Highlights of the 2006 Institute on Psychiatric Services

The 2006 Institute on Psychiatric Services, held October 5–8 in New York City, drew 2,263 participants—the largest attendance in its 58-year history—to a program of more than 550 lectures, symposia, plenary sessions, workshops, and poster sessions. The theme chosen for the 2006 institute by APA President Pedro Ruiz, M.D., was "Trauma and Violence in Our Communities." In remarks at the institute's opening session, Dr. Ruiz noted that violence and trauma are increasingly a part of daily life—terrorist acts, the Iraq War and other armed conflicts, and Hurricane Katrina, along with continued incarceration and homelessness among persons with severe mental illness. The mental health profession is being challenged by government and managed care policies that can severely limit access to care for vulnerable groups, he said.

Dr. Ruiz invited Suzanne Vogel-Scibilia, M.D., president of the National Alliance on Mental Illness (NAMI), to deliver the opening address. She began by describing how NAMI was founded in 1980 by a small group of parents who felt that their ill children could not speak for themselves. NAMI is now the largest mental health advocacy group in the country, with more than 1,100 local affiliates. Primary consumers of mental health services—no longer voiceless—account for 30% of NAMI's membership.

Dr. Vogel-Scibilia described herself as "the first NAMI president to wear three hats"—consumer, family member, and mental health professional. As an adolescent she was diagnosed as having bipolar disorder with psychotic features, she is the mother of children with the disorder, and she is medical director of Beaver County (Pennsylvania) Psychiatric Services, a community mental health center serving a mostly uninsured population. "I have seen the bad aspects of mental illness personally," she said, "and I have also seen recovery."

Dr. Vogel-Scibilia went on to outline six areas for further collaboration between APA, NAMI, and other advocacy groups. First, she described the frustration felt by advocates about the lag time in translating research findings into real-world practices. Outmoded treatments continue despite important advances. Second, the criminalization of people with mental illness, which has been exacerbated by public concerns about safety after the terrorist attacks of 2001, must be addressed. Third on the list was the same problem cited by Dr. Ruiz, limitations on access to care. The fourth area for collaborative advocacy—metabolic side effects of the newer antipsychotics—is one that mental health professionals need to be more aware of. Medications put some consumers on "medical death row," Dr. Vogel-Scibilia said.

A fifth area for collaboration is improving the detection of physical illness among people with severe mental illness, whose symptoms are often attributed to their disorder. Dr. Vogel-Scibilia provided a personal account. On a visit to a city far from home she experienced a recurrence of pneumonia, and she encountered almost insurmountable difficulties convincing emergency department personnel that she was physically ill—they had deduced her bipolar diagnosis from the medications listed on the intake form. The sixth area is destigmatization of mental illness. Dr. Vogel-Scibilia spoke of the "risky business" of telling other people about one's diagnosis, at the same time acknowledging that it can be a powerful antistigma weapon.

Mental health and the public health agenda

In a lecture titled "The Public Health Challenge for Psychiatry," Neal L. Cohen, M.D., described the importance of bringing the mental health system into closer alignment with the public health system. Dr. Cohen was commissioner of the New York City Department of Health from 1998 to 2002 as well as commissioner of the city's Department of Mental Hygiene from 1996 to 2002. During his dual tenure he oversaw the public health responses to the first outbreak of West Nile virus in the Western hemisphere in 1999 and the terrorist attacks and the outbreak of anthrax in 2001. These experiences reinforced his long-held view that mental health should be incorporated into the public health agenda—mental health workers must assume a first-responder role. Dr. Cohen was a proponent of the merger of his two departments, which New York City voters approved in November 2001.

Dr. Cohen described how the public health system's focus has shifted from infectious diseases to behavioral factors, such as smoking and lack of exercise, noting that the need to understand and address people's behavior bolsters the case for alignment of the two systems. The 20th century saw a 30-year increase in U.S. life expectancy, resulting in large part from a crusade against infectious diseases. However, the preoccupation with infectious disease came at a cost—the system's neglect of other serious illnesses and its failure to address the high toll of untreated mental illness. A seminal paper published in 1990

showed that although 50% of all U.S. deaths could be linked to behavioral factors, only 5% of the public health dollar was devoted to addressing them. Also, in the mid-1990s researchers began to use a new measure of illness burden—disability-adjusted life years—which showed that mental illness and substance abuse have a much greater impact than previously thought, accounting for half of all disability worldwide.

