are associated particularly with the model Rotter (1954), which suggests that the child's social environment influences on future occurrence of his mental disorder (Lochman, Magee & Pardini, 2005. Initially, human behaviour was seen as a process, subject to change depending on the subjective value attributed by some people to factors, that actively reinforce behaviour and to their expectations regarding the receipt of awards in certain conditions.

The interpretation of the concept of behaviour as a process of social learning by Mischel (1973) is important because it is the attempt to combine the latest achievements of learning theory with studies on cognitive processing and mental representations. According to this model, processes and capacities are treated as personality variables that mediate the relationship between the influence of the environment and the behaviour of people (Lochman, Magee & Pardini, 2005). However, situational variables affect behaviour through the effect on human cognitive patterns at different stages of their occurrence and modification, which in turn contributes to some behavioural changes in life situations.

Early behavioural therapies for children and adolescents have focused mainly on behavioural self-control. This is evidenced by, among others, by Meichenbaum program of cognitive therapy for hyperactive children self-control developed in 1971. The therapy teaches children to control their behaviour by modelling verbalization, and mastering inner speech usage. Kendall futher developed a more comprehensive treatment program to teach children various problem-solving skills of internalizing the statements related to coping with frustration and failure (Lochman, Magee & Pardini, 2005).

The treatment of choice for behavioural problems aimes to reduce maladaptive behaviours and increase adaptive behaviours through the systematic training of parents (Eyberg, Nelson, & Boggs, 2008). Yet these same authors commented that the results are poorer in adolescents older than twelve years of age and in adolescents who exhibit psychiatric comorbidity, aggressive behaviours and family dysfunction (Barckley, Edwards, Laneri, Fletcher, & Metevia, 2001; Greco & Eifert, 2004). One reason for such a loss of effectiveness might be that this type of intervention focuses mainly on reducing disruptive behaviours and acquiring socially acceptable behaviours. In contrast, the interventions do not consider the acquisition of emotion regulation skills, despite this being one of the main characteristics of ODD. Furthermore, parents are often not willing to participate in therapy or allow their

children with with psychiatric comorbidity to be treated thus, family dysfunction often predict a poorer therapeutic outcomes (Kazdin & Wassell, 1999).

As mentioned before, adolescents with ODD display similar symptomatology to Borderline Personality Disorder (BPD), and they share common risk factors such as dysfunctional child-raising patterns, rejection or family problems. One of the treatments that has received greatest empirical support for BPD and for problems of emotional instability is dialectical behavioural therapy (DBT) (Staffers et al., 2012).

DBT is an intervention program that deals primarily with the main symptomatology of ODD (emotional instability, low tolerance with frustration, interpersonal problems and impulsiveness) which leads us to believe it could be effective in treating ODD in adolescents. Some preliminary evidence of the usefulness of DBT in this group already exists. Nelson-Gray et al., (2006) applied DBT to a group of participants diagnosed with ODD, noting a reduction in emotional symptomatology after receiving skills training. Participants received training only in emotional self-regulation skills, but not the full DBT intervention (Linehan, 1993). These participants did not exhibit psychiatric comorbidity, parasuicidal behaviours or aggressive behaviour toward their parents.

Modern cognitive-behavioural theories and models of behavioural disorders are based on the assumption that the cognitive content (beliefs, assumptions or thoughts) affect person's behaviour. The change in clinical outcomes deals mainly with patterns of behavioural response and cognitive content, that accompany or trigger that behaviour. In this approach, the behaviour is understood as a function of the perception of social environment and the idea of the best way to solve perceived difficulties and social conflicts. The model of anger eliciting and model of social information processing are important from the scientific point of view and from the perspective of this study.

The model of anger eliciting is actively used in the treatment of children and adolescents with conduct disorder, which brings significant and measurable results. The main advantage of this model is that it emphasizes the sequential nature of the cognitive processing process, which consists of several phases. The first phase includes naming, assigning reasons and perceiving an event, object or person. Phase two includes an action plan regarding person's response to perceived danger or threat (Lochman, Magee & Pardini, 2005). This model emphasizes specifically the correlation among the cognitive assessment of the situation, cognitive assessment of the problem's solutions, physiological arousal, and individuals behaviour. The assumption developed within the framework of this model allows us to explain the chronic nature of the difficulties of coping with behavioural disorders among children, showing their cyclical nature and causes of ineffective coping with rooted patterns of aggressive behaviour.

