
Working with Violent Youth: Application of the Transtheoretical Model of Change

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ABSTRACT

Violent behaviour by adolescents has become a growing concern in Canada. Many authors highlight the need to provide specialised services to this population. However, violent youth present multiple challenges to professionals. This article highlights how the Transtheoretical Model of Change (TMC) can be utilized to guide treatment interventions with adolescents who engage in violent behaviour. Section one reviews treatment issues related to providing services to violent adolescents. Section two describes the use of the TMC with adolescents from different cultural backgrounds who change their high-risk behaviours. Section three overviews the utilization of the TMC in dealing with violence. Section four provides suggestions regarding the application of the TMC with violent adolescents. The paper concludes with a discussion of the applicability of TMC across a range of clinical and counselling settings. The positive aspects of TMC, including the provision of cost-effective services to clients and working with reluctant clients, are highlighted.

RÉSUMÉ

Le comportement violent des adolescents est devenu de plus en plus inquiétant au Canada. Plusieurs auteurs ont souligné le besoin d'offrir des services spécialisés à cette partie de la population. Cependant, les jeunes violents représentent plusieurs défis pour les professionnels. Cet article traite plus particulièrement de la façon dont le modèle transthéorique du changement (MTC) peut être utilisé afin de guider les interventions de traitements avec les adolescents qui ont des comportements violents. La première section voit les enjeux qui touchent l'offre des services pour les adolescents violents. La deuxième section décrit l'utilisation du MTC avec des jeunes venant de différents milieux ethniques qui ont changé leurs comportements à haut risque. La troisième section donne un aperçu de l'utilisation du MTC pour contrer la violence. La quatrième section donne des suggestions afin d'appliquer le MTC avec les adolescents violents. La dissertation se termine avec une discussion sur l'applicabilité de la méthode du MTC à une vaste gamme de situations cliniques et consultatives. Les aspects positifs du MTC, incluant l'assurance de services rentables et le travail avec les clients réticents, sont mis en valeur.

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Violent youth present multiple challenges to professionals in a variety of settings (e.g., schools, mental health, and justice settings). As a result of these challenges, many authors (e.g., Borduin et al., 1995; Leschied, Cummings, Van Brunschot, Cunningham, & Saunders, 2001; Perry & Orchard, 1992; Tate, Reppucci, & Mulvey, 1995) have highlighted the need to provide specialised services to violent youth. However, counsellors and staff continue to struggle with how to intervene effectively with these youth, who are often labeled as unmotivated and resistant. This labelling often strains relationships between the client, professionals, and involved agencies. As a result, violent youth may not receive appropriate services for their needs and remain at risk for hurting others.

Prochaska and his colleagues (e.g., Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 1994) developed the Transtheoretical Model of Change (TMC) as a theoretical model to define the therapeutic change process. The purpose of this article is to highlight how TMC can be used to guide interventions with violent adolescents.

This article is comprised of five sections: (a) a review of treatment issues related to providing services to violent adolescents, (b) a description of TMC and how this approach has been used to help adults and adolescents change their high-risk behaviours, (c) an overview of the appropriateness of applying TMC to violence, (d) a review of how TMC can be applied to service provision for violent adolescents, and (e) contributions of TMC to working with reluctant clients, providing cost-effective services, and matching interventions to the needs of youth.

OVERVIEW OF TREATMENT ISSUES WITH VIOLENT ADOLESCENTS

Violent behaviour by adolescents is a major concern in Canada. According to Sinclair and Boe (1998), between 1991 and 1997 the violent crime rate for male young offenders in Canada ranged from 141.6 to 155.7 per 10,000 males. These numbers represent approximately 17,000 male young offenders each year (Sinclair & Boe, 1998). Statistics for 1998 indicated that the violent crime rate for youth was substantially higher than it was in 1988, and the increase in the violent crime rate for female youth was significantly greater than that for male youth during the same period (Savoie, 1999).

Several authors have pointed out the struggles involved in providing services to violent youth (Davis, 2000; Perry & Orchard, 1992), including working with reluctant clients, time management, choosing effective interventions, and safety of the community and treatment staff. Reluctant clients are often perceived as being less motivated and less compliant; they make fewer behavioural changes, and leave treatment earlier (Preston & Murphy, 1997). Many clinicians agree that motivation for change is a key element for therapeutic success and a major treatment objective involves increasing a client's motivation for treatment (e.g., Prochaska & DiClemente, 1982; Serin & Brown, 1996).