Advances in psychiatric epidemiology have also bolstered the case for alignment of the two systems. New methods used in the National Comorbidity Survey (NCS) in the 1990s—and more recently, in the NCS Replication—have gone beyond simply calculating prevalence rates to examining risk and protective factors, which are largely behavioral in nature. Epidemiological findings showing the early onset of mental illness—half of all lifetime cases by age 14—and its link to midlife pathology have also underlined the need for a public health approach to mental illness. For Dr. Cohen, however, the 1999 report on mental health by Surgeon General Satcher's office and the supplemental reports from that office were the critical factor in bringing the high toll of mental illness to the public's attention.

Dr. Cohen briefly outlined a new public health policy based on knowledge acquired in the past two decades. First is a closer examination of protective factors. After the World Trade Center attacks, "resiliency" became more than just a concept in the domain of protective factors, he said. A post-9/11 public health campaign placed "New York Needs You!" posters across the city, and most New Yorkers were able to rally to that call. A second component of a new policy is parity of insurance coverage for mental and physical illnesses; lack of parity challenges the system's ability to widen its net to facilitate early detection and intervention. A third component is a better understanding of positive mental health—how do you promote good mental health without a clear picture of it? asked Dr. Cohen. A fourth component—use of the latest information technology—will provide a foundation for many advances. Reducing and eliminating the stigma of mental illness is another important component of a new public health policy.

Dr. Cohen concluded his discussion of stigma by describing his "proudest moment" as dual commissioner. During the October 2001 anthrax outbreak, the city set up clinics inside the headquarters of affected media outlets, such as NBC. On visits to these clinics, he saw public health and mental health professionals working side by side—the first group dispensing prophylactic antibiotics and the second group helping people talk about their fears in a nonstigmatizing way. "It's very early in the game," he said, but the future of public health lies in this direction.

Suicide prevention and the antiscreening movement

Suicide is the fourth leading cause of death for ten- to 14-year-olds and the third leading cause of death for 15- to 19-year-olds. Almost as many teens die by suicide as those who die from all natural causes combined. Ninety percent of teens who die by suicide have a diagnosable mental illness when they die.

The TeenScreen program, developed by Columbia University, offers parents a free, voluntary mental health screening for their teenager. Most teenagers do not reveal suicidal ideation. In 63% of completed suicides, psychiatric symptoms were evident more than one year before before death, which indicates that there is ample time to intervene. Laurie M. Flynn, whose daughter had a near-fatal suicide attempt, is director of the Carmel Hill Center for Early Diagnosis and Treatment at Columbia. She presented a lecture on TeenScreen and described the antiscreening movement that has challenged the program.

TeenScreen is a national, privately funded progam that is focused on the early identification of mental illness and suicide prevention among youths, and it links those in need with resources for further assessment. TeenScreen does not involve diagnosis or treatment. Instead, its goal is to identify teens at risk of suicide and those who are depressed or experiencing other psychiatric disorders. The screen, which requires parental consent and the teen's assent, involves answering a questionnaire as part 1 of the screen. With nearly 500 programs operating in 43 states, TeenScreen settings include schools, doctors' offices, youth groups, and other settings that serve youths. If a teen answers yes to a certain number of questions, then he or she proceeds to part 2, an interview with a mental health professional, to further determine risk and the need for further evaluation.

Although TeenScreen is privately funded, has widespread support on national and community levels, and has been recognized as a model screening program for youths by the President's New Freedom Commission on Mental Health, the program has been challenged by organized political opposition from several conservative advocacy groups and the Church of Scientology. The latter group, for example, maintains that psychiatry has no scientific basis and considers TeenScreen to be a front group for the pharmaceutical industry.

In fact, many of the groups opposing TeenScreen are concerned about overmedication or "hooking" children on prescription drugs; suspicious of the profit-making motives of the pharmaceutical industry; fearful that selective serotonin reuptake inhibitors, not an underlying psychiatric disorder, cause teen suicide and violence; and fearful that schools may force medication as a condition for school attendance. Groups that are anti–big government contend that screening is a violation of liberty and privacy, should not be a federal issue, and should be kept out of public schools. Some groups that advocate "family values" contend that screening interferes with parents' child rearing and could stigmatize youths. Opposition is waged largely via blogs and Web sites, not through the mainstream media. Overall, negative coverage has had little impact on the growth of the TeenScreen program, and most coverage in the media has been positive or neutral. Ms. Flynn shared her strategies of deciding when and when not to respond to criticism; of disseminating

positive information through briefings, the media, and the Web; and of repeating the key messages—voluntary screening can identify teens at risk of suicide and save lives, parental consent is required, and identifying problems early can prevent more serious problems later.

