INDEX OF TREATMENT PROCEDURE OUTLINES
DR. AZRIN

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early as is feasible. (See also Standard 4.08, Interruption of Services.)

(f) If the patient, client, or other recipient of services does not pay for services as agreed, and if the psychologist wishes to use collection agencies or legal measures to collect the fees, the psychologist first informs the person that such measures will be taken and provides that person an opportunity to make prompt payment. (See also Standard 5.11, Withholding Records for Nonpayment.)

1.26 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists accurately state the nature of the research or service provided, the fees or charges, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standard 5.05, Disclosures.)

1.06 Basis for Scientific and Professional Judgments

Psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors.

2. Evaluation, Assessment, or Intervention

2.01 Evaluation, Diagnosis, and Interventions in Professional Context

(a) Psychologists perform evaluations, diagnostic services, or interventions only within the context of a defined professional relationship. (See also Standard 1.03, Professional and Scientific Relationship.)

(b) Psychologists' assessments, recommendations, reports, and psychological diagnostic or evaluative statements are based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings. (See also Standard 7.02, Forensic Assessments.)

2.02 Competence and Appropriate Use of Assessments and Interventions

(a) Psychologists who develop, administer, score, interpret, or use psychological assessment techniques, interviews, tests, or instruments do so in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information. (See also Standards 1.02, Relationship of Ethics and Law, and 1.04, Boundaries of Competence.)

2.03 Test Construction

Psychologists who develop and conduct research with tests and other assessment techniques use scientific procedures and current professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

2.04 Use of Assessment in General and With Special Populations

(a) Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies of, and proper applications and uses of, the techniques they use.

(b) Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.

(c) Psychologists attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals' gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

2.05 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant reservations they have about the accuracy or limitations of their interpretations.

2.06 Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons. (See also Standard 1.22, Delegation to and Supervision of Subordinates.)

2.07 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Similarly, psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

2.08 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring procedures to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the

Behavioral Assessment Interview

A. 1) What is the problem (that brings you here) for which you seek help?
   2) When did the problem begin? What events were associated with it?
   3) Describe the problem behaviorally. What was a recent example(s)?
   4) How frequently does it occur?
   5) When and in what*situations does it occur?
   6) Under what circumstances is it least likely?
   7) Under what circumstances is it more likely?
   8) Generally, what occurs before and after it?
   9) What are the self-statements (cognitions), feelings, (affect) and physical sensation preceding, the problem episode?
   10) What has been done to change it thus far?
      a) by oneself?
      b) by other professionals?
      c) medications?
      d) what benefit from 10 a-c above?

B. 1) Identify significant others: parents, family, siblings, peers, school
   2) Functional interference by problem: social, vocational, family, educational
   3) Identify major reinforcers: persons, places, tangibles
   4) Experimental functional assessment
      a. Arrange structural situation with differential consequences and settings
         i. patient alone (intrinsic – "automatic")
         ii. caretaker present (social precipitator)
         iii. caretaker provides attention, i.e., "don't do that" (attention)
         iv. caretaker terminates teaching when problem occurs (escape)
         v. caretaker gives tangible reinforcer "to distract" (reinforcer)
      b. Record the rate of problem behaviors under each of above
      c. Reverse the condition identified as causing the problem behavior

References:

Iwata, B.A. et al. (1982). "Assessment and training of clinical interviewing skills: analogue analysis and field replication. Journal of Applied Behavior Analysis, 15, 91-204.

Iwata, B.A. et al. (1994). "Toward a functional analysis of self-injury. Journal of Applied Behavior Analysis, 197-209.

From Iwata, B.A., et al "Assessment & training of clinical interviewing skills: Analogue analysis & field replication." Journal of Appl. Behavioral Analysis, 15, pp. 191-204 (1982)

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Table 1

Therapist Responses Used During Assessment and Training

1. *Gives salutation*—Greets client prior to interview.[1]
2. *Gives name*—States first and last name.[1]
3. *Gives job title*—States that (s)he is a postdoctoral fellow, clinical assistant, etc., in the Division of Behavioral Psychology.[1]
4-7. *Describes clinical functions of division: (a) Identification of client strengths and problems, (b) gathering of specific information about behavior problems, (c) identification of prior treatments and their outcomes, (d) training of parents in alternative treatments*—Outlines services provided by division that differentiate it from other disciplines within the institute (e.g., psychological testing, psychiatry).[1]
8. *Completes/verifies biographical information*—Asks for address, phone number, school, teacher, medical information, family structure.[2,3]
9. *Describes purpose of behavior checklist*—Explains to parents that they will be presented with a list of problems typically treated by the division.[2]
10. *Presents at least 10 checklist items*—Therapist selects and describes problems, asks parents if the item represents a problem for the child/parents.[2,3]
11. *Determines if there are further problems*—Asks parents if they can identify any additional problems not covered by the checklists.[2,3]
12. *Requests problem ranking*—Reviews problems identified by parents, and asks them to rank in terms of priority.[2,3]
13. *Elicits general description of highest priority problem*—Asks parents to provide an example of the problem in terms of observable behavior.[2,3]
14. *Requests additional description*—Using parents' initial comments as a base, asks parents to be more specific regarding instances and noninstances of problem.[2,3]
15. *Requests approval of an operational definition*—Summarizes parents' description as an observable, countable behavior, and asks parents to comment on the accuracy of the definition.[2,3]
16. *Determines onset of problem*—Requests that parents describe when the problem began, along with events that appeared correlated with its onset.[2,3]
17. *Identifies significant dimensions*—Asks parents to estimate frequency, duration, etc., of problem.[2,3]
18. *Identifies antecedents/settings*—Asks parents to describe times, places, events, or persons associated with the occurrence of the problem.[2,3]
19. *Identifies current consequences*—Asks parents to describe what happens after the behavior does/does not occur, and who provides consequences.[2,3]
20. *Notes prior treatments*—Asks parents to describe any prior attempts to deal with the problem and their outcomes.[2,3]
21. *Reviews problem*—Summarizes discussion of problem, requests confirmation, and asks if parents would like to expand on any area.[2,3]
22. *Determines goals of treatment*—Asks parents to specify criteria for successful "problem solution."[2,3] (NOTE: items 13-22 are repeated for additional problems previously identified).
23. *Identifies strengths and reinforcers*—Asks parents to describe things the child does well, likes to do, etc.[2,3]
24. *Conducts direct observation*—When appropriate (e.g., if the problem lends itself to observation during the evaluation), therapist asks parents to engage in one of several activities with the child, and collects data on parent and child behavior.[2]
25. *Describes active treatment program*—When the formal evaluation has been completed, therapist describes goals and requirements of outpatient program, including appointments, parent training, data collection, and homework.[1]
26. *Describes referral service*—Presents alternative options of receiving general recommendations without active treatment, or of receiving referral to another program.[1]
27. *Determines parent option*—Asks parents to select one of the service options described.[1,3]
28. *Initiates data collection procedures*—In an active case, therapist describes home data collection procedures, and prompts verbal commitment to collect data.[2,3]
29. *Completes therapy contract*—In an active case, therapist presents contract specifying therapist and client behavior, and asks parents to sign contract.[1,3]
30. *Schedules next appointment*—In an active case, therapist arranges date and time of next appointment.[1,3]
31. *Informs parents of interdisciplinary conference*—In cases where a number of disciplines are conducting evaluations, therapist explains that final determination of case status will be made at an interdisciplinary conference.[1]
32. *Provides recommendations or referral*—In cases where active treatment will not take place, therapist provides general recommendations and/or makes referral to another program.[1]
33. *Closing*—Escorts parents from room, says, "Goodbye," etc.[1]

