



MODIFICATION OF DYSFUNCTIONAL PATTERNS BY THE MEANS OF COUNSELLING IN THE CASE OF TEENAGERS FACING BEHAVIOUR PROBLEMS. THE ROLE OF THE FAMILY IN MAINTAINING THE RESULTS

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Abstract

The study is focused on the efficiency of counselling in the case of teenagers facing behaviour problems and their families. We investigate the semeiology modification of Behaviour Disorder in the case of teenagers and the improvement of cognitive, emotional dysfunctions and the perception of social support and family relations. As an extra, we also analyse the family relations as vulnerability factors in teenager`s after counselling psycho-pathologic reactivity. The research aimed two samples of teenagers and one of parents from the western part of Romania. The instruments applied aimed concepts such as: self-esteem, problem solving, irrational values, social support, satisfaction with life etc. We indicate that during the first six weeks, the teenagers with behaviour problems modified the way in which they perceived problems solving and decisions making but also the trust in their own ability to solve problems. After counselling we registered the decrease of semeiology and the increase of the trust in their own abilities to solve problems, the embracement of problems approach style also by the development of personal control. The involvement of parents in the counselling indicates a modification in the perception of behaviour problems, and the therapeutic techniques used confirm the efficiency of the counselling mainly by a better management of the conflicts.

Keywords: behaviour problems, problem solving, irrational values, social support

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The parents model their children's lives since birth until they become adults. During adolescence, the influence of friends and colleagues has a bigger importance, but the studies clearly prove the fact that parents are the main factor in shaping teenagers' behaviours and choices along their confrontation with the challenges of maturity.

Close relations between parents and teenager, good parenting abilities, the activities developed together with the family and positive modelling of parental role, they all have well documented effects on the teenager's health and development (Aufseeser, Jekielek, & Brown, 2006). In this context, Rutter's study (1994) brings a solid proof of the fact that conflictual familiar environment can lead to the development of a behaviour disorder, but we must mention that despite the fact that conflictual family is a risk indicator, the mechanism by which it interacts has not been identified.

Some authors claim the idea according to which the ability for solving problems is important for the impact that stressing events have on the teenager; negative life events are associated to depression and behaviour problems during adolescence only when this ability is reduced. These aspects are important as the above mentioned disorders are associated with dysfunctional copying mechanisms, with a problematic attributional style (Marian, 2012), cognitive errors and poor social competences (Marian, 2006; 2009).

The family with dysfunctional parental role

Formative role of the socio-cultural environment depends on the orientation, support, modelling and external fortification of the individual, elements which ply on a series of potential genetic availabilities, mouldable supports which are not enough for the assimilation and integration of surrounding reality. The latest implicitly suppose the character of a human being sociable by excellence, harmoniously adapted and having possibilities to rise from the ranks. Education, stable life environment, firm and safe norms and principles according to the ideals of the society, appeal to human being's immaturity and plasticity and lead the individual to the adult and mature person statute.

All these mentioned aspects depend on the life environment that the child is being offered by his family. We stick to the general idea according to which the family holds the supreme role in building the child's surrounding world and in his psychological development and any anomaly in his life

environment has negative consequences (Milea, 2009).

Behaviour disorder versus the influences of school environment and community - the relevance of researches

The main feature in Behaviour Disorder is represented by a persistent and repetitive behaviour pattern in which the basic rights of the others are broken and in which social norms are not observed. Also, behaviour disturbance must cause a significant deterioration within the social, academic or occupational functioning. Based on the criteria from DSM IV (APA, 2000), three or many of the 15 specific behaviours, including aggressiveness towards people and animals, destruction of goods, larceny or lie and rules breaking (e.g. run away from home), must be presented on a 12 months period in order to be allowed to put the Behaviour Disorder diagnosis. Frequently, persistent behaviours which appear in many different contexts may be the symptoms of the disorder (Lerner & Steinberg, 2004).

Age average in the beginning of the specific symptom for Behaviour Disorder depends on the child's age at the moment of the assessment and on the cumulative prevalence of the symptoms. In a study carried out by Robins (1989) the age average for the beginning of steal was 10 years old for both boys and girls, and for vandalism deeds the age average was 11 years old. Anyhow, beginning age was generally higher for girls rather than for boys. This observation lead to the formulation of a model with three pattern for disruptive behaviour during childhood. *The overt pathway* starts with minor aggression deeds such as intimidation and progresses with physical fights and maybe serious acts of violence. *The covert pathway* starts with minor non-violent behaviours, such as stealing from stores and evolves in vandalism deeds and maybe destruction of material goods. The conflict with authority pathway starts with a refractory behaviour which reaches the contempt and avoidance of authority, such as running away from home.

There is a considerable continuity and stability of behaviour disorder for a period of a few years, consequently 45% of the children aged between 4 and 12 years old who had a behaviour disorder in 1983 (Lerner & Steinberg, 2004), also manifested the symptoms of this disorder even 4 years later, as compared to the 5% of those who did not have the disorder. Also, the stability proved to be higher for the children aged between 8 and 12 years old (symptoms persistent in 60% of the cases) than for children aged between 4 and

7 years old (symptoms persistent in 25% of the cases). However, the interpretation of the results obtained in these studies was complicated due to the co-morbidity of Behaviour disorder with other disorders; consequently, 35% out of those having a behaviour disorder in 1983 also had ADHD 4 years later, and 34% of those who had ADHD in 1983, 4 years later also had the Behaviour disorder. Referring to inter-individual differences, there were not registered significant differences according to age or gender membership with regards to stability of this disorder, but the persistence of disruptive behaviours increases in the same time with the severity of Behaviour disorder.

In a meta-analysis carried out by Rothbaum and Weisz (1994), they reached at the conclusion that fortifications from parents, their reasoning, the punishments that they apply to children are associated to child's externalised behaviour. Consequently, the lack of surveillance and disciplinary instability foretell the appearance of Behaviour disorder mainly when there is a anti-social Personality disorder within the family.

Negative parenting style, characterised by severe and inconsistent disciplinary measures, is clearly associated to child's anti-social behaviour, the prevalence of child's severe behaviour problems being twice higher as compared to the cases where parenting style is a proper one. Next to passive or careless punitive attitudes, these factors can lead to juvenile delinquency. It is also important to underline the fact that the parents who have children with Behaviour disorder have a difficult task in managing this kind of behaviour and most of times, in these situations the parental style is less positive, permissive and inconsistent, it has violent disciplinary measures which maintains or even worsens the child's behaviour problems (Scott, Doolan, Beckett, & Cartwright, 2010).

Violent behaviour and aggression seem to be transferred from parents to children, those who were physically abused until they were 11 years old are significantly more inclined to become violent law breakers during the next 15 years and they report aggression deeds between 14 and 18 years old, independent of gender, ethnic belonging, socio-economic status or family structure (Widom, 1994).

From the researches carried out so far on this theme, it is not clearly made evident if and to what extent antisocial persons of the same age encourage or facilitate the manifestation of antisocial behaviour in the case of teenagers. Still, having friends with anti-social behaviour, influences the

manifestation of same type behaviour but also teenagers who are more antisocial tend to have friends with similar features and manifestations (Lerner & Steinberg, 2004; Leiner, 2009). On the other side, most of the times, aggressive teenagers are rejected by colleagues, but low popularity is a marginal predictor of aggression and violence during adolescence (Farrington, 1972; 1990). However, even if aggressive children are rejected by conventional colleagues, they can be popular in other group with aggressive children (Cairns, Cairns, Neckerman, Gest, & Garipey, 1988).

The influences of school environment and community

According to the studies carried out, it was established that teenagers who have antisocial behaviour usually they frequent a school where there is a high level of disbelief between teachers and students, poor commitments from students for the school and unclear and inconsistent rules. It is not clear to what extent the school as an institution influences the antisocial behaviour by organization, climate and educational practice or if the number of pupils with antisocial behaviour is main function in the contribution that the school has in maintaining these problems in school environment. The studies indicates the fact that in schools where there are consistent, correct and clear rules, the number of pupils with inadequate and antisocial behaviour tends to be lower (Graham, 1988; Farrington, 1972; Gottfredson, 2001; Herrenkohl, Hawkins, Chung, Hill, & Battin-Pearson, 2001).

With regards to the influences of the community, the studies indicate that boys who live in urban areas are more violent as compared to those who live in rural areas. In urban areas, in disreputable neighbourhoods or the ones with a higher rate of criminality, the frequency of emerging antisocial and aggressive behaviours in children and teenagers increases. We reached at the conclusion that the influences of the neighbourhood or the one of the community on the antisocial behaviour are indirect by their effects on the individual and his family (Gottfredson, McNeil, & Gottfredson, 1991; Rutter, 1971; 1981). The results obtained by Offord et al. (1987) indicate the fact that teenagers with Behaviour disorder most of the times come from families with poor social-economic statute, with jobless parents who live in houses provided by the state and they depend on social security benefits. Also, parents` social-economic statute, the income and low educational level are predictors of children`s Behaviour disorder.

Out of 230 psychotherapeutic models available for children and teenagers, the great majority were not studied; out of those for which the efficiency was studied, there was not found any approach to prove that combats Behaviour disorder and its course on long term, although many interventions seem to be conceptually justified for treating Behaviour disorder.

Multi-world interventions either include multiple interventions within schools or multiple contexts, combining the interventions from schools with trainings for parents (Carr, 2006; Szabo & Marian, 2012). Multi-world programs want to assure for both children and their parents, the necessary abilities for an adequately encouraging the development of pro-social behaviour patterns. After implementing these programs there were registered lower levels of aggression in children who were in play contexts and a decrease of behaviour problems frequency (for example: bullying, steal, vandalism etc.).

Cognitive Training of Problem Solving Abilities (PSST)

PSST resides in developing cognitive and interpersonal abilities for solving problems. Although there were applied series of variants of PSST for children with Behaviour disorder, there are mutual characteristics. First of all, the emphasis is on the way the child approaches the situations. Second of all, the behaviours (solutions) which are selected for interpersonal situations have the same level of importance. Pro-social behaviours are maintained/ supported by modelling and direct fortification as part of the process for problems solving. Third, the treatment/intervention uses structured tasks which imply games, academic activities and stories (Trip, 2007). During the training, problems solving cognitive abilities are progressively applied in ecologic context. Forth, most of time, the therapists have an active role within the intervention. Last, PSST combines some different procedures: modelling and application, role-play and fortification. They are systematically implemented so that the teenager develops a complex answer repertory (D'Zurilla & Nezu, 1999).

The results of many studies carried out on children and teenagers facing impulsivity, aggression and behaviour problems, indicated that the interventions which place the accent on cognitive dimension, significantly reduce aggression and antisocial behaviour at home, at school and in the community. The advantages obtained were evident even during follow-up measurements which took place one year later. Duriak, Fuhrman and Lampman

(1991) indicated that the results of the programs implemented for children (teenagers compared to younger children) are more efficient probably due to cognitive development but the variations of treatment responsivity according to age are not rigorously investigated.

Parents` Training

Training programs can be applied either individually with one parent or both parents, in order to approach their specific difficulties in detail, or in group where parents help each other reciprocally by offering suggestions and solutions. Materials are often used as a base for the discussions and most of times there are video recordings. Typically, training programs follow a plan structured in weekly meetings (roughly 10-12) during which parents are being informed about the principles of child behaviour disorders management (Gowers & Bryan, 2005).

The researches which compare different “delivery” modalities for parental training suggest that self-administered programs by modelling video tapes are more efficient in reducing child`s deviation if therapeutic consultancy is available as compared to treatments where the therapist is not involved (Webster-Stratton, 1990).

Although there are many experimental results which attest the efficiency of parental training, they are not always maintained in follow-up as many researches avoid to use follow-up measures long time periods after finishing the training; those who used post treatment measuring obtained a percent between of 25% and 46% of the parents who reported clinical behaviour problems of their children and 26% of the teachers of children`s families who took part in training reported the re-emergence of behaviour problems (Webster-Stratton, 1990).

One of the main limits of parental training with regards to its efficiency is that it focused exclusively on parents` abilities without approaching child`s individual risk factors. The programs „*The Incredible Years*”, „*Basic*”, „*Advance*”, „*School*”, „*Dina Dinosaur Social Skills*” and „*Problem Solving Curriculum*” were assessed in randomised clinical studies carried out by Webster-Stratton and their collaborators; they obtained results for „*Basic*” program for reducing behaviour problems and for improving the interactions between parent and child and for the program „*Advance*” as it developed parents` communication abilities, problems solving and collaboration (Gowers

& Bryan, 2005).

Behavioural Parent Management Training (Patterson, Chamberlain, & Reid, 1982) is one of the most promising approaches. The observations on parent-child interactions indicated that the parents of children with antisocial behaviour had deficits at the level of parenting abilities. By this program, Patterson has the purpose of teaching parents efficient methods for raising and educating the child, such as: the observation of child's actions, long term behaviour monitoring, clear establishment of rules, choosing fortifications and their adequate use, choosing punishments contingent with negotiation of misunderstandings in order to avoid conflicts and crises escalate. This parental training proved to be efficient in reducing stealing and child's anti-social behaviour (Patterson et al., 1982).

Although there are no parental training programs specifically built for treating Behaviour disorders for teenagers, parents can be helped to identify much more useful perspectives in approaching teenagers' behaviour problems by monitoring and observing the impact of antecedents and the consequences of their behaviour. Also, the parents can be aware of the fact that behaviour problems can be maintained by patterns of interaction within the family and social network (Carr, 2006).

Interpersonal abilities training

Theoretical reasoning for training approaches is the belief according to which the lack of interpersonal abilities is the main cause for children's behaviour problems. Consequently, the solution is to teach children the abilities that they are missing. In practice, the abilities that the great majority of the programs aim to are the same, so the differences between the existent programs are caused by learning modalities and not by learned abilities. Problems solving abilities are the most common competences learned during interpersonal abilities training programs. Typically, problem solving abilities programs start by learning the technique „Stop and think” when they deal with a problem. The children are being taught fury control abilities, including behavioural techniques such as profound breathing exercises and using a calming internal language (Taylor, Eddy, & Biglan, 1999).

Besides problems solving abilities, interpersonal abilities training programs also have as a purpose the learning of social competences and coping strategies. Although different programs give more or less importance to some

competences, all of them combine problem solving abilities with social abilities and coping strategies (Sommers-Flanagan & Sommers-Flanagan, 2004).

There is a reduced number of studies regarding the efficiency of interpersonal abilities training in the case of teenagers and still they revealed a decrease of moderate behaviour problems in the reports made by teachers, in the observations regarding the behaviour during tasks in the laboratory and in the behavioural assessments made by the staff of the institutions. In these studies there were not significant differences in the case of more severe behaviour problems. Therefore, the researches on the efficiency of interpersonal abilities training for teenagers offer a limited support regarding the short term effects on facile behaviour problems but they do not claim the efficiency of this approach in obtaining a significant reduction of behaviour problems on long term.

Objectives

We investigate the efficacy of counselling in modification of the semeiology for Behaviour disorder in the case of teenagers and also in improving cognitive, emotional dysfunctions and for the perception of social support and family relations.

We investigate the efficacy of intervention in modifying irrational values, satisfaction with life and self-esteem which maintain behaviour problems for teenagers and family dysfunction problems. The endeavour proposed shall investigate the statute of irrational values and family relations as vulnerability factors for teenagers and their families in post-counselling psychopathological reactivity and to which extent irrational values or believes can play a mediatory role in teenager`s psychopathology.

Method

Participants

Below we present relevant demographic data in the case of each participant lot.

Teenagers participants with clinical level behaviour problems (PA.1)

There were 41 teenager participants with behaviour problems, aged between 15 and 17 years old ($m=16,58$; $AS=,54$); they were recruited from many secondary schools from the western part of Romania, from psychological offices, Probation Service belonging to Arad High Court. There were 33 boys (80,5%) and 8 girls (19,5%) out of which 2 teenager participants (4,9%) were in the 9th grade, 14 (34,1%) in the 10th grade and 25 (61%) in the 11th grade. The teenagers took part in the two moments of the evaluation (before test - T1 and after test T2). The participants selected had gross scores at ASEBA - YSR over 11 points.

Teenagers participants with clinical level behaviour problems and included in counselling program (PA.2)

There were 39 teenager participants with behaviour problems who followed a counselling and they were aged between 15 and 17 years old ($m=16,43$; $AS=,59$). The participants or their parents solicited the initial assessment and to be included in a counselling program in order to improve or to eliminate the manifested semeiology. There were 37 boys (94,9%) and 2 girls (5,1%); 3 teenager participants (7,7%) were in the 9th grade, 18 (46,2%) in the 10th grade and 18 in the 11th grade. The selected participants had gross scores of more than 16 points at ASEBA - YSR.

Participants who were the parents of teenagers with clinical level behaviour problems and included in counselling programs (PP)

The participants who were parents of teenagers (PA.2) with behaviour problems who followed counselling programs were 39 and they were aged between 40 and 55 years old ($m=46,38$; $AS=4,15$). The participants solicited the initial psychological assessment and to be included in a counselling program in order to improve or to eliminate their children manifesting semeiology. From the point of view of the participant gender, there were 6 men (15,4%) and 33 women (84,6%). From marital point of view there were 5 unmarried mothers (12,8%), 18 married (46,2%), 13 (33,3%) divorced and 3 widows (7,7%). Teenagers` parents took part to the three moments of the assessment (before test - T1, middle of the intervention - T2 and after test T3).

Research instruments

The Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001) is made out of a set of questionnaires which

assesses the competences, adaptive functioning and the problems that children and teenagers are facing. The instrument is efficient in the domain of mental health and that of counselling. Being based on scales derived from DSM, the instrument measures affective problems, anxiety problems, somatic accusers, problems connected to ADHD, opposing behaviour problems and behaviour problems. Besides that, ASEBA measures Internalization and Externalization by the means of which they generally group the problems, so representing an over organised level of the scores for ASEBA. Reported fidelity is very good .96 and test-retest fidelity .95.