Mental health leadership in New York City

Lloyd Sederer, M.D., was appointed director of the Division of Mental Hygiene after the New York City Departments of Health and of Mental Hygiene were merged in 2002. In a lecture he described the common elements of several public health interventions undertaken by his department to improve the mental health of New Yorkers: solid epidemiological work, strategic advocacy, and reliance on empirical knowledge about what treatments are effective and how best to deliver them.

As director Dr. Sederer's first task was an assessment of the prevalence and burden of mental illness and substance abuse, which had not been done before. A report released during his sixth month as director showed that the costs of not treating the 1.3 million New Yorkers who needed services far outweighed the costs of treatment. Release of the report attracted media attention, and the findings enabled Dr. Sederer's office to broadcast an advocacy message first propagated by Surgeon General David Satcher: "There is no health without mental health."

In March 2004 the Department of Health and Mental Hygiene launched "Take Care New York," the city's new health policy. It outlined ten steps that individuals could take to stay healthy. Among such steps as "Be tobacco free" and "Know your HIV status" were two that were specifically related to mental health: "Get help for depression" and "Live free of substance dependence." Dr. Sederer described how his department launched an initiative to address depression. The first step was another citywide assessment, which revealed a public mental health crisis: of the 400,000 people in New York with major depression, about 40% were receiving any treatment and only 13% of this group received treatment that met criteria for minimal adequacy. Public health officials would never tolerate such low numbers for tuberculosis or diabetes, Dr. Sederer said. Why allow such rates for depression?

Dr. Sederer was well aware of research showing that a majority of patients with depression seek help in primary care settings: depression is the third most common presenting problem, after hypertension and diabetes, and it has powerful secondary effects when it is comorbid with chronic disease. "Research tells us to go to where the patients are," he said. To have the greatest effect, an initiative to fight depression should be based in primary care. Dr. Sederer's office set a "modest goal" of establishing depression screening and management as a standard of care in 100% of the city's primary care practices.

Even with the low rates of adequate depression treatment in primary care, Dr. Sederer knew that physicians wanted to do better, so he assumed that something must be wrong with the system. What was missing was a quantitative measure. "Physician and patients understand numbers," he noted. People who see a physician get a numerical profile—blood pressure, weight, blood levels, and so forth. Having a number for depression would lead to better outcomes, he hypothesized. "Once a number goes into the record, it is inescapable. If it is high, the number has to come down."

On the basis of research findings, Dr. Sederer selected the PHQ-9, the nine-item, self-report depression scale of the Patient Health Questionnaire, a highly reliable instrument that is available in eight languages. First targeted were 1,000 primary care physicians in the city's Health and Hospitals Corporation, because one in six New Yorkers receive ambulatory care through one of its hospitals. Physician detailing was a key strategy: public health educators armed with a kit describing the PHQ-9 and best practices in depression care visited primary care offices, where they were able to engage physicians for an average of eight to nine minutes—far longer than the two to three minutes typically granted drug company detailers. Senior centers and university hospitals have also been targeted, and a media campaign was launched to create consumer demand for depression screening.

By January 2007 an estimated 20% of primary care practices will be engaged in depression screening, Dr. Sederer said. "We are going to keep this march going until we hit the tipping point," said Dr. Sederer. He envisions that tipping point as coming in the next few years, when "if you're not doing screening then you start doing it," either out of a sense of shame or fear of attention from lawyers and administrators.

In his lecture Dr. Sederer also described how his office has used the same methods—careful epidemiological work, strategic advocacy, and key findings of clinical and public health research—to launch a "teachable moment" intervention for substance abuse in emergency departments and trauma centers and an initiative to build 9,000 units of supportive housing for the city's large homeless population over the next ten years.

Assessing and treating aggression in preschool children

Aggression is difficult to interpret among two- to three-year-olds. Aggressive behavior is a natural aspect of early childhood development, and with some redirection, most children learn to control their impulses and acquire social skills for getting their needs met. For some children, however, such strategies do not work. How can parents and teachers distinguish between aggression that is typical in early childhood and aggression that is atypical? The distinction is important because aggression is disruptive when it occurs and can signal more serious developmental and adjustment problems for the future.

