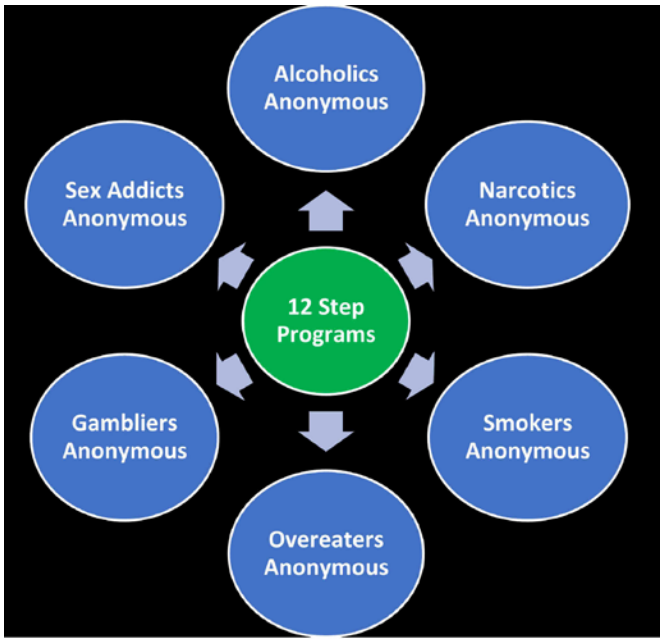
Developing a Comprehensive Treatment for Unhealthy, Harmful Behavior

Introduction

Treatment programs for unhealthy, harmful behavior are typically specific focusing on one type of harmful behavior. Harmful behavior-specific Twelve-Step programs span the harmful behavior continuum and cognitive-behavioral treatments limiting referrals to sexual abuse, physical abuse/domestic violence, substance abuse and food abuse/obesity are numerous. From a clinical perspective, harmful behavior specific treatments allow group therapy client identification and therapist specialization. From a research perspective, a carefully selected harmful behavior-specific population makes it easier to demonstrate treatment effectiveness. Unfortunately, many harmful behavior-specific treatments lack the comprehensive approach needed to adequately address unhealthy, harmful behavior in one or more of the following areas.



Harmful Behavior Comorbidity

Harmful behavior comorbidity defined as co-occurrence of other forms of harmful behavior with the referral behavior is quite common in the community clinical setting. It is not unusual for individuals referred for sexual abuse (e.g., child molestation and rape), substance abuse (i.e., drugs and alcohol) or food abuse (i.e., overeating), to also have a history of involvement in property abuse such as theft, gambling or overspending (Burton, 2008; Crockford and el-Guebaly, 1998; Desai, Desai & Potenza, 2007; Ribel, 2000; Nower, Derevensky & Gupta, 2004; Pietrzak et al. 2007; Toch & Adams, 1992). While there are many co-occurring harmful behaviors, substance abuse is a relatively prevalent co-occurring problem across harmful behaviors including sexual abuse, physical abuse, property abuse and food abuse/overeating (e.g., Baltieri & de Andrade, 2006; Basu, Paltiel & Pollack, 2008; Conason & Sher, 2006; Stuart et. al., 2008), making it an important target for harmful behavior-specific treatment programs which do not routinely treat multiple forms of harmful behavior. In summary, the referral harmful behavior is not usually the

The referral harmful behavior is not usually the only harmful behavior

Source: Yokley, J. & Seeholzer, E. Developing A Comprehensive Treatment for Harmful, Abusive Behavior. 117th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada, 2009 (August). APA Division 29- Society for the Advancement of Psychotherapy [Updated & illustrated for educational use only]

only harmful behavior. Harmful behavior comorbidity is a serious problem in harmful behavior-specific treatment because it enables comorbidity adverse impact and harmful behavior migration.

