Volume 26

1990

Progress in Behavior Modification

Edited by
Michel Hersen
Richard M. Eisler
Peter M. Miller

PROGRESS IN BEHAVIOR MODIFICATION

Volume 26

CONTRIBUTORS TO THIS VOLUME

Philip W. Drash
Robert E. Emery
Eva L. Feindler
E. Scott Geller
Shirley M. Glynn
Kim T. Mueser
Karen C. Rogers
Bruce A. Thyer
Roger M. Tudor
S. Lloyd Williams

PROGRESS IN BEHAVIOR MODIFICATION

EDITED BY

Michel Hersen
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Richard M. Eisler
Department of Psychology
Virginia Polytechnic Institute and State University
Blacksburg, Virginia

Peter M. Miller
Hilton Head Health Institute
Hilton Head Island, South Carolina

Volume 26

1990

For information address:

SAGE Publications, Inc.
2455 Teller Road
Newbury Park, California 91320

SAGE Publications Ltd.
6 Bonhill Street
London EC2A 4PU
United Kingdom

SAGE Publications India Pvt. Ltd.
M-32 Market
Greater Kailash I
New Delhi 110 048 India

Printed in the United States of America

Library of Congress: 75-646720

ISBN 0-8039-3927-2

FIRST PRINTING, 1990

Sage Production Editor: Diane S. Foster

CONTENTS

Language and Cognitive Development: A Systematic Behavioral Program and Technology for Increasing the Language and Cognitive Skills of Developmentally Disabled and At-Risk Preschool Children

Philip W. Drash and Roger M. Tudor

CONTRIBUTORS

PHILIP W. DRASH (Ph.D.) is Professor in the Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida. His research interests include language and cognitive development in developmentally delayed children with special emphasis on the development of behavioral technology for the prevention of and total recovery from functional mental retardation.

ROBERT E. EMERY is Associate Professor, Department of Psychology, University of Virginia, Charlottesville. His research and clinical interests are focused on family conflict, including marital distress and divorce, and the effects on children and on mediation as an alternative to the adversarial settlement of divorce disputes.

EVA L. FEINDLER (Ph.D.) is Associate Professor, Department of Psychology, and Director of Psychological Services Center, Long Island University/C. W. Post Campus, New York. Her research and clinical interests cover a wide range of clinical behavior therapy with aggressive adolescents and families experiencing domestic violence.

E. SCOTT GELLER is currently focusing his behavior change research in the domain of injury control, especially the promotion of safety belt use and the prevention of impaired driving. He is editor of the *Journal of Applied Behavior Analysis* (1989-1992) and associate editor of *Environment and Behavior* (since 1983).

SHIRLEY M. GLYNN is Research Psychologist on the Behavioral Family Therapy for Veterans with Schizophrenia Project at Brentwood VA Medical Center in Los Angeles, California. Her research interests include behavioral family therapy, intensive behavior therapy with the chronically mentally ill, and developing smoking cessation and other health promotion programs for psychiatric patients.

KIM T. MUESER is Assistant Professor of Psychiatry at the Medical College of Pennsylvania at Eastern Pennsylvania Psychiatric Institute, where he is also Coordinator of the Schizophrenia Treatment Program. His clinical and research interests include behavioral family therapy and social skills training for schizophrenia, the assessment of social competence in mental illness, and posttraumatic stress disorder.

KAREN C. ROGERS (B.A.) is a member of the Department of Psychology, University of Virginia, Charlottesville. Her research and clinical interests focus on family conflict and its impact on children.

BRUCE A. THYER (Ph.D.), School of Social Work, University of Georgia, Athens, has published in the areas of promoting safety belt use, the nature and treatment of anxiety disorders, and the applications of behavior analysis within the field of social work.

ROGER M. TUDOR (Ph.D.) is Professor in the Department of Psychology, Georgia Southern University, Statesboro. His major research interests include verbal behavior, instructional design, computer-assisted instruction, and the application of behavior analysis to education.

