Integration of expressive techniques in multisystemic therapy with at-risk adolescents: A retrospective case analysis

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Abstract:

The multisystemic therapy (MST) treatment model is derived from social ecological theory, through which known risk and protective factors of ecological systems are identified by indirect and direct contribution to at-risk behaviors. However, youth with emotional disturbances postdischarge from residential treatment facilities are often referred to MST due to managed care organizations extending beyond the once identified population of juvenile offenders. Consequently, MST works within the ecological system at which an integration of MST and expressive techniques (ETs) can occur in order to simultaneously work within the individual system. In this article, we discuss the foundation of MST and present a retrospective case analysis of the integration of MST and ETs. We discuss limitations and future research considerations.

Keywords: multisystemic therapy | expressive techniques | adolescents | family therapy

Article:

Multisystemic therapy (MST) is as an evidenced-based, comprehensive family and community-based treatment model designed for youth and adolescents with severe conduct problems who are at-risk of out-of-home placement (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). The MST model differs from other community-based supports through its cultural competence and strong supportive research (Burns, Hoagwood, & Mrazek, 1999) among juvenile offenders. However, as a result of managed care and the definition of youth with severe emotional disturbances as youth who are currently in or at imminent risk of out-of-home placement (Rowland et al, 2005), MST has been extended beyond juvenile offenders to with youth who exhibit emotional disturbances (Henggeler et al., 1998) and those returning to the community. Examples of this are youth diagnosed with emotional disturbances and youth who have discharged from residential treatment as a way of returning to the community and equipping parents with the skills necessary to support the transition back into the community (Painter, 2010).

Disruptive mood dysregulation disorder (DMDD) is one example of youth diagnosed with emotional disturbances. As a new addition to the *Diagnostic and Statistical Manual of Mental*

Disorders (*DSM-5*) in 2013, DMDD is characterized by 1 year of persistent irritable mood and severe and frequent temper outbursts in adolescents beginning prior to the age of 10 (APA, 2013). The *DSM-5* requires that the disruptive behavior severely impairs at least one system (i.e., home, school, or peers) while being present in a second setting (APA, 2013). Individuals with DMDD are in need of substantially more services (Conner, Meldrum, Wieczorek, Duberstein, & Welte, 2004; Nock, Kazdin, Hiripi, & Kessler, 2007; Peterson, Zhang, Santa Lucia, King, & Lewis, 1996; Pickles et al., 2010; Stringaris, Vidal-Ribas, Brotman, & Leibenlft, 2017) such as residential treatment or intensive-in-home services. In particular, MST supports an approach that targets all the systems that are identified as disrupted in the diagnosis allowing for the youth to return home with support in all systems through reciprocation and exchange between the levels of the ecology (Saleebey, 1992).

Youth with emotional disturbances postdischarge from residential treatment return to the community with a significant change in treatment modality that is not addressed with MST. Within residential treatment, youth receive group and individual therapