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The role of therapeutic change in the treatment of patients with behavioural disorders using CBT approach

Ivanna Shubina[a]*

* Corresponding author: Ivanna Shubina, ivanna.shubina@aum.edu.kw

[a] *American University of the Middle East, Block 3, Building 1, Egaila, Kuwait, ivanna.shubina@aum.edu.kw, +96597420150*

Abstract

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The role of therapeutic change for patients with BD needs to be analyzed. The factors of therapy success and impact of change should be specified. What are the principles and mechanisms of behavioral change among patients with BD? What factors contribute to the occurence of BD? How is CBT effective in the treatment of BD? The author will attempt to find answers to the research questions, using the discourse analysis method. Current research analysis shows high influence of therapeutic change on the CBT success with patients suffering from BD. This allows researcher to assume that CBT has a high efficiency in the treatment of BD by using CBT techniques and strategies in order to cause and maintain the therapeutic change. Future research on the role of change in treatment of patients with BD should focus on important areas such as mechanisms, indicators and processes of change, effective methods of individualization of intervention, identification and management of group processes and group dynamics, motivation to change, and finally the factors that can maintain a change and prevent relapse.

Keywords: Cognitive-behavioral therapy, behavioral disorder, therapeutic change.

1. Introduction

Currently, the issue of therapeutic change during the disease treatment is extremely important from both theoretical and practical perspectives. Therapeutic change can underlie the treatment success or result of from it. In terms of behavioural disorders, the main approaches and treatment models admit that therapeutic change has to be explored in a complex way, showing its connections with therapeutic relationships and treatment outcomes.

On the other hand, oppositional, antisocial, and destructive behaviour along with prevention and intervention programs have been of particular interest to researchers from different applied areas. Thus,

the studies have focused mainly on the characteristics of individuals with behavioural disorders, their environment, diagnostic symptoms, as well as causes and consequences of conduct disorders occurring at different levels with varying severity. It has to be emphasised, that different types of behavioural disorders are characterized by persistent long time dysfunction and the lack of therapeutic intervention or lack of change that can have strong negative consequences at personal, family and social life levels. This study aimed to identify the main causes, principles and mechanisms of effective therapeutic change in relation to the treatment of patients with diagnosed behavioural disorders (BD).

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

What are the principles and mechanisms of therapeutic change among patients with BD? What factors contribute to the occurrence of behavioural disorder and to what extent? What models and approaches are currently used in the treatment of behavioural disorders? Are cognitive-behavioural therapy (CBT) and programs based on CBT effective in the treatment of behavioural disorders? In this study, the author attempted to examine the basic principles and mechanisms of therapeutic change among patients with BD based on cognitive-behavioural therapy - as well as to find answers to above-mentioned questions.

This paper consists of several parts. The first part briefly describes the diagnostic features of behavioural disorder, distinguishing between conduct disorder (CD) and oppositional defiant disorder (ODD), as well as the risk factors of their occurrence. The next part describes the genesis of cognitive-behavioural therapy. It presents the latest model of therapeutic intervention in the field of behavioural disorders along with current research on the effectiveness of cognitive-behavioural therapy and programs aimed at patients with CD. The last part of the paper defines the principles and mechanisms of therapeutic change in terms of CBT.

2. Definition and diagnostic criteria of behavioural disorder and oppositional defiant disorder

When diagnosing behavioural disorder in terms of respect of social norms, authority and other people's rights, antisocial behaviours, such as aggression, delinquency, and substance abuse have to be considered. A comprehensive analysis of the "behavioural disorder" concept indicated a wide range of behaviours, starting from strong affects, highly conflicting relationships with adults, rage and deliberate irritability of other people, alcohol and drugs abuse and possibly injuring oneself or another person. These behaviours are characterised by high level of co-occurrence with beharioural disorder (Shubina, 2012).