Comorbidity Adverse Impact

There is a growing body of evidence that one type of unhealthy, harmful behavior can set the occasion for or trigger another. For example, there is a strong association between alcohol abuse and physical abuse supported by seven meta-analytic studies (Exum, 2006). Although rates vary across studies, findings that half of the clients in batterer programs have diagnosed alcohol problems (e.g., Stuart et. al., 2003) and 40-60% of clients in substance abuse treatment report partner aggression (e.g., Fals-Stewart & Kennedy, 2005) may indicate a bidirectional relationship where some clients beat their partners, feel guilty, then get drunk while others get drunk, lose control, then beat their partners. Indications that substance abuse may set the occasion for sexually abusive behavior (e.g., Abbey et. al., 2001; Lightfoot & Barbaree, 1993) presents another serious comorbidity adverse impact issue for harmful behavior-specific treatment. This is a particular problem in light of data indicating that alcohol abuse in sex offenders can be up to ten times that of violent offenders and that a large proportion of sex offenders are under the influence during their offense (e.g., Abracen et. al., 2006).

One unhealthy, harmful behavior can trigger another

Harmful Behavior Migration

The presence of co-occurring unhealthy, harmful behaviors in harmful behavior-specific treatment allows target behavior migration to a co-occurring harmful behavior during treatment when the target behavior is under observation and shifting back afterwards. Problem gamblers, drinkers or both shift these behavior patterns regularly (Shaffer and Hall, 2002). Preventing harmful behavior migration by targeting co-occurring harmful behaviors that present with the referral behavior is needed to enhance treatment outcome. This point is exemplified by treatment research in the area of drinking and smoking where: 1) continued smoking appears to place abstinent alcohol and drug abusers at elevated risk for relapse (Sees & Clark, 1993); 2) smokers were less likely to be abstinent from alcohol/drugs over the past 30 days at five-year follow up (Satre, Kohn & Weisner, 2007) and; 3) being a non-smoker at treatment entry is an alcohol abstinence predictor at seven-year follow up (e.g., Hintz & Mann, 2007). Evidence that even decreases in smoking over time can significantly decrease the likelihood of alcohol relapse (Friend & Pagano, 2005)

Stopping one unhealthy, harmful behavior but starting another does not develop self-control

may illustrate the positive effect of adding self-control practicing to co-occurring harmful behaviors.

Stopping one unhealthy, harmful behavior but starting another one does not develop self-control. Successful elimination of the target behavior through self-control development cannot occur when the response focus simply migrates back and forth between comorbid harmful behaviors as this prevents practicing self-control/self-

regulation procedures. Harmful behavior migration is not likely to be effectively addressed by continuing to implement harmful behavior-specific interventions in the hopes that generalization to the co-occurring harmful behavior will result without targeting co-occurring harmful behavior for self-control practice. For example, in the area of co-occurring drinking and smoking, systematic review and meta-analysis reveals that implementing an alcohol abuse-specific intervention alone does not reduce cigarette smoking (McCambridge & Jenkins, 2008). Concurrent interventions that target the primary contributing factors to both the referral behavior and the co-occurring harmful behaviors are recommended to block the path of behavior migration.

Negative Social Influence

Contemporary research and clinical emphasis on developing internal self-regulation skills may have overshadowed the impact of external factors such as negative social influence. This is of particular concern because negative social influence can impede treatment by encouraging multiple forms of unhealthy, harmful behavior including physical abuse, property abuse, substance abuse, smoking, food abuse/overeating and delinquency (e.g., Chapple, Hope & Whiteford, 2005; Etcheverry & Agnew, 2008; Harper & Robinson, 1999; Higgins & Makin, 2004;

"Birds of a feather fail or succeed together"

Salvy et al., 2007; Shortt et al., 2003). Peers, partners and parents/family are identified sources of negative social influence that particularly impact youth treatment (e.g., Shortt et. al. 2003). Just as comorbidity adverse impact appears to be bidirectional, the impact of social influence also appears to be bidirectional. Thus, while negative social influence is a risk factor for multiple forms of unhealthy, harmful behavior, positive social influence appears capable of exerting an opposite, protective factor effect in a number of areas including substance abuse, smoking and unhealthy eating (e.g., Christakis & Fowler, 2008; Goodrick et al., 1999; Inciardi, Martin & Butzin, 2004). In other words, "Birds of a feather fail or succeed together".

