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Substance Abuse Prevention Programs: A Review of Risk Factors, Fundamental Program Components and the Coping Power Program

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Substance Abuse Prevention Programs: A Review of Risk Factors, Fundamental Program Components and the Coping Power Program

This is to certify that the Capstone Project of

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Abstract

The Substance Abuse Mental Health Services Administration created the National Household Survey, which showed children are already abusing substances by ages 12 or 13 (Robertson, David, & Rao, 2003). Often, signs of risk can indicate whether children will have a higher or lower likelihood of substance abuse. The signs can be detected as early as infancy in certain cases. Risk signs identify as risk factors, predictive factors, and adverse childhood experiences. The risk signs may vary within cultures. Prevention programs target risk signs at different developmental levels because risk continues to evolve while children age. An example prevention program, The Coping Power Program, will be reviewed as how it incorporates risk sign identification and its results in reducing substance abuse.

Keywords: Prevention, Risk, Risk Factors, Protective Factors, Substance Abuse

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Substance Abuse Prevention Programs: A review of risk factors, fundamental program components and the Coping Power Program

The prevention field of alcohol, tobaccos, and other drugs continues to evolve as research continues to show evidence of early risk factors. Substance abuse risks factors can be determined as early as infancy in some cases. Identifying the risk factors at earlier ages is essential in prevention. Students can spend up to eight hours a day in a school setting which provides school personnel an opportunity to help identify risk factors. Studies have shown that children with poor academic performance and inappropriate social behavior at ages seven to nine are more likely to be involved in substance abuse by age 14 or 15 (Robertson, David, & Rao, 2003).The scope of this research is reviewing what prevention from a school's vantage point. A school is not a single entity. Schools collaborate daily with student's families, the community, and other local, statewide, and national resources. The focus of this capstone is to review risk factors, fundamental prevention program components in a school setting, and the program: Coping Power Program.

The National Institute on Drug Abuse (NIDA) identified 16 prevention principles regarding risk and protective factors, prevention planning of family, school, and community programs, and prevention program delivery. The 16 prevention principles (Robertson, David, & Rao, 2003) include:

1. Prevention programs should enhance protective factors and reverse or reduce risk factors.
2. Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs, illegal drugs, and the inappropriate use of legally obtained substances, prescription medications, or over-the-counter drugs.

3. Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.
4. Prevention programs should be tailored to address risks specific to population or audience risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.
5. Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.
6. Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse such as aggressive behavior, poor social skills, and academic difficulties.
7. Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse such as early aggression, academic failure, and school dropout. Education should focus on the following skills: self-control, emotional awareness, communication, social-problem-solving, and academic support, especially in reading.
8. Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of antidrug attitudes, and strengthening of personal commitments against drug abuse.
9. Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families

and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

10. Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.
11. Community prevention programs reaching populations in multiple settings- for example, schools, clubs, faith-based organizations, and the media- are most effective when they present consistent, community-wide messages in each setting.
12. When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention, which include: structure, content, and delivery.
13. Prevention programs should be long-term with repeated interventions to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.
14. Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding.
15. Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.
16. Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen.

These principles derived from research and current studies funded by the NIDA. The 16 principles can be used to assist in planning, developing, and delivering substance abuse prevention programs. Principles six through eight align with the school setting and identify fundamental program components to the three primary educational settings. In addition to these, other particular needs should also be examined when a school is selecting the most appropriate prevention program. For example, cultural considerations are important to ensure the material is applicable and developmentally suitable for the population. Secondly, selecting the population receiving the instruction will affect the type of prevention program. When identifying recipients for the prevention program, there are three levels to consider: universal, targeted/selected, and indicated.

Universal, targeted/selected, and indicated are three levels of intervention that determine the program's audience. Universal programs are for the general population or in a school setting, the entire student body. An example of this would be a sex education program taught to all students in a particular grade. Every student is receiving the education regardless if they are considered “at risk.” Selective or targeted programs work with people who have been identified “at risk.” In a school situation, this could be a group of students who are failing one or more classes. Indicated programs are composed of a population at the highest risk. For example, they may already be using or have used substances. Identifying the target population is an essential step in the planning process of prevention programs.

Review of Literature

Prevention programs aim to reduce factors that increase the likelihood of obstacles and barriers to an individual's developmental trajectory path. Specifically, this is done by identifying signs of risk at the earliest stage, increasing elements that protect people from problems and are supportive, and identifying adverse childhood experiences that may have occurred and providing appropriate supports. Risk signs are present at every developmental stage and transition. Prevention programs work to target these risk factors to reduce both current and projected substance abuse concerns.

Early Signs of Risk

When exploring the early signs of risk, the following key terms surface risk factors, protective factors, predictive variables, and adverse childhood experiences. According to the Substance Abuse and Mental Health Services Administration (2016), SAMHSA, a risk factor can be defined as, "characteristics at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes " (p. 8). Examples of risk factors include aggressive and impulsive behavior, substance abuse, academic failure, and poverty. The risk and protective factor theory bases the first premise off the idea of risk factors: to prevent a problem from occurring, factors that increase the likelihood of the problem from occurring should be reduced. For example, a fourteen-year-old student has been smoking cigarettes after school with friends at an abandoned building near the school. The student says they have no place to go after school until his/her parents can pick his/her up and peers invited him/her to join them. The student feels lonely and doesn't enjoy smoking, but feels he/she has nothing else to do until he/she gets picked up. The risk factor is smoking. Factors increasing the smoking are peer influence, sense of belonging to the specific peer group, and a

two-hour window with no supervision or activity to do. Based on the theory, if these factors are reduced or addressed, the likelihood of the student continuing to smoke should decrease. The opposite of the risk factors are protective factors described next.

Risk and Protective Factors

SAMHSA (2016) defines protective factors as, "a characteristic of the individual, family, or community level that is associated with a lower likelihood of problem outcomes" (p.8). Examples of protective factors include impulse control, antidrug-use policies, and parental monitoring. The second premise of the risk and protective theory believes it is equally as important to identify and increase the factors that protect individuals from present risk factors (Hogan, Reed Gabrielsen, Luna, & Grothaus, 2003). Review the example of student smoking after school with peers. Protective factors here include parental monitoring by finding a place or activity after school until they can pick up the student, refusal skills, and communication between the child and parents about peer pressure and consequences of smoking. These factors should be increased to protect the student from the risk factor of smoking. This example takes place in both a school and community setting. To fully comprehend the capacity and depth of risk and protective factors, one must examine the variety of the settings they can occur.

NIDA identified five domains or settings risk and protective factors occur in: individual, family, peer, school, and community (Robertson, David, & Rao, 2003). Risk and protective factors evolve throughout and affect a child's development. NIDA described this as the risk trajectory when risk and protective factors surface throughout the different periods of a child's development (Robertson, David, & Rao, 2003). Risk factors can be present as early as infancy in some cases while protective factors can begin at that age as well. Next, predictive factors focus on four primarily concerns that can lead to a path of substance abuse.

Predictive Factors for Substance Abuse

Predictive factors of substance abuse present in both children and adults include a lack of the following: social competence, self-regulation and self-control, negative bond with school, and career giver involvement (Lochman & Wells, The coping power program at the middle-school transition: universal and indicated prevention effect, 2002). Lacking social skills can result in misinterpretations of social situations including signs of peer rejection and social isolation in children and adolescents. Lochman (2002) describes this lack of competence leading to a "maladaptive problem-solving style" and relying on "physically and verbally aggressive strategies" (p. 41). At the elementary level, high levels of aggressive behavior were predictive of adolescent (Kellam, Ensimger, & Simon, 1980) drug and alcohol use (Lochman & Wells, The coping power program at the middle-school transition: universal and indicated prevention effect, 2002). Children and adolescents are also at risk if they do not have a healthy school relationship which may result in truancy, low achievement, or lack of commitment. This risk is also connected to low caregiver involvement with their child. If a parent is not active in or supportive of their child's education, it can be considered a risk factor. Parental monitoring or inconsistent regulation are additional indicators. A final risk sign to examine is adverse childhood experiences.

Adverse Childhood Experiences

Adverse childhood experiences, or ACES, is a term that describes abuse, neglect and other types of trauma an individual under the age of 18 experiences (Sheehan, 2015). The first ACEs study was conducted from 1995 to 1997 to research the relationship between adverse childhood experience and later adulthood health care concerns and or causes of death. The study bases on individual, self-reported experiences through questionnaires. ACEs have three

categories: abuse, neglect, and household dysfunction. The three are further broken down into subcategories: abuse: emotional, physical and sexual; neglect: emotional and physical; household dysfunction: mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and incarcerated household member (Centers for Disease Control and Prevention, 2014).

It is common for ACEs to co-occur. A study (Dube et al. 2006) looked at the relationship between ACEs and association with alcohol use and its initial use during adolescence. Participants responses to the study were regarding their first 18 years of life and their initial alcohol consumption. As a whole, 89% reported having a drink of "more than a few sips" (Dube et al. 2006). Specific traumatic experiences indicated a higher initial use of alcohol during adolescence. For example, all participants that experienced sexual abuse were three times more likely at all ages to initiate alcohol use than those that didn't experience sexual abuse (Dube et al. 2006). An additional study examined the relationship between adverse childhood experiences and behavioral health outcomes. Participants ranged from twelve to seventeen. Lucenko (2014) identified an increased risk of adolescent substance abuse for older youth who were Hispanic, American Indian, or multiracial. Participants that experienced abuse or neglect were twice as likely to have a substance abuse problem than those who did not (Dube et al. 2006).

