

The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention

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Publisher's Statement

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The mission of The Journal of Behavior Analysis of Offender and Victim - Treatment and Prevention will be to highlight the role of behavior analysis in adult and juvenile crime prevention, assessment of offenders including risk assessment, and treatment programs from a behavioral orientation including but not limited to the use of behavioral counseling, collaborative goal setting, contingency management, functional assessment, functionally based interventions, respondent conditioning and counter conditioning procedures, functional analytic psychotherapy and acceptance and commitment therapy.

The journal will also place a major focus articles on that present behavior analytic and social learning models of the development of criminal behavior, the behavioral treatment of victims, victimology from a behavior analytic perspective, behavioral interventions for violent crime, functional assessment of offender motivation, and other types of criminal activity, including behavioral approaches to the reduction of terrorism and insurgency reduction. We see all of these topics as suitable for publication in this journal. In addition, the journal will publish articles on behavior analysis in the treatment of the offender that are policy oriented. Articles on forensic behavior analysis, testifying, due process, and behavioral profiling of criminal behavior will be considered. Finally,

organizational behavior management and positive behavioral support articles dealing with system change issues in schools and criminal institutions will also be considered."

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evidence and scholarship; and (3) the clarity of writing style. Comments provided by the editorial consultants will then be provided to the author(s) for follow up.

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- * Include in the abstract only information that appears in the body of the manuscript.

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· Use the present tense to describe results with continuing applicability or conclusions drawn and the past tense to describe variables manipulated or tests applied.

*** As much as possible, use the third person rather than the first person.**

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Abstracts for empirical studies are also generally about 100 to 120 words in length. They should include the following information:

*** Problem under investigation (in one sentence)**

*** Pertinent characteristics of participants (e.g., number, type, age, sex, genus and species)**

*** Experimental method, including apparatus, data-gathering procedures, and complete test**

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*** Conclusions and implications or applications**

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*** Sources used (e.g., personal observation, published literature)**

*** Conclusions**

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The Behavior Analyst Online Journals Department

Attachment Theory and Its Relation to Adult Men Who Sexually Offend

By Heather Staufenberg, Psy.D.

Abstract

There is extensive research examining the attachment styles of men who sexually offend. The results indicate that this population often has insecure attachment styles with significant deficits in their attachment behaviors. It has been theorized that such deficits are influential factors in both the etiology and maintenance of sexually offending behaviors. This article first describes attachment theory and then explains how it is related to the development of human sexuality. Next, empirical research examining the relationship between attachment and men who sexually offend is reviewed. Finally, a description and the possible benefits of an attachment theory informed approach to the treatment of adult men who sexually offend are discussed.

Keywords: Attachment, sex offenders, theory development

Attachment theory, originally proposed by John Bowlby in the 1950s, integrates multiple theoretical perspectives into a coherent approach used to account for the continuity of emotional and interpersonal behavior experienced across one's life span (Burk & Burkhart, 2003). Bowlby proposed the following: there is survival value in emotional connections between people; attachment behaviors have neural corollaries in the central nervous system; each person in an attachment dyad builds internal mental representations of the other as a way to maintain a sense of proximity should separation occur; and development occurs continuously rather than in discrete phases (Shorey & Snyder, 2006). Furthermore, Bowlby proposed that attachment styles are developed and internalized early in childhood and can impact one's ability to develop quality relationships throughout life (Miller, 2002; Shorey & Snyder, 2006).

Infant Attachment Patterns

A famous series of experiments on infant monkeys carried out by Harlow and Harlow in the 1950s demonstrated that attachment is not a simple reaction to internal drives. In these experiments, monkeys were separated from their mother shortly after birth and offered two dolls serving as surrogates. The first "mother" had a bare wire body with a feeding bottle attached at its chest area and the other was covered with foam rubber and a soft terrycloth exterior, but had no bottle. Upon placement in the cage, the infant monkey promptly ran and clung tightly to the terrycloth figure. Then, while anchoring itself to the soft "mother," the infant stretched across to the wire "mother" to feed. Knowing baby monkeys run to their mothers when frightened, researchers later placed a teddy bear that marched forward while beating a drum in the cage. As a result, the infant sought refuge with the terrycloth "mother." These classic studies indicate that perhaps even more basic than the need for physical nourishment is the need for body contact with a soft and comforting object (Smith, 1993).

The attachment system is the pre-adapted behavioral system for combating and reducing stress or fear (Mash & Dozois, 2003). Its purpose is to maintain a balance of comfort and confidence in his surroundings; the attachment system can be thought of as "environmental homeostasis." For example, perhaps a child is frightened by a clown, activating the attachment system which motivates the child to seek protection by staying close to his mother ("attachment behavior"). When successful, the attachment system de-activates leading to a reduction in anxiety and the

resumption of play and exploration. When these needs are not met, the child experiences extreme arousal and terror accompanied by primal anger. These responses subsequently set a template for later reactions to abandonment (Sonkin & Dutton, 2003).

High-functioning attachment relationships, however, provide more than just protection. Myron Hofer’s work with rodent pups revealed that the survival value of attachment behavior goes beyond protection and may be expanded to many pathways available for regulation of the infant’s physiological and behavioral systems (Polan & Hofer, 1999). Hofer posed that the attachment “relationship provides an opportunity for the mother to shape both the developing physiology and the behavior of her offspring through her patterned interactions with her infant” (Polan & Hofer, 1999, p 177). Within the intimacy of this “partnership,” the child learns how to modify his relationship goals to accommodate the partner’s goals. Such a relationship allows for the learning of a range of essential social skills and methods for negotiating mutually satisfying resolutions to conflicting desires. Through these processes children understand that their attachment partners possess a point of view separate from their own, and they develop skills to accurately assess that viewpoint. This suggests that the attachment relationship provides children with fundamental lessons in interpreting social cues and empathic responsiveness (Cunningham & Page, 2001).

Patterns of attachment are thought to be dependent on how caregivers support the child. Of the three patterns identified, one is related to healthy development while the other two are predictive of disturbed development (Bowlby, 1969). With the use of the “Strange Situation,” Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) helped refine attachment patterns. The studies identified that the infant’s response to the mother’s departure was dependent on the infant’s expectation of the mother’s behavior. For example, it appeared that older children upset by laboratory separation were distressed not because of the mother’s absence, but due to her seemingly arbitrary behavior. As such, it was determined that the disruptions experienced by separation from the primary caregiver were regulated by an increasingly complex set of (unconscious) evaluative processes. Based on their work, Ainsworth and her colleagues proposed three distinct infant attachment styles: “secure,” “avoidant,” and “anxious/ambivalent” (see Figure 1).

Child and Caregiver Behavioral Patterns		
Attachment Pattern	Child	Caregiver
Secure	Somewhat distressed and play less after caregiver’s departure but reacts positively to stranger. Upon return, child greets caregiver and is comforted, returning to exploration.	Sensitive and responsive to child’s signals for needing comfort.
Anxious/Ambivalent	Extremely distressed on departure of caregiver but warms to stranger. On return, child is ambivalent, seeking contact yet angrily pushing the caregiver away. There is also reluctance about returning to play	Respond slowly and inconsistently to child’s needs.
Avoidant	Little or no distress of departure, little or no visible response to return. Quality of play often low.	Little or no response to distressed child. Discourages crying and encourages independence.

Figure 1. Child and caregiver behavior patterns seen in Ainsworth et al.’s (1978) “Strange Situation.”

A “secure” attachment pattern related to healthy development is created when an infant is confident that his parent will be there when needed. This allows the infant to maintain security and expend energy in other areas such as exploration (Miller, 2002; Marshall, 2001). Such a parent employs a care giving style in which she is sensitive and responsive to the child’s needs (Bowlby, 1989). The power of such an attachment was expressed by Bowlby who wrote that “no concept within the attachment framework is more central to the development of personality than that of a secure base...” (Bowlby, p 244, 1989). A secure attachment provides the child with the

confidence necessary to function effectively in the world, particularly in relation to others. When parents are loving and treat their child with respect, the child concludes that he is loveable and that others will be nice to him. He also acquires, through interpersonal interactions, the skills necessary to form effective relationships and to meet his interpersonal, affectionate, and later sexual, needs in prosocial ways (Marshall, 2001).

Alternatively, when the caregiver is repeatedly unavailable or unresponsive, stress develops and can lead to a traumatic experience for the child. The behaviors of parents who are abusive or neglectful convince the child that he is unlovable and that others are not to be trusted. As a result, an “insecure attachment” style persists. Rather than engaging in exploratory behavior, “insecure” infants direct their attention and energy to maintaining their attachments to inconsistent, unavailable, or rejecting parent. For example, if the child is able to maintain closeness to the parent only by behaving as if the parent is not needed, that child may learn not to express his needs for closeness and attention (Shorey & Snyder, 2006). Such a child will not only lack self-confidence and appropriate social skills, he will also seek ways to meet his needs that make no demands on his confidence or skills (Marshall, 2001).

Such is the case with the pattern of attachment termed “anxious-ambivalent.” Although parents of “anxious-ambivalent” children may not be overtly rejecting, they are often unpredictable and inconsistent in their response to the child’s needs (Shorey & Snyder, 2006). As such, the child is prone to separation anxiety and may present as clingy, distressed, and difficult to soothe (Bowlby, 1989). Fearful of abandonment, the “anxious-ambivalent” child becomes hypervigilant for signs of threat or rejection and often learns that he is not capable of getting what he needs from another person (Shorey & Snyder, 2006; Karen, 1994).

The last attachment pattern is “avoidant attachment” in which the child has no confidence that he will obtain help from his parents when it is elicited as the caregiver’s style is usually unresponsive, impatient, rejecting, and unavailable. This attachment pattern can be recognized by a lack of exploration, allowing the child to avoid any situation that may activate his attachment needs (Bowlby, 1989; Karen, 1994). As a result the child learns to retreat, shutting down the attachment system when faced with disappointment or pain and experiences no need for love (Karen, 1994). Over time, such suppression may occur below the level of consciousness such that “avoidant” children may not acknowledge their distress even to themselves (Shorey & Snyder, 2006).

Adult Attachment Patterns

Drawing from Bowlby’s notion that attachment behavior stems from how people view themselves and others, Bartholomew and Horowitz (1991) designed a four-category model that also captures how people vary in terms of anxiety and avoidance: “secure” (low anxiety, low avoidance; positive sense of self and other), “preoccupied” (high anxiety, low avoidance; negative sense of self, positive sense of other), “dismissing” (low anxiety, high avoidance; positive sense of self, negative sense of other), and “fearful” (high anxiety, high avoidance; negative sense of self and other). A “preoccupied” style describes people who so strongly desire intimacy that they are almost obsessed with it, but have such a negative view of themselves that as soon as someone gets close to them they withdraw for fear of rejection (Marshall, 2001). The “fearful” and “dismissive” categories, when combined, are equivalent to the attachment category more commonly referred to as “avoidant” (Lyn & Burton, 2004).

Brennan, Clark, and Shaver (1998) suggested a dimensional approach better captures more subtle variations in attachment styles than is possible with a categorical approach (see Figure 2). From this perspective, avoidance reflects the degree to which individuals feel comfortable with closeness and emotional intimacy in relationships. Those who score higher on the avoidance dimension tend to demonstrate less investment in relationships and strive to remain psychologically and emotionally independent (Hazan & Shaver, 1994). Anxiety reflects the degree to which individuals worry and ruminate about being rejected or abandoned by others. Prototypically secure people tend to score low on both of these dimensions (Butzer & Campbell, 2008).

Stability of Attachment Patterns

Bowlby’s view that patterns of attachment, once developed, are stable throughout life has been supported by empirical research (Hazan & Shaver, 1987). Adult attachment styles have also been found to correspond with memories of parenting in childhood that are theoretically congruent with those same attachment styles (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998). In addition, percentages for the three main attachment styles found in adult samples (56% secure, 25% avoidant, and 19% anxious-ambivalent) are similar to the percentages reported for infant samples (70% of infants are securely attached, 20% are avoidant, and 10% are anxious-ambivalent) (Ainsworth, 1989; Hazan & Shaver, 1987). This persistence can be at least partially explained by the fact that parenting style does not usually change, thereby strengthening the pattern of attachment over time.

It is through these early interactions that individuals develop internal representations of the self, the other, and the relationship between the two (Craissati, McClurg, & Browne, 2002).

		Models of Others	
		Positive <i>Low</i>	Negative <i>High</i>
Models of Self <i>Anxiety</i>	Positive <i>Low</i>	Secure	Dismissing
	Negative <i>High</i>	Preoccupied	Fearful

Figure 2. Four-category attachment typology developed by Bartholomew and Horowitz (1991) based on models of self and others, and reframed by Brennan et al. (1998a) according to levels of attachment anxiety and attachment avoidance. (Figure taken from Shorey and Snyder, 2006, p 4).

The internal representation of attachment relationships, what Bowlby termed the “internal working model,” function as a lens through which all future interpersonal interactions are interpreted (Burk & Burkhart, 2003). These representations are based on early experiences with significant others, particularly parents, and serve to guide behaviors and expectations in social interactions throughout life (Tucker & Anders, 1996). The internal representations underlying these attachment styles are internalized and direct the developing child to behave in ways consistent with his expectations of how others will respond to him. In turn, the child’s behaviors elicit reactions from others consistent with the child’s beliefs (Shorey & Snyder, 2006). Shorey and Snyder (2006) acknowledged that “attachment related working models are reinforced throughout the developmental years and become the road maps for perceiving, interpreting, and responding to environments as children mature into adulthood” (p 3). For this reason, distortions

in early attachment experiences are indicated as a key determinant of abnormal adult emotional bonds (Craissati, et al., 2002). For example, it has been suggested that non-optimal attachment may be most significant in terms of influencing a child's relationship pattern with peers, future partners, and future offspring (Mash & Dozois, 2003).

While "internal working models" tend to retain their essential qualities over time, they are always subject to updating and revision (Cunningham & Page, 2001). Rothbard and Shaver (1994), as well as Hamilton (2000), have demonstrated that attachment styles may be modified in the context of close interpersonal relationships or negative life events. This suggests that attachment patterns are a property of relationship, not a person's genetically based patterns of emotionality and reactions to the environment (Smith, 1993). In other words, change can result via sustained disconfirming evidence that contradicts the "internal working models" developed in early childhood (Rothbard & Shaver, 1994). Bowlby (1988) wrote about "developmental pathways" along which children and adults travel, moving toward and away from attachment security due to events such as the death of loved ones, supportive therapy, and the quality of a marital relationship. As one moves along these pathways, it is possible for "internal working models" of relationships with parents to diverge from working models of romantic relationships; the person may feel and act different in different relationships. There is, however, evidence suggesting that attachment style and the personality features that accompany it become more resistant to change the longer they are reinforced.

Attachment and Human Sexuality

There are many factors which contribute to the development and expression of human sexuality and to the form of sexual behavior pursued by any individual. Perspectives investigated include genetic contributions to factors such as aggressiveness and impulsiveness, physiological differences such as sex drive, neurotransmitter function and hormone levels, the use and abuse of alcohol and other substances, sociocultural demands, gender differences, and interpersonal factors (Burk & Burkhart, 2003).

Attachment theory is one theoretical perspective that is particularly applicable to the research on sexuality, as it focuses on the processes involved in the development of close emotional bonds with others (Butzer & Campbell, 2008). Attachment theorists have argued that caregiving, attachment processes, and sexuality are all involved in romantic (Bogaert & Sadava, 2002). Laschinger, Purnell, Schwartz, White and Wingfield (2004) make the case that the psychological dimension of the experience of human sexuality cannot be separated from the psychological dynamics of attachment within a social and cultural context. Furthermore, the quality of interactions with significant others in times of need has been found to shape the relationship goals, beliefs about the relationship, and one's interpersonal behaviors (Birnbaum, Mikulincer, Reis, Gillath, & Orpaz, 2006).

Empirical research has validated adult attachment by linking it to how adults think about and act in intimate relationships (Bartholomew & Horowitz, 1991). Generally, "secure" attachment is related to positive relationship outcomes. Intimacy and nurturance become primary interaction goals and partners are thought of as trustworthy and reliable (Laschinger, et al., 2004). "Insecure" attachment, however, is related to less adaptive relationship outcomes. In comparison to "securely" attached individuals, those who demonstrate an "avoidant" attachment style tend to minimize emotional intimacy and "anxiously" attached individuals are needy for emotional intimacy (Bartholomew & Horowitz, 1991). Laschinger, et al. (2004) believe that primary erotic attachments can be profoundly feared because of past losses, sexual intrusion, and abandonment.

In such cases, insecurities and doubts about close relationships dominate, leading to the use of defensive strategies to deal with these insecurities (Birnbaum, et al., 2006). For example, in the case of early sexual intrusion, a pattern of later difficulties in sexual relationships which include intrusive fantasies and aggressive sadomasochistic repetitions has been identified. With an early history of abandonment, the subsequent loneliness and isolation linked to “insecure” attachment along with the conflicted longings for closeness can lead to needs for bodily emotion regulation processes (e.g. masturbation to calm and soothe). With a history of separation and loss, anger and aggression may infuse sexual relating. Further, in all attachment difficulties there can be a profound insecurity about inhabiting one’s body or having a sexual identity of one’s own (Laschinger, et al., 2004).

Attachment and Men Who Sexually Offend

Marshall (1989) developed a theoretical framework integrating research on attachment theory, intimacy deficits, and sexual offending. He was the first to introduce concepts of attachment into the discussion of sexual offending, highlighting a characteristic failure to achieve “secure” attachment bonds in men who sexually offend. Marshall’s theory focuses on the development of vulnerability, primarily generated by a problematic relationship between child and parent, that is channeled by subsequent experiences into sexual offending (Marshall, 2001). This process occurs, according to Marshall (1989), because “insecure” childhood attachment results in deficits of interpersonal skills, self-confidence, and empathy, which then leads to difficulties in engaging in appropriate courtship behaviors and in achieving intimacy as an adult. He further suggests that one consequence of lacking intimacy skills and the subsequent experience of emotional loneliness is that men may indirectly seek emotional intimacy through sex even if they have to force a partner to participate. This fusion of the need for emotional closeness with the drive for sex, together with a minimal awareness that their needs remain unfulfilled, can lead to persistent promiscuity and increasing sexual deviancy as offenders escalate their attempts to achieve emotional intimacy through sexual contact.