Violent youth often consume a disproportionate amount of a therapist's time and energy without a proportional reduction in risk. Davis (2000) stated that when placed into therapy, violent youth often see that their problem is attending counselling. In contrast, the therapist's role is to help youth change their violent behaviour and convince youth that they need and will benefit from the service being offered. Many youth respond by defending their violent behaviours and attitudes. As a result, youth and therapists are often at odds during treatment.

In developing a therapeutic intervention plan for violent youth, many therapists struggle to determine what intervention works for whom under what conditions and in what settings (Loeber & Farrington, 1998). Therapists who rely on interventions empirically proven to alter general antisocial behaviour may encounter difficulties because these interventions may not reduce violence effectively (Guerra, 1998). Thus, therapists may plan and deliver interventions to violent youth that vary in their effectiveness.

The challenge of providing services to violent youth is compounded by the potential risk they pose to others. As a result of disagreements during counselling sessions (e.g., regarding the necessity of therapy), the youth may behave violently toward the therapist. In addition, the safety of the public is a concern and raises liability issues for the therapist working with violent youth.

THE TRANSTHEORETICAL MODEL OF CHANGE (TMC)

TMC is a theoretical model of motivation or readiness to change that has evolved since the 1970s (e.g., Prochaska, 1979; Prochaska & DiClemente, 1982; Prochaska & Norcross, 1994). TMC was developed to reflect the stages in self-motivated change and has been adopted by various professions as a way to understand the change process in a broader context. TMC also integrates therapeutic factors common to divergent theoretical perspectives as a means of identifying mechanisms that promote positive behavioural and attitudinal change.

As a model of readiness for change, TMC has received extensive support in the research literature. It has been utilized with a number of health problems, including addictive behaviours (Prochaska et al., 1992), anxiety disorders (Prochaska, 1991), and eating disorders (Treasure & Ward, 1997). Furthermore, TMC has been applied across a wide range of cultural groups, including North Americans (Collins, Kohler, DiClemente, & Wang, 1999), Europeans (Schmid & Gmel, 1999), and Asians (Lafferty, Heaney, & Chen, 1999). In addition, Dewhurst and Nielsen (1999) have proposed a model that incorporates TMC into traditional North American Aboriginal styles of healing (i.e., the medicine wheel). Thus, TMC is a useful strategy for assisting clients from different genders, cultures, and age groups.

TMC is comprised of three major components: stages of change, processes of change, and levels of change. These have been identified as the when, how, and what, respectively, of change (Prochaska et al., 1994; Prochaska & Norcross, 1994). Since the levels of change lack empirical support, this article will focus on

the stages and processes of change. There are six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska, 2001). Relapse is common during the change process, resulting in movement backwards and forwards through the stages. As a result, progression through the stages is typically spiral rather than linear in nature (Petrocelli, 2002; Prochaska et al., 1992).

In the precontemplation stage, the person does not demonstrate a desire to change (Prochaska et al., 1992). The negative behaviour is likely an automatic habit under minimal cognitive control. The lack of desire for change may be due to lack of awareness of the problem, demoralization from past failures to change, or defensiveness. People in this stage are more likely to generate reasons to continue their unhealthy behaviour than reasons to stop. As a result, people in this stage are unlikely to seek help on their own, and may only attend counselling as a result of pressure from others.

In the contemplation stage, people believe that it would be a good idea to change their behaviour, but they do not intend to do so in the near future (Prochaska & Norcross, 1994). Individuals in this stage are likely to ask themselves "how important is this change?" or "will I like myself better after changing?" (Prochaska, 2001; Prochaska & DiClemente, 1986). People are more able to generate reasons why they should change their behaviour and are more aware of the costs of their negative behaviour. However, there is an even balance between the costs and benefits of behavioural change (Prochaska & Norcross, 1994).

Preparation is the stage that combines action with intention (Prochaska et al., 1992). Individuals in this stage may ask themselves "when I act, will I fail?" (Prochaska, 2001). The benefits of change finally overshadow the costs of maintaining unhealthy behaviours. These clients need to set realistic goals and commit to follow through at a specific point in the immediate future. They may report making some small behavioural changes but have not yet reached their desired goal.