According to the DSM-IV, two major types of behavioural disorders are 1. conduct disorders (CD) - defined as symptoms of aggressive behaviour, which cause a physical threat to other people or animals and symptoms of non-aggressive behaviours, which can damage objects or can lead to property infringement, fraud and theft, as well as violation of rules; and 2. Oppositional defiant disorder (ODD), defined as a recurring pattern of negativistic, stubborn, disobedient and hostile

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behaviour toward authority (APA, 1994).

The DSM-IV states that an individual with behavioural disorder acts aggressively towards people and animals and engages in theft or fraud, in a serious breach of the rules and in destruction of property (Bloomquist, 2011). ODD is characterized by a pattern consisting of disobedient, oppositional and hostile behaviours directed at authority figures (American Psychiatric Association, 2000). These individuals tend to argue continuously with adults, display emotional instability and get highly furious, irritable, and resentful. Furthermore, they have difficulty coping with various emotional states, such as emotional liability and frustration. Patients with ODD can present different levels of comorbidity, which signifies a greater or lesser degree of severity and personal adjustment (Loeber, Burke, Lahey, Winters, and Zera, 2000).

Considering the significance of therapeutic or behavioural change in a BD treatment, it is extremely important to describe briefly the main causes and risk factors. Some sources suggest that behavioural disorders have an important diagnostic cause, such as neuropsychiatric disease, ADHD, a low level of intelligence, aggression and mental illness in the family (McMains, Maynard and Conlan, 2003). Other studies have provided data showing that behavioural disorders are the result of a complex interaction among certain specific groups of factors (Frick, 1994; Lochman, 2003). Lochman, Magee and Pardini distinguished four groups of factors: biological background, family context, social ecology and relationship with peers, social cognitive content (Lochman, 2005). Biological factors are associated with the possibility of inheritance of diseases and disorders, as well as occurrence of other diseases with biological background that predict behavioural disorder. Family determinants include poor mental adaptation, low level of parents' socialization and marriage instability (Frick, 1994). Ecological indicators refer to low socio-economic status, low level of education, neighbourhood and related environmental stressors and lack of acceptance among peers in early childhood (Miller-Johnson, Lochman, Coie, Terry and Hyman, 1998). Some studies have shown the relationship of the rejection by peers with substance abuse, truancy and violence (Lochman, Wayland, 1994). The cognitive factors should include social deficits in cognitive content and processing of information. Those factors provided the basis for planning and implementing of cognitive-behavioural interventions.

Other approaches, which are difficult to generalize across populations and different cultures, have been used to classify risk factors for behavioural disorders. Some cases of patients suffering from BD or ODD correlate with genetic factors, brain damage, experiencing psychoactive substances in early life, the specificity of temperament, behavioural disorders in the family, negative parent duties, maternal smoking during pregnancy, child abuse, and inadequate peer relationships. The other group of determinants comprises parental competence, specific features of the child's personality and appropriate social environment, all of which can have a positive effect and increase the resilience of the child. Modern studies consider the general assumption that approximately 40% of the behavioural disorders result in antisocial personality disorder in the future (McMains, Maynard and Conlan, 2003).

Another classification distinguishes psychological, social and biological risk factors. Irresponsible parenting, social and problem solving deficits, misattributing of negative motives and hostile actions to others, and aggressive behaviour are among the most prevalent psychological factors. Social factors are classified as violence and severe punishment, poverty, dysfunctional environment, lack of control and

support from parents, behaviour deviant peer groups, child molestation and, the tendency to experience weak therapeutic effects. Biological determinants are defined as occurrence of some specific problem in a family, such as ADHD, addiction or affective disorder. (Oppositional Defiant Disorder and Conduct Disorder, - n.d.).

