

A Cognitive Behavioral Model For Program Design and Administration

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Cognitive Behavioral approaches to treatment have been empirically demonstrated to produce treatment outcomes efficacious to children and adolescents.

The literature is replete with evidence-based treatments for clinical issues that range from phobias, weight management, cardiovascular dyscontrol, anxiety, depression, sexual dysfunction, PTSD, OCD, and in particular, social skill and cognitive and emotional deficits related to Asperger Syndrome, to list a representative sample of issues. CBT is used in conjunction with medication therapy, and when appropriate, in place of medication, with effective results.

The key assumptions underlying CBT are:

1. Clients participate in their treatment as informed participants
2. Maladaptive behaviors (e.g. phobic avoidance, anxiety, depression/hopelessness, poor interpersonal boundaries, excessive need for reassurance and social acceptance) are the result of a distortion and misinterpretation of experiential cues/available information that becomes established as erroneous core beliefs about oneself, others, and the world.
3. A client plays an active role in treatment; in the definition of clinical issues and goals, self-assessing behavior to establish a baseline, developing treatment hierarchies, engaging in collaborative empiricism (i.e. systematically and repeatedly examining the evidence both supporting and disconfirming their distorted perceptions and beliefs), and applying skills learned in treatment settings to other in vivo environments.
4. Client behavioral changes are related to fundamental changes in their cognitions (i.e. beliefs/assumptions/perceptions), and as the result of client mediation of their behavior.
5. Therapist-designed interventions in collaboration with clients commonly result in measurable outcomes, which can be tracked over time and analyzed in terms of treatment approach and efficacy.
6. A favorable treatment environment includes multiple opportunities for exposure to challenging situations and for practicing learned skills. This should positively influence treatment results.
7. A favorable environment is cohesive, reliable, and interdependent.
8. A treatment environment, whether an institutional setting, community worksite, home, or other venue, requires a task analytical approach prior to the design of specific interventions.
9. Social Learning and behavior modification principles are the basis for intervention design. This includes, but is not limited to role modeling from older and responsible students and staff/community leaders, use of token economies and other contingency management strategies, individual, yoked, and group contracting, reinforcing successive approximation of skills, use of video feedback, and self-instruction.
10. An integrated multisystemic approach, in conjunction with CBT, results in efficacious treatment. A multisystemic approach includes CBT, family work, possibly pharmacotherapy, psycho-educational aspects, and even community collaboration.

11. CBT uses multi-sensory stimuli, e.g., visual, verbal, tactile, auditory, etc. as part of treatment interventions. For example, stimuli that elicit a phobic response may be stimulated with computer response training to overcome a fear reaction.
12. CBT enables clients to generalize behavioral change to novel situations and settings.
13. CBT interventions may be assessed to determine cost and resource use and treatment efficacy in relation to treatment outcome through time and over time.
14. CBT facilitates the accountability of client and therapist in relation to program design and administration.

With regard to this articulated therapeutic model, The Learning Clinic offers the following specific CBT-based interventions:

1. Weekly individual therapy with CBT-proficient clinicians
2. Family therapy which can involve the nuclear family, particular dyads/subsets (e.g. especially in blended/separated families), or the extended family.
3. All TLC staff adhere to a common philosophy, language, and operational definitions, and deliver services according to a reliable manualized protocol.
4. This is exemplified in the use of the Functional Analysis model to assess student challenges, strengths, and progress, and to develop goals based upon this systematic and functional assessment.
5. Theme-based group therapy during school program (e.g. self-presentation, social pragmatic skills, anger management, moral decision-making, relationship issues, young women's/young men's issues).
6. Weekly residential group process therapy during residential hours (specific to each residence and the interpersonal dynamics/challenges therein).
7. 2 to 4pm Extended School Day social skills workshop: social skill-based activity groups that rotate every 5-6 weeks. Here students design a social skill goal and self-assess on this goal and track their own progress.
8. Dyadic/conjoint therapies as needed
9. Daily in-school/residence and in vivo community social skills coaching
10. Regular use of video feedback from the classroom, residences, and various therapy sessions. This has emerged as one of the most highly effective and empirically supported treatment strategies for social and self-regulatory deficits.
11. Scheduled and as-needed student treatment team planning meetings with the student, therapist, residential case manager, teacher, and administrator.

The effective use of CBT as a treatment model within a treatment milieu requires:

1. All clinicians must be knowledgeable in and proficient with CBT principles and techniques. They must be able to train, coach, and effectively collaborate with direct-care staff on CBT principles and approaches.

2. In addition, administrative team members must be knowledgeable of the principles of CBT and committed to the application of principles in all treatment venues. They must also be able to accept a high degree of performance accountability for staff at all levels of responsibilities.
3. Administrative team members must collaborate and consult within a team model with clinicians and direct-care staff.
4. Sufficient planning and resource allocation must be provided in order to train staff to implement CBT-based interventions and monitor outcomes within the milieu.
5. A data-based system designed to provide ongoing assessment of client and overall treatment performance compared to program standards, through time and over time.
6. Data described and represented in a way that they can be used as a basis for determining treatment efficacy and program efficacy throughout the service system. The data must also be used as part of the process for program decisions at all levels in the milieu.
7. Technology and hardware to both facilitate treatment interventions and enable real-time data utilization for decision-making purposes.