In the action stage, individuals are committing substantial time and effort to changing the negative aspects of their life (Prochaska & Norcross, 1994). Clients are described as motivated, compliant, and willing to work. Clients may ask "how long will the worst last?" (Prochaska, 2001) in order to gauge the level of discomfort that will accompany a major life transition. At this stage, change is accompanied by the conscious application of healthier behaviours and thoughts.

Clients in the maintenance stage have made the necessary changes to their lives and are working towards consolidating these gains (Prochaska & Norcross, 1994). Individuals start to integrate behavioural changes into their regular lifestyle, and such change is maintained with the assistance of a schedule, script, or set of rules (Prochaska, 2001).

Individuals in the termination stage have successfully integrated change into their lifestyle and no longer experience temptation to return to unhealthy aspects of their lives (Prochaska & Norcross, 1994). At this point, change has become

the status quo and, like the negative behaviour it has replaced, has become an automatic habit (Prochaska, 2001).

In addition to the six stages of change, Prochaska (1979) identified therapeutic techniques that are common to most psychotherapeutic approaches. These are the processes of change and are identified as the "how" of change. Table 1 provides a summary of eight processes of change. Prochaska and his colleagues found that certain processes were more effective at different stages. Techniques that rely on cognitive or verbal processes were better applied at earlier stages of change (DiClemente & Prochaska, 1982), while behaviourally oriented techniques were more effective during later stages of change (Prochaska & Norcross, 1994). More specifically, consciousness raising and dramatic relief are useful in the precontemplation stage. In the contemplation stage, consciousness raising, environmental reevaluation, and self-reevaluation are effective. Self-liberation is helpful in the preparation stage. Counterconditioning, contingency management, and stimulus control are effective in the action and maintenance stages.

TABLE 1

Processes of change (from Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 1994)

Process	Purpose	Description
Consciousness raising	Increase awareness	Increasing knowledge about the problem through exposure to others' observations and interpretations
Dramatic relief	Emotional release	Releasing or experiencing negative emotions that are related to the unhealthy behaviour
Environmental reevaluation	Increase awareness	Learning about the effects of negative behaviours on the environment (including significant others)
Self-reevaluation	Decision making	Self-assessment regarding which internal values and beliefs to accept and to reject
Self-liberation	Self-efficacy	Belief that one has the ability to change successfully
Counterconditioning	Behaviour change	Learning to substitute healthy change in situations that previously evoked the negative behaviour
Contingency management	Behaviour change	Positive change is rewarded while the negative behaviour is punished
Stimulus control	Behaviour change	Changing one's environment in order to remove stimuli that trigger negative behaviour

TMC marks a transformation in how therapists can conceptualise their clients (i.e., stages of change) and work with clients (i.e., processes of change). One cost

to adopting a TMC-style approach is therapists may need to develop proficiency in unfamiliar therapeutic approaches. For example, behaviourists may need to learn skills related to dramatic relief, while client-centred therapists may benefit from a primer on contingency management. However, the cost of professional training is outweighed by the potential reduction in youth violence.

Exposure to TMC may challenge some therapists to modify their viewpoints about traditional psychotherapy. Some clinicians use psychotherapy as a one-dimensional or stage-restricted tool to either promote awareness of the need for change, assist the client to accept the need for change, or implement change. In a TMC-based approach, psychotherapy is a multi-dimensional or stage-flexible tool used to promote awareness of the need for change, accept the need for change, *and* implement behavioural change.

APPLICABILITY OF TMC TO ASSESSMENT AND TREATMENT PLANNING

TMC has been applied to male batterers (Brownlee, Ginter, & Tranter, 1998; Daniels & Murphy, 1997; Easton, Swan, & Sinha, 2000), sexual offenders (Dewhurst & Nielsen, 1999; Kear-Colwell & Pollock, 1997), and juvenile delinquents (Hemphill & Howell, 2000). TMC has potential for guiding both assessment and intervention services.

Two TMC-focused measurement tools are the University of Rhode Island Change Assessment scale (URICA; McConaughy, Prochaska, & Velicer, 1983) and the Violence Risk Scale (VRS; Wong & Gordon, 2000). The URICA (sometimes referred to as the Stages of Change Scale) is a 32-item self-report measure that involves rating statements related to change on a five-point Likert scale. There are four factors underlying the URICA that correspond to the precontemplation, contemplation, action, and maintenance stages of TMC.