3. Cognitive-behavioural therapy for behavioural disorders

Cognitive behavioural therapy (CBT) is a problem-oriented approach, aimed at identifying and changing dysfunctional thoughts, beliefs and behavioural patterns associated with a particular clinical problem. CBT assumes that thoughts affect emotions, which in turn affect the individual's behaviour. Hence, cognitive-behavioural therapy for behavioural disorders is well-structured, active, and time-limited treatment, during which both therapist and patient cooperate to develop treatment plan and goals and to implement them in real life. The CBT for treatment of behavioural disorders utilizes several basic techniques. It can be used to identify the basic thoughts and beliefs; clarify the relationship among thoughts, emotions, physical symptoms and behaviour; seek evidences of the rightness of dysfunctional beliefs and conduct behavioural experiments; and generate alternative hypotheses (Beck, 2005).

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

Cognitive-behavioural approach assumes that different people understand the situation and think about these situations differently according to their fundamental beliefs of themselves, their experiences and the world around them. These beliefs are formed based on previous experience and maintained through the person’s entire life. The wrong way of perceiving and interpreting the events leads to learning a maladaptive behaviour (Beck, 2005). Cognitive-behavioural therapy aims to modify these behaviours through the cognitive restructuring of the content of thoughts, assumptions and beliefs, rather than directly. Thus, cognitive behavioural therapy focuses on helping patients understand the processes and their effect on thoughts, emotions and behaviour when re-evaluating the perception of themselves, their behaviour, and others.

Furthermore, cognitive-behavioural approach focuses on the "here and now" principle. Thus, it focuses on individual's experiences based on which it can identify factors that may contribute to the development of the disorder and determinants that may cause a therapeutic change. The typical

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cognitive-behavioural therapy session includes: 1. evaluating the frame of mind since the last session, 2. summarizing previous session and determining the current plan, 3. working with the planned symptoms or problems, 4. setting up homework, 5. summarizing the session, and 6. setting up the treatment plan for the next session (Shubina, 2015).

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

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

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

1. Case conceptualization; 2. Assessment of the level of desired change and therapeutic needs; 3. Cognitive-behavioural level (Cole, 1989).

Conceptualization is the basis of the treatment, its progress, and achievements. It involves the analysis of the problem in a comprehensive, holistic way along with the disorder, and it includes the identification of negative automatic thoughts, their meanings and images, and their emotional and behavioural responses (Cole, 1989). Well-prepared case conceptualization allows to draw meaningful hypotheses and determinants of behaviour disorders, as well as to identify problems associated with them. The most commonly used strategies in CBT for behavioural disorders are excitation processes control, self-observation, learnings of new functional skills, the development of alternative behaviours. The aim of these fundamental techniques is to teach the patient to effectively overcome his/her difficulties by acquiring the ability to make the right decisions, engage in cognitive restructuring, and conduct behavioural experiments. CBT includes the identification and modification of dysfunctional cognitive thoughts, assumptions and beliefs, which cause relatively permanent therapeutic (cognitive and behavioural) change in a person with behavioural disorder.

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

Defiant Disorder and Conduct Disorder, - n.d.).

CBT is mainly used to address the behavioural symptoms of violence and crime, pregnancy, risky sexual behaviour, substance use, school failure, and suicidal attempts. Various analyses of programs developed for the criminals have shown that cognitive behavioural therapy is highly effective in reducing recidivism rates. A meta-analysis conducted by Landenberger and Lipsey (2005) confirmed that some selected components of CBT can enhance the effect on the prevention of relapse. Ferrer-Wreder et al.'s (2003) research demonstrated the effectiveness of CBT-based programs for people with substance abuse (Oppositional Defiant Disorder and Conduct Disorder,- n.d.).

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

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

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

4. Therapeutic change in behavioural disorder treatment

The literature review underlies the importance of therapeutic (cognitive and/ or behavioural) change in CBT's success, demonstrating different perspectives of this change. Some studies have focused on the concept of „readiness to change", mechanisms and processes of change, predictors of change, or facilitating of change. The analysis of research data on treatment success presented above seems to supports the proposition that any model or program used for behavioural disorder therapy has to include building specific skills and modifying attitudes, beliefs and behaviours of patients. Thus, a therapeutic change, including both behavioural and cognitive components, may be considered as one of the most significant factors in the treatment success.