Fundamental Program Components

NIDA describes part of prevention's foundation as, "an important goal of prevention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors" (Robertson, David, & Rao, 2003, p. 7). The NIDA principles were created to assist in planning and guiding the delivery of prevention programs. There are two considerations when selecting a substance abuse prevention program. First, identify the

population the program is targeting. The audience can be a general population, target at-risk groups, or people already experimenting with drugs. When an audience is selected, it is important to consider if families and communities are participants in the program as well. After identifying an audience and setting where the program will take place, one can examine the content of the program.

Substance abuse prevention programs are created to adapt to the developmental levels of different educational settings: elementary, middle, and high school. Programs vary in their content because it is designed to be developmentally appropriate for the target audience. For example, an elementary substance abuse program's content is adapted to their developmental level. Much of the same core knowledge still is covered while adjusting to the appropriate developmental level. Drug information, social and behavioral skills to improve relationships, and emotion management could present in lessons at all academic levels. Each academic level identifies objectives suitable and relevant for their audience. NIDA principles seven and eight explicitly apply to the school setting.

NIDA principle seven identifies the following skills as critical at the elementary level: “self-control, emotional awareness, communication, social-problem solving, and academic support” (Robertson, David, & Rao, 2003, p. 3). NIDA principle eight’s identified skills at the middle and high school include: “study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of antidrug attitudes, and strengthen of personal commitments against drug abuse” (Robertson, David, & Rao, 2003, p. 3). Next, a review of the Coping Power Program in how it aligns with the prevention principles seven and eight identified by NIDA.

Coping Power Program

The Coping Power Program (CPP) is a group-based, targeted prevention program, developed by the University of Alabama, derived from the school-based Anger Coping Program (Coping Power Program, 2006). It targets late elementary students considered high risk for anger, impulsive behavior, and aggressiveness which could later lead to substance abuse. An important factor in targeting these is because impulsive behavior, lack of self-regulation, self-control, social competence, and parental involvement in children at the elementary and middle school level are risk factors on a trajectory path towards substance abuse (Robertson et al., 2003; Lochman & Wells, 2002). The program is school-based with a separate parental component that occurs in addition to the child's in-school group sessions. First, a description of the course specific population and content.

The University of Alabama developed CPP for an intended audience of males and females in fourth through sixth grade. The participants are a targeted/selected, high-risk group. The 15-month program composition includes 34 group sessions of children in a school setting delivered by a teacher or counselor. The sessions are 50 minutes and aimed to take place during nonacademic periods typically with five children per group. Program objectives for the children include teaching how to identify and cope with anger and impulsivity and developing academic, social, and conflict-resolution skills (Robertson, David, & Rao, 2003). The parental component includes 16 group sessions with combined parent/child sessions. Parent's objectives are to develop and reinforce the following skills: clear rules and expectations, promotion of child study skills, appropriate discipline practices, parental stress management, family communication and problem-solving, and reinforcement of problem-solving skills the children the learn in CPP

(Coping Power Program, 2006). Next, a review of two studies that used this program and some of their results.

Lochman and Wells' (2002) study of high-risk, fifth-grade students used the CPP. The results from the interventions regarding substance abuse showed participants, “had significantly lower alcohol, tobacco, and marijuana use than did the control group” (p. 47). Teachers reported significant improvements in participant’s behaviors, specific social skills, and reduction of aggressive behavior while parent’s interactions became more emphatic but did experience low-attendance in parent groups which was a problem for the study (Lochman & Wells, 2002).

The domains identified by the CPP include individual, family, school, and peers. The key risk factors it identifies are social competence, self-regulation, and parental involvement which especially support NIDA's elementary age critical skills in principle seven (self-control, emotional awareness, communication, social-problem solving) and middle school skills in principle eight (peer relationships and communication) (Lochman, Palardy, Mcelroy, Phillips, & & Holmes, 2004). Lochman and Wells' (2002) study of high-risk, fifth-grade students used the program to address social problems, generate alternative solutions and consider consequences of them to social problems, cope with peer pressure to use drugs, making self-statements, and increase study and organizational skills. These also align with the outstanding NIDA critical elementary and middle school skills of academic support, study skills, drug resistance skills and reinforcement of antidrug attitudes, and strengthen personal commitments against drug abuse (Robertson, David, & Rao, 2003).

Conclusion

The principle of prevention programs is to target and reduce risk factors where they are present. While there are universal risk factors, multiculturalism should be a primary

consideration when selecting a prevention program. Examining the normed population for the program comparing that to a needs assessment of the indicated population is important to see if it is an appropriate fit. Also, risk factors may be present within the specific culture. A program should be selected that aligns within the protective factors that are driving the problem in the community. In addition to this, the program must be culturally competent within the community.

While the CPP demonstrated its successes, a major limitation was the parental involvement in some cases (Lochman & Wells, 2002; Lochman, Palardy, Mcelroy, Phillips, & Holmes, 2004). The primary concern was consistent attendance at the group sessions by parents. Parents were provided information and psychoeducation at meetings about what the child was learning along with new skills for them to practice at home with the child. However, even with parents that had inconsistent attendance, the research showed that parents made some positive and warmer adjustments to interactions with their children (Lochman & Wells, 2002). The children's attendance wasn't an issue due to the 50 minute sessions took place during the school day.

Risk signs are identifiable by anyone involved with a child's, but limitations are present as well in identifying risk factors. For example, parents may not always be able to identify them as they are a risk factor. Teachers may also be limited in identifying risk factors if they don't have a positive relationship with the student or have a negative attitude towards the student. The earlier risk signs are identified and interventions can take place, the more probable the outcome for the child (Robertson, David, & Rao, 2003).

Author's Note

To address these shortcomings of the CPP, I have designed an intervention that is similar to the CPP. I have created a manual for a self-regulation group. The group will be a selected

high-risk individuals within a school setting. The purpose of the group is addressing the specific risk factors impulsive behavior and self-regulation. Important concepts for the group will be identifying the type of aggressive behavior, emotion management, and utilizing coping skills. The idea is to learn and practice the skills within the group while openly communicating with parents at home to reinforce the new skills. The group will meet twice a month for 30 minutes during a nonacademic period such as lunch or recess. In comparison to the CPP, the students met for a 50 minute duration. Meeting twice a month provides the students ample opportunity to work on skills and report back their successes and challenges. As always, it is important for a facilitator to be aware of student engagement and progress. If the materials to the group aren't connecting or developmentally appropriate for the specific group, adjustments must be made to meet the needs of the students.

Since parental attendance was a major limitation to the CPP, the materials for parents that I have created to support my self-regulation group can be accessed electronically. The format of the group is for parents to meet once a month. This provides parents an opportunity to answer questions, gather new materials, and essentially provide support to each other. If parents aren't able to attend, they still are receiving information about what skills and topics are being covered in group so they can continue to reinforce at home in addition to tools for themselves. Secondly, I felt the parents needed a more information on risk and protective factors. In session five of the parental component, the parent tool is an overview of what are risk and protective factors, examples, and how it can lead to substance use. The CPP is a successful and effective program and many of the materials in my intervention come from it. By adjusting some formalities of the group and making materials available electronically, I hope it increases parental involvement in a future group scenario.

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Self-Regulation Group Manual

8 Sessions

Table of Contents

Overview

The purpose of the group is addressing the specific risk factors impulsive behavior and self-regulation. Important concepts for the group will be identifying the type of aggressive behavior, emotion management, and utilizing coping skills. The idea is to learn and practice the skills within the group while openly communicating with parents at home to reinforce the new skills.

Risk Factors

A risk factor is defined as a, “factor shown to increase the likelihood of adolescent substance abuse, teenage pregnancy, school dropout, youth violence, and delinquency (Hogan et al 2003).” There are four domains of risk factors: community, family, school, and individual/peer.

Goals

1. Recognize symptoms and physiological effects
2. Identify triggers of aggression
3. Compare and contrast the consequences of anger in the present and the future
4. Assess readiness and willingness to change through self-reflection
5. Explore coping skills
6. Create a self-assessment including the following: triggers, consequences of anger, barriers to success, explanation of readiness to change, and one successful and beneficial coping skill.
7. Connect session goals and objectives to current situation and apply skills.
8. Apply newly learned skills in practice setting through individual reflection, role-playing, or other structured activity.

Requirements

Students must be referred to the group via parent, teacher, administrator, or counselor. Parental consent must be obtained prior to participating in the group. Disrespectful behavior towards the facilitator or group members will not be tolerated and could result in dismissal from group. Parental involvement via assignments or communication with the counselor is encouraged.

Parent Component

Supplemental materials are included with each session for parents. These can be used essentially to reinforce skill students learn in group as well as tools to develop awareness of managing anger/impulsive behavior and understanding of the long terms risk that come with it. The parental component is laid with the following format:

- Child’s Component

- Discussion Starters
- Parent's Tools

The "Child's Component" is a summary of the activities and skills from the student group session. Discussion starters are ideas to increase communication about topics and continued reinforcement of skills. "Parent's Tools" are resources for parents to utilize. They are available to assist parents to effectively manage their child's aggressive behavior, increase positive reinforcement in the relationship and decrease stress. Materials for the parental component can be found in Appendix B.

Format

The students will meet with the counselor bimonthly during a nonacademic period at school. This way, there is ample practice time in between the sessions for student to practice newly acquired skills. The parents will meet on a monthly basis, if needed, during the evening. Here, parents will have an opportunity to ask questions and provide or receive support.