Social information processing model created by Dodge consists of the phases and sub-phases of cognitive processing of the information pertaining social problems. This model contains five consecutive stages, namely: 1. encoding the relevant social guidance, 2. interpretation of the guidance, 3. generation of potential solutions, 4. their evaluation, and 5. implementation of the selected response. The author demonstrated that aggressive tendencies in children could occurred at any of the stages. The most important here are the cognitive and behavioural deficits. In addition, Dodg's study has shown that children with aggressive behaviour are more likely to remember less important information related to events (Lochman & Dodge, 1994); their interpretations are based on a smaller amount of those tips (Dodge& Nemwan, 1981); and they selectively pay attention to hostile rather than neutral information or the latest information related to events or guidance, selectively ignoring guidance, as mentioned earlier (Milich & Dodge, 1982). In turn, studies have shown that in the interpretation stage aggressive children tend to have a hostile attribution style distortion (Dodge, Petit, McClaskey & Brown, 1986).

On the stage, reminding possible solutions to the problem of children with conduct disorder exhibit deficits in terms of quality and quantity of produced solutions: such children propose less verbal solutions, they compromise less, they engage in more direct action, and react more aggressively (Lochman, Magee & Pardini, 2005). The fourth stage consists of identifying and evaluating the consequences of each of the behaviours. Children diagnosed with aggressive behaviour percieve aggresiveness as more positive because they have cognitive beliefs about the usefulness and effectiveness of aggression in achieving its goals. In the final stage, children with conduct disorder have greater difficulties engaging in a pro-social behaviour. In summary, according to that model it is possible to utilize therapeutic intervention along with cognitive content, and thus with the behavioural content.

1.3. Types of cognitive-behavioural intervention

Cognitive-behavioural models discussed above have been used as a basis for the development and implementation of practical therapeutic programs for the behavioural disorders. The most important and effective cognitive-behavioural intervention programs used to treat behavioural disorders, i.e., Anger Management Program and Problems Solving Program, are going to be discussed in detail in the following section.

Anger Management Program is a structured group intervention (around 4 - 6 person groups) for aggressive children consisting of eighteen sessions. It was originally used as a preventive program at school and as a therapeutic program for children with CD and ODD. Each sessions has moderate structure with well-defined goals and action plan.

The main objectives of the Anger Management Program are helping and supporting the child in finding appropriate ways to deal with the sudden increase of physiological arousal and anger; assisting in retrieving some effective strategies that could be applied after adapting to a situation of conflict resolution retrieved from the memory; teaching the child to recognize the level of anger in difficult situations or triggering responses of high excitation; helping the child apply of several effective ways to cope with physiological arousal and offering impulsive responses prevention (eg, distraction, relaxation techniques, inner monologue, etc.) (Lochman, Magee & Pardini, 2005).

The objectives of the programme in relation to each session, include the introduction and establishment of group rules and amplification systems (session 1); setting goals (Session 2); anger management skills training (session 3, 4); accepting other people's perspectives (Session 5, 6); awareness of the physiological state of excitation and anger (Session 7); social problems solving (session 8-18). The last objective is the longest part of the program implementation, as it encourages the child to develop various of socially desirable solutions to problems. During the program implementation each participant prepares his/her own video, recording one or more of difficult situations with which he/she had to cope with in reality (Lochman, Magee & Pardini, 2005) .

The methods used in the program (including different ways of dealing with physiological tension, role-play, puppet theatre, and autoinstructions) promote the acquisition and the strengthening of relevant and useful mechanisms, methods and techniques to cope with difficult situations.

Another effective and useful treatment is the Problem Solving Program, which was developed to enhance the effects of therapy and relapse prevention, increasing the durability of the improvements. This program is implemented in 33 group sessions. In addition, it includes work with emotional consciousness, social skills, positive and desirable social and personal objectives, as well as the skills to deal with peer pressure. Another important and distinctive element of the Program is having regular individual sessions every 4-6 weeks, which are designed to increase the applicability of mastered the techniques and methods in practice.

Program Problems Solving also includes consultation with teachers of children with behavioural problems, and its aim is to strengthen the competence of parents in dealing with difficult behaviours of their children. The implementation of the Program component targeting parents was divided into 16 group sessions conducted over 15-18 months. The main objective is to teach the parents to use positive attention, and social empowerment, to establish rules and behavioural reinforcement, to establish the methods for monitoring discipline strategies, as well as to develop the ways to improve communication in the family, and effective stress management skills (Lochman, Magee & Pardini, 2005).

The cognitive-behavioural intervention programs considered above showed remarkable effectiveness in the treatment of children and young people diagnosed with behavioural disorders and proved to be a complex and deeply analysing approach to clinical problems.