Desired change in behavioural disorder treatment has to include cognitive, social, behavioural,

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psychomotor, and affective/emotional dimensions (Boone and Boone, 2005). However, some therapeutic programs typically target and measure only cognitive change, such as knowledge and information. According to Clara Pratt and Sally Bowman (2005), few important steps should be considered to achieve a behavioural change successfully:

- Reduce the environmental conditions that support negative behaviours, and increase the conditions that support positive or desired behaviours;
- Modify behaviour sequentially and reward progress;
- Train in naturalistic conditions and settings;
- Teach specific cognitive rules or principles that can guide behaviour in new settings;
- Model and offer many opportunities for participants to practice the desired behaviour;
- Increase dosage leads to achieve a greater response;
- Facilitate social and other supports over time to support and sustain behaviour change;
- Focus individual as the key to behaviour change.

It is necessary to emphasize that prospective studies on principles of change in psychotherapy are in demand (Castonguay and Beutler, 2006). It has been frequently emphasized that psychotherapy should consider on patient's strengths (Duckworth, Steen, and Seligman, 2005; Fluckiger and Regli, 2007; Orlinsky, Ronnestad, and Willutzki, 2004; Snyder and Elliott, 2005). According to Grawe (1998), psychotherapy works with what the patient brings to therapy, which can be defined as a motivational readiness for a change. Accordingly - focusing on patients' strengths usually initiates and maintains positive feedback that potentially fosters the therapeutic alliance and support the implementation of functional coping strategies. Some strengths that are helpful in psychotherapy are motivational preparedness, individual qualities, interactional qualities, and personal skills. These strengths should be either discussed with the patient during a session or directly experienced by the patient with relation to the consequences of using these strengths (Fluckiger and Wusten, 2008; Grawe, 1998/2004, 2004/2006). The literature review stressed resource orientation as an important mechanism of therapeutic change that develops its influence through complex interactions with other mechanisms (e.g., mastery experiences, problem actuation, therapeutic bond, and clarification experiences). However, some studies show that interventions focused on patients' strengths have an effect particularly at the beginning of therapy (Regli, Bieber, Mathier, and Grawe, 2000).

Various reviews of the existing studies have stressed the importance of positive expectations for change and have supported their intentional and proactive implementation in the therapeutic intervention (Arnkoff, Glass, and Shapiro, 2002; Greenberg, Constantino, and Bruce, 2006). Utilizing the resource-activating interventions, therapist can successfully reinforce patients' positive expectations along with their individual abilities and empower a therapeutic change based on these abilities (Grawe, 1998/2004).

Some studies that examined the correlation between process and outcome, have shown that psychotherapy sessions after which the patients reported intense experiences are characterized by high levels of resource-activating level and a stronger focus on change (Gassmann and Grawe, 2006; Regli et al., 2000; Smith and Grawe, 2003, 2005). On the contrary, improper activation of patients' resources can cause undesired side effects (Grawe and Grawe-Gerber, 1999). For instance, if during the therapy

the focus lays on goals that are too difficult to achieve, patients may experience strong discrepancy between perceived reality and own wishes, which may cause some negative emotions and defensive reactions (Grawe and Grawe-Gerber, 1999). Additionally, unsuccessful therapies are characterized by delayed interventions on resources activation and a weak therapeutic alliance (Gassmann and Grawe, 2006). While the quality of the early alliance has been proved to be a reliable predictor of therapeutic success (Horvath and Bedi, 2002; Orlinsky et al., 2004), the existing evidences has shown that it is difficult to influence the therapeutic alliance intentionally (Crits-Christoph et al., 2006; Holloway and Neufeldt, 1995).

Although the above-mentioned results taken from correlational studies provide evidence for the interventional importance of resource-activating strategies, they do not prove directly the causal influence of these strategies on the patient's change. To determine the causal interpretations of mechanisms of change, it is necessary to experimentally manipulate the variables related to those mechanisms, explore the influence of this manipulation on relevant process variables, and finally demonstrate the influence of these variables on the therapy outcome (Grosse Holtforth, Castonguay, and Borkovec, 2004).