The Problem Solving Inventory (PSI; Heppner & Peterson, 1982) is a 35 items instrument designed so that it measures the way in which the individuals believe they generally react in every day life to personal problems including their personal style of solving problems (Marian & Roşeanu, 2012). Heppner and Peterson (1982) and Heppner (2000, p. 591) reported a fidelity of PSI between .72 and .85 for subscale and an alpha coefficient of .90 for general Index of problem solving perception. After adapting PSI items in our study, we observe that subscales present an internal consistency similar to the studies previously mentioned. In the case of global index for PSI we obtain a coefficient of .86 and this value indicates a very good internal consistency.

Irrational Values Scale (IVS) was proposed by MacDonald and Games (1972) as a consequence of the endorsement given by irrational values and believes. Irrational believes present the following characteristics: logical inconsistency, inconsistency with empirical reality, absolutism and dogmatism, affecting emotions and impediment for reaching the objectives (Ellis, 2001; Roşeanu, 2011). IVS is made of a set which includes 9 items and alpha Cronbach coefficient is .85.

Satisfaction With Life Scale (SLS). Satisfaction with life refers to the decision process where individuals assess the quality of their own life based on their own and unique set of criteria (Pavot & Diener, 1993, p. 165; Marian, 2007). Stevens, Constantinescu, Lambriu, Butucescu, Sandu, & Uscătescu (2012) indicated that the age when the scale can be applied can be lowed up to 16 years old. The scale includes 5 items formulated in sentences for which the subjects are asked to express their approval using a Likert scale. The correlation between items and total score for SLS is between .69 and .80 and internal consistency indicates a coefficient of .81.

Positive and Negative Affect Scale (PANAS). Watson and Tellegen

(1985) tried to connect negative emotions and positive emotions with sensitive psycho-biological constructs such as punishment and reward. PANAS includes 20 items representing adjectives for which the subjects are invited to express their opinion using a Likert scale c (1-5). In the case of total score for PANAS there was obtained a coefficient of .72 (20 items). In our study the results of the examinations carried out in test and retest phase present a good stability of subscales for PANAS.

Rosenberg Self-Esteem Scale (SES). Rosenberg (1965) proposes an instrument made out of 10 items which in time became an international level bench-mark for self-esteem assessment. SES was conceived as a single-dimensional assessment instrument for self-esteem. SES indicates the self-esteem level, it includes 10 items and the answers are presented in Likert format (between 1 and 4). SES has a good internal consistency (.89) (Rosenberg, 1965).

The Multidimensional Scale of Perceived Social Support (MSPSS). Zimet, Dahlem, Zimet and Farley (1988) propose an evaluation of social support by the means of „The Multidimensional Scale of Perceived Social Support” (MSPSS), an instrument designed to measure the way in which people perceive social support coming from three sources: family, friends, and from other significant persons for them. MSPSS scale includes 12 items. The correlation between items and total MSPSS score is between .63 and .79 and internal consistency of MSPSS indicates a coefficient of .89 (12 items).

The Index of Family Relations (IRF; Hudson, 1997) measures relation problems between children and their parents. IRF is an instrument made of 25 items designed to measure the degree, severity or magnitude of relation problems between parents-child reported by a patient or by a person who is under psychological counselling. The global purpose is seen as being a general index of family problems severity. Internal consistency in our study is .83, a close value to the one reported by the authors of IRF.

Procedure

The participants to the study, teenagers and parents were selected based on the scores obtained to ASEBA - YSR and CBCL. The scale package which was presented was applied during each phase (Time 1, 2 and 3).

The participants in the lot PA.2 and PP asked for a speciality intervention (counselling) and before that they were not under any other type of

psycho-therapeutic or pharma-therapeutic treatment for Behaviour disorder or other psychical treatment disorders.

The participants who were in counselling meetings and who were included in the experimental lot PA.2 and PP were assessed during the phase before the test (Time 1), after seven meetings (Time 2) and after counselling (Time 3). Similarly, the participants PA.1 (with higher scores at ASEBA - YSR) were assessed at Time 1, Time 2 and Time 3 without being submitted to a specific psychological intervention.

There were eliminated the participants who did not take part in the three assessment sessions and those who did not manifested credibility for the examiner. The participants admitted in the study constituted the groups: *clinic de control* (PA.1) and *counselling* (PA.2 and PP). In the case of the lot included in counselling program (PA.2 and PP) there were 14 meetings with a duration of one hour each week.

Work methods and techniques applied in the case of teenagers and parents included in counselling program who presented behaviour problems

The counselling of teenagers and their families was based on the following stages: 1. Assessment of client`s problems; 2. Initiation of change; 3. Middle stage of counselling and 3. The end of counselling. These stages are in agreement with cognitive-behavioural orientation in counselling (Ellis & Dryden, 1997).

First meeting supposed initial assessment (for example, during the assessment of counselling, the diagnosis can be changed due to symptoms remission) and the clarification of client`s expectances but also a clear delimitation of confidentiality. The assessment, diagnosis and planning of the treatment were in the middle of attention during the whole time of counselling.

The *second meeting* aimed the identification and clarification of problem situations. The third meeting aimed the establishment of the purposes, of the expected results, of the scenario wanted by the client and his family but also the establishment of intervention strategies and action plan. Starting with the *fourth meeting*, the counsellor appealed to the application of the action plan negotiated and accepted by the customer. *The last meeting* was dedicated to final assessment of the client and his family and to establishing possible long term targets (by negotiation with the teenager or the adult) with the role of maintaining the positive results obtained during counselling.

The most frequent techniques used in counselling the teenager but also his family were the following: problem solving, self-control, modification of values and beliefs, behavioural techniques.

Experimental design

In order to verify the first hypothesis, the experimental design is a basic one with measurements repeated between the pre-test phase (T1) and the middle of the intervention (T2). In this case we shall use the test T1 for pair samples and ANOVA with repeated measurements.

