

Behavior Excesses and Deficits in Children

Promising Recent Developments

Tracy L. Morris & Robert P. Hawkins

Interventions for children encompass a diverse array of techniques designed to reduce maladaptive or excess behavior and to increase social functioning (cf. Mash & Barkley, 1989). Contemporary intervention strategies are increasingly multidisciplinary in application, involving teachers, social workers, pediatricians, psychiatrists, and child clinical psychologists. This chapter focuses on developments in the field of child behavior therapy since the mid-1980s. Following a discussion of functional assessment and the constructional approach, the chapter presents a brief and selective review of the most promising developments in intervention for conduct problems and social anxiety.

BEHAVIOR EXCESSES AND DEFICITS

In applied behavior analysis of or behavior therapy for clinical problems, the initial assessment process leads to the selection of fairly specific target behaviors (Hawkins, 1979, 1986) or, more proper, specific environment-behavior functional relations (cf. Donahoe & Palmer, 1994). These relations usually can be characterized as either behavior *excesses* or behavior *deficits*. An excess behavior occurs when a per-

son shows a certain class of response too often, too intensely, or in too many stimulus contexts, such as a child's grabbing toys from peers, having tantrums at bedtime, scratching his or her skin, lying, or stealing. It is considered excess because it occurs at a rate or an intensity that is maladaptive in that it is "costly" to the child or to others in the long run (Hawkins, 1986). The cost can be in terms of either lost reinforcers or unnecessary punishers. The behavior may also be viewed as socially maladaptive in that it is atypical and thus may bring about undesirable social consequences (e.g., being teased or ostracized). The behavior is, of course, also adaptive in the sense that it is a product of the learning history that the child's environment has provided (see Meyer & Evans, 1989). A deficit behavior occurs when a person shows a certain class of response at too seldom a rate, at too low an intensity, or in too few stimulus contexts, such as a child's failing to learn to read, infrequently interacting with other children, failing to do homework, talking too quietly, or rarely expressing his or her wishes (i.e., being nonassertive). Again, these are considered deficits only if they are maladaptive in the sense noted above.

- past teachers and administrators were not skillful and motivated enough to make sure that he acquired the skills despite the absences.
5. Gary's present teachers—each of whom has him for only one period per day and thus does not know him well—are mostly unaware of both his asthma and his limited reading skills.
 6. The academic subjects in which Gary cheats are taught by rather "cold" teachers who take very little interest in individual children.

This additional assessment information should give the reader a very different interpretation of Gary's cheating and some further ideas for intervention. The prospect of punishing Gary's cheating should seem not only much less humane than it did initially but also unlikely to improve Gary's long-term adjustment—presumably the goal of intervention. This assessment is *systemic* in that it considers various possible sources of the current behavior problem and various resources for alleviating the problem.

The assessment also is *functional* in that it looks for influential variables in the individual's past and present environments rather than at fictional inner causes, such as personality traits, self-efficacy, self-esteem, locus of control, schemas, and so forth. A systemic, functional assessment often will suggest several possible constructional interventions—ones that build skills instead of eliminate behaviors and ones that are both constructional and systemic. They will not necessarily focus on the identified individual; they may focus primarily on other parties. In Gary's case, for example, the school psychologist might work with certain teachers to help them become more sensitive to students' individual life situations, arrange for assessment and remediation of very specific reading skills, and work with Gary's parents to help them arrive at more constructive ways to help Gary progress in school and in life.

DEVELOPMENTAL ISSUES

The chapter authors' approach to behavior excesses is to intervene in *developmentally ap-*

propriate ways, attending to the unique developmental and family factors present. Developmental factors have important implications for behavioral intervention. Age-by-treatment interactions are one example. A common clinical assumption is that intervention tends to be more effective when implemented earlier, as opposed to later, in the individual's life. It is generally held that behavior patterns are less well established in young children and are thus more responsive to change (Mash, 1989). A meta-analysis of the effectiveness of psychotherapy with children and adolescents (Weisz, Weiss, Alicke, & Klotz, 1987) provides indirect support for age-by-treatment interactions—a mean treatment-effect size of .92 was reported for children ages 4–12, whereas the mean treatment-effect size was .58 for children ages 13–18. Although the results of the meta-analysis suggest that positive therapeutic change *in general* may be more rapid with younger individuals, *specific* change strategies may be more effective with older children. Age differences have been reported for the efficacy of self-instructional training across a range of problems (Hobbs, Moguin, Tyroler, & Lahey, 1980). Ability to engage in imagery also has been found to vary as a function of age (Purkel & Bornstein, 1980). Some evidence suggests that the effects of reinforcement and punishment are also a function of age-related factors (Johnson & McGillicuddy-Delisi, 1983).