S. LLOYD WILLIAMS (Ph.D.) is Associate Professor of Psychology, Lehigh University, and Director of the Lehigh phobia program, Bethlehem, Pennsylvania. His research interests center on the procedures and cognitive mechanisms of therapeutic change in phobia, especially agoraphobia.

ADOLESCENT ANGER CONTROL: REVIEW AND CRITIQUE

EVA L. FEINDLER
Long Island University/C. W. Post Campus

I. INTRODUCTION

A. Problems in Anger and Aggression

Recent reviews of adolescent behavior therapy have indicated that the number and the nature of changes and challenges that occur simultaneously during adolescence require the development of effective coping strategies for adaptive functioning (Peterson & Hamburg, 1986). The authors suggest that only in a few areas, for example, crime and delinquency, do adolescents engage in problem behaviors more frequently than other age groups. Indeed, Snyder and Patterson (1987) indicate that between 15% to 35% of all males are arrested before the age of 18 for a variety of offenses, although the majority are arrested only once. Certainly, antisocial behaviors, in particular, conduct disorder and delinquency, peak in middle to late adolescence and portend continued adjustment problems in adulthood. Kazdin (1987) concluded that prevalence rates are high and that among adolescents more than 50% admit to theft, 35% admit to assault, 45% admit to property destruction, and 60% engage in other antisocial behavior. These figures represent a critical clinical area requiring the development of effective prevention and intervention strategies.

For this antisocial population, the use of violence and aggression increases during the adolescent years (Peterson & Hamburg, 1986) and is sustained throughout adulthood. In fact, longitudinal studies have indicated that the relative level of aggressive behavior that a child or adolescent displays in interpersonal contexts remains fairly stable over time (Olweus, 1984). The results reported by Olweus (1984) suggest that important determinants in this continuity of aggressive behavior are to be found in relatively stable, individually differentiated reaction tendencies or motive systems. These personality variables may compose a cognitive component that in highly aggressive individuals may involve a biased perception of situational events. This discriminating characteristic has been supported by the extensive work of Dodge (1985) and his colleagues, who have studied attributional biases in aggressive children. It seems that the persistently aggressive child is biased toward interpreting events as evidence that peers are hostile and provocative and that they do not like him or her. Further research has indicated that these deviant information-processing mechanisms and hostile biases may be the result of early socializing and conditioning experiences.

There has been a growing consensus that antisocial children and adolescents have parents who lack appropriate family management and parenting skills (Loeber & Dishion, 1984; Patterson, 1986). Indeed, Eron and

Huesmann (1984), in a 22-year follow-up of aggressive children, suggest that the major productive factor in adult aggression is the early use of extensive physical punishment. Other research has shown that parents' failure to use consistent and contingent reinforcement and failure to teach reasonable levels of compliance set in motion a process of coercive interactions within the family (Patterson, 1986). Poor and erratic disciplinary practices contribute directly to the development of aggressive behavior patterns (a) by failing to label, track, and "consequate" inappropriate and/or antisocial behaviors and (b) by modeling and reinforcing aggressive, impulsive modes of problem solving and interpersonal communication (Snyder & Patterson, 1987). Aggressive responses to family members may then be considered instrumental in obtaining desired outcomes.

Often then, the aggressive child or adolescent experiences peer rejection, academic failure, and lowered self-esteem. He or she continues to be persistently aggressive in interactions with both peers and adults and is at risk for social rejection (Dodge, 1985). Arguments with parents and siblings may increase (Montemayor & Hanson, 1985) and the adolescent may develop other significant behavior problems. School difficulties such as truancy, increased detentions and academic detainment, substance abuse, and adolescent health problems may all be linked to aggressive and antisocial behavior patterns.