[1]Professional courtesy item.
[2]Behavioral assessment item.
[3]Items for which a client response is appropriate.

Treatment of Depression

Cognitive Emphasis: Beck, Ellis
Behavioral Emphasis: Lewinsohn; Hersen; Azrin; McLean & Hakstian; Rehm

	Beh.	Cog.
<u>Reinforcing Activities Priming:</u> Assign Daily Planner, current and new activities	XX	(X)
<u>Behavioral Goal Setting</u> overt activity, specific, "do" vs. "don't", record	XX	
<u>Functional Behaviors relevant to cause of depression</u> Behavior marital therapy, vocational (job counseling) Educational (Study schedule), Social (Soc. Skills training) Problem-Solving Training	XX	
<u>Positive Statements</u> re self, to others (compliments, appreciations), about events, possible positive aspects of causal event.	XX	
<u>Self-monitoring Assignment</u>: mood-cognition relation		XX
mood-behavior relation	XX	
<u>Challenging Negative Cognitions</u>: Socratic method, Underlying Assumptions Cognitions vs. statements, catastrophizing vs. reality testing all-or-none vs. probability, "should" vs. "preferable", alternative explanations to negative Cognitions.		XX

Behavioral Family Therapy for Schizophrenia

Patient characteristics: Psychosis, schizophrenia, living with the family

Setting: In clinic or at home; individual family or multiple (preferable); patient is present and participating

Assessment: 1). pre-treatment individual interviews 2). Structured problem-solving tasks provided by the therapist 3). observation during treatment session

Education re schizophrenia: causes, treatability symptomatology, pharmacotherapy, relapse indicators. Information provided verbally and with written materials

Communication Training: non-critical listening, positive statements, attending to positive vs. negative actions, avoiding criticism, making requests for change, compromising and negotiation, reacting calmly to disturbing behavior, compliments

Problem-Solving Training: Weekly planned family session; 1). Identify the goal - do not dwell on problem 2). "brainstorming" possible alternative solutions - several 3). evaluate the advantages and disadvantages of each alternative -only after the "brainstorming" 4). select the best of the alternatives, or designate which will be attempted first

Specific Procedure: Medication adherence guidelines, assignment of household responsibilities, anxiety reduction procedures, token economy or contingency contracting

Ward/Home Token Economy

I. Selecting Responses
Actions, not attitude: response products preferred
Functional or essential for situation, i.e., chores, homework
Precise definition
Assist with, or substitute, for caretaker's responsibilities
Initial selection, and final decision, by caretaker with client feedback

II. Identifying/Selecting Reinforcers
Question client and caretaker; peer reinforcers; observed high probability behavior
Only authorized access
Short-term (daily) and long-term (weeks, months), major and minor
Activities and interaction opportunities as well as tangibles
Initial suggestion by patient, then caretaker, then therapist prompts
Include presently existing reinforcers allowed infrequently/inconsistently
Include discontinuation of program as a reinforcer
Caretaker encouraged by Th to include very major reinforcers

III. Point Value
Tokens for young children/retarded/cognitively impaired
Assign point value to each Resp., each reinforcer
Point value of Resp a function of its importance
Point value of Reinforcer a function of its time/cost/effort by caretaker
Sum of all points earnable equal to sum of cost of all reinforces
Adjust point values periodically

IV. Records
Keep written record of points earned/spent/balance each day
Nightly review with caretaker praise for all responses

V. Alternatives to Points:
Level System: Resp. and Reinf. clustered at each Level (3-4)
Good Day: When all or X% of R's performed, Reinforcer = N good days

VI. Overcorrection (Make-up) for omitted behavior within 1 day

VII. Response Cost: Points subtracted for (grossly) inappropriate behavior, i.e., aggression

VIII. Agreement: Signed by caretaker, client, therapist, handshake.

Reference:

Ayllon, T. & Azrin, N.H. (1968). The Token Economy: A motivational system for therapy and rehabilitation. New York: Prentice-Hall.

Social Skills Training for Schizophrenia
(From Bellak and Mueser, pp. 115 & 116 in Craighead)

Table 7.3 Skill Topic areas

Interpersonal skills
Conversation skills
Dating and friendship
Assertiveness
Problem-solving
Self-care and maintenance skills
Vocational rehabilitation
Home finding and maintenance
Medication management
Leisure and recreation
Self-care and personal hygiene
Use of public transportation
Food preparation
Money management
Use of community agencies

Description of SST Procedures

The clinical procedures involved in SST, whether conducted in group or individual format, generally adhere to the following basic steps:

1. The patient's behavioral assets, deficits, and excesses in social situations are systematically assessed, through such methods as role-plays, naturalistic observation, and interviews.

2. Specific social behaviors are targeted for modification and a rationale for learning these behaviors is provided to the patient. (See below and "Skill Topic areas")

3. The therapist models the skill in a role-play.

4. Specific instructions are given to the patient to rehearse the skill.

5. The patient practices the skill in a role-play.

6. Positive feedback is given to the patient for specific components of the skill performed well, and corrective feedback is given to improve performance.

7. Repeated rehearsal and feedback take place.

8. A homework assignment is given to practice the skill in the natural environment, to facilitate generalization of the skill.

Conversation/Social skills: eye contact; voice clarity and loudness; facial and voice affect; expressing greetings and departure; initiating conversation; responding to requests; expressing interest; making requests; positive statements, no complaints.

Setting: Patient alone in office, family not present.

Treatment of Social Inadequacy

I. Identify whether depression or general anxiety exists. If so, treat for the depression or anxiety - relaxation training.