Although patients respond to CBT treatment differently (Newman, Crits-Christoph, Connolly Gibbons, and Erickson, 2006), not much is known about the patient characteristics that can potentially modify or moderate the outcome in CBT. The patient's readiness to change includes the intentional aspect of change and assumes that help-seeking individuals are not consistently ready to proceed through the change process (Prochaska and DiClemente, 2005). The Transtheoretical Model (TTM) defines "readiness" as the central component of the Stage of Change (SOC) dimension, an integrative structure for understanding the process of behaviour change (Prochaska and Norcross, 2002).

The SOC comprises five stages, pre-contemplation, contemplation, preparation, action, and maintenance. Patients in the pre-contemplation stage do not admit that they have a problem and do not currently intend to engage in the therapeutic change. Individuals in the contemplation stage are aware of having a problem and are interested in obtaining more information about it, but they have not made a commitment to take any action. Patients in the preparation stage intend to take an action in the near future, or they took some initial steps related to their problem, but with little effect. Patients in the action stage have already decided that the therapeutic change is necessary, and they have already started to actively implement change strategies. Lastly, individuals in the maintenance stage have made significant changes, but they may still experience some difficulty maintaining these changes. Although patients can be placed into a particular stage, dimensional scores for each of those stages are evaluated simultaneously and overall readiness score is determined by the combination of factor scores (Carbonari, DiClemente, and Zweben, 1994). Some research has indicated that readiness stage of change is an important determinant of behaviour change in the majority of areas of mental health (Brogan, Prochaska, and Prochaska, 1999; Smith, Mezydlo, Subich, and Kalodner, 1995).

Patient motivation or readiness to change has received increased empirical and clinical attention among researchers (Arkowitz, Westra, and Miller, 2007; Wilbourne and Levensky, 2006), and recent attempts have been made to integrate motivational reinforcement strategies into CBT for anxiety disorders (e.g., Barlow et al. 2011; Kertes, Westra, Angus, and Marcus, 2010; Westra, Arkowitz and

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Dozois, 2009). Although correlations between readiness to change and positive outcome have been observed in pharmacotherapy studies for panic disorder (Beitman et al., 1994; Reid, Nair, Mistry, and Beitman, 1996), generalized anxiety disorder (GAD; Wilson, Bell Dolan, and Beitman, 1997), and OCD (Pinto, Neziroglu, and Yaryura-Tobias, 2007), this construct remains understudied in the field of psychotherapeutic treatment (Newman et al., 2006).

Overall, the literature review suggests that the correlation between specific patient variables (such as readiness and initial severity) and psychotherapy outcome is complex and requires further studies.

The mechanisms of change in CBT interventions have been stated and examined carefully in a theoretical way in a number of empirical studies. According to CBT framework, dysfunctional automatic thoughts that reflect underlying cognitive beliefs cause and maintain mental health patients' symptoms. In CBT treatment, therapist uses psycho-education, Socratic questioning, and coaching when observing and modifying patterns consisting of thought, affect, body and behaviour. Theoretical assumptions of CBT recommend focusing on automatic thoughts during the early stages of treatment, progressing to more unexpressed dysfunctional attitudes and beliefs (Beck, 1995).

When analyzing the issue of therapeutic change in CBT treatment, it is important to understand some of the mechanisms and processes through which change occurs during the entire treatment process. A number of studies have shown that changes in automatic thoughts or dysfunctional attitudes predict decrease in disease symptoms. DeRubeis et al. (1990) discovered that early change in dysfunctional attitudes and beliefs, but not by change in negative automatic thoughts predicts reduction in depression rate. Kwon and Oei (2003) showed that changes in dysfunctional automatic thoughts predicted decrease in symptoms, and changes in dysfunctional attitude influenced decreased symptoms through changes in automatic thoughts.. Furlong and Oei (2002) found that change in dysfunctional attitudes was a better predictor of reduced depression symptoms compared to change in automatic thoughts. The studies on the relationship between cognitive change and symptom change showed that a focus on cognition is only one dimension of CBT, so to increase the success of a therapeutic change, some behavioural techniques have to be implemented (i.e. homework assignments, behavioural experiments etc.) (Bennett–Levy, 2003).