Oscar A. Barbarin, Ph.D., with the School of Social Work at the University of North Carolina, Chapel Hill, described the screening tool he developed for making that distinction. He also presented several models for its use, from a universal screening tool to use in a low-resources environment. Dr. Barbarin began developing the tool while working for Head Start. The program requires a

mental health assessment as part of its performance standards but does not specify which tool to use. He found that the commonly used Child Behavior Checklist included many items oriented toward adolescents and therefore was not a good fit for assessing young children. Therefore, he and his colleagues developed the Attention, Behavior, Language, and Emotions (ABLE) tool, which reliably and validly screens for aggression exclusively in early childhood. It can be used to identify an individual child who may need assistance from a mental health professional, or, ideally, it can be used as a universal screen, which can provide data for shaping preventive interventions for a school system, for the classroom, and for families.

The ABLE is a two-part instrument completed by parents, teachers, or early care providers who interact with the child on a regular basis. The first tier, which takes about three minutes to complete, checks whether certain behaviors that interfere with adjustment in preschool settings are a concern—persistent misbehavior, poor expressive and receptive language, bad temper, impulsivity, fearfulness, sadness, and fragility of feelings. For behaviors that are of concern, part 1 probes for dimensions of severity, such as duration of the problem, exacerbation of the problem, and need for professional assistance. If respondents answer true to more than one severity indicator, they complete the second tier of questions, which takes about 15 minutes. Forty questions are rated on a 5-point scale from 1, not a problem, to 5, a very serious problem. Items cover hyperactivity, aggression, opposition, language difficulties, and emotional regulation.

ABLE can be included with registration packs for parents to complete when a child begins a preschool program. Teaching staff can complete ABLE at the same time they are completing other developmental assessments, six to eight weeks into a program. ABLE results can then be linked with evidence-based intervention protocols, such as briefs offered through the Center on the Social and Emotional Foundations of Early Learning (www.csefel.uiuc.edu). For example, at the program level, interventions may include a professional development program for teachers, specific teacher training for dealing with aggression and oppositional behavior, and so on. Mentoring and follow-up consultation can be made available for teachers in their classrooms. At the teacher-child level, intervention is focused on establishing an emotional connection, communicating clearly with the child, and giving teachers alternatives for dealing with specific problem behaviors. Partnerships between school and family encourage sharing effective strategies for dealing with problematic behavior and making interventions more powerful. They can also help to identify when further professional help is needed.

Serious mental illness and the death penalty

Ronald Honberg, J.D., M.S.W., legal director for the National Alliance on Mental Illness, chaired a forum on the death penalty and people with serious mental illness. According to a report from Amnesty International, at least 100 people with serious mental illness have been executed in the United States since 1992, close to 10% of the total number executed. In addition to a personal account provided by David Kaczynski concerning the life and trial of his brother, Unabomber Theodore Kaczynski, the forum reviewed ongoing work of an American Bar Association (ABA) task force to shape new legislation to restrict capital punishment when people have a serious mental illness.

David Kaczynski, formerly a social worker and now executive director of New Yorkers Against the Death Penalty, provided a first-hand account of his family's coming to terms with Ted's illness, turning Ted in to authorities, and navigating a legal system that aimed to put his brother to death. While growing up, David noticed periodically that his older brother seemed different—he lacked friends and kept to himself. Their mother attributed this difference to feelings of abandonment after Ted was hospitalized as an infant, and their father cited Ted's extraordinary intelligence. Ted entered Harvard at the age of 16.

Through Ted's diaries, the family learned that Ted had his first psychotic break in graduate school, when he became convinced that people were laughing at him. He stopped attending classes, but he continued to excel in mathematics by producing original work, which led to a post at the University of California, Berkeley. While there, fears about technology began to emerge. Ted eventually left Berkeley for a primitive cabin in Montana—not unusual in the 1960s counterculture—and his letters home became painful 25-page rants against his upbringing. When David saw Ted in 1986, Ted was clearly disheveled and his mental health was deteriorating.

David's future wife, Linda, persuaded the family to take the letters to a psychiatrist for some insight into his struggles. The psychiatrist recognized features of schizophrenia and urged the family to seek treatment for him. By then, however, Ted was extremely resistant, was increasingly hostile toward family members, and cut off communication completely. Several years later, at Linda's urging, David began reading accounts of the Unabomber, who had delivered 16 bombs over 17 years. David had difficulty believing that mental illness could transform Ted's sense of moral judgment. However, on reading the Unabomber's manifesto, which had been published in two prominent newspapers, David recognized, on an emotional level, similarities to Ted's scathing letters home. Faced with the moral dilemma of turning his brother in and vividly recalling Ted's kindness as an older brother, David realized that others' lives were at stake and contacted authorities.