II. If situation-specific: dating, making friends, improving a relation, etc.

A. If no skill deficit exists, use systematic desensitization, active relaxation or anxiety management training

B. If skill deficit exists, or insufficient motivation

1. Assist patient to identify socially appropriate actions
2. Arrange the possible actions in a hierarchy of difficulty
3. Model the least difficult action
4. Role-play this least difficult action with therapist feedback
5. Conduct imaginal rehearsal of the action with an imagined favorable reaction
6. Assign in vivo practice of the action i.e. "exposure"
7. Repeat # 1- 6 in ascending hierarchy of difficulty thereby shaping successive approximations

Treatment of Eating Disorders: Obesity

I. <u>Physical factors</u>: Exercise program and nutritional counseling

II. Depression: identify as possible cause and treat if present

III. <u>Stimulus Control</u> and Psychological factors

1. Eat meals in same place (stimulus control)
2. Eat at same times each day - 3 to 4 meals (temporal control)
3. Do not skip meals (temporal control - hunger cycle)
4. Do not eat while engaged in other activities (response chaining)
5. Keep foods out of sight between meals (stimulus control)
6. Eat slowly savoring each mouthful (satisfy taste sensations)
7. Swallow food in mouth before reaching for next morsel (same as above)
8. Delay eating for 1 minute after being served (practice food refusal)
9. Leave slight amount of food (practice food refusal)
10. Avoid foods that require no preparation (avoids impulsive eating)
11. No snacks between meals (disturbs hunger cycle)
12. Use small plate (stimulus control)
13. Discard left-overs (same as #10)
14. Shop from a shopping list (stimulus control)
15. Shop when not hungry (decreased excessive food availability)
16. Eat bulky food items (simulates satiation)
17. When eating at a restaurant, decide on the meal type before looking at menu (stimulus control)
18. Weigh self frequently (reinforcement, corrective feedback)
19. Enlist family support (social prompts/reinforcement)
20. Establish weight loss goal of 1-2 lbs. per week (successive approximation)
21. Engage in another activity if hungry between meals (competing behavior)

Treatment of Bulimia

I. Cognitive - Behavioral Treatment

A. Follow the same steps as in treating obesity

In addition:

1). Provide correction of belief that non-purging results in weight gain
2). Stress not skipping meals; eat slowly, avoiding "taboo" foods
3). Weigh weekly (to avoid incidental slight day-by-day weight increase).
4). Identify problem situations and associated self-statements/cognitions
   a). rehearse corrective self-statements (cognitive rehearsal)
   b.) problem solve for possible competing activities
5). Self-recording of binge and purge episodes (progress chart-reinforcement)

II. Exposure/Interruption procedure (Extinction of anxiety rationale)

1. In-session eating of taboo foods
2. Eat until uncomfortable
3. Record SUDS level from start of eating at intervals of about 2 minutes
4. Delay purging (vomiting) for at least 2 hours
5. Focus thoughts on sensations of fullness
6. In vivo, the patient is instructed to delay vomiting for progressively longer periods
7. In vivo monitoring of binges, purges, food intake

Anorexia Treatment

Medical Precautions: tube feeding, vitamins, intravenous feeding, etc

No coaxing to eat (SR+ attention for food refusal)

Fixed eating time: 3-4 regular meals (hunger cycle peak)

No special food (SR+ for food over selectivity)

Weigh each day at same time (immediate feedback)

Large meals: 4,000 calories: (% of food available eaten)

Large plate: (apparent small volume of food)

Response Goal: 1/4 lb. gain over previous peak (R+ for SR+)

Partial Response Feedback: number of calories eaten, number of mouthfuls.

Reinforcers: Exercise, jogging, walks, special social interactions, passes, visits, hospital discharge, recreational activities, no tube feeding, no intravenous feeding

Post-meal observation: 1+ hours (to prevent purging)

Cognitive restructuring: ? re body image, food-weight beliefs, interpersonal relations.

Alcoholism Treatment

I. Community Reinforcement Approach – Incompatible activities (Hunt & Azrin)

Identify "risky" and "safe" situations/persons

Marital Functioning: Behavioral Marital Therapy

Vocational: Job-Club vocational counseling, full-time, permanent, supervised, not seasonal

Peer Associations: Non-alcoholic associations

Stimulus Control: Non-drinking situations

Daily Planner: Schedule associations and situations

Social clubs: non-alcoholic

Religious services (if applicable) regular attendance

Significant Other: Accompany to "risky" situations

Drink-refusal: In-session rehearsal

School/College: Enroll and attend

Enriched environment (for alternative reinforcers): TV, magazine subscription, radio, recreational activities, visits to relatives and "safe" friends

II. Relapse Prevention (Manlatt)

Identify "risky" and "safe" situations

Identify antecedent cognitions, rehearse alternatives

Teach drink refusal, leaving situations

Problem-solve for alternative activities (see all of the above in Community Reinforcement treatment)

III. Problem-Solving ("Self-directed," Motivational Interviewing) Miller, Sobells

a. Have patient reconstruct drinking occurrence during past 6 months on a calendar, designating which persons, places, situations were associated with each drinking episode, as well as quantity of liquor ingested. Summarize these aspects for the patient. Also, have patients list reasons for wishing to change.

b. Instruct the patients to devise their own plan for reducing drinking. Avoid any suggestions so as to maximize patient commitment and avoid unwelcome suggestions.

Covert Sensitization

1). Identify the details of the S- (negative stimulus sequence)

2). Identify the details of the SR- (natural negative consequences)

3). Demonstrate and rehearse gagging as an alternative SR-

4). Eyes closed, distraction - free setting

6). P imagine S- at full intensity

7). Therapist then instructs to imagine R- including cognitions and situation features

8). Therapist gives verbal prompts to heighten the aversiveness of the SR- Continued for approximately 1 minute of maintained distress

9). Alternate between incipient S- and full S- trials

10). Alternate between positive escape response and R- trials

11). Obtain 0-100 rating after each trial regarding strength of urge

12). Continue until ability to create urge is difficult - long latency

Reciprocity Counseling

A. Communication Training

Positive Request Procedure: How to make requests
1. State problem: a). no blame/criticism b). brief c). no numerous examples d). impersonal terms
2. Make request: a). for action, not trait b). "do" not "don't" c). specific
3. Why reinforcing to self, specific, not "make me happy"
4. Why reinforcing to partner to do it
5. Offer to help in some way to carry out the requested action
6. State alternatives