Emotional loneliness, a result of the lack of intimacy in personal relationships, may lead to superficial involvement with others. However, this does not mean that these relationships are emotionally unfulfilling (Ward, Hudson, Marshall, & Siegert, 1995). It has been suggested that emotional loneliness generates a self-interested and aggressive disposition as it can lead to hostile attitudes toward women and children, as well as to the acceptance of violence and interpersonally aggressive behavior (Hudson & Ward, 1997; Marshall, 2001). This, combined with an inability to meet relationship needs in appropriate ways, may increase one’s likelihood of sexual aggression. It is therefore believed that many men who sexually offend tend to display a low level of intimacy and experience emotional loneliness (Marshall, 2001).

Using Bartholomew’s model of attachment, Ward, Hudson, and Marshall (1996) worked to expand Marshall’s original suggestion into a model that relates attachment style to offending styles and related interpersonal goals. Data was gathered regarding the attachment style of men who both engaged in sexual offending behavior and were in close relationships. The participants, recruited from medium security prisons in New Zealand, included incarcerated offenders defined as child molesters (n=55), rapists (n=30), violent non-sexual offenders (n=32), and non-violent non-sexual offenders (n=30). In this study, child molesters are defined as men offending against children with a range of acts from masturbating in front of a child to complete intercourse or sodomy with force. Rapists are defined as men offending against adult women with acts ranging from indecent assault to predatory, sadistic rape with high levels of force and violence. Opposed to previously determined normative data in which 35-45% of a normal population is insecurely attached, Ward, et al. found that rapists (69%) and child molesters (78-82%) were insecurely

attached in their romantic relationships with adults. This trend, however, did not seem to be a unique feature of this group as both violent and non-violent non-sexual offender groups were also predominantly insecurely attached.

When examining attachment subtypes, the results of the Ward, et al. (1996) study found that rapists were most likely to be “dismissive,” demonstrating a tendency to exhibit high levels of aggression. This may be due to their perception of others in a hostile and deprecatory manner. Child molesters were more likely to have either a “fearful” or “preoccupied” attachment styles, which may be related to their high levels of social anxiety and poor social skills. “Fearful” individuals are likely to express their aggression indirectly, experience loneliness as their relationships tend to be impersonal, and be rather unempathic due to their negative view of others. “Preoccupied” people are typically sexually preoccupied and prone to sexualizing their need for security and affection (Hudson & Ward, 1997).

The relationship between several interpersonal variables (such as loneliness, fear of intimacy, anger, and hostile and abuse-supportive attitudes toward women) and both offense type and attachment style was examined by Hudson and Ward (1997). Participants were gathered from two medium security prisons and consisted of 55 men who had sexually offended against children, 30 men who had sexually offended against adult women, 32 men who had committed violent offenses, and 30 men incarcerated for neither sexual nor violent offenses. Attachment style indicated that 31 (21%) of the participants were classified as “securely” attached, 17 (12%) as “preoccupied,” 48 (33%) as “fearfully” attached, and 52 (35%) as “dismissive.” The results indicate that the “secure” and “preoccupied” groups reported significantly lower scores regarding fear of intimacy than those in the “fearful” and “dismissing” groups. Findings also indicated that the “secure” and “dismissing” groups reported the lowest loneliness scores, as compared to the “preoccupied” and “fearfully” attached men. Child molesters and nonviolent offenders were significantly less angry, in a generalized way, than rapists and violent offenders. According to this study, “securely” attached offenders reported the lowest hostility toward women, and those with a “fearful” attachment style reported the highest scores in this domain. The latter may be a function of their distrust and negative view of themselves and their prospective partners. “Preoccupied” offenders were the least agreeable with distortions related to rape, possibly reflecting their goal of closeness and intimacy. “Dismissingly” attached offenders were the most accepting of such distortions, however, which may be a function of their positive view of themselves and their negative view of others.

Craissati, McClurg, and Browne (2002) examined parental bonding relationships in 76 men who committed sexual offenses [57 child molesters (men whose victim was under the age of 16) and 19 rapists (men whose victim was over the age of 16)]. The results indicated that the most frequently encountered category for men who sexually offend, in general, was that of “affectionless control.” This category describes an individual who has experienced inconsistent parenting, characterized by neglectful and indifferent parental care combined with intrusive, rejecting, and abusive control. Child molesters were significantly ($p < .05$) more likely to rate both parents as providing “affectionless control” rather than any other combination of categories. Craissati, et al. found that child molesters report high levels of disturbed bonding with their parents, with only one-fifth of the sample describing optimum bonding with at least one parent. These men were clearly prone to experiencing their mothers, in particular, as failing in care. Not differing from the normal population, the rapists in the sample rated their mothers as most likely to provide “optimum bonding” (high care and low overprotection) over any other category and their fathers equally as likely to provide “optimum bonding” and “affectionless control.”

Lyn and Burton's (2004) study hypothesized that men who sexually offend would exhibit "insecure" attachment. One hundred seventy-eight inmates (144 men who sexually offended and 34 non-sexual offenders) from a Midwestern low security prison volunteered to participate. The study found that among the sexual offender sample for whom attachment status could be determined ($n = 129$), 110 (85.3%) of them were "insecurely" attached, 73 (56.6%) were in the "fearfully" attached category, 22 (17.1%) were in the "preoccupied" category, and 15 (11.6%) had a "dismissive" attachment style. Among the non-sexual offenders for whom attachment status could be determined ($n=25$), 16 (64%) were "insecurely" attached with 5 (20%) in the "fearful" category, 5 (20%) in the "preoccupied" category, and 6 (24%) in the "dismissing" category. The number of men who committed sexual offenses in the "fearfully" attached category was three to four times larger than expected on the basis of data derived from non-incarcerated, non-offending samples. This result, as well as the finding that the sexual offender and non-sexual offender groups did not differ on a measure of criminal behavior, suggests that "insecure" attachment is not a characteristic of general criminality. Rather, it appears more likely that "insecure" attachment status is specific to men who sexually offend; "insecurely" attached subjects were 5.53 ($p<.05$) times more likely than "securely" attached subjects to be in the sexual offender population. More specifically, the likelihood of membership in the sex offender group was 11.86 ($p<.001$) times greater for those who were "fearfully" attached than for those who were not. Membership in the "preoccupied" and "dismissing" categories was not significantly associated with sex offender status.

Stirpe, Abracen, Stermac, and Wilson (2006) looked at the beliefs about attachment held by men who sexually offend. The insecure patterns described are the "dismissing" (idealizing or derogatory about attachment), the "preoccupied" (angry or passive) and the "unresolved" in relation to loss or abuse. The "dismissing" and "preoccupied" categories map both conceptually and empirically onto the "avoidant" and "ambivalent" infant categories, respectively. The "unresolved" category corresponds to the general disorganization of the attachment system (Fonagy, 2001). Results of the Stirpe, et al. (2006) study suggest that individuals who sexually offend demonstrate a more "insecure" attachment than normative samples; less than 10% of men who sexually offend were "secure" compared to 45-55% of normative samples. While "insecure" attachment was common to all offender groups, there were some important differences noted in regard to type of insecurity. Most notable were child molesters (men convicted of a sexual offense against an unrelated person under the age of 16), who were much more likely to be "preoccupied." Violent offenders, rapists, and incest offenders (to a lesser degree) were more likely to be "dismissing." In this study, rapists are defined as men convicted of a sexual offense against a female over the age of 16. Incest offenders are defined as men convicted of a sexual offense against a related person (either biological or step) under 16 years of age.

In recent years, the etiological significance of "insecure" childhood attachment among men who sexually offend has received theoretical consideration and tentative empirical support (Smallbone & McCabe, 2003). It has been argued that difficulties with attachment and interpersonal skills may be related to sexually inappropriate ways utilized by individuals who commit sexual offenses when seeking intimacy (Stirpe, et al., 2006). The type of "insecure" attachment and its associated intimacy problems may predispose someone to be more likely to offend against one or another potential victim groups (e.g. adult women, children, family members). It is also suggested that some attachment styles may be more likely associated with aggressive or sadistic sexual crimes (Marshall, 2001).

When thinking of "insecure" attachment processes as a diathesis for engaging in more maladaptive interpersonal behaviors, however, it may be better to return to the general distinction

between “secure” and “insecure” attachment and think in terms of the severity of the attachment disruption, rather than in terms of specific types of “insecure” attachment (Burk & Burkhart, 2003). Within the protective relationship resulting from “secure” attachment bonds, the developing child becomes less and less dependent on the bond with the parent to provide protection. Eventually, the child has the necessary skills within himself, and within the relationship with his larger social network, to control internal change and environmental input in ways that get his needs met in a prosocial manner (Marvin & Britner, 1999). On the other hand, severe “insecurity” has been proposed as a diathesis for committing sexual offending behavior, as well as other maladaptive interpersonal behaviors. While poor attachment alone is insufficient to produce sexual offending behavior, it likely obstructs the acquisition of critical self-regulatory skills, leads to less organized self-perceptions, and engenders negative emotional states. These factors may lead a person to rely on externally based self-regulatory strategies, including strategies of interpersonal control. For sexual offending behavior to serve as an externally based self-regulatory strategy, an individual would have to manifest severe disruption of attachment and controlling interpersonal behavior, as well as other environmental and experiential factors, which would ultimately determine an idiosyncratic sexualized response (Burk & Burkhart, 2003). Main (2000) proposed that less secure attachments negatively impact the availability of attentional and other resources usually directed towards exploration and interpretation of the environment. “Insecure” attachments may thus have long-standing negative consequences by impacting broad learning capabilities, including learned self-regulatory strategies (Burk & Burkhart, 2003).

An Attachment Informed Perspective on Treating Men Who Sexually Offend

From an attachment informed perspective, therapy is conceptualized as an attachment process. As such, it is expected that patients' “internal working models” of self and other will be operating in the therapy and that patients' attachment styles will be observed in the therapeutic relationship (Connors, 1997). It is important to note, that not all people identified as having a specific attachment style are identical. Everyone is a unique individual, which distinctive “internal working models” of self and other. In this way, it is possible to view attachment style as akin to culture, in that understanding and competence in the area offers a framework for commonalities while allowing for individual manifestations of one's issues.

In the context of therapy, Bowlby (1988) defined five tasks:

1. Create a safe place, or “secure base,” for client to explore thoughts, feelings and experiences regarding self and attachment figures;
2. Explore current relationships with attachment figures;
3. Explore relationship with psychotherapist as an attachment figure;
4. Explore the relationship between early childhood attachment experiences and current relationships; and
5. Find new ways of regulating attachment anxiety (i.e., emotional regulation) when the attachment behavioral system is activated.

Creating a “secure base”

The task of creating a “secure base,” carried out by establishing a therapeutic alliance, creates the safe place from which representational models of the client and his attachment figures can be explored. Bowlby (1988) outlined this task as follows:

The therapeutic alliance appears as a secure base, an internal object as a working, or representational, model of an attachment figure, reconstruction as exploring memories of

the past, resistance as a deep reluctance to disobey the past orders of parents not to tell or not to remember (p. 151).

If the patient has an “insecure” attachment style, it can be helpful to engage his intellectual interest and curiosity concerning less threatening aspects of his development. It can be helpful to incorporate terms, references, and analogies that relate to areas of the patient’s interests (e.g., discussions of sports may help decrease anxiety). It may also be useful with “insecurely” attached patients to frame therapeutic interventions in relatively distant and cognitive terms, especially at first. For example, the work could be described as exploring patterns learned growing up and working to change them. Offering assistance with stress-related symptoms or a concrete problem early in treatment may also facilitate trust in the clinician, thus being a potentially vital component in the patient's engagement in a collaborative relationship (Connors, 1997).

If the client’s attachment strategies are not taken into account, the therapist’s responses will likely confirm the client’s “inner working models,” thereby reinforcing the current manifestation of the attachment behavioral system. However, if the therapist responds with empathy and attunement, two things can happen. First, the client may have a different experience of himself. The attuned therapist, like the attuned parent, looks beyond the client’s response set and helps him recognize his unconscious motivations, needs, and emotions. The therapist also helps the client view his attachment behaviors from a different perspective. This basic process is the beginning of the client altering his inner working model of self. The second possible outcome is that the client may feel understood, seen, and cared for. Such an experience can be relieving and soothing, thereby beginning to alter the client’s inner working model of others. These processes, feeling understood and recognizing underlying needs and feelings, are the rudimentary beginning of the creation of a secure base in psychotherapy. Furthermore, it is a necessary first step in the process of altering the attachment system (Sonkin & Dutton, 2003).

Exploring current relationships

As the therapy proceeds, the task of exploring current relationships with attachment figures becomes a focus of the therapy. This is especially important as most dynamic risk factors for sexual recidivism are rooted in interpersonal domains (Newring & Wheeler, in print). By exploring the “internal working models” of self and other, the client can begin to understand why he may have difficulties in regulating affect or why he experiences a need to control others as a means to regulate attachment-related affect (Sonkin & Dutton, 2003). Focusing on current relationships may highlight that some “insecurely” attached individuals get their needs met by exploiting interpersonal situations. As part of this task, one should focus on preserving appropriate interpersonal boundaries and developing safe, socially appropriate ways of meeting unmet attachment needs of the short- and long-term (Lyn & Burton, 2004).

Another therapeutic consideration is the importance of affective processes in attachment relationships. Past attachment experiences are believed to be coded in memory along with their associated affect and then activated by current relationships that bear some similarity to earlier ones. The emotions consequently influence further information processing, as well as the coping strategy utilized to deal with a situation (Ward, et al., 1995). As such, suggestions to speak freely and inquiries into emotional states will be foreign to clients whose caregivers discouraged expression of negative affect and may signal potential retraumatization. Main (1995) described how “dismissing” individuals resist therapist’s inquiries by cutting interactions short. Such clients experience anxiety around the possibility of experiencing powerful affects in relationships and will consistently minimize the intensity and importance of emotional matters. “Avoidant”

individuals, on the other hand, tend to be anxious about threats to their organization, including threats emanating from a focus on attachment processes (Connors, 1997).

Exploring the relationship with the therapist

Sitting in a room with a stranger and talking about emotionally laden material can be anxiety provoking and likely activates the attachment system right from the start. Unlike the infant whose attachment experiences are not yet solidified into firmly established working models, the adult client has developed a response set to stress and vulnerability within an interpersonal context. Depending on attachment style, the response set will be similar to the client's responses to other interpersonal relationships in his life (e.g. behaviors that contribute to the problems for which they are seeking help) (Sonkin & Dutton, 2003). For example, when faced with distressing interpersonal conflict outside of the session, a client may turn to sexualized coping through masturbation, impersonal sex, use of pornography or other topographically similar sexual problem. In the therapeutic context, the response demands may overwhelm an overtly sexual coping response yet may foster a response that works similarly, such as sexualized talk, directed conversation towards a previous sexually inappropriate act, that would function in the same sexually self-soothing manner as would more overtly sexual behavior (Newring & Wheeler, in print). As attachment behaviors can be obvious or subtle, it is important the therapist pay close attention to the client's verbal and non-verbal behaviors in order to hypothesize how the client's attachment system is activated (Sonkin & Dutton, 2003). The rules that govern Functional Analytic Psychotherapy (FAP) can also be utilized here to guide the clinician on noticing, evoking, and reinforcing behaviorally specific treatment targets ("clinically relevant behaviors"). These rules include: 1. Watch for clinically relevant behavior, 2. Evoke clinically relevant behavior, 3. Naturally reinforce clinically relevant behavior, 4. Notice the clinician's effect on the client, and 5. Provide functional interpretations of the client's behavior (Newring & Wheeler, in print).

Most clients do not readily admit to having feelings about being in therapy or toward their therapist. Understanding a client's particular attachment style informs the attachment-oriented therapist of how and when to address the therapeutic relationship with a particular client (Sonkin & Dutton, 2003). For example, therapists need to be supportive and gently challenging with "anxious ambivalent" men due to their negative self-perceptions and tendency to overvalue others. However, such a stance would not likely be successful with "avoidant" offenders because of their need to remain independent and their disdainful attitude toward displays of emotions (Ward, et al., 2005).

Clinicians need to be prepared for patients who display aversion and discomfort. Some evidence suggests that avoidant individuals are the least accepting of their partners' faults (Hazan & Shaver, 1987); it is possible that these negative attitudes might appear with therapists as well. Connors (1997) found that inviting dismissive patients to discuss their discomfort and lack of trust can be useful, especially when the therapist communicates the attitude that, of course the patient is distrustful and should determine over time if therapist might be worthy of his trust. Connors also found, with dismissive patients, that a slightly matter-of-fact attitude and a focus on pathogenic early learning are more facilitative of building trust than overt displays of empathy for their suffering.

Addressing therapeutic relationship from an attachment perspective is important. It is through the relating that occurs during the clinical hour that there is opportunity to explore and hopefully change the representational models that determine a client's attachment style. Also, working with the client when feelings arise in therapy helps him find ways of regulating attachment anxiety and

patterns of avoidance while the attachment system is activated (Sonkin & Dutton, 2003). Viewing attachment from the perspective of anxiety and avoidance, Hazan and Shaver (1987) suggest that modifying attachment styles involves the client learning to regulate attachment anxiety and/or finding other means of expressing attachment needs other than through avoidance.

Exploring relationship between early attachment experiences and current relationships

As intimacy deficits have already been defined as one of the dynamic variables implicated in risk prediction of individuals who sexually offend, it may be that victim empathy work can be enhanced by increasing the offenders' emotional awareness of their own impoverished parental relationships (Craissati, et al., 2002). This may be particularly difficult for avoidant individuals who, as determined by Connors (1997), self-disclose less than secure or preoccupied individuals and seem unaffected by the level of partner disclosure. It is crucial that people who sexually offend learn to appreciate the close relationship among emotions, behaviors, and "internal working models." This knowledge will enable them to create behavior chains associated with their own intimate relationships and lead to interventions designed to modify problematic elements. As such, cognitive interventions may be useful in challenging core beliefs and attitudes associated with a particular attachment style (Ward, et al., 1995). Additionally, the use of Functional Ideographic Assessment Template (FIAT) can help to breakdown the client's responding into classes of behavior based on function of responding. The use of this type of assessment looks at the correlation between interpersonal effectiveness and distress (Newring & Wheeler, in print).