The URICA has been applied to forensic populations, including violent offenders (i.e., Hemphill & Howell, 2000; Levesque, Gelles, & Velicer, 2001). Hemphill and Howell (2000) applied the URICA to a sample of 225 adolescent offenders. Their goal was to develop norms for this population. The URICA, Paulhus Deception Scales (Paulhus, 1999), and the Multidimensional Anger Inventory (Siegel, 1986) were administered to the participants. The results were interpreted as indicating that youth who were thinking about change or actively changing did not report inflated self-descriptions, in contrast to precontemplative participants who did engage in self-deception. Likewise, participants in lower stages were more likely to deny experiencing problems with anger, while those at higher stages were more likely to admit to such difficulties. The authors concluded that matching interventions to clients' stages of change may reduce treatment drop-out and increase client motivation and therapeutic progress.

Levesque et al. (2001) developed a version of the URICA entitled the URICA-Domestic Violence (URICA-DV) to assess batterers' readiness to cease their use of relational violence. The URICA-DV had a four-factor structure

similar to the URICA. Participants in more advanced stages made more efforts to reduce their violence, engaged in less partner blame, and identified more benefits to changing than participants in less advanced stages.

A TMC approach is also being used to develop risk assessment measures that focus on violent and sexual offending for adults (Gordon, Nicholaichuk, Olver, & Wong, 2000; Wong & Gordon, 2000). The VRS and the Violence Risk Scale: Sexual Offender Version (VRS: SO; Gordon et al., 2000) are being used as clinical measures in the Correctional Service of Canada and in the British correctional system. A version of the VRS for violent youth is also under development (Lewis & Wong, 2002). These measures have incorporated the stages of change as a means to address risk for violent recidivism, guide treatment interventions, and measure therapeutic progress.

Brownlee et al. (1998), Daniels and Murphy (1997), and Easton et al. (2000) have discussed the application of stage-matched interventions in order to maximize treatment with male batterers. Interventions should be tailored to the client's degree of readiness for change, should enhance motivation at different stages of change, and should guide the application of treatment techniques. Dewhurst and Nielsen (1999) and Kear-Colwell and Pollock (1997) have demonstrated that TMC is a useful model in conceptualizing treatment approaches for adult sexual offenders. Kear-Colwell and Pollock (1997) compared a confrontational treatment approach with a stage-based approach, and concluded that the stage-based approach was more effective in helping sexual offenders to make treatment progress. Dewhurst and Nielsen (1999) proposed a model that integrated TMC with a relapse prevention model, culturally sensitive strategies (e.g., Aboriginal medicine wheel), resiliency-based treatment, and narrative treatment.

TMC appears to be a useful model for assessment, guiding treatment interventions, and measuring treatment progress. It is a model that matches services to the specific needs of the client at each stage. It offers a respectful, nonconfrontational manner of relating to challenging clients that is consistent with professional codes of ethics.

CLINICAL APPLICATION OF TMC TO VIOLENT YOUTH

In TMC-based therapy, the content of therapy varies according to the client's needs, strengths, and degree of preparedness (Prochaska & DiClemente, 1982). We believe that this approach has equal applicability to helping adolescent males and females alter their violent behaviour. The therapist's role is to serve as a guide for the processes that produce change (Prochaska & DiClemente, 1982).

We believe TMC can assist therapists working with violent youth. In terms of case conceptualization, the therapist will have an understanding from assessment tools of how willing the youth is to change those factors that are related to violence. There will likely be an uneven "profile" of preparedness, in which the youth is more willing to address some factors (e.g., substance use) and less willing to

address others (e.g., antisocial peers). Therapists who are mindful of this difference decrease the likelihood of developing a negative halo effect resulting from negative client expectations.

In terms of service delivery, TMC provides guidelines to help design stage-matched interventions. When service delivery is matched to the youth's degree of readiness to change, the youth is likely to be more cooperative and perceive the clinician as less of a figure to struggle against. In contrast, client behaviour that may be labeled resistant may occur when the client and therapist are working at different stages of change (Prochaska & DiClemente, 1986). For example, a precontemplative youth would likely perceive action-oriented interventions as too invasive. In contrast, a precontemplation-oriented intervention would be more likely to get this youth to discuss the situation in a constructive manner and allow for rapport to be established.