An integration of classic developmental and behavioral approaches enriches the assessment process and may lead to more effective intervention. Mash (1989) emphasized the importance of identifying specific age-related developmental skills and incorporating those skills into intervention. Undoubtedly, certain approaches will be demonstrated to be more effective within specific age periods than will others. Too often, efforts toward intervention with children have reflected mere downward extensions of work with adults. For example, early work with social skills training (SST) emphasized skills that had been effective in improving the social-interactional performance of adults (e.g., eye contact, formal conversational skills), but those skills were found to be of little consequence in enhancing the performance and social acceptance of children (e.g., Berler, Gross, &

they can be summarized by the terms *systematic* and *intensive*. To illustrate, six aspects are described as follows:

1. Staff receive intensive training in which they must *demonstrate* and be certified in key skills before taking responsibility for youth; they do not merely learn *about* such skills.
2. After the teaching parents begin serving youth, they are not merely turned loose to implement the system in any way they see fit; they receive consultation, are observed directly at certain intervals, and must meet on-the-job performance criteria.
3. Teaching parents are taught to be both affectionate and firm in their interactions with youth.
4. Every youth is on an extensive point system so that desirable behaviors are consistently reinforced (primarily with commonplace privileges) and undesirable behaviors are consistently punished (with loss of points).
5. The teaching parents are involved with the youth's school in ways that support the teachers' and the youth's academic progress.
6. Although there is a certain set of social, housekeeping, and self-help skills that every youth is taught, there is also considerable individualization based on the youth's needs.

A great deal of research has been conducted on the Teaching-Family Model. Some studies have tested the effects of specific techniques (e.g., Bailey, Wolf, & Phillips, 1970; Braukmann, Maloney, Fixsen, Phillips, & Wolf, 1974; Minkin et al., 1976), whereas other studies evaluated the model as a whole (e.g., Kirigin, Braukmann, Atwater, & Wolf, 1982). The model has had immense influence on numerous other programs, including programs that do not use group homes as a context for intervention.

Foster Family-Based Treatment

One type of intervention that the Teaching-Family Model has influenced is a strategy that is variously called foster family-based treatment (FFBT; see Hawkins, Meadowcroft, Trout, & Luster, 1985), therapeutic foster care, or treat-

ment foster care, among other names (Bryant & Snodgrass, 1990; Hawkins, 1989). In FFBT,

One recruits couples from the community who are willing to learn a set of treatment procedures, then accept a disturbed or disturbing child or youth into their family who has been removed from her or his own home for one or more reasons. The couples then apply the learned procedures consistently, under supervision, along with just plain good care and parenting. (Hawkins, Luster, & Meadowcroft, 1987, p. 3)

FFBT programs usually are developed as an alternative to institutional placement of youth (Snodgrass & Bryant, 1989), with the goal that the youth will either return to the biological family or, if 18 years old, move on to successful independent living. The intervention may last as little as a few months or as long as several years, depending on the youth's progress and the conditions to which she or he will be discharged. It is the least expensive of all out-of-home intervention strategies (Snodgrass & Bryant, 1989).

