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The Evolution of a Contextual Approach to Therapy: From Comprehensive Distancing to ACT

Robert D. Zettle
Wichita State University

Abstract

This paper traces the developmental history of acceptance and commitment therapy (ACT) from its beginning as comprehensive distancing to its current form and status. It is maintained that technical differences between the two approaches are overshadowed by ones of conceptualization. Comprehensive distancing emerged from efforts to extend Skinner's work on verbal behavior and rule-governance to clinical phenomena, while relational frame theory as a post-Skinnerian account of human language has served as the conceptual foundation for ACT. Possible research strategies to further clarify conceptual differences between the two approaches are discussed.

Key Words: Acceptance and commitment therapy, relational frame theory, rule-governance, verbal behavior, language, clinical phenomena, functional contextualism, private events.

During the past decade and a half, a series of interventions have ascended within behavior therapy that have been viewed collectively as constituting a "third wave" (Hayes, 2004). Included are such seemingly disparate interventions as functional analytic psychotherapy (Kohlenberg & Tsai, 1991), dialectical behavior therapy (Linehan, 1993), integrative behavioral couples therapy (Jacobson & Christensen, 1996) and mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002) that, nevertheless, are united in emphasizing a contextualistic approach to psychological phenomena such as private events and interpersonal relationships over direct attempts to modify or control them.

Within the "third wave" of behavior therapies, the approach that has perhaps received the most increased visibility as of late is acceptance and commitment therapy (ACT). Recent books have detailed the basic approach (Hayes, Strosahl, & Wilson, 1999) as well as providing practical guidelines for its implementation with various types of presenting problems and populations (Hayes & Strosahl, 2004). In addition, an entire special issue of *Behavior Therapy* (Haaga, 2004) was recently devoted to ACT. It is not the purpose of this paper to provide an overview of ACT nor a review of its empirical support. The interested reader is advised to consult the above references for more on these issues.

It is perhaps understandable for many both inside and outside the behavior therapeutic community to regard ACT as ostensibly a "Johnny-come-lately" intervention that is simply the most recent to ride the crest largely created by other "third wave" approaches already mentioned that preceded it. The purpose of this paper is to address this possible misperception by tracing the historical and conceptual developments occurring over the last quarter of a century that provided the context for the evolution of ACT from its earliest beginnings as "comprehensive distancing" to its current form. Before doing so, it seems appropriate to explicitly acknowledge some of the caveats inherent in such an endeavor. A history of necessity is constrained by the verbal behavior

of the historian and this verbal behavior may be under multiple sources of control. While I believe my verbal behavior here to be under reasonably tight stimulus control of the actual events being discussed (particularly those that I witnessed and/or participated in during the first time period discussed below in the evolution of ACT), it should be recognized that it cannot be other than "personal" in nature and others may have differing stories to tell (particularly those who may have been more prominent participants in events occurring during the second time period to be discussed).

As just alluded to and for purposes of discussion, it seems useful to divide the history of ACT's development into three temporal phases: (1) an initial formative period in the late 1970s and early 1980s that provided a conceptual foundation for an early version of ACT by emphasizing an extension of basic behavior analytic approaches to verbal (Skinner, 1957) and rule-governed behavior (Skinner, 1969) to clinical phenomena; (2) a transitional period beginning from the late to mid 1980s through much of the next decade during which time relational frame theory (RFT) was developed as a post-Skinnerian account of language, verbal control, and especially rule-governance (Hayes, Barnes-Holmes, & Roche, 2001); and (3) most recently, a phase in which ACT has been increasingly disseminated and investigated as a fully integrated functional contextualistic approach to psychotherapy grounded in RFT

The Initial Formative Period and Comprehensive Distancing (Late 1970s -1985)

The earliest work that in retrospect appears to have contributed substantially to the development of ACT occurred while I was doctoral student under the mentorship of Steve Hayes at the University of North Carolina at Greensboro beginning in 1976. Steve has just been hired as an assistant professor and I was to be his first doctoral student. The two of us shared the sense that an understanding of the role that verbal behavior and language played in the initiation, maintenance, and treatment of abnormal human behavior was of critical importance in developing a behavioral approach to clinical psychology. We also agreed that the answers to the questions we sought would not be found in mainstream cognitive and mechanistic accounts popular at the time (e.g., Bandura, 1976, 1977; Mahoney, 1974).

Instead, we looked to apply Skinner's (1957, 1969) basic conceptual work in verbal and rule-governed behavior to clinical phenomena and issues (Zettle, 1980b). For the most part, these efforts at first essentially involved reinterpreting nonbehavioral clinical approaches such as those emphasizing the process of insight (Zettle, 1980a) and the use of coping self-statements (Zettle & Hayes, 1983) by extending a Skinnerian perspective on verbal control and rule-governance. In particular in doing so, thinking, believing, and related cognitive phenomena were regarded as mere behavior that was not accorded any causal status because of its private nature. Moreover, because initiating causes from a radical behavioral perspective are reserved for directly manipulable environmental events that can both predict and control behavior (Hayes & Brownstein, 1986), any influence that thinking might have on other behavior could not be regarded as being causal in nature. However, consistent with Skinner's (1953) account of self-control, thinking as behavior was not viewed as being precluded from entering into a controlling behavior-behavior relationship

with other actions provided the necessary environmental supports were in place.

When "cognitive control" was reconceptualized as a possible behavior-behavior relation, the question of "What role do thoughts play in controlling human behavior?" became transformed into one of "What type of contingencies would lead one behavior, namely thinking, to occur and influence another behavior?" Not only was it necessary to specify the contingencies that give rise to each member of the behavior-behavior relation, but, even more importantly, also the contingencies that support such a controlling relation itself. To the extent that the contingencies that support "cognitive control" are of an arbitrary and verbal-social nature, it appeared possible to create a special verbal community within the context of therapy to weaken any dysfunctional control by thinking and other private events. In particular, the verbal behavior of reason-giving, especially reasons offered by clients that make reference to private events in support of dysfunctional behavior (e.g., "I didn't go to work today because I was too depressed to get out of bed'), was regarded as problematic.

While these basic points about dysfunctional verbal-cognitive control were expanded upon in subsequent publications (Hayes, 1987; Zettle, 1990), they were initially developed several years earlier (Zettle & Hayes, 1982) in a chapter that reinterpreted and critiqued the cognitive therapeutic approaches of Ellis (1962, 1973) and Beck (Beck, Rush, Shaw, & Emery, 1979) from the perspective of rule-governance. This chapter in hindsight appears noteworthy for several reasons. For one, it clearly departed from the mere extension of Skinner's (1966, 1969) depiction of rule-governed behavior as under the control of "contingency-specifying stimuli" by proposing functional units of rule-following (pliance, tracking, and augmenting) and redefining rule-governed behavior as being "in contact with two sets of contingencies, one of which includes a verbal antecedent" (p. 78). Secondly, it also paved the way a few years later for a series of basic studies contrasting rule-governed versus schedule control of human operant performance (Hayes, Brownstein, Haas, & Greenway, 1986; Hayes, Brownstein, Zettle, Rosenfarb, & Korn, 1986) that further explored distinctions among functional units of rule-following. Of perhaps greatest importance, distinguishing rules as verbal antecedents from discriminative stimuli more generally, as will be seen, proved to be instrumental in the later development of relational frame theory and a reconceptualization of rule-governance within it.

The 1982 chapter is also noteworthy as it was written around the same time Hayes (1981) compiled the first treatment manual for what became to be known as comprehensive distancing and work began on the first comparative outcome study to evaluate its efficacy. How and why a treatment approach derived from a radical behavioral view of cognitive phenomena came to be known as comprehensive distancing requires some elaboration. Our critique and reconceptualization of Beck's cognitive therapy identified "distancing" as a component within his approach that most closely addressed (albeit in an attenuated fashion) some of the same processes our still unnamed intervention also targeted:

> . . . Beck has emphasized the necessity of clients being able to "distance" themselves from their beliefs, or stated somewhat differently, being able to observe their own

> verbal behavior from the perspective of a listener. Over time, self-rules are often not viewed critically by the person formulating them. The usual listener behaviors in a public interaction (e.g., examining the credibility of the statement and the speaker; recognizing that reality and descriptions of it may not always be in harmony; and so on) may be gradually suspended for self-rules. This has several destructive effects. For example, augmenting functions may occur automatically – in a sense, the person-as-listener may become needlessly emotionally invested in a particular view of things. Similarly, obvious impure tacts or intraverbals may be seen as tacts in a way they never would be for others' rules. Distancing allows self-rules to be viewed as behavior of an organism – not as literal reality or as the organism itself. (Zettle & Hayes, 1982, p. 107)

Readers familiar with ACT will recognize references to mindfulness, defusion, and deliteralization in the above passage. Because we viewed the intervention being developed as at least in part extending and expanding upon "distancing" within cognitive therapy, it came to be known as "comprehensive distancing." An initial evaluation of comprehensive distancing found it to compare favorably with cognitive therapy in treatment of outpatient depression (Zettle, 1984), but to apparently operate through different processes (Zettle & Hayes, 1986). An inspection of the treatment manual used in the dissertation reveals several similarities, but also differences between comprehensive distancing and ACT as it is currently presented and practiced. Comprehensive distancing can be conceptualized as consisting of components that addressed deliteralization and defusion by inclusion of exercises (e,g., physicalizing) and metaphors (e.g., polygraph and the chessboard) still integral to ACT. However, the observer exercise was not included to create awareness of self-as-perspective (Hayes et al., 1999, p. 188) and engendering a state of creative hopelessness was not given the prominence it currently receives within ACT.

Parenthetically, it seems relevant to note that the observer exercise was not incorporated into comprehensive distancing untilaround 1985 at the suggestion of Terry Olson, a graduate student in the Hayes' lab at the time (S. C. Hayes, personal communication, March 28, 2005). While the exercise itself was adopted from Assagioli (1971), the conceptual and therapeutic rationale for enhancing a transcendent sense of self had been presented by Hayes (1984) at least a year earlier in a paper entitled, "Making Sense of Spirituality." Although it included no explicit mention of deictic framing, the paper clearly described the "behavior of seeing seeing from a perspective" (p. 103) as a basis of spirituality, and, consequently in hindsight, can be viewed as providing a key initial link in the developing relationship between ACT and RFT.

One final technical difference between comprehensive distancing and present day ACT concerns behavioral homework. While behavioral homework was included within comprehensive distancing, the clarification and identification of client values were not. Consequently, homework was not value-directed, but instead appeared to be more similar to behavioral activation (Jacobson et al, 1996; Jacobson, Martell, & Dimidjian, 2001) as it was "designed to provide subjects with experience in activities in the presence of private events which otherwise might undermine such commitments" (Zettle, 1984, p. 55).

The Transitional Period and RFT (1985 -1999)

This second phase in the evolution of ACT begins when the previous one ends around 1985-1986 and continues until the publication of the first ACT book (Hayes et al.) in 1999. Several historically important events appeared around the start of this phase. First and perhaps most importantly, Hayes and Brownstein (1985) presented the first detailed overview of RFT in an invited address at the Association for Behavior Analysis (ABA) convention. Around the same time, Hayes left UNC-Greensboro to accept at faculty position at the University of Nevada, Reno. What began as an initial attempt to provide an alternative explication of equivalence class formation by appealing to synonymic relational framing subsequently would be developed over the next decade and a half by Hayes and his lab in collaboration with Dermot Barnes-Holmes, Bryan Roche and their Irish colleagues into a comprehensive post-Skinnerian account of human language and cognitive phenomena (Hayes et al., 2001).

While it is beyond the scope of this paper to provide an overview of RFT [the interested reader is referred to Hayes et al (2001) for this purpose], some discussion of how rule-governance, that had served as the backdrop for the development of comprehensive distancing, came to be replaced and subsumed within RFT as the existing conceptual foundation for ACT appears warranted. As discussed previously, Zettle and Hayes (1982) had earlier argued that Skinner's definition of rule-governed behavior should be modified to explicitly incorporate control by a verbal antecedent rather than a "contingency-specifying stimulus." Hayes and Brownstein (1985) moved even further from Skinner's position towards RFT by proposing that "a verbal stimulus has its discriminative, eliciting, establishing, or reinforcing effects because of its participation in relational frames established by the verbal community for the purpose of producing such effects" (p. 19).

An important intermediate contribution between the initial efforts of Hayes and Brownstein (1985) to subsume rule-governance within RFT and the culmination of this process with the publication of the RFT book (Hayes et al, 2001) and, in particular, its chapter on self-directed rules (Barnes-Holmes, Hayes, & Dymond, 2001) was an edited volume devoted exclusively to issues involving rule-governed behavior (Hayes, 1989). Of special significance was a chapter by Hayes and Hayes (1989) with the stated purpose "to apply a relational perspective to the issue of rule-governance" (p. 177). In doing so, relational responding was conceptualized as a functional unit of behavior entailing both "speaking with meaning and listening with understanding." Readers familiar with the RFT book will recognize these perspectives on speaking and listening. Parenthetically, it should be noted that there is some lack of clarity when and where speaking and listening as verbal behavior were first explicitly defined in this manner. Hayes in the prologue to the RFT book claims (p. viii) that it first occurred in his 1985 paper with Brownstein. While there are clear allusions to such a definition ("verbal behavior is speaking and listening"), I have been unable to locate any passages [unlike in the Hayes and Hayes (1989) chapter] in the document that explicitly provides it.

Another historical fact that appears somewhat unclear is when and where "ACT" was first

used instead of "comprehensive distancing". What is documented is that within a few years after the name "comprehensive distancing" was first coined, efforts were underway to replace it with a designation that avoided the dissociative connotations associated with the term and to more clearly distinguish it from cognitive therapy. For example, terms such as "a contextual approach to psychotherapy" (Zettle & Hayes, 1986), "a contextual approach to therapeutic change" (Hayes, 1987), and simply "contextual therapy' (Zettle & Rains, 1989) were used as synonyms for "comprehensive distancing."

As I can best determine, the first documented use of the term "acceptance and commitment therapy" in the title of a paper occurred in May, 1991 at ABA in a presentation by Hayes and members of his lab (Wilson, Khorakiwala, & Hayes, 1991). By contrast, 6 months earlier, several papers were presented at the Association for Advancement of Behavior Therapy (AABT) convention that still included "comprehensive distancing" in their titles (Follette, 1990: Hayes, 1990; Hayes, Wilson, Afari, & McCurry, 1990). It thus seems fairly clear that the transition in the use of terms occurred from late 1990 to early 1991. In November of 1991, the first paper I am aware of that contained "ACT" in its title was presented at AABT (Wilson & Taylor, 1991). However, as far as I can verify, the first use of "acceptance and commitment therapy" in a publication's title did not occur for another 3 years (Hayes & Wilson, 1994).

The Hayes (1987) chapter mentioned earlier warrants some further attention as the first publication to present an in-depth treatment of the therapeutic approach and to suggest modifications to it based upon newly emerging research in relational responding. Mention is made of the Skinnerian framework of rule-governance that provided the initial conceptual foundation for comprehensive distancing ("the control exerted by rules may involve alteration of the contingencies surrounding verbal control, *without having to change the rules themselves*"). But more importantly, Hayes also hints at further refinements to come that proved to be instrumental in the transformation of comprehensive distancing to ACT:

> Furthermore, it (a modification of the control exerted by rules) might involve alternation of the nature of the relational classes in which the rule participates, again *without actually changing the form of the rule itself*. While a skeptical reader might claim that the special nature of verbal control to which I am pointing is exactly what the cognitive theorists have held all along, the occurrence of this analysis in a behavioral context gives rise to fundamentally different conclusions and techniques. (p. 336)

In effect, two ways of weakening dysfunctional verbal control are being proposed. One is management from a straightforward Skinnerian operant perspective of verbal-social contingencies that support a controlling relationship between verbal and other forms of behavior. The other emphasizes defusion and deliteralization procedures and techniques derived from RFT. With the further development of RFT, ACT, relative to comprehensive distancing, would come to place differing emphasis on the two change strategies proposed by Hayes (1987). Simply put, I believe a case can be made in hindsight that comprehensive distancing placed relatively more emphasis on

what might be termed contingency management than it did upon defusion and deliteralization in attempting to weaken dysfunctional verbal control. The emphases in ACT as it is currently presented and practiced appear to have been reversed (what).

Another important development occurring during the time period under discussion in the evolution of ACT from comprehensive distancing that further embeds it within RFT involves its inclusion of values identification and clarification. Within ACT values are defined as "verbally construed global life consequences" (Hayes et al., 1999, p. 206). Verbal control and rule-governance over other behavior can have both dysfunctional and functional consequences. While comprehensive distancing clearly sought to reduce self-destructive forms of verbal control, unlike ACT, it did not provide an equivalent emphasis on strengthening constructive forms of rule-following. In particular, although comprehensive distancing stressed changes in overt behavior through making and keeping commitments, such behavioral changes were not explicitly guided by values identification and clarification as is the case in ACT. Unfortunately, the immediate contingencies surrounding behavior often support dysfunctional actions (e.g., substance abuse). However, through participation in temporal relational frames (e.g. "if . . . then," " before . . . after"), values as verbal constructions may come to control more functional behavioral changes (e.g, "I can be a better parent to my children if I stop drinking.") (see Barnes-Holmes, O'Hora, Roche, Hayes, Bissett. & Lyddy, 2001, pp. 113-114). In essence, embedding ACT within RFT increased the likelihood that any instigated changes in overt behavior would participate in a value-driven process.

The Coming-of-Age Dissemination Period (2000 - Present)

Although exactly when ACT "came of age" is perhaps debatable, there can be no dispute that the last 5 years have seen an explosive growth in basic (Feldner, Zvolensky, Eifert, & Spira, 2003; Karekla, Forsyth, & Kelly, 2004; Zettle et al., in press), outcome (Hayes, Masuda, Bissett, Luoma, & Guerrero 2004), and process research (Hayes, Bissett et al, 2004; Gifford et al, 2004) related to ACT. The reader especially interested in a review of the latest outcome research on ACT is encouraged to consult Hayes, Masuda et al, (2004). A good deal of the growth in ACT apparently can be attributed to its dissemination internationally. Recent publications, for example, have reported applications of ACT conducted in England (Bond & Bunce, 2000), Spain (Gutierrez, Luciano, Rodriguez, & Fink, 2004), and Sweden (Dahl, Wilson, & Nilsson, 2004). On a related note, not to be overlooked are the seminal contributions of Dermont Barnes-Holmes and his colleagues and students at the National University of Ireland to the development of RFT.

Summary and Conclusions

Aristotle wrote, "If you would understand anything, observe its beginning and its development." In this respect, it is my hope that this paper may further contribute not only to our understanding of ACT as it currently exists and is practiced, but also of how it evolved from comprehensive distancing. It might be argued that the name change from comprehensive

distancing to ACT was, and still is, a mere matter of semantics. From a relational frame perspective, though, words do make a difference.

As has been pointed out, comprehensive distancing and ACT shared the common goal of undermining dysfunctional control by private events but differed from each other in some of their treatment techniques and procedures. However, it seems more useful to view both interventions as integrated approaches rather than as mere "toolboxes" that may or may not contain some of the same treatment procedures. From this perspective, any critical and meaningful difference between comprehensive distancing and ACT seems more conceptual than technical. I believe history shows that the primary conceptual foundation for comprehensive distancing was Skinner's radical behavioral accounts of controlling relationships, verbal behavior, and rule-governance. However, as limitations and cracks in this conceptual foundation became more obvious, efforts to address them ultimately resulted in the transformation of comprehensive distancing into ACT and its grounding in RFT as a post-Skinnerian account of human language and cognition

Conceptual differences, of course, also often give rise to technological differences (Hayes, 1978) and it may be that a closer analysis of some of the technical dissimilarities between comprehensive distancing and ACT may loop back to improve our conceptual understanding of ACT. One possible strategy towards this end would be to subject ACT to a component analysis. A dismantling strategy akin to what Jacobson and his colleagues (Jacobson et al, 1996, 2001) conducted with cognitive therapy might be considered. For example, one approach that exclusively emphasizes procedures and techniques commonly employed in ACT in the service of mindfulness, defusion, and deliteralization could be compared against another that focuses solely on making and maintaining changes in value-driven overt behavior. A variant on the latter approach could still emphasize behavioral commitment (ala behavioral activation) but exclude any explicit linkage to values and thus, technically at least, approximate comprehensive distancing.