1.4. Characteristics of cognitive-behavioural therapy of behavioural disorders

CBT is a problem-oriented approach, aimed at identifying and changing dysfunctional beliefs, thoughts and behavioural patterns associated with the clinical problem. CBT assumes that thoughts affect emotions, which in turn

affect the individual's behaviour. Both the style and the process of cognitive-behavioural therapy is based directly on the classical approach developed by Beck and colleagues. Hence, cognitive-behavioural therapy of behavioural disorders is an active, structured, and time-limited form of treatment, where the therapist and patient cooperate to develop treatment plan and goals. The CBT for treatment of behavioural disorders utilizes several techniques. It identifies the basic thoughts and beliefs, clarifies the relationship among thoughts, emotions, physical symptoms and behaviour, looks for evidences of the rightness of dysfunctional beliefs and unlike, behavioural experiments, it generates alternative hypotheses (Beck, 2005).

However, the standard approach of cognitive-behavioural therapy must be modified in connection with the specific problems arising from the specific behavioural disorders. Specifically, the characteristics of the child, parents and family as a system, as well as contextual conditions must be considered. Among the child characteristics it is possible to distinguish comorbidity with other disorders, having a variety of deficits, low ambitions level, poor school achievement, school problems and difficulties, poor social skills, and high suspicion and hostility toward others. The family characteristics include criminal behaviour and alcoholism, excessive discipline, ineffective parenting, little supportive and more demanding communication with children, dysfunctional relationships, unhappy marital relationships, interpersonal conflicts, and aggression. The contextual features refer mainly to large families, inadequate housing and school reinforcement conditions, which increase aggressive and anti-social relations (Kazdin, 1997).

Cognitive-behavioural approach assumes that the understanding of the situation by different people, as well as a way of thinking about these situations stems from the fundamental beliefs that people have about themselves, their experiences and the world around them. These beliefs are formed based on of previous experience. The wrong way of perceiving and interpreting the events leads to learning a non-adaptive behaviours (Beck, 2005). Cognitive-behavioural therapy aims to modify these behaviours through the cognitive restructuring of the content of thoughts, assumptions and beliefs, rather than directly. Thus, cognitive behavioural therapy focuses on helping the patient understand the processes and their effect on thoughts, emotions and behaviour, when re-evaluating the perception of themselves, their behaviour, and others.

Furthermore, cognitive-behavioural approach focuses on the "here and now", 2 but behavioural disorder development is closely interwoven with individual's experience. Discussing these experiences in the course of therapy enables – both patient and therapist to recognize factors that may contribute to the development of the disorder. The typical cognitive-behavioural therapy session includes: 1. evaluating the frame of mind since the last session,2. summarizing previous session and determining the current plan, 3. work with the planned symptoms or problems, 4. setting up homework, 5. summarizing the session, 6. setting up the treatment plan for the next session.

Cognitive-behavioural therapy in the treatment of behavioural disorders includes a systematic re-learning a realistic and functional response to both external and internal factors. This teaching is supplemented with psychoeducation. To achieve the treatment effect, learning has to occur in various situations and take place regularly. (Shubina, 2012).

Cognitive-behavioural therapy of children with CD and ODD uses various techniques and methods focusing on explaining the cognitive element role in therapy, including trust, promoting cooperation, and finding common cognitive patterns. The cognitive-behavioural model aims to show the relationship among thoughts, emotions and behaviour theoretically, practically by evaluating the patients' thoughts or metaphorically, what makes this model more comprehensive and practical for the patient. Building trust is essential in cognitive-behavioural therapy, as it encourages addressing the problem more effectively, achieving changes faster and encouraging proactive patient's participation in the therapy (Cole, 1989). Cooperation between therapist and patient at the advanced level guarantees the acquisition of real indicators of therapy, specifically life events as well as the maximum commitment of the therapist in the process of treatment.

The involvement in the treatment of patients with behavioural disorders, based on the cognitive-behavioural techniques has three basic levels, namely:

- case conceptualization;
- assessment of the level of desired change and therapeutic needs;
- 3 cognitive-behavioural level (Cole, 1989).

Conceptualization is the basis of the treatment, its progress, and achievements. It involves the analysis of the problem in a holistic, comprehensive context of the functioning of the person with the disorder, and includes the identification of negative automatic thoughts, their meanings and images, and their emotional and behavioural reactions (Cole, 1989). Good case conceptualization allows one to draw meaningful hypotheses and factors of

behaviour disorders, as well as to identify problems associated with them. The most commonly used strategies in cognitive-behavioural therapy of behavioural disorders are self-observation, excitation processes control, the development of alternative behaviours, learnings of new functional skills. The aim of these fundamental techniques is to teach the patient to effectively overcome his difficulties by acquiring the ability to make the right decisions, engage in cognitive restructuring, and conduct behavioural experiments. Cognitive-behavioural therapy includes the identification and modification of dysfunctional cognitive thoughts, assumptions and beliefs, that cause relatively permanent cognitive and behavioural changes in a person with behavioural disorder.