Early attempts to start intervention programs that involved foster parents did not consider the foster parent as a primary intervention agent (Bryant & Snodgrass, 1990) and did not have the benefit of behavioral methods. These attempts had very limited success (e.g., DeFries, Jenkins, & Williams, 1970). Nevertheless, several foster parent-based programs were attempted in the 1970s in Canada and the United States (Snodgrass & Bryant, 1989), and several of them survived, although they often were very small. In the 1980s, concerted efforts to develop systematic, behaviorally oriented programs began. Perhaps in part because of the success of these programs, the 1980s saw a burgeoning of FFBT programs all over the United States and Canada. Hawkins (1989) estimated that by 1989 there were approximately 250–500 in Canada and the United States combined, and as of the late 1990s, there may be several times that number. Also in 1989, an international Foster Family-based Treatment Association was organized (Foster Family-based Treatment Association, 1991). The association developed standards of FFBT that are used by member programs for self-assessment, and it publishes a regular newsletter.

extensively from families who already provide regular foster care partly because it is a disservice to deplete the ranks of these care providers. Some of the strategies used by various programs include special recruitment campaigns, writing articles for the internal newspapers of industrial plants, addressing PTAs or church groups, paying current intervention parents a "finder's fee" for recruiting successful families, holding Tupperware-type parties for friends and neighbors of current intervention parents, mailing brochures to schools and colleges for placement on bulletin boards, putting brochures in displays of other advertising brochures for tourists, and, of course, advertising in newspapers (Gross & Campbell, 1990).

The recruitment process is selective in itself because the recruited intervention parents are informed of how difficult the youth and the job are. For those who are still interested, the first issue is whether they can meet the state's criteria for licensing as foster families. The next issue is whether they have already demonstrated desired parenting skills, such as holding realistic expectations and being consistent in discipline. Also, they must show a desire to learn new skills and must show resilience because problems will arise repeatedly. Finally, their references must suggest good character (Gross & Campbell, 1990).

Placing Children in Specific Families

Grealish and Meadowcroft (1990) suggested that children be placed in families that are similar to their biological families in socioeconomic status and that the youth have a voice in the selection of the family, just as the family has a voice in selection of a youth. Usually, potential families are given extensive information about the child in advance, followed by two or more preplacement visits; the first visit often is in an office, and the second is in the family's home, perhaps overnight. When all parties agree that a good match has been found, the youth joins the family for the duration of her or his intervention.

Training and Supporting Intervention Parents

Programs vary greatly in both the goals and the methods of training. Among the three behav-

iorally oriented programs described by Meadowcroft and Grealish (1990), the following behaviors were considered crucial for intervention parents:

- Consistently discussing and enforcing rules
- Frequently using reinforcers for good behavior and rarely using punishment
- Nurturing and accepting a child as she or he is
- Giving the child age-appropriate responsibilities
- Modeling adaptive behavior

All three programs required participation in preservice training for 10–24 hours; the training was found to be useful as a screening tool as well. The content of the training differed somewhat across the programs, but all had criteria regarding attendance, homework completion, objective evaluation of the presence of required skills, subjective evaluation by staff, and adherence to state requirements.

Once parents pass the preservice training, they become eligible to serve a child, and the placement process begins. Then, while a child is in the family's home, staff consult with the parents frequently in their home and by telephone. The content of this consultation varies greatly from family to family, program to program, and day to day; but generally it deals with current problems and solutions, use of the procedures taught in preservice training, and record keeping. To continue the professional development of intervention parents, FFBT programs often require participation in the program's in-service training workshops.

FFBT parents typically are paid a per diem fee or a salary that is equivalent to several times what typical foster parents receive. Many programs also provide respite for intervention parents because the job of working with a disturbed youth for 24 hours per day and 7 days per week can be quite stressful.

Serving Children While They Are in the Program

As Meadowcroft, Hawkins, Grealish, and Weaver pointed out, the goal of FFBT is "to bring about

bances are unprepared to reimburse programs at a level that would make it possible to provide all of the family services needed.

In the face of this gloomy picture, it is often amazing how much can be done to help biological families when staff are creative, energetic, and persistent. Most families can make gains that will make it possible for them to accept the child back into their home or at least to have better interactions with the child while she or he lives elsewhere. FFBT programs work with families individually, providing services that range from individual training in the skills of family communication to assistance in finding a job. Sometimes working with biological families in groups can be a useful adjunct to this (Grealish, Hawkins, Meadowcroft, & Lynch, 1990).

Discharge and Follow-Up

When a youth has met her or his goals adequately and the biological family is ready to receive her or him back, the child is discharged to the family. There are, however, numerous exceptions. Sometimes the biological parents are never ready to have the child back and to be even minimally responsible parents. On rare occasions, the family has even moved away and left the child. In such cases, the options range from allowing the intervention parents to adopt the child to reducing services to a level that approximates typical foster care.