The experiences with early caregivers form the representational models of self and other from which the client views himself and the significant attachment relationships in his life. As such, the therapist must be willing to work through unresolved trauma, loss, and other emotionally laden relationship experiences with the client. It is also important to note that painful recollections of subtle and obvious rejections and misattunements by parents can evoke powerful feelings of sadness, loss, and anger (Sonkin & Dutton, 2003).

Another important part of this process involves the exploration of the representational models of self and attachment figures that result from early experiences. The goal is to reassess and restructure the models of self and others in light of the understanding and insight gleaned from this process. Shifts of "internal working models" may be accomplished through a combination of achieving insight and perspective on one's developmental trajectory within a particular family context, as well as by accruing new attachment-related experiences that are discrepant with the old working models (Bowlby, 1988). The goal of this exploration is helping the client to be less controlled by historical experiences with attachment figures. In doing so, current relationships with attachment figures will be less emotionally charged (Sonkin & Dutton, 2003).

Looking forward to the ultimate goals of therapy, clinicians should help men who sexually offend to develop insight into how attachment may relate to their inappropriate sexual behavior (Connors, 1997). For patients for who are more dismissive or fearful in their attachment style, a positive shift would be an increased capacity to process affect and discuss painful events without idealization and minimization. Hazan and Shaver (1994) suggested that the shift from an avoidant stance to a more secure model involves acknowledging long-repressed insecurities, noting that this acknowledgment may require a transitional phase of anxiety and insecurity. For more preoccupied patients, the goal would be greater detachment and decreased enmeshment (Connors, 1997).

One intervention by which to attain such goals would be to provide the patient with guidance around identifying his attachment insecurities (Lyn & Burton, 2004). An additional focus needs to be the mobilization and remobilization of defenses against the awareness of the impact of one's attachment history and of longings for a different experience (Connors, 1997). For example, it is suggested that individuals with a dismissive attachment style have immense difficulty with the therapeutic process as they have learned to become organized around the avoidance of attachment-related information. Further, the notion of relying on a new attachment figure is strenuously resisted by those who have been consistently rebuffed and treated harshly in their original attachment relationships. As such, implications for treatment of patients with dismissive attachment include the necessity for understanding this stance as an adaptation to consistent rejection and having patience with its rigidity (Connors, 1997).

Finding new ways of regulating attachment anxiety

As previously mentioned, the activation of the attachment system in the therapeutic hour can be the most effective way to address attachment anxiety with the client. The distancing of the dismissing attachment style, the pleasing and idealizing behaviors of the preoccupied attachment style, and the erratic dependency and distancing of the fearful attachment style will eventually manifest in therapy. When a secure base is developed and the client has some insight into his attachment relationships, the ground is set to address these behaviors as they manifest with in the therapeutic relationship. Through the interpretation and confrontation of these behavioral manifestations of the activated attachment system, the client can learn to face the pain and vulnerability that underlie these defenses. This approach also allows the clients to feel understood and supported by the therapist, and eventually develop within themselves new skills in self-soothing, reassurance, and relaxation. The net result is the client is able to reduce the reactivity and sensitivity to perceived cues of threatened safety or protection (Sonkin & Dutton, 2003).

Although insight into attachment patterns is an important task from an attachment perspective, the strong agent of change is the development of new strategies for coping with attachment related anxiety. On a practical level, one immediate therapeutic objective is developing the ability to recognize an anxious reaction to loss and the ability to self-soothe. However, because this ability should have developed through sensitive attunement by the early attachment figure, it must now be learned through the attunement of an attachment figure such as a therapist. The therapist must be that soothing voice until the client learns to find that voice within himself (Sonkin & Dutton, 2003).

Summary

Cognitive and behavioral interventions have been empirically validated as helpful when treating men who sexually offend. However, it is this author's belief that treatment gains may be enhanced and perhaps become more robust if attachment theory-informed approaches provided the framework from which sex offender specific treatment was based. Treatment from an attachment-informed perspective may include the missing elements that can ultimately lead to lasting change with clients, manifested not only by the cessation of violence but also by a significant change in the client's experience of close relationships in general.

As the nature of attachment of individuals who sexually offend continues to be explored, it is reasonable to apply what is already known. By viewing troubled behaviors through a lens of attachment theory and building our understanding, evaluation, and treatment of a framework informed by attachment theory, we can begin to build and add to the existing treatment a model that is attachment-informed (Marshall, 2001). It is possible that such a treatment approach, once

developed, validated, and disseminated, would help to further decrease the risk of recidivism currently reported for men who sexually offend.

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An Employment Model to Increase Employment Rates and Reduce Recidivism for Parolees with Mental Illness

Michael A. Vernale III, Jonathan E. Larson, Ph.D & Diana M. Van De Kreeke

Abstract

This paper proposes a service model to increase employment rates for parolees with severe mental illness (SMI) and indirectly reduce prison recidivism. Evidence suggests that employment reduces recidivism; however, parolees with SMI demonstrate extremely high unemployment rates and they have limited access to evidence-based supported employment before and after discharge. Therefore, in order to increase employment rates, we advocate that criminal justice and mental health professionals collaboratively provide Evidence-Based Supported Employment enhanced with Motivational Interviewing (EBSE/MI). In this paper, we propose a four step process to integrate EBSE/MI within these settings.

Keywords: Evidence-Based Supported Employment, Motivational Interviewing, Recidivism, Parolees

The Pew Center on the States research team estimated that in 2008 the total population of inmates in the United States was 2,319,258, with costs exceeding \$49 billion (The Pew Center on the States 2008). By the midpoint of 2005 it was reported that half of all inmates suffered from some form of mental illness (James & Glaze, 2006). Raphael (2000) suggested the deinstitutionalization movement was to blame. He asserted that between 1971 and 1996 the deinstitutionalization movement coupled with a lack of community support merely transferred individuals with severe mental illness (SMI) from psychiatric hospitals to either prisons or jails. Seltzer (2005) asserted that in addition to incarceration, numerous individuals with SMI have been transferred from mental institutions to nursing homes and board and care houses. Research suggests the high rate of incarceration of persons with mental illness can be partially attributed to limited access to community treatment, increased criminalization of SMI, decreased public funding for community treatment facilities, and limited diversion programs (Raphael, 2000; Seltzer, 2001; Munetz, 2001; and Draine & Solomon, 2001).

Common recommendations emerge from the literature to alleviate the problems raised by the overrepresentation of individuals with SMI in the criminal justice system. The recommendations often stem from the identified risk factors to reoffense, such as lack of employment, emotional/personal issues, marital status, etc. (Mueser, Clark, Haines, Drake, McHugo, Bond, Essock, Becker, Wolf, & Swain, 2004; Vose, Cullen, & Smith, 2008). Research has suggested improving mental health and criminal justice collaboration, increasing access to diversion programs, and improving community integration programs (Draine & Solomon, 2001; Munetz, 2001, Raphael, 2000; Seltzer, 2001 & 2005). However, little research addresses supported employment services for parolees with SMI. Given that employed offenders are less likely to reoffend, this is an important factor in reducing recidivism (National Alliance for Mental Illness, 2004). Research demonstrates that Evidence-Based Supported Employment (EBSEI) effectively assists with community integration (Drake, R.E., McHugo, G.J., Becker, D.R., Anthony, W.A., Clark, R.E., 1996).

While some departments of corrections have been successful in reducing their total prison population (i.e. Nevada, South Carolina, Arkansas, etc; The Pew Center on the States 2008), the fact remains that many parolees who suffer from SMI are more likely to re-offend, rely more

heavily on government funding, and display a lower job retention rate compared to individuals without a history of mental illness (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003; U.S. Department of Justice, 2000; Anthony, Cohen, Farkas, & Gagen, 2002; Bricout, 2002; National Alliance for Mental Illness [NAMI], 2004). We argue that by focusing the attention on people with SMI we can reduce the rate of recidivism in the SMI/criminal population which in turn will reduce the rate of recidivism as a whole. To achieve this goal, we propose a four step model to increase employment rates and decrease recidivism by integrating EBSE with motivational interviewing (MI) into correctional and mental health settings. We utilize a conceptual model guiding re-entry research (Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005) as a starting point.

The model proposed by Draine et al., (2005) is a unique integration of the individual and the community post-incarceration. The premise of the model is the exchange of resources between the individual and the community, thereby allowing an equal balance between both parties. This model indicated jobs as one of four domains of support for re-entry; it also emphasizes the importance of obtaining jobs to gain social capital. Our goal is to build upon aspects of this model, present a pragmatic and simple integration model for conceptualizing future employment research, and prompting the allocations of resources to increase work and reduce recidivism. We initially review our four step integration model and then discuss components of EBSE/MI.

EBSE/MI Correctional and Mental Health Integration Model

Within our four step process, step one (Engagement) takes place ideally at least six months before. We propose six months provides sufficient time for engagement and exposure to employment and motivational interviewing interventions. However, it is noted that six months is not always possible or applicable; in this case, appropriate changes to the model can be made according to the judgment of the facilitator. The first step includes criminal justice practitioners (i.e. any person involved in the treatment and care of the prisoner, such as counselors and correctional officers) identifying prisoners with both mental illness and an interest in exploring employment options. This step also includes linking individuals with EBSE/MI services close to their living place when released and identifying barriers to successful employment, which may include risk factors for reoffense, such as drug and alcohol problems, lack of education, and extent of criminal history (Vose, Cullen, & Smith, 2008). Step two (Implementation), from 6 months to day of release, criminal justice practitioners introduce and utilize EBSE/MI. We understand and do not underestimate problems associated with criminal justice and mental health practitioners providing EBSE/MI. To address these problems we propose to provide adequate training/resources, utilize supervisor support, and highlight incentives for the integration of EBSE/MI into these settings; this would also provide a format for relationship building, crucial for continuity of services. Step three (Integration) takes place the day of release; it includes the transition and continuation of EBSE/MI in mental health settings. Mental health practitioners continue with the employment plans developed during the first six months in prison. Step four (Evaluation) contains analyzing outcome and process variables to evaluate and to improve the integration of EBSE/MI within correctional and mental health settings. This process leads to program fidelity development to ensure consistency among providers and to collect similar data sets for comparison studies. The process of collecting program variables starts during step one and continues until step three.

Evidence-Based Supported Employment

Between 10% and 15% of individuals with psychiatric disabilities are employed, however, they report shorter job retention rates when compared to the general population (Anthony, Cohen, Farkas, & Gagen, 2002; Bricout, 2002; National Alliance for Mental Illness [NAMI], 2004). Over 70% of individuals with psychiatric disabilities rely exclusively on Social Security programs and reported an annual income of less than \$20,000 (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003; U.S. General Accounting Office, 1996). Despite high unemployment rates, individuals with psychiatric disabilities reported the desire to work and considered employment an important recovery goal (Cook & Pickett, 1995; Crowther, Marshall, Bond, & Huxley, 2001; McQuilken et al., 2003; Mueser, Salyers, & Muser, 2001; Anthony & Rogers, 1995; Rogers, Walsh, Masotta, Danley, & Smith, 1991). Further studies demonstrated that employment reduced poverty, improved quality of life, increased self-esteem, and played an important role in psychological health and social well-being (Arns & Linney, 1993; Lehman et al., 2002; Mueser et al., 2004). Employment was found to reduce utilization of government benefit programs and decrease the financial strain on mental health care systems (Baron, 2000; Drake, McHugo, Becker, Anthony, & Clarke, 1996; Kouzis & Eaton, 2000).

In order to address these employment issues, the Robert Wood Johnson Foundation and Federal Substance Abuse and Mental Health Services Administration identified Supported Employment as an evidence-based vocational rehabilitation intervention; they also developed a toolkit to disseminate this practice (Becker & Bond, 2004). Evidence-Based Supported Employment utilizes an employment specialist (ES) and incorporates seven principles to assist individuals with psychiatric disabilities to obtain and maintain employment (Becker & Drake, 1993, 2003; Bond, 1998, 2004).

1. **Competitive work:** People pursue competitive wage rates within the community rather than paid positions within sheltered or day treatment programs. Individuals with competitive positions receive their paychecks directly from an employer rather than a mental health agency.
2. **Rapid job search:** The job hunt should happen quickly instead of emphasizing the importance of pre-job training, assessment, and counseling.
3. **Integration of rehabilitation and mental health:** In collaboration with ES, program participants develop a plan for maintaining linkage with a mental health team. ES attend team meetings and provide employment feedback to employment seekers and team members.
4. **Attention to consumer preferences:** Participants seek out employment that meets their strengths, interests, skills, and education level. ES promoted and supported personal job choice.
5. **Eligibility based on consumer choice:** IPS eligibility criteria include only the desire to obtain and maintain competitive employment. Potential participants are not excluded because of level of disability, work readiness, work skills, diagnosis, symptoms, substance abuse, or hospitalizations.
6. **Time-unlimited support:** Participants and ES collaborate to develop an individualized support plan to maintain employment success. The length of support is not predetermined by a set of program requirements and can proceed indeterminately.
7. **Benefits Counseling:** Participants and ES engage a benefits specialist to review the impact on government programs. Participants are offered a referral for a benefits counseling session.

Motivational Interviewing

Forty to 60% of individuals do not obtain employment through EBSE. Possibly, EBSE works best with individuals who are determined to locate employment; however, it lacks components to intervene with individuals demonstrating ambivalence about finding work after they start an employment program. In addition, employment process and outcome variables may be related to participants' motivation to work and perspectives on pros and cons of working rather than limitations of EBSE. In order to engage with individuals with ambivalence about work, we propose to merge EBSE with Motivational Interviewing (MI) into one service package to increase motivation for getting and keeping jobs. Although limited, previous research indicated some promising findings about utilizing MI to help people resolve ambivalence within employment decisions (Larson, et al., 2007; Larson, et al., (In Press). We initially review the Trans-Theoretical Model (Stages of Change) (DiClemente & Prochaska, 1998).

Stages of Change

The Stages of Change Theory explains why some people may be more successful in obtaining therapeutic goals (employment) than others (DiClemente & Prochaska, 1998). The 6 stages of change -- pre-contemplation, contemplation, determination, action, maintenance, and relapse -- may be understood in terms of the costs and benefits of change plus the actual steps that individuals have implemented to accomplish the goal (Corrigan, McCracken & Holmes, 2001).

1. Pre-contemplation: People in this stage perceived no benefits to work and many costs.
2. Contemplation: People in this stage perceived both benefits and costs to work and believed the costs outweigh the benefits.
3. Determination: People in determination also perceived benefits and costs but perceived the benefits to outweigh the costs and are setting job goals.
4. Action: People in the action stage recognized more benefits than costs to getting a job and actively pursued employment or vocational training.
5. Maintenance: People in the maintenance stage have been actively involved in the pursuit of their goal for six months or more.
6. Relapse: The relapse stage represented the negative behaviors that may undermine a person's efforts to achieve or maintain employment. This stage is not applicable to everyone; however, it is more likely than not that a person will experience setbacks.

EBSE/MI Intervention

Within EBSE/MI, we recommend that Supported Employment addresses steps leading to jobs, Motivational Interviewing deals with ambivalence about work, and Stages of Change Theory provides a treatment matching framework.

The Stages of Change model provides guidance to continually assess individuals' stage of change and match it with either EBSE or MI. Individuals in pre-contemplation, contemplation, and relapse is considered ambivalent about locating employment. Individuals in these stages received MI with a goal of moving to the next stage. For example, if contemplating individuals report ambivalence about looking for a job, then MI highlights discrepancies, reviews pros and cons of employment, and prepares individuals for change.

Individuals identified in determination, action, or maintenance stages are considered ready to locate employment. Individuals in these stages received EBSE with goals of obtaining or keeping employment. For example, if an individual in the action stage reported she or he is accepting a job but required help identifying transportation, then EBSE intervention provides a collaborative support plan for getting to and from the job. We suggest utilizing the stages of change to match the right intervention with the right person at the right time. We argue that it makes little practical sense to provide EBSE when individuals are still unsure if employment makes sense for them. However, we recommend that it makes sense to provide MI for individuals still deciding if employment is right for them. Before implementation, criminal justice and mental health practitioners will need skills training on EBSE, MI, and stages of change for treatment matching. After training, professionals will need resources, supportive supervision, and ongoing consultation groups to practice intervention skills and solve the program's problems.

Evidence for Supported Employment

Evidence-Based Supported Employment demonstrated significant increases in employment rates, between 40% and 60% for individuals with psychiatric disabilities (Lehman et al., 2002; Bond et al., 2001; Cook & Razzano, 2000; Rogers, Anthony, Toole, & Brown, 1991; Becker & Drake, 1993, 2003; Bond, 1998, 2004; Bond, Drake & Becker, 1999; Drake, Becker, Biesanz, Wyzik, & Torrey, 1996; Honey, 2000; Schneider, Heyman, & Turton, 2002). Five randomized controlled trials specifically on EBSE indicated three to five fold increases in employment rates and income (Drake et al., 1996; Cook et al., 2005a; Meisler & Williams, 1998).

Evidence for Motivational Interviewing

Motivational Interviewing was developed to move individuals from pre-contemplation/contemplation to determination/action stages of change. It has been defined as a motivational enhancement technique for behavioral change during rehabilitation by identifying and resolving ambivalence and discrepancies between verbal and behavioral actions (Miller & Rollnick, 2002). Reviews of randomized trials of MI reported the effectiveness of changing behavior with various populations and settings (Miller & Rollnick, 2002; Noonan & Moyers, 1997; Dunn, Deroo & Rivara, 2001). We propose that crucial MI skills within employment settings are costs/benefits analysis, readiness ruler, active listening, asking for permission, change talk, and avoiding arguments. Additional skills include rolling with resistance by accepting and not confronting resistant employment behaviors; expressing empathy through active listening with reflection of meanings and feelings; highlighting discrepancies by stating the incongruity between desired employment goals and behaviors that block these goals; and supporting self-efficacy through highlighting successful steps toward employment. (Miller & Rollnick, 2002).