In order to verify *the second hypothesis*, the experimental design is a basic one with repeated measurements. The data shall be analysed by ANOVA with repeated measurements.

In order to verify *the third hypothesis* we appealed to a multi-factorial experimental design, with the moment of the assessment (T1, T2 and T3) and the implication of the family in the counselling as independent variables (VI) and personal control at PA.2 and irrational values at PA.2 as dependent variables (VD). The data was processed by ANOVA.

Results and interpretation

According to the first objective of the research where we claim that by the counselling oriented on cognitive and behavioural elements, this is efficient in the modification of dysfunctional patterns and socio-cognitive dysadaptive and also in improving behaviour problems for teenagers (after six weeks).

In Table 1 we present the descriptive statistic in pre-counselling stage (T1) and at half time during counselling process (Time 2) for the eight variables in the case of the teenagers` lot PA.2 who followed counselling meetings and in the case of PA.1 - teenager participants with clinical level behavioural problems who were assessed pre-test (T1) and after the test (T2 - after 14 weeks).

Between pre-test (T1) and after-test week (T2 - after 14 weeks) the averages were equivalent for most of the scales for group PA.1. for the lot PA.1 the differences between T1 and T2 we register at the scale perception of friends [$t(40)= 2,813$; $p<.008$; $d=-0,02$] in the direction of a slight increase of friendship relations and a slight decrease of the average for self-esteem [$t(40)=3,559$; $p<.001$; $d=0,59$], of negative emotions [$t(40)=3,524$; $p<.001$; $d=0,79$] and of the Family Relations Index [$t(40)=4,177$; $p<.001$; $d=0,31$]. We

observe that Family Relations Index is an instrument extremely sensitive to the variations of the intra-family climate (Table 1).

Table 1. Comparisons between pre-intervention stage (Time 1) and the first half of the intervention (Time 2) for the participant to the lots PA.1 and PA.2

Source		PA.1				PA.2			
		<u>m</u> SD	t df. 40	p	d	<u>m</u> SD	t df. 38	p	d
Conduct Problems ASEBA-YSR	T1	11,60 1,11	,925	NS	-	19,66 2,92	8,779	.001	1,86
	T2	11,34 2,25				12,94 4,19			
Problem solving confidence	T1	38,04 5,27	-1,000	NS	-	46,25 4,63	6,240	.001	1,06
	T2	38,29 5,79				41,10 5,00			
Approach- avoidance style	T1	60,6 5,93	,538	NS	-	68,07 9,20	6,477	.001	0,97
	T2	60,3 5,44				58,64 10,11			
Personal control	T1	16,6 3,36	1,022	NS	-	16,48 3,24	6,787	.001	1,42
	T2	16,3 3,02				12 3,05			
General index of problem solving perception	T1	111,6 10,35	1,539	NS	-	121,2 12,94	8,821	.001	1,73
	T2	109 13,64				100,5 10,85			
Perceived Social Support (MSPSS)	T1	4,59 ,73	-1,302	NS	-	3,79 ,58	-4,450	.001	-0,57
	T2	4,60 ,73				4,12 ,57			
Family (MSPSS)	T1	4,39 1,13	-,673	NS	-	3,23 ,56	-5,949	.001	-1,21
	T2	4,45 1,05				3,97 ,65			
Friends (MSPSS)	T1	4,41 ,70	-2,813	.008	-0,02	4,23 ,91	-3,431	.001	-0,15
	T2	4,55 ,64				4,36 ,82			
Significant other (MSPSS)	T1	4,96 ,93	-,575	NS	-	3,91 ,78	-4,256	.001	-0,48
	T2	4,98 ,82				4,27 ,70			

Note: PA.1 - Teenagers participants with clinical level behaviour problems; PA.2 - Teenagers participants with clinical level behaviour problems and included in counselling program; d = effect size; * p<.001

Table 1. Comparisons between pre-intervention stage (Time 1) and the first half of the intervention (Time 2) for the participant to the lots PA.1 and PA.2 - *continued*

Source		PA.1				PA.2			
		\bar{m} SD	t df. 40	p	d	\bar{m} SD	t df. 38	p	d
Satisfaction With Life	T1	17,24 5,64	-1,17	NS	-	14,89 2,54	-5,480	.001	-0,72
	T2	17,26 4,99				17,23 3,83			
Self-esteem	T1	24,09 1,49	3,559	.001	0,59	22,66 2,73	-3,650	.001	-0,34
	T2	22,73 2,88				23,58 2,62			
Negative affect	T1	20,19 4,50	3,524	.001	0,79	25,69 8,30	5,413	.001	1,12
	T2	16,00 5,92				18,07 4,72			
Positive affect	T1	32,17 3,41	-7,752	NS	-	33,66 3,81	2,248	.03	0,23
	T2	32,46 3,59				32,71 4,14			
Irrational Values	T1	50,68 9,28	1,244	NS	-	50,05 12,41	6,554	.001	0,73
	T2	50,68 9,59				41,69 10,09			
Index of Family Relations	T1	86,80 22,88	4,177	.001	0,31	100,1 15,87	6,297	.001	1,28
	T2	79,97 20,91				80,74 14,12			

Note: PA.1 - Teenagers participants with clinical level behaviour problems; PA.2 - Teenagers participants with clinical level behaviour problems and included in counselling program; d = effect size; * p<.001

We observe in Table 1 an improvement between T1 (pre-counselling) and T2 (after the first six weeks of counselling) [$t(38)=8,779$; $p<.001$; $d=1,86$]. The averages registered in T1 ($m=19,66$) by ASEBA - YSR which indicated behaviour problems in the clinical interval decreased to T2 ($m=12,94$) in the sub-clinic interval, and the dimension of the effect is powerful ($d=1,86$) which indicates the efficiency of the counselling process in the modification of the semeiological patterns for the teenagers.