Some studies have examined the relationship between psychotherapy outcome and the therapy alliance. According to some of them, the therapy alliance appears in approximately 5% of the variation in patient outcome (e.g., Wampold, 2001). This result does not depend on factors such as the length of the treatment, type of psychotherapy, sample size, outcome measure, publication status of the research, or time of alliance evaluation (Horvath and Symonds, 1991; Martin et al., 2000). In addition, empirical research on the alliance has been conducted in relation to therapists' styles of interaction and techniques.

Ackerman and Hilsenroth's (2001) literature review on alliance suggested that therapists who were critical, uncertain, tense, distant, or distracted had poorer alliances. Some studies examined patient and therapist styles as factors influencing the alliance (Black, Hardy, Turpin, and Parry, 2005; Hietanen and Punamaki, 2006); however, on the contrary no relationship has been found in other studies (Reis and Grenyer, 2004). Additionally, another literature review on the psychotherapy alliance (Castonguay, Constantino, and Holtforth, 2006) argued that future alliance research should identify methods that

therapist uses to balance the techniques in therapy while developing and maintaining a strong alliance.

The literature review underlies an importance of therapeutic change for CBT success, analysing motivation to change, mechanisms, processes and predictors of change. The results proved that therapeutic change plays a significant role in CBT or other therapeutic approaches, since it is strictly related to the treatment success. Futhermore, it allows patients with behavioural disorders to gain some needed skills and learn new ways of acting or thinking.

5. Conclusion

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

Current studies on the effectiveness of the therapeutic treatment have indicated that CBT is comparatively more effective. The therapeutic interventions that utilize cognitive-behavioural approach, and the studies on their effectiveness, as described in this paper, suggest that cognitive-behavioural techniques and strategies can be used to successfully treat destructive, aggressive and other types of behavioural disorders, leading to therapeutic change. However, the success of CBT intervention is strictly related to therapeutic change. The literature review examined the behavioural change in few perspectives, starting with „readiness to change", mechanisms and processes of change, predictors of change, or facilitators of change.

The results of litearure review show different aspects and perspectives on the concept of change in the treatment. Some studies suggest that desired therapeutic change in behavioural disorder treatment has to include different dimensions, such as, cognitive, social, psychomotor, and affective. It has been frequently emphasized that patients's strengths can lead to and can maintain therapeutic change in a patient. Positive expectations for change, high motivation and readiness are equally important, especially since readiness to change involves intentional aspect of change and help-seeking strategies. Additionally, some studies found a correlation between process and treatment outcome. It is important to know a patient's exact stage of change as a measurement and evaluation of readiness for change and treatment success. Considering basic assumptions of CBT, it has to be emphasized that changes in automatic thoughts or dysfunctional attitudes predict a decrease in the patient's disease symptoms. Future studies need to investigate the mechanisms of therapeutic change and methods that cause and maintain that change.

It seems that future research on the role of behavioural change in the treatment of patients with behavioural disorders should focus on important areas, such as multi-component interventions, effective methods of individualization of intervention, as well as the identification and management of group processes and group dynamics. Studies should also focus on the strengths and motivation of patients with BD to change and reduce risk factors. The factors that can maintain a change in the behaviour of patients suffering from behavioural disorders after the intervention, and prevent relapse

should also be explored in the future.

The future studies on the role of therapeutic change in CBT treatment should examine the process and mechanisms of behavioural change in a combination with other effective approaches and models of intervention. Thus, combining CBT with the motivation therapy may enhance the efficiency of therapeutic relationship building, particularly the cognitive and behaviour content implementation, what may empower the therapeutic change.

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