Discussion

We argue early EBSE/MI will increase employment rates of parolees and indirectly decrease recidivism. We proposed a four step process (Engagement, Implementation, Integration, and Evaluation) to integrate EBSE/MI within correctional and mental health settings. In our model, to improve continuity of services, we proposed to initiate employment services six months before release and to continue services after release. Providing early interventions within correctional settings allows exploration of job goals, identification of employment barriers, discussion of disclosing criminal records to employers, and reflection about the pros and cons of work. For prisoners, early EBSE/MI may provide incentives for work and increase motivation to engage with mental health centers for employment services. Initially obtaining employment may then assist with increasing social capital, securing housing, developing relationships, engaging with treatment, and improving health care benefits.

Practitioners in correctional settings gather valuable information and engage prisoners in developing solutions for employment before they are overwhelmed with housing, medication, treatment, services, financial, and additional issues after release. In this model, mental health practitioners engage with parolees at their current point in the employment process rather than starting from scratch. Providing similar services in both settings allows for prisoners/parolees to focus on employment rather than spending time on either finding employment services or learning how to benefit from completely different treatment modalities. Our proposed four step model also provides a framework to conceptualize and investigate the impact of integrated EBSE/MI.

We offer our model may be oversimplified but propose it as an effective starting point to initiate the investigation of integrated employment for persons with serious mental illness re-entering the community from prison. We found limited evidence suggesting that employment services can be integrated within correctional and mental health settings. We acknowledge a limited discussion on barriers and solutions addressing practical issues of training and integrating EBSE/MI into correctional and mental health settings. Overall, we suggest our integration model builds upon a current re-entry model and provides a systematic framework to study the impact of implementing EBSE/MI within correctional and mental health settings. Our model also offers a framework for practitioners to implement EBSE/MI to increase employment and indirectly reduce recidivism.

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Mode Deactivation Therapy (MDT) Comprehensive Meta-Analysis

Jack A. Apsche, Christopher K. Bass & Lucia DiMeo

Abstract

MDT provides an empirically based treatment for adolescents with behavioral problems such as anger, oppositional defiant and sexual and physical aggression (Apsche & DiMeo, 2010). It offers therapists a more efficient and timely intervention that positively effects recidivism rates (Apsche, Bass & Murphy, 2004). Based on Cognitive Behavioral Therapy (CBT) (Beck, 1996), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), Dialectical Behavior Therapy (DBT) (Linehan, 1993) and Functional Analytic Therapy (FAP) (Kohlenberg & Tsai, 1993), MDT has surpassed standards of CBT, DBT and Social Skills Training (SST). This article will review essential MDT studies and present the data in a meta-analysis and Cohen's *d* meta-analysis format.

Keywords: Mode deactivation therapy, meta-analysis, evidenced based practice, Acceptance and commitment therapy.

Introduction

Mode Deactivation Therapy (MDT) is a derivative of Cognitive Behavior Therapy, Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Functional Analytic Psychotherapy and Mindfulness and Meditation from ancient Buddhist practices. Since its earliest conception (Apsche & Ward, 2002) MDT has evolved into a so called "Third Wave Therapy". This evolution has produced what appears to be ever more robust and efficacious results in studies (Apsche & DiMeo, 2010). Apsche & DiMeo (2010) completed a rudimentary meta-analysis including thirty-eight published and unpublished studies on MDT. They included any MDT article with reported data and then examined data from unpublished MDT studies. The results were promising, yet incomplete. That meta-analysis examined all related articles and was, at the time of writing, current and updated. Since that publication, Apsche has completed a large data analysis study that was not included in the Apsche & DiMeo (2010) publication.

In this meta-analysis only MDT studies with N's over seventeen and comprehensive data analysis were examined, as well as the large unpublished study with an N of 143. All previous unpublished studies with smaller N's were not included and were removed for clarity and to not rely on non-published studies or case studies with small data basis. This meta-analysis includes nineteen published and one unpublished MDT studies. The unpublished study includes data for both meta and mediation analysis. The purpose of this study is to examine the overall effectiveness of MDT individual and family groups with a diverse group of male adolescents.

Methods

All published and unpublished MDT studies were evaluated for inclusion. Only studies implementing MDT, in residential and outpatients units, were selected resulting in a total of 20 studies included in the meta-analysis. All the studies included in the meta-analysis are listed in Table 1.

Table 1.

List of Studies

Study	Sample	DV	Design	N	d
Apsche (unpublished) (2006)	Juvenile sex offenders	Outcomes	PP	143	1.28
Apsche & Bass (2006a)	Adolescent males with CD/PD	Outcomes	PP	40	1.24
Apsche & Bass (2006b)	Outpatient	Outcomes	PP	30	.92
Apsche & Bass (2006c)	Family	Outcomes	PP	13	
Apsche & Ward Bailey (2004)	Children/Adolescent with Reactive CD or PD who sexually abuse	Outcomes	PP	20	1.16
Apsche & Ward (2002)	Adolescents with Personality Beliefs, Sexual Offending and Aggression	Outcomes	PP	14	1.05
Apsche, Bass & Houston (2006)	Adolescent Males with aggression	Outcomes	PP	20	1.29
Apsche , Bass & Houston (2007)	Family	Outcomes	PP	20	1
Apsche, Bass & Murphy (2004a)	Adolescent male sex offenders with Reactive Disorder	Outcomes	PP	20	.24
Apsche, Bass & Murphy (2004b)	Adolescent males with CD and Sexually reactive Bxs	Outcomes	PP	30	.92
Apsche, Bass & Siv (2006a)	Outpatient	Outcomes	PP	20	1.31
Apsche, Bass & Siv (2005)	Adolescent Males with CD/PD	Outcomes	PP	21	1.51
Apsche, Bass & Siv (2006b)	Suicidal Adolescents with PD/Traits	Outcomes	PP	20	.97
Apsche, Bass & Siv (2006c)	MDT, SST & CBT- two year post tx	Outcomes	PP	21	1.17
Apsche, Bass, Jennings & Siv (2005)	Adolescent males with CD/PD	Outcomes	PP	40	1.20
Apsche, Bass, Jennings, Murphy, Hunter	Adolescent males	Outcomes	PP	21	1.13

&Siv (2005)	with physical /sexual aggression					
Apsche, Bass, Siv & Matteson (2005)	Aggressive adolescent males	Outcomes	PP	20		1.22
Apsche, Bass, Zeiter & Houston (2009)	FMDT, residential, adolescents with CD/Multi Axial	Outcomes	PP	20		.89
Apsche, Siv & Bass (2005)	Adolescents with CD and fire setting bxs	Outcomes	PP	20		.29
Murphy & Siv (2007)	Adolescent residential patients with CD and PD's	Outcomes	PP	20		1.10
TOTAL					573	

The selected studies were divided into three categories: Individual, Family, and Replication studies. A separate meta-analysis was conducted for each category. All data was extracted by the first author and an associate. The data was entered and calculated using the Cohen's *d* and Effect Size *r* methodologies (Cohen, 1988). The present meta-analysis used the DSTAT statistical package for the computation of effect sizes (Johnson, 1993).

Participants

The 21 studies yielded a sample population of 573 male adolescents between the ages of 14 through 17. Participant characteristics included Axes I and II diagnoses, many with co-morbid presentation (Table 2). Conduct disorder (51%), oppositional defiant disorder (42%), and post-traumatic stress disorder (54%) were prevalent among the population. Additionally, 56% of the population presented mixed personality traits. Fifty-four percent of participants were African American, 43% Caucasian, 4% were Hispanic American and one percent are listed as other (mixed race). Ninety percent of participants had experienced all four types of abuse - sexual, physical, verbal, and neglect. Furthermore, 56% had witnessed violence and 24% were parasuicidal. General participant recidivism was less than 7%, and sexual offense recidivism less than 4% after two years post MDT treatment.

Table 2.

Participant Demographic Characteristics

Characteristics	%
Axis I	
Conduct Disorder	51%
ODD	42%
PTSD	54%
Other Secondary	28%
Axis II Beliefs	
Mixed	56%
BPD	38%
NPP	28%
HPD	2%
DPD	30%
APD	20%
Ethnicity/Race	
African-American	52%
Caucasian	43%
Latin	4%
Other	1%
Ages	
14.5	10%
15	18%
16	42%
17	30%
Background	
Experienced 4 types of abuse*	90%
Witnessed Violence	56%
Parasuicidal	24%
Recidivism (Two Years Post-Treatment)	
General Recidivism	< 7%
SO Recidivism	< 4%

N=573

*Sexual, physical, verbal, neglect

Procedure

The meta-analysis measured the effectiveness of MDT on two separate, although similar, adolescent populations - adolescent sexual abusers and adolescents with conduct disorder. In the individual studies the data was gathered and the effect size and Cohen's d were calculated using the standard Cohen (1988) methodology:

$$\text{Cohen's } d = \frac{M_1 - M_2}{\sigma_{pooled}}$$

$$\text{Where } \sigma_{pooled} = \sqrt{\frac{\sum (x - m)^2}{n}}$$

The effect size r was calculated by the following:

$$r^2 = d^2 / (d^2 + 4)$$

The means and standard deviations were computed using the Lipsey & Wilson (1993) calculation methodology. Cohen (1998) defined effect size as small: $d = .2$, medium: $d = .5$ and large: $d = .8$

Adopting procedures recommended by Rosenthal (1991), each effect size was weighted by sample size, and averaged to yield a grand weighted mean d based on 20 studies. Weighting effect sizes by sample size is an unbiased and objective procedure for assigning different weights to studies that vary in statistical power. The grand weighted mean d was tested for significance (d compared to zero) using a one sample t - test, and 95% confidence intervals were calculated. A chi square was also calculated to test for heterogeneity of variance within the set of effect sizes. The heterogeneity test is the basis for a decision on whether or not to search for moderator variables; in case of significant heterogeneity, it would be necessary to disaggregate the effect sizes according to the variables influencing effect size. Finally, to address the file-drawer problem, a fail -safe N , as recommended by Rosenthal (1991), was calculated to test for robustness. A robust finding indicates that the probability of a Type I error arising from unpublished, non-significant results is negligible.

Results

The results will be separated into 3 categories; Individual studies, Family Studies and Replication studies. We chose to separate the section because of the three separate meta analysis conducted on the selected articles.

Individual Studies

Table three shows the results of the meta analysis on the individual studies. Cohen's d show large effect sizes with SO- Physical Aggression (1.81) and CD- Physical Aggression (1.85). Total Physical Aggression and Sexual Aggression were also large at 1.86 and 1.94 respectively. Child Behavior Check List (CBCL) scores were also large, yet were smaller than the aggression numbers. CBCL scores measuring internal states were 1.10 and External was 1.25. The total CBCL effect size was 1.78. The State-Trait Anger Expression Inventory (STAXI) scores showed internal expressions of anger were not as controlled as external expressions of anger. With subjects who had the Conduct disordered (CD) diagnosed delegation; STAXI scores for inner control was 1.4. Conversely, the control for outward expression was 1.51. The total Anger effect size expressed by this group was 1.82. STAXI effect size scores for Subjects who had offended sexually (SO) were similar to aggressive CD population. Inner control was 1.0. Outward expression of anger control was 1.10. External aggression was among the largest of all groups at 1.9.

Table 3. *Individual Studies*

Category	Cohen's Standard	d	r	% of Non-overlap
SO- Physical Aggression	Large	1.81	.710	75.3
CD- Physical Aggression	Large	1.85	.679	51.6
Total- Physical Aggression	Large	1.86	.674	48.4
Sexual Aggression	Large	1.94	.774	72.9
CBCL -INT	Large	1.10	.450	70.2
CBCL-EXT	Large	1.25	.551	74.1
CBCL Total	Large	1.78	.581	72.7
CD-STAXI Anger Con In	Large	1.4	.521	66.7
CD-Anger Con Out	Large	1.51	.612	63.2
CD- Anger Ex	Large	1.82	.710	75.1
SO-STAXI Anger Con In	Large	1.0	.428	75.4
SO-Anger Con Out	Large	1.10	.410	50.1
SO-Anger Ex	Large	1.9	.670	79.5
J-SOAP Total	Large	1.89	.721	79.4

$N = 13$

Family Studies

Table four- shows the effect sizes of the studies which looked at the family in treatment using Mode Deactivation Therapy. Of the studies chosen Cohen's d produced large effect sizes on most of the categories. The CBCL effect size for internalization was 1.4 whereas, the externalization size was 1.6. The total effect size for CBCL was 1.5. STAXI scores showed 1.3 effect sizes for internal anger control and its expression. Outward anger control was 1.2. The total effect size for anger and its expression was 1.6. Physical expression of anger was large at 1.4 but, the verbal expression of anger showed a medium effect size (.7). Finally, related to physical aggression; Property aggression also showed a large effect size (1.1).

Table 4. *Family Studies*

Category	Cohen's Standard	<i>d</i>	r	% of Non-overlap	
CBCL- INT	Large	1.4	.570	51.6	
CBCL-EXT	Large	1.6	.625	55.4	
CBCL-Total	Large	1.5	.600	53.5	
STAXI- Anger Con In	Large	1.3	.545	58.9	
STAXI-Anger Con Out	Large	1.2	.514	68.1	
STAXI-Anger Ex	Large		1.6	.625	77.4
Behaviors-Physical Aggression	Large	1.4	.513	61.1	
Behaviors-Verbal Aggression	Medium	.7	.330	43.0	
Property Destruction	Large	1.1	.188	58.9	

N=10

Replication studies

Murphy and Siv (2007) provided the data for replication studies. Table five shows the results of the analysis. Replication data was derived from residents in a Residential treatment facility. Physical Aggression had a large effect size of 1.23. Therapeutic holds within the facility showed an effect size of 1.25. CBCL effect sizes for internalization was 1.07 and 1.38 for externalizing behaviors. Total effect size for the CBCL was large (1.33). A matter of note, was the Beck Depression Inventory (BDI) effect size which showed a small size of .28. Also of significant interest was the hand scored, Suicidal ideation questionnaire (SIQHS) size, which showed a medium effect size of .52.

Table 5. *Replication Data (Murphy & Siv, 2007)*

Category	Cohen's Standard	<i>d</i>	r	% of Non-overlap	
Behaviors- Physical Aggression	Large	1.23	.523	65.3	
Behaviors –Therapeutic Holds	Large	1.25	.530	63.8	
CBCL- INT	Large	1.07	.472	75.4	
CBCL-EXT	Large	1.38	.569	67.1	
CBCL-TOTAL	Large	1.33	.554	65.5	
BDI	Small	.28	.137	20.1	
SIQHS	Medium	.52	.251	33.1	

N=20

Table six-a shows graphically the effect size as measured by Cohen's *d*.