Sometimes the youth is close to the age of 18, the age at which reimbursement for services usually must be terminated unless the child is in school. The child then will often remain in the program until age 18 and be discharged to live independently.

Programs differ considerably in how much postdischarge follow-up they do with youth who are former program participants. Because there is no reimbursement for follow-up services, programs have a disincentive to invest much in them. PRYDE and all other Pressley Ridge programs have a commitment to each youth that resembles parents' commitment to their children. The commitment is conveyed in the phrase that staff often utter: "Once a Pressley Ridge kid, always a Pressley Ridge kid." In practice, this means that staff are expected always to be available to and interested in former program partic-

ipants, even if the youth was discharged so long ago that few staff who worked with her or him remain. This may involve merely a 10-minute social conversation with a former participant who walks in unannounced; or it may mean spending several hours helping him or her with some current problem, such as finding a job. It also sometimes means drawing from a special Pressley Ridge fund to help a youth through a difficult but temporary situation. Of course, it does not mean providing long-term housing, food, or other basic support.

Evaluation

There have been few evaluations of FFBT programs. However, a study by Hawkins, Almeida, and Samet (1989) evaluated PRYDE by inspecting the child welfare records of 461 youth who were referred to or accepted by PRYDE. Of these, 341 referrals had been served by other programs in the Pittsburgh area because these programs had spaces for the youth before PRYDE did (a common phenomenon because child welfare typically refers a youth to more than one program at the same time). Thus, the youth who were served by programs other than PRYDE were assumed to be very comparable to PRYDE-served youth, an assumption confirmed by analysis of several demographic variables.

The concept behind the evaluation was that a youth's success after being served by the type of program to which she or he was assigned—called "target programs"—to be evaluated (of which PRYDE was just one) would be reflected in the restrictiveness of the youth's subsequent placements. As the subsequent placement generally reflects the youth's current behavior, the eventual discharge of a youth from a target program to a highly restrictive placement would suggest that the target program had been less successful with the youth than if she or he had been discharged to a less restrictive placement. The authors developed a Restrictiveness of Living Environments Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) to assign restrictiveness values to these subsequent placements. The 27 different living environments on the scale ranged from jail (restrictiveness value of 10) to independent living by oneself (restrictiveness of 0.5).

grounded in respondent conditioning (Jones, 1924), operant conditioning (Skinner, 1953), and two-factor theory (Mowrer 1947, 1960). The following sections present a brief overview of common behavioral approaches to the management of anxiety. A description of several promising approaches in the intervention for anxiety and social competence deficits follows this overview.

Respondent-Based Procedures

The behavioral intervention for fear and anxiety in children dates to the classic work of Jones (1924) and the elimination of a fear of rabbits in a small boy referred to as "Peter." Intervention consisted of progressively exposing the child to the rabbit while the child was engaged in a pleasurable activity (eating) that was incompatible with fear. Following intervention, Peter's fear dissipated with respect to the rabbit as well as to other, similar objects to which the fear had generalized. The case of Peter typically is presented as an example of "deconditioning" through principles of respondent conditioning.

Systematic Desensitization

Building on Jones's early work, Wolpe (1958) developed a "graduated deconditioning" technique called *systematic desensitization*. The rationale was that anxiety is a set of classically conditioned responses that can be unlearned or counterconditioned through associative pairing with anxiety-incompatible stimuli and responses. In systematic desensitization, anxiety-arousing stimuli are systematically and gradually paired (imaginally or in vivo) with competing stimuli, such as food, praise, imagery, or cues generated from muscular relaxation. Imaginal presentation of fearful stimuli was used predominantly in the initial work with systematic desensitization.

Systematic desensitization with children consists of three basic steps:

1. Training in progressive muscle relaxation
2. Ranking fearful situations from lowest to highest
3. Presenting hierarchical fear stimuli via imagery while the child is in a relaxed state (see Morris & Kratochwill, 1983, for a review of procedures)

Systematic desensitization appears to work well with older children and adolescents (see Barrios & O'Dell, 1989, for a review). Younger children, however, often have difficulty with both obtaining vivid imagery and acquiring the incompatible muscular relaxation response (Ollendick & Cerny, 1981). Strategies such as using developmentally appropriate imagery (Ollendick, 1979) and adjunctive use of workbooks (see Kendall, 1990) may enhance the effectiveness of these procedures with children.