Session 1: Understanding Self-Regulation

Students will be able to:

- Define self-regulation.
- Give a basic description of the brain's response to anger.

Materials

- Video: Amygdala Hijack
- WDEP Worksheet[1]

Instruction

- Introduction (10 minutes)
    - Introduce group: overall format and layout, expectations, objectives, risk factors, and topics.
    - Create group rules to align with expectations.
- Ice-breaker
- WDEP Worksheet (10 minutes)
    - Identify student's expectations: what brings you here and what do you hope to learn. Students will independently complete the worksheet as a baseline assessment of themselves and goals for group.
- Content introduction (10 minutes)
    - Define self-regulation.
        - Managing emotions and impulses prior to reacting.
    - Amygdala Hijack
        - Video: Amygdala Hijack
        - Volcano description and "hand signal"- when emotions take over our brain, aka, amygdala hijack, our ability to think clearly is cloudy.

[1] Warren, Ken. Reality Therapy Worksheet. http://positivepeoplesolutions.com.au/products.html

Session 2: Recognizing Emotions

Students will be able to:

- Identify personal physical and emotional symptoms when experiencing anger
- Explore other feelings that anger is often to blame for.

Materials

- Pictures for icebreaker
- Anger Thermometer Worksheet 6.2 [2]

Instruction

- Icebreaker: What's going on in the picture
    - Students look at pictures and analyze the scene. Segway into "unmasking" anger.
- Review group rules, self-regulation definition, what happens to your body when you get angry.
- Group check-in, indicate emotion on chart to best describe their day.
- Iceberg Activity
    - Draw an iceberg on the whiteboard. Review with an iceberg, with only see what is above the water and not the largest part below water. Often times with anger, it is the emotion we portray to others. However, hurt, sadness, jealousy, are some examples of emotions we use to "mask" anger.
    - Give examples of situations and draw "anger" above the surface. Ask the students to explore other feelings they may be feeling.
        - Parent asks if homework is done, student yells and throws their homework on floor.
    - Ask for specific situations, if they wish to share, they may have used anger as mask
- High Intensity Emotions
    - What do high intensity emotions (excitement, sadness, anger) look and feel like? (Draw thermometer and list examples from "high" to "low".)
- Discuss pros/cons of reactions of peers and families when you show anger versus stating "real" emotion.
    - Would they react differently or would consequences be different, why or why not?
- Practice
    - Fill out the journal describing "why" you got angry at the specific time.

[2] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

Session 3: Identifying Triggers

Students will be able to:

- Identify triggers of aggression
- Identify specific situations, people, or activities that trigger anger

Materials

- Anger Thermometer Worksheet 6.2[3]
- Tennis Balls

Instruction

- Icebreaker: Tennis Ball Activity
    - Students will sit in a circle. One student will bounce the tennis ball to another student and so forth. The students must throw to the person and receive from the same different person. A second and third ball will eventually be entered. Segway into "identifying triggers" when an error is made, the game stops because the ball is dropped.
- Group check-in, review iceberg.
- Introduction
    - Trigger definition and examples.
- Journals
    - Give the students 2-3 minutes to see if they can identify similar situations or people that resulted in feeling angry.
    - Provide students an opportunity to share any patterns or "triggers" based on their journals.
        - Was "anger" the appropriate emotion or was it used as a mask?
- In-group practice
    - Provide a situation, have students break it down using "ABC" method.
        - Antecedent, Behavior, Consequence
- Practice
    - Fill out the journal describing "why" you got angry at the specific time and what your reaction was.
    - Important step: building awareness of how we are feeling and reacting in situations where we are more emotionally reactive.

[3] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

Session 4: Assessing Readiness

Students will be able to:

- Assess readiness and willingness to change through self-reflection
- Distinguish items within personal control and out of personal control

Materials

- Icebreaker photos and paper for students to draw.
- Students original WDEP worksheet

Instruction

- Icebreaker: Back to Back Drawing
    - Leader will show a picture on the board. Students will be in pairs sitting back to back where partner A can see the drawing on the board and partner B cannot. Partner A has to describe the picture to partner B to draw. Discuss experiences in each role.
- Group check-in and discussion
    - Review WDEP worksheet from first session
    - Is increasing awareness of triggers and reactions helpful, indifferent, or hurtful?
    - On a scale from 1-5, are you feeling in control of your anger (1) to out of control (5)?
    - Are you experiencing changes with relationship? EX: peers, teachers, and family:
    - What can we change, increase, or eliminate to better meet expectations?
- Journals
    - Review journals: why students were angry and what did they do about it. Provide students an opportunity to identify patterns.
- Reducing triggers
    - Identify top 3 triggers, can use journal as a resource and determine you can or can't control
        - EX within control: my reaction, my choices to participate or decline, telling the truth
        - EX out of control: things other people say or do, ability to follow through with
        - Can these triggers or people be avoided?
- Practice
    - In the journal, write situations where you felt emotionally reactive and a "W" if situation was within your control or "X" if it was out of your control.

Session 5: Coping Skills Reflection

Students will be able to:

- Compare and contrast current consequences of anger and future consequences of anger
- Apply newly learned skills in practice setting through individual reflection, role-playing, or other structured activity
- Brainstorm options to reduce triggers
- Assess readiness and willingness to change through self-reflection

Materials

- "Would you rather" questions

Instruction

- Icebreaker: "Would you rather" questions.
- Consequences of anger
    - Short-Term: How can it affect: peers, family, education, work, relationships, and choices?
    - Long-Term
        - How can it affect: peers, family, education, work, relationships, choice
        - What can anger lead to if I don't learn how to cope properly?
- Exploration of coping skills
    - Benefits of coping skills
    - "Pause Signals" and naming your feeling
        - What can you tell yourself right when you feel a strong feeling coming on?
            - Examples: Chill out, relax, calm down
- Brainstorm 5 strategies currently use to cope with anger.
    - Write "E" for effective or "I" for ineffective. Question: Do you react impulsively?
- Brainstorm 5-10 activities you enjoy doing
    - Are they healthy? What do you need to do them? Can you do them anywhere?
    - Do they help calm you down or can they increase the intensity of your emotions?
        - EX: Aggressive video games or hitting a pillow- ineffective.
- Practice
    - In your journal, continue to monitor different calm down methods.

Session 6: Coping Skills Exploration

Students will be able to:

- Apply newly learned skills in practice setting through individual reflection, role-playing, or other structured activity.
- Connect session goals and objectives to current situation and apply skills.
- Explore coping skills

Materials

- Hoberman's sphere
- Instructor's iPad

Instruction

- Ice-breaker: Progressive Muscle Relaxation
- Group check-in
    - Review journals: what different methods are you using to calm down?
- Introduce coping skills
    - Deep breathing
        - Hoberman's sphere
        - Breathe2Relax App
    - Active
        - Walking, Sports, Yoga, Running
    - Self-talk (positive coping statements)
    - Listening to music, Reading
- Variety of coping skills
    - What skills can you use in these places
        - Home, classroom, lunchroom, athletic practice, work
- Individual Reflection
    - What type of coping skills are most helpful for you?
- Practice
    - Select 2 coping skills that you can practice in a variety of settings.

Session 7: Creating a Plan

Students will be able to:

- Assess readiness and willingness to change through self-reflection
- Create a self-assessment including the following: triggers, consequences of anger, barriers to success, explanation of readiness to change, and one successful and beneficial coping skill.
- Connect session goals and objectives to current situation and apply skills.

Materials

- Self-Regulation Plan

Instruction

- Icebreaker
- Check-in
- Review : definition of self-regulation, amygdala hijack, iceberg, triggers
- Create a self-regulation plan
    - Identify your top 3-5 triggers
    - Write down 3 consequences (short or long term) use aggressive behavior to cope
    - Determine, if any, barriers that may interfere with reducing triggers or coping positively.
        - EX: friends, family, peer pressure, items or individuals out of your control, limited support, etc.
    - In 3-5 sentences, describe how and why you think are ready to change your reactions.
    - Distinguish 2-3 items you need from others to be supportive of you.
    - Identify at least one successful coping skill you can utilize in a variety of situations.
- Barriers
    - What barriers do you foresee? Peer pressure?
    - If you are hanging out with two different groups of friends, what are the differences between the two?
    - Write your top 3-5 people you are closest to, do they meet the supports you listed?
- Practice
    - Put the plan into practice and we will meet again in 4 weeks. Share with parents or guardians to increase support.

Session 8: Reflect and Review

Students will be able to:

- Identify triggers of aggression and any new ones that may occur.
- Assess readiness and willingness to change through self-reflection
- Reflect and adjust self-regulation plan if needed.
- Connect session goals and objectives to current situation and apply skills.