Table 6a. *Effect Size and Cohen's d*

Cohen's *d* -Effect size-a

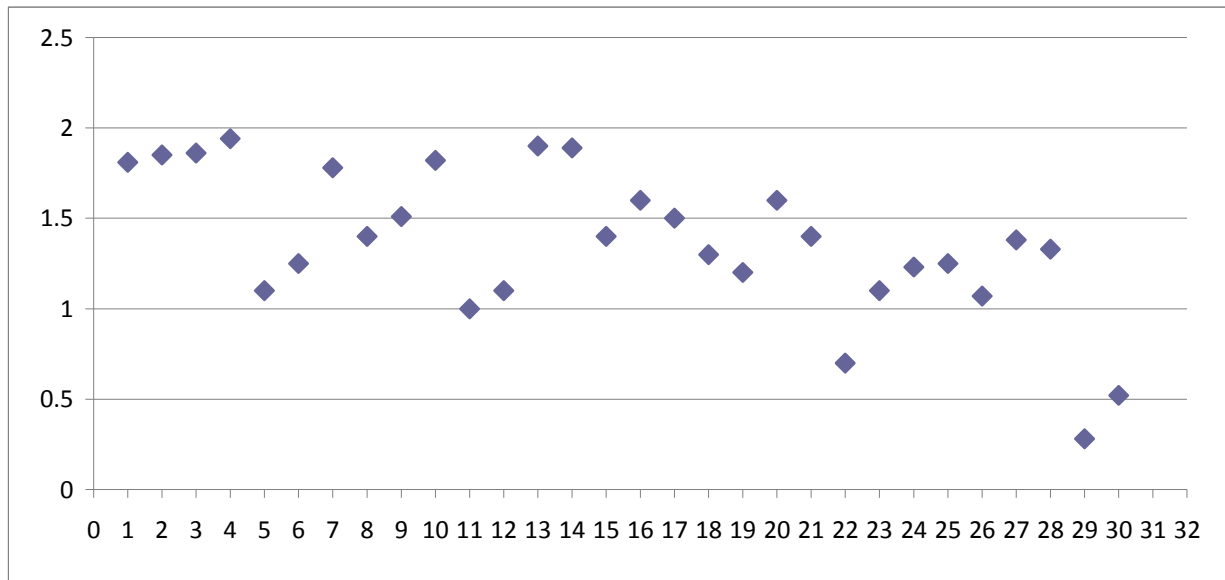


Table six-b shows graphically the effect size calculated *r* scores

Table 6-b. *Effect Size* calculated *r* scores

R scores- Effect Size-b

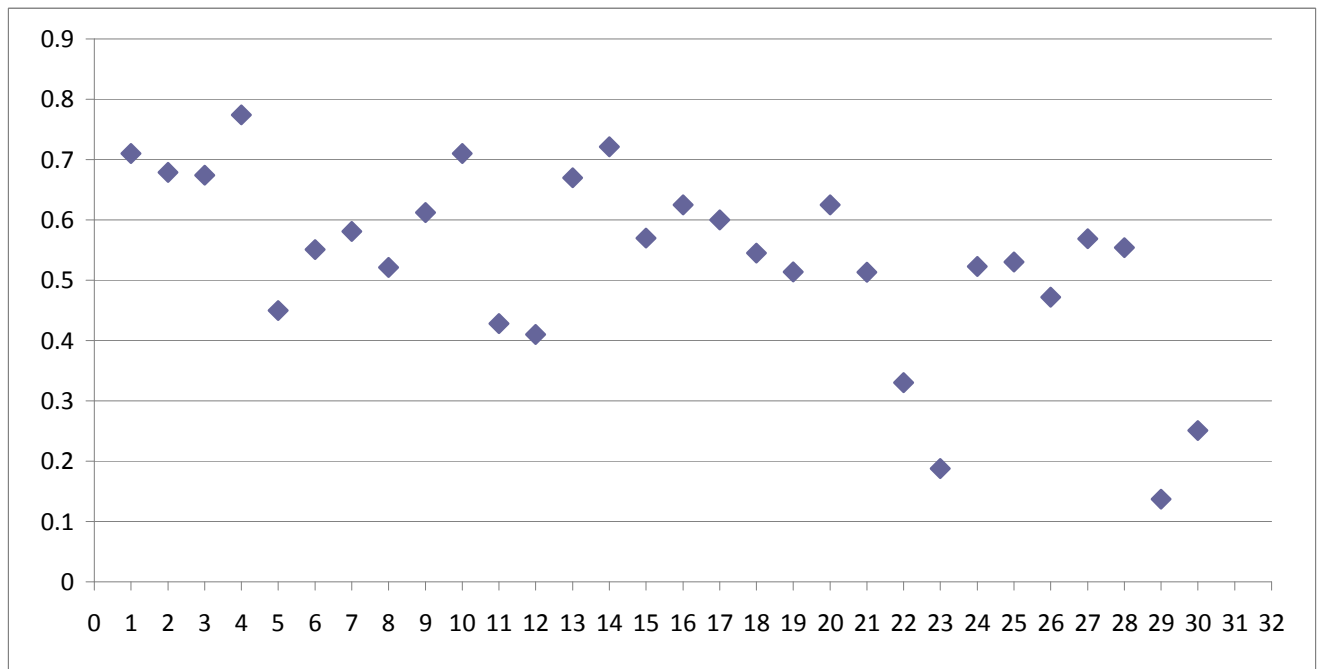


Table 6. *Effect Size and Cohen's d Key*

#	Category
1	SO- Physical Aggression
2	CD- Physical Aggression
3	Total Physical Aggression
4	Sexual Aggression
5	CBCL INT
6	CBCL EXT
7	CBCL Total
8	CD STAXI Anger Con In
9	CD Anger Out
10	CD Anger Ex
11	SO STAXI Anger Con In
12	SO Anger Con out
13	SO Anger Ex
14	JSOAP Total
15	Family CBCL INT
16	Family CBCL EXT
17	Family CBCL Total
18	Family STAXI Anger Con In
19	Family STAXI Anger Con Out
20	Family STAXY Anger Ex
21	Family Behaviors- Physical Aggression
22	Family Behaviors Verbal Aggression
23	Family Behaviors Property Destruction
24	Replication- Physical Aggression
25	Replication- Therapeutic Holds
26	Replication- CBCL INT
27	Replication CBCL EXT
28	Replication CBCL Total
29	Replication BDI
30	Replication SIQHS

Conclusion

There are numerous conclusions to be drawn from the MDT meta-analysis study. First, MDT is an effective-evidenced based methodology with the specific target population of male adolescents. Second, the study validates the MDT hypothesis that adolescent externalizing disorders are the function of adolescent internalizing disorders.

The meta-analysis data demonstrated the effectiveness of MDT with adolescent males, ages 14 through 17. The effect size for the target behaviors, physical aggression for both the conduct groups and the sexual abusing groups, demonstrated a large effect size. While the differences in aggressive behavior were statistically the same for sexually offending juveniles and those who have had histories of conduct disorder, sexual aggression was statistically significant in both populations. This suggests that some aggressive adolescents, like those who have histories of sexual offense may begin to use sex as outward expressions of internal anger states. This work indicated that both the conduct disordered and sexual abusing groups had large effect sizes for their sexual behaviors while in treatment and for two years post-treatment. This finding supports the notion that Mode Deactivation therapy as a superior form of cognitive behavioral therapy addresses not just the acting out behavior, but internal states as well. MDT had a large effect size in all areas of the CBCL and STAXI. As symptoms of externalizing disorders are addressed, internalizing disorders can be addressed. The results of this data, from the assessments confirm the hypothesis that MDT reduces internalizing disorders. It further supports the idea that these internalizing disorders are the behavioral function of the reduced externalizing disorders. Thus, as symptoms of externalizing disorders decrease, internalizing disorders may appear as co-morbid behavioral issues.

Physical aggression and property destruction within the family dynamic was observed in the studies focusing on the family. Initial verbal expressions of anger showed medium effect sizes. For this population, verbal expressions of feeling and internal state maybe met with inconsistent family support. MDT addresses this support issue and operates within the family dynamic to increase needed support by the family unit. This is done by teaching family members and youngsters effective ways to engage in dialogue. Its important to note that the entire family is identified client, not just the youngster. Follow-up studies have consistently shown that families who have undergone MDT show less aggression, property destruction and increase in family synchronization.

Within the residential milieu, MDT showed effectiveness with youngsters who continued to act out aggressively. Externalizing behaviors were consistently shown before internalizing behaviors. Replication of treatment shows that MDT is consistently reliable in addressing the externalizing behavior disorders as well as the internalizing behavioral disorders. While addressing internalizing behavioral disorders, it is important to note that although MDT has, in small samples, reduced parasuicidal behavior; it has shown minimal effect on the reduction of symptoms of severely depressed respondents as measured by the BDI-II (29-63) and the SIQHS. Further meta-analyses of MDT treatment studies are warranted to clarify and confirm or disprove this hypothesis.

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An Independent Evaluation of Mode Deactivation Therapy for Juvenile Offenders

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Abstract

Juveniles who commit crimes are likely to exhibit conduct problems in their youth. Persistent and long-term antisocial behavior can be seen in very young children. To treat these children, programs must be designed to meet the needs of them on an individualized basis. Residential treatment, typically, is the answer, but research has shown its ineffectiveness. Longitudinal studies and meta-analyses have shown cognitive behavioral therapy (CBT) to be effective. Mode deactivation therapy (MDT) is a form of CBT based on the theory of a network of cognitive, affective, motivational, and behavioral components that create a personality – “modes.” Modes are activated and create emotional dysregulation and behavioral disorders. In MDT, using a manualized treatment, the therapist reduces symptoms of behavior disorder, physical and sexual aggression, anxiety, and traumatic stress while keeping the juvenile offenders out of long-term, out-of-home placements. This present study examines 39 adjudicated Pennsylvania males (ages ranging from 14 to 17). Using baseline scores and comparing them to post-treatment scores, outcomes are measure and the effectiveness of MDT can be observed. It is important to note that all measures of the DSMD, the CBCL, the Beliefs about Victims, the Beliefs about Aggression, and the JSOP-A show a significant decreases in antisocial behaviors. Additionally, at the one year mark, recidivism rates were 7% and none were personal or sexual offenses.

Keywords: Juvenile offenders, Mode Deactivation therapy, recidivism

In the United States, about 5% of juvenile offenders are responsible for the majority of juvenile crimes (Moffitt, 1993; Mulder, Brand, Bullens, & Van Marle, 2010; Schumacher & Kurz, 2000). This group continue with their criminal careers into adulthood and evolves into committing more serious offenses (Mulder et al., 2010; Moffitt & Caspi, 2001). Research has shown that those most likely to become juvenile offenders can be identified as early as nine years old (Patterson, 2002; Walker, Colvin, & Ramsey, 1995).

Juvenile delinquency in many cases can be traced back to conduct problems in young children (Patterson, 2002). Persistent and long-term antisocial behavior can be manifested and observed in children as young as two or three years old (Keenan, 2001; Loeber and Farrington, 2000; Nee & Ellis, 2005). Snyder, Schrepferman, McEachern, and Suarez (2010) report that conduct problems should be targeted before they manifest themselves as covert conduct problems. The authors operationally define covert conduct problems as “lying, stealing, covering emotional displays of guilt, and secretiveness” (p. 16). Conduct problems can become “viral” and these children can also infect peers and increase their deviancy. This is termed deviancy training. Deviancy training often occurs through deviant talk and the bonding and reinforcement of such talk in other children (Snyder, Stoolmiller, Patterson, Schrepferman, Oeser, Johnson, & Soetaert, 2003).

Efforts began to show interventions targeted to children with emotional and behavioral disorders, the group mostly likely to develop delinquency began showing efficacy (Brestan & Eyeberg, 1999; Wells, 1988) and effectiveness (Thoder, Hesky, & Cautilli, 2010; Cautilli, et al. 2002). These programs often developed from behavioral models. These models focused on skill development in the family context. Behaviorists often suggest that building rule governed behavior through compliance training; rule giving, behavior tracking, and training in word-behavior corresponded can alleviate covert behavior problems. Behaviorists and cognitive behaviorists have had some success in treating conduct disorders in particular

through parent training models (Wells, 1988) and through problem solving skill training (Kazdin, 1975). Enhancing behavioral treatments has become a focus of particular interest for society. Nee and Ellis (2005) report, for treatment to be effective, it needs to be responsive to the evolving needs of the child and, later, the adolescent. Programming for the disruption of antisocial behavior is important and the intensity of the treatment should be dictated by the needs of the clients. As the problems harden, later programs need to target the function of the antisocial behavior and often can be very intensive (e.g., Thoder, Hesky, & Cautilli, 2010).

Often disruptive children when they reach adolescence, are placed in residential treatment programs (Barker, 1998; Underwood, Baggett-Talbott, Mosholder, & Von Dresner, 2008). Several problems have persisted in the study of residential treatments including post release maintenance of treatment gains. This concern combined with the overall restrictiveness of residential treatment has led to a host of criticism about residential programming. These include: (1) Many of the evidenced based treatments that exist in residential treatment programs have been studied on groups with less intense problems than residential youth (Underwood, Baggett-Talbott, Mosholder, & Von Dresner, 2008); and (2) there are many opportunities for youth in residential facilities to learn inappropriate behavior (Barker, 1998). These factors may contribute to why, according to the U.S. Surgeon General Report (1999), residential programs are considered to be ineffective.

Non-behaviorally based residential programs consistently show failure to reduce aggressive and antisocial behavior (see Joshi & Rosenberg, 1997). Indeed, in a longitudinal study, children in publicly funded RTCs in six U.S. states found, by year seven, 75% of youth treated in a residential treatment program were either readmitted to a mental health facility (about 45 percent) or incarcerated in a correctional setting (about 30 percent) (Greenbaum, Dedrick, Kutash, Brown, Larieri, & Pugh, 1998). There is a critical need for effective residential treatment.

The use of behavioral principles in such programs has been found to reduce aggressive and disruptive behavior (Chen & Ma, 2007). When taken into a psychologically informed context, contingency management systems can have a powerful effect (Andrew, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). Residential programs based on behavioral principles have had mixed results, but recent research suggests that they may be helpful in breaking the cycle of violence both in the program and after discharge (e.g., Kingsley, 2006); however, the mechanism and who responds remain unclear (Kingsley, Ringle, Thompson, Chmelka, & Ingram, 2008).

Overall, behavioral and cognitive behavioral programs have been successful in reducing recidivism (Redondo Illescas, Sánchez-Meca, & Garrido Genovés, 2001) and misconduct in correctional settings (French & Gendreau, 2006). Due to the inherent lessened intensity and demands placed on the staff, cognitive-behavioral programs have considerable appeal. In addition, several well-conducted meta-analyses have identified cognitive behavioral therapy (CBT) as a particularly effective intervention for reducing recidivism (Landenberger & Lipsey, 2005). Specifically with adolescents, CBT has been identified as an effective approach to treating juvenile delinquency and reducing recidivism (Latessa, 2006; Lipsey, 1999; Pealer & Latessa, 2004; Roush, 2008).

Mode deactivation therapy (MDT) is a form of CBT that attempts to examine the aspects of personality that leads to criminality and delinquency and, ultimately, remediate problematic schemas. MDT is based on the work of Aaron Beck, M.D. Beck (1996) suggests that the model of individual schemas do not adequately address a number of psychological problems. Thus, the MDT approach addresses a more global methodology (Apsche & Ward, 2002; Beck, 1996). The concept of modes is defined as a network of cognitive, affective, motivational, and behavioral components that integrate sections of a personality (Beck, 1996). Modes consist of beliefs that contain the specific memories, the

system on solving specific problems, and the experiences that produce memories, images, and language that form perspectives (Apsche & Ward, 2002).

These modes can be charged – or activated – to explain the fluctuations in the intensity gradients of cognitive structures. According to Apsche and Ward (2002), “modes are activated by charges that are related to danger in the fear → avoids paradigm” and “the understanding of conscious and unconscious fears being charged and activating the mode explains the level of emotional dysregulation and impulse control” in the targeted population (p. 461). To return these modes to the unexcited phase is the goal of the treatment. MDT has been shown to be an effective treatment for emotional and behavioral disorders, physical aggression, sexual aggression, anxiety, and traumatic stress (Apsche, Bass, & Siv, 2006; Apsche & Ward-Bailey, 2004; Apsche, Bass, Murphy, 2006; Apsche, Bass, & Houston, 2007a; Apsche, Bass, Jennings, Murphy, Hunter, & Siv, 2005; Apsche & Bass, 2006). MDT has shown to be more effective than Treatment as Usual (TAU) in reducing arguments between family members, displays of anger, and physical and sexual aggression while keeping adolescents out of restrictive, long-term, and out of home settings while reducing recidivism (Apsche, Bass, & Houston, 2007). It has also been shown to be more effective in treating delinquent children and adolescents than CBT, especially with regards to internal distress, critical pathology, and externalizing aberrant behaviors (Apsche & Ward, 2002).

The purpose of this present study was to provide an independent evaluation of MDT in the treatment of juvenile offenders. A second purpose was to replicate previous MDT research and to check its efficacy (Apsche, Bass, & Siv, 2006; Apsche & Ward-Bailey, 2004; Apsche, Bass, Murphy, 2006; Apsche, Bass, & Houston, 2007a; Apsche, Bass, Jennings, Murphy, Hunter, & Siv, 2005; Apsche & Bass, 2006).

Method

Participants. The population assessed is a high-risk population and are adjudicated Pennsylvania residents. This population was 39 males between the ages of 14-17 years old. Each participant received 12 months of MDT sessions and each were placed in the same residential setting.

Interventions. According to Apsche, Bass, and Houston (2007), MDT “is an individual and family manualized treatment that incorporates treatment strategies from behavioral, cognitive, dialectical, and other supportive psychotherapy approaches” (p. 364). It includes weekly individual or group therapy session. It begins with an exhaustive case conceptualization that includes a diagnostic interview, a comprehensive behavioral history, and a complete family history. A battery of assessments, dictated by the needs of the individual, are scored and used in the development of the conceptualization. A functional behavior assessment is also included (Apsche, Bass, & Houston, 2007). According to Apsche and Ward (2002), the “case conceptualization helps the clinician examine the underlying fears of the resident” (p. 462). MDT involves imagery and relaxation to enhance cognitive thinking. Balance training follows and the child’s perception and interpretation of informational and internal stimuli are taught. Appropriate responses are expected. Initially, the imagery is used to reduce external emotional dysregulation. Also important to MDT is the concept of validation, clarification, and redirection (VCR). Validation, defined by Linehan (1993), is the therapist’s ability to uncover the validity within the client’s beliefs; clarification refers to the ability to understand and agree with the truths; and it is important to redirect responses to other, pro-social possibilities on the continuum of truths (Apsche & Ward, 2002).

Procedure. Staff administered the instruments to the adolescents on entry and their families. Each participant was treated with only MDT. At the time of discharged, the families and adolescents were re-assessed to procure outcome data. Research assistants collected the data at baseline (admission) and, again, at discharge.

Results

The behavior support program (BSP) for the residents uses several assessments to measure the outcomes. These include the Child Behavior Checklist (CBCL), the Youth Self-Report (YSR), the Devereux Scales of Mental Disorders (DSMD), the Fear Assessment [which is a measure of post traumatic stress disorder (PTSD)], the Beliefs Analysis of Aggression, the Beliefs Analysis of Victims, the Beliefs Analysis of Intimacy, the Beliefs Analysis of Control, the Juvenile Sex Offender Protocol – Adolescent (JSOP-A), and a reading test. Found below are abbreviated reports of five of the assessments (the CBCL, the DSMD, the Beliefs Analysis of Aggression, the Beliefs Analysis of Victims, and the JSOP-A). These results are intended to demonstrate preliminary outcome measures data.

DSMD (Naglieri, J., LeBuffe, P., & Pfeiffer, S.I., 1994). The DSMD has a mean score of 50 and a standard deviation (SD) of 10. It is important to note that any score of 60 is considered significant. Externalizing scores indicate the prevalence of negative overt behaviors or symptoms. Internalizing scores measure negative internal moods, cognitions, and attitudes. Critical pathology is behavior that represents severe disturbances of children and adolescents. The total scale, or T-Score, indicates a conglomerate of all scores. These include general Axis I pathology, delusions, psychotic symptoms, and hallucinations.

All DSMD scores were significantly decreased. Additionally, scores were reduced by or near one SD. Specifically, results related to the DSMD Externalizing scores indicate a slight, but negligible, increase in overt behaviors at six months. This might suggest the initial period of adjustment to the group living in a residential program. By the 12 month mark, these behaviors were reduced from 54.4 to 48. With regards to internalizing problems, scores, at the six month mark, suggest that many internal symptoms, moods, cognitions, and attitudes were beginning to be addressed and remediated. This reduction continued to the 12 months mark. Representing a reduction of internal symptoms of one SD from the mean, the score was reduced to 51.8. Examining the DSMD critical pathology scales, scores showed significant improvement with a decrease in scores from 55.9 to 46.4 at the 12 month timeline. These results suggest that the most serious of symptoms were reduced significantly in MDT treatment. The DSMD T-Score represents the composite of the sums of all the aforementioned scores. The total score mean for the BSP was 58.6 prior to the MDT implementation. This score is of a higher value, indicating significant pathology. The reduction of the DSMD total score to 48.5 represents a significant reduction of one standard deviation and it reduced to an I-score of BSP 1.5 under the DSMD mean.