Annoyance Prevention: reacting to perceived annoyance by partner
1. State problem: a). no blame/criticism b). brief c). no numerous examples d). impersonal terms
2. State partial self-responsibility or contribution
3. State possible "excuses" for partner's action/inaction, plausible.
4. Request a corrective action (See Positive Request above)

Reacting to an "unacceptable" request
1. Self-relaxation by Active Relaxation
2. Do not say "no" or interrupt
3. Rephrase/repeat request to assure correct understanding
4. State what part of request/reason is acceptable/reasonable
5. Suggest an alternative action (See Positive request above)

Behavioral Exchange (Contracting)
1. Request an action from partner - using Positive Request above
2. Partner requests an action in return for above - in same domain
3. Partner requests an action in a different (same if desired) domain
4. Continue alternating requests
5. Agreement written out, scheduled, signed by H, W, therapist

Problem-solving:
1. Same as Annoyance Prevention #1; (#2), self-relaxation
2. Generate several alternatives, evaluate after final list, select best

General Guidelines

Impartiality: Alternate between H & W
Counsel H & W together, not separately
H & W, not therapist, defines role standards

Increase Reinforcers (mutual); Assign, to
Compliments
Appreciations
Offers to help
Pleasant surprises

Emphasize satisfactions, not problems, past and current
Reciprocity Awareness
1). H & W separately list on a divided sheet what
a). I do for him/her b). He/she does for me
2). Each states to other a) & b) above
3). Therapist prompts appreciation by recipient
4). Therapist expresses praise for action by either
5). Assign additional listings of existing satisfactions

Criticism of Partner
1) Therapist interrupts 2). Requests rephrasing

Progress Measures
1). Locke-Wallace 2). Marital Happiness Inventory - weekly

Sexual Dysfunction Treatment

I. Low sexual desire - male, female
   a). Negative cognitions: identify, restructure
   b). Priming: Books, pictures, videos, kissing, touching
   c). Communication: Request, negotiation, manual
   d). Sexual technique

II. Premature Ejaculation: - male
   a). male - pause b). female - pause, squeeze before ejaculation

III. Impotence (erectile failure) - male
   a). Anxiety reduction - systematic desensitization, etc.
   b). Assure F orgasm - (manual, oral, mechanical)
   c). Sensate Focus: nude, stroking, mutual, stop before orgasm, F guides

IV. Orgasmic Reconditioning: situational orgasmic failure: Masturbation
   a). Fantasize adequate stimulus
   b). Substitute inadequate stimulus just prior to ejaculation
   c). Initiate inadequate stimulus progressively earlier
   d). New stimulus sufficient from initiation through ejaculation - Final goal

V. Orgasmic dysfunction - female - Shaping
   a). Identify genital parts, touching b). masturbation c). erotic material d). mechanical masturbation e). M views (participates) in masturbation f). F instructs M to stimulate g). F guides insertion

VI. Vaginismus
   a). Systematic desensitization, Relaxation
   b). Dilator cylinders: gradually increased diameter after desensitized on the earlier diameter

Behavioral Medicine Treatments

I. <u>Pain Management</u>

1. Progressive muscle relaxation training or Biofeedback
2. Cognitive restructuring
   a). Distraction b). alternative positive coping statements
3. "Well Behavior" enhancement
   a). Activity-rest cycling each hour. Gradually increase the activity portion within each hour
   b). Engage in all possible functional, recreational activities
4. Analgesic scheduling - not PRN
   a). Calculate average duration (N hours) between medication dosing on PRN
   b). Take medication every N hours - even if no pain present
   Delay medication for the N hours - even when pain is present
   c). Gradually increase the time between dosing

II. <u>Stress Management</u>

1. Identify cognitions/situations associated with stress
2. Identify earliest precursors (cognitions, affect, stimuli) of stress
3. Progressive muscle relaxation, Active Relaxation, breathing
4. Cognitive restructuring for negative cognitions
5. Problem-solving for alternative coping responses
6. Time Stress
   a). Daily Planner
   b). Problem-solving
7. Anger
   a). Annoyance Prevention Procedure
   b). Active Relaxation
8. Competitiveness
   a). Cognitive restructuring

Habit Reversal (Tics, Tourette, Trichotillomania, Stuttering, Nail-biting)

Awareness Training

1. P demonstrates R- describing each component
2. P views tic in mirror
3. Therapist prompts P at each occurrence re state of awareness
4. Self-Recording

Annoyance Awareness: describing SR- of R- for Patient

Relaxation Training: PMR and Active Relaxation

Competing Response identification

1. Incompatible with R-
2. Inconspicuous, natural appearance
3. Compatible with ongoing functioning – no interruption

Contingent R incompatible
Perform the R inc. for 1 minute after each R-, or R- precursor

Precursor identification

1. Cognitive
2. Bodily Sensation
3. Movement
4. Subjective "feeling"

Imaginal Rehearsal

1. Self-induce R- or R- precursor
2. Perform the incompatible response at earliest moment of precursor; continue till zero SUDS
3. Obtain patient's urge level (0-100) pre- and post
4. Duration (in seconds) needed to reduce urge to zero level
5. Assign as home practice trials

General C.B. Th
Treatment assignment, self-recording, significant other (prompt and reinforce)

Public Display
Deliberate exposure to previously avoided/risky situations to experience SR+ for absence of R-

Specific type of R incompatibility: for sample problems

Nail-biting and Trichotillomania: Hands down, grasping, hand functional
Tics/Tourette: Isometric tensing of affected muscles
Stuttering: Regulated breathing: initially reading, dictionary; subsequently discourse

a. before speaking, inhale and then exhale slightly with the initial sound
b. juncturing (pause at natural pause points)
c. rhythm and affect in speech
d. gradually lengthen phrases

Children:

1. Token Economy
2. N minutes of nightly supervised practice (see Imaginal Rehearsal above) proportional to number of tics
3. R+ in Token Economy
   a. Thank parent for prompt
   b. Correct R- when prompted
   c. Scheduled nightly practice of "Imaginal Rehearsal" above performed by child

References:

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JOB CLUB DISTINCTIVE FEATURES

1. *Job Seeking as a Full-time Job* The job seeker treats job finding as a full-time job. About one-half of each day should be devoted to obtaining job leads and arranging interviews. the rest of the day is then spent on actual interviews. This schedule is followed every day until a job is obtained.

2. *Friends, Relatives, and Acquaintances as Sources of Job Leads* The job seeker makes a systematic effort to contact friends, relatives, and acquaintances as a primary source of job leads.

3. *Standard Scripts and Forms* The job seeker is given standard scripts and forms that he follows when contacting friends or employers, writing letters, making telephone calls, and keeping records.