Materials

- Self-Regulation Plan
- Student's Original WDEP

Instruction

- Group check-in
- Plan review
    - What's working?
    - What isn't working?
    - Adjustments?
    - Triggers:
        - New ones?
        - Are they reduced at all?
    - Coping Skills
        - Effectiveness or new ones to share
- WDEP Worksheet
    - What changes have you made since you first completed the worksheet?
- Support System
    - Who/what has been the most supportive?
        - Least supportive?
- Continuity
    - Counselor available as a resource.
    - "Booster" sessions available

Parental Resources

- Session 1:
    - Child's Component
        - The students learned how their brain functions when emotions take over their brain. They watched the video, "Amygdala Hijack" fora visual. Students completed a worksheet describing their current coping skills, group expectations, and what they hope to obtain by the end of the group.
    - Discussion Starters
        - Ask about the video or the "volcano" example when emotions overtake the brain.
    - Parent's Tools
        - Risk factors worksheet. Managing stress and its impact on your life
- Session 2: Managing Stress
    - Child's Component
        - The students completed an "iceberg" activity. Often times, anger is used to "mask" other emotions such as sadness, frustrations, embarrassment or jealously. Using guided and student provided examples, we drew anger as the tip of the iceberg, the emotion we and others see. Beneath the water, the students drew other emotions they were feeling when portraying signs of anger. They concluded with reflecting on how others may respond differently if they stated they were ____ instead of angry and the pros/cons of it. The students were given a journal to record instances of anger and why they became angry.
    - Discussion Starters
        - Reinforce the "iceberg" concept at home when your child is experiencing an emotional moment.
        - Share with your child a time when you displayed anger but were feeling a different emotion and what the results of the situation were.
    - Parent's Tools:
        - Positive Praise, Behavior Checklist and Consequences
- Session 3
    - Child's Component
        - Students reflected on the specific situations, people, and activities that triggered their anger. They described how they felt and if anger was used as a mask. Using the ABC chart in the "tools" for this session, they broke down the events further and began to explore the consequence for their reaction. Students will continue to fill out their journals explaining why they got angry and will add what their reaction was.
    - Discussion Starters
        - Share any "triggers" you experience, at the workplace or at home. Are you aware of how you feel and your reactions in situations?
            - Parent's Tools
                - ABC Chart
- Session 4

    - Child's Component
        - As a halfway point, the students reviewed their goals, expectations, and indicated any adjustments needed. The group discussion included students sharing their journals: why they were angry and how they reacted. The identified any patterns that may be occurring. To begin working to reduce triggers, the students determined if the situation was something within their control or out of their control. Throughout the next two weeks, they will work on identifying their reactions to situations within or out of their control.
    - Discussion Starters
        - If the child is comfortable, review their journal with them regarding triggers. Be sensitive and open to the triggers as you could be a part of one of them. Utilize this as an opportunity to engage in a meaningful discussion with your child and learning opportunity.
        - Offer assistance: ask how you can be more supportive in identifying triggers or items within or out of their control.
    - Parent's Tools
        - Ignoring disruptive behavior
- Session 5
    - Child's Component
        - The students reflected on their current coping skills to emotional reactions and determined if they were effective or ineffective. They looked at the short-term and long-term consequences of coping through aggressive behavior.
        - Students learned to use a "pause signal" to tell themselves when they feel a strong feeling coming on. They began to brainstorm activities they enjoy to use as healthy coping skills.
    - Discussion Starters
        - Ask your child what their "pause" signal is. Share any self-talk you tell yourself in stressful or emotion-provoking situations.
    - Parent's Tools
        - Risk and Protective Factors
- Session 6
    - Child's Component
        - Student's explored a variety of coping skills: progressive muscle relaxation, deep breathing with a Hoberman's sphere, being active, using self-talk, and other ideas they currently use. They discussed why it is important to have a variety of skills to use because certain situations may be limited. For example, they cannot go running during class but they can use deep-breathing. Students selected two coping skills to practice until next session.
    - Discussion Starters
        - Ask what coping skills they selected.

        - Ask them to teach you have to do deep breathing or progressive muscle relaxation. This can be an opportunity to instill hope, confidence, and reinforce healthy coping skills.
    - Parent's Tools
        - Instructions that do and don't work
- Session 7
    - Child's Component
        - Students created a self-regulation plan. They assessed their readiness and identified any barriers they may encounter when practicing their coping skills. Students identified specific items they need for others to be supportive of them. They will practice the plan and meet again in 4 weeks.
    - Discussion Starters
        - Students were asked to share their plan with you. Offer assistance and support by asking what you can do for them. If appropriate, you can create one yourself and continue to be accountable toward each other.
    - Parent's Tools
        - Establishing Rules and Expectations
- Session 8
    - Child's Component
        - The final session was a review on the student's progress. Adjustments were made and new triggers discussed if necessary. The students discussed any additional supports they needed and booster sessions were offered.
    - Discussion Starters
        - Continue to ask the child how you can be supportive and hold them accountable.
    - Parent's Tools
        - Effective and Ineffective Punishment

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Appendix A

1. Reality Therapy Worksheet: WDEP

REALITY THERAPY – WDEP WORKSHEET

Wants • What do you want? • What do you want instead of the problem? • What is your picture of a quality life, relationship, etc? • What do your family/friends want for you? • What do you want from counseling?	**Comments**
Doing • What are you doing? (acting, thinking, feeling, physiology • When you act this wayk, what are you thinking? • When you think/act this way, how are you feeling? • How do your thoughts/actions affect your health?	
Evaluate • Is what you are doing, helping you get what you want? • Is it taking you in the direction you want to go? • Is what you want achievable? • Does it help you to look at it in that way? • How hard are you prepared to work for this? • Is your current level of commitment working in your favor?	
Plan • What are you prepared to do/ think differently that will take you in the direction you want to go? • Are you clear about what you are going to do? • Is it achievable? • How will you know you have done it? • Can you start doing it immediately? • Is it in your control? • Are you committed to doing it?	

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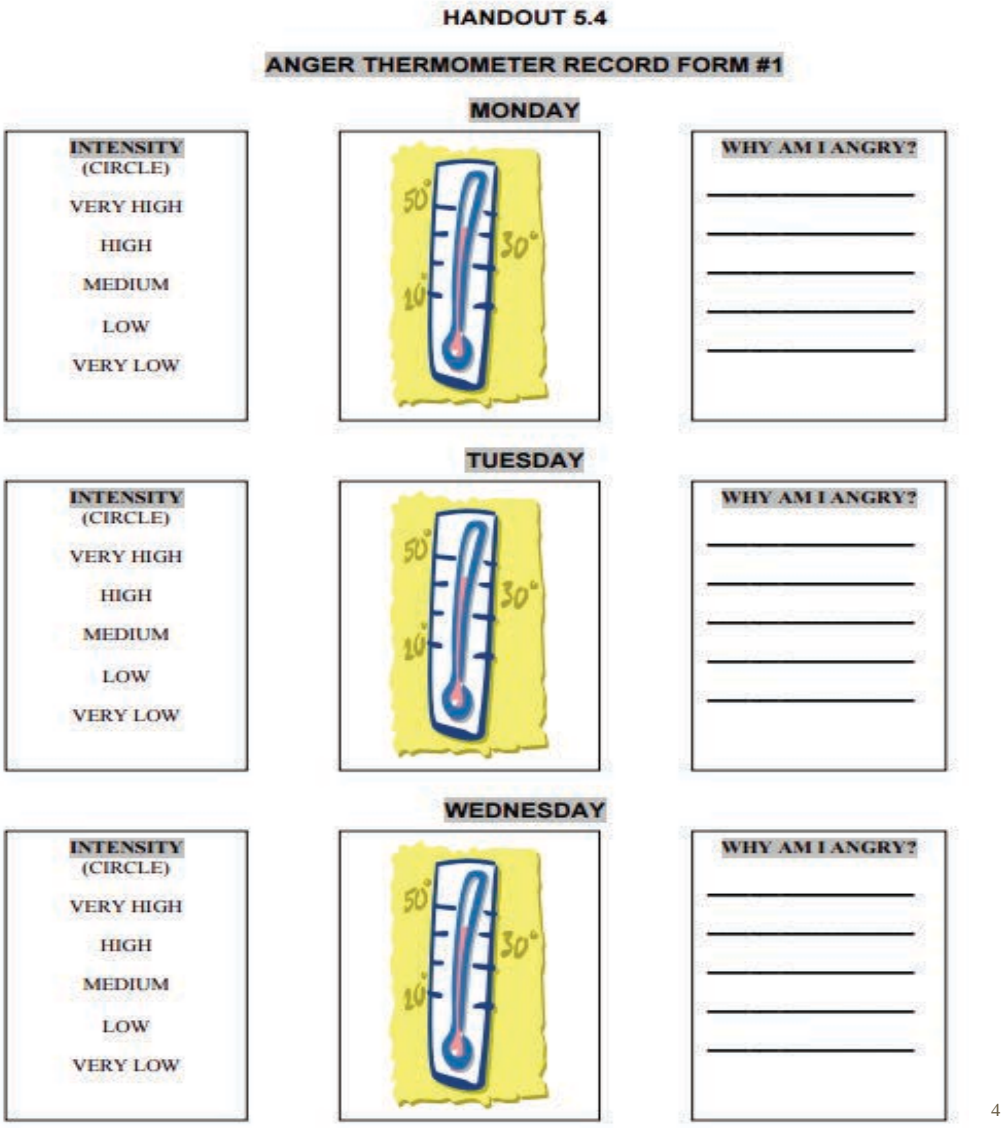
2. Anger Thermometer Worksheet 5.4 (page 1)



HANDOUT 5.4

ANGER THERMOMETER RECORD FORM #1

MONDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW	50° 30° 10°	

TUESDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW	50° 30° 10°	

WEDNESDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW	50° 30° 10°	

[4]

[4] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

Anger Thermometer Worksheet 5.4 (page 2)