While there is perhaps something to be said for such a dismantling strategy in strengthening our conceptual understanding of ACT, there would appear to be even stronger reasons instead to continue to recommend any alternative approach. ACT has emerged from an inductive approach in which new techniques have either been added or existing ones validated through evaluating the impact of specific therapeutic components and related processes with both nonclinical (e.g., Gutierrez et al., 2004; Hayes, Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999; Masuda, Hayes, Sackett, & Twohig, 2004) and clinical populations (e.g., Heffner, Eifert, Parker, Hernandez, & Sperry, 2003; Levitt, Brown, Orsillo, & Barlow, 2004). At some point in the future, a component analysis of ACT may prove to be useful. However, for the time being it seems premature to dismantle an approach; that in spite of its recent coming-of age and differentiation from its ancestor, comprehensive distancing; continues to grow and, in large measure, is still being built.

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Author Contact Information:

Robert D. Zettle, Ph.D.
Department of Psychology
Wichita State University
Wichita, KS 67208
Phone: (316) 978-3081
E-mail: robert.zettle@wichita.edu

A Program for Engaging Treatment-Refusing Substance Abusers into Treatment: CRAFT

Robert J. Meyers, Jane Ellen Smith, & Denise N. Lash

Abstract

Community Reinforcement and Family Training (CRAFT) is a scientifically-supported program for family members who are desperate to get a treatment-refusing substance abuser to enter treatment (Meyers & Wolfe, 2004; Sisson & Azrin, 1986; Smith & Meyers, 2004). CRAFT teaches these family members how to apply behavioral principles at home so that clean and sober behavior is reinforced and substance use is discouraged. CRAFT-trained family members consistently are able to engage their substance-abusing loved one into treatment in nearly seven out of 10 cases. Notably, the program is effective with ethnically diverse populations, across various types of relationships (spouses, parent-adult child), and without regard for the particular drug of abuse (alcohol, cocaine). This paper provides a rationale for working with family members when a resistant individual refuses treatment, and supplies an overview of both the CRAFT program components and the research findings.
Key words: CRAFT, Community Reinforcement and Family Training, substance use, behavioral treatment

Traditional Programs

Imagine the following common clinical scenario: a therapist receives a desperate telephone call from a family member about a loved one who refuses to seek professional help for a substance abuse problem. Until recently, the therapist had few options to offer this family member, aside from traditional programs such as Al-Anon (Al-Anon, 1984) and the Johnson Institute Intervention (Johnson, 1986). In addition to lacking empirical support for getting resistant individuals to enter treatment, each of these programs has characteristics that many Concerned Significant Others (CSOs) find unappealing.

The 12-step programs, such as Al-Anon and Nar-Anon, instruct CSOs to acknowledge their powerlessness over the substance abuser's alcohol or drug problem, to detach, and to focus on themselves. Although CSOs who attend Al-Anon *do* feel better, they typically are unsuccessful at getting the substance abuser to enter treatment (Barber & Gilbertson, 1996; Dittrich & Trapold, 1984; Meyers, Miller, Smith, & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999; Sisson & Azrin, 1986). Importantly, many CSOs report that they are uncomfortable with the directive to detach from their loved one. A second traditional option, the Johnson Institute Intervention, entails a "surprise party" in which a group of family members and friends confront the substance abuser about his or her problem. When the intervention is carried out, it results in a high rate of treatment engagement. However, since only a small percentage of CSOs actually complete the intervention, treatment engagement rates range from 24%-30% (Liepman, Nirenberg, & Begin, 1989; Miller et al., 1999). CSOs frequently report opposition to the confrontational tactics (Barber & Gilbertson, 1997).

Unilateral Family Therapy

Unilateral family therapy (UFT) is a label often applied to less traditional approaches for CSOs (Thomas & Santa, 1982). UFT is geared toward the individual who agrees to attend treatment; namely, the CSO. The objective is to teach the CSO techniques that will change the problematic behavior of the substance abuser (identified patient; IP) and increase the likelihood

that the IP will seek treatment. Thomas and colleagues conducted several of the earliest UFT trials, and obtained rather promising results in terms of engaging resistant drinkers into treatment (Thomas & Ager, 1993; Thomas, Santa, Bronson, & Oyserman, 1987). Yet there were methodological limitations of the studies, including non-random assignment to some of the treatment conditions. A second UFT, Pressure to Change, also showed moderate success in modifying IP drinking behavior and influencing IPs to begin treatment (Barber & Crisp, 1994; Barber & Gilbertson, 1997). A limitation was a confrontational component to the program for the more resistant IPs.

There have been few programs aimed at working with family members who are trying to encourage illicit drug-using family members to seek help. A relatively new UFT program, ARISE (A Relational Intervention Sequence for Engagement), attempts to address this deficit. The program offers specific treatment engagement advice for the family, much of which is conducted over the phone. An important distinction is that the IPs are not necessarily treatment resistant. Although ARISE has several promising case studies (Garrett et al., 1998; Landau et al., 2000; Loneck et al., 1996), there have been no controlled studies to date.

Community Reinforcement and Family Training

Rationale for Working with Family Members

Community Reinforcement and Family Training (CRAFT) grew out of an operant program that originally was developed for problem drinkers called the Community Reinforcement Approach (CRA; Azrin, 1976; Hunt & Azrin, 1973; Meyers & Miller, 2001; Meyers & Smith, 1995; Smith, Meyers, & Miller, 2001). In the course of working directly with the drinkers, CRA researchers realized that the spouses had access to powerful reinforcers and contingencies in the home. Importantly, the spouses also had extensive contact with the substance abusers (Stanton & Heath, 1997). Furthermore, as part of the marital work that was included in the CRA program, the spouses had repeatedly proven that they were dedicated to positive change (Azrin, 1976; Azrin, Naster, & Jones, 1973; Azrin, Sisson, Meyers, & Godley, 1982). Finally, substance abusers frequently reported that they sought treatment, in part, due to the insistence of a family member (Cunningham, Sobell, Sobell, & Kapur, 1995; Room, 1987). Thus it appeared that family members potentially could play an important role in engaging a resistant loved one into treatment (Sisson & Azrin, 1986). Another prime consideration for working with CSOs was concern for their psychological health. CSOs' days were replete with an array of stressors that are characteristic of life with a chronic substance abuser: constant arguments, isolation, financial difficulties, violence, and disrupted relationships with children (Jacob, Krahn, & Leonard, 1991; Velleman et al., 1993). Not surprisingly then, these CSOs were often depressed, anxious, and angry, and appeared to be good candidates for psychotherapy themselves (Brown, Kokin, Seraganian, & Shields, 1995; Spear & Mason, 1991).

CRAFT Overview and Objectives

The CRAFT program has three major goals: (1) decrease the IP's substance use; (2) get the substance user into treatment; and (3) increase the CSO's own happiness, independent of the IP's treatment status. It is critical to keep in mind, however, that since the IP refuses treatment, these goals must be addressed by working with *the CSO as the client*. CRAFT teaches CSOs how to change their own behavior at home toward the IP in a carefully orchestrated manner. More specifically, CSOs learn to rearrange contingencies in the IP's environment so that clean and sober IP behavior is effectively rewarded, and drinking or drug use is discouraged (Meyers & Wolfe, 2004; Sisson & Azrin, 1986; Smith & Meyers, 2004).

The CRAFT program is a very active process that utilizes role-plays and other behavioral skills-training exercises during sessions, and homework assignments between sessions. CRAFT components include: (1) enhancement of CSO motivation; (2) functional analysis of the IP's problem behavior; (3) domestic violence precautions; (4) communication skills training for family members; (5) judicious use of positive reinforcement; (6) use of negative consequences for substance using behavior; (7) enrichment of CSOs' own lives; and (8) IP treatment invitation.

Enhancement of CSO Motivation

One might wonder why the issue of motivation even needs to be addressed, given that CSOs appear determined to find professional help for their loved one. However, the desperation that prompts many CSOs to start therapy does not always translate into committed efforts to change their own behavior. In other words, they sometimes want CRAFT therapists to "fix" the problem. Fortunately this is more the exception than the rule. Still, initially motivated CSOs periodically lose sight of the delayed reward (i.e., getting their IP into treatment) when the demand on CSOs' own time and energy becomes strong, or if the IP does not seem to be responding immediately to the procedures.

A motivational style is an extremely important part of CRAFT. Critical qualities for any good clinician include being empathic, nonjudgmental, genuine, and warm. The CRAFT therapist strives to convey a positive and accepting attitude, which serves to strengthen the therapeutic relationship. Arguments and confrontation are avoided (Miller, Benefield, & Tonigan, 1993), and defensiveness is deflected through supportive and understanding statements. CSOs typically have a long history of being judged, and so discovering a therapist who is respectful and trustworthy is a valuable step toward having CSOs take risks with new strategies at home.

Another motivational strategy used in CRAFT is setting positive expectations for success. CSOs need to believe that they can take control of their lives. One way to do this is to describe the outcomes of the CRAFT scientific trials. This includes mentioning that: (1) CRAFT-trained CSOs can influence their IPs to enter treatment in approximately seven out of 10 cases; (2) treatment engagement is not influenced by the type of drug use (e.g., alcohol, cocaine, heroin) nor by the type of CSO-IP relationship (i.e., romantic partners, parent- adult child, siblings); (3) on average, IPs enter treatment after only five CSO sessions; and (4) regardless of whether the IP ever begins treatment, CSOs' psychological functioning improves (Meyers, Miller, Hill, & Tonigan, 1999; Meyers et al., 2002; Miller et al., 1999).

Occasionally when therapists first describe the CRAFT rationale or its procedures, some CSOs report that they have already tried aspects of the suggested plan, and that they did not work. With probing it usually becomes apparent that the somewhat-similar strategies were neither carried out properly nor consistently. The therapist can explain that expert advice and guidance throughout the CRAFT program will maximize the chance for success. It is also critical for therapists to address the issue of responsibility and blame early in treatment. Specifically, CSOs are told that although they can sometimes influence their IP's behavior, they are never responsible for it.

Functional Analysis of the IP's Problem Behavior

As noted, a major objective of the CRAFT program is to teach CSOs to change their behavior toward the IP, so that the IP modifies his or her behavior in turn. To guide this process, CSOs need a clear picture of the IP's problem behavior and the context in which it occurs. The functional analysis serves as a framework in which CSOs can begin to understand the factors that

influence IP behaviors of interest. The CRAFT functional analysis is a modification of the functional analysis used in the CRA program; the main difference being that, in CRAFT, the *CSO* completes the functional analysis for the *IP's behavior*.

The CSO outlines the IP's substance use triggers (antecedents) first, so that the establishing operations are obvious. Both external triggers (e.g., certain people, places, times) and internal triggers (e.g. negative thoughts or feelings) are identified, so that the factors that set the stage for the substance use are clear. High-risk situations and emotions are highlighted, thereby enabling the therapist to later develop suitable strategies for the CSO to intervene. For example, imagine that an IP's *external* triggers for drinking include one particular friend and a local bar for Friday night Happy Hour. The CSO might plan an enjoyable activity to compete with Happy Hour that she and her husband might do with another (non-drinking) couple. If an *internal* trigger for the same IP's drinking is stress, the CSO may encourage him to buy a bike so that the two of them can take leisurely rides after work. A word of caution: It is very important that the activities being introduced to compete with drinking are actually experienced as pleasurable by the IP. The CRAFT functional analysis also outlines the drinking/using behavior itself. This enables CSOs to see the connection between the trigger and the substance use, and allows for changes in use to be tracked over time. The functional analysis next focuses on the short-term positive consequences of the substance use, given that these factors are responsible for maintaining the behavior. For instance, CSOs might report that their IP drinks because it makes him feel outgoing and happy. In other words, the drinking is positively reinforcing (Type P drinking). Alternatively, some CSOs essentially state that their IP appears to drink as an escape mechanism. Drinking is negatively reinforcing (Type N drinking) because it allows the drinker to temporarily avoid facing any unpleasant emotions (Wulfurt, Greenway, & Dougher, 1996). This information is used to develop strategies that may be introduced in order for the CSO to help the IP find healthier ways to achieve these objectives. The final piece of the functional analysis entails outlining the various long-term negative consequences of substance use. The "cost" of the substance use in terms of reinforcers lost (e.g., failed job, struggling marriage) is listed. Periodically CSOs are reminded of these driving forces behind their hard work in therapy.

Domestic Violence Precautions

There is a clear association between drinking and domestic violence (Caetano, Schafer, & Cunradi, 2001; Leonard, 2000; White & Chen, 2002). The concern about potential IP aggression is probably even more pronounced in the CRAFT program, since at times CSOs are specifically being asked to alter their behavior in ways that their IPs will find undesirable. Therefore it is important to examine the potential for violence with CSOs, such as with an instrument called the Conflict Tactics Scale (Straus, 1979). For cases in which there is a history of violence, one must weigh this information carefully in deciding whether and how to proceed. CRAFT sometimes employs a functional analysis to gather additional information about domestic violence (Smith & Meyers, 2004), as it can be helpful for identifying violence triggers, and for formulating new ways for the CSO to respond. CRAFT devotes time to role-playing these new behaviors to minimize the likelihood of violent outbursts. CRAFT also aids CSOs in building a safety plan that can be used in the event that violence appears imminent (Smith & Meyers, 2004).

Communication Skills Training for Family Members

CRAFT is designed to help family members and friends maintain their relationship with the substance user in a new positive way. Many people get "stuck" in negative communication patterns, perhaps even more so in substance abusing homes in which it is common to see communication extremes marked by angry outbursts and "the silent treatment". Not surprisingly,

communication skills training is a standard component of behavioral couples therapy with this population (Epstein & McCrady, 1998; O'Farrell & Fals-Stewart, 2003). CRAFT works on changing those negative conversational styles by starting communication training with at least one half of the "couple" (the CSO). The communication rules are: (1) be brief, (2) be positive, (3) be specific and clear, (4) label your feelings, (5) offer an understanding statement, (6) accept partial responsibility when appropriate, and (7) offer to help. As with all CRAFT procedures, role-plays, modeling, and shaping are used to properly train CSOs. This newly-adopted communication style is incorporated into all of the remaining CRAFT procedures.

Judicious Use of Positive Reinforcement

Learning when and where CSOs can modify their behavior as a means of supporting the IP's sobriety is an integral part of the program. CSOs' own attempts to change their behavior toward the IP tend to be haphazard and sporadic, and commonly CSOs resort to old unsuccessful habits characterized by nagging, threatening, and pleading. Initially the notion of regularly "rewarding" IP behavior is sometimes met with CSO alarm, as it is confused with "enabling". CRAFT therapists point out that "enabling" refers to (unintentionally) rewarding alcohol or drug use, whereas positive reinforcement in the CRAFT program only occurs when the IP is *clean and sober*. The rationale for using positive reinforcement is made explicit: it will increase the rate of behavior that it follows.

The CSO is asked to identify several small rewards that could be introduced when the IP is clean and sober, such as a compliment, a hug, or a favorite meal. It is necessary to discuss whether the reward is powerful enough to move the IP toward positive behavior change, while at the same time informing CSOs that *one* such modification alone on their part is merely one step in the direction of persuading the IP to enter treatment.

A list of skills required before implementing the use of positive reinforcers with the substance abuser is as follows: (1) The CSO can describe the concept and has identified appropriate positive reinforcers; (2) The CSO has the capability of delivering suitable reinforcers, as demonstrated in role-plays and by practicing first with another family member or friend; (3) The CSO has discussed possible resentment for being expected to give rewards to someone who has caused so much pain; (4) The CSO understands that the reward should be introduced only when the user is clean, sober and not hungover (Meyers & Smith, 1997); (5) The CSO is aware of the variety of possible consequences of this new behavior, and is prepared to address any problematic negative reactions. CSOs are taught how to use positive reinforcement throughout the CRAFT treatment (Smith & Meyers, 2004).

Use of Negative Consequences for Substance Using Behavior

Another important segment of the CRAFT protocol is the CSOs proper implementation of negative consequences for IP substance using behavior. The first of two procedures simply involves a time-out from positive reinforcement. Specifically, the CSO is taught how to withdraw a reward from the IP during or immediately after a substance-abusing episode. Although the rationale for such a procedure makes intuitive sense to CSOs, particularly when contrasted with the notion of giving rewards for sober behavior, it nevertheless requires careful planning and practice. For example, imagine that a CSO regularly helps her husband (IP) with the bookkeeping for his business. However, she has noticed that whereas he used to wait until later in the day to smoke marijuana, he now begins smoking as soon as she starts working on his books Saturday afternoons. The CSO conceivably would be taught to communicate to her husband that she loves

him and is happy to help him with his bookkeeping, but only if he refrains from smoking pot. If he begins smoking, she will stop the bookwork.

The second negative consequences procedure is the allowance for the natural consequences of substance use. CSOs are taught to prevent themselves from stepping in and "rescuing" the IP at a time when he or she has used recently. Therapists must proceed gently when describing this procedure and its rationale to CSOs. The message to convey is that although they inadvertently may have made it easier for the IP to continue using at times, this does *not* imply that CSOs are somehow responsible for the alcohol or drug use. As with all of the assignments resulting from CRAFT procedures, careful consideration of potential problems for the CSO (e.g., safety issues) must be given in advance. In terms of allowing the natural (negative) consequences, assume a CSO routinely either holds dinner each night until her husband finally returns from the bar. As a result, the children are cranky and do not settle down easily for the evening. The CSO could be taught to discuss with her husband the fact that while she and the children love having him join them for dinner, she is no longer willing to upset the children and disrupt their schedules daily by delaying it. She might also add that she will leave the meal out for him if he is late, but he will need to re-heat it himself. The hope is that the act of eating dinner with his family is rewarding enough to the IP that he will at least consider shortening (and eventually forgoing) his trip to the bar.

Enrichment of CSOs' Own Lives

One of the main goals of CRAFT is to help CSOs feel better about their lives regardless of whether their IP enters treatment. In order to accomplish this, CSOs are asked to set personal goals in various life areas (e.g., job, social life, personal habits), and to map out reasonable strategies for obtaining them. For example, assume a female CSO decided to focus on the job arena, and her goal was to take a Continuing Education course in computer skills so that she could advance at work. Since in many cases the CSO has already considered the stated goal on numerous occasions but has been unwilling or unable to attempt it, a plan must be in place for accomplishing it step by step. In this scenario, for the first step the CSO might opt to identify an appropriate course to take, either by getting the catalog or searching online. Step number two could be to register for the course. Although it is not necessary for all of the CSOs' goals and strategies to be totally independent of the IP, the majority of them should be.

IP Treatment Invitation

The positive communication skills acquired by CSOs throughout CRAFT are heavily relied upon when training CSOs how (and when) to invite their IP to treatment. As with all of CRAFT, the content and style of the treatment invitation is positive. Additionally, motivational "hooks" are suggested that have been successful at engaging IPs in the past. For instance, CSOs frequently mention that IPs will have their own (different) therapist, and that they can address problems other than just substance use (e.g., depression, job loss). Oftentimes CSOs simply suggest that IPs come in once to meet the CSOs' therapist and to hear about the program. As far as *when* to raise the topic of treatment, the fact that motivation is a dynamic process that fluctuates is discussed (Miller, 2003; Prochaska & DiClemente, 1986). And thus, "windows of opportunity" are explored in an effort to present the invitation at a time of relatively higher IP motivation. Some of these include: when the IP questions why the CSO is acting so strangely (i.e., rewarding sober behavior), or when the IP expresses remorse over a drinking-related crisis, such as an auto accident (Longabaugh et al., 1995).

In order to prevent an unnecessary delay in getting IPs into treatment once they have agreed to attend, the therapist assists the CSO in having a suitable therapist arranged for the IP in advance (see Chapter 9 in Smith & Meyers, 2004). It is also important to prepare CSOs for the realistic possibility that their IP may once again refuse their request, and to remind CSOs that treatment engagement may be a process that unfolds over time and with continued efforts.

CRAFT's Empirical Support

CRAFT Studies with Problem Drinkers as IPs

The first version of CRAFT was called CRT: Community Reinforcement Training. The initial study investigated 12 female CSOs of male problem drinkers in rural Illinois (Sisson & Azrin, 1986). Seven women were assigned to CRT, while the other five received individual disease-concept based counseling sessions and referrals to Al-Anon. For the seven women in the CRT condition, six (86%) of their problem drinkers entered treatment, while none of the males affiliated with the control group did. In addition, the CSOs in the CRT group reported that the IPs significantly reduced their drinking before even entering therapy.

A larger study funded by the National Institute on Alcohol Abuse and Alcoholism randomly assigned 130 CSOs to CRAFT, Al-Anon Facilitation, or the Johnson Institute Intervention (Miller et al., 1999). The CSOs were an ethnically diverse sample living in Albuquerque, New Mexico. CSOs were a mixture of the parents, spouses, girlfriends/boyfriends, and children of IPs. Results showed that the IPs of CSOs in the CRAFT condition were significantly more likely to enter treatment (64%) within a 6-month time frame than were the IPs of CSOs in the Johnson Institute Intervention (30%) or the Al-Anon Facilitation condition (13%). For those IPs who entered treatment, CRAFT-trained CSOs averaged less than five CSO sessions prior to engagement. Interestingly, CSOs showed overall improved functioning (e.g., less depression, anger, and family conflict; more family cohesiveness and relationship happiness) independent of treatment condition and IP treatment engagement status.