Exposure-Based Interventions

Exposure-based interventions include *flooding* (with response prevention) and *graduated exposure*. These interventions are based on respondent conditioning and the classical extinction paradigm. In the natural environment, individuals typically do not remain in the presence of anxiety-arousing stimuli for a sufficient duration to allow extinction to occur. Moreover, escape and avoidance behaviors are negatively reinforced by removal of the aversive stimuli and cessation of anxiety. Exposure-based procedures require extended presentation of feared stimuli with concurrent prevention of escape and avoidance behaviors for the extinction of the conditioned responses to occur (see Eisen & Kearney, 1995; Morris & Kratochwill, 1983), thus addressing both components of the two-factor model.

Flooding involves sustained exposure (imaginally or in vivo) to feared stimuli—the individual is required to remain in the presence of feared stimuli until his or her self-reported anxiety level dissipates. The term *graduated exposure* refers to progressive in vivo exposure to hierarchically presented fear stimuli. Unlike with systematic desensitization, stimulus presentation generally is not accompanied by progressive muscle relaxation. Reinforced practice often is used in conjunction with graduated exposure whereby positive reinforcement is provided for progressively longer exposure to fear stimuli (Leitenberg & Callahan, 1973). Graduated exposure generally is considered to produce less stress for the individual (and the therapist) and thus often is preferred over the use of flooding with young children.

development of social relationships. In the typical SST program, children are provided with group instruction in the execution of specific behaviors (e.g., play group initiations), group leaders model effective behaviors, and children are given practice opportunities accompanied by feedback and reinforcement. Although SST programs largely have been successful in increasing the specific target behaviors trained, changes in social acceptance by peers typically have *not* followed from traditional SST alone.

Interventions that involve a child's peers (peer mediated) appear to be superior to adult-mediated approaches for remediating social isolation (Strain & Fox, 1981). Typical peer-mediated approaches provide peers with incentives and/or training to increase their rate of positive interaction with target children (e.g., Christopher, Hansen, & MacMillan, 1991; Strain & Odom, 1986). Alternative peer-mediated strategies, however, rely merely on pairing socially isolated children with either "typical" or "popular" status peers in an attempt to provide age-appropriate models of social interaction and opportunities for exposure to social-anxiety provoking stimuli (e.g., Furman, Rahe, & Hartup, 1979; Morris et al., 1995). The inclusion of peers may be a necessary component to effect changes in social acceptance. Although peer-mediated programs have demonstrated efficacy in increasing the social interaction of children with mild to moderate levels of social withdrawal, children with extreme fears and social avoidance may require more intensive and extensive intervention strategies (see the section "Social Effectiveness Therapy for Children"). The following sections describe approaches to the intervention for social anxiety and interaction deficits.

Peer Pairing

In a 1995 study, Morris and colleagues investigated the utility of a peer-pairing procedure in improving the peer acceptance and positive social interaction rate of children who have been neglected by their peers. Children who are peer-neglected are those who are rated as neither liked nor disliked by their peers and who typically are characterized as shy and withdrawn. Children who are peer-neglected have been

found to report higher levels of social anxiety (LaGreca, Dandes, Wick, Shaw, & Stone, 1988) than popular children or children who are rejected by their peers. Conversely, children with an anxiety disorder were more likely to be classified as peer-neglected than were psychiatric and nonpsychiatric controls (Strauss, Lahey, Frick, Frame, & Hynd, 1988).

In the study by Morris et al. (1995), 24 children who were peer-neglected and 24 children who were popular (matched for gender, age, and classroom) were identified through sociometric nominations from an initial pool of 390 first- and second-grade children. Playground observations of social interaction during recess also were obtained (e.g., positive interaction, negative interaction, solitary play). Twelve of the children who were peer-neglected (and their matched popular peers) were assigned at random to the peer-pairing intervention. The remaining children were assigned to a no-treatment, control condition. Peer-pairing consisted of 12 interaction sessions (15–20 minutes each) conducted across a 4-week period; each child who was peer-neglected was paired with a same-gender child who was popular from his or her own classroom. During the peer-pairing sessions, children engaged in joint-task activities (e.g., board games) that required interaction.