FBI agents were described as compassionate toward the family's concerns about Ted's mental condition, and for the first time, Ted received a psychiatric evaluation, which confirmed acute paranoid schizophrenia. Once the case advanced to the legal system, David felt intense betrayal. The family was concerned about saving lives and saving Ted, but the legal system was focused on taking his life. While awaiting trial, Ted attempted suicide because of the humiliation of the

pending exposure of his mental illness at trial. Ted attempted to fire his attorneys and represent himself, which the court denied. Ultimately, Ted accepted a plea bargain solely to avoid trial, not to save his own life.

After Mr. Kaczynski's moving account, Mr. Honberg reviewed the ABA proposal from a multidisciplinary task force comprising law professors, scientists, psychiatrists, and representation from the American Psychiatric and American Psychological Associations, the National Mental Health Association, and NAMI. Without taking a position of supporting or opposing the death penalty, the proposal recommended three main policies. The first policy extends the landmark *Atkins v. Virginia* decision, which made executing persons with mental retardation unconstitutional, to cover analogous intellectual and cognitive impairments among persons up to age 21.

The second policy covers the sentencing phase. Those who were delusional or highly symptomatic because of serious mental illness at the time the crime was committed cannot be sentenced to death. The policy exempts people with antisocial personality disorders that manifest with repeated criminal behavior and those with acute psychosis secondary to alcohol and drug use. The policy applies to psychosis associated with schizophrenia and other severe mental illnesses.

The third policy addresses the period after sentencing. If a prisoner has delusional behavior, which may include volunteering for execution, inability to assist counsel, and inability to understand execution or its purpose, a death sentence must be reduced to "the sentence imposed in capital cases when execution is not an option."

The proposal has passed the ABA House of Delegates. The next step is to draft legislation and to mobilize at the grass-roots level. Whereas Mr. Kaczynski is a self-described abolitionist, he urged that people in the psychiatric profession are in a key position to effect change in the national debate; with their expertise, they can make a credible case and lead an informed discussion.

Lesbian and gay families

The 2006 institute was held a month before the mid-term elections, in which same-sex marriage continued to be a divisive issue. In a lecture, "Lesbian and Gay Families," Ellen Haller, M.D., summarized research findings that counter negative beliefs of many Americans. Dr. Haller is professor in the department of psychiatry at the University of California, San Francisco, and director of its adult psychiatry clinic. Much of the existing research, she noted, has focused by necessity on divorced lesbian mothers, who had children in heterosexual marriages. However, the past two decades have seen a "gayby boom," with many gay couples opting to have biologic children through donor insemination or surrogacy or to adopt children or raise children as foster parents.

First, Dr. Haller described several issues that make research on gay and lesbian families difficult to do. Usually the samples are small, with the many problems inherent in snowball or convenience samples. Questions have been raised about the validity of the comparison groups—many studies have compared divorced lesbian mothers and their children with divorced heterosexual mothers and their children. Generalizability is also an issue, because most lesbian and gay research participants are comfortable with being "out," whereas a large proportion of lesbian and gay couples live in rural areas, where they are reluctant to reveal their sexual orientation. Also, most research participants are white, middle class, and well educated. An important problem that Dr. Haller has found is that research tends to focus on showing that there are no differences between children raised in heterosexual families and gay and lesbian families, which may miss interesting and subtle differences.

Many Americans believe that lesbians and gays are "unfit parents" because they are mentally ill by definition of their sexual orientation, because lesbians are "less maternal," because gays and lesbians will molest their children (based on the belief that all gay people are pedophiles), or because lesbians and gays are so focused on having sex all the time that they will not be attentive to their children, Dr. Haller said. She cited research indicating that lesbian mothers are similar to heterosexual mothers in terms of their psychological health, their attitudes toward their children, and the quality of the relationship with their children. Studies also show that gay men are no less invested in the paternal role than heterosexual men. Some studies have shown more "synchronicity" in child-rearing attitudes and behaviors between lesbian coparents than between heterosexual parents and that lesbian "social mothers" (the nonbiological mother in a couple) are more connected to their children than heterosexual fathers.