4. *Facilities and Supplies* To simplify the task of job seeking, the Job Club program provides all of the supplies and services necessary for a job search, such as a telephone, a typewriter, photocopies, stationery, postage, newspapers, and a work area.

5. *Group Support from Other Job Seekers* The program provides a group setting that is structured to enable job seekers to assist each other. Participants are directed to look for leads for other members of the group, and job leads from previous club members are made available to current members. The program is designed to foster mutual encouragement and support. Motivation is stimulated as fellow participants, who seemed to be unemployable, find jobs.

6. *Buddy System* Job Club members are paired off so that everyone has a "buddy" who gives advice and assistance in monitoring telephone calls, writing letters, scrutinizing want ads, and practicing for interviews.

7. *Obtaining Unpublicized Jobs* The Job Club teaches job seekers how to obtain interviews for jobs that have not been publicly advertised or that may not even yet exist. This procedure results in the discovery and creation of job openings.

8. *Use of the Telephone as the Primary Contact for Leads* The telephone, rather than letters or personal visits, is used extensively as the method of obtaining job leads and arranging interviews.

9. *Classified Directory (Yellow Pages) of Telephone Book* The yellow pages section of the telephone book is used daily to obtain new lists of potential employers.

10. *Emphasis on Personal and Social Skills* The Job Club program teaches job seekers how to emphasize distinctive personal and social skills in addition to work skills. These personal skills are stressed in the job seeker's résumé, in making contacts to obtain job leads, and in the interview.

11. *One Job Lead Uncovers Others* The program teaches job seekers how to turn unsuccessful job inquiries into job leads so as to generate a continuous fresh supply of leads and contacts.

12. *The Call-back* The job seeker is taught to arrange a second contact with an employer following an interview in order to facilitate the employer's decision. Similarly, a call-back is arranged with highly attractive employers in order to learn quickly about forthcoming openings.

13. *Transportation* The program teaches the job seeker how to arrange transportation to otherwise inaccessible job locations, thereby permitting consideration of a greater range of job possibilities. Also, the members of the group assist each other with transportation to the Job Club office and interviews.

14. *Former Employers* · Job seekers are trained to approach former employers for job leads as well as job openings.

15. *Open Letters of Recommendation* The job seeker obtains open letters of recommendation to provide interviewers with the information necessary for reaching an immediate decision.

16. *Résumé* The program helps the job seeker construct a résumé that stresses personal skills, attributes, and functional work skills rather than a formal listing of job titles.

17. *Employment Application* The program teaches the job seeker how to emphasize positive personal attributes on standard application forms.

18. *Interview Training* The program teaches job seekers how to act during an interview and how to respond to common interview questions.

19. *Interview Checklist* The job seeker is given a list of actions to be covered during any interview. This list is reviewed immediately after each interview to highlight omissions or problems that might require subsequent correction.

20. *Job Wanted Ads* For job seekers who have great difficulty finding a job, the program provides for a job wanted ad to be placed in the newspaper. The wording of the ad emphasizes the job seeker's positive personal-social attributes.

21. *Nonemployment Derived Work Skills* The program teaches the job seeker to identify marketable work-related skills that may not have been acquired from or related to other previous paid employment.

22. *Structured Job Seeking Schedule* Job seekers use a form to plan each day's schedule of interviews, calls, and visits.

23. *Leads List* Job seekers maintain a running record of job leads to organize contacts and call-backs of potential employers.

24. *Progress Charts* The job seeker keeps a formal record of job seeking activities to permit quick evaluation of progress and to pinpoint possible reasons for job finding difficulty.

25. *Job Supervisor* Job seekers learn how to contact potential job supervisors in a company rather than personnel staff because the supervisor usually plays a critical role in hiring decisions and is also sometimes able to create a job geared to the skills or attributes of a particular applicant.

26. *Relocation* If no suitable jobs are available locally, the program teaches the job seeker how to obtain a job in another location.

27. *Handicaps* The program teaches job seekers how to deemphasize and discuss apparent handicaps, such as a physical disability or a prison record, and how to view the apparent handicaps in terms of their positive attributes.

28. *Letter Writing for Job Leads* The program provides sample letters and forms to be used as models by the job seeker in writing to people for job leads.

29. *Family Support* The job seekers enlist the support of their family and give them instructions as to the specific ways in which they can help.

30. *Photograph* (Optional) When feasible, the job seekers personalize their résumés by attaching a photograph.

31. *Employment Applications* The job seekers learn how to answer typical questions on employment application forms in such a manner that their positive attributes are emphasized.

32. *Capability for Many Positions* The job seekers learn to consider many types of positions, thereby not restricting themselves to one type of job.

Classroom Management

Active participation: overt response: speaking, writing vs. listening

Praise-Ignore:
a) Ignore minor R-'s
b) Praise R+ (DRO, DRI, DRA)
c) Praise non-targeted students for R+ absent in the targeted student

Reprimands: soft, given in proximity of student (minimize attention)

Overcorrection: for negative behavior (make-up)

Shaping/Successive Approximation: praise components of R+

Rules: conspicuously post and discuss (specify R+ standards)

Specification of Response: in terms of R+, not R-

Token Economy: for motivation increase/problems
Sample reinforcers: free time, self-study, teacher assistant, early recess
Sample response: correct completion of task

Home-based Token Economy:
1.) Establish SR+ to be provided by parent at home (See "Ward/Home Token Economy" for details)
2) Classroom response categories defined by teacher-simple recording (either √or X number)
3) Daily Report Form sent home

References:

Bailey, J.W. et al (1970). Home-based reinforcement and the modification of predelinquents' classroom behavior. Journal of Applied Behavior Analysis, 3, 223-233.

Hall, P.V. et al. (1968). Effects of teacher attention on study behavior. Journal of Applied Behavior Analysis, 1, 1-12.

O'Leary, K.D. & Becker, W.C. (1969). A token reinforcement program in a public school. Journal of Applied Behavior Analysis, 2, 3-13.

Azrin, N.H. & Besalel, V.B. (1999). Positive Practice, Self-Correction and Overcorrection. Austin, TX: Pro-Ed Publisher.