Substantial improvements in peer acceptance and positive interaction rates were noted following the peer-pairing intervention. With regard to social status, 75% of target children in the treatment group shifted from the peer-neglected status at pretreatment to average or even popular status posttreatment (only 17% of controls demonstrated improvement in social status). Individual gains in absolute percentage of time spent in positive interaction on the playground during recess ranged from 13% to 45% over baseline levels (average gain of 28%). Prior to intervention, all children who were peer-neglected were found to have positive interaction rates significantly below the mean rates of children with average and popular status. Following the peer-pairing intervention, 50% of the treatment group had positive interaction rates above the mean rate obtained for children with average and popular status. No increase in posi-

adolescents ages 13–17, CBGT–A combines psychoeducation, skills training (cognitive restructuring, problem solving, social and assertiveness skills), and systematic behavioral exposure both within session and in vivo. Therapists utilize modeling, role playing, positive reinforcement, and skill rehearsal. Parents are involved in a limited number of sessions so that the intervention rationale and conceptualization of the disorder can be presented to them and to enlist the parents as coaches to assist with the between-session exposure homework. Results of preliminary studies (Albano & Barlow, 1996; Albano, Marten, et al., 1995) have been promising.

The Family Context

An evaluation of the family context is essential for effective assessment of and intervention for social anxiety and phobia. Patterns of familial aggregation of anxiety disorders have been identified through epidemiological studies (e.g., Turner, Beidel, & Costello, 1987). Higher rates of fears, somatic complaints, school difficulties, and solitary activity have been reported in children of parents with anxiety disorders (Turner et al., 1987).

Retrospectively, adults with anxiety disorders have rated their parents as high on overprotection and low on emotional warmth (Arndell, Emmelkamp, Monsma, & Brilman, 1983; Morris & Huffman, 1996), as having isolated them from social events, and as expressing excessive social evaluative concerns (Bruch, Heimberg, Berger, & Collins, 1989). Anxious parents may be more likely to model dependency, to reinforce anxious behaviors in their children, and to be socially isolated. In early childhood, opportunities for social interaction must be arranged by the parents. A restrictive family environment may have an adverse impact on the child's development of social proficiency (Daniels & Plomin, 1985; Parke & Bhavnagri, 1989).

Recognizing the impact of anxiety on the family system (see Albano, Chorpita, & Barlow, 1996) and the potential for family members to participate inadvertently in the maintenance of an anxiety disorder, several investigators have developed behavioral intervention protocols that directly incorporate family members in the inter-

vention. For example, Family Anxiety Management (FAM; Heard, Dadds, & Rapee, 1992) is based on behavioral family intervention strategies that have been found to be effective in the intervention for externalizing disorders in youth (Sanders & Dadds, 1992). Following each individual child session, children and their parents participate in a FAM session. Parents are taught reinforcement strategies, with emphasis on differential reinforcement and selective *inattention* to anxious behavior. Contingency management strategies are used to enhance communication and problem-solving skills within the family. The inclusion of FAM sessions has been reported to improve intervention outcomes significantly when compared with individual child intervention alone (Barrett, Dadds, & Rapee, 1996).

CONCLUSION

Contemporary child behavior therapy reflects an awareness of the unique developmental and family contexts that are relevant to the construction and implementation of intervention programs for children, as opposed to mere downward applications of interventions that have been designed for adults. This chapter has discussed functional assessment and the constructional approach to intervention for childhood problems and presented a selective review of promising developments that emphasize a constructional, or educative, approach to intervention for conduct problems and social anxiety and social competence problems. Although considerable advances have been made, continued empirical work is necessary to identify factors that facilitate and that impede successful intervention. Emphasis on the development of *cost-effective* intervention strategies is of particular relevance given the financial climate surrounding mental health–related issues and the increasing need for accountability. Additional areas of concern and needed development with these forms of behavior excesses and deficits include functional diagnostic criteria (Scotti, Morris, McNeil, & Hawkins, 1996) and the further development of functional analysis procedures and their application to various populations (see Scotti, Mullen, & Hawkins, 1998, as well as var-

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