Violent youth who are precontemplative are likely to attend treatment sessions due to pressure from others (e.g., school, parents, justice system), and they may demonstrate superficial change as long as pressure is maintained. These youth are least likely to use the processes of change. Unless the therapist is able to facilitate a desire for change, the youth is likely to return to (or continue) patterns of violence.

When working with precontemplative youth, the therapist's role is to act as a "nurturing caregiver" (Prochaska & Norcross, 1994). Therapists avoid direct confrontation with youth and instead present themselves as a prosocial ally. Precontemplative clients are most likely to proceed to the contemplation stage when they feel the therapists genuinely care about their welfare (Prochaska & DiClemente, 1986). Therapists must also help precontemplative clients understand why environmental forces are advocating for change.

The goal in the precontemplation stage is to help youth want to change. Youth need to acknowledge that a problem with violence exists, assess their abilities to reduce violence, and identify the costs of violence (Prochaska & Norcross, 1994). Although precontemplative clients are least open to the change processes, consciousness raising and dramatic relief appear to be the most appropriate processes to use with these clients.

In terms of acknowledging the problem of violence, youth need to understand that their violence results from their own actions. This task most clearly involves consciousness raising (e.g., providing information). While the therapist acknowledges that environmental factors influence violence, these factors should not be used by the youth as an excuse. The therapist must help youth to acknowledge that it was he or she that threw the punch or pulled the trigger. As long as youth blame others, they will expect that society (rather than themselves) must change in order to reduce violence. In a similar vein, youth must understand that violence is a result of decisions that could have been made differently. Using a violent act as the starting point, therapists ask youth a series of questions involving "what happened before that" to move the youth backwards in time to the point when violence was not considered.

Having violent youth assess their abilities to reduce violence helps to determine their degree of confidence in handling challenges nonviolently. The therapist can address this by reminding the youth that violence is only one in a range of choices, and that the youth is capable of making other choices. The process of experiencing negative emotions associated with violence (i.e., dramatic relief) may be helpful in helping the youth to express feelings of low self-confidence. Such feelings may be accessible as a result of realistic role-plays.

In terms of identifying the costs of violence, youth in the precontemplation stage will be able to generate a number of benefits of being violent but will lack knowledge about the costs. Providing the youth with information regarding these costs can be helpful. It is extremely important for a therapist to avoid challenging youths' perceived benefits of violence, as this will likely force the youth into defending or rationalizing the choice of violence. As youth progress through the stages, they will be better able to identify the costs of violence.

As a clinical example, consider a youth named Tom whose frequent fighting is tied closely to his membership in a street gang. His attitude toward his gang is precontemplative at the start of therapy. He is unable or unwilling to acknowledge that being in a gang contributes to his violence. In order to begin the process of changing, Tom needs to acknowledge that a problem exists. He must be able to state that he fights alongside his friends. This does not mean he feels sorry for fighting, but rather he admits to the behaviour. The therapist may use this as an opportunity to learn more about Tom (e.g., use of leisure time). Tom sees a number of benefits to gang membership (e.g., protection of his family while he is incarcerated) but cannot generate any costs. The therapist should help Tom generate potential costs (e.g., always having to do what the gang says) rather than attacking the perceived benefits (which may be realistic). Overall, the therapist must remember that the short-term goal at this stage is to have Tom voice a desire to leave his gang, rather than get him to leave the gang (the long-term goal).

In working with contemplative youth, the therapist's role is to be a Socratic teacher (Prochaska & Norcross, 1994). The therapist engages the youth in a series of rational discussions that involve reevaluating oneself and the world. The youth is likely to ask "how important is this change" or "will I like myself better after changing." The therapist must construct rational arguments that demonstrate the importance of change. The short-term goal is to move the violent youth from wanting to change to planning to change. This is the first step toward a "willpower is not enough" viewpoint to stopping violence (i.e., wanting to change and planning to change are different).