Compliance Training for ODD, ADDH (Forehand)

Ages: 3-7 years

Parent Training: Therapist does not train child directly

Attend Phase: To teach parent to avoid SR- and to attend to R+ of child
Child is given games to play with for 15-minute period
Parent avoids giving instructions or criticisms or questioning
Parent describes the functional/acceptable actions of child
Therapist prompts parent continuously out of view
Parent "attends" continue until 2 or more per minute average

Command Phase: after successful Attend Phase: To teach prompt compliance
Commands: for action (not trait); "do," not don't; simple, brief
Praise: for initiating compliance and at completion, physical SR+
If no compliance: wait -5 seconds, state the consequence (see below) for non-compliance
Time-Out: If no compliance after 5 seconds

a) do not repeat request
b) restate calmly the consequence: time-out
c) escort child to a pre-designated time-out chair
d) child remains in the time-out chair for 1 minute for each year of age
e) C.O.D: Change Over Delay. Exit from chair delayed for R- during Time-Out for n seconds
f) no discussion during time-out by parent
g) when time-out duration is completed, repeat initial command

Assignment: Assign Attend and Command training at home for structured/unstructured situations

Reference:

Forehand, R. & McMahan, R.J. (1981). Helping the Non-compliant Child: A Clinician's Guide to Parent Training. New York: Guilford Press.

Cognitive Problem-Solving Treatment for Conduct Disorder/ADDH (Kendall)

Problem-Solving Steps: Define problem, focus, describe alternatives-several, evaluate positive and negative consequences for each, choose one, self-praise for correct use of steps.

Prompt Card of Above Steps: Available to child at all times, therapist encourages use

Tasks:
a) games (checkers, tic tac toe, etc) then
b) academic (arithmetic, reading) then
c) real-life social situations

Think-Aloud
a) state step aloud initially, then on subsequent trials
b) whisper
c) lips move, silent
d) silent/covert

Modeling: - Therapist alternates tasks initially with child, then less frequently

Token-Economy in Office:
Response-cost model: Assures motivation and attention of ADDH and conduct disordered child

Reinforcers: Inexpensive trinkets; assortment-assign point value
Tokens: Child given fixed number at start of session-approximately 15
Subtract Token: Any error, skipping steps, non- "focusing," irrelevant actions
Token Exchange at end of session for 1 (only) of the reinforcers selected by child

Bonus Points:
a) for bringing real-life applications to session
b) for self-evaluation of performance equal to therapist's

Reinforcement (praise) only for correctness of the steps. No advice, praise, judgment by therapist for social appropriateness

Reference:

Braswell & Kendall (1987). Treating impulsive children via cognitive behavior therapy, chapter 5 in Jacobson, N.S. Psychotherapists in Clinical Practice. New York: Guilford.

Operant Treatment Procedures for Conduct Disorder/Antisocial Behavior

I. Parent Management Training (Patterson)

A. Young children and pre-adolescents

Parent alone – child not necessarily present

Bibliotherapy: review of learning principles; workbook; fill-in

Recording: 2 R-'s 2 R+'s at home

Token Economy:

R+: chores, self-care, bedtime, on-time, homework, compliance, grades

SR+: TV privileges, phone, eat out, visits by/to friends, late bedtime, extra favorite foods, trips, special clothing, games, bicycle, CDs, tangibles, allowance, magazines

SR-: Point-loss, over-correction (make-up), room time-out; no physical SR-

Child Input: regards Sr+; R+ and R- defined primarily by parent with child input

Responses: overt action-not attitude

Reinforcers: only those under control of parent

B. Older children/youth: adolescents, teenagers

Same as above, but:

Behavioral Contracting with more negotiating by youth re R+, SR+

Youth present in session as active participant

II. Achievement Place

Same as above, (I.), but with non-parents in small group home: mean age: 12 yrs.

III. Parent-Youth Counseling: conduct disorder and/or drug abuse: mean age: 16 yrs.

Behavioral Contracting/Token Economy (see above and Token Economy sheet)

Communication Training (see Behavioral Marital treatment)

Urge Control (drug urges): Imaginal rehearsal of:

A. inducing slight drug urge

B. imagined SR-, alternative R+

C. SR+ for R+

Stimulus Control: Listing of

A."safe"

B. risky situations/persons with time spent in each daily

IV. Affect: Anger Control

A. PMR: Muscles, Breath, Relax

B. State:

1. problem (no blame)
2. external cause
3. self-contribution
4. solution

V. Cognitive: Problem-solving (see p. 22 – Cognitive Problem Solving)

A. Define problem
B. List several alternatives
C. Advantages & disadvantages of each
D. Select best to do first

References:

Patterson, G.R. (1976). Families: Applications of Social Learning. Champaign, IL: Research Press.

Feindler & Ecton (1986). Adolescent Anger Control. Pergamon Press

Besalel, V.A. & Azrin, N.H. Reduction of parent-youth problems by reciprocity counseling. Behavior Res and Therapy, 19, 297-301

Azrin, et al. (1994). Youth drug abuse treatment. Journal Child and Adolescent, 3, 1-15

Insomnia Treatment

I. Progressive Muscle Relaxation (See separate sheet)

II. Stimulus Control:
Sleep only in bed - not sofa, chair
Naps - None during day
No other activity in bed - no reading, TV, eating, problem-solving
Arise at same time in morning - even if tired
Retire at the same time at night
If unable to fall asleep in 15 minutes, arise, leave bed and bedroom
Return to bed only when tired
If wakefulness persists for several nights, retirement time is scheduled later

II. Sleep Hygiene:
Education re duration of sleep needed: individual differences, less with age
Distraction: Eliminate; masking noise considered
Diet: Reduce alcohol, caffeine
Exercise: During day, not immediately prior to bedtime

Post-Traumatic Stress Disorder

I. Flooding, Implosion Therapy

Identify details of several trauma-associated experiences

Relaxation at start and end of each session

Hierarchy: Initially use lessor distressing scene

Imaginal creation of trauma scene-eyes closed

- Maintain scene for extended duration
- Therapist prompts continuously re scene details and distress affect
- Implosion: therapist emphasize distress affect/cognitions

Session Duration: 2+ hours

Situations: Actual trauma situation; also current trauma- related situations

Therapy Assignment: when stress is managed during session

a). Audiotape of successfully managed scene- daily listening

b). Self-exposure to successfully managed trauma- related situations in vivo

SUDS level: Pre and post each imaginal and in vivo- exposure

Anxiety Reduction Therapy (Veronen & Kilpatrick; Foa) for rape victims

Give rationale: Classical conditioning as cause; anxiety reduction as treatment

Progressive Muscle Relaxation: See separate page for details

Active Relaxation: See separate page for details

Controlled Breathing: deep, slow, diaphragmatic; exhale slowly

Thought-Stopping: Stop!! aloud, then silently

Functional skill rehearsal to trauma-related situation

Cognitive Restructuring: Functional, positive self-statements re anxiety-producing situations. Initially think aloud in office.