CRAFT Studies with Illicit Drug Users as IPs

CRAFT and CRT programs have also been used with CSOs seeking help for drug-abusing IPs. A study funded by the National Institute on Drug Abuse (NIDA) was conducted in the northeastern United States. A total of 32 CSOs were randomized into individual CRT training sessions or 12 step-meetings (Kirby, Marlow, Festinger, Garvey, & LaMonaca, 1999). The CSOs were primarily white (75%) or African American (22%) females with an average age of 40, and a mean of 14.5 years education. They were the spouses, parents, or siblings of the drug abusers. Their IPs tended to be abusing cocaine (56%) or heroin (22%). In terms of treatment engagement, CSOs in the CRT condition had a significantly higher engagement rate (64%) than did the CSOs in the 12-step condition (17%). It is unclear whether a difference in program completion rates that favored the CRT CSOs may have influenced the treatment engagement findings. Again, CSO psychosocial functioning improved in both treatment groups.

NIDA also funded an uncontrolled CRAFT trial for 62 CSOs of drug abusing IPs in Albuquerque (Meyers et al., 1999). This primarily female sample was ethnically diverse, and had similar relationships to the IP as did previous studies. The main drugs of abuse were marijuana, cocaine, stimulants, and opiates. It was found that 74% of CSOs engaged their IPs into treatment. Importantly, the IPs attended 7.6 out of 12 sessions. This study also replicated the previous findings of CSO benefit (Kirby et al., 1999, Miller at al., 1999): CSOs' levels of depression,

anxiety, anger, and physical ailments dropped, on average, to within the normal range by the 6-month follow-up.

Given the promising results of the above-described uncontrolled trial, NIDA next funded an experimentally controlled study in Albuquerque. Participants were randomized into one of three conditions: CRAFT, CRAFT + Aftercare, or an Al-Anon/Nar-Anon Facilitation Therapy (Al-Nar FT) program (Meyers et al., 2002). The purpose of the CRAFT + Aftercare condition was to test whether the effects of CRAFT would be improved with the addition of a 6-month aftercare supportive group therapy component. The participants were again predominately female and ethnically diverse (Hispanic = 49%). Regarding the CSO-IP relationship, over half of the CSOs were parents, nearly one-third were intimate partners, and 10% were siblings of the IPs. According to the CSOs, IPs were abusing the same main drugs as in the previous study. Results showed that CRAFT-trained CSOs again outperformed the 12-step trained CSOs, with treatment engagement rates of 59% for CRAFT, 77% for CRAFT + Aftercare, and 29% for Al-Nar FT. The difference in rates between the two CRAFT conditions was not significant. In part, this was probably due to the fact that the majority of the IPs (79%) were already in treatment when the aftercare component began, and attendance at aftercare was relatively low.

Conclusions

In summary, these studies demonstrate that CRAFT is an effective method for CSOs to influence treatment-resistant loved ones to seek treatment. The research reveals that IP engagement rates for CRAFT are markedly higher than for both traditional treatments and for other UFT programs. An additional benefit is that CSOs experience considerable psychological relief upon participating in CRAFT. Particularly impressive is CRAFT's applicability to different ethnic groups, substances, and CSO-IP relationships. Future research conceivably could apply CRAFT to other treatment resistant realms, such as obesity, eating disorders, smoking, and gambling.

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Author Contact Information:

Robert J. Meyers, Ph.D., Jane Ellen Smith, Ph.D., and Denise N. Lash, MS.
University of New Mexico
Psychology Department, Logan Hall
1 University of New Mexico
MSC03 2220
Albuquerque, NM 87131-1161
Phone: (505) 277-4121
Fax: (505) 277-1394

Send all correspondence to Robert J. Meyers, bmeyers@unm.edu

Empirical Comparison of Three Treatments for Adolescent Males With Physical and Sexual Aggression: Mode Deactivation Therapy, Cognitive Behavior Therapy and Social Skills Training

Jack A Apsche, Christopher K. Bass, Jerry L. Jennings, Christopher J Murphy, Linda A. Hunter and Alexander M. Siv

This research study compared the efficacy of three treatment methodologies for adolescent males in residential treatment with conduct disorders and/or personality dysfunctions and documented problems with physical and sexual aggression. The results showed that Mode Deactivation Therapy, an advanced form of cognitive behavioral therapy based on Beck's theory of modes, was superior to traditional Cognitive Behavioral Therapy and Social Skills Therapy in reducing both physical and sexual aggression. At the same time, Mode Deactivation Therapy was the only treatment of the three that significantly reduced sexual aggression for these youth.
Keywords: Treatment Effectiveness, Conduct Disorders, Adolescent Sex Offenders, Cognitive Behavioral Therapy, Mode Deactivation Therapy, Personality Disorders

INTRODUCTION

Youth with conduct disorders and personality dysfunctions are extremely difficult to conceptualize and treat effectively. Such youth typically come from deprived environments with multiple stressors and often extensive histories of physical, emotional and sexual victimization and neglect. As a group, conduct disordered youth present with a complex array of recurrent behavioral problems, including aggression, bullying, violence, intimidation, delinquency, rule violations, recklessness, property destruction, callous disregard for others, substance abuse, sexual abuse and other disruptive and anti-social behaviors (Kazdin and Weisz, 2003). In fact, the prevalence rate for conduct disorder is 6% to 16% for males under age 18 and it is one of the most frequent problems diagnosed in outpatient and inpatient mental health programs. Moreover, 80% of these youth are likely to meet criteria for psychiatric disorders in the future (Kazdin and Weisz, 2003). For example, a longitudinal study by Johnson, Cohen, Brown, Smailes, and Bernstein (1999) showed a clear connection between childhood maltreatment and the development of cluster B personality disorders in later adolescence. Moreover, conduct disorder is by far the most frequent psychiatric diagnosis given to youth involved in the juvenile justice system with rates as high as 81% to 91% of incarcerated youth (Boesky, 2002).

Dodge, Lochman, Harnish, Bates and Petti (1997) have contributed a useful distinction between two types of conduct disordered youth: "Reactive aggressive" youth show extremely strong emotional responses to perceived threats and then react aggressively. The second type, "proactive aggressive" youth, initiate or use violence and aggression in an instrumental fashion to gain an objective or "pay-off." The former category appear to share a common characteristic pattern of "emotional dysregulation," in which the youth is overwhelmed by a sudden surges of intense emotions, sensations and irrational thoughts that are occur in combination and are disproportionate to the situation. Koenigsberg, Harvey, Mitropoulou, Antonia, Goodman, Silverman, Serby, Schopick and Siever (2001) found that many types of aggression, including self-destructive behavior, are linked to the personality disordered traits of affective instability and impulsivity (i.e., emotional dysregulation). Our research and clinical experience with violent and sexually aggressive youth suggests that this common phenomenon of "emotional dysregulation" is the same process that Aaron Beck (1996) has described as "modes" and that treatment must be modified to accommodate and address this process in order to be effective.

Need for Effective Treatment

Given the prevalence of conduct disorders and its major contribution to juvenile crime, societal violence, delinquency and sexual violence, there is a urgent need for effective treatment methods for such youth. While Kazdin and Weisz (2003) delineates some evidence-based treatment practices for children with Conduct Disorder, the same has been not achieved for adolescents over 14 years old. In recent years, Multisystemic Treatment has shown promise for antisocial youth (Henggeler, Schoenwald, Borduin, Rowland and Cunningham, 1998) and for adolescent sex offenders (Swenson, Henggeler, Schoenwald, Kaufman, and Randall, 1998), but it requires a resource-rich combination of services, one of which is psychotherapy, and it is not a realistic option for most such youth. Cognitive behavioral therapy (CBT) is widely employed in the treatment programs for behaviorally disordered youth across many settings and is frequently used with aggressive youth and adolescent sex offenders. But there are clear limits to the effectiveness of CBT in the treatment of personality disordered clients, especially borderline and narcissistic types (e.g., Young, Klosko and Weishaar, 2003).

Apsche developed an advanced form of cognitive behavioral treatment called "Mode Deactivation Therapy" (Apsche and Ward Bailey, 2004a) in order to simultaneously address the multiple problems issues of conduct- and personality-disordered youth, while also accommodating the particular defensive characteristics of the adolescent. Mode Deactivation Therapy (MDT) has been applied to adolescent sex offenders and mentally ill adolescents alike. MDT is an evidence-based treatment that blends key elements from Beck's theory of "modes" (Beck, 1996); traditional Cognitive Behavioral Therapy and Schema Therapy (Alford and Beck, 1997; Beck and Freeman, 1990); Dialectical Behavior Therapy (Linehan, 1993); and Functional Analytic Behavior Therapy (Kohlenberg and Tsai, 1993; Nezu, Nezu, Friedman and Haynes, 1998).

Beck's Theory of "Modes"

Recognizing that his earlier model of cognitive schemas was inadequate to explain a number of psychological problems, Beck (1996) introduced the concept of "modes" in his article, "Beyond belief: A theory of modes, personality and psychopathology." Beck conceives of "modes" as sub-organizations of the personality, which are comprised of integrated networks of cognitive, affective, motivational and behavioral components, that have developed through experience as an "automatic" response to particular types of situations, notably perceived threats (Beck, 1996; Apsche, 2004). Thus, modes are consistent, coordinated, self-protective response systems for an individual, which are controlled by schema. Moreover, modes are charged (or "cathected") such that some schemas are more intensive and powerful than others in driving responses to perceived threat.

In Beck's theory, when an individual is faced with a perceived danger or potential threat, his orienting schema can activate a dysfunctional "mode" with all its simultaneous aspects – a particular conglomerate of beliefs, emotions, motivation, and behavior (Apsche, 2004). Dysfunctional modes are typically characterized by high levels of anxiety, fear, irrational thoughts and feelings, and aberrant behaviors. Further, "modes" are self-reinforcing and maintained by a group of fundamental beliefs. For this population, individuals have developed maladaptive orienting schemas and modes as protective strategies in response to their traumatic and abusive life experiences. Originally these modes were useful survival strategies that protected the individual from distress and threat, but they have become ingrained, virtually automatic, maladaptive responses.

As repeated victims of various trauma, neglect and abuse, these youth are ultra-sensitive to learned experiential cues, often unconscious, that signal danger and vulnerability. Alford and Beck (1997) refer to this phenomenon in describing how the schema that typify personality disorders operate on a more continuous basis and are more sensitive to triggering events. Hence, such individuals are always ready to defend and/or attack at the first sign of perceived danger. In short, when faced with a perceived risk of victimization/vulnerability, such individuals are unable to override the primal, automatic "mode" response by

employing cognitive controls because they are instantaneously flooded with powerful feelings, sensations and fear.

Mode Deactivation Therapy

Mode Deactivation Therapy is designed to disrupt ("de-activate") the pre-established maladaptive cognitive/affective/motivational/behavioral response set ("mode") that is automatically triggered by the situational occurrence of the orienting schema. For example, a youth has the orienting schema that, "You can't trust anyone because you will be betrayed" and he is in the situation of developing more closeness with a peer or staff person in the treatment program. For this youth, his orienting schema would trigger a maladaptive "mode" in which the youth may become anxious, have intense physiological sensations, have paranoid thoughts that the person is "out to get me" and start to withdraw or act aggressively.

Apsche repeatedly found that traditional cognitive behavioral therapy was not adequate to the instantaneous, primal and extremely powerful effects of maladaptive "modes" with conduct disordered and personality disordered adolescents. Similarly, in using CBT with Axis II disorders, Young, Klosko and Weishaar (2003) found that personality-disordered clients, especially borderline and narcissistic, continue to experience significant emotional distress following treatment. Apsche observed that most aggressive and sexually aggressive youth tend to lose control with such sudden primal intensity that they are unable to tolerate the traditional procedures of cognitive restructuring. Moreover, cognitive behavioral therapy itself needed to be modified to accommodate the adolescent's natural developmental sensitivities to resisting authority in the therapeutic relationship.

Consequently, Apsche and his colleagues blended methods from three proven treatment models – Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Functional Analytic Behavioral Therapy – to create an advanced form of cognitive behavioral therapy called "Mode Deactivation Therapy" (MDT).

Elements from Cognitive Behavioral Therapy: As described above, the term "mode de-activation" itself derives from Beck's (1996) term "modes" and uses his cognitive behavioral theoretical formulation of "modes." MDT shares the basic tenets of classic cognitive behavior therapy, including "Schema Therapy," which holds that internal schemas are at the core of the personality disorders (Young, Klosko and Weishaar, 2003). MDT agrees that aberrant behavior derives from dysfunctional schema that trigger "modes," but it takes a radically different approach to correcting such schema. Unlike cognitive therapy, MDT does not directly challenge the irrationality of the orienting schema by "arguing" the concepts of cognitive distortions. Even when the therapist has a good rapport, such youth are acutely sensitive to the power dynamic of being in a one-down position. Given their histories of victimization, they typically have serious difficulties with interpersonal trust. Challenging the reality of a youth's beliefs and perceptions is negatively experienced as an attack on his esteem, his world-view and his fragile sense of self. Developmentally, such youth perceive the cognitive therapist as another adult trying to impose their authority and force him to change. Adolescents bristle and respond poorly to direct cognitive corrections – even when such interventions seem to be delivered in the most gentle and collaborative fashion. Cognitive therapy then, as it is normally practiced, can trigger a negative response that undermines progress (Apsche and Ward Bailey, 2004a).

Elements from Dialectical Behavior Therapy: To accommodate this developmental and clinical barrier to traditional cognitive therapy, MDT uses two key principles from Dialectical Behavior Therapy (Linehan, 1993), which was originally developed to treat extremely unstable and volatile patients with severe personality disorders. Dialectical Behavior Therapy (DBT) uses the technique of *radical acceptance* in which the therapist elucidates and validates the unique "truth" in each individual's perceptions. Rather than directly challenging the validity or empirical support for the youth's beliefs and perceptions, MDT uses radical acceptance in fully validating the "grain of truth" of the individual adolescent's beliefs based on his life experiences and trauma history. The goal is to join with the youth in order to discover how the belief system is a legitimate reflection of the youth's life experience, relationships, sense of self and world view.

Subsequently, given radical acceptance and increased trust, the therapist can use the therapeutic relationship as well as the youth's direct experiences in the treatment program to show how beliefs can be modified based on corrective therapeutic experiences. MDT also adopts the technique of *balancing* from Dialectical Behavior Therapy. This is an interactive method of introducing increasing flexibility or balance in the individual's rigid and maladaptive dichotomous (either/or) beliefs by redirecting the person to considering a continuum of truth or a continuum of possibilities.

Elements from Functional Analytic Behavioral Therapy: MDT also incorporates principles from Functional Analytic Behavioral Therapy (Kohlenberg and Tsai, 1993). First, MDT aligns with FAB in affirming that perceptions of reality and unconscious motivations evolve from past contingencies of reinforcement, such as families of origin. Second, MDT uses an assessment and Case Conceptualization method that combines elements from Beck's (1996) case conceptualization and the Factor Analytic Behavior Therapy model of Nezu, Nezu, Friedman and Haynes (1998). The assessment and case conceptualization procedure concentrates on core beliefs, fears and avoidance behaviors that are reflective of the Post-Traumatic Stress Disorder and developing personality disorders (see Apsche and Ward Bailey, 2003, 2004b, 2004c).

The crucial difference between Mode Deactivation Therapy and Cognitive Behavioral Therapy is that the core beliefs (or schemas) of the individual are *not* seen and challenged as dysfunctional because this action necessarily invalidates the person's life experience. Instead, in MDT, core beliefs are consistently validated as legitimate creations from the person's life experience (no matter how irrational and even if they have little more than a tiny "grain of truth"), which are then "balanced" through the collaborative therapeutic process to deactivate the maladaptive mode responses.

The present study was designed to assess the effectiveness of Mode Deactivation Therapy (MDT) as compared to Cognitive Behavior Therapy (CBT) and Social Skills Training (SST) in the treatment of conduct disordered and personality-disorder youth with problems of aggression and sexual aggression.

METHOD

Sample Characteristics

A total of 60 male adolescents participated in the study. All subjects were referred to the same residential treatment facility for the treatment of aggression and/or sexual aggression. In this real world setting, subjects were randomly assigned to one of the three treatment conditions at the time of admission based on available openings in the caseload of the participating clinicians. The three treatment conditions showed similarity in terms of the frequency of Axis I and Axis II diagnoses, age, and racial background. To ensure consistency in the delivery of the three respective treatments, therapists were specifically trained in the one of the three treatment curriculums/methods. The average length of residential treatment across all conditions was roughly 11 months.

Condition one: Cognitive Behavioral Therapy (CBT): A total of nineteen male adolescents were assigned to the CBT condition. The group was comprised of 14 African Americans, 4 European Americans and 1 Hispanic American with an average age of 16.5. The principal Axis I diagnoses for this group included Conduct Disorder (14), Oppositional Defiant Disorder (4), and Post Traumatic Stress Disorder (7). Axis II diagnoses for the group included Mixed Personality Disorder (4), Borderline Personality Disorder (2), Narcissistic Personality Disorder (1) and Dependent Personality Disorder (1).

The particular CBT methodology used for this group employed a published treatment curriculum and workbook system for adolescent sex offenders called "Thought Change" (Apsche, 1999, Apsche, Evile and Murphy, 2004). This structured treatment program is specifically designed for personality disordered and conduct-ordered youth with psychosexual disturbances and high levels of aggression and violence. Components of this psycho-educational treatment curriculum included daily recording of negative thoughts,

cognitive distortions, cognitive restructuring, sexual offense patterns and beliefs, aggressive patterns and beliefs, mood management, dysfunctional beliefs, taking responsibility, mental health maintenance, substance abuse issues, and victim empathy.

Condition two: Social Skills Training (SST): A total of twenty male adolescents were assigned to the SST condition. The group was comprised of 14 African Americans, 4 European Americans and 2 Hispanic American with an average age of 16.1. The principal Axis I diagnoses for this group included Conduct Disorder (17), Oppositional Defiant Disorder (3), and Post Traumatic Stress Disorder (5). Axis II diagnoses for the group included Mixed Personality Disorder (4), Borderline Personality Traits (1), Narcissistic Personality Traits (1), and Avoidant Personality Traits (1).

The Social Skills Training program included identification and reinforcement of appropriate behaviors, target skill identification, modeling, practicing skills, and role playing. The youth in this condition were encouraged to practice skills and were reinforced by shaping and fading procedures. All staff and therapists were trained and supervised in SST by a doctoral level psychologist. All skill training was performance based and evaluated for each individual (Henggeler, Schoenwald, Borduin, Rowland and Cunningham, 1998).

Condition three: Mode Deactivation Therapy (MDT): A total of twenty-one male adolescents were assigned to the MDT condition. The group was comprised of 15 African Americans, 5 European Americans and 1 Hispanic American with an average age of 16.5. The principal Axis I diagnoses for this group included Conduct Disorder (15), Oppositional Defiant Disorder (2), Post Traumatic Stress Disorder (7), and Major Depressive Disorder, primary or secondary (5). Axis II diagnoses for the group included Mixed Personality Disorder (6), Borderline Personality Traits (3), and Narcissistic Personality Traits (2). The MDT condition used the methodology described earlier in this paper.

Table 1. Diagnostic and Demographic Similarity of Subjects Across Treatment Conditions

Axis I	**CBT**	**SST**	**MDT**
Conduct Disorder	14	17	15
Oppositional Defiant Disorder	4	3	2
Post Traumatic Stress Disorder	7	5	7
Major Depression	0	0	5
Axis II			
Mixed Personality Disorder	4	4	6
Borderline Personality Traits	2	1	3
Narcissistic Personality Traits	2	1	2
Dependent Personality Traits	1	0	0
Avoidant Personality Traits (	0	1	0
Race			
African American	14	14	15
European American	4	4	5
Hispanic/Latino American	1	2	1
Total	19	20	21
Average Age	16.5	16.1	16.5

Measures

The key measures of physical and sexual aggression used in this study consisted of Daily Behavior Reports and Behavior Incident Reports. The Daily Behavior Reports were completed by all levels of staff, both professional and paraprofessional, across all settings of the residential treatment program (e.g., schoolroom, psychoeducational classes, treatment activities, residential dormitories, etc.). The Behavior Incident Reports were only completed by staff following the occurrence of serious or critical incidents, namely, acts of physical and sexual aggression. Inter-rater reliability in the use of the measures was determined by independently totaling the number of physical and sexual aggression incidents on both the Daily Behavior Report cards and the Behavior Incident Report forms and calculating the percentage of agreement. The agreement for this study was at the 98% level.