Table 1. Mean Scores of the DSMD

	Externalizing	Internalizing	Critical Pathology	Total Scale
First Round	53.3	64.6	55.9	58.6
Second Round	54.4	61.8	51.7	54.4
Third Round	48.0	51.8	46.4	48.5

Table 2. Devereux Scales of Mental Disorders

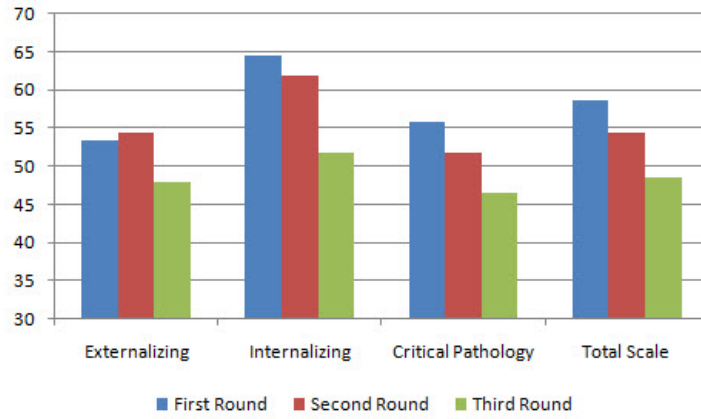


Table 3. DSMD Externalizing

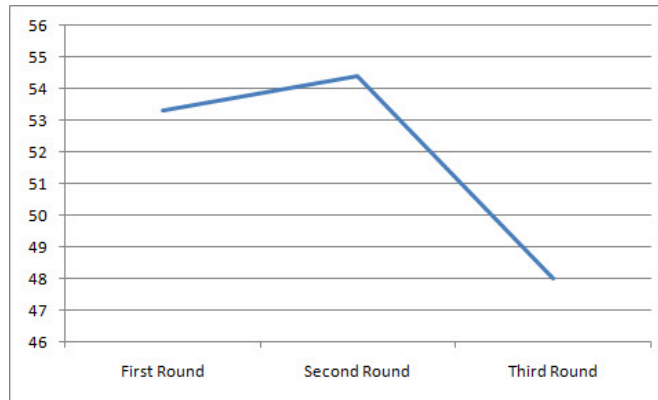


Table 4. DSMD Internalizing

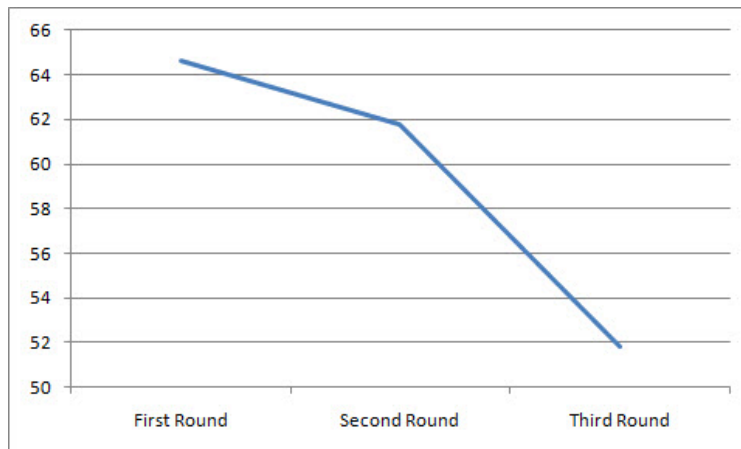


Table 5. DSMD Critical Pathology

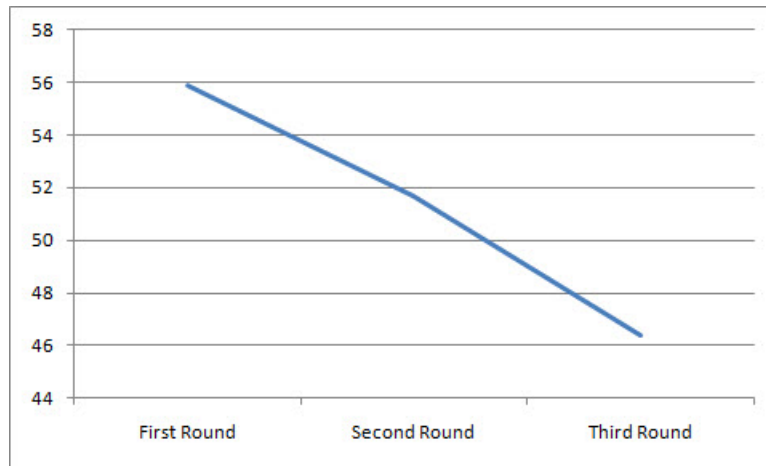
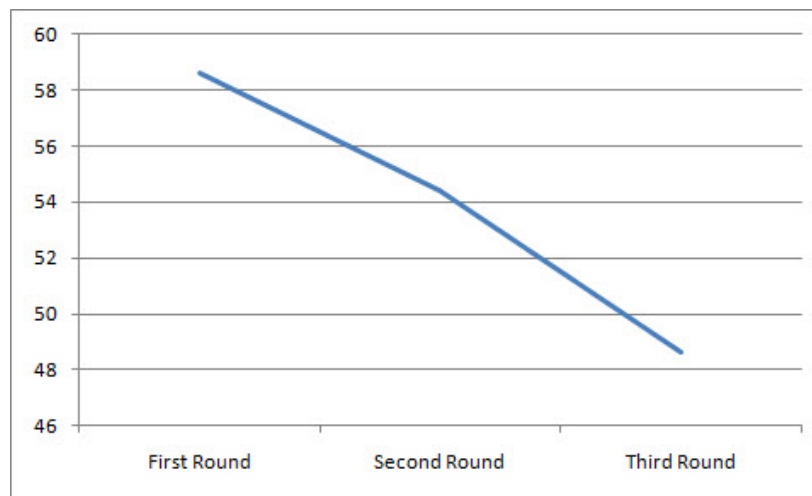


Table 6. DSMD Total Scale



CBCL (Achenbach & Rescorla, 2001). The CBCL means and SDs are divided into three categories. These include internalizing behaviors that measure withdrawn, somatic complaints, and anxiety and depression, externalizing behaviors that measure delinquent and aggressive behavior, and total problems that represent the conglomerate of total problems and symptoms (both internal and external).

All CBCL scores of the BSP residents were reduced by more than one SD from the mean. The significance of the total score being reduced by more than one SD suggests that the residents participating in the BSP are holistically. MDT improved to the level of the sample that did not need treatment in the CBCL sample of non-referred children and adolescents. This suggests that the BSP residents significantly improved during their participation in Thought Change. Specifically, the CBCL internalizing problems mean score was 63 on the pre-test. It was 64 at the six month re-test and 53 at the one year re-test time. This represents a significant reduction of internal symptoms for the residents at 12 months. The CBCL externalizing problems mean score at baseline was 63. It was reduced to a mean of 61 at six months and significantly reduced to 42 at the 12 months. This represents a significant reduction in aggression and delinquent behavior at the 12-month participation period in the Thought Change System program. CBCL total scores were reduced from a mean score of 63 to 47 at the 12-month score.

Interestingly, the total score increased from a mean of 63 to a mean of 64 at the six month period. The actual reduction in the score occurred at the 12-month period of the resident’s participation in MDT.

Table 7. Mean Scores of the CBCL

Scales	Mean	SD	First Round	Second Round	Third Round
Internalizing Problems	62	11.4	63	64	53
Externalizing Problems	62.6	12.0	63	61	42
Total Problems	63.8	11.5	63	64	47

Table 8. CBCL – Internalizing Problems

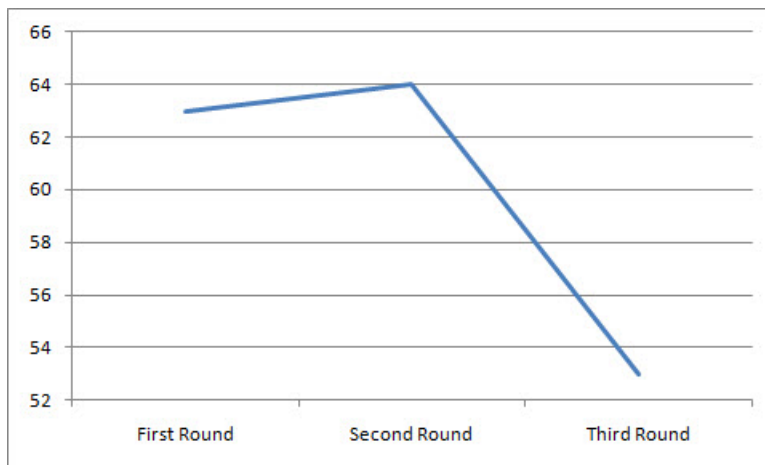


Table 9. CBCL – Externalizing Problems

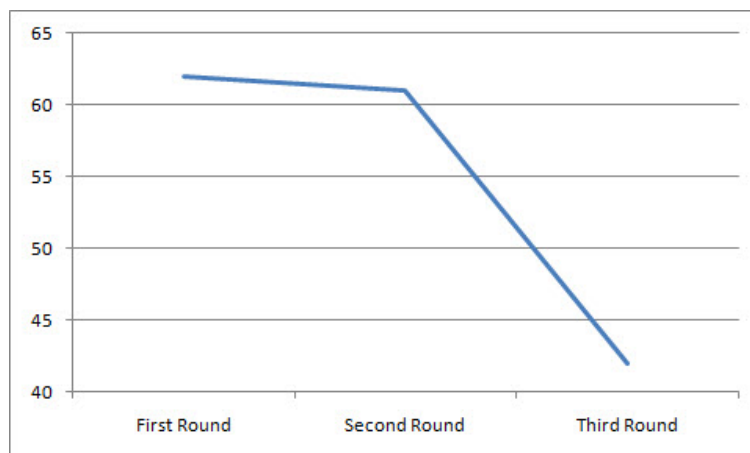
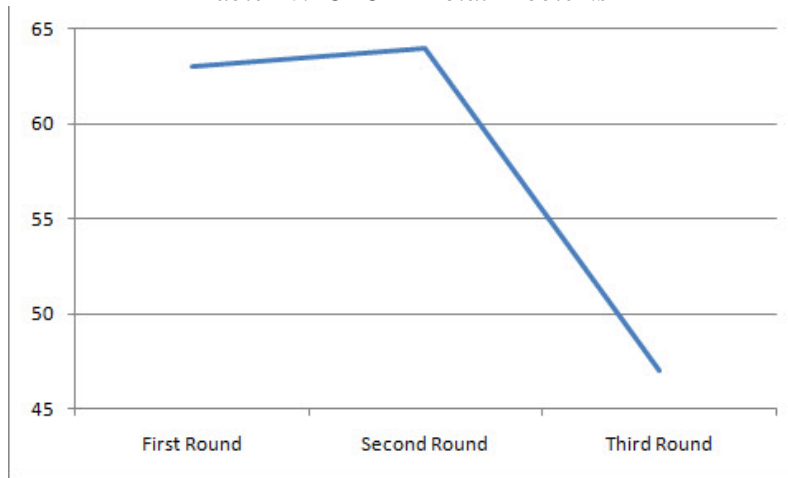
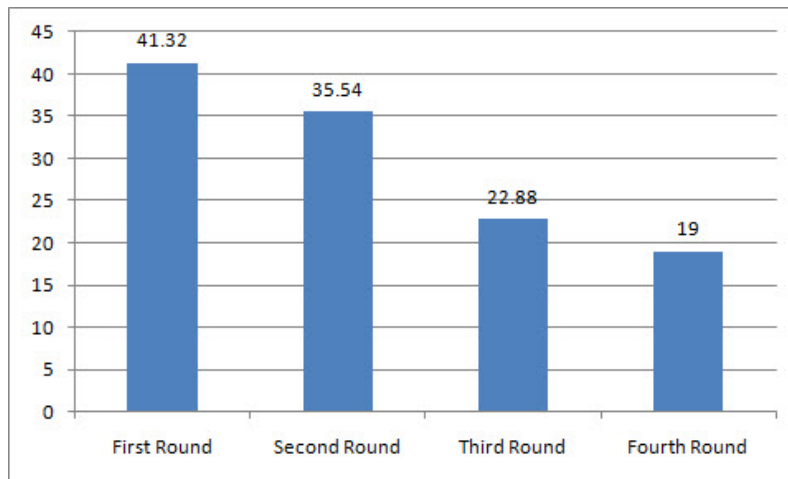


Table 10. CBCL – Total Problems



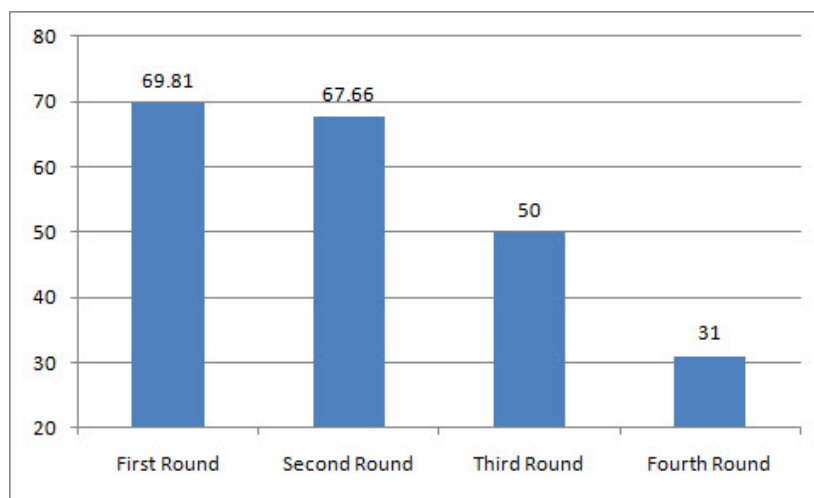
The Beliefs about Victims (Apsche, 1999). The Beliefs about Victims is a 20 question belief assessment based on faulty beliefs about victims of sexual offenses. It represents a measure of cognitive distortions that sex offenders endorse. The Belief Analysis is based on a Likert-like scale of seven items, ranging from “totally disagree” to “totally agree.” Baseline scores were 41.32 with a range of 20 to 140. The reduction of more than 50% of these beliefs is significant and helps reduce overall risk. If the child/adolescent can identify, change, and remediate their distorted thinking, they lower their risk of sexual offending.

Table 11. Beliefs about Victims



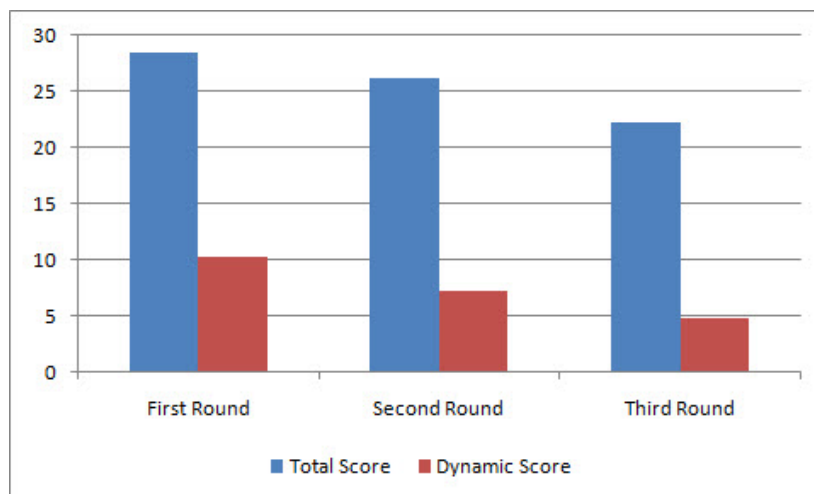
The Beliefs about Aggression (Apsche, 1999). The Beliefs about Aggression is a 25 question assessment that measures dysfunctional beliefs/cognitive distortions about aggression. The scores ranged from a low of 25 to a high of 175. The reduction from a mean of 69.81 to 31 represents a 44.4% reduction of aggressive beliefs. This is significant in reducing the beliefs and cognitions about aggression which also resulted in a reduction of aggressive behaviors in these individuals.

Table 12. Beliefs about Aggression



JSOP-A (Prentky & Righthand, 2003). The *JSOP-A* is a 23 question risk assessment designed to measure risk factors of adolescent sexual offenders. With a maximum total score of 46 points possible, 1-12 is considered a low risk, 13-27 is considered a moderate risk, and 28+ represents a high risk for re-offending. The reduction of risk, as measured by the *JSOP-A*, is significant. It is an overall reduction of risk from 28.48 (high risk) to 22.22 (mild-moderate risk). Questions 1 to 13 on the *JSOP-A* do not change, as they are historical in nature and remain static. Questions 14-23 are dynamic risk factors, remediable to treatment. Dynamic risk factors include those related to the acceptance of responsibility for offenses, the internal motivation for change, the understanding of risk factors and the application of risk management strategies, the development of empathy and feelings of remorse and guilt, any cognitive distortions, and the quality of peer relationships. The BSP mean score was 10.25 on the pre-treatment assessment. This score deduced nearly 60% to 4.86 in the 12-month follow-up assessment.

Table 13. Juvenile Risk Assessment Protocol



Recidivism. At the intake, 60% of the residents displayed anti-social values. Over a four year period, of the 39 juveniles used in this present study, none of them re-offended during the program stay. Only two (5.13%) had criminal charges during the first six months following their discharge. The overall

recidivism rate was 7%. Four of the seven new offenses were drug-related charges. It is important to note that none of the offenses were personal offenses and the sexual offense recidivism rate was 0%.