During the first seven weeks (between T1 and T2), the teenagers with behaviour problems from the lot PA.2 were taught, then they were prescribed to apply *the problem solving technique*, which lead to the modification of the

perception of problem solving and decisions making. The results presented in Table 1 regarding the trust in problem solving ability for the lot PA.2 [t(38)=6,240; p<.001; d=1,06] indicates an increase for T2; an increase in T2 we also register in the case of the variable approach of the problems and implicitly a decrease for avoiding decisions [t(38)=6,477; p<.001; d=0,97] and an increase of personal control [t(38)=6,787; p<.001; d=1,42].

General Index for Problems Solving [t(38)=8,821; p<.001; d=1,73] supports the data previously presented and the registered effect is a strongly significant one in the case of all variables presented; this proves that the longitudinal study on the modifications occurred during the counselling meetings does not only catch sensitive modifications from statistically point of view but also those with an applicative impact.

Irrational values were modified by *cognitive restructuring* including *pragmatic disputing* (based on functioning criterion: "Where does this thing lead you to? "What happens the moment you think like that?" etc.), *dialectical disputing* (by analogies, parables etc.) and disputing of *specific irrational convictions* („I must", „I need to ...", „human valour", „low frustration tolerance" etc.).

The result registered [t(38)=6,554; p<.001; d=0,73] during the counselling for PA.2 lot between T1 and T2 sustains previous affirmations in the case of modifying irrational values and the size of the effect is medium (Table 1). The situation is similar in the case of satisfaction with life [t(38)=-5,480; p<.001; d=-0,72] where the modification has a medium effect and in the case of self-esteem [t(38)=-3,650; p<.001; d=-0,34] the size of the effect is reduced. The data registered (between T1 and T2) indicate the need for a long term speciality intervention, which justifies the number of counselling meetings in the case of PA.2 lot.

A decrease of negative emotions averages between T1 and T2 for PA.2 lot [t(38)=5,413; p<.001; d=1,12] with a large effect magnitude, indicates the installation of a calm condition and serenity as Watson et al. indicated (1988); on the other side, positive emotions [t(38)=2,248; p<.03; d=0,23] have a diminished increase of the average and with a low effect (d=0,23) which indicates that there are still problems in committing in the tasks prescribed during counselling meetings, so a low enthusiasm.

After the first seven weeks of counselling (between T1 and T2), the teenagers with behaviour problems from the lot PA.2 together with the

members of their families (mother or father) received tasks aiming the forming of social abilities or in other words, the *abilities training* (tasks which involve at least one member of the family, significant persons etc.). Our results at IRF indicate a decrease of intra-familial conflicts [$t(38)=6,297$; $p<.001$; $d=1,28$] between T1 and T2, and an improvement of socialising of teenagers with their parents involving a decrease of problems severity.

In consonance with the data previously presented, the perception of family support (Table 1) for PA.2 [$t(38)=-5,949$; $p<.001$; $d=-1,21$] indicates an increase of the average in T2, which claims the efficacy of the intervention even in the improvement of family relations perception. The magnitude of the registered effect is not situated at medium level in the case of friends` support perception ($d=-0,15$) and of significant persons ($d=-0,48$), which indicates rather a focus of counselling on improving behaviour problems and on improving the relations with the family. The perception of global social support presents an improvement [$t(38)=-4,450$; $p<.001$; $d=-0,57$] between T1 and T2 with a increase of the effect at medium level.

Efficacy of counselling in attenuating behaviour problems for teenagers

We also investigate the extent to which the teenagers with dysfunctions at socio-cognitive level caused by behaviour problems present a consistent improvement after the intervention if they applied the specific stages of the counselling.

The results presented in Table 2 regarding the efficacy of counselling in improving behaviour problems at teenagers indicate a consistent diminish of initial manifesting problems (from T1 to T3) at the lot PA.2 [$F(2, 76)=115,413$; $p<.001$; $\eta^2=0,75$] measured with ASEBA - YSR and implicitly an increase of teenager`s familiar and social adaptability. We register after an average period of 14 weeks by the means of counselling, the decrease of the scores for ASEBA - YSR from the clinical interval (T1) in the non clinic interval (T3). The tendency for decreasing the average, as we have also seen during the investigation of the first half of the intervention (the first seven weeks - T2) is maintained; this indicates the acceptance for including the gradual adaption to the rational values promoted by the counsellor in the counselling process.

Table 2. Comparisons between pre-intervention stage (Time 1), the first half of the intervention (Time 2) and after intervention (Time 3) for the participants of the lot PA.2

Source	F	df	p	η^2	Time	m	SD
Conduct Problems	115,413	2	.001	0,75	T1	19,66	2,92
					T2	12,94	4,19
					T3	10,48	2,71
Problem solving confidence	80,166	2	.001	0,67	T1	46,25	4,63
					T2	41,10	5,00
					T3	35,79	5,62
Approach-avoidance style	68,213	2	.001	0,64	T1	68,07	9,20
					T2	58,64	10,11
					T3	50,51	8,83
Personal control	60,468	2	.001	0,61	T1	16,48	3,24
					T2	12,00	3,05
					T3	10,69	2,31
Family (MSPSS)	48,185	2	.001	0,55	T1	3,23	,56
					T2	3,97	,65
					T3	4,15	,58
Friends (MSPSS)	14,654	2	.001	0,27	T1	4,23	,91
					T2	4,36	,82
					T3	4,45	,80
Significant other (MSPSS)	22,322	2	.001	0,37	T1	3,91	,78
					T2	4,27	,70
					T3	4,35	,65
Negative affect	42,379	2	.001	0,52	T1	25,69	8,30
					T2	18,07	4,72
					T3	15,17	3,73
Irrational Values	39,837	2	.001	0,57	T1	50,05	12,41
					T2	41,69	10,09
					T3	37,76	8,21
Index of Family Relations	69,044	2	.001	0,64	T1	100,1	15,87
					T2	80,74	14,12
					T3	66,61	14,98

Note 1: PA.2 - Teenagers participants with clinical level behaviour problems and included in counselling program; η^2 effect size; * $p < .001$

Regarding the perception of problems solving, the counselling of teenagers having short term behaviour problems explicitly aimed the educational, preventive, professional, supportive, situational aspects and the

development process.