B. The Role of Anger in Aggressive Behavior Patterns

Although there have been numerous treatment strategies employed in the modification of aggressive behavior (see Bornstein, Hamilton, & McFall, 1981; Goldstein, Glick, Reiner, Zimmerman, & Coultry, 1987), reductions in adolescent aggression have generally not been maintained following program termination. Feindler and Ecton (1986), in a review of factors contributing to equivocal results reported for contingency management approaches to delinquent behaviors, emphasize the following impediments: (a) difficulty in completing peer reinforcement contingencies, (b) lack of powerful reinforcers, (c) low-frequency or covert aggressive behaviors that go undetected and unconsequated, and (d) inconsistent behavior change agents. Further, developmental changes that occur during adolescence (namely, increased autonomy, separation from family, increased stress) may undermine the effectiveness of external reinforcement contingencies on interpersonal behavior.

In addition to these shortcomings, traditional behavioral approaches to aggression management have overlooked the direct treatment of high anger arousal, which may accompany impulsive and explosive behavior. Although aggressive behavior need not be accompanied by anger arousal, most theorists agree that anger often acts as a determinant of aggressive behavior. Anger has been defined as the drive or motive behind aggressive behavior

and as the subjective experience that accompanies aggressive impulses (Averill, 1983). Berkowitz (1983), in a reformulation of the frustration-aggression hypothesis, proposed that anger and the interpretation of aggressive cues mediate the relationship between frustration and aggression. In this conceptualization, like that of Novaco's (1975, 1986), cognitive processes play a major role in determining what experience will be made to aversive/provocative stimuli. For Novaco, cognitive processes—namely, detection of arousing events, appraisals of provocation cues, expectations and underlying belief systems, and the physiological arousal experienced during anger arousal—have a direct impact on response to provocation. (The reader is referred to Novaco, 1986, for a detailed review of the conception of anger in theories of aggression.)

Although the relationship between anger and aggression is not always a clear one, and although anger is a hypothetical construct difficult to target for behavioral intervention, it is proposed that a primary focus in the treatment of aggressive adolescents should be on anger control. In line with developmental strivings for autonomy and the need for increasing self-control of emotions, the appropriate regulation of the anger arousal that often accompanies aggressive behavior and the development of alternative, prosocial experiences to interpersonal provocation seem like logical therapeutic goals. Because ample research has demonstrated that the appraisal of situation events as provocation stimuli influences the magnitude of aggressive behavior, and that aggressive adolescents have hostile attribution biases (Dodge, 1985; Lochman, 1984), the cognitive component of anger arousal must be explored. Additionally, Berkowitz (1983) has suggested that cognitive processes are also responsible for the *absence* of overt aggression because of their inhibitory aspects. Clearly, explosive adolescents seem to be lacking inhibitory self-control skills. Finally, because expressive physiological arousal may interfere with prosocial skills performance in interpersonal situations, the effective management of the physiological determinants of anger arousal must also be explored.

The cognitive-behavioral approach to anger control training has developed since the early work of Novaco (1975) and also since Meichenbaum's (1985) stress inoculation model, in which anger was conceptualized as an affective stress reaction. Although the skills acquisition and application approach predominates, and although cognitive and physiological determinants are still emphasized, adolescent anger control includes several additional features designed to ameliorate the social, self-management, and problem deficiencies found in this population. In addition to arousal reduction and cognitive restructuring components, the adolescent anger control program designed and evaluated by Feindler and her colleagues (Feindler, 1979, 1988; Feindler & Ecton, 1986; Feindler, Ecton, Kingsley, & Dubey, 1986; Feindler, Marriott, & Iwata, 1984) includes the development of self-observation and

self-management skills, discrete problem-solving skills, assertiveness, and prosocial responses to provocation.

Initial results of program effectiveness have been encouraging; however, generalization and maintenance of treatment effects have yet to be demonstrated. Further, evaluations of discrete treatment components, as well as therapeutic formats, are needed to maximize treatment outcomes for the aggressive adolescent population. The remainder of this chapter will focus on a review and critique of anger control training, and directions for future research and intervention will be enumerated.