The baseline ("pre-treatment") measure of physical and sexual aggression consisted of the average number of incidents per week that occurred during the first 60 days following admission and the post-treatment measure was the rate of occurrence during the 60 day period prior to discharge.

RESULTS

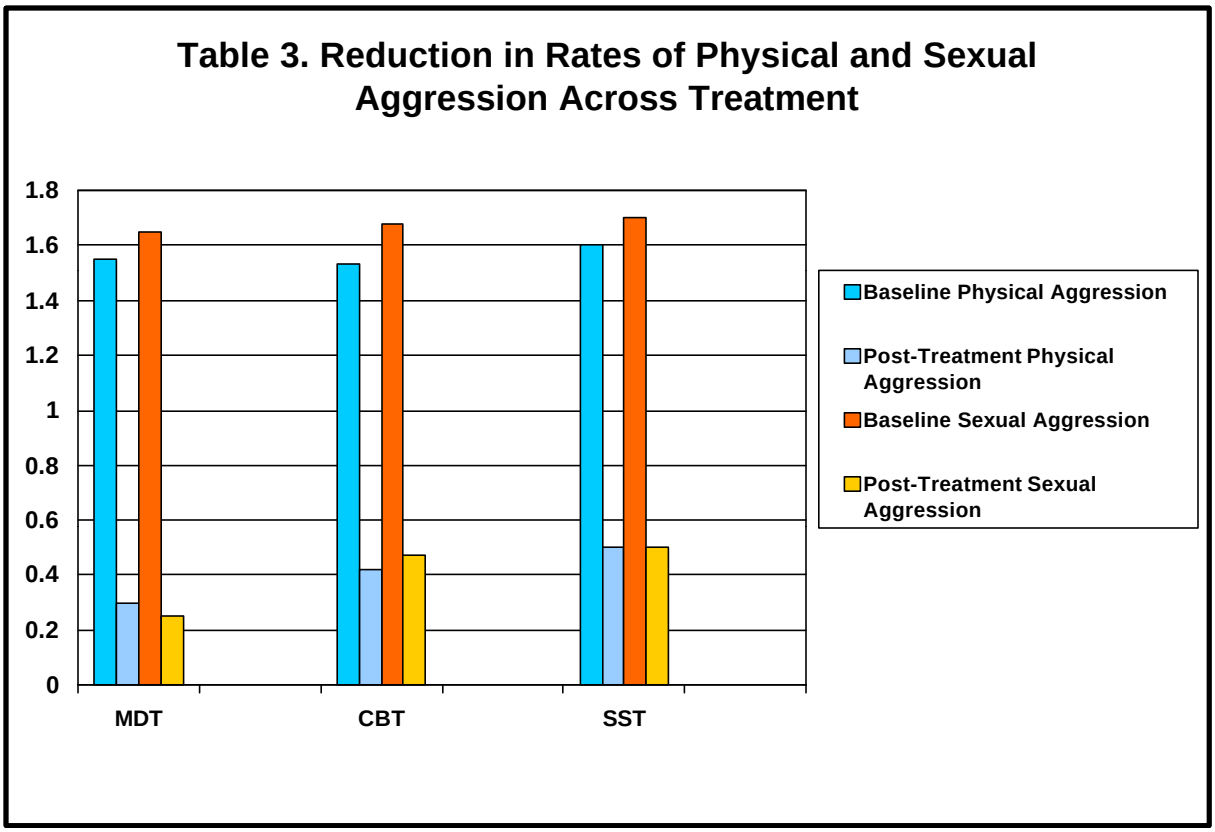
This research study was initiated to compare the efficacy of three different treatment methods for male adolescents in residential treatment for physical and/or sexual aggression. We began the analysis by assessing weekly behavioral reports, which indicated a number of observed sexual or aggressive acts. Once reports were compiled, statistical analysis of the results ensued. It was found that all participants benefited from treatment regardless of theoretical orientation (see table one). The baseline average rate of aggression across all groups was 1.56 with a total standard deviation of .501 and standard error of .065. There was a 74% reduction in rate of aggression to the post treatment mean of .41, with a standard deviation of .495 and standard error of .065. An independent T test was performed on the difference in means. The T-test found a significant difference between the baseline and post-treatment measures $T = 18$, $df = 59$, $p < .01$.

Further analysis was performed on the difference between baseline and post-treatment rates of sexual aggression. The baseline mean across all groups was 1.68 with a total standard deviation of .471 and standard error of .061. There was a 76% reduction in the rate of sexual aggression to the post-treatment mean of .41 with a standard deviation of .495 and standard error of .065. A One-way ANOVA was computed and indicated a significant difference, $F(2,56) = 8.32$, $p < .01$.

TABLE 2. Descriptive Statistics

Measure	Tx Type	N	Mean	Std. Dev.	Std. Error	95% confidence Interval		Min	Max
						Lower bound	Upper Bound		
Baseline Physical Aggression	CBT	19	1.53	.513	.118	1.28	1.77	1	2
	MDT	20	1.55	.510	.114	1.31	1.79	1	2
	SST	20	1.60	.503	.112	1.36	1.84	1	2
	Total	59	1.56	.501	.065	1.43	1.69	1	2
Baseline Sexual Aggression	CBT	19	1.68	.478	.110	1.45	1.91	1	2
	MDT	20	1.65	.489	.109	1.42	1.88	1	2
	SST	20	1.70	.470	.105	1.48	1.92	1	2
	Total	59	1.68	.471	.061	1.56	1.80	1	2
Post-Treatment Physical Aggression	CBT	19	.42	.507	.116	.18	.67	0	1
	MDT	20	.30	.470	.105	.08	.52	0	1
	SST	20	.50	.513	.115	.26	.74	0	1
	Total	59	.41	.495	.065	.28	.54	0	1
Post-Treatment Sexual Aggression	CBT	19	.47	.513	.118	.23	.72	0	1
	MDT	20	.25	.444	.099	.04	.46	0	1
	SST	20	.50	.513	.115	.26	.74	0	1
	Total	59	.41	.495	.065	.28	.54	0	1

Thus, the first analysis suggests that all types of treatment – Mode Deactivation Therapy, Cognitive Behavioral Therapy and Social Skills Training – had a positive effect of reducing rates of physical and sexual aggression over the course of treatment (see Table 3).



behavior when treated with MDT as compared to CBT or SST. To test this hypothesis, a one way analysis of variance (ANOVA) was conducted on the baseline and post-treatment measures of physical and sexual aggression. Both post-treatment physical aggression and post-treatment sexual aggression were significantly affected by type of treatment, $F(2, 56) = 8.32$, $p < .01$ (post-treatment aggression); $F(2, 56) = 10.02$, $p < .01$ (post-treatment sexual aggression).

Table 4. ANOVA -- Difference in Outcomes Between MDT, CBT and SST Treatment Groups

Measure		Sum of Squares	df	Mean Square	F	Signif.
Baseline Physical Aggression	Between Groups	.707	2	.353	1.413	.252
	Within Groups	14.005	56	.250		
	Total	14.712	58			
Post-Treatment Physical Aggression	Between Groups	3.299	2	1.649	8.316	.001
	Within Groups	11.108	56	.198		
	Total	14.407	58			
Baseline Sexual Aggression	Between Groups	.537	2	.269	1.074	.349
	Within Groups	14.005	56	.250		
	Total	14.542	58			
Post-Treatment Sexual Aggression	Between Groups	3.483	2	1.742	10.017	.000
	Within Groups	9.737	56	.174		
	Total	13.220	58			

To better elucidate between-group differences in magnitude of effect, independent factorial analyses on treatment model and variable were conducted.

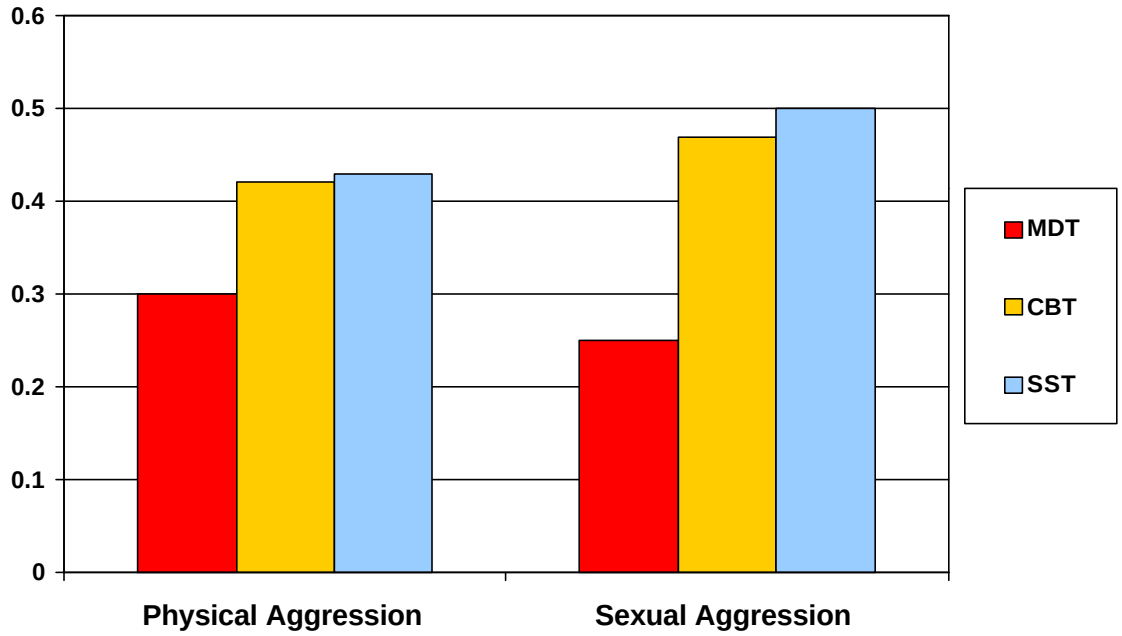
With a overall percent reduction of 80.7% in rates of post-treatment physical aggression, Mode Deactivation Therapy was found to be superior to Cognitive Behavioral Therapy at 72.6% and Social Skills Training at 68.8%. The greater magnitude of effect for MDT was statistically significant compared to both CBT and SST, which were not significantly different from each other.

The most dramatic difference between treatment groups was found in reduction of post-treatment rates of sexual aggression. In this instance, *only* Mode Deactivation Therapy showed a statistically significant reduction in rates of sexual aggression from baseline to post-treatment. MDT showed a reduction of 84.5% in sexual aggression compared to CBT and SST at 72.0% and 70.6% respectively. Post-treatment rates of sexual aggression were .30 for MDT, .42 for CBT, and .43 for SST. The differences were significant using an independent *T*-test comparing, CBT, MDT and SST. The *T* test showed $T = 2.21$, $df = 39$, $p = .01$. The results clearly show that MDT produced significantly superior results when compared to CBT and SST. These differences in magnitude of effect are graphically represented in Table 6.

Table 5. Post-Treatment Scores and Percent Reduction in Types of Aggression Across Treatments

	MDT		CBT		SST	
	Post-Treatment Score	Percent reduction	Post-Treatment Score	Percent reduction	Post-Treatment Score	Percent reduction
Physical Aggression	.30	80.7%	.42	72.6%	.43	68.8%
Sexual Aggression	.25	84.5%	.47	72.0%	..50	70.6%

Table 6. Post-Treatment Reduction in Rates of Aggression Across Three Treatment Conditions



DISCUSSION

The data indicates that Mode Deactivation Therapy (Apsche and Ward Bailey, 2004a) may achieve superior results to traditional Cognitive Behavioral Therapy (CBT) and Social Skills Training (SST) in reducing both physical aggression and sexual aggression in conduct-disordered and personality-disordered youth in a long-term residential treatment setting. Moreover, while all three treatments were effective in reducing physical aggression, only Mode Deactivation Therapy (MDT) demonstrated a significant reduction in

rates of sexual aggression. This finding suggests that the technical modifications of cognitive behavioral treatment used in MDT may be better suited to the unique developmental and clinical presentation of these behaviorally disturbed adolescents and yield superior outcomes, especially with regard to sexual abuse issues.

At the same time, several factors may limit the strength of the conclusions drawn from the outcomes. First, the results were derived in a long-term residential treatment program and may not find replication in less intensive outpatient treatment settings. Second, there are inherent difficulties in identifying "pure" diagnostic types for multiply-challenged youth such as these. While there was striking similarity in the distribution of diagnostic categories across treatment conditions (e.g. Conduct Disorder, Oppositional Defiant Disorder, Personality Disorders), exact matching by diagnosis could not be realistically achieved in this real world setting. Moreover, while all of the youth had documented histories of physical aggression and nearly all had histories of sexual aggression, it was not possible to definitively distinguish individual youth as primarily sex offenders or primarily aggressive youth nor match them accordingly across the three conditions.

As in any real world study, it is always difficult to control for the levels of competence of the participating therapists and their adherence to the "purity" of each of the three treatment methods. Best efforts were made to control for this common problem by ensuring that therapists shared the same professional degree and level of clinical experience in each of the three methodologies and by providing training in the delivery of each model prior to the study.

The strength of the outcomes could be further enhanced with the inclusion of additional outcome measures and, ideally, long-term follow-up of the youth who participated in the study. It is important to note that the authors do not purport that MDT will generalize to any groups other than youngsters with conduct and personality disorders.

The authors hope that future research may use randomized trials in outpatient clinics and attempt to replicate these findings in other residential treatment facilities and with other relevant adult and adolescent populations, particularly with those identified primarily as sexual offenders.

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Author Contact Information:

[1] Jack A Apsche, Ed.D., A.B.P.P. The Apsche Center 111 South Main Street Yardley, PA 19067 (215) 321-4072 jackmdt@aol.com www.ApscheCenter.com

[2] Christopher K. Bass, Ph.D., Dept of Psychology, Clark Atlanta University, 207 Knowles Hall, Atlanta, GA 30313 (404) 880-8481 cbass@cau.edu

[3] Jerry L. Jennings, Ph.D., Liberty Behavioral Health Corporation, 401 E. City Ave., Suite 820 Bala Cynwyd, PA, 19004.

[4] Christopher J Murphy, MA Regent University 1000 Regent University Drive, Virginia Beach, VA 757-226-4488 chrimur@regent.edu

[5] Linda A. Hunter, Regent University 1000 Regent University Drive, Virginia Beach, VA 757-226-4488 lindhun@regent.edu

[6] Alexander M. Siv, MA. Brightside for Families and Children 2112 Riverdale Street West Springfield, MA 01089. 413-827-4327 alexmsiv@hotmail.com

Unacceptable Risk Factors in Child Maltreatment: Formulations from Caseworkers

Virginia DeRoma and Christy Bingley, The Citadel,
Maria Lynn Kessler, Oregon Institute of Psychology, and
Cesar Merino, Sembrar Association, Lima, Peru

Abstract

Approximately one million children are victims of maltreatment are assessed and placed in the child welfare system. The purpose of the current study was to identify caseworker perceptions of (a) reasons for youth removal from a home environment and (b) the parameters of intolerable problem categories that prompt such decisions. Four categories of maltreatment were generated to account for over 70% of the caseworkers' 249 reasons identified for youth removal using structured interviews. Within each category, perceptions of risk factors identified as intolerable for allowing youth to remain in the home were identified for each of the categories. Results may help providers to target the areas in which future program development and treatment delivery efforts should be directed.
Keywords: Maltreatment, caseworker decision-making, treatment motivation, risk-assessment.

The Department of Social Services division of Child Protective Services (CPS) serves those individuals who are in need of protection from potentially abusive settings. More than three million referrals are made to child protective services throughout the United States for child abuse and neglect each year (Children's Bureau Administration on Children, Youth and Families, 2002). Out of these referrals, roughly one million children have been as the victims of substantiated abuse and neglect, with reports of maltreatment ranging from neglect to physical and sexual abuse. Caseworkers are mandated, by law, to protect children from abuse and neglect from any individual who is responsible for the child's welfare, including biological parents, foster parents, grand parents or any other individual who takes responsibility. In providing protection, Child Protective and Preventive Services have two main functions: (a) protection of a child and his/her best interests and (b) family preservation.

Of the three million child maltreatment cases reported each year, an estimated 55% receive services to prevent abuse and neglect, with one-fifth of these children placed in foster-care or group homes and institutions (Children's Bureau Administration on Children, Youth and Families, 2002). The length of time a child can spend in foster care is alarming, however, and raises issues about what procedure or decision-making process caseworkers adhere to in determining whether or not a child should be returned to his/her home. Some youth spend over two years in out-of-home placement (Ansay & Perkins, 2001). How a caseworker decides when a child's removal from the home is appropriate and in the best interest of the child should be examined in order to better serve maltreated children.

The decision-making process for frontline CPS workers is not an easy one. In an analysis of the decision-making process in which social workers undertake, Proctor (2002) noted that social workers are considered experts in their field and are, thus, responsible for making sound practical decisions that rely heavily on their knowledge. However, these decisions are compromised by a variety of factors, ranging from time constraints to lack of available information on which to make these decisions. Child protective professionals faced with growing criticism about the decision-making procedures utilized when a child has been placed in an unfit home or stays in the system too long have been forced to examine their practices. Several models have been implemented in order to reduce the error rate among CPS workers and to make the decision-making process less painstaking. The CPS worker must use judgment to determine what is in the child's best interest as well as how to maintain the ethical standards set forth by the agency. The rate of error may be high for CPS workers if they fail to adhere to a decision-making

model. To help reduce personal bias, structured risk-assessment systems have become more popular among social workers (Baird, Wagner, Healy, & Johnson, 1999; Gelles, 2000a). This more formalized method of gathering data is designed to assist the CPS worker with assessing the risk for future abuse/neglect with minimal subjectivity.

Schuerman, Rossi, and Budde (1999) asserted that a more formalized method of decision-making is indeed needed, in part due to the increased concern by family preservation advocates on the excessive out-of home placements of abused and neglected children. Schuerman et al. (1999) found that there was a lack of consensus between the experts and CPS workers on placement decision in response to case vignettes of serious maltreatment issues. However, experts had higher consensus compared to frontline workers, suggesting that caseworkers' experience may not necessarily positively influence their objective expertise. Nonetheless, future studies need to assess caseworks' priorities of what criteria are important in order to understand the decision to reunify a family.

CPS workers often compile data using instruments that have no predictive validity (Baird et al. 1999). There are two primary types of risk-assessment systems designed to target family reunification criteria objectively: (a) consensus-based and (b) actuarial based. Consensus based systems involve criteria based on expert opinions of client characteristics that may predict high risk status for future abuse or neglect by the individual. Actuarial systems involve identification of families at low, medium, and high risk based on base rate occurrence data from examination of characteristics of prior offenders (Baird et al, 1999). Consensus-based systems rely heavily on the CPS caseworkers' past clinical experience, but tend to do very poorly when predicting outcomes without use of empirically supported instruments (Baird et al 1999).

Rossi, Schuerman, and Budde (1999) examined several characteristics that may affect child placement in maltreatment cases. These variables included persons living in the home, type of complaint, victim demographics, and the response of persons involved with the investigation. When deciding placement for an abused or neglected child, CPS workers placed the most emphasis on previously recorded complaints on the family (Rossi et al., 1999). Families that have had previous complaints of child maltreatment had a greater chance of having their children removed and placed in alternative homes. Secondly, Rossi, et al. (1999) concluded that the type of complaint, whether physical or mental abuse, did not influence the decision of placement. Thirdly, families who showed interest in change and possessed some household income were more likely to receive family preservation services and less likely to be recommended for placement (Rossi, et al. 1999). This data suggests the need to examine motivation as a criterion for reunification. Nelson, Mitriani, and Szapocznik (2000) also identified factors that facilitate successful reunification which include: (a) environmental stability, (b) a supportive family, and (c) a willing mother.

The current study examines the reasons caseworkers identify as critical for removal of a child from the home and how the thresholds within these categories affect decisions made by CPS caseworkers. In the current study, the following questions were addressed: (a) what are the categories of behavior that are identified by caseworkers as important factors in the decision to reunify a family? and (b) what are the behaviors associated with the unacceptable level of risk that accompanies the decision to reunify a family?

Method

Subjects

Participants (N=41) included employees from the Department of Social Services in Charleston, Berkeley, Dorchester, and Richland counties in South Carolina. Slightly less than two-thirds of the workers were African-American (61%) and all others were Caucasian (39%). Workers were all female with a mean age of 34 years, 4 months and a mean of two years and 10 months of experience in their current positions.