Many studies have evaluated various therapeutic models and treatment programs for behavioural disorders. Many of them have demonstrated remarkable effectiveness of cognitive-behavioural approach. According to the current research on the effectiveness of behavioural disorder models and approaches, problem-solving skills training, anger management training developed and implemented within cognitive-behavioural therapy, as well as cognitive behavioural therapy in combination with management training for parents have proven to be the most effective (Opositional Defiant Disorder and Conduct Disorder. n.d.).

Cognitive behavioural therapy is used mainly for the following symptoms of behavioural disorders: violence and crime, substance use, pregnancy, risky sexual behaviour, school failure, and suicidal attempts. Meta-analysis of programs developed for the criminals have shown that cognitive behavioural therapy is highly effective in reducing the recidivism. Meta-analysis conducted by Landenberger and Lipsey (2005) confirmed that the selected components of cognitive-behavioural therapy can enhance the effect on the prevention of relapse. Ferrer-Wreder Research et al. (2003) demonstrated the effectiveness of programs based on the of cognitive-behavioural therapy assumptions aimed at people with substance abuse (Opositional Defiant Disorder and Conduct Disorder. n.d.).

Another group of pregnancy prevention programs utilizing cognivite-behavioural therapy to target adolescents who engage in risky sexual behaviour has been found to be effective. These types of programs can reduce the level of risky behaviour; increase the skills to take positive decisions in life; increase positive attitudes towards health and help adolescents make positive choices about their own health (Opositional Defiant Disorder and Conduct Disorder. n.d.). Overall, these programs have demonstrated significant reduction in the level of unwanted pregnancy among minors.

Programs for students who have difficulties at school developed based on the assumptions and strategies of cognitive-behavioural therapy were effective at individual, class, school, and community levels. Such behavioural programs were based on four categories: structured basic activities; behavioural consultation; behavioural monitoring and increasing the presence, academic achievement and school behaviour; and deliberate education students who quit or are incapable of schooling (Cognitive behavioural Treatment, n.d.). Review of research of Brestan and Eyberg (1998) pointed out that effective programs included significant cognitive-behavioural components: ofAnger Management Program, and Problem Solving Program (Lochman, Magee & Pardini, 2005).

According to Kazdina's research, training for parents, multistandard therapies and training for cognitive problem-solving skills should be considered effective. Multiple therapies that focus on children's cognitive and behavioural processes as well as educational activities for parentshave proven their effectiveness, as they affect various risk factors and protective behaviours, inducing more positive results and supporting more effectively the cognitive-behavioural change among in children with behaivoral disorders (Kazdin, 1997).

Conclusion

Consideration the discussion above, it is possible to state that behavioural disorders (CD and ODD) are complex clinical problems that affect the functioning of individuals in various spheres of their lives. These disorders may be caused by more cumulative risks factors such as biological, psychological and social, which may take various behavioural forms, and entail problems of various cognitive and emotional character. Additionally, they can be different, depending on the severity of the presented symptoms and diagnostic indicators.

The prevalence of behavioural disorders oscillates between 2 and 16% of adolescents. Behavioral disorders often co-occur with alcohol abuse, drug dependency, emotional instability, suicidal and parasuicidal acts, communication disorders, low language proficiency, school failure, dropping out, unemployment, and contact with mental health or criminal justice systems.

Current studies on the effectiveness of the therapeutic interventions' have indicated that cognitive-

behavioural models, are more effective. The therapeutic interventions that utilize cognitive-behavioural approach, and the studies on their effectiveness, as described in this paper, suggest that cognitive-behavioural techniques and stretegies can be used to successfully treat destructive, aggressive and other types of behavioural disorders.

It seems that future research on the treatment of children and youth with behavioural disorders should focus on important areas such as multi-component interventions, effective methods of individualization of intervention, as well as the identification and management of group processes and group dynamics. For example, planning research on the group processes and group dynamic might be interesting and useful for examining whether therapeutic interventions have a direct and immediate effect on cognitive and behavioural changes among children and adolescents with behavioural disorders and how. Studies should also focus on such variables as the characteristics of children and adolescents participating in therapy, risk factors for developing behavioural disorders, and the like. The factors that can maintain a change in the behaviour of children and adolescents with behavioural disorders after the intervention, and prevent relapse should also be explored in the future.

The future of the CBT does not preclude combination with other effective approaches and models of intervention. Thus, for example, combining the CBT with the motivation therapy may enhance the efficiency of therapeutic relationships building, particularly the cognitive and behaviour content implementation. The success of cognitive-behavioural therapy of patients with the behavioural disorders depends on whether a large clinical practice confirm the results of research carried out in controlled conditions.

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