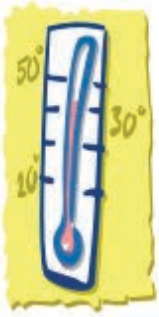
Handout 5.4 continued …

ANGER THERMOMETER RECORD FORM #1

THURSDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW		

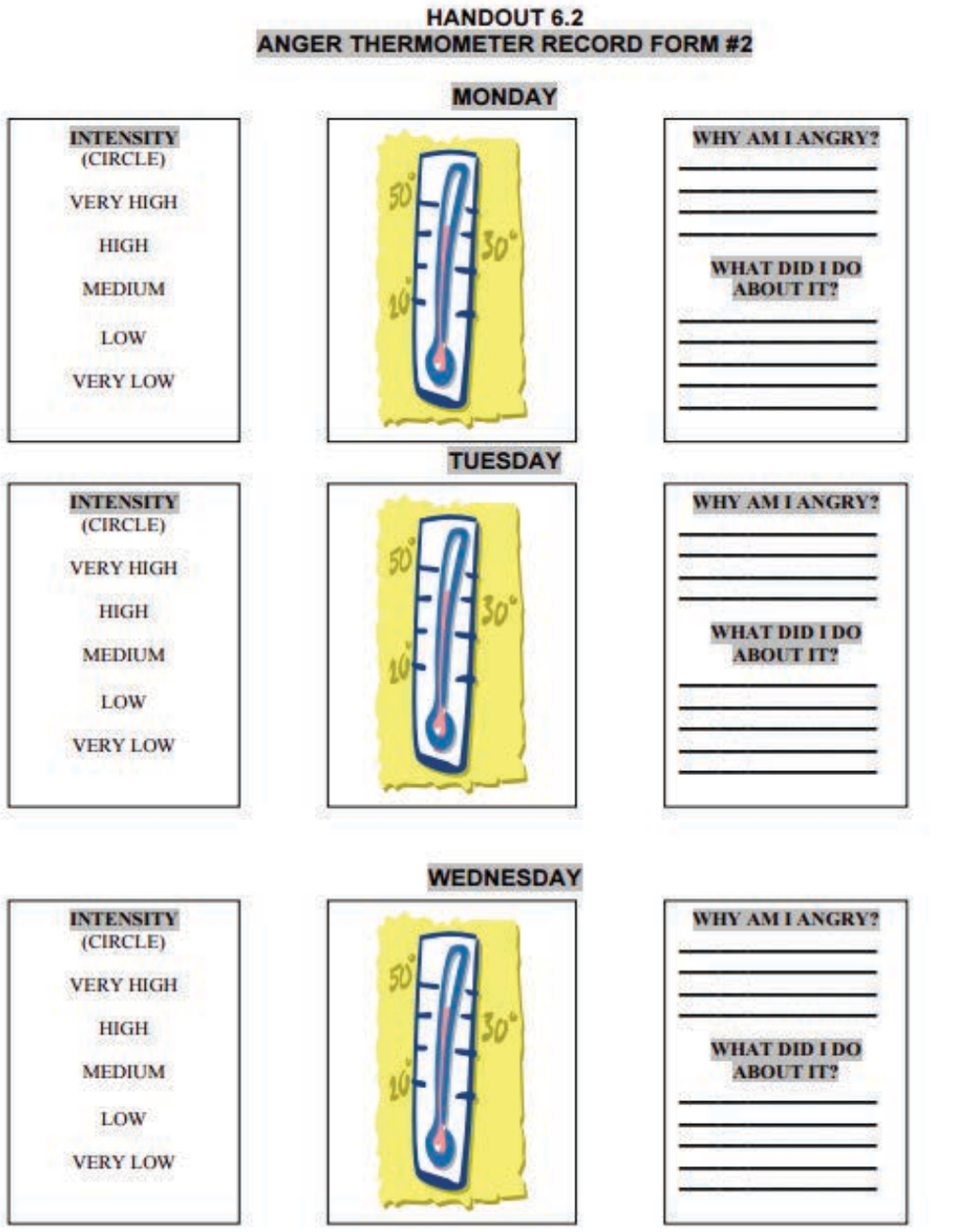
FRIDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW		

5

[5] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

3. Anger Thermometer Worksheet 6.2 (page 1)



HANDOUT 6.2
ANGER THERMOMETER RECORD FORM #2

MONDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW		WHAT DID I DO ABOUT IT?

TUESDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW		WHAT DID I DO ABOUT IT?

WEDNESDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH HIGH MEDIUM LOW VERY LOW		WHAT DID I DO ABOUT IT?

[6]

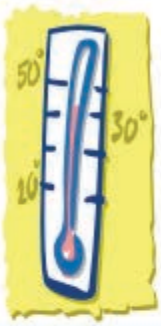
[6] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

Anger Thermometer Worksheet 6.2 (page 2)

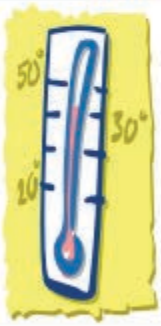
Handout 6.2 continued ...

ANGER THERMOMETER RECORD FORM #2

THURSDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH		
HIGH		WHAT DID I DO ABOUT IT?
MEDIUM		
LOW		
VERY LOW		

FRIDAY

INTENSITY (CIRCLE)		WHY AM I ANGRY?
VERY HIGH		
HIGH		WHAT DID I DO ABOUT IT?
MEDIUM		
LOW		
VERY LOW		

7

[7] New York State Office of Mental Health. (2008). Handouts from Coping Power. Retrieved from https://www.omh.ny.gov/omhweb/ebt/resources/coping_handout.pdf

4. Self-Regulation Plan

1. Identify your top 3-5 triggers

2. Write down 3 consequences (short or long term) of not coping with anger in a healthy manner

3. If there are any barriers that may interfere with reducing triggers or coping positively, describe them.

4. In 3-5 sentences, describe how and why you think you are ready to change your reactions.

5. Determine 2-3 items you need from others to be supportive of you.

6. Identify 1 coping skill you find beneficial.

Appendix B

Managing Stress and Its Impact on Your Life (Page 1)

Chapter 3 *Session 3: Managing Your Stress—Part I*

Goals

- To talk about stress and the impact it has on your life
- To learn the importance of time management and taking care of your personal needs
- To learn active relaxation

The Causes of Stress

Many people think of stress as being caused only by negative events or crises. Obvious examples include the death of a family member or someone close to you, physical injury, illness, and natural disasters. However, stress can also be caused by events that most people would think of as positive. For example, getting married, buying a home, relocating, or starting a new job are often highly stressful. Regardless of the cause, stress can sometimes build up to extreme levels.

What Is Stress?

Stress has to do with the physical reactions that take place in your body. When you are faced with difficult events to which you must adjust, your body may respond with a number of changes. Your heart rate and breathing rate may increase, your blood pressure may rise, your muscles may become tense and tight, your hands may feel cold and sweaty, or all of these things may happen at once. If you are already in a state of chronic stress, and then another stressor is added (e.g., your car breaks down, your child yells at you or is being very uncooperative), the chemicals in your brain may overreact, causing you to experience an emotional reaction that may be extreme. When your body is reacting and overreacting in this way you feel anxious,

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[8] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Managing Stress and Its Impact on Your Life (Page 2)

tired, and tense, and over a long period of time you can feel chronically fatigued or even physically sick.

Stress in Parenting

Parenting can be very stressful at times, especially if parents also have a number of other ongoing daily stressors in their lives. Children can be quite demanding of their parents' attention, and if they are having behavior or learning problems at home or at school, they may require extra energy, effort, and problem solving on the part of the parent. Such children present their parents with many situations that require some type of disciplinary action, creative solutions, or thoughtful, positive consequences. Parents may find that they must take themselves off "automatic pilot" in their reactions to their children and must constantly think through how they want to manage their child. While this kind of proactive approach is in the child's best interest, it can also be stressful for the parent, who must constantly be on the front line thinking, planning, and acting. When parents are also experiencing other stressful events in their lives, the possibility for emotional overreaction and loss of control in parent–child encounters increases.

Time Management

Most parents devote little time to themselves. Use the form on page 19 to help you visualize how you are prioritizing your time. It is not uncommon for people to be unaware of the demands on their time and the areas of their lives that they are neglecting.

Taking Care of Your Personal Needs

Think about some of the ways in which you can take care of your personal needs. What are some things you can do to better take care of yourself? Some examples include the following:

- Reading a book
- Listening to music

[9]

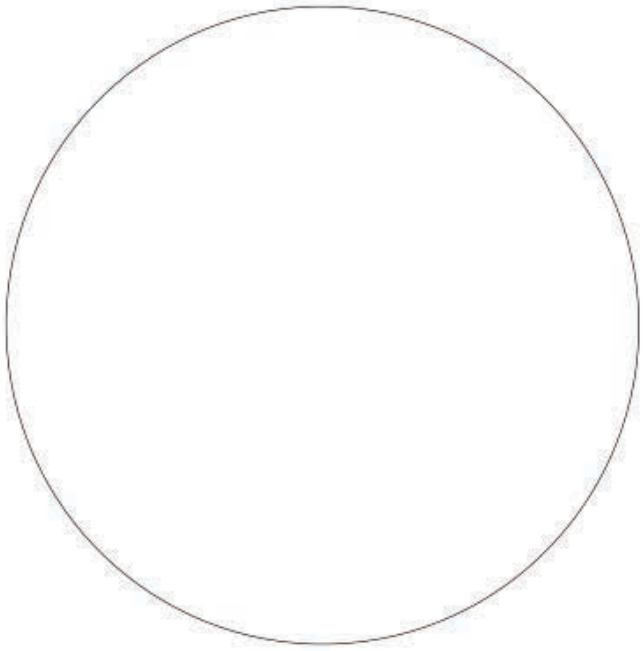
[9] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Managing Stress and Its Impact on Your Life (Page 3)

Pie Chart of Life

Use this page to create a pie chart in which each slice of the pie represents a part of your life. Write down all of the various roles you play, count them up, and divide the pie into that many slices. Make sure each slice is correctly sized to correspond to how much time and energy the role currently takes up in your life.