Dependent Measure

In order to examine the threshold for removal and factors affecting family reunification analyzed for this study, the primary question asked of caseworkers was: "Now consider all cases that you have worked on involving the recommendation for a child not to return to the home – against family reunification. List all of the reasons the children in all cases were not returned to their home and the threshold for removal, meaning the level at which the circumstance is intolerable for the child to remain in the home."

Procedure

The director of research at the Department of Social Services granted permission for the graduate assistants in the project to interview child protective caseworkers. The project was then introduced to one of each of four site directors in our local area. Once permission was granted by the site directors, names of subjects who met criteria (e.g., role in job required them to make decisions related to youth removal from the home) were solicited. Caseworkers were contacted by phone to introduce the project and arrange for an appointment if the caseworker was interested in participating in the study. At the onset, the purpose, procedures, risk, and benefits of the project were reviewed and consent was solicited from caseworkers. Time for completion was approximately one hour. Responses to the interview were recorded and then coded into discrete categories and entered into a database by a trained rater. Definitions of categories developed for the study were utilized for training.

Reliability

Two graduate students were trained to accurately code responses to the interview and enter them into a database. Reliability checks were conducted on twenty five percent of completed interviews. Inter-observer agreement was calculated by dividing disagreements by agreements and multiplying by 100. Inter-observer agreement for reason for child removal and threshold level were 97% and 98% respectively.

Results

For the 249 free form reasons identified by CPS caseworkers as the basis for removing the child from the home, fifteen categories were created (in addition to an "other" category). Endorsements for all categories are presented below in Table 1:

Table 1.
Percentage Endorsement of Categories for Reasons for Child Removal from Home

Reasons a Child Might be Removed from Home	Percentage Endorsement
Neglect	32.9
Physical abuse	14.9
Sexual abuse	12
Substance abuse/addiction	12
Related to main factors	8.8
Other	8.3
Domestic violence	3.6
Mental health issues	2.4
Parenting issues	2
Finances	1.6
History related factors	1.6
Treatment issues	1.2
Child related factors	.8
Cooperation with DSS	.8
Responsibility	.4

In the current study, only the most highly endorsed four categories the majority (71.8%) of all responses were examined. The four categories encompassing over 70% of all responses included: (a) neglect (32.9% endorsement); (b) physical abuse (14.9% endorsement); (c) sexual abuse (12% endorsement); and (d) substance abuse/addiction (12% endorsement). The family-specific/other category of responses captured 13% of all responses.

One hundred seventy-seven responses of intolerable markers were generated for the four primary categories of maltreatment. Sixty-five responses of intolerable markers were related to the category of neglect. Percentage endorsements for intolerable risk factors for the category of Neglect (See Table 2 below) were noted in the following subcategories: (a) Poor Supervision/Inadequate Caretaker – 26.2%; (b) Educational Neglect – 1.5%; (c) Conditions of Home – 19.9%; (d) Medical Neglect – 16.9%; (e) Inadequate/Lack of Housing – 15.4%; (f) Physical Neglect 3%; and (g) Nutritional – 3%. The following subcategories received no endorsements: General Neglect, Lack of Clothing, Emotional Neglect, and Too Many People in and out of Home.

Table 2.

Percentage Endorsement for "Intolerable" Threshold Markers for Physical Abuse

Threshold Subcategories	Percentage Endorsement
Poor Supervision/Inadequate Caretaker	26.2
Medical Neglect	18.5
Condition of Home	16.9
Inadequate/Lack of Housing	15.4
Physical Neglect	3
Nutritional (Lack of Food)	3

Thirty intolerable marker responses were related to the category of Physical Abuse. For this category, the following percentage endorsements were noted for the subcategories (See Table 3 below): (a) Reference to Severity of Abuse (e.g. marks above the waist, broken bones in infants) – 43.3%; (b)Evidence of Physical Abuse – 20%; (c) Treatment Issues – Compliance – 16.7%; (d) Treatment Issues – Willingness – 6.7%; (e) Treatment Issues – Completion – 6.7%; (f) Risk or Threat of harm due to Physical Abuse – 3.3%; and (g) Child Afraid to Return to Home – 3.3%.

Table 3.

Percentage Endorsement for "Intolerable" Threshold Markers for Physical Abuse

Threshold Subcategories	Percentage Endorsement
Reference to Severity of Abuse	43.3
Evidence of Physical Abuse (bruises, welt, etc.)	20
Treatment Issues- Compliance	16.7
Treatment Issues- Willingness	6.7
Treatment Issues- Completion	6.7
Child Afraid to Return Home	3.3
Risk or threat of Harm due to Physical Abuse	3.3

Thirty-seven responses of intolerable markers related to the category of Sexual Abuse were identified. For this category the following percentage endorsements were noted for subcategories (See Table 4): (a) Perpetrator still in Home – 46%; (b) Believing/Blaming the Child – 19%; (c) Treatment Issues – Compliance – 10.8%; (d) Perpetrator no longer in home/access to Child – 8.1%; (e) Allegations of Sexual Abuse – 2.7%; and (g) Protection Issues – 2.7%.

Table 4.
Percentage Endorsement for "Intolerable" Threshold Markers for Sexual Abuse

Threshold Subcategories	Percentage Endorsement
Perpetrator Still in the Home	46
Believing/Blaming Child	19
Treatment Issues- Compliance	10.8
Perpetrator No Longer in Home/has Access to Child	8.1
Treatment Issues- Willingness	5.4
Evidence of Sexual Abuse	2.7
Allegations of Sexual Abuse	2.7
Protection Issues	2.7
Child Exposed to Pornography or Sexual Activity	2.7

Forty-five responses of intolerable markers were noted as related to the category of Substance Abuse were identified. For this category the following percentage of endorsements were noted for subcategories (See Table 5 below): (a) General Drug Use – 29%; (b) Treatment Issues – Compliance – 22.2%; (c) Treatment Issues – Willingness – 17.8%; (d) Treatment Issues – Completion – 15.6%; (e) Prenatal Exposure – 4.4%; (f) Exposure to Drug Activity or Paraphernalia – 4.4%; (g) Relapse – 4.4%; and (h) Arrested or Convicted – 2.2%.

Table 5.

Percentage Endorsement for "Intolerable" Threshold Markers for Substance Abuse

Threshold Subcategories	Percentage Endorsement
Using	29
Treatment Issues- Compliance	22.2
Treatment Issues- Willingness	17.8
Treatment Issues- Completion	15.6
Relapse	4.4
Exposure to Drug Activity or Paraphernalia	4.4
Arrested or Convicted	2.2

Discussion

The results of this study are unique in that their identification of those prominent categories of maltreatment behaviors that serve as a threshold. In comparing the data collected in this study on reasons for child removal with national data on child abuse and neglect, correspondence in the magnitude of each type of maltreatment can be noted: (a) Neglect 32.9% vs. 63% (NCANDS; National Child Abuse, April 2002); Physical Abuse 14.9% vs. 19% (NCANDS;); and Sexual Abuse 12% vs. 10% (NCANDS).

According to Leung and Cheung (1998), skills, knowledge, and attitudes are essential in predicting outcomes for families who have been reported and for which abuse/neglect has been substantiated. These training components impact a caseworkers' threshold level through influencing the decision-making process of CPS workers. This study is important in its identification of problematic sub-categories of parenting that stand out as alarms to caseworkers for danger. Specifically, this study also broadened the typical categories (i.e., neglect, physical abuse, sexual abuse) of maltreatment to emphasize substance abuse as a factor that plays a major role in a caseworker's decision to remove a child from the home. This data can help readers to fully appreciate the services needed to support families with deficits in these critical areas.

In the area of physical abuse, the physical evidence of abuse comprised only 20% of all intolerable markers for the category, while 43.3% of intolerable markers related to a reference to the severity of the abuse. This data suggests that, unless the severity of abuse is high, as indicated by the use of force that impacts an area above the waist or that results in broken bones, children may not be removed from a home environment. The data may also reflect the habituation to the widespread practice of introduction of corporal punishment in our country and the need to attenuate responsibilities based on this normative practice. Statistics indicating that 23% of intolerable thresholds identified in this category related to treatment motivation issues may also underscore the reluctance of parents to acknowledge or take actions to change such practices. The results may point to the shortage of out of home placements for children removed from homes and a resulting need to raise the threshold for what constitutes substantive risk to youth. Perhaps the few spots available for youth placed out of home must, necessarily, be reserved for families with more severe forms of physical abuse. Regardless, data suggest the need for stronger parent education campaigns related to heightened awareness of child rights and the inappropriateness of corporal punishment that is delivered with enough force to be categorized as physical abuse.

In the area of sexual abuse, 48% of the intolerable markers were related to the perpetrator remaining in the home following a child's disclosure of abuse. Blaming or failing to believe the child was the second most commonly endorsed situation identified as intolerable circumstances for the child to remain in the home. This data suggests a need for interventions aimed at increasing assessment.

Overall, endorsements of treatment compliance issues comprised 23% of the threshold markers for physical abuse, 16% of the threshold markers for sexual abuse, and 39% of the threshold markers for substance abuse. In fact, treatment compliance issues in general comprised over 50% of the "intolerable" markers in the substance abuse category. This suggests that CPS workers highly value factors related to motivation toward ameliorating parenting deficits and base their decision for a child's removal on them. Risk factors for families resistant to change or sustain change for any significant period of time include poverty, sexual abuse, antisocial characteristics and early aggressive tendencies, and a history of social isolation (Gelles, 2000b).

It is noteworthy that Substance Abuse/Addiction tied with the percentage endorsements for Sexual Abuse at 12%. Interestingly, "using" was only endorsed by 29% of caseworkers as an intolerable marker. It appears that DSS caseworkers consider failure to successfully secure follow through help with

an addiction a more serious threat to safety of youth than the initial identification of a substance abuse problem. In other words, once the parent has been made aware of the problematic nature of the substance abuse, caseworkers view it as critical that they engage in successful treatment. Moreover, such individuals should be placed in programs with interventions should be evaluated for efficacy. Gelles (2000c) has noted that the failure to appropriately evaluate child welfare programs accounts for much of the inefficiency of child welfare systems.

The range of responses between respondents for results from the threshold question in this study suggests that caseworkers have varying degrees of tolerance. In some instances, such as Sexual Abuse, as many as nine different endorsed threshold levels were identified, with perpetrator still being in the home having the highest endorsement rate at 46%. This suggests that the decision-making process varies among caseworkers as well, and that a more uniformed approach to decision-making may need to be examined and trained.

One such uniformed approach to decision-making is a model identified as the Family Group Decision-Making (FGDM; Holguin, n.d.). FGDM engages family networks in decision-making and establishes plans with members to keep their children safe from future abuse/neglect as well as providing their needs. Using this model CPS caseworkers and families develop a relationship that is based on cooperation, collaboration, and communication (Holguin, n.d.). FGDM provides the family with private time where the family reflects on information presented and then renders a decision about reunification, which then is presented back to the caseworkers for discussion and approval. More agencies are beginning to implement a more accurate system; however, more research needs to be conducted in order to establish its validity and reliability.

The use of classification and regression trees (CART) in determining critical decisions, such as the decision to investigate a report, have also been utilized with success (Johnson, Brown, & Wells, 2002) with success. CART analysis uses hard science formulaic methods of prediction based on regression equations and predictor and criterion variables of high- and low-risk groups to estimate risk of negative outcome (Johnson, Brown, Wells, 2002). CART allows a caseworker to analyze potential outcomes associated with certain risk factors. Although CART adds objectivity to the decision making process, it is not error proof. For example, some data may be missing from the analysis that could affect the decision and its outcomes. Further studies need to be conducted in caseworker decision-making with the goal of developing a more reformed model for reunification decision-making.

It is clear that the child welfare system, like any system, depends on the expertise of their employees; however, such a system may rely too heavily on opinion and not on empirical data. Inconsistency in the decision-making process may be attributed to an unstructured decision-making system and varying thresholds among CPS caseworkers. It becomes inherent for professionals to identify the basis of caseworkers' decisions and the threshold level for which caseworkers decide it is best not to attempt to reunify a family, either immediately after removal following temporary placement. Some agencies utilize risk assessments to determine an acceptable amount of risk that does not rise above their threshold for risks associated with abuse/neglect. Although caseworkers can receive training on how to utilize risk assessments, the threshold level for problems being so severe to be considered unacceptable is difficult to train because of the nuances of decision-making.

This study had several limitations that can be used as reference for future assessment and research of the decision making process. First, the study was conducted with a small sample size, which may not be representative of the general population. Therefore, interpreting this data is limited to cases of child abuse/neglect in the South. Secondly, some workers were relatively inexperienced, having a mean of 2 years, 10 months, having little or no exposure to decision-making regarding the need to reunify a family.

Future research conducted in this area needs to be more expansive, addressing categories that affected some of the decisions that were made, and examining the referral process by CPS caseworkers for additional services (e.g., job placement). Research is also needed to identify all possible threshold levels with empirical evidence to support them so that they can be incorporated into a model of training for risk factors. Also, future research needs to expand the sample size for better representation and generalization beyond the scope of one region. Strategies for helping families to overcome substance abuse treatment issues, including lack of finances, as a barrier for family reunification should also be examined. Furthermore, future research is needed to better understand the "whys" behind the decision-making process in order to develop decision-making and/or risk-assessment models to prevent further injury or unwarranted placement of abused/neglected children.

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Authors Notes

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Author Contact Information:

Virginia DeRoma, The Citadel: e-mail: DeRomaV@Citadel.edu. Phone: 843-953-7081.

Christy Bingley, The Citadel: e-mail: Bingleyc@Citadel.edu. Phone: 843-953-5320

Maria Lynn Kessler, Oregon Institute of Technology: e-mail: Kesslerm@oit.edu. Phone: 541-850-9147.

Cesar Merino, Sembrar Association: e-mail: Sikayax@yahoo.com.ar. Phone: 51-1-96515486.

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Board Certified in Clinical, Clinical Child and Adolescent, Counseling Behavioral and Group Psychology by The American Board of Professional Psychology

Phone: 215 264 9746
E-Mail: jackmdt@aol.com

Concurrent Parent and Child Group Outcomes for Child Externalizing Disorders: Generalizability to Typical Clinical Settings

Lori Listug-Lunde, Keith Bredemeier & W. Douglas Tynan
A.I. duPont Hospital for Children

Parent behavior management and child social skills training programs have demonstrated efficacy in clinical research settings and are highly efficient treatment modalities. Few studies have examined their effectiveness and efficiency within the typical clinical setting. The current paper examines the use of a concurrent parent behavior management and child social skills training program, evaluating the current sample, which consists of 22 children (ages 5-10) and their guardians, as well as two previous typical clinical samples. The Eyberg Checklist was utilized to assess pre and post treatment intensity scores for childhood externalizing symptoms, with an average treatment effectiveness of 0.89 standard deviations. This is consistent with previous findings (Tynan, et al., 1999; Tynan, et al., 2004) and further demonstrates the effectiveness of the concurrent parent and child training approach as utilized within the typical clinical setting.

Keywords: Parent Management Training, Child Social Skills Training, Outcome Study

Introduction

Among child and adolescent populations, the most frequent referrals for mental health services consist of children and adolescents with externalizing disorders, including: oppositional-defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), intermittent explosive disorder, and adjustment disorder with disturbance of conduct (Kazdin, 1996). Hence, it is essential that a mental health system aimed at providing services to children needs to provide effective and efficient services for children with externalizing disorders. This is particularly important given the growing need for services among this population (Achenbach, ., 1993), coupled with the current environment of managed care, which demands increased accountability among mental health providers (Hoagwood, Jensen, Petti, & Burns, 1996). For this population, parent training programs and child social skills training programs have demonstrated efficacy in research settings (Brestan & Eyberg, 1998; Webster-Stratton & Hammond, 1997); yet there continues to be a paucity of information on their implementation and effectiveness within typical clinical settings (Weisz & Weiss, 1993). Based on their proven efficacy within clinical research settings, as well as their well-defined, short-term, and goal-oriented nature, parent training programs and child social skills training programs appear ideal to meet the need for efficient and effective services within the typical clinical setting; however, further examination within typical clinical settings is needed. An example of the application of these group training programs provided within a community setting was discussed by Tynan, Schuman & Lampert (1999). Tynan, et al., (1999) utilized a community sample of children with externalizing disorders and their parents from an affluent suburban community and later replicated that study among a lower-income rural population (Tynan, Chew, & Algermissen, 2004). Both of these studies examined the effectiveness of concurrent parent behavior management training and child social skills training. In both studies, the 8-week treatment program yielded similar results to those of research-based programs. Yet, further examination of this training program is needed, particularly in regard to its ability to generalize to more diverse clinic or community samples. The purpose of the current paper is to further assess the generalizability of this training program, by examining data from a more geographically and socieoeconomically diverse client population. In addition, the data from the current sample, as well as the two previous clinic samples will be combined for examination.

Method

Referrals

The Behavioral Health division at A.I. duPont Hospital for Children in Wilmington, Delaware, has been offering concurrent parent behavioral management training and child social skills groups for children ages 5-10 years of age with externalizing disorders for the past two years. Over this time, data has been collected on 6 groups. Children and their parents were referred to the group, if indicated, following either an initial intake or a more comprehensive psychological evaluation at the clinic. Groups were offered at the clinic 4 times per year, with a new group starting approximately every 3 months.

Participants

Thirty children and their parents entered the concurrent group treatment program. Twenty-two of these families completed the treatment protocol and were administered pre- and post- treatment measures. This drop out rate (26%) is comparable to the prior two studies (Tynan et al 1999, Tynan et al. 2004). The mean age of the children that completed the group treatment was 7.05 years, with children ranging from 4 to 10 years of age. All participants were male. Participants were from a large catchment area, including city, suburban, and rural settings in Delaware, Pennsylvania, and Maryland. The majority of participants carried private health insurance, while some participants carried Medicaid and a couple self-paid for services. Although specific socioeconomic data was not gathered from the participants, it is believed that participants represented a diverse socioeconomic and geographic range.

Treatment Program

The concurrent treatment program consisted of 8 weeks of parent behavioral management training and child social skills training. Groups were scheduled once weekly from 5:30 to 6:45 in the evening to best accommodate family schedules. Each parent and child group had treatment manuals (described in more detail in Tynan, et al., 1999). The program was developed to utilize 4 therapists, two for the child group and two for the parent group and to have 8 children in each group, hence providing 5.25 therapist hours per child for the completed treatment protocol. A pre-and post-treatment measure was utilized to assess participants' externalizing behaviors and determine group effectiveness. Parents completed the Eyberg Questionnaire (Robinson, Eyberg, & Ross, 1980) during the first session and again during the final session. The Eyberg was chosen because of its focus on externalizing problems, brevity (approximately 8 minutes to complete), and extensive use in research settings evaluating similar behavioral outcomes (i.e., Taylor, Schmidt, Pepler, & Hodgins, 1998; Webster-Stratton & Hammond, 1997).

Results

In the current sample, analysis was conducted to examine differences in participants externalizing problems as reported by their parents on the Eyberg Questionnaire. The mean pre-treatment intensity score reported by parents on the Eyberg Questionnaire was 140.9. The mean post-treatment intensity score reported by parents on the Eyberg was 112.5, yielding a mean difference score of 28.4, comparable to results in previous samples utilizing this treatment protocol (Tynan, et al., 1999; Tynan, et al., 2004; See table 1).

Table 1

Outcome of Eyberg Scores and Effect Size Compared with Previous Samples

	Pre-treatment Intensity Mean	Post-treatment Intensity Mean	Effect Size (SD)
Current Sample ($N = 22$)	140.9	112.5	0.89
Tynan, Shuman, & Lampert (1999) ($N = 55$)	152.9	131.4	0.89
Tynan, Chew, & Algermissen (2004) ($N = 51$)	161.5	132.3	1.00

The overall effect size for the current intervention, which represents the average change for the group, was 0.89 standard deviations. This finding is clearly comparable to the effect size of 0.89 standard deviations found in the original suburban clinic sample (Tynan et al., 1999), as well as the effect size of 1.00 standard deviations found in the rural replication clinic sample (Tynan et al., 2004). In the current sample, 14 out of 22 participants showed an improvement of 0.50 standard deviations or greater and 6 showed an improvement of 1.00 standard deviations or greater. The current finding is also comparable to results of research conducted by Kazdin (1996) for similar treatments with children with externalizing disorders.

A categorical evaluation of the data was also performed in order to assess clinical significance in the current sample. Based upon normative data, a cutoff score of 132 has been established on the intensity scale for the Eyberg Questionnaire (Eyberg, Colvin, & Adams, 1999). Scores of 132 or higher are considered to be in the clinical range, while scores of 131 or below are considered to be in the normal range. Applying these categories to the data, 14 of 22 participants scored in the clinical range prior to treatment. Of these 14 subjects, 8 scored in the normal range following treatment, while 6 remained in the clinical range. Hence, over half of the participants who started in the clinical range prior to treatment moved into the normal range following treatment. All of the 8 participants who scored in the normal range prior to treatment also scored in the normal range following treatment (See table 2).