Intervention Intensity: Strong problems require strong treatment

The highly resistant, self-reinforcing nature of many unhealthy, harmful behavior habits can be too strong for willpower, cognitive interventions or other Internal Control skills alone. These strong problems require a strong treatment response with multiple intervention methods across multiple intervention pathways. The Multimethod-Multipath Behavior Therapy utilized in SRT targets these strong problems with multiple: Internal Control interventions (e.g., relapse prevention, emotional regulation, decisional balance, social problem solving); External Control interventions (e.g., reinforcement, consequences, medications) and; Social Learning interventions (e.g., prosocial modeling, positive social influence).

Highly resistant, self-reinforcing unhealthy, harmful behaviors can be too strong for cognitive interventions alone

In harmful behavior-specific treatment, the severity and/or resistance of unhealthy, harmful behavior warrants increased intervention intensity in confrontation, contact and monitoring. With respect to confrontation of harmful behavior, intervention intensity cannot be diluted to the point where it is ineffective and enables harmful behavior or concentrated to the point where it is toxic and impairs the therapeutic relationship (Yokley, 2008). There is also need to increase treatment contact frequency to provide increased positive modeling, prosocial talk and behavior re-direction in highly supervised structured group therapy sessions. This is required to compete with the negative social influence and antisocial talk from peers, partners and family that has been demonstrated to have an adverse impact on youth (Shortt et al., 2003). Increasing intervention intensity by extending behavior monitoring across multiple settings and systems where the patient interacts has a solid research support base in the treatment of conduct disordered youth (e.g, Swenson et al., 2005) and is critical with juvenile sexual offenders (e.g., Letourneau, 2008).

Harmful Behavior Conceptualization: How unhealthy, harmful behavior was acquired, maintained and generalized

In order to help clients develop resiliency from risk factors, support relapse prevention efforts and develop resistance to new forms of unhealthy, harmful behavior, it is important for them to understand the basic factors involved in the etiology and development of their unhealthy, harmful behavior. Attention has traditionally been focused on helping clients understand and break the cycle that maintains multiple forms of harmful behavior including sexual abuse, physical abuse, substance abuse and food abuse/overeating (e.g., Dutton, 2007; Schulherr, 2005; Scott, Dennis & Foss, 2005; Wheeler, George & Stephens, 2005). Comprehensive understanding of unhealthy, harmful behavior needs to extend beyond the cycle that maintains that behavior. Addressing the risk factors involved in how the unhealthy, harmful behavior was acquired is essential in helping clients fully resolve those problems and in preventing the development of new problems related to those risk factors. Targeting primary contributing factors that support multiple forms of harmful behavior is important in preventing behavior migration and the generalization of harmful behavior to other forms.

Comprehensive understanding of unhealthy, harmful behavior needs to extend beyond the cycle that maintains that behavior

In SRT "The Problem Development Triad" provides a client-focused case conceptualization (Sperry, 2005) to help clients understand how unhealthy, harmful behavior was acquired, maintained, and generalized to other problem areas. A client-focused case conceptualization creates a therapeutic alliance with the client towards understanding etiology and development of their unhealthy, harmful behavior. A detailed description of how to implement this client-focused case conceptualization with case illustrations involving unhealthy eating, substance use and sexual behavior is provided in Chapter's 10- 12 of the Clinicians Guide to Social Responsibility Therapy. Client workbooks that are structured to help clients discover how their unhealthy harmful behavior was: acquired

(i.e., How did I get this problem?); maintained (i.e., Why do I keep doing this?) and; generalized to other problem areas (i.e., How did my problem spread?) are available. This offers clinicians the choice on whether or not to give learning experience assignments.