Some Americans believe that children in lesbian and gay families will have gender identity problems or will "grow up gay." However, more than 500 children from gay and lesbian families have participated in research studies, and no case of gender identity confusion has been reported. Nine studies of such children have found no elevated rates of homosexuality. Also, studies have consistently found no differences in gender role behavior among these children. Dr Haller noted that most parents will confirm that these behaviors appear to be "hard wired"; for example, most boys raised in homes where toy guns are not permitted continue to want to play with guns.

Fears about problems in psychosocial development and peer relationships among children from gay and lesbian families are also widespread, but studies examining adjustment, self-esteem, depression and anxiety, connectedness to the school environment, and performance in school have found no differences. In one study adolescents from lesbian families reported being teased by peers about their sexual orientation, but the overall level of teasing was no higher for these children.

Dr. Haller noted that lesbian and gay families continue to be a largely hidden population. However, data from the 2000 census indicated that children were being raised in about 25% of same-sex households—34% of female couples and 22% of male couples—and that the number of

children in such families ranges from two million to 14 million. She directed her listeners to the Web site of the Human Rights Campaign for recent research reports and a database of adoption laws by state.

Social competence, mental illness, and aggression

In a seminar on trauma, violence, and psychoeducation, Robert Paul Liberman, M.D., of the School of Medicine at the University of California, Los Angeles, offered a presentation on teaching social competence for people with serious mental illness and aggressive behavior. Given that aggression is to some extent a learned behavior, principles of human learning can be used to build social competence and supplant aggressive behavior. Policies aimed at reducing seclusion and restraint are worthwhile and somewhat successful but fail when used exclusively, he said. Supplementing such policies by training people with aggressive tendencies to develop appropriate social behavior has resulted in sustained reductions in aggression.

In the past, people with serious mental illness were considered to be no more aggressive than the general population. Recent studies have shown, however, that aggressive behavior is five to seven times more frequent among people with schizophrenia and psychotic disorders, particularly those who also have a substance use disorder. The most common victims of such aggression are family members and mental health professionals. Aggression and violence contribute greatly to the stigma associated with mental illness. Stigma can be reduced by reducing aggressive behavior and by educating the public and family members that schizophrenia and serious mood disorders are treatable, stress-related brain disorders.

Building a successful social skills training program starts with a functional analysis to discover the context in which aggressive behavior occurs, as well as its antecedents and consequences. In addition to identifying the triggers that spark aggression, the aftereffects that perpetuate aggressive behavior must be understood. Once the functional analysis is completed, the next step is to build the program by applying specific, detailed educational techniques. Such techniques include providing instructions, visual cues and presentations, stimuli, and social modeling; prompts; positive reinforcement; shaping; chaining; schedules of reinforcement; and positive programming.

Dr. Liberman emphasized that observational learning is an extremely powerful method of social modeling—for example, small talk done pleasantly with the aggressive patient can teach the individual how to improve social interaction. Shaping involves shifting from using aggressive behavior to get needs met to gradually building appropriate social behavior by taking small, incremental steps in an instructional format. Positive, continuous reinforcement is especially helpful in stabilizing aggressive inpatients. As patients prepare for program discharge, tapering from continuous to intermittent reinforcement for positive social behavior helps to mimic real-world situations yet still provides durable reinforcement.

Therapeutic programs that offer planned, scheduled activities in which patients can participate and succeed are an excellent way to displace aggressive behavior. Activities may be simple, structured games where patients practice asking each other appropriate social questions and learn through the positive reinforcement of supervising staff about how to respond in an appropriate conversational way. Other examples include role playing and videotaped feedback.

Dr. Liberman provided time-sample data indicating that within a year of initiating programs that incorporate these techniques, the number of average weekly aggressive incidents declines and the percentage of appropriate behavior increases.

In addition to these techniques, Dr. Liberman described a multistep teaching interaction for training social skills "on the spot" whenever an aggressive act occurs. Originally developed for use in family and group homes, the technique can be used in various settings. The steps involve praising an aggressor's earlier positive behavior, describing the current inappropriate behavior, describing alternative behaviors, having the person acknowledge what occurred, providing positive feedback when the person practices the alternative appropriate behavior, and providing tangible rewards for doing so. By using sound teaching technologies and incorporating social skills training into a collaborative and compassionate system of comprehensive care, aggression can be substantially reduced and appropriate behavior sustained.

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