Table 2

Eyberg Intensity Score Outcome Categories for Current Sample (N = 22)

	Post-treatment	
Pre-treatment	Clinical Range (≥ 132)	Normal Range (≤ 131)
Clinical Range (≥ 132)	6	8
Normal Range (≤ 131)	0	8

In order to gain a more complete picture of the clinical significance of this treatment protocol across different clinic and community samples, the data from the current clinic sample was aggregated with data from the two previous clinic samples (Tynan, et al., 1999; Tynan, et al., 2004). When data from all three clinic populations were aggregated, 100 of a total 128 subjects scored in the clinical range prior to receiving treatment (Table 3). Of these 100 subjects, 47 scored in the normal range following treatment, while 53 remained in the clinical range. All of the 28 subjects who scored in the normal range prior to treatment also scored in the normal range following treatment (See table 3).

Table 3

Eyberg Intensity Score Outcome Categories for Aggregated Sample (N=128)

	Post-treatment	
Pre-treatment	Clinical Range (≥ 132)	Normal Range (≤ 131)
Clinical Range (≥ 132)	53	47
Normal Range (≤ 131)	0	28

Conclusions

There is an increasing demand for effective and efficient services for children with externalizing disorders and their families within typical clinical settings. This is due in part to the increasing need among this population, as well as pressure from managed care to provide effective and affordable services. Clinical research settings have evaluated several treatment modalities, finding that parent behavior management training programs and child social skills training programs are efficacious (Brestan & Eyberg, 1998; Kazdin, 1996; Webster-Stratton & Hammond, 1997). However, continued evaluation of the effectiveness of these modalities is needed in typical clinical settings. Further, it is essential to determine if treatment protocols utilized within a clinical research environment are generalizable to a variety of mental health care settings; and therefore practical for clinicians to utilize in a typical clinical setting. This current paper aims to address the generalizability of these treatment modalities through the evaluation of a concurrent parent behavior management training program and child social skills training program. The concurrent training program as described in Tynan et al. (1999) was implemented and evaluated across three different clinic and community samples. The first clinic sample was implemented with an affluent suburban population, the second clinic sample with a rural population, and the third with a diverse socioeconomic and geographic population. The third clinic sample is the focus of this paper and demonstrates the effectiveness of this training program among a more heterogeneous client population. The use of different clinic settings suggests that this treatment protocol is generalizable across typical clinical settings and can be utilized by various trained practitioners. In addition to being an effective treatment modality, the current training program also has demonstrated efficiency of service. The current training program demonstrated effectiveness utilizing 5.25 therapist hours per client. In fact, this finding suggests that similar rates of treatment effectiveness can be gained in 8 sessions, less than research protocols that have utilized treatment protocols up to 22 sessions (Webster-Stratton & Hammond, 1997). This evaluation suggests that for children with externalizing behavior disorders and their families, a concurrent parent behavioral management training program and child social skills training program is effective and an efficient treatment modality when provided within a typical clinical setting. Further, this evaluation suggests that this training program can successfully be implemented by a range of clinicians and utilized with a diverse client population.

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Author Information:

Lori Listug-Lunde, Ph.D.
A.I. duPont Hospital for Children
Division of Behavioral Health
1600 Rockland Road
Wilmington, DE 19807
(302) 651-5876
llistugl@nemours.org

Keith Bredemeier, B.S.
A.I. duPont Hospital for Children
Division of Behavioral Health
1600 Rockland Road
Wilmington, DE 19807
(302) 392-6873
keithbredemeier@hotmail.com

W. Douglas Tynan, Ph.D., ABPP
A.I. duPont Hospital for Children
Division of Behavioral Health
1600 Rockland Road
Wilmington, DE 19807
(302) 651-4560
dtynan@nemours.org

Mode Deactivation Therapy (MDT): A Theoretical Case Analysis on a Suicidal Adolescent

Jack A. Apsche & Alexander M. Siv

This case study presents a case study of the effectiveness of Mode deactivation therapy (MDT) (Apsche, Bass, Jennings, Murphy, Hunter, and Siv, 2005) with an adolescent male, with reactive conduct disorder, PTSD and 8 lethal suicide attempts. The youngster was hospitalized four times for suicide attempts, three previous placements in residential treatment centers. MDT is a form of cognitive behavioral therapy (CBT) that combines the balance of dialectical behavior therapy (DBT) (Linehan, 1993), the importance of perception from functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1993), and A.T. Beck's (1996) mode theory with a methodology to address the adolescents' belief system. MDT has been shown to be effective in a descriptive study with CBT (Apsche & Ward, 2002). The analysis of this case will illustrate the potential effectiveness of MDT as applied an actively suicidal adolescent.
Keywords: Adolescent, MDT, Suicide, Conduct Disorder, Personality Disorder.

Introduction

Mode deactivation therapy (MDT) as an applied CBT methodology was developed for adolescents with reactive conduct disorder and/or personality disorders/ traits. MDT is targeted for adolescents with a complicated history of abuse, neglect, and multi-axial diagnoses.

Many of these adolescents are victims of sexual, physical, and/ or emotional abuse, as well as neglect. They have developed personality traits as survival coping strategies. These personality disorders and/or traits are not true to their cluster, or are cluster bound, meaning that they are translated into beliefs and schemas that are inclusive of beliefs from all three personality disorder clusters. Often it has been thought that individuals with personality disorders stay true to their cluster (Beck, Freeman, and Associates, 1991), which is not true with the adolescent typology as represented by Charles case in this case analysis.

Often CBT, as viewed by "arguing" or "challenging" the concepts of cognitive distortions, fails with these youngsters (Beck, Freeman, Davis and Associates, (1994). Freeman, A., Preter, J., Fleming, B.A, and Simion, K. M., (1990) Cognitive therapy as normally practiced will eventually trigger a negative reaction by the reactive youngsters. They perceive the therapist as another person attempting to change them from a system of defenses that has been developed to protect them. MDT was developed in response to the need for more effective treatment for this specific adolescent typology. MDT has been shown to be more effective than standardized normalized CBT in a descriptive study (Apsche and Ward, 2002). MDT has also been demonstrated as effective in a series of case studies (Apsche, Ward, Evile, 2002 a & b; Apsche and Ward Bailey, 2003) and a empirical study (Apsche, Bass, Siv, 2005).

Mode Deactivation Therapy (MDT)

Mode deactivation therapy (MDT) (Apsche and Ward Bailey, 2003) as an applied

CBT methodology aims to address reactive conduct disorders and personality disorders/ traits. MDT is based on A.T. Beck's (1996) mode model, with aspects of other therapies, including functional analytic psychotherapy (FAP) (Kohlenberg and Tsai, 1993) and dialectical behavior therapy (DBT) (Linehan, 1993). Additionally, there are areas of MDT which reflect concepts of schema therapy (Young, Klosko, and Weishaar, 2003).

The theoretical underpinnings of mode deactivation therapy are based on A.T. Beck's model of modes. In his article Beyond Belief: A Theory of Modes, Personality, and Psycho-pathology (1996), A.T. Beck defines modes as specific suborganizations of the basic systems of the mind. Specifically, suggesting that people learn from unconscious experiential components and cognitive structural processing components. Functional analytic psychotherapy (FAP) (Kohlenberg and Tsai, 1993) theory focuses on the deeper unconscious motivations that were formed as a result of past contingencies of reinforcement. Perception is based on past con-tingencies, therefore, reality and the concept of reality reflects what has been experienced in the past. Considering reinforcement history in the context of a person provides a more complete assessment of a person and specific behaviors (Kohlenberg and Tsai, 1993). Therefore, to change behavior of individuals there must be a restructuring of the experiential components, and a corresponding cognitive restructuring of the structural components. The dysfunctional experiential and structural learning (conscious and unconscious) develop dysfunctional schemas that generate high levels of anxiety, fear, and general irrational thoughts and feelings, as well as aberrant behaviors. This system is self-reinforcing and protected by the development of the conglomerate of the beliefs underlying the developing personality disorders. This conglomerate is comprised of multiple clustered compound core beliefs, which are the most pronounced impediment to treatment (A.T. Beck, 1996). The compound core beliefs are systematically treated and restructured throughout mode deactivation therapy, beginning with the MDT Case Conceptualization.

By restructuring beliefs, MDT addresses underlying perceptions that may be applicable to setting in motion the mode related charge of aberrant schemas, that enable the behavior integration of dialectical behavior therapy (DBT) principles, (Linehan, 1993) when treating adolescents with reactive conduct disorder and personality disorders/ traits. Many of Linehan's teachings describe radical acceptance and examining the "truth" in each client's perceptions. This methodology of finding the grain of truth in the perception of the adolescent is at the crux of MDT. We also "borrow" radical acceptance in the form of helping the youth accept who he is based on his beliefs. The other major similarity between DBT and MDT is the use of balancing the dichotomous or dialectical thinking of the client. Just as DBT emphasizes the importance of maintaining "balance," so does MDT.

The study of cognitive therapy emphasizes the characteristic patterns of a person's development, differentiation, and adaptation to social and biological environments (Alford & A.T. Beck, 1997). Cognitive theory considers personality to be grounded in the coordinated operations of complex systems that have been selected or adapted to insure biological survival. These consistent coordinated acts are controlled by genetically and environmentally determined processes or structures termed as "schema." Schema are essential both conscious and unconscious meaning structures. They serve as survival functions by protecting the individual from the trauma or experience. An alternative and more encompassing construct is that of modes and suggest that the cognitive schematic processing is one of many schemas that are sensitive to change or orienting event.

A.T. Beck, Freeman and Associates (1990) suggested that cognitive, affective and motivational processes are determined by the idiosyncratic structures or schema that constitute the basic elements of personality. This approach suggests that the schema is the determinant to thoughts, moods, and behaviors.

According to Young et al. (2003), CBT has helped many patients with Axis I disorders. However, many patients with Axis II disorders have gone largely untreated with their Axis II disorders. Using CBT alone, Axis II disordered patients continue to experience significant emotional distress and impaired functioning, especially patients with borderline personality disorder and narcissistic personality disorder. (Young, et al., 2003) In FAP theory, contingencies of reinforcement, such as families of origin, create the perception of reality and resulting beliefs, which drives behaviors. (Kohlenberg and Tsai, 1993)

Therefore, continuing to reinforce these perceptions/ beliefs thereby perpetuates the resulting aberrant behaviors. Modifying the beliefs and perceptions will in turn modify the behaviors. "In general, it is much better for patients with borderline personality disorder not to live with or have frequent contact with their family of origin, especially in the early stages of treatment. Their family is very likely to continue reinforcing the very schemas and modes the therapist is fighting to overcome." (Young et al., 2003)

Schema therapy (Young et al., 2003) states that internal schemas lie at the core of personality disorders and the behavior patterns. The behaviors are what is seen and therefore are usually the basis for Axis II diagnoses. Young et al. (2003) agrees that in order to address the underlying schemas beliefs) and take into account the modes, a concept which Young et al. acknowledges has been difficult to address in the past but is important. Mode oriented therapy is used when therapy seems stuck and patients are rigid, such as with personality disorders and those who display frequent fluctuations in affect (Young et al., 2003). Personality disordered patients present with varying symptoms, including: being highly self-punitive, self-critical, and experiencing emotional numbness. MDT is used because of the complexities of personality disorders.

Linehan (1993) views individuals with borderline personality disorder analogous with burn victims where the slightest movement is automatic and causes extreme pain. "Because the individuals cannot control the onset and offset of internal or external events that influence emotional response" she suggests that the experience is itself a "nightmare of intense emotional pain" and a struggle to regulate themselves.

The reactive adolescent has similar experiences of the world as Linehan's (1993) clients with borderline personality disorder. Their intense emotional pain has led them to "shut down" emotionally to control life's painful experiences. When they are in a situation that triggers fear, it is a reminder of pain and they cannot control the "internal or external events that influence emotional response" and they react with anger and/or aggression, they also often emotionally dysregulate.

According to Dodge, Lochman, Harnish, Bates, and Pettit (1997), there are two sub-groups of aggressive conduct type youngsters; proactive, the sub type that receives benefit and rewards from aggression and reactive, the sub type that is aggressive due to being emotionally reactive or dysregulates. Frequently, reactive adolescents have a conglomerate of personality problems according to Dodge, et al.(1997). It appears that reactive conduct disorder adolescents emotionally dysregulate and many of their aberrant responses are results of their emotional dysregulation. Reactive conduct disorder youth tend to have a history of early life trauma, such as parental rejection, exposure to family violence, and family instability. In addition, these youth show a pattern of emotional dysregulation that includes somatization, depressive symptoms, sleep disorder symptoms, and personality disorders (Dodge et al., 1997). Reactive conduct disorder youth demonstrate a greater tendency to interpret peers' intents as hostile, responding to their environment similarly to individuals with borderline personality disorder. They are reactive and engage in dialectical thinking that seems contradictory and often attention seeking. In reality, these youngsters often endorse dichotomous beliefs and engage in dichotomous behaviors. Often what appears to be impulsive behavior may be their acting upon these dialectical beliefs or being reactive (Dodge, et. al., 1997). Reactive conduct disorder youth have difficulty regulating their emotions with incoming stimuli. (Dodge et al., 1997) Koenigsberg, Harvey, Mitropoulou, Antonia, Goodman, Silverman, Serby, Schopick and Siever (2001) found that many types of aggression, as well as, suicidal threats and gestures were associated with emotional dysregulation.

Reactive conduct disorder youth have greater problems than proactive conduct disorder youth in encoding relevant social cues (Dodge et al., 1997), i.e., reactive youth have difficulty with modes and perception. As FAP theory states, perception is based on past experiences. MDT addresses reactive

conduct disorder by identifying beliefs that were developed from past experiences, borrowing validation of truth of the perception from DBT, and taking it a step further by balancing the beliefs and modifying them into healthier beliefs.

In CBT theory, it is believed that aberrant behavior is related to dysfunctional schema. CBT attempts to identify dysfunctional schemas and modify them. A.T. Beck (1996) suggested that the model of individual schemas (linear schematic processing) does not adequately address a number of psychological problems, therefore the model must be modified to address such problems. Working with adolescents who present with complex typologies of aberrant behaviors, such as anxiety→fear reactions and personality beliefs and/or disorders, it was necessary to address this typology of youngsters from a more "global" methodology.

The concept of modes provided the framework to develop such a methodology. MDT incorporates the model of individual schemas with A.T. Beck's notion of modes as integrated suborganizations of personality (1996). Modes assist individuals to adapt to solve problems, such as, the adaptation of adolescents to strategies of protection and mistrust when they have been abused. They consist of schemas (beliefs) that are activated by the fear↔avoids paradigm. To address the schema processing based on thoughts and beliefs without understanding the modes is insufficient and does not explain the specific adolescent typology referred to in mode deactivation therapy (MDT). MDT is a methodology that addresses dysfunctional schemas through systematically assessing and restructuring underlying dysfunctional compound core beliefs. MDT is applicable to adolescents with personality disorders/ traits, reactive conduct disorder, and/or who engage in aggressive and/or delinquent behaviors.

Specifically, A.T. Beck (1996) describes modes as a "network of cognitive, affective, motivational, and behavioral components" (pg. 2). He further described modes as "consisting of integrated sections or suborganizations of personality, that are designed to deal with specific demands" (pg.2). A.T. Beck continues to describe "primal modes" as including the derivatives of ancient organizations that evolved in prehistoric circumstances and are manifested in survival reactions and in psychiatric disorders. Young (2003) describes modes as "the set of schemas or schema operations – adaptive or maladaptive – that are currently active for an individual" (pg. 271). A "schema mode" is the "predominant state that we are in at a given point in time" (pg. 37). A.T. Beck also explains that the concept of charges (or cathexes) being related to the fluctuations in the intensity gradients of cognitive structures.

Alford and A.T. Beck (1997) explain that the schema typical of personality disorder is theorized to operate on a more continuous basis, the personality disorders are more sensitive to a variety of stimuli than other clinical syndromes. Since these youngsters are often personality activated, it seems that they are in continuous operation. This is one of the difficulties, they are always ready to defend and/or attack.

Modes are important to understanding reactive adolescents in that they are particularly sensitive to danger and fear, serving to charge the modes, that as multi victims of various abuse these youngsters are sensitive to danger and fear. These fears signal danger and are activated by conscious and unconscious learned experiential fears. The unconscious refers to the cognitive unconscious as defined by Alford and A.T. Beck (1997). Abused children develop systems to adapt to their hostile environment. These systems are often manifested by personality disorders/ traits (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999). Longitudinal studies demonstrate that abused children frequently develop personality disorders in adolescence. From the perspective of modes, these disorders are adaptations to a dangerous environment. MDT suggests that the danger produces a fear reaction that is often reactive to danger and fear. This reactivity and sensitivity do not respond to traditional CBT. The adaptation of a theory, that was proposed by A.T. Beck (1996), on modes into the dialectical methodology of DBT, Linehan (1993),

created the blueprint for MDT. The understanding of conscious and unconscious fears being charged and activation the mode system explains the level of emotional dysregulation and impulse control of this typology of youngsters.

Modes provide the content of the mind, which is reflected in how the person conducts their perspectives. The modes consist of the schemas (beliefs) that contain the specific memories, the system on solving specific problems, and the experiences that produce memories, images and language that forms perspectives. As A.T. Beck (1996) states disorders of personality are conceptualized simply as "hypervalent" maladaptive system operations, coordinated as modes that are specific primitive strategies. Although the operation of dysfunctional modes in the present state is maladaptive, it is important to note that they were developed over time for survival and adaptation. These systems prove to become maladaptive as problematic behavior resulting in destructive behaviors.

Mode Activation

A.T. Beck (1996) introduced the concept of modes to expand his concept of schematic processing. He suggests that his model of individual schemas (linear schematic processing) does not adequately address a number of psychological problems, therefore he suggests the system of modes. A.T. Beck described the network of modes as consisting of integrated sectors of sub-organizations of personality that help individuals adopt to solve problems such as, the adaptation of adolescents to strategies of protection and mistrust when they have been abused.

A.T. Beck (1996) also suggests that these modes are charged, thereby explaining the fluctuations in the intensity gradients of cognitive structures. They are charged by triggers, fears and dangers that set off a system of modes to protect the fear. Modes are activated by charges that are related to the danger in the fear→avoids paradigm. The orienting schema signals danger, activates or charges all systems of the mode. The affective system signals the onset and increasing level(s) of anxiety. The beliefs are activated simultaneously reacting to the danger, fear→avoids and physiological system. The motivational system signals the impulse to the attack and avoids (flight, fight) system. They physiological system produces the heart rate or increases or lowers the blood pressure, the tightening of muscles, etc.

Additionally, mode deactivation therapy (MDT) includes imagery and relaxation to facilitate cognitive thinking and then balance training, which teaches the youngster to balance his perception and interpretation of information and internal stimuli. The imagery is implemented to reduce the external stimulation of the emotional dysregulation, which is the basis for the underlying typologies of these youngsters. Many of their underlying behaviors include aggression (physical and verbal) as well as addiction and self-harm.

Apsche & Ward (2002) found that MDT reduced personality disorder/trait beliefs significantly and fought the individual to self-monitor and balance their personality disorder beliefs. The study also found a reduction of internal distress, resulting from various psychological disorders, as well as a reduction of sex offending risk in the group that participated in MDT. Overall, the study indicates that treating this typology without addressing the underlying compound core beliefs, appears to be related to recidivism.

Often these classifications are not immediately recognizable when treating these youths. In addition, treatment protocols often are complicated by the presence of conglomerate of personality disorders, Johnson, Cohen, Smailes, and Bernstein (1999) found in their longitudinal study that childhood maltreatment results in the development of personality disorders in adolescents. The combination of

conduct disorders and personality traits or disorders presents a challenge to the clinicians and researchers alike when working with adolescents.

Conduct Disorder has been found to be a difficult disorder to understand and treat. Problems and symptoms associated with Conduct Disorder include chronic violence, various forms of physical aggression, sexual aggression and property destruction (Dodge, Lochman, Harnish, Bates and Pettit, 1997). While Kazdin, Weiz (2003) delineates evidence based treatments practices for children with Conduct Disorder, no evidence based procedures exist for adolescents over 14 years old with Conduct Disorder. Further, Kazdin and Weiz cite the prevalence rate for Conduct Disorder is 2% to 6% for children in the United States today (2003). In addition, clinical referral rates of 33% to 50% of cases referred to outpatient treatment: and 80% of these children and adolescents are likely to meet criteria for a psychiatric disorder in the future. This presents a major dilemma when attempting to treat this difficult disorder.