My Roles:



Ideally, there should be one piece of the pie that is devoted to taking care of yourself. However, for many parents, this piece of the pie gets smaller and smaller with the passage of time and the imposition of new responsibilities. The end result is often the complete neglect of self. You may think that you have to do this in order to meet the demands of the other roles in your life, but if you neglect yourself for too long, you will end up having little stamina, energy, or enthusiasm to give to those other areas of your life. Taking care of yourself is one of the first steps in stress management. It will help you feel better and be more effective in all areas of your life.

19 [10]

[10] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Positive Praise, Behavior Checklist, and Consequences (Page 1)

Positive Consequences for Good Behavior

You can modify your child's behavior by using positive consequences to reward good behavior. Research has shown that if children receive positive consequences for their good behavior, they are more likely to repeat that behavior in the future. The consequence should occur as close to the behavior a possible; this increases the likelihood that the child will make the connection that their behavior resulted in this consequence. Examples of positive consequences include things like trips to the store, getting a movie, going out for ice cream, etc. Sometimes parents give these treats "free of charge"—that is, they don't require anything of the child first. However, to function as a positive consequence, it is necessary to communicate to the child that these special treats or activities are being given because the child displayed some specific good behavior(s). Without specifically making that connection, the special treat will not function to help improve the child's behavior. Of course, this also means that if the child does not perform the specified behavior(s), the parents must withhold the special treat until the child does perform the behavior(s). You may have to learn to manage tantrums or negative emotional reactions from your child the first few times you withhold treats from her.

In addition to special treats, activities, or outings, praise can also be used as a positive consequence or reinforcer. Praising your child increases the likelihood that your child will exhibit good behavior, and it will improve her self-esteem.

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[11]

[11] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Positive Praise, Behavior Checklist, and Consequences (Page 2)

Praise

Praise should be given at the time your child exhibits a good behavior. It is okay to offer praise long after the behavior has occurred, but it is important to note that immediate praise is more effective than delayed praise. Try to remember the phrase, "catch my child being good." If you happen to forget to praise your child right away or if you notice something praiseworthy after the fact, it does not mean you should not praise your child. Praise can be given at any time, although it is always better to do it earlier rather than later.

There are two types of praise that parents can give.

- *Labeled praise* identifies exactly what your child did that was good. For example, "I like the way you completed your homework before dinner" is an example of labeled praise.
- *Unlabeled praise* indicates to the child that they did something well but does not say exactly what the behavior was. For example, "good job" is an example of unlabeled praise.

Both types of praise are effective and each may be more or less appropriate to any given situation. Labeled praise may be better if your child is having a hard time learning or displaying a new good behavior.

The Power of Praise

- Tell your child when you are proud of them.
- Use the words "thank you" as often as you would like to hear it back.
- Thank your child for behaving in positive or prosocial ways.
- Say, "You did a good job" *every time* you see your child doing something that is good.
- Tell your child that you appreciate them TRYING to follow the rules. If they do follow the rules, praise them again!
- Let your child know that you love them for who they are.

Tell them! Children are not mind readers; they need to hear praise directly from you.

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[12] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Positive Praise, Behavior Checklist, and Consequences (Page 3)

Child Behavior Checklist

Negative Behavior	Positive Behavior
☐ Argues	☐ Discusses things calmly; accepts adult decisions
☐ Cries if doesn't his get way	☐ Doesn't cry; discusses things calmly
☐ Defies authority	☐ Follows directions; obeys rules
☐ Destroys property	☐ Uses objects appropriately
☐ Is fearful (inappropriately)	☐ Brave; assertive
☐ Fights with siblings	☐ Plays and shares with siblings; assists them
☐ Fire setting	☐ Does not play with fire
☐ Hits others	☐ Solves problems verbally
☐ Hyperactive	☐ Behaves calmly
☐ Irritable	☐ Concentrates
	☐ Good natured; easy going
☐ Lies	☐ Is honest
☐ Noisy	☐ Quiet; still; peaceful
☐ Does not mind adults	☐ Follows directions; accepts decisions
☐ Does not eat meals	☐ Good appetite
☐ Pouts	☐ Handles disappointments
☐ Stays out too late	☐ Obeys curfew
☐ Steals	☐ Respects others' property
☐ Talks back to adults	☐ Is respectful; listens
☐ Teases others	☐ Compliments others; doesn't insult others
☐ Throws temper tantrums	☐ Accepts "no"; negotiates well
☐ Whines	☐ Uses age-appropriate voice
☐ Yells	☐ Uses normal voice volume
☐ Gets in trouble at school	☐ Performs well in school
☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____

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[13]

[13] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

ABC Chart

ABC Model

From this point on in the program, the group will talk a lot about children's behavior. *Behavior* is represented by the letter *B* on the ABC model (see Fig. 5.1). A behavior is something observable that a child does. It can be good or bad. For example, walking, screaming, arguing, hitting, and washing the dishes are all behaviors.

The *A* on the model refers to *antecedents* and the *C* refers to *consequences*. Antecedents are the events that happen just before a child's

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Figure 5.1
ABC Model of Social Learning Theory

behavior, and consequences are the events that happen just after it. These events have a lot to do with how you can control your child's behavior.

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[14] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Ignoring Disruptive Behaviors (Page 1)

Ignoring Minor Disruptive Behavior

At the last group meeting, you learned how to reinforce your child's good behavior by using praise. Another effective strategy you can use to manage your child's behavior is to ignore certain behaviors. This entails withdrawing all attention, verbal and physical, from your child's minor disruptive behavior—that is, behavior that is irritating or annoying, but not dangerous. Examples of this type of behavior include whining and begging.

Research shows that talking to a child immediately after he has been caught behaving badly may serve to reward the behavior so the likelihood of it occurring again is higher. Talking, or even reprimanding or scolding, your child can actually increase the likelihood that he will repeat the negative behavior. Some children enjoy getting their parents' attention, regardless of whether it is positive or not. This is why ignoring is an effective technique. When you ignore your child you should cut off all communication with him while the negative behavior is happening. This means not speaking to or looking at your child at all.

Although it sounds easy, ignoring your child is actually very hard to do. This is especially true if your child persists in arguing with you. When you first start to ignore some of your child's minor negative behavior, the frequency of the behavior may actually increase. This is normal and to be expected. It just means that your child is trying

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harder to get the negative attention he has come to expect. After a while of using the ignoring technique, however, the negative behavior will eventually decrease in frequency. Once you have successfully ended an episode of bad behavior by your child through use of the ignoring technique, it is important for you to look for positive behaviors that you can praise.

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[15] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Ignoring Disruptive Behaviors (Page 2)

Using the Techniques of Praise and Ignoring

Remember the following about using praise:

- Praising your child will increase the likelihood that he will repeat a behavior again.
- Praising your child helps him to develop a positive idea of who he is.
- Praising your child sets a good example for how he should interact with others.

When praising your child you should:

- Maintain good eye contact
- Speak clearly and repeat the praise so that they really do hear you
- Label the behavior that you are praising them for
- Use unlabeled praise when appropriate
- Praise as close in time to the behavior as possible

Remember the following about using ignoring:

- Ignoring bad behavior and paying attention to good behavior go hand-in-hand.
- Paying attention to bad behavior may make the bad behavior worse instead of better.
- Ignoring a bad behavior may make things worse in the beginning, but if you continue to ignore it, the behavior should eventually decrease or go away.

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[16] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Risk and Protective Factors (Page 1)

Chapter 1: Risk Factors and Protective Factors

This chapter describes how risk and protective factors influence drug abuse behaviors, the early signs of risk, transitions as high-risk periods, and general patterns of drug abuse among children and adolescents. A major focus is how prevention programs can strengthen protection or intervene to reduce risks.

What are risk factors and protective factors?

Studies over the past two decades have tried to determine the origins and pathways of drug abuse and addiction—how the problem starts and how it progresses. Many factors have been identified that help differentiate those more likely to abuse drugs from those less vulnerable to drug abuse. Factors associated with greater potential for drug abuse are called "risk" factors, while those associated with reduced potential for abuse are called "protective" factors. Please note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. Also, a risk factor for one person may not be for another.

As discussed in the Introduction, risk and protective factors can affect children in a developmental *risk trajectory*, or path. This path captures how risks become evident at different stages of a child's life. For example, early risks, such as out-of-control aggressive behavior, may be seen in a very young child. If not addressed through positive parental actions, this behavior can lead to additional risks when the child enters school. Aggressive behavior in school can lead to rejection by peers, punishment by teachers, and academic failure. Again, if not addressed through preventive interventions, these risks can lead to the most immediate behaviors that put a child at risk for drug abuse, such as skipping school and associating with peers who abuse drugs. In focusing on the risk path, research-based prevention programs can intervene early in a child's development to strengthen protective factors and reduce risks long before problem behaviors develop.

The table below provides a framework for characterizing risk and protective factors in five *domains*, or settings. These domains can then serve as a focus for prevention. As the first two examples suggest, some risk and protective factors are mutually exclusive—the presence of one means the absence of the other. For example, in the Individual domain, early aggressive behavior, a risk factor, indicates the absence of impulse control, a key protective factor. Helping a young child learn to control impulsive behavior is a focus of some prevention programs.