We register changes between T1 and T3 regarding the trust in problem solving ability [$F(2, 76)=80,166$; $p<.001$; $\eta^2=0,67$], adopting the problems approach style [$F(2, 76)=68,213$; $p<.001$; $\eta^2=0,64$] and by developing and/ or regaining personal control [$F(2, 76)=60,468$; $p<.001$; $\eta^2=0,61$].

Even if they are more difficult to be changed, irrational believes about self value which were approached during the counselling process by *cognitive restructuration*, allow us to observe significant differences between the three experimental conditions. The result registered in the modification of irrational believes [$F(2, 76)=39,837$; $p<.001$; $\eta^2=0,57$] during the counselling process of the lot PA.2 prove the efficacy of using specific counselling techniques at cognitive level (Table 2). According to our expectances, in the same with installing some changes at cognitive level, we implicitly assist to a decrease of negative emotions [$F(2, 76)=42,379$; $p<.001$; $\eta^2=0,52$] but also in association with the frequency decrease of familial conflicts [$F(2, 76)=69,044$; $p<.001$; $\eta^2=0,64$] meaning an improvement of teenager-parent relationship.

The improvement of familial support perception by the teenager with behaviour problems as a consequence of the fact that his parents took part in meetings [$F(2, 76)=48,185$; $p<.001$; $\eta^2=0,55$] but also as a consequence of the tasks between the meetings, such as activity planning, prioritising the tasks or behavioural experiments (teenagers` affirmations are treated like research hypotheses which shall be tested by observing the fixation of the abilities or the frequency increase of desirable behaviours) indicate the efficiency of counselling for the improvement of this dysfunction.

The tasks given during the counselling meetings indicate an improvement of perception regarding social relations and those with friends [$F(2, 76)=14,654$; $p<.001$; $\eta^2=0,27$] but also a modification of significant persons` perception [$F(2, 76)=22,322$; $p<.001$; $\eta^2=0,37$] including the counsellor with whom the teenager created a constructive therapeutic alliance.

Modification of socio-cognitive patterns and of behaviour problems perception by the family during the counselling process

The first objective of the research aimed the efficiency of the counselling oriented towards the elements of cognitive, behavioural and social type, in changing the perception of the family towards the teenager`s problems.

Hereby, the PP lot was made out of 39 participants who were assessed during pre-counselling phase (T1) with the instruments previously presented.

The 39 parents who formed the initial lot, 17 parents (2 men and 15 women) committed in the parental training program for a period of 14 weeks. 22 parents (4 men and 18 women) took part sporadically to the counselling meetings (roughly 5 meetings) out of reasons independent from the therapeutic process. The motivations of the parents for not joining the meetings were different, from not having the necessary time, to not admitting their personal problems, to fear of self-exposure and to being busy at work during the whole day.

The parents who did not took part to all counselling meetings (N=22), according to the solicitations of the counsellor, filled in the set of scales for T1, T2 and T3. Statistic arrangements which shall be presented in Table 3 and 4 aim only the participants PP (N=17) who took part in the counselling meetings (parental training program).

Starting from the initial focus set on teenager's behavioural problems, the parental training extended and addressed both to academic difficulties, to the relations with the same age persons, to communication abilities and problem solving abilities and to parental factors such as: trust in their own parenting abilities, stress, values (rational versus irrational), satisfaction with life etc.

The program aimed the forming of a collaborative relation between family and counsellor. As Gower and Bryan (2005) indicated, during the counselling, the counsellor played the role of the expert, meaning that he did not approached the parents in a directive way, by indicating them what they should do with their own, but they admitted their experiences and knowledge on their children and implicitly the counsellors admitted their role of experts regarding the behaviour of their own child/ teenager. In this way, the parents and the counsellor contributed in the program with their own expertise, and the work had a collaborative character for reaching the objectives.

The results registered in Table 3 in the case of the lot PP (N=17) who got involved in the counselling process, indicates a modification of perceiving the behaviour problems by the parents (ASEBA - CBCL) in the same time with the improvement of the teenager's problems and it indicates a realistic perception of the change [$F(2, 32)=221,675$; $p<.001$; $\eta^2=0,93$]. We also register modifications of the averages for ASEBA - CBCL from T1 to T2 where they

descend from clinical interval to the subclinical one and from T2 to T3 to the normal interval.

The efficiency of the counselling in the case of the parents is also proved by the results registered at IRF (which indicates a better conflict management) [$F(2, 32)=19,080$; $p<.001$; $\eta^2=0,54$], the perception of family support [$F(2, 32)= 15,173$; $p<.001$; $\eta^2=0,48$], friends` support [$F(2, 32)=3,662$; $p<.001$; $\eta^2=0,18$] and that of significant persons [$F(2, 32)=9,122$; $p<.001$; $\eta^2=0,36$] where we register a substantial increase of the averages from T1 to T2 and T3 with a great magnitude of the effect (η^2) (Table 3).

Table 3. Comparisons between pre-intervention stage (Time 1), the first half of the intervention (Time 2) and after intervention (Time 3) for the participants to PP lot

Source	F	df	p	η^2	Time	m	SD
Conduct Problems (ASEBA – CBCL)	221,675	2	.001	0,93	T1	23,47	2,91
					T2	6,41	4,55
					T3	5,23	2,51
Family (MSPSS)	15,173	2	.001	0,48	T1	3,52	,48
					T2	3,97	,44
					T3	4,21	,39
Friends (MSPSS)	3,662	2	.03	0,18	T1	4,51	,85
					T2	4,53	,83
					T3	4,60	,73
Significant other (MSPSS)	9,122	2	.001	0,36	T1	4,14	,75
					T2	4,33	,57
					T3	4,47	,59
Irrational Values	27,261	2	.001	0,63	T1	51,58	15,05
					T2	35,88	9,16
					T3	33,35	7,63
Index of Family Relations	19,080	2	.001	0,54	T1	87,82	24
					T2	71,23	15,89
					T3	61,35	12,47