Discussion

Historically, the first CBT program used in the treatment of juvenile offenders was implemented by the Tennessee Department of Corrections' Intensive Treatment Unit (ITU) (Glick, 2006; Roush, 2008). Largely, practitioners sensed the ineffectiveness of non-directive, individual centered, and psychoanalytic models (Roush, 2008). Lipsey (1999) would later show the ineffectiveness of such programs in his meta-analysis of nondirective intervention. Thus, newer, more novel treatments, such as the positive peer culture program, evidenced-based behavior therapy, and CBT, emerged (Roush, 2008). Roush (2008) remarks that CBT provided staff, clinicians, and practitioners with an understandable and more effective way of building relationships, managing behavior, and increasing safety. Additionally, CBT provides youth with a positive behavior change in very short periods of time and successfully teaches cognitive, behavioral, and interpersonal skills that result in a reduction in recidivism (Roush, 2008; Nee & Ellis, 2005; Gillis, Gass, & Russell, 2008). Research reports that the odds of success, defined as no recidivism in a post-intervention interval of approximately 12 months, is more than one and a half times as great for those receiving CBT (Landenberger & Lipsey, 2005).

Over the last ten years, considerable research has been conducted on what leads to re-offense. A substantial amount of research that identifies risk factors for recidivism that include family background measures and peer group factors (Benda & Tollet, 1999; Conger, Neppl, Kim, & Scaramella, 2003; Barnow, Lucht, & Freyberger, 2005; Hoeve, Blokland, Dubas, Loeber, Gerris, & van der Laan, 2008). There is also research that places an emphasis on the personality characteristics and modifying these malleable risk factors (Carcach & Leverett, 1999; Loeber & Farrington, 2000; Cottle, Lee, & Heilbrun, 2001; Duncan, Duncan, & Strycker, 2001; Huang, White, Kosterman, Catalano, & Hawkins, 2001; Vermeiren, de Clippelle, Schwab-Stone, Ruchkin, & Deboutte, 2002; Chang, Chen, & Brownson, 2003; van Dam, Janssens, De Bruyn, 2004; Lattimore, Macdonald, Piquero, Linster, & Visser, 2004; Lipsey, 2009). Over time, both behavioral and cognitive programs like MDT have begun to target factors known to be associated with risk.

MDT is a third generation cognitive behavior therapy. This study adds to the growing body of literature that supports the use of MDT in the treatment of adolescents with conduct difficulties (Apsche, Bass, & Siv, 2006; Apsche & Ward-Bailey, 2004; Apsche, Bass, Murphy, 2006; Apsche, Bass, & Houston, 2007a; Apsche, Bass, Jennings, Murphy, Hunter, & Siv, 2005; Apsche & Bass, 2006). In this study, it appears that considerable reduction in the overall symptomology, as measured by the DSMD and the CBCL occurred. Reduction in symptomology is associated with decreased risk of re-offending. In this study specifically, this reduction is related to the reduction of aggressive and sex offending cognitions using the aforementioned measures. All of these significant reductions may account for the significant reduction in the JSOP-A as a measure of risk assessment of juvenile sexually based offenders.

Core to the MDT approach is the use of case conceptualization (Apsche, & Bass, 2006). Case conceptualization also offers the opportunity for integrating risk assessment information into treatment (see Vess, Ward, and Collie, 2008; Collie, Ward, & Vess, 2008). In addition, the MDT model makes use of family involvement. Underwood, et al (2008) has suggested that family involvement will help skills learned in the residential program to generalize to the home environment. Replication of effective interventions is of critical importance in residential treatment (see Fixsen Blasé, Timbers, and Wolf, 2007).

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Aftercare for a cognitive-behavioral program for juvenile offenders: A pilot investigation

Ronald W. Thompson, Jay L. Ringle, Mona Way, Jeffery Peterson, and Jonathan C. Huefner

Abstract

Cognitive-behavioral and behavioral interventions have shown the most promise for reducing recidivism, and aftercare has been suggested as a promising approach to enhance these effects. This paper describes a pilot study of a cognitive-behavioral residential and aftercare intervention, using both process and outcome data. Thirty-three adolescents referred by juvenile courts for residential placement who had a goal of family reunification participated. Results indicate that youth had significantly decreased behavior problems and families had significantly improved parenting skills. Follow-up data also suggested that at six months post-discharge, youth who departed at home or in a homelike setting had a high rate of remaining arrest free, were still in a homelike setting, were attending school, and had remained drug and alcohol free. Finally, the data suggested that program implementation quality and outcomes improved over the course of the study. Implications for future research and practice are discussed. **KEYWORDS:** Residential care, Aftercare, Intensive aftercare, Cognitive-behavioral intervention, Recidivism reduction, Boys Town Model, Treatment Family Home Program, Teaching Family Model

Introduction

Historically, juvenile offenders have been punished, locked up, heavily monitored, or subjected to attempts to scare them with the consequences of illegal and antisocial behavior. In 2004 alone, 2.2 million youth were arrested by law enforcement agents (Snyder, 2006). As a result, public monies have been spent on juvenile detention centers, probation services, and boot camps. Research, however, has failed to support the efficacy of these approaches, and studies have indicated that approximately half of the youth involved in the juvenile justice system re-offend within the first few years after they are released (Snyder & Sickmund, 2006). Both monetary and societal consequences are incurred through costs associated with juvenile delinquency; such as the loss of productive workers, increased crime and incarceration rates, physical and mental health care, and an over-reliance on social services. Current research estimates the value of saving a high risk adolescent from a life of crime to range from \$2.6 to \$5.3 million (Cohen & Piquero, 2009). To this end, results of research studies on the efficacy of behavioral and cognitive-behavioral treatment approaches with juvenile offenders have been promising. Redondo, Sanchez-Meca, and Garrido (1999) conducted meta-analyses using 32 European studies of programs' impact on recidivism for delinquent youth. Interventions with the greatest treatment effect sizes were behavioral (.231) and cognitive behavioral (.226). Penal theory/deterrence was the only intervention with a negative effect size (iatrogenic) on recidivism (-.006).

One of the most important studies of interventions for juvenile offenders was a comprehensive meta-analysis completed by Mark Lipsey at Vanderbilt University (Lipsey, 1999; Lipsey & Wilson, 1998). Lipsey summarized more than 500 studies that were completed between 1950 and 1995. The results indicated that programs for juvenile offenders that had the lowest rates of recidivism were: 1) staffed by treatment staff rather than law enforcement personnel, 2) lasted longer than six months, 3) included a well-articulated treatment model which was implemented with fidelity, and 4) had been operating for at least two years. The Teaching-Family Model was listed by these researchers as a program that met these criteria and had demonstrated scientific evidence of effectiveness.

Teaching-Family Model (TFM)

TFM is a community-based, family-style residential program, staffed by a married couple who cares for six to eight youth at a time in a family home and is based on social learning theory (Patterson, Reid, & Dishion, 1992). The program was developed by Montrose Wolfe and his colleagues at the University of Kansas and has been extensively evaluated (Kirigin, Wolf, Braukmann, Fixsen, & Phillips, 1979; Kirigin, Braukmann, Atwater, & Wolf, 1982; Kingsley, 2006). This program was also adapted and scaled up by Boys Town (Treatment Family Home Program; TFHP) and a number of other service and university affiliated agencies (Fixsen, Blasé', Timbers, & Wolf, 2007). It focuses on teaching positive interactions with peers and adults, specified motivation systems for managing positive and negative consequences, relationship building, and self-control and self-government. The Boys Town application also includes a specified component emphasizing moral and spiritual development (Davis and Daly, 2003). Outcome research on this model at Boys Town has continued to provide evidence of long-term educational success (Thompson et al., 1996; Thompson, Huefner, Ringle, & Daly, 2005), reduced domestic violence (Huefner, Ringle, Chmelka, & Ingram, 2007), and reduced recidivism (Kingsley, 2006). The original TFM is listed on the California Evidence-based Clearinghouse for Child Welfare (www.cachildwelfareclearinghouse.org), and the Boys Town TFH program is listed on the FindYouthInfo (www.findyouthinfo.gov) and the OJJDP Model Programs Guide (www2.dsgonline.com/mpg).

Despite the evidence base for the TFM/TFHP, national policy shifts in recent years have had an impact on all types of residential care for children. The primary result is that residential care has been viewed by public agencies as more of a short-term intervention in systems of care for children. As a result, residential care for juvenile offenders and other youth populations has become more focused, youth and family members have become more involved in planning and implementing treatment strategies, and length of stays have become shorter (Lieberman, 2004). At the same time, therapeutic foster care and intensive in-home interventions have been developed as alternatives.

Multi-Dimensional Treatment Foster Care (MTFC)

Therapeutic foster care has been suggested as one alternative to residential care for high risk adolescents. The MTFC program is based primarily on social learning theory. MTFC focuses on closely supervised and simultaneous interventions with the youth, the biological or adoptive parents, and foster parents. Researchers have completed two randomized controlled outcome studies about MTFC, and have found that positive treatment results were maintained for up to two years after discharge (Chamberlain & Moore, 1998; Chamberlain & Reid, 1991). MTFC recidivism rates at twenty-four months post discharge were reported at approximately 20%, in comparison to national rates near 50% noted above. In addition, this research has indicated that the following specific program elements accounted for these positive outcomes, regardless of the setting: 1) the quality of supervision provided to youth, 2) the perceived consistency and fairness of discipline used by adults, 3) a positive teaching approach to behavior management, 4) positive relationships with mentoring adults, and 5) the lack of opportunity for youth to associate with antisocial peers. MTFC has a strong research base and is listed on several national registries of evidence-based programs (e.g., Blueprints for Violence Prevention- www.colorado.edu/cspv/blueprints, OJJDP- www2.dsgonline.com/mpg, NREPP- www.nrepp.samhsa.gov/).

Multisystemic Therapy (MST)

Intensive in-home treatment programs have also been suggested as an alternative to residential care. MST is based on the assumption that antisocial behavior is developed by a combination of individual characteristics in family, peer, and community contexts. It is an intensive in-home intervention that combines multi-disciplinary treatment team supervision with a cognitive-behavioral emphasis and an ecological focus in working with families of at-risk youth in their homes and communities. Research on MST has indicated long-term reduction of recidivism when compared to results from institutional placements and treatments (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). Studies have suggested that critical MST program elements include: 1) changing youth peer groups, 2) improving family relationships, 3) improving school performance, 4) removing barriers to service, 5) and developing a social support networks to help sustain improvement. MST has a strong research base and is also listed on several national registries of evidence-based programs.

Aftercare

These cognitive-behavioral approaches have found success at achieving positive outcomes. Two involve out-of-home placement and the third is an in-home intervention. Regardless of the type of intervention, discharge data often reveal that adolescents make considerable emotional and behavioral gains while in services, but many of them live in home and community settings that are ill equipped to sustain gains and provide support during the transition period (Altshuler, 2003; Courtney & Dworsky, 2006). As a result, former problems may resurface and the possibility for recidivism increases. Researchers and experts in the fields of mental health, child welfare, and social services have all called for the development of aftercare services for youth and their families to support the transition of youth back into home and community settings (Barratt, 1987; Leichtman & Leichtman, 2002; Lieberman, 2004); however, limited research exists to support a particular model of care. Although no evidence-based aftercare programs have been developed specifically for juvenile offenders, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has supported research on Intensive Aftercare Programs (IAP). These studies have identified effective program elements that reduce recidivism by impacting factors that influence delinquency (i.e. inadequate socialization, internal controls and social disorganization). Results of these studies suggest that successful aftercare interventions should emphasize supervision and support while youth are in care and supported transition into the home and community. Three components have been identified that effectively prepare youth for a successful reentry into the community: 1) discharge planning throughout the custody period; 2) participation of institution and aftercare staff throughout the entire process; and 3) re-integrative services that ensure effective service provisions and appropriate levels of social control (Altschuler & Armstrong, 1996).

Practice Implications from this Research

Taken as a whole, this research indicates that there is a significant need to evaluate research-based models of care that incorporate elements of these evidence-based programs along with IAP findings about aftercare in order to delineate effective practices that improve the lives of juvenile offenders. Promising programs should emphasize: 1) teaching positive interactions with peers and adults, 2) providing consistent and fair discipline, 3) using consequences for positive and negative behavior, 4) monitoring and supervising of youths' activities, 5) insuring a lack of opportunity for youth to associate with peers who continue to engage in antisocial behavior, 6) promoting positive behavior and achievement in school, and 7) developing formal and informal supports in

the youth and family's environment. In addition, an intensive aftercare component supporting them and their families is critical to reduce recidivism.

This paper is about an initial process and outcome study of an intervention for juvenile offenders. The approach was designed to utilize practices that have demonstrated evidence for reducing recidivism. It includes a short-term family-style, cognitive-behavioral residential care component utilizing the Boys Town Treatment Family Home model as well as an intensive in-home aftercare intervention with consistent theoretical and practice elements to support the transition of youth to home and community. It is consistent with the fundamental theoretical and practice elements of MTFC, MST, promising aftercare programs as described from OJJDP IAP studies, and community-based, family-driven philosophies. Specifically, this model incorporates the common characteristics and factors that predict post-discharge success (i.e., well planned reunification efforts; involvement of treatment and aftercare staff throughout the process; and thorough re-integrative services linking families to community supports).

Method

The study

In 2007, Boys Town received a grant from OJJDP to design a family reunification process for families with youth under the jurisdiction of the juvenile courts. This process was designed for youth who are in need of out-of-home placement and who, along with their families, express a desire to develop the capability to make reunification possible and positive. This process was implemented and studied at five sites throughout the United States (California, Nevada, Rhode Island, Louisiana, New York).

Participants

Thirty-three youth were admitted and discharged from the program. The average age at departure was 16 years (range= 13 to 18) with the majority being male (22 youth; 67%). In terms of distribution by site, the Rhode Island site had the most discharged youth with (27.3%), followed by Nevada (21.2%), Louisiana (18.2%), California (18.2%), and New York (15.2%).

Procedure and Intervention

The intervention included intensive, targeted residential services for youth while the family participated in an intensive in-home intervention. The residential length of stay was targeted at approximately six months, with an aftercare component involving both the youth and family for an additional three months following residential discharge. It was designed to intervene with youth and family members simultaneously; including more intensive work with youth early in the program and more intensive work with the family as the youth neared discharge from residential care. Six family success factors were derived directly from the research literature about juvenile offenders and provided the framework for assessment and service planning. The six family success factors were: 1) supervising and monitoring skills, 2) parenting skills, specifically consistency and fairness in discipline, 3) relationship development 4) choosing appropriate pro-social peers for youth, 5) academic and behavioral success in school, 6) formal and informal support networks that support youth and family development. Both the family and youth interventions focused on these factors. While parents were learning interventions to improve their skills, youth were working on skills that would help make them more responsive to their parents' supervision and guidance as well as learning skills to make better decisions in their lives.

The intervention also included a five-stage process guide that helped staff monitor progress for the youth and families. The stages were: 1) assessment and relationship development – establishing rapport with the youth and family and beginning the process of assessing strengths and weaknesses, 2) mediating family stressors – working with families to access needed resources to resolve issues such as financial or emotional stress, 3) family skill development – training the youth and family in any needed skills, 4) implementation of skills and techniques – applying the skills as youth began home visits with oversight and coaching from the staff, and 5) proficiency, mastery, and generalization – continuing work with the reunified youth and family through coaching and support and generalizing skills to new situations

Instruments

Model Fidelity. Model fidelity assessment is an essential component of both process and outcome evaluations. Assessing model fidelity can also provide a wealth of information for various stakeholders and ultimately help improve outcomes for the target population. Objective model fidelity instruments that operationalize the program components were developed. Program supervisors rated staff on adherence to the model for study purposes. These instruments were designed to be multi-functional in that they also were used as a staff consultation, management and training tools with the goal of improving the quality of treatment implementation for youth. There were 7 model fidelity components for the family-style residential model: teaching components, motivation systems, relationship building, family style living, moral and spiritual development, self-government, and youth skills. In-home model fidelity components consisted of 4 areas: teaching components, relationship-building and engagement, enhancing natural therapy systems, and professionalism and safety. All areas were assessed on multiple observable items and rated on an anchored 5-point scale, where a 3 is considered adequate and higher scores indicate better quality and fidelity. Appendix A displays sample items from the residential model fidelity observation form and Appendix B displays sample from the in-home observation form.

Child Behavior Checklist. The child's primary caregiver was asked to complete the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) at intake and discharge. The CBCL is based on 113 parent ratings of their child's behavior using a 3-point response scale. The CBCL examines behavior on a variety of specific sub-scales. However, two broad band scales commonly used are Internalizing (withdrawn, somatic complaints, and anxious/depressed) and Externalizing (delinquent behavior and aggressive behavior), as well as Total Problems which is a composite score. Studies assessing the psychometric qualities of the CBCL have found adequate levels of inter-rater ($r = .96$), test-retest ($r = .91$ to $.95$) reliability and long-term ($r = .50$ to $.82$) stability and satisfactory levels of content, construct, and convergent validity (Achenbach & Rescorla, 2001).

Alabama Parenting Questionnaire-9. Parenting style was assessed by the Alabama Parenting Questionnaire-9, a short nine-item version of the original instrument, at intake and discharge (Elgar, Waschbusch, Dadds, & Sigvaldason, 2007). The measure is completed by the primary caregiver. The measure has three items for each subscale, including Positive Parenting, Inconsistent Discipline, and Poor Supervision. Elgar, et. al (2007) reports the APQ-9 to have good convergent validity by differentiating parents of children with disruptive disorders and parents without such disorders.

Follow-up Questionnaire. Families were interviewed by an impartial interviewer at six months post discharge to assess a number of long-term outcomes, including recidivism (re-arrest), placement stability, school attendance, and drug or alcohol usage.

Responder/Non-responder analysis. Because this pilot study involved initial program development and implementation as well as data collection methods across a number of site locations, pre-post data on standardized assessments were collected on only about one-half of the sample. As such, we compared those who departed the program and completed the departure CBCLs and APQs (i.e., the “responders”) with those who departed the program and did not complete the departure measures (i.e., the “non-responders”) across 6 variables using logistic regression. Logistic regression is a variation of ordinary regression that is used when the dependent variable is a dichotomous (e.g., 0=non-responder, 1=responder) and the independent variables are continuous, categorical, or both. Logistic regression produces two statistics which bear explanation: Wald and Exp (B). The Wald statistic is the statistical test for each coefficient in the regression model and Exp (B) indicates the increase in odds that an event will occur (e.g., being a responder) for each unit increase in the predictor variable.