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Impulse Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Antidrug Use Policies
Poverty	Community	Strong Neighborhood Attachment

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[17] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Risk and Protective Factors (Page 2)

Other risk and protective factors are independent of each other, as demonstrated in the table as examples in the peer, school, and community domains. For example, in the school domain, drugs may be available, even though the school has "antidrug policies." An intervention may be to strengthen enforcement so that school policies create the intended school environment.

Risk factors for drug abuse represent challenges to an individual's emotional, social, and academic development. These risk factors can produce different effects, depending on the individual's personality traits, phase of development, and environment. For instance, many serious risks, such as early aggressive behavior and poor academic achievement, may indicate that a young child is on a negative developmental path headed toward problem behavior. Early intervention, however, can help reduce or reverse these risks and change that child's developmental path.

For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. By adolescence, children's attitudes and behaviors are well established and not easily changed.

Risk factors can influence drug abuse in several ways. They may be additive: The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors are particularly potent, yet may not influence drug abuse unless certain conditions prevail. Having a family history of substance abuse, for example, puts a child at risk for drug abuse. However, in an environment with no drug-abusing peers and strong antidrug norms, that child is less likely to become a drug abuser. And the presence of many protective factors can lessen the impact of a few risk factors. For example, strong protection—such as parental support and involvement—can reduce the influence of strong risks, such as having substance-abusing peers. ***An important goal of prevention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors.***

Chapter 1 **Principles**

Risk Factors and Protective Factors

PRINCIPLE 1 Prevention programs should enhance protective factors and reverse or reduce risk factors.

- The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support).
- The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent.
- Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviors.
- While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

PRINCIPLE 2 Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

PRINCIPLE 3 Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.

PRINCIPLE 4 Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

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[18] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Risk and Protective Factors (Page 3)

Gender may also determine how an individual responds to risk factors. Research on relationships within the family shows that adolescent girls respond positively to parental support and discipline, while adolescent boys sometimes respond negatively. Research on early risk behaviors in the school setting shows that aggressive behavior in boys and learning difficulties in girls are the primary causes of poor peer relationships. These poor relationships, in turn, can lead to social rejection, a negative school experience, and problem behaviors including drug abuse.

What are the early signs of risk that may predict later drug abuse?

Some signs of risk can be seen as early as infancy. Children's personality traits or temperament can place them at increased risk for later drug abuse. Withdrawn and aggressive boys, for example, often exhibit problem behaviors in interactions with their families, peers, and others they encounter in social settings. If these behaviors continue, they will likely lead to other risks. These risks can include academic failure, early peer rejection, and later affiliation with deviant peers, often the most immediate risk for drug abuse in adolescence. Studies have shown that children with poor academic performance and inappropriate social behavior at ages 7 to 9 are more likely to be involved with substance abuse by age 14 or 15.

In the Family

Children's earliest interactions occur within the family and can be positive or negative. For this reason, factors that affect early development in the family are probably the most crucial. Children are more likely to experience risk when there is:

- lack of mutual attachment and nurturing by parents or caregivers;
- ineffective parenting;
- a chaotic home environment;
- lack of a significant relationship with a caring adult; and
- a caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior.

These experiences, especially the abuse of drugs and other substances by parents and other caregivers, can impede bonding to the family and threaten feelings of security that children need for healthy development. On the other hand, families can serve a protective function when there is:

- a strong bond between children and their families;
- parental involvement in a child's life;
- supportive parenting that meets financial, emotional, cognitive, and social needs; and
- clear limits and consistent enforcement of discipline.

Finally, critical or sensitive periods in development may heighten the importance of risk or protective factors. For example, mutual attachment and bonding between parents and children usually occurs in infancy and early childhood. If it fails to occur during those developmental stages, it is unlikely that a strong positive attachment will develop later in the child's life.

[19] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Risk and Protective Factors (Page 4)

Outside the Family

Other risk factors relate to the quality of children's relationships in settings outside the family, such as in their schools, with their peers, teachers, and in the community. Difficulties in these settings can be crucial to a child's emotional, cognitive, and social development. Some of these risk factors are:

- inappropriate classroom behavior, such as aggression and impulsivity;
- academic failure;
- poor social coping skills;
- association with peers with problem behaviors, including drug abuse; and
- misperceptions of the extent and acceptability of drug-abusing behaviors in school, peer, and community environments.

Association with drug-abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behavior. Research has shown, however, that addressing such behavior in interventions can be challenging. For example, a recent study (Dishion et al. 2002) found that placing high-risk youth in a peer group intervention resulted in negative outcomes. Current research is exploring the role that adults and positive peers can play in helping to avoid such outcomes in future interventions.

Other factors—such as drug availability, drug trafficking patterns, and beliefs that drug abuse is generally tolerated—are also risks that can influence young people to start to abuse drugs.

Family has an important role in providing protection for children when they are involved in activities outside the family. When children are outside the family setting, the most salient protective factors are:

- age-appropriate parental monitoring of social behavior, including establishing curfews, ensuring adult supervision of activities outside the home, knowing the child's friends, and enforcing household rules;
- success in academics and involvement in extracurricular activities;
- strong bonds with prosocial institutions, such as school and religious institutions; and
- acceptance of conventional norms against drug abuse.

What are the highest risk periods for drug abuse among youth?

Research has shown that the key risk periods for drug abuse occur during major transitions in children's lives. These transitions include significant changes in physical development (for example, puberty) or social situations (such as moving or parents divorcing) when children experience heightened vulnerability for problem behaviors.

The first big transition for children is when they leave the security of the family and enter school. Later, when they advance from elementary school to middle or junior high school, they often experience new academic and social situations, such as learning to get along with a wider group of peers and having greater expectations for academic performance. It is at this stage—early adolescence—that children are likely to encounter drug abuse for the first time.

[20] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Risk and Protective Factors (Page 5)

Then, when they enter high school, young people face additional social, psychological, and educational challenges. At the same time, they may be exposed to greater availability of drugs, drug abusers, and social engagements involving drugs. These challenges can increase the risk that they will abuse alcohol, tobacco, and other drugs.

A particularly challenging situation in late adolescence is moving away from home for the first time without parental supervision, perhaps to attend college or other schooling. Substance abuse, particularly of alcohol, remains a major public health problem for college populations.

When young adults enter the workforce or marry, they again confront new challenges and stressors that may place them at risk for alcohol and other drug abuse in their adult environments. But these challenges can also be protective when they present opportunities for young people to grow and pursue future goals and interests. Research has shown that these new lifestyles can serve as protective factors as the new roles become more important than being involved with drugs.

Risks appear at every transition from early childhood through young adulthood; therefore, prevention planners need to consider their target audiences and implement programs that provide support appropriate for each developmental stage. They also need to consider how the protective factors involved in these transitions can be strengthened.

When and how does drug abuse start and progress?

Studies such as the National Survey on Drug Use and Health, formerly called the National Household Survey on Drug Abuse, reported by the Substance Abuse and Mental Health Services Administration, indicate that some children are already abusing drugs by age 12 or 13, which likely means that some may begin even earlier. Early abuse includes such drugs as tobacco, alcohol, inhalants, marijuana, and psychotherapeutic drugs. If drug abuse persists into later adolescence, abusers typically become more involved with marijuana and then advance to other illegal drugs, while continuing their abuse of tobacco and alcohol. Studies have also shown that early initiation of drug abuse is associated with greater drug involvement, whether with the same or different drugs. Note, however, that both one-time and long-term surveys indicate that most youth do not progress to abusing other drugs. But among those who do progress, their drug abuse history can vary by neighborhood drug availability, demographic groups, and other characteristics of the abuser population. In general, the pattern of abuse is associated with levels of social disapproval, perceived risk, and the availability of drugs in the community.

Scientists have proposed several hypotheses as to why individuals first become involved with drugs and then escalate to abuse. One explanation is a biological cause, such as having a family history of drug or alcohol abuse, which may genetically predispose a person to drug abuse. Another explanation is that starting to abuse a drug may lead to affiliation with more drug-abusing peers which, in turn, exposes the individual to other drugs. Indeed, many factors may be involved.

[21] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Risk and Protective Factors (Page 6)

Different patterns of drug initiation have been identified based on gender, race or ethnicity, and geographic location. For example, research has found that the circumstances in which young people are offered drugs can depend on gender. Boys generally receive more drug offers and at younger ages. Initial drug abuse can also be influenced by where drugs are offered, such as parks, streets, schools, homes, or parties. Additionally, drugs may be offered by different people including, for example, siblings, friends, or even parents.

While most youth do not progress beyond initial use, a small percentage rapidly escalate their substance abuse. Researchers have found that these youth are the most likely to have experienced a combination of high levels of risk factors with low levels of protective factors. These adolescents were characterized by high stress, low parental support, and low academic competence.

However, there are protective factors that can suppress the escalation to substance abuse. These factors include self-control, which tends to inhibit problem behavior and often increases naturally as children mature during adolescence. In addition, protective family structure, individual personality, and environmental variables can reduce the impact of serious risks of drug abuse. Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.

COMMUNITY ACTION BOX

- **Parents** can use information on risk and protection to help them develop positive preventive actions (e.g. talking about family rules) before problems occur.
- **Educators** can strengthen learning and bonding to school by addressing aggressive behaviors and poor concentration—risks associated with later onset of drug abuse and related problems.
- **Community Leaders** can assess community risk and protective factors associated with drug problems to best target prevention services.