Kazdin, Weiz (2003) suggested that Conduct Disorder is comprised of a compendium of behaviors and symptoms. Dodge, et.al(1997), proposed a distinction in conduct disorders based on the differences in which the disorder is manifested by the youths. These categories differ in the youth's perception of threats and the function that the aggression serves. The reactively aggressive is aggressive to perceived threats and danger signals that the youth interprets from others verbal or physical behavior. These behaviors are interpreted by the youth completely separate and not including the other person's actual intent. The proactively aggressive youth is aggressive to receive something, or a "pay-off."

There are often numerous associated Axis I disorders within the Conduct Disorder diagnosis. Many of these youths have secondary diagnosis' of Major Depressive Disorder, Post Traumatic Stress Disorder as well as a variety of Axis II disorders (Apsche, Bass, Jennings, Murphy and Hunter, 2005). As part of their compendium of behaviors, many youngsters with the diagnosis of Conduct Disorder engage in suicidal and parasuicidal behaviors (Apsche, Bass, Murphy, 2004).

MDT and Suicide

In a comprehensive review of 12 years of published studies on adolescent suicide, Links, Gould, Ratnayake, (2003) found that the rate of personality disorders among adolescents who died by suicide were as high as 17%. They also found that the rates of serious suicide were 9 times higher with adolescents who were diagnoses with Anti-Social Personality Disorder, Bipolar Personality Disorder and Narcissistic Personality Disorder.

Links, et.al.2003, also reported that suicide rates for adolescents who had Borderline Personality Disorder was 44%. In addition, they indicated that adolescents with Narcissistic Personality Disorder were 9% more likely to die by suicide.

These data suggest that there is a significant risk of serious suicide attempts for category of reactively aggressive conduct disorder. This group represents a high risk of lethality, as well as, aggression and other destructive behaviors. Links, et al., 2003, clearly state that complications of conduct disorder as it is paired with Anti-Social Personality Disorder, Bipolar Personality Disorder and Narcissistic Personality Disorder as being the manifestation of the disorder by lethal behaviors, both internally and externally.

This research underscores the necessity for the clinician to be aware of the personality beliefs as delineated in the COBB. When implementing MDT, the clinician is required to be aware of these personality indicates of potential lethal suicide attempts.

Case Summary

This case analysis is a step-by-step case study, with a corresponding theoretical analysis based in mode deactivation therapy (MDT). The methodology known as MDT suggests potential for effective treatment of youngsters with similar backgrounds as Charles. Consider a case of this youngster -- Charles is a 17-year-old African American male who meet the criteria for MDT. He has been diagnosed with Post Traumatic Stress Disorder, Conduct Disorder, Major Depressive Disorder and Borderline Personality Disorder. He has a history positive for 7 serious and nearly lethal suicide attempts. Charles' last suicide attempt, an attempted hanging, prompted his entering treatment with the first author.

Client Family History

Charles' mother died from an overdose of cocaine. His father was a recovering addict and lived in a half-way house. Charles saw his father about once a year. He has two brothers. One brother was a drug dealer and had been extremely physically and emotionally abusive to Charles. His oldest brother lived out of state and wanted Charles to move in with him and attend a local college.

This was Charles's first admission to a sexual offender residential treatment program, although he was incarcerated in two separate juvenile detention facilities. He had a two year history of progressively increasing initial and midstate insomnia, mood variation, dysphoria, and difficulty concentrating.

From age 2, Charles was sexual abused by a family friend until he was 10 years old. He stated that they participate in 9 to 10 total incidents he fondled her vagina and she fondled his penis. He was forced to have sex. He also sexual abused an 8 year old neighborhood girl, when he was 4. Charles also forced his primary victim to perform oral sodomy on him, he started with sex play while they fondled each other through their clothing, and partly naked. He hasn't disclosed this information with any one other then his therapist.

Charles was physical abused by his grandmother, he was beaten with electrical extension cords, fishing pole and "any thing else they could get their hands on". He was told that this was discipline and that not abuse. He experienced emotional abuse as the result of from his mother and brother who were drug addicts. He started to "walk the streets" at the age of 14 for a year coming home "only to shower".

Charles preformed at the normal grade level at school, but he required increased structure and individualized attention. Charles has a history of repeated violations of school rules and disruption in class. He often was aggressive and often cut school.

Diagnosis

Axis I:	Major Depression, Recurrent and Specified Post Traumatic Stress Disorder Sexual Abuse of a Child (victim and offender issues) Conduct Disorder
Axis II:	Personality Disorder, NOS - Mixed Features of borderline, antisocial, histrionic, avoidant, and narcissistic
Axis III:	
Axis IV:	Problems with primary support system, the social environment, educational problems.

Axis V: Highest GAF past year: 43
Current GAF: 61
Admission GAF: 43

Mode Deactivation Therapy (MDT) Case Conceptualization

Underlying the MDT methodology is the MDT Case Conceptualization. MDT Case Conceptualization is a combination of J.S. Beck's (1995) case conceptualization and Nezu, Nezu, Friedman, and Haynes's (1998) problem solving model, with several new assessments and methodologies recently developed to address the specifics of adolescents. Conceptualizing a case is a fluid and dynamic process (J.S. Beck, 1995). Many therapists "dismiss case conceptualization as an abstract exercise" (Friedberg & McClure, 2002). Although, as Friedberg & McClure (2002) have observed, conceptualizing a case is "one of the most practical tools" clinicians can use. The case conceptualization not only helps the clinician to have a clear idea of developing a treatment plan, but it can also aid in diagnosing a client (Friedberg & McClure, 2002). The goal is to provide a blueprint to treatment within the case conceptualization.

Case conceptualizations include the presenting problems, test data, cultural issues, history and development, cognitive issues, and behavioral issues (Friedberg & McClure, 2002). The MDT Case Conceptualization takes conceptualizing a case a step further. The MDT Case Conceptualization helps the clinician examine underlying fears of the youth. These fears serve the function of developing avoidance behaviors in the youngster. These behaviors usually appear as a variety of problem behaviors in the milieu. Developing personality disorders often surrounds underlying post traumatic stress disorder (PTSD) issues. The MDT Case Conceptualization method provides an assessment for the underlying compound core beliefs that are generated by the developing personality disorders; it is known as the Fear Assessment.

Thus far, preliminary results suggest that this typology of youngsters have a conglomerate of compound core beliefs associated with personality disorders. This conglomerate of beliefs may be a personality disorder reason why many youngsters fail in treatment. One cannot treat specific disorders, such as aggression, without gathering these conglomerate beliefs. It is also apparent that these beliefs are not cluster specific as suggested by Beck, Freedman, Davis and Associates, 2004. That is to say, that the conglomerate of beliefs and associated behaviors contains beliefs from each cluster that integrate with each other. Because of this complex integration of beliefs, it makes treatment for this typology of youngster more complicated. The conglomerate of compound core beliefs represents protection for the individual from their vulnerability issues, which may present behaviors that interfere with treatment. The conglomerate of beliefs and behaviors is consistent with schema therapy's categories of maladaptive modes (Young et al, 2003), although this acknowledges the complexities of these modes to allow for more individualized, specific identification through identifying the understanding beliefs and corresponding behaviors for the individual. The conglomerate of beliefs and corresponding behaviors serves to sort out the schemas of each individual. In contrast to Young, et al's (2003) schema therapy, MDT does not label the client's modes. Rather, MDT recognizes that modes are fluid and ever changing and therefore, they are not categorized.

The attempt to use the usual didactic approaches to treatment, without addressing these beliefs amounts to treatment interfering behavior on the part of the psychologist, or treating professional, is not empirically supported and counter-initiated. The MDT Case Conceptualization is a schematic representation of A.T. Beck's (1996) theory of modes combined with Apsche and Ward Bailey's (2003) interpretation of the applied methodology of Linehan's (1993) DBT, and

Kohlenburg and Tsai's (1993) FAP. It is intended to provide the blueprint for treatment for the youngster. The MDT Case Conceptualization provides a functional treatment methodology that integrates into the treatment plan.

The MDT Case Conceptualization also provides a methodology to identify and address the reactive adolescent's emotional dysregulation. The emotional dysregulation refers to the Linehan (1993) model of the Borderline Personality Disorder (BPD) emotional dysregulation, integrated with the Reactive Conduct Disorder (Dodge, et al, 1997).

MDT Case Conceptualization offers a step-by-step methodology to implement MDT. The MDT Case Conceptualization becomes the basis for implementing MDT methodology. Additionally, MDT offers specifically designed assessments, Fear Assessment, Compound Core Belief Questionnaire (CCBQ), and the Typology Survey, which are the basis of completing the MDT Case Conceptualization. All of these assessments have been tested for validity, reliability, and effectiveness. The results of statistical analysis of these assessments will be presented in future articles by the authors of this paper.

Charles' Fear Assessment Results

Results from the Fear Assessment suggest that Charles is an individual who has anxiety and fear that relates to external areas or things outside of himself, over which he has little or no control. Endorsed fears indicate that Charles' behavior is in response or reaction to external stimuli, which he perceived as threats. This appears to validate his history of sexual abuse and strong family enmeshment. He endorsed fears of being emotionally alone, trusting anyone, going to bed/being alone, someone coming up behind him, confronting his abuser, being physically hurt for no reason, his feelings and emotions, hurting someone and loosing control, not being masculine enough, being weak, that they will know his secret and failing. These fears are matched with corresponding beliefs to complete the Trigger, Fear, Avoids, Beliefs (TFAB) worksheet.

The Compound Core Beliefs Questionnaire (CCBQ) suggests that Charles has a personality disorder NOS – with mixed features of borderline, paranoid, antisocial, histrionic, and narcissistic. He endorsed numerous beliefs of the borderline personality. Many of these beliefs appear to have gone untreated by the previous therapists. Examining his beliefs indicates that Charles' sexual aggression and oppositional behavior are related to his dichotomous borderline beliefs and emotional dysregulation. He endorsed the following compound core beliefs as occurring always: "If I am not loved, I am unhappy," "If I don't do it, it won't be done right," "I can not trust others -- they will hurt me," "If I trust someone today, they will betray me later," "If I let others know information about me, they'll use it against me," "When I'm bored, I need to become the center of attention," "If I act silly and entertain people, they won't notice my weaknesses," "When I hurt emotionally, I do whatever it takes to feel better," "When I'm in pain, I'll do whatever I need to do to feel better," "I deserve admiration and respect, whether I work for them or not, others don't deserve recognition," "I try to control myself and not show my grieving, loss, and sadness, but eventually it comes out in a rush of emotions," "When I'm angry, my emotions are extreme and out of control," "If I'm afraid something will be unpleasant, I will avoid it," "If I'm not on guard, others will take advantage of me," "Weaker people are here for the strong to prey on, using any means I can," "Only I count, others are there to fill my needs," "If something makes me feel good, I do what I want," "If you annoy me, I'll go off and let you know it."

Case Conceptualization

The MDT Case Conceptualization is typology driven and individualizes the treatment based on empirically based assessment. The MDT Case Conceptualization also provides a methodology to address the reactive adolescent emotional dysregulation. The typology of these adolescents often demonstrates aggressive and destructive reactions through emotions to threats or perceived threats. The case provides the structure of the conglomerate of beliefs and behaviors to address the dysregulation by balancing the beliefs.

The conglomerate of beliefs and behaviors identifies behaviors that correlate with beliefs and is the structure needed to work with the youngster. This provides a method to relate the emotional dysregulation to the beliefs. The goal is to teach the youngster to balance beliefs by recognizing that they activate the emotional and behavioral dysregulation.

Once the information is gathered and the case is formulated, the client and the therapist collaboratively develop the Conglomerate of Beliefs and Behaviors (COBB). The collaborative nature of this process allowed Charles an opportunity to gain trust in his therapist as well as in himself. By empowering him to actively participate in the development of his MDT Case Conceptualization and the course of his treatment, he became significantly more motivated in participating in his treatment. Charles remarked as to the amount of his beliefs, which tended to correspond with most of his negative behaviors. He demonstrated insight, recognizing that resolving his compound core beliefs would enable him to address his negative behaviors. He was pleased with this realization and expressed optimism for true change and relief.

The Conglomerate of Beliefs and Behaviors (COBB) is the crux of treatment for the client. Once he collaboratively validates the Triggers→Fear→ Avoids→ Compound Core Beliefs (TFAB) and begins this form, he helps validate his behavior responses that are congruent with his compound core beliefs.

The COBB remains with him throughout treatment and is the basis for all of his work in the MDT Workbook. Charles recognized that these beliefs could be activated throughout his lifetime and he continually works to deactivate his fears, by balancing his beliefs. The MDT Case Conceptualization includes a situations worksheet, real life examples, to test the "hypotheses" developed with the COBB and TFAB.

After completing the COBB and TFAB, the MDT Case Conceptualization moves to address mode activation and the deactivation of modes. Following through the mode activation worksheet and inserting the already identified information into the appropriate boxes, Charles' experience became clearer. By providing a visual representation, the worksheet clearly demonstrates the overwhelming nature of Charles' cognitive system (preconscious processing, perceptions, beliefs, motivational schema), physiological system, affective schema, and behavioral schema all activating simultaneously. The deactivation of Charles's modes was evident. Addressing his unbalanced, dichotomous beliefs, would prevent the rest of the sequence from occurring. This meant that by balancing his beliefs, Charles could prevent his negative behavior from happening.
If Charles perceived that he could be in a situation where he may be confronted or reprimanded, his anxiety would increase and he would emotionally shut down. Anticipating the confrontation set in motion the cognitive, affective, behavioral, and physiological processes.

Although Charles may not be consciously thinking about confrontation (and may actually be focused on another activity), an attempt to elicit his thought at this point would generate the same information as if he were actively thinking about the anticipated event. He would express

anger about the upcoming perceived confrontation or attack on his vulnerability and he would be able to discuss that he has a dichotomous belief that had been activated. He would be able to identify the fear that was endorsed related to his anger and that he perceived physical danger from the perceived upcoming situation.

As the time of the perceived confrontation nears, he would have a conscious fear or threat of being a victim and was also fearful that he would become verbally and/or physically aggressive to protect himself. The situation appeared threatening (real or perceived) based on his life's experiences. He was fearful of his own actions in this situation and worried that he would later feel humiliated by the outcome of the situation.

At a later time, when Charles is no longer confronted with the dangers of the situation, he is not experiencing the fears of the perceived situation. The distance from the dangerous situation represents the Woody and Rachman, (1994) concept of a "safety signal." When the parameters of the same situation recur the pattern of fears ↔ avoids beliefs is repeated.

Reviewing the fear reaction pattern in Charles, using A.T. Beck's (1996) analysis of modes, the activating circumstances are directly related to the anticipated event and the perception of the re-victimization of the meeting. These circumstances are processed through the orienting component of the "primal mode relevant to danger" -- the imagined risk of being victimized, beaten and letting someone else control him. As this related fear is activated, the various systems of the mode are also activated and energized. During the physiological manifestation of the activation of the mode, Charles becomes tense, grinds his teeth, has involuntary muscle movements, increasingly intense headaches, tightened facial muscles, his hands and legs shake and move around, anxiety increases, and his fists may tighten.

The actual progression of the mode activates as Charles nears the time of the group or meeting, i.e., his orienting schemas signal danger ahead. This system is based on the perception of danger of victimization/ vulnerability and is sufficient to activate all the systems of the mode. The affective system generates rapidly increasing levels of anxiety; the motivational system signals the impulse and the flight/fight signal, increasing the attack or avoid and the physiological system, which produces the following: grinding of his teeth, involuntary muscle movements, tachycardia, etc.

Charles became aware of his distressing feelings at this point and he is often unable to activate his own cognitive controls, or "voluntary controls" to override this "primal" reaction to be able to mediate the conflict. Once he is able to mediate the fears and avoidance, he is able to participate in a supportive meeting and the anxiety begins to de-escalate.

Charles' interpretation of his physiological sensations magnifies his fears of the anticipated physical and psychological re-victimization. Throughout the process of the feedback that he received from his bodily sensations, the flush anxious feelings, the powerful fear of loss of control and the sequel of physiological responses develops the fear of yelling and screaming and potential aggression and a disastrous situation. This fear is compounded by the events that led to another fear, which is the fear of feeling humiliated by the perceived threat of victimization/ vulnerability and loss of control in the presence of other people.

The final step in the MDT Case Conceptualization is completing the Functionally Based Treatment Development Form. This form literally walks the client through how to balance dysfunctional beliefs and attempt to consider a more functional "healthy belief". The form is written from left to right demonstrating to the therapist each step in the process of developing

competing beliefs for the youngster. First, the therapist identifies the new healthy beliefs, then identifying the thoughts that will reinforce the new beliefs, developing compensatory strategies, reinforcement of behaviors, and most importantly, the V-C-R for each new healthy belief. The form is implemented right to left, beginning with the V-C-R to develop new thinking, new behaviors, and new beliefs. The therapist breaks the process into the smallest steps necessary, by actually completing a task analysis on the client's potentially healthy competing beliefs. The therapist and the client have a scripted methodology for the youngster and his parents or staff to follow in aiding him in developing new beliefs, one step at a time.

An integral part of MDT is the concept of validation, clarification, and redirection (VCR). Validation was defined by Linehan (1993), as "the therapist's ability to uncover the validity within the client's beliefs." The grain of truth reflects the client's perception of reality. The truth in this reality needs to be validated to clarify the content of his responses, and also to clarify the beliefs that are activated. It is important to understand and agree with the "grain of truth" in the clarification.

Redirect responses to others to other views or possibilities on his or her continuum of truths are important. There are numerous continuums implemented, as scales from 1 to 10 to evaluate areas such as truth, trust, fear, and beliefs. These continuums are essential to MDT in that they give both the client and the therapist an empirical measure of the client's measured perception of truth.

Teaching a youth who often engages in dichotomous thinking that their perception can fall within the range of a continuum, rather than only a 1 or a 10 scale (all or nothing), is extremely validating and it is the basis for a positive redirection to other possibilities for the client. This is a form of MDT mindfulness. The youngster is trained to be aware of how he feels at each movement. Being aware of his feelings is essential for the youngster to accept honesty his behavior in the moment.

In Charles' case, he was able to develop healthier beliefs due to his therapist and all staff members working with him using the V-C-R as described in his treatment plan, originating from his Functionally Based Treatment Development Form. For example, take Charles' belief about not being able to trust anyone outside the family. Validating his fears of trusting anyone outside of the family, clarifying that he could trust one person outside the family at a time, and redirecting him to use the trust scales to objectively to measure his level of trust for others allowed Charles to open his mind to possibilities, thereby balancing his beliefs about trust. The process also taught Charles how to balance his beliefs for himself. As a result, he developed a new belief, to trust some people some of the time.

Summary

This case study suggests that in at least this case, MDT was helpful in reducing lethal suicide attempts. The authors do not suggest MDT is effective in treating adolescent suicide without further rigorous study.

However, MDT might hold some promise in treating adolescent males with PTSD, CD and personality disorders, who engages in lethal suicide attempts. It is hoped that the results of this case study might prompt further study in a carefully monitored and controlled study.

Charles was discharged from treatment and moved with his brother in another state. Charles is currently attending a university, and reports that he has not attempted suicide since the

lethal attempt that landed him as a client of the first author. He also reports that he uses his "balance the beliefs" regulating exercise.

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Author Information;

Jack A. Apsche, Ed.D., ABPP.,
Apsche Center for Evidenced Based Psychotherapy
111 South Main Street,
Yardley, PA 19067.
ApscheCenter@Comcast.net ; jackmdt@aol.com
www.ApscheCenter.com
(215) 321- 4072

Alexander M. Siv, M.A.
Brightside for Families and Children
2112 Riverdale Street
West Springfield, MA 01089
Alexander.siv@sphs.com; alexmsiv@hotmail.com
(413) 827-4327

Current Behavioral Models of Client and Consultee Resistance: A Critical Review

Joe Cautilli, St. Joseph's University & Children's Crisis Treatment Center,
T. Chris Riley-Tillman, East Carolina University,
Saul Axelrod and Phil Hineline, Temple University

Abstract

Resistance is the phenomena that occurs in the therapeutic relationship when the patient refuses to complete tasks assigned by the therapist which would benefit the patient in improving their psychological situation. Resistance is also used to describe situations in the consulting relationship where the consultee does not do what the consultant suggests. Often resistance leads to poor treatment integrity and/or staff burn out. As a result, this resistance is a factor that warrants a behavioral interpretation and investigation. Currently several behavioral models of resistance exist. In this paper, we explore each of these models and critique the logical and empirical support. Future research directions will be discussed.
Key words: Resistance, Behavioral Models, Functional Assessment, Consultation

Introduction

The functional analysis of verbal behavior began in 1945, with the publication of the Harvard Symposium on Operationalism in Psychological Review. In paper by B.F. Skinner entitled "The Operational Analysis of Psychological Terms" it was argued that by observing the contingencies and setting conditions under which a verbal community typically used the ordinary language terms, the interpreter could interpret the terms in a descriptive functional assessment. This approach is critical to the scientific investigation of events that on the surface may not appear to be readily available to a behavioral interpretation or behavioral research (Leigland, 1996). Leigland lamented that behaviorally oriented clinicians have done little research on terms that have been important to non-behavioral clinicians.