Violent youth in this stage are most likely to benefit from consciousness raising, environmental reevaluation, and self-reevaluation (Prochaska et al., 1992; Prochaska & Norcross, 1994). Consciousness raising attempts such as educational videotapes, or observations about when the youth does and does not engage in violence, may be useful to stimulate discussion. In terms of environmental reevaluation, the violent youth may become aware of the effect on victims through activities such as reading victim impact statements and realistic role-plays

(Kear-Colwell & Pollock, 1997). In terms of self-reevaluation, the youth and therapist discuss how proviolence beliefs and values are central to the youth's life. The more central violent beliefs are to the youth's self-image, the more that progression through the stages will involve a substantial change in the youth's view of him/herself (Prochaska & Norcross, 1994).

After several sessions, Tom begins to realize there are costs associated with gang membership. At this point, Tom would like to change but does not intend to in the near future. Tom and his therapist talk about the effects of his violence on the victims. This is *not* meant to have Tom feel sorry for his actions (although this would be beneficial); rather, it is meant to assist Tom to develop a realistic appraisal of the impact of his violence. After Tom has become more aware of the costs of his actions, his therapist begins to explore Tom's violent self-talk (e.g., "I only get respect by fighting") and how it contributes to his violence.

Clients in the preparation stage require a therapist to act as an "experienced coach" (Prochaska & Norcross, 1994). The youth is likely to ask "when I act, will I fail?" Part of the therapist's job is to provide encouragement to the youth. The therapist may need to console a youth who has tried to change and failed by pointing out that recycling through the stages occurs frequently as individuals try to alter negative behaviours and that change is not all-or-nothing.

The process of change used most in the preparation stage is self-liberation (i.e., the belief that one has the ability to change). Exploring with youth the times they wanted to be violent but refrained can increase this feeling. Such exercises help to show youth that being violent is a choice that they have control over. The therapist assists the youth in developing an awareness of negative behaviour as it happens. The short-term goals involve developing specific objectives for change and establishing a plan to accomplish them. Furthermore, the youth must commit to implementing the plan at a specific point in the near future.

At this point in treatment, Tom is uncertain whether he can divorce himself from his friends. The therapist provides Tom with strategies that have worked for other youth, such as joining clubs and enhancing social skills. In addition, the therapist explores Tom's past experiences with his peers, particularly those times when he has been able to say "no" to them. At this point, Tom understands that associating with negative peers leads him to fight. Together, Tom and his therapist establish a goal to spend less time with his current friends and make more prosocial friends.

With clients in the action stage, the therapist acts as a consultant (Prochaska & Norcross, 1994). The youth has developed an awareness of the factors that produce and maintain violent behaviour and has decided to make changes. The therapist's role is to channel the energy to change. Since youth in this stage are actively changing their lifestyles, they are likely to face discomfort. They are likely to ask "how long will the worst last?" At this point, youth are at high risk for relapse because their level of confidence in changing and temptation to revert to old ways are equally balanced (Prochaska, Rossi, & Wilcox, 1991). The

therapist will need to offer encouragement and reminders as to why these changes are being attempted. Youth may need to be reminded about their responsibility for their violence, their ability to control it, and the benefits of change.

The short-term goal for youth in the action stage is movement toward developing conscious habits and learning concrete skills. The processes of change most useful at this stage are behavioural management strategies: counterconditioning, contingency management, and stimulus control.

At this point in treatment, Tom had decided to stop hanging out with the gang. Together Tom and his therapist decide to change his environment in order to remove stimuli that trigger violence. By removing gang members from his life, Tom is less likely to find himself in situations where he needs to fight. Instead, Tom joins a soccer league that can provide him with prosocial supports and give him an outlet for excess energy. As a result, Tom can get into the habit of attending his games, which may generalize to attending other prosocial activities. In terms of counterconditioning, Tom and his therapist begin to develop positive self-statements that Tom can say to himself when he has violent thoughts. The therapist also works with Tom to improve his interpersonal skills by participating in social skills and empathy training.

During the maintenance stage, the therapist still acts as a consultant (Prochaska & Norcross, 1994), but provides advice regarding relapse prevention. Since a major cause of relapse is psychological distress (Prochaska et al., 1994), youth and their therapists need to discuss the situations under which they may be coerced into violence and develop coping alternatives. The therapist may address topics related to relapse prevention (Laws, Hudson, & Ward, 2000).

The short-term goal for youth is to develop rule-based control over their behavioural changes. While youth integrate change into their lifestyles, they need to have a script about "this is what I do and/or say to myself when I am tempted to engage in the negative behaviour," a schedule, or some type of established routine.