II. ASSESSMENT ISSUES

A. Diagnostic Decisions

To maximize treatment efficacy and efficiency, it is important to determine a priori which clients might benefit from which treatment procedures. Given the rather bleak outlook that Kazdin (1987) has projected in terms of prognoses for antisocial children and adolescents, it behooves both clinicians and researchers not only to consider alternative forms of treatment, as Kazdin has suggested, but to more closely examine the very heterogeneity of the aggressive adolescent population. There are certain characteristics and behavioral patterns of aggressive adolescents that require assessment in the initial screening for anger control training.

Although anger in all theories is understood as being neither necessary nor sufficient for aggressive behavior to occur, most diagnostic decisions regarding appropriateness of anger control revolve around the topography and intensity of aggressive behaviors. Snyder and Patterson (1987), in a case against homogeneity in descriptions of juvenile delinquents, highlighted major differences in the delinquent population in terms of (a) recidivism versus nonrecidivism, (b) property versus person offenses, (c) status versus nonstatus offenses, (d) covert (stealing, fire setting) versus overt antisocial behavior, and (e) aggressive (unsocialized) versus delinquent (socialized) antisocial behavior. Each of these differences may have direct implications for treatment decisions; however, little is known about treatment discrimination. In terms of the last issue and anger control training, a further look at aggressive behavior is in order.

In an earlier review of behavior modification for adult aggression, Bornstein, Hamilton, and McFall (1981) indicated a need for the development of subcategories of aggressive behavior patterns as there appear to be very different forms of temper loss and violence. Although the relative level of aggressive behavior that a child or adolescent displays in interpersonal contexts is fairly stable over time (Olweus, 1984), there may be important differences in adolescent acting-out patterns that directly affect treatment

outcomes. Lochman (1984), in his review of factor analytic assessment studies on aggressive adolescents, has suggested two major dimensions of aggressive behavior to consider. The internalizing-externalizing dimension refers to the expression of anger and the target of that expression. Although both types of adolescents may benefit from different therapeutic strategies, the effective component of the anger control training package remains an empirical question. The externalizing adolescent will need to reconceptualize the cognitive and emotional mediators of his or her aggressive response to provocative stimuli, to inhibit direct aggressive behavior, and to implement appropriate prosocial and problem-solving skills. The internalizing adolescent may have concurrent anxiety or depression and may need to dispute irrational thinking styles, to reduce physiological arousal, and to learn assertive responses to provocation.

The second dimension, trait versus reactive aggression, reflects the degree to which the aggressive behaviors either are predictable and perhaps planned responses to provocation or are impulsive responses characterized by a lack of cognitive processing of the antecedent-response relationship. According to Novaco (1986), premeditated aggression is thought to be fueled by anger as it is enacted as vengeance or retaliation to achieve retribution. However, this type of anger, which may be replete with the attributional biases reported by Dodge (1985) and with preoccupation and extensive negative ruminations concerning the aversive experiences, differs greatly from the explosive temper losses adolescents display in reaction to perceived provocations. Intuitively, it would seem that, although the anger level for both subcategories may be quite intense, there seem to be clear differences in latencies, topography of anger expression, physiological arousal, and impulse control. Only continued research on the distinctions between various types of anger and aggressive patterns will help to further delineate subgroups and to direct treatment efforts. Clinical impressions indicate that anger control strategies are more effective with the impulsive and reactive adolescent who requires skills acquisition and application with appropriate cognitive mediation during provocation; however, reliable data are needed to support this general conclusion.

Another issue related to maximizing the success of the client-treatment match is clinical diagnoses of aggressive adolescents. Although anger and aggression are not problems formally identified by diagnostic category, there are a range of clinical conditions that have anger as a dynamic element (Novaco, 1986). Most adolescents responding to anger control treatment have been diagnosed as either conduct disordered or oppositional defiant disordered according to *DSM-III-R* criteria. An essential feature of the conduct disorder is a repetitive and persistent pattern of antisocial conduct in which the basic rights of others are violated for at least six months. Of particular relevance is the subtype of the solitary aggressive in which the essential feature is the predominance of aggressive physical behavior toward adults