One term, which appears to have importance to traditional clinicians and consultants, is "resistance". Resistance can be defined as anything that a client or consultee does that impedes progress (Wickstrom & Witt, 1983). What is termed resistance in consultation can have serious implications for treatment integrity (Wickstrom, Jones, LaFleur & Witt, 1998). Resistance to change in verbal therapies and consultation is a phenomenon that has substantial representation (Cautilli & Santilli-Connor, 2000; Patterson & Chamberlain, 1994) with some early discussion within the behavioral literature (e.g., DeVoge & Beck, 1978; Skinner, 1957). Resistance appears to interest a broad spectrum of clinicians both behavioral (e.g., DeVoge & Beck, 1978; Lazurus & Fay, 1982) and non-behavioral (e.g., Mandanes, 1981) in orientation. However, supporting data are lacking to most of the theoretical conceptualizations including behavioral interpretations (Patterson & Chamberlain, 1994).

In deconstructing resistance or conducting an analysis of its use, behavioral psychologists find therapists and consultants use the word in the context of therapeutic failure. For example, Dougherty (2000) refers to resistance as a consultee's failure to participate constructively in the process of consultation. Resistance can occur in the treatment relationship, where the client does not improve or, in the consulting

relationship, where the consultee fails to implement the treatment. The clinical literature is replete with examples from different traditions of techniques to manage this problem if it arises in the therapeutic context (e.g., Spinks & Birchler, 1982). In one study using regression analysis, Patterson and Chamberlain (1994) showed that parental resistance to parent training reduced therapist effectiveness and these parents showed fewer improvements in discipline.

As pointed out by Cautilli and Santilli-Connor (2000), the term resistance is often used to describe a relationship in which the client, or in the case of consultation, the consultee, does not comply with the tasks that the therapist or consultant suggests. A review of the literature shows that many factors increase the probability that a consultee will be "resistant." One of the important aspects of this suggestion is that resistance can affect treatment integrity. That is, when the consultee does not do what the consultant asks, the consultee is less likely to carry out treatment as designed.

Why Study the Effects of Resistance?

Resistance is common to practicing school psychologists (Hyman, Winchell, & Tillman, 2001; Tingstrom, & Edwards, 1989; Witt, 1986). Resistance can be either an overt or covert process (Butler, Weaver, Doggett, & Watson, 2002) but either way can result in poor treatment integrity (Gresham, MacMillian, Beebe-Frankburger, & Bocia, 2000; Sterling-Turner, Watson, Wildmon, Watkins, & Little, 2001). Thus, a comprehensive approach to increasing treatment integrity should include training school psychologists in methods to lessen resistance.

Treatment integrity, and hence resistance, is critical because the benefits of consultation is based on consultee's ability to implement the selected intervention with integrity (Galloway & Sheridan, 1994). In addition, the ability to determine overall treatment efficacy and effectiveness depends largely on whether the consultee shows high treatment integrity. The question is "Do teachers do what the consultants suggest need to be completed?" If the consultee does not implement that intervention as intended, it is difficult to determine the cause of any resulting outcomes (Gresham, 1989; Gresham, Gansle, Noell, Cohen, & Rosenblum, 1993; Sterling-Turner et al., 2002). \

This line of questioning has led to research to determine interventions that produce less resistance and greater treatment integrity. For example, Busse, Kratochwill, & Elliot (1999) provided evidence for the predictive validity of behavioral interviews and treatment outcomes. Using a series of multiple regressions, they looked at specific verbalizations on a behavioral consultation coding scale observing their affect on teachers' perception of the consultant effectiveness, treatment outcomes, and single case effect sizes. They found that the behavioral consultation model accounted for about 30% to 34% of the variance in the consultation process. Providing more direct evidence, Bergan and Kratochwill (1990) and Sheridan, Dee, Morgan, McCormick, and Walker, (1996) found that the consultation process can produce high treatment integrity among consultees. Several researchers have tried to identify the specific techniques that promote high treatment integrity. Multiple suggestions have resulted from that line of study. These suggestions include the consultant: (a) making use of treatment scripts for the consultee

to follow (Erhardt, Barnett, Lentz, Stollar, & Reifin, 1996); (b) implementing consultee goal-setting and feedback procedures (Martens et al, 1997); (c) incorporating performance feedback interviews (Noell, Witt et al., 1997); (d) directly training teachers on treatment integrity for each intervention (Sterling-Turner, Watson, & Moore, 2002); and (e) making use of interventions that have high treatment acceptability for the teachers (Finn & Sladeczek, 2001; Riley-Tillman & Chafouleas; 2003; Rones & Hoagwood, 2000). Thus, resistance may function to lower treatment integrity and may influence the effective treatment of children's behavioral problems. If this is the case, then a functional analysis of resistance may lead to effective interventions, to lessen resistant behaviors, and to greater integrity of treatment.

Defining consultation

Behavioral consultation is a major role for school psychologists (Fagan & Wise, 2000) and behavior analysts. Traditionally, school psychologists define consultation as a relationship where the consultant works with the consultee to change the behavior of the client (Bergan & Kratochwill, 1990). As Erchul and Martens (1997) observed, consultation is an indirect service delivery model, where two people focus on the problem of a third. This contrasts with psychological therapy in which the therapist uses himself or herself as the instrument of behavior change. Consultation differs as a service delivery model from therapy in that in consultation, the consultant works with the consultee to change the behavior of the client, where in therapy the therapist serves as a direct instrument of behavior change (Bergan & Kratochwill, 1990).

Behavioral consultation is a problem solving process (Feldman & Kratochwill, 2003). The basis of the problem-solving interview is to gather information about functional variables (setting, antecedent, sequencing of behavior and environmental consequences of behavior) and skill levels (through curriculum based assessment and other methods) (Bergan & Kratochwill, 1990). In short, behavioral consultation is a problem solving process guided by a comprehensive functional assessment that attempts to generate evidenced based interventions based on the function of problem behaviors. Increasingly, professional support for behavioral consultation grows as federal legislation (IDEA, 2004) mandates the use of functional behavioral assessment and positive behavioral support for special education students with behavioral problems (Crone & Horner, 2003; Watson & Steege, 2003).\

Behavioral and Cognitive Behavioral Models of Resistance

Some argue that resistance may just be a reflection of the consultant's failure to give consultees the skills to perform the tasks requested by the consultant (Cautilli & Santilli-Connor, 2000; Watson & Robinson, 1996). Others argue that the consultee had "erroneous ideas" about consultation (Cautilli & Santilli-Connor, 2000; Watson & Robinson, 1996). These explanations, while being correct in some cases, tend to focus on skills deficits to the exclusion of potential motivational deficits. On the motivational end, Williams (2002), drawing on Golddamond's (1974, 1975) constructional approach, argued that resistance is idiosyncratic and a useless concept. He argues that if the client is

not collaborating, then the therapist needs to determine the function that the client's behavior is serving. A comprehensive behavior analytic model should give an analytic account integrating both facets of motivation and skills deficits. If this analytic model has psychological reality, then synthesis of these behaviors should produce the phenomena (Catania, 1992).

As with other phenomena such as generalization (Riley-Tillman & Eckert, 2001; Tillman, 2001), conceptual models on resistance are important. Several models presently exist (e.g., Alford & Lantka, 2000; Cautilli & Santilli-Connor, 2000; Munjack & Ozial, 1978; Patterson & Fogatch, 1985; Skinner, 1957). Although some of these models are more comprehensive, considerable overlap exists between models. For example, Cautilli and Santilli-Connor (2000) drew on Daly, Witt, Martens & Dool's (1997) model of why academic behavior does not occur, as the basis for developing a competing behaviors' model for the functional analysis of resistance in clients. A competing behaviors model identifies the current performance level, as well as a desired behavior. The goal of the model is to make the alternative behavior functionally equivalent to the behavior that one seeks to replace, and then make the behavior that one wants to replace, less efficient. The authors hypothesized that resistance can come from establishing operations, history effects, and antecedent and consequence relations. They considered six factors critical to resistance. These were (a) consultant setting factors; (b) client motivation to perform the task; (c) the amount of practice to build fluency in skill; (d) assistance in implementing the skill under non-ideal environmental conditions; (e) retroactive interference in which old learning blocks the acquisition of new learning; and (f) complexity of the skill that is being required to be performed. The older Munjack and Oziel (1978) model draws on clinical experience of resistance to homework completion during sex therapy. This model proposed five reasons for resistance: (a) poor patient understanding of what is to be done, (b) specific patient skills deficits, which block performance, (c) lack of motivation or poor expectations for success, (d) anxiety or guilt mobilized from the treatment setting, and (e) secondary gain from positive reinforcement for displaying alternative behavior. Both of these models link interventions to the specific type of functions that resistance may serve. Both models place equal emphasis on relational as well as task factors. While these two models have several areas of overlap, only formal testing will determine if they are distinct. Two questions remain as to whether these models can be added or integrated into each other, or if they are really discussing the same issues. Unfortunalty, to date neither of the two models has generated research to support or reject its basic tenets.

In his book, Verbal Behavior, Skinner (1957) discussed the historic factors that may lead to resistance. He links these factors to the psychotherapeutic techniques that a therapist might use to lessen resistance. For example, Skinner (1957) discusses that a history of punishment of various verbal "themes" is important. Due to this history of punishment, the client's expressions of those themes are less likely to occur and the client appears "resistant" to the therapist. For example, the client who may come from a strict religious background may have experienced punishment for discussing sexual matters and, thus, may be reluctant to discuss such matters with his or her therapist. Skinner (1957) discussed the importance of a psychotherapist's passive acceptance of client

verbal behavior to produce a "release," which allows the client to become "more open" to their verbal behavior. While this form of intervention might be good for emotionally avoiding patients (Hayes, Strosahl, & Wislon, 1999; Kohlenberg & Tsai, 1991), it may not be beneficial to other types of clients. For example, as this author will discuss later, in parent training with conduct disorder children, Patterson and Chamberlain (1994) showed how the therapist becoming more accepting and supportive leads to unfavorable outcomes. This occurs because the therapist slows the teaching process and therapeutic process down. This slowing lessens the overall consultee progress and as a result, the consultee does not acquire adequate skills by the end of treatment. This differential use of support leading to drastically different outcomes, underscores the importance of interventions based on function when dealing with "resistance."

Skinner (1957) discusses how the exploration of client "themes" in verbal behavior may be helpful in determining the historical consequential factors, which leads to resistant behavior. In addition, Skinner (1957) does not discuss within-session factors that might produce "resistance"; however, he does hypothesize that passivity on the part of the therapist will reduce resistance. This hypothesis, as will be later stated, has some support (see review of Patterson & Forgatch, 1985). As already noted however, sometimes passivity of the therapist, while reducing resistance, can lead to poor clinical outcomes (Chamberlain & Patterson, 1994).

In a somewhat different vein, Alford and Lantka (2000) in a study of resistance attempted to link behavioral processes with presumed cognitive functions. Thus, they attempted to link behavior from the behavior-environment scale of analysis with a presumed cognitive-affective underlying process. They identify two forms of resistance: (a) persevering when one should not, and (b) quitting when one should not. The former they exemplify by continuing to act in a manner that is dysfunctional over the long term but rewarding in the immediate. The latter, they hold as refusing to complete things like homework assignments, missing sessions or otherwise undermining treatment. These two forms of resistant actions would result in long-term consequences. This model sees resistance as a problem with task avoidance rather than a relational problem. This is different from the previous models discussed, where most of the focus of the model is on the nature of the instructions given and the role of the therapist in rendering consequences as the major role. Indeed, the only mention of resistance from this relational standpoint of the therapist's role is in the form of collateral contingencies created by the therapist who is giving the instructions, or, as Cerutti (1989) would call it, "rule-governed behavior." For example, if a therapist tells a client to complete a homework assignment confronting a task that the client is avoiding, the client is now under control of the aversive task but also under control of collateral relational contingencies of the therapist (i.e., therapist may be disappointed). To summarize, the Alford and Lantka (2000) model places primary focus on the task that the client is avoiding and less on the contingencies of the therapist-client relationship, which are central to the other models.

The Alford and Lantka (2000) model hypothesizes that the avoidance of therapist or consultant suggestions is immediately reinforced by escape from a difficult task. However, they point out that co-varying the tasks will produce long-term gain. The

inherent conflict is small immediate negative reinforcement or long-term positive rewards. Drawing on cognitive theory, the model holds that the patterns are primarily cognitive-affective-behavioral processes and are automatic in their functioning. For example, first, the person thinks, "I can't do this." Next, the person gets angry or afraid. Finally, the person avoids the task. While this model has appeal because of its greater focus on the types of tasks that produce resistance, the model has not received any research to this point to either confirm or reject its basic tenets (i.e., does task avoidance increase resistance in consultees). In addition, it remains unclear if the synthesis needs to remain for either of the two basic tenets to stand. For example, the cognitive-affective theorizing can stand independently of a behavioral explanation, and the explanation based on contingency history can stand independent of the cognitive description. Finally, while the authors view the model as more inclusive because it hypothesizes cognitive variables, one can question, "What is added by these variables to either explanation by the inclusion of the other?" The answer to this is not clearly stated.

In a similar model, Fuchs and Fuchs (1996) hypothesized resistance is often encountered by teachers based on rules they have developed about school reform. For example, if a teacher believes that s/he should not have a child in his or her class because s/he is a regular education teacher, then s/he is more likely to be resistant. In a related analysis of resistance, Hyman and colleagues (2001) found that matching teacher's rules about client misbehavior to intervention could lessen the amount of resistance experienced. The Hyman and colleagues (2001) study used only three teachers and results were variable.

Studying the rules, contingencies, meta-contingencies (Glenn, 1988) and their interlocking patterns (Cautilli & Hantula, 2002) acting on the teacher and the consultant could have a powerful impact on practical organizational behavior management (OBM) interventions to improve education for students, as it has in social services. For example, Ivancic, Reid, Iwata, Faw, and Page (1981) evaluated a behavioral supervision program designed to incorporate language training into the routine care of people with developmental disabilities to increase treatment integrity. The supervisor used prompts and feedback to train seven direct care staff to use four language-training techniques. They showed that increased use of the techniques occurred with six of the staff. Supervisory feedback was faded without decreases in staff performance during a maintenance condition. Yet, these types of interventions are outside the domain of intervention that a school psychologist can render. While this model does have some practical appeal and parallel literatures support this type of intervention, little research exists in this area, unlike the next model.

By far, the most explored position on resistance is that of Gerald Patterson and his colleagues at the Oregon Social Learning Institute (OSL). The OSL group developed its model in training parents of children with conduct problems. They acknowledge that the model that they developed might not generalize to other populations. Their model predicts that: (a) history of defeat in changing the child's behavior (b) parent traits such as depressed or antisocial, (c) contextual factors such as stress and social disadvantage and (d) therapist behavior such as teaching and confronting and the frequency and

intensity with which the teaching and confronting behavior was used, would all predict resistance.

Research on the OSLC model of Resistance

Patterson studied resistance as it occurred in parent training sessions. Parent training may be a good place to start a study of resistance because, according to O'Dell (1982), in parent training therapists only rate 25% of clients as "easy". In addition, experienced therapists are more successful in keeping families in parent training than novice therapists (Frankel & Simmons, 1992), as well as motivating, confronting and supporting parents through parent training (Barkley, 1997; McMahon & Wells, 1998). Readers can then conclude that parent training might be a therapeutic area that entails a lot of "resistance." In one study, Patterson and Forgatch (1985) explored the impact of therapist behavior (the independent variable) on client resistance (dependent variable). These researchers used an ABAB experimental design and observed the resistance displayed by parents in parent training for two conditions. The baseline involved the therapist using verbal behavior to convey "support" or "facilitate" (short statements indicating attention or agreement). In the treatment phase, the behavior of the therapist was "to confront" and "to teach." Resistance was measured by a coding system developed by Patterson and colleagues (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984) which identified as resistant such behaviors as talking over/interrupting, challenging/confronting, negative attitude, "own agenda," and "not tracking" as resistant. As the model predicted, "teaching" and "confronting" led to increases in resistant behavior, while "facilitate" and "support" led to decreases in resistant behavior.

In Patterson's model, resistance serves three main functions: (a) it reduces the amount of confrontation, teaching, or support that the consultee is given; (b) it increases the number of sessions needed to bring about therapeutic change; and (c) it reduces the therapists' "liking" for the consultee. The OSL group hypothesized that resistance would be lower in the beginning of therapy and then gradually increase as the therapist made more suggestions or attempts to teach techniques for change. As parents became more familiar with the techniques and began to experience some success with the interventions, resistance would gradually lessen. The model predicted an upside down U-shaped curve. Patterson and colleagues at OSL refer to the intervention, as the struggle-with-working-through hypothesis. Stoolmiller, Duncan, Bank, and Patterson (1993) set out to test this hypothesis by using a quadratic growth model formula. Stoolmiller and colleagues (1993) used the formula to test the goodness of fit of the model. Since their model predicts that resistance is low in the beginning of therapy, they looked for low resistance in the beginning of treatment as the therapist built rapport and began to understand the child's problems. In the second phase of their model, they predict that the therapist will begin to make demands. Thus, they hypothesized an increase in resistance. As parents became more successful with the techniques, a third phase would occur. In this third phase, the OSL group hypothesized a lowering of resistance due to the success the parents had with the interventions.

Drawing from a clinical sample of 68 mothers, Stoolmiller and colleagues (1993) studied whether resistance followed the quadratic model. They randomly assigned mothers to either a community eclectic treatment (n=14), which was a mixture of Adlerian therapy with structural family therapy, or to the behavioral parent-training group (n=53). Using latent growth curve modeling to test the hypotheses of the OSL model, Stoolmiller and colleagues (1993) reported the models predictions matched what they observed. They concluded that parent training tends to see sessions of increased resistance to a point in training, then a decrease in resistance, presumably, as the parents begin to achieve some success with the training. This model was predictive of therapy outcome as compared to a linear model of resistance. However, not all mothers followed this pattern. Indeed, some mothers stayed highly resistant or showed increasing resistance through the entire training series of sessions.

Patterson and Chamberlain (1994) followed up on these findings. They found in cases where the mother's resistance did decrease, greater gains were evident in parental discipline. In addition, regression analysis showed that decreasing "resistance" leads to more teaching of the parents and, in turn, decreases future arrests of the child. Patterson and Chamberlain (1994) correlated increases in parental resistance with contextual variables such as parental pathology and therapist interventions. Thus, through a decade of research, the OSL group has shown that therapist behavior can lead to an increase in client resistance (Chamberlain & Patterson, 1994; Patterson & Forgatch, 1985). This resistance follows a struggle-with-and-work-through pattern (Patterson & Chamberlain, 1994; Stoolmiller et al., 1993). That is, parents become resistant to using the techniques offered by the behavior therapist until they begin to experience the benefit of those techniques in the child's behavior. At the point of the technique's success, the parents begin to become more complaint.

Finally, Stoolmiller and colleagues (1993) found that resistance mediates parent training effectiveness in which parents, who do not experience a reduction in resistant behaviors, acquire less parenting skills. In addition to acquiring fewer skills, these parents' children experience more arrests in the future (Patterson & Chamberlain, 1994).

Summary and Conclusion

Many behavioral clinicians have studied resistance. Conceptual models exist and offer clinicians much in the lines of theoretical ways to pursue the problem. More research needs to be done to determine the effects of resistance on the consultant in the case of consultation as well as the effects on the therapist in the case of therapy. Future research needs to study the mechanisms of resistance and how they effect both the consultant as well as the consultee.

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Author Contact Information:

Joseph Cautilli
Children Crisis Treatment Center
1823 Callowhill Street
Philadelphia, Pa. 19130
1-215-496-0707, ext. 1166...
jcautilli@cctckids.com

T. Chris Riley-Tillman
East Carolina University
Department of Psychology
Rawl Building
Greenville, North Carolina 27858-4353
252-328-6800
crileytillman@yahoo.com

Saul Axelrod
Temple University
13th Street & Cecil B. Moore Avenue
Philadelphia, Pa. 19122
1-215-204-6060
axelrod@astro.ocis.temple.edu

Phil Hineline
Temple University
13th Street & Cecil B. Moore Avenue
Philadelphia, Pa. 19122
1-215-204-7000
hineline@astro.ocis.temple.edu