Gradualness: Non-rape related, then rape-related, then rape scene

Imaginal rehearsal: Induce anxiety scene; imaginally rehearse relaxation, breathing, functional behavior, thought-stopping, and cognitive restructuring noted above

In Vivo assignments of above behaviors after successful imaginal treatment

Self-recording of situation, behaviors, pre/post SUDS

Obsessive - Compulsive Disorder (Contamination ritual)

<u>Exposure - Interruption</u>: Rationale - 2 factor theory
In- office creation of contamination situation
<u>Hierarchy</u>: Initial use of mildly feared situation
<u>Session duration</u>: 2+ hours
<u>Session frequency</u>: daily initially
<u>Interruption</u>: Washing not permitted except before meals; brief shower.
<u>Focus</u>: Keep patient focused cognitively on the feared object(s).
<u>Imaginal</u>: initially before in-office or in-vivo out-of-office exposure
<u>SUDS</u>: Frequent self-recording by patient of distress level
<u>Exposure Continued</u> each trial until distress level (SUDS) decreases each trial

<u>Therapy Assignment</u>: In-vivo deliberate exposure/interruption

Parent Child AbuseTreatment

I. Positive Parenting

Punishment: Time-out, (over) correction, positive practice; not physical

Focus on child's positive behaviors: praise, appreciation, frequency increased

In-session role-play:

Therapy Assignments - keep record

Identify problem situations

Rehearse solutions: T.O., overcorrection, warning

Communication:

Praise for positive aspect of behavior

Instruction: Action (not trait), "do" not "don't", specific

II. Anger Control: See Annoyance Prevention procedure, Relaxation

III. Stress Management: See Stress Management

IV. Marital Counseling: See Marital Counseling

Active Relaxation Training

Progressive Muscle Relaxation: prior (2+ weeks)

Cue-Word: ("Relax", "Calm") at start of each relaxation, "Cue-Controlled Relaxation"
Regulated Breathing: at start of each relaxation, during.
Identify tense body muscles: use recording form in vivo

When to Use: At onset of anxiety - cognitive, affective, motor and physiological cue.

Immediately prior to entering anxiety-prone situation.
In-session listing of known anxiety-prone situation.

Procedure: Relax all muscles - except those used in the functional activity
Do not interrupt the functional activity
Use the cue-word (silently), initiate and maintain regulated breathing
Attend to and relax the previously identified tension-prone muscles.

Scan the various muscle groups - all
Attend to and relax the generally tense muscle groups: Teeth clenched, forehead, neck, stomach, hands
Attend to and relax hands if they are being used: writing, driving, etc.
Duration: continue until SUDS near zero
Record: On a form: pre and post SUDS, situation, which muscles tense, approximate duration

In-office rehearsal imaginal of simulated anxiety situations
Self-induce anxiety symptoms
Therapist feedback during patient's active relaxation

Systematic Desensitization

Progressive Muscle Relaxation prior - for 1-2 weeks -

Hierarchy Construction: 10-20 anxiety scenes
- SUDS rating (0-100) each scene
- Equidistant: SUDS between scenes
- Anchor points: least (05 SUDS) or extreme (95-100 SUDS)
- Prompting scene identification: actual fears ? N SUDS ?
  Spatial-temporal variations, thematic variations

Relaxation Scene: Identify, details, used only between trials with muscle relaxation.

Settings: Lounge, distraction free, eyes closed

Procedures:
- Patient signal by raising finger briefly when image is clear
- Patient holds image for 7 seconds, therapist terminates
- If anxiety during scene excessive, patient signals, trial terminates
- Number of trials: At least 2 per scene; repeat if SUDS greater than 10
- SUDS rating: pre and post trial and verification of clarity
- If SUDS remains high: repeat scene
  - return to previous scene
  - construct intermediate SUDS scene
- Next session: Begin with previous mastered scene

Scene Presentation:
- Ascending sequence of SUD
- Zero SUDS prior to scene presentation - relaxation scene if necessary
- Therapist prompts: gives details of scene

Anxiety (Affect) Management Training (AMT)

Progressive Muscle Relaxation: prior 1 - 2 weeks
- Cue - Word: ("Relax") at start of each muscle relaxation
- Regulated breathing: at start of each muscle relaxation
- Identify tense body muscles: use recording form

Relaxation Scene Identification: real, no motor activity, details, at end of PMR

Anxiety Scene Identification: at least 2: 60 and 90 SUDS; details: cognitive, affect, motor, physical details; no "escape" cognitions

Setting: Lounge, distraction free, loosen tight clothing, eyes closed

In Vivo Recording of stress situations: situation, SUDS level

Self-Induction imaginal (in office) of 60 SUDS stress scene
- Therapist instructs initiation of stress scene.
- Patient raises finger when 60 SUDS level and keeps raised during 60 SUDS
- Therapist gives detailed prompts until 60 SUDS achieved appropriate voice affect.
- Duration of Anxiety: 10-15 seconds, then induce relaxation

Self-Induction of Relaxation Scene after 10-15 seconds of anxiety
- Therapist prompts initiation of relaxation and prompts further relaxation until "near- zero"

Fading of prompts on succeeding trials
- Reduce detail prompts during the anxiety and relaxation scene
- Eliminate relaxation scene, focusing on muscles and breathing
  - Maintain anxiety scene imaginal while relaxing muscles and breathing
- Patient initiates anxiety scene (finger raised) with no therapist prompt
- Patient initiates relaxation efforts when SUDS = 60 with no therapist prompt

End Stage: Patient induces anxiety and relaxes self (to-near-zero-SUDS) with no therapist prompts

Alternate: 60 and 90 SUDS anxiety scene

Recording: Therapist records time (seconds) needed to reduce anxiety (finger raised)

In Vivo: Performance of above and self-recording of situation, SUDS, time to reduce anxiety

Progressive Muscle Relaxation Training

Provide conceptual basis; relate to presenting problem/diagnosis, estimated benefit

Setting: Distraction-free, lounge chair/recliner, loosen clothing: tie, belt

Precautions: Sensitive/vulnerable body parts: back, teeth, contact lens, neck

Model: Hands (both), arms (both); performing concurrently with eyes open only initially.

Muscle Groups: head-to-toe: forehead, eyes, mouth, tongue, neck, shoulders, breathing, back, stomach, hips, legs, feet, toes; Emphasize (repeat) muscles specific to patient's locus of tension

Tense/Relax: Tense: 10 seconds; Relax 15-20 seconds: Only the designated muscle groups

Voice: Soft, mellifluous during "relax"; strident during "tense"

Associated Images: Tense: "hard", "stiff, "pressure", "hard as a rock", "tight", etc.
Relax: "limp", "loose", "water flowing from jar", "tenseness evaporating", etc.