Multicultural Recognition in Treatment Program Design: The SRT Inclusive Multicultural Treatment Approach

Unhealthy, harmful behavior is multicultural, occurring across cultures and countries. For example, in the area of substance abuse, although levels can vary across cultures, abuse of alcohol and other drugs is multicultural with studies showing consistency in risk factors, predictive factors, personality variables and need patterns across cultures (e.g., Bloomfield et al., 2003; Brook et al., 2001; Huq & Mahmud, 1994; Teichman, et al., 1992). Likewise, physical abuse/interpersonal violence has been labeled a global public health problem (e.g., Hollin & Bloxsom, 2007). Sexual abuse, sexual trafficking and rape are also global, multicultural problems (e.g., Yakushko, 2005). Multicultural recognition in treatment program design has been recommended to address ethnic minority mental health service problems including high dropout rates after one treatment session, infrequent session use and poor level of functioning at the end of treatment (Maramba and Hall, 2002). SRT utilizes an Inclusive Multicultural Treatment approach based on multicultural values theory and "diversity within unity" (Etzioni, 2001). This approach provides a more inclusive path for multicultural recognition in unhealthy, harmful behavior treatment by identifying cultural similarities to celebrate in addition to the traditional approach of developing awareness of cultural differences to respect.

Inclusive Multicultural Treatment identifies "Similarities to celebrate"

Social Responsibility Therapy: A Comprehensive Treatment for Unhealthy, Harmful Behavior

Social Responsibility Therapy is a hybrid skills-based treatment that combines evidence-based interventions and procedures to target the referral unhealthy, harmful behavior along with co-occurring unhealthy, harmful behaviors. Combining interventions and procedures demonstrated effective in achieving behavior change using different methods and pathways is required to address the aforementioned issues in harmful behavior-specific treatment. Intervention methods in SRT are integrated across pathways such that the development of self-awareness and self-efficacy enables self-control success which further enhances self-efficacy. Intervention pathways are categorized in SRT as primarily utilizing internal control (e.g., cognitive processing), external control (e.g., operant conditioning) or social learning (e.g., modeling). SRT combines internal control, external control and social learning procedures to increase *intervention intensity* and target primary contributing factors to multiple forms of harmful behavior in order to address *harmful behavior comorbidity, comorbidity adverse impact and, harmful behavior migration*. For example, SRT targets 20 irresponsible thinking types along with cognitive, social and emotional triggers of multiple forms of harmful behavior for cognitive restructuring to avoid harmful behavior relapse. *Multicultural recognition in treatment program design* and *negative social influence* are addressed with motivationally enhanced awareness training on

multicultural prosocial values and social situations that are high risk for relapse. SRT directly reinforces multicultural prosocial values, behaviors and positive peer modeling as competing factors against harmful behavior while providing direct consequences for multiple forms of harmful behavior and negative social influence. In younger clients and those needing a high level of structure, SRT utilizes a response-cost Token Economy to target these issues. In older clients and those who require less structure, SRT implements a behavior feedback slip system that involves peers, partners and parents/family as agents of change in a support circle. These external control methods increase *intervention intensity* by extending intervention out of the treatment setting to everyone around the client. SRT addresses the *harmful behavior conceptualization* issue with a structured discovery approach involving structured workbooks designed to help clients work with their therapists to discover how they acquired, maintained and generalized their harmful behavior. SRT has a published treatment manual that provides a detailed description of the treatment model implementation methods and protocol (Yokley, 2008) along with a clinician's guide that provides practical applications with case study illustrations across multiple forms of unhealthy, harmful behaviors (Yokley, 2016)

SRT provides a comprehensive treatment for unhealthy, harmful behavior by addressing contemporary issues in unhealthy, harmful behavior-specific treatment

In summary, SRT assesses multiple forms of unhealthy, harmful behavior at intake and targets the referral behavior along with co-occurring behaviors with multiple intervention methods across multiple intervention paths to increase therapeutic pressure towards positive behavior change. SRT provides a comprehensive treatment for unhealthy, harmful behavior by identifying and addressing contemporary issues in unhealthy, harmful behavior-specific treatment including: Harmful Behavior Comorbidity; Comorbidity Adverse Impact; Harmful Behavior Migration; Negative Social Influence; Intervention Intensity; Harmful Behavior Conceptualization and; Multicultural Recognition in Treatment Program Design.

Treatment Program References

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