The predictor variables for this analysis are: sex (0=female, 1=male), age at admission in years, length of stay in the residential facility in months, race (0=Caucasian, 1=non-Caucasian), age at departure in years, and restrictiveness of placement upon departure from the program. The model indicated that respondents and non-respondents were not statistically different on the variables tested.

Results

Model fidelity

Results indicated that the residential and in-home staff implemented the model to a satisfactory degree overall. Average ratings for the degree to which programs implemented a family-style environment (n = 43 residential observations) ranged from 2.7 (Youth Skills) to 3.3 (Relationship Building). Average ratings for the degree to which in-home staff demonstrated quality of care (n=44 in-home observations) ranged from 3.4 (Natural Therapy Systems) to 3.6 (Relationship Building). In addition to these scores, qualitative comments by observers and consultation by the authors suggested some trends. At some sites, the in-home program was being implemented for the first time, and at all of the sites these two separate intervention programs were being integrated for the first time. As a result, staff implemented the program more consistently as they had more experience with the in-home program and as they developed communication channels and management procedures necessary to integrate the two programs to make a more seamless intervention for the youth and family.

Length of stay and recidivism during care

The average length of stay in residential services for the 33 youth receiving services was 6.7 months ($SD=2.4$ months; range=1.5–10.8 months). For youth who received both the residential and in-home components (n=19), the average length of services for in-home aftercare was 3.4 months ($SD=1.4$ months; range=1–6.3 months). While in care, 36% (11 while in residential care; 1 while in aftercare) of the youth re-offended or were moved to a more restrictive placement.

Multivariate Results

A MANOVA was used to compare the pre- and post-test outcomes on the CBCL Internalizing and Externalizing subscales and the APQ Poor Supervision, Inconsistent Discipline, and Positive Parenting subscales. The multivariate result was significant for the testing condition (pre/post), Pillai's Trace = .665, $F = 4.37$, $df = (5, 11)$, $p = .02$

Univariate Results

Behavioral/Emotional Functioning. Sixteen families completed pre/post Child Behavior Checklist. The univariate *F* tests revealed significant reduction on the CBCL Externalizing subscales, $F = 5.78, df = (1,15), p = .03$. Ninety-four percent of parents reported that their children were displaying borderline/clinical levels of Externalizing problem behaviors at admission. This percentage dropped significantly to 56% at departure. For Internalizing Problems, 44% of parents reported their children as displaying borderline/clinical levels of Internalizing behavior at admission. This dropped to 28% at departure. For Total Problem behaviors 72% of parents rated their children as functioning in the borderline/clinical range at admission. At departure, 56% were in the borderline/clinical range. Results indicate small to moderate effect sizes for behavioral and emotional functioning. Table 1 presents the means, standard deviations, and effect sizes for the CBCL.

Table 1. Admission and Departure Mean Scores and Effect Sizes for Youth and Parent Functioning

Youth Behavioral/Emotional Functioning			
	<u>Intake</u>	<u>Departure</u>	<u>Cohen's r</u>
<i>CBCL Mean T-Score (SD) (n=16)</i>			
Externalizing Problems	67.19 (6.6)	58.00 (15.6)	.52(Mod)
Internalizing Problems	56.19 (9.8)	50.9 (14.7)	.31(Sm)
Total Problems	63.44 (6.3)	55.88 (16.9)	.29 (Sm)
Parent Functioning			
<i>APQ-9 –Mean (SD) (n=16)</i>			
Poor Supervision	10.8 (2.9)	7.94 (3.2)	.64(Mod)
Inconsistent Discipline	8.25 (1.8)	6.94 (1.9)	.40(Sm)
Positive Parenting	13.06 (1.9)	12.13 (2.1)	.37(Sm) ¹

¹. Effect size not in the anticipated direction

Parenting.

Sixteen families completed pre/post the Alabama Parenting Questionnaire-9 (APQ-9). The univariate *F* tests showed significant improvement for APQ Poor Supervision, $F = 10.68, df = (1,15), p = .005$, but not for APQ Inconsistent Discipline, $F = 2.84, df = (1,15), p = .113$ or APQ Positive Parenting, $F = 2.43, df = (1,15), p = .14$. Although somewhat mixed, results indicate small to moderate effect sizes for parenting skills. Table 1 presents the means, standard deviations, and effect sizes for the APQ-9 subscales.

Six month follow-up data

We obtained 6-month follow-up data for eight of the 19 youth who departed the program at home or to a homelike setting (42%). Unfortunately, we were unable to obtain follow-up surveys on the other eleven youth for a variety of reasons (e.g., unable to locate). At 6 months post-departure, all of these youth had remained arrest-free, seven (88%) were living in a homelike setting or independently, seven (88%) were enrolled in school or have graduated from high school, seven (88%) had remained drug-free and all remained alcohol-free.

Discussion

In this project, 33 youth and families were served in a comprehensive out-of-home and in-home aftercare intervention that was based on the research literature about evidence-based practices for juvenile offenders. Nineteen of the 33 youth (58%) received both the residential and aftercare components of the program. Model fidelity for both the residential and in-home models indicated adequate implementation. Model implementation appeared to improve over time, as this was the first time the in-home component of the program was implemented at some of the sites and the first time the residential and in-home program components were integrated at all of the intervention sites. Residential stays and in-home family lengths of services were on target with the six- and three-month timeframe outlined in the program design. At intake, most youth presented with elevated levels of problem behaviors, especially externalizing behaviors. Further, parents were in need of parenting assistance, especially regarding supervising and monitoring their youth. By discharge, youth problem behaviors declined significantly and parents demonstrated significant improvement in parenting skills related to poor supervision and non-significant trend suggesting improvement related to inconsistent discipline. The only area of parent functioning that did not change in the expected direction was positive parenting. Although this was part of the intervention model, parents were also taught to use negative consequences more consistently and perhaps that was the reason they did not rate their parenting as more positive after the intervention. Further, it is not surprising that indicators of poor supervision improved significantly and had the largest effect size of all areas measured. Consistent with research that points to supervision as a primary protective factor with juvenile delinquents, supervision is the first of our six family success factors and was a primary focus of the intervention.

In terms of maintaining outcomes, at six months follow-up, the majority of youth who departed residential care to a homelike setting and received the aftercare intervention were still in school and had remained arrest-, alcohol-, and drug-free. By comparison, we have six-month follow-up data for nine youth who left residential care and did not receive in-home services (departed to a more restrictive placement). These youth were less likely to be enrolled in school or have graduated from high school or to be living in a homelike environment. Also, these youth were more likely have been arrested, and to have used drugs or alcohol. Figure 1 displays a side by side follow-up comparison for those who received aftercare services and for those who did not. These initial evaluation results indicate that youth and families that completed both the residential and aftercare components of the program were able to achieve promising outcomes. In order to better understand the effectiveness of the intervention, the authors made site visits and case files were reviewed for the fourteen youth who were not successful and left the program early (42%). Three factors emerged from this qualitative review. First, some youth and families who were admitted to the program were not good candidates for reunification and remained in the program for less than three months. These youth ran away, were transferred to a long-term residential program, placed in detention, or alternate permanent placements were identified. Second, some youth were pulled out of the program by probation officers even when they exhibited relatively minor problems (e.g., fighting with other youth). In retrospect, some of these youth may have had more positive outcomes if they had remained in the program. Finally, even though we had designed the intervention to include both a residential and in-home component with consistent theoretical foundation and practices, at some sites program components were not well integrated. Consequently, there were not clearly identified supervision responsibilities and communication vehicles required to deliver a well coordinated multi-program intervention. Because of these findings, along with the observation that model fidelity appeared to improve over time during the project, we disaggregated some the outcome data for the first and second years of the project. We found striking differences between year one and two. After the first year,

19 youth were discharged from the residential portion of the program, but only nine (47.4%) successfully completed the program. For the 10 youth who did not complete the program, four ran away, and six were removed by either the court or a probation officer. In contrast, during the second year, 14 youth were discharged, and 11(78.6%) successfully completed the program. The other three youth (21.4%) ran away during the second year. Because the first year of the project included training staff, process implementation, new programs, and identifying procedures for management, staff supervision, and quality improvement, it appears that youth served during the second year experienced significantly more success.

As a result of these findings, the intervention has been refined, staff training has been revised and implemented, and the program will be continued for the next two years at these program sites because of additional congressional appropriations that have been awarded and administered through OJJDP. In addition, the target population was expanded to include youth who are at risk for entering the juvenile justice system. The evaluation study will be continued to assess the impact of these refinements and better assess the impact of the process itself with a larger sample of youth and families. The trends identified above in the outcome results for year one and two support the use of the intervention going forward to produce positive results for youth served in this next phase of the project. Follow-up interviews will be continued and extended to include twelve-month post-discharge interviews to assess long-term outcomes for both cohorts of youth.

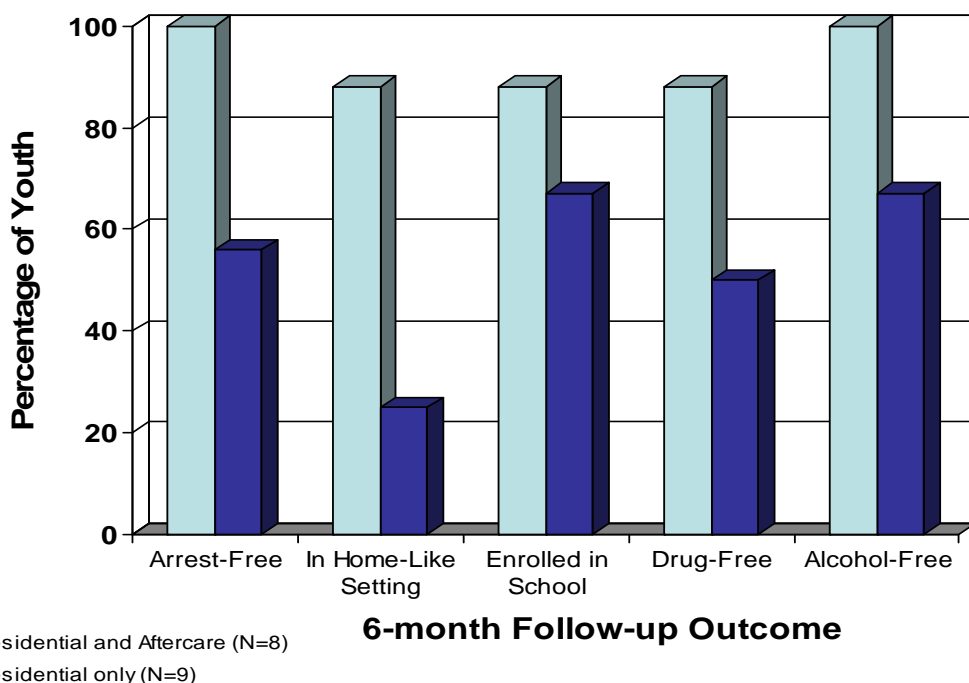


Figure 1. Six-month follow-up outcome data for youth completing both the residential and aftercare components of program vs. youth who received only residential care

Limitations

The present pilot study was based on a small sample of youth and families, and complete standardized assessment data were available for only about one-half of those who departed the

program. The family reunification process was designed and implemented for the first time at five program sites across the country making staff training and supervision, program implementation, and data collection a challenge. In addition, even though it consisted of simply integrating two existing and consistent intervention programs (cognitive-behavioral, family-style residential and intensive in-home), the integration of these programs still needed additional refinement at the end of this initial study. Program refinements have been made, staff have been trained and the study is being continued to include a larger sample of youth and families, addressing these limitations.

Second, we only have follow-up data for eight of the 19 youth (42%) who received both residential and aftercare services. Although the data are positive in comparison to those that did not receive both components, results need to be interpreted with caution. However, we are currently conducting 12-month follow-up interviews with this cohort and will be conducting 6- and 12-month follow-up interviews with those youth and families in the subsequent two-year wave of the study. As such, we will have more substantial numbers to make more conclusive statements about post-treatment outcomes.

Implications for Research and Practice

Despite these limitations, data collected on youth and families who successfully completed the program indicated the youth and families made significant progress on important indicators for long-term success. Family reunification interventions hold promise for youth in the juvenile justice system. To keep youth from re-offending, it is necessary to strengthen family members as well as teach new skills to youth. Results appear promising from these initial process and outcome data.

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See Appendix, Next Page!

Appendix A
Sample Items from the Residential Model Fidelity Observation Form

A. TEACHING COMPONENTS

Teaches youth how to discriminate social skill steps for different situations.

- (1) **No/Incorrect:** Routine/rote teaching, not varied to meet different situational needs.
- (2) **Below Average:**
- (3) **Average:** Recognizes most opportunities to adapt social skills steps for different situations. Explains to youth why the steps need to be modified for a particular situation.
- (4) **Above Average:**
- (5) **Excellent:** Consistently helps youth recognize when social skill steps need to be modified to meet situational needs (e.g. how to introduce self to peers versus a teacher or boss).

B. MOTIVATION SYSTEM

Teaching interactions include consequences (positive/negative as appropriate)

- (1) **No/Incorrect:** Omits consequences when teaching. (e.g. overuse of prompting/general praise without a consequence).
- (2) **Below Average:**
- (3) **Average:** The majority of teaching interactions include consequences (as appropriate for system level).
- (4) **Above Average:**
- (5) **Excellent:** All teaching interactions include consequences that are appropriate and individualized to the system and developmental level of youth.

C. RELATIONSHIP-BUILDING

Expresses interest in the happiness and well-being of each youth

- (1) **No/Incorrect:** Demonstrates little concern regarding youth happiness and well-being.
- (2) **Below Average:**
- (3) **Average:** Expresses concern about youth happiness and well-being. Staff are complimentary and positive towards youth.
- (4) **Above Average:**
- (5) **Excellent:** Demonstrates individualized interest in and concern for the happiness and well-being of each youth, including the most difficult youth. Interest and concern for youth is natural, spontaneous, and warm.

D. FAMILY-STYLE LIVING

Teaches youth how to fulfill their family responsibilities (e.g. chores, peer support, public behavior, etc.)

- (1) **No/Incorrect:** Nonspecific or absent teaching around family responsibilities. (e.g. staff do all the cooking/shopping OR do not monitor task completion)
- (2) **Below Average:**
- (3) **Average:** Teaches youth how to complete family responsibilities. Provides specific teaching around positive family behavior and involvement.
- (4) **Above Average:**
- (5) **Excellent:** Consistently and spontaneously teaches youth to fulfill family responsibilities with both social skills and independent living skills. Teaches youth to assist each other as family members.

E. MORAL & SPIRITUAL VALUES

Models the “Pillars of Character” (trustworthiness, respect, responsibility, fairness, caring, citizenship)

- (1) **No/Incorrect:** Demonstrates behaviors in violation of the Pillars of Character. Condone inappropriate youth behaviors regarding moral issues.
- (2) **Below Average:**
- (3) **Average:** Models moral behavior for youth, e.g., respect and responsibility. Supports the Pillars of Character in conversation surrounding moral issues with youth.
- (4) **Above Average:**
- (5) **Excellent:** Capitalizes on opportunities to model and spontaneously teach good character values (e.g., teaches youth to see situations from others’ perspectives).

F. SELF-GOVERNMENT

Encourages use of problem-solving strategies where warranted (e.g. discussion with youth, moral dilemmas, SODAS strategies, etc.)

- (1) **No/Incorrect:** Misses opportunities to problem-solve. Provides solutions to youth without allowing them to problem-solve. Does not encourage use of problem-solving strategies where warranted.
- (2) **Below Average:**
- (3) **Average:** Routinely uses problem-solving strategies to meet program standards (i.e., problem solves after critical incidents).
- (4) **Above Average:**
- (5) **Excellent:** Spontaneously and effectively uses problem-solving strategies. Naturally integrates critical thinking with problem solving and teaching (i.e., handles divergent youth opinions well, maintains objectivity, etc.).

Appendix B. Sample Items from the In-Home Model Fidelity Observation Form

A. RELATIONSHIP BUILDING AND ENGAGEMENT**Demonstrates respect for the family's traditions, values, and beliefs.**

- (1) Well below criteria for certification. Implementation is absent and/or incorrect.
- (2) Below criteria for certification. Implementation lacks consistency and/or effectiveness.
- (3) Meets criteria for certification. Represents effective implementation
- (4) Exceeds criteria for certification. Implementation is consistent and effective
- (5) Well above criteria for certification. Implementation is natural, consistent and spontaneous effective

B. TEACHING COMPONENTS**Addresses the family's issues based on identified needs and the Family Service Plan.**

- (1) Well below criteria for certification. Implementation is absent and/or incorrect.
- (2) Below criteria for certification. Implementation lacks consistency and/or effectiveness.
- (3) Meets criteria for certification. Represents effective implementation
- (4) Exceeds criteria for certification. Implementation is consistent and effective
- (5) Well above criteria for certification. Implementation is natural, consistent and spontaneous effective

C. PROFESSIONALISM AND SAFTEY**Promote appropriate and effective monitoring of children.**

- (1) Well below criteria for certification. Implementation is absent and/or incorrect.
- (2) Below criteria for certification. Implementation lacks consistency and/or effectiveness.
- (3) Meets criteria for certification. Represents effective implementation
- (4) Exceeds criteria for certification. Implementation is consistent and effective
- (5) Well above criteria for certification. Implementation is natural, consistent and spontaneous effective

D. ENHANCING NATURAL THERAPY SYSTEMS**Strengthens existing resources to improve family functioning**

- (1) Well below criteria for certification. Implementation is absent and/or incorrect.
- (2) Below criteria for certification. Implementation lacks consistency and/or effectiveness.
- (3) Meets criteria for certification. Represents effective implementation
- (4) Exceeds criteria for certification. Implementation is consistent and effective
- (5) Well above criteria for certification. Implementation is natural, consistent and spontaneous effective