TLC Broad Clinical Goals

It is important to have a shared focus on the broad goals. Goals need to be consistent and relevant to our program mission:

Provide TLC students with the necessary skills and competencies to be self-reliant and capable to live within the larger community and achieve personal objectives.

The personal goals and objectives of each individual student need to be within the context of socially responsible behavior and an articulated moral framework.

The goals we incorporate into the treatment planning process require three primary aspects of equal relevance:

- I. An individualized plan for a student's personal:
 - a. Competence
 - b. Adaptability
 - c. Resilience
- II. A methodology that demonstrates:
 - a. Use of the milieu as an aspect of "therapy"
 - b. Management of the ecology and its resources to fit student needs
 - c. Use of cognitive behavior principles
 - d. Medication at levels to assist self-regulation and not compromise cognitive or other health related functioning
 - e. Psycho-educational principles incorporated to assist students develop a student role that is generalized to future learning, and results in academic competence
- III. Results – The treatment and designed intervention outcomes must permit measurement and evaluation in key areas of performance:
 - a. Independent living skills
 - b. Ability to work
 - c. Demonstrate competencies with academic content and use of tool skills
 - d. Maximum self-regulation, social competence, and moral judgment

Clinical Goals (example)

Operationalize self-regulation / self-control:

Demonstration of self-control has six aspects:

1. Self-regulation responses by an individual that are directed at him rather than the environment that initiated them.
2. Actions that are designed to alter the probability of subsequent responses by the individual.
3. Functions that change a later rather than an immediate outcome.
4. Students develop a preference for long-term rather than short-term outcomes.
5. Actions by an individual are a coherent property of bridging time delays across the elements comprising behavioral contingencies time delays demonstrate preferences for future over immediate rewards related to delayed gratification implies a level of executive functioning.
6. Mental facility to sense time and the future and put a relationship between time and future in an organization to execute behavior preference for future over immediate rewards and ability to conjecture the future ability to “see” patterns in sequential chains of events. Behavior implies goal directed persistence.

Related behaviors to self-control are:

Memory (STM and LTM)
Perspective taking
Sense of past, time, plans, and future
Ability to intentionally manipulate covert mental events (“inner speech” and images) used in process of self-control

Clinical Process

What cognitive process enables us to produce better clinical formulations?

Comprehensiveness of data on student

Formulation elaboration

Diagnosis
Problems in global functioning
Inferred symptoms as problems
Predisposing experiences
Precipitating stressors
Psychological mechanisms
Social cultural factors
Strengths
Potential therapy interfering events
Precision of language

Process in Treatment Formulation

Complexity of issues

Coherence of
resources
treatment environments
other

Goodness-of-fit of formulation to treatment plan

Treatment Plan elaboration

Systematic formulation of process

Relevance of data collection to outcome assessment

CBT is a treatment approach not suited to all student-clients nor the environments in which they spend substantial time living, or while at work or school.

The two client groups most questionable as a fit for CBT are: (according to Barkley, R.A. (1997) and Reinecke, et.al. (2003, p. 12) those with attention deficit hyperactivity disorder and those individuals with a diagnosis of Asperger Syndrome (PDD, NOS, HFA).

The principle reasons that these authors cite for this “misfit”, which our researches are able to corroborate are:

1. impulsive cognitive patterns
2. inability to process social cues “invivo”
3. cognitive rigidity
4. poor or impaired sub vocal “mentalizing” ability e.g. capable of mediating behavior
5. lack of “empathy”
6. limited ability to operationalize moral imperatives under situational pressure or stress
7. inability to generalize treatment tactics in authentic, open environments that elicit the need for spontaneous, measured responses
8. limited organizational and general executive function impairment
9. demonstrated need for extreme over learning to master functional routines – thousands of repetitions
10. marginal “sense of time” and time management skills

These ten competencies relate to the acquired and applied strategies and tactics rehearsed in therapy. They also place the student-client in the position of controlling neurologic-based behaviors outside their control.

CBT is a very effective treatment in preparing skill hierarchies and replacement behaviors to be applied in “reliable” well structured home settings or residential treatment settings that have defined, structured environments that cue and support CBT behavioral repertoires defined to be part of treatment.

Most clinicians who provide “office” oriented therapies have little influence, let alone control, over the “open” unstructured daily environments in which the student-client is to apply strategies as part of their routine.

Clinicians using CBT would need to have a clear understanding of the environments, their arrangement, present elicitors, cues and support or competitors for the behavior repertoires developed in treatment. Photos or videos with over time and through time samples will, at least, be needed in order to establish a high support, low risk setting in which to apply therapeutic CBT tactics or replacement behaviors.

Visual-environmental setting analysis is generally not the current practice nor the acknowledgement of the prerequisite client readiness for CBT.

References:

Barkley, R. (1997). *ADHD and the nature of self-control*. New York. The Guilford Press.

Reinecke, M., Dattilio F., & Freeman A. (2003). *Cognitive Therapy with Children and Adolescents*. New York : The Guilford Press.