Note 1: PP - Participants who were the parents of teenagers with clinical level behaviour problems and included in counselling programs (N=17); * $p<.001$; η^2 effect size

Even if at present parental training programs specifically built for treating Behaviour disorder are defectives, in our study, the parents were supported in identifying the useful perspectives in approaching teenagers` behaviour problems by observation and by monitoring the impact of the antecedents and the consequences of their behaviour. By the means of

repositioning, the parents were encouraged to modify their dysadaptive or irrational beliefs and values regarding the teenagers' behaviour problems. By cognitive restructuring the parents adopted a rational and efficient perspective to see their child as a good child with bad or inappropriate habits which are initiated by certain situations and fortified by certain consequences. Additionally, by the modification of irrational values [$F(2, 32)=27,261$; $p<.001$; $\eta^2=0,63$] the parents ($N=17$) are aware of the fact that teenagers' behaviour problems can be maintained by interaction patterns within the family and social network (Table 4).

Table 4. Comparisons between pre-intervention stage (Time 1) and post-intervention (Time 3) for the participants to PP lot

Source		PP (N=17)					
		m	SD	t	df	p	d
Satisfaction With Life	T1	17,82	3,37	-2,545	16	.02	-0,56
	T3	19,47	2,45				
Self-esteem	T1	23,70	4,10	-,588	16	.56	NS
	T3	23,88	4,22				

Note: PP - Participants who were the parents of teenagers with clinical level behaviour problems and included in counselling programs; d = effect size; * $p<.05$

Counselling program did not substantially modified self-esteem but only parents' satisfaction with life [$t(16)=-2.545$; $p<.02$; $d=-0.56$] between T1 and T3. The results presented in Table 4 prove that an action on certain area of life does not lead itself to personal major changes.

Conclusions

In the study we investigate the efficacy of counselling in modifying the semeiology for Behaviour disorder in the case of teenagers and also for improving cognitive, emotional dysfunctions and the perception of social support and family relations. Additionally, we investigate the efficacy of the intervention in modifying the irrational values, the satisfaction with life and self-esteem related to behaviour problems for teenagers and family dysfunction.

By counselling oriented towards the cognitive and behavioural elements

proposed by Ellis (2001, 2002) but also by Kazdin (2000), we modify the dysfunctional and dysadaptive socio-cognitive patterns. The first concrete signs of the change take place during the half of the intervention (between T1 and T2) which proves the fact that a re-assessment of the intervention is necessary for the success of the psychotherapeutic act in general. These aspects experimentally proven, come as a support for the approach proposed by Kazdin (1997, 2000). In other words, we prove that from experimentally point of view, the failure of counselling does not necessarily mean the defence of the client (in our case, the teenager) and the resistance of change, but the persistence in error of the counsellor.

Changes between Time 1 and Time 2

During the first seven weeks (between T1 and T2), the teenagers with behaviour problems modified the way in which they perceived problem solving and decision making but also the trust in their own abilities, personal control and orientation towards decisions (and less their avoidance). The changes appeared during the counselling meetings do not catch only statistically sensitive modifications but also those with applicative impact.

The frequency of irrational values approached by cognitive restructuring decreased and consequently the results ply on those obtained by theoreticians such as Kerig and Alexander (2012) and Lucas (2004).

Teenagers with behaviour problems and the members of their families received tasks aiming the formation of social abilities, in other words *the abilities training* which lead to the decrease of intra-familial conflicts rate and to the improvement of relation between teenagers and their parents involving a decrease of problems` severity. Sommers-Flanagan and Sommers-Flanagan (2004) also obtained general results without a gradation in this direction. Additionally, starting from the registered results, we claim that the perception of family support indicates an increase of the average after the first seven weeks, which supports the efficacy of the intervention even in the improvement of family relations.

Changes between Time 1 and Time 3

D'Zurilla and Nezu (1999) claimed that in counselling it is important for the teenager to develop a complex answer repertoire. Therefore, the results obtained regarding the efficacy of counselling in the improvement of teenagers`

behaviour problems indicate a consistent diminish of initial manifest problems and implicitly an increase of teenager`s familial and social adaptability. After a period of 14 weeks by counselling we register a decrease of the scores for ASEBA - YSR from the clinical interval (T1) in the non-clinic interval (T3) which indicates the acceptance of the counselling process and gradual adjustment to the rational values promoted by the counsellor.

By forming the necessary pre-requisites needed for problem solving during the counselling meetings, the teenager becomes less disorganised and dependent on the others as we have seen during the research. The results attest the changes produced from T1 until T3 with regards to the trust given to problem solving ability, to the adoption of problems approach style and by the development of personal control.

Irrational believes about their own value approached during the counselling process by *cognitive restructuration*, indicate substantial modifications and this supports the efficiency of using specific counselling techniques at cognitive level (as Ellis used to indicate, 1994, 2001; Carr, 2006). The installation of cognitive level changes, implicitly involves the diminish of negative emotions in association with the frequency decrease for family conflicts and the improvement of relations between parents and teenagers. From the same direction come the arguments of Gower and Bryan (2005) who underlined the need for the parents and counsellors to contribute in the counselling with their own expertise, as the work has a collaborative character for reaching the objectives.

The role of the family

The participation of parents to meetings is often a bench mark in changing the teenager`s behaviour as Webster-Stratton claim (2001). We were aiming the formation of a collaborative relation between the family and the counsellor. Our approach supports the point of view of Gower and Bryan (2005).

The involvement of the parents in the counselling indicates a modification of perceiving behaviour problems and the therapeutic techniques used (including role play) attest the efficacy of counselling mainly by diminishing the results for IRF (which indicates a better conflict management).

The modification of parents` irrational values generated the awareness of the fact that teenagers` behaviour problems can be maintained by interaction

patterns within the family and social network.

Counselling program did not substantially modified self-esteem but only parents` satisfaction with life between T1 and T3 which proves that an action on a certain area of life does not lead to major personal changes. Therefore we bring proofs which support the arguments presented by Ellis (2001, 2002) regarding these aspects.

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