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[22] Robertson, E., David, S., & Rao, S. (2003). Preventing drug abuse among children and adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Retrieved from: https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

Instructions That Don't Work (Page 1)

Buried Instructions: Instructions that are followed by too much talking by the parent. The talking usually takes the form of too much explaining and rationalizing about why the task should be done. It can also take the form of a lot of scolding or criticizing after the command is given.

Example: "John, go put on your sweater because it's cold outside. You know how you always get chilled and then you catch a cold. Then you have to stay home from school, and this gets you behind in your schoolwork."

Chain Instructions: Stringing or chaining too many commands together. If more than two commands are given at once, the child may not be able to sustain attention through the entire string. The child may also begin to obey the first command in the string but become distracted and lose track of the later commands in the string.

Example: "Get to you room, and clean up that mess on the floor, and make up your bed, and take out the garbage, and then get in there and fix a sandwich for your little brother."

Questions Instructions: Phrasing the instruction in the form of a question instead of a command. By doing this you convey to the child that he or she has a choice as to whether or not to follow the instruction. Punishing a child for not following an instruction like this (where he or she has been given a choice) is not fair and it elicits further noncompliance.

Example: "Don't you think you should turn off the TV and do your homework now?"

Repeated Instructions: Repeating the same command over and over again. Parents often have a "magic number" that defines how many times they are willing to repeat a command before they reach their limit. After repeated experiences with their parents, children learn the "magic number." This teaches children that they may ignore their parents until the parent begins to get close to her limit. Then and only then does the child have to listen and comply. This kind of experience teaches the child to tune the parent out.

Example: "Take out the garbage. I said, take out the garbage. Didn't you hear me? I said take out the garbage!"

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[23]

[23] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Instructions That Don't Work (Page 2)

Vague Instructions: Vague commands that are not specific. They do not state exactly what the parent wants the child to do.

Examples:

"Stop that!"

"Behave yourself!"

"Be good."

"Calm down."

"Grow up!"

"Act your age!"

"*Let's . . .* " *Instructions*: Commands that begin with "Let's . . . ." These commands imply that the parent and child are going to do the task together when, in fact, the parent wants the child to do the task independently. In addition to conveying a lack of confidence in the child's ability to perform the command independently, these types of instructions elicit noncompliance, probably because the child feels tricked into complying when the parent does not help.

Example: "Let's go clean up your room."

Instructions Yelled from a Distance: This is when the parent yells an instruction to the child from another room in the house. In this scenario, the parent may not be aware of what the child is doing and may be interrupting the child in the middle of a highly absorbing task. In addition, it is more difficult to keep your tone of voice respectful when a command is being yelled from another room. All of these conditions make it less likely that the child will comply with the instruction.

Example: "Emily! I am waiting in the laundry room for you to bring me your clothes! Go to your room and get your clothes right now!" Meanwhile, Emily is heavily engrossed in playing her videogame. She is beating her older brother Al for the very first time, and the two have made a deal: if she wins this game he will take her out for ice cream on Saturday. Unfortunately, Emily hears her mother screaming from down the hall, she becomes upset and loses the game. Emily begins to cry and her brother starts teasing her that she will not get any ice cream on Saturday.

[24]

[24] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Instructions That Do Work

Instructions that Work

If you are able to give your child good instructions, he or she is more likely to follow them. If you give your child bad or ineffective instructions, he or she is more likely not to follow them. Punishing your child for not following bad instructions is not a good decision. This is why it is so important that you learn to give effective instructions.

Good instructions are

- Direct and specific
- Stated clearly
- Limited to only one or two at a time
- Followed by 10 seconds of silence

An example of a good instruction is as follows:

"Johnny, your room is very messy. Please, go clean it up now."

When giving your child instructions, be sure to keep the following guidelines in mind:

1. Do not give an instruction if you are not willing to follow through with a punishment when your child does not comply.
2. Do not give an instruction that your child does not have the skill or capacity to complete.
3. Respect your child's ongoing activities. Do not give your child an instruction if she is in the middle of something that you have given permission to do. Wait until that activity is completed.
4. Show respect for your child. Use a pleasant (not hostile or sarcastic) tone of voice.

[25]

[25] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Establishing Rules and Expectations (Page 1)

Behavior Rules and Expectations

This week you will learn about behavior rules and expectations and how to establish them in your household.

It is important to note the difference between rules and expectations. *Behavior rules* refer to behaviors that you would like your child to decrease, whereas *expectations* refer to behaviors that you would like your child to increase and include things like chores.

Examples of behavior rules include the following:

- No hitting
- No cursing
- No name-calling
- No breaking of things
- No rough play in the house
- No arguing

Examples of expectations include the following:

- Making the bed in the morning
- Taking out the garbage
- Feeding the animals

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- Cleaning up after dinner
- Cutting the grass
- Completing homework

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[26] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Establishing Rules and Expectations (Page 2)

Establishing Behavior Rules and Expectations

Behavior Rules

Follow these four steps for setting up behavior rules in your household:

1. Think of two or three (no more than three) behaviors that you would like your child to learn to stop doing or do without having to be told every time. After your child has learned to follow the first two or three rules, you can add more to the list.
2. Put those behaviors in the form of a rule.

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3. Write the rules on a piece of paper and place the paper in a prominent place where everyone in the family can see it (e.g., on the refrigerator door).
4. Tell your child that these are the household rules and that they are in effect in the house at all times. Explain to your child that over the course of the next 1 to 2 weeks you will point out times when he is breaking a rule, but that you will not punish him. For example, "Ashley, you just called your brother a name. That is against our behavior rules." This will give your child a chance to learn the rules before the consequences are implemented. After 1 or 2 weeks, your child will get a punishment every time he breaks the rules or does not do what is expected of him.

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[27] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Establishing Rules and Expectations (Page 3)

Expectations

Follow these four steps for setting up household expectations and chores:

1. Think of two or three chores or expectations that you want your child to do every week. Examples include vacuuming or sweeping, taking out the garbage, cleaning his room, helping cook dinner, or doing the dishes.
2. Sit down with your child and ask for his suggestions. You may let your child have some say in what he will do or allow the expectations to change as needed.
3. Tell your child that these are new expectations and chores will be in effect at all times.
4. Explain to your child that over the course of the next 1 to 2 weeks you will point out times when he does not comply with an expectation or complete a chore, but that you will not punish him. For example, "Johnny, you did not put your toys away after you were done playing with them. This is one of your chores and I expect you to do it." This will give your child a chance to get used to your expectations. After this period of pointing out the behaviors, your child will receive a punishment every time he does not do what is expected of him.

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[28]

[28] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Ineffective and Effective Punishment (Page 1)

Following are some examples of effective punishment (and non-punishment) in everyday life:

- Jeremy fights with his little brother and is grounded for the weekend—no TV, no phone calls, and no games. Jeremy does not fight with his little brother again or the frequency of fighting decreases.
- Paul is late for football practice and the coach keeps him out of the game for the first quarter. Paul is never late for football practice again.

Following are some examples of ineffective punishment:

- Jason hits his little brother. His mother yells at him and tells him never to do this again. Jason hits his brother again the next day and every day after that for the next week. His mother yells at him every time he hits his brother. Jason stops hitting his brother at the moment his mother yells at him, but he does it again every day.

The "punishment" in this last example is ineffective because the behavior (hitting his brother) actually increases. Therefore, it is not really punishment, even though the mother may intend it to be punishment. To be an effective punishment, the negative consequence should result in a decrease or total elimination of the bad behavior.

Sometimes parents think that something they do is punishment because it stops the child's behavior at that moment. This includes yelling, screaming, or otherwise verbally reprimanding your child. If your child continues to do the behavior day after day, then what you are doing is not really punishment—it is not working to teach your child to stop doing the behavior in the long run.

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[29] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press

Ineffective and Effective Punishment (Page 2)

Rules for Good Punishment

1. **Punish immediately.** If you wait an hour to punish your child for hitting her brother she may think she is getting punished for something else done in the meantime. She may never make the connection between hitting her brother and being punished.
2. **Be calm, rational, and matter-of-fact.** If you get angry and yell or scream or criticize your child while you are punishing her, you are likely to cause your child to resent you and hate you for the moment.
3. **Do not "give in."** Rewards should never be given for behaviors you want to stop. For example, you want your children to stop throwing tantrums when they do not get their way. Usually you ignore them for doing this. But sometimes you give in and give them what they want. This practice rewards them for throwing tantrums. So they will continue to have tantrums, hoping that sometimes they will get you to give in. If you really want them to stop the tantrums, punish them every time this happens. This behavior will stop much faster than if you punish them some times and reward them other times.
4. **Give a warning signal.** If you must use punishment to control your child's behavior, it is best to give them a warning signal first. Soon the warning will be enough to make your child stop misbehaving.
5. **Make it brief.** Long lectures often reduce the effectiveness of punishment; the same is true for extended periods of grounding. Long lectures may make parents feel better, but they do not usually decrease children's misbehavior. Parents may threaten long periods of grounding when they are angry, but then they often do not follow through with the long grounding. Keep your statements specific and short.

Good punishment is used along with rewards for other positive behaviors. If you reward your children a great deal for positive behavior, they will learn that they do not have to misbehave to get your attention. They can get your attention when they behave.

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[30] Wells, K., Lenhart, L., Lochman, J. (2008). *Coping Power: parent group program workbook*. New York: Oxford University Press