Continuous Talk by therapist for above

Feedback comments, praise for appropriate response for each muscle, alert for movements/tensing of other muscles

Breathing: During each relaxation: slow smooth breathing, diaphragmatic breathing

Total Body Relaxation: After all individual muscles

SUDS: Pre and Post TX

Tape Recording: Given to patient for home use

TX Assignment: Twice daily with tape for approximately 15 minutes each time

Recording: Form indicating date, time, duration, pre and post SUDS

Applied Behavior Analysis
General Features

Reference:	Martin, G. & Pear, J. (1983). *Behavior Modification*, 2nd edition. New Jersey: Prentice-Hall.
Type of Patients and Settings:	Children, institutionalized adolescents and adults, classroom, setting in which training and consequences are required by the caretakers.
Positive Consequences:	Emphasize positive – SR+, not negative. Contrived: edibles, toys, games, Primac Principle Natural: praise, stroking, facial-smile, gestural-applause Multiple: multiple and varied SR+ more effective than fixed or single Individually Determined: Question & observe child, question caretaker Reinforcement Frequency: Every response for acquisition, then intermittent for generalization Relation to Response: Immediately after R, also after initial components of a chain of response during acquisition – "shaping" Conditioned Reinforcement: Praise or points with subsequent tangible reinforcement when immediate tangible reinforcement not feasible
Negative Consequences:	Mild-never physical pain: Examples: time-out, point loss, postponed or loss of privileges, correction/overcorrection/positive practice Concurrent positive reinforcement for alternative appropriate behavior Alternatives to Negative Consequences: Functional analysis (attention, avoidance) or Functional Communication Training Shaping/Successive Approximation: Reinforce all approximations to the desired behavior Generalization: (a) Construct the training situation to be similar to the intended generalized situation. (b) If feasible, also alter new situation to be similar to the training situation. (c) Train parents/caretaker in use of the above principles with child in home. (d) Intermittent reinforcement. (e) Natural reinforcers Selection of Behavior: Overt not trait, "do" not "don't," specific so as to be positive and clear. Recording: By caretaker, or self-recording by older children: Progress measure. Of target behavior and prescribed treatment procedure. "Recording Reactivity" effect: facilitates improvement

Retardation – Skill Acquisition

The following considerations are most important with greater degrees of retardation.

I. Instruction:

a. Brief, simple verbal instructions with gesture added, then touch, then manual guidance added if compliance is not initiated within 1-2 seconds of the earlier instructional prompt.
b. Graduated Guidance: Guide trainee's hand or movement with only sufficient guidance to produce movement in the correct direction – no pushing or undue pressure. "Hand over hand."
c. Shadowing: When movement is correct, trainer keeps own hand close to trainee so as to guide immediately if needed.

II. Reinforcers:

a. Praise, edibles, stroking, at start, during and end of R chain. When mastery occurs, reinforce only at end, then intermittently
b. Praise: Immediately as correct movement is initiated and then continuously during entire movement.
c. Provide extrinsic reinforcement – edible, stroking, game, etc., at end of response chain.
d. Provide intrinsic reinforcement – if possible at end of the response chain – e.g., going outdoors to play after dressing self.

III. Selection of Response:

a. Select R's that are functional in their living environment
b. Basic self-care skills (toileting, dressing, eating) and language.

IV. Imitation:

For higher level, useful to have trainee observe others, and trainer models (demonstrates).

V. Forward Chaining vs. Backward Chaining to teach long response chain.

VI. Attention: Assure attention before giving instruction by:

a. Reinforcing eye contact when addressed
b. Manual graduated guidance to orient head toward trainer

VII. Distinctive Problem Behaviors

a. Self-Stimulation
b. Self-Injury
c. Aggression
d. Pica

VIII. Self Care Skills

a. Toilet training
b. Enuresis
c. Dressing
d. Proper eating

IX. Negative Consequences: non physically aversive

a. Interruption
b. Time-out (exclusionary, non-exclusionary)
c. Extinction, positive practice, overcorrection

Reference:

Whitman, et al (1983). Behavior modification with the severely and profoundly retarded. New York: Academic Press.

Therapy Style Considerations with Children

I. Rapport: Especially important before TX initiation since TX with child usually motivated by parent, not child.

II. Communication to Child:

a. Because of undeveloped receptive language: use common words only, speak slowly, distinct, brief, redundant (alternative phrasings), accompany with appropriate facial affect and voice tone, model.

b. Interactive: request an active response by child that indicates understanding, role play.

III. Positive Ambiance: Again, since referral is by others and not self-motivated

a. Extrinsic tangible reinforcers are often needed

b. High frequency of praise, positive expressions, successive approximation.

c. Create self-awareness by the child of the problem to the child to create intrinsic motivation to pursue treatment.

IV. Outcome research:

a. with children is often done in TX groups since school/institutional recruitment is more convenient. So individual therapy often requires modification of the procedure.

b. Similarly, much of the research is done with adults or older youth so modification is needed for young children.

V. Involve parent/guardian in all aspects of TX including presence in session both for full disclosure as well as to promote generalization by enlisting the parent as the motivator: reinforcer and reminders.

Child Fears and Phobias

I. Systematic Desensitization
- A. 1. PMR
  2. Anxiety Hierarchy
  3. Scene Presentation

- B. Home Practice
  1. 30 min per day
  2. tape cassette of PMR procedure

- C. Effective primarily with in vivo practice

II. Contingency Management
- A. Reinforce for engagement with feared situation
  1. Feedback for duration of engagement
  2. Gradual increase in duration – shaping
  3. Gradual increase in feared stimulus – Fading

III. Modeling
- A. Live vs. symbolic modeling (film tapes, stories)
- B. Mastery vs. coping style of modeling
- C. Controlled group outcome clinical trials

IV. Cognitive-Behavioral Procedures – "Self-Control"
- A. "Brave" statements
- B. Self-statements
- C. Self-relaxation
- D. Information re safe aspects of situation

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Wolpe, J. (1973). The practice of behavior therapy (2nd edition). New York: Pergamon.

Leitenberg, H. & Callahan, E.J. (1973). Reinforcement practice and reduction of different kinds of fears in adults and children. Behavior Research and Therapy, 11, 19-30.

Grazaria, A.M., et al (1979). Behavioral treatment of children's fears: a review. Psychological Bulletin, 86, 804-830.

Rimm, D.C. & Masters, J.C. (1974). Applicability of Systematic Desensitization. Behavior Therapy, 45-67 in Rimm & Masters' Behavior Therapy. New York: Academic Press, Chapter 2.