Tom attends soccer games and practices on Mondays, Wednesdays, and Fridays. He has also developed a rule for himself that he will avoid settings in which he would find his old friends (e.g., the pool hall). If his old friends confront him about his "desertion" of them, he has some ready-made responses for them, including "I don't have time for you guys right now" and "I'm getting in extra practise at the soccer field."

In the termination stage, the therapist is phased out over time as youth develop stimulus-based control over the behaviour change (Prochaska & Norcross, 1994). Violence is not part of their lives and they do not consider being violent because other opportunities for satisfaction have developed. They feel confident that they will not be tempted to return to violence and the behavioural changes are fully integrated into their lifestyles (Prochaska, 2001). In other words, the behavioural change is now the status quo. Contact with the therapist may be limited to brief telephone calls or occasional booster sessions, leading to a cessation of contact.

In Tom's case, he keeps in touch with his therapist by telephone once a month. He continues to play soccer and he has found a job. He has no contact with his violent friends and has developed a prosocial network.

A word about the use of confrontation is warranted. Confrontation may be useful at certain stages after youth are more prepared to approach change and a therapeutic alliance has been established. However, confrontation must be used as a motivational tool, such as having youth argue the opposite side of the argument or explain why they can change (i.e., paradoxical strategies).

BENEFITS OF USING TMC

The writers believe that TMC presents an approach that will maximize therapeutic services provided to violent youth. It offers clear guidelines about how to conceptualize reluctant youth and provides guidelines regarding how to intervene with them. In a general sense, reluctant youth are merely clients that do not share the therapist's goals. TMC reminds us as therapists that if we persist in providing stage-mismatched interventions, clients are unlikely to cooperate with us. As Blanchard (1995) stated "There is no such thing as a resistant client, only therapists who don't know how to connect" (p. 41). When therapists match their interventions to youth's readiness for change, youth are more likely to be compliant, exhibit greater behavioural changes, and remain in treatment longer. Following a TMC-based approach, a therapist can help a youth reach an apparently unobtainable long-term goal (i.e., leading a life free of violence) by working through a series of short-term obtainable goals.

One consequence of working with violent youth is the possibility of therapist burnout (e.g., Shelby, Stoddart, & Taylor, 2001). TMC helps therapists to establish workable goals with youth, to generate gradual yet observable changes in youth, and to maintain a positive attitude toward their work.

Stage-appropriate interventions based on TMC are also more cost-efficient. They will reduce the amount of time and effort needlessly expended by the therapist and youth because the model promotes a mutually-supportive treatment approach rather than an adversarial one. The youth and therapist are less likely to disagree about the purpose of treatment and will be able to work together to prevent either from "digging in" and hindering progress. In addition, this approach will assist therapists in developing a positive therapeutic relationship that will improve the possibility of long-term client commitment to change.

TMC influences safety in two ways. First, stage-matched interventions should reduce the amount of conflict during therapy sessions, thereby decreasing the likelihood of aggression directed toward therapists. In turn, this could produce a more productive therapeutic environment that is conducive to client change. Second, a TMC-based approach may keep youth in treatment longer, increasing the likelihood that they will learn the skills necessary to reduce their risk for violence.

CONCLUSION

The therapist's role is not confined to deciding what works, but rather deciding what intervention works for which youth under what conditions and in what settings (Clements, 1988; Guerra, 1998; Loeber & Farrington, 1998; Prochaska & Norcross, 1994). TMC has the potential to assist therapists in answering this complicated question. Stage-matched interventions can provide multiple benefits, including helping youth to become more motivated, reduce the amount of time wasted in treatment, decrease youth's risk of violence toward others, and is applicable in a variety of settings. Since other variables outside youth's control may contribute to their violence (e.g., poverty), TMC-based therapy would need to function within the context of a multisystemic approach (e.g., involving family, school, peers).

Working with violent youth is a stressful undertaking. Therapists need to examine different approaches to working with violent youth and their attitudes toward these youth. Therapists need to heed Davis's (2000) warning that "if we do not expect them to grow and change, then they will not. If we do not see them as human beings capable of growth, affirmation, and reconciliation, then neither will they" (p. 87). Prochaska (2001) reminds us that when treatment is not progressing, the onus is on the therapists to make changes, not only in terms of service provision, but also in how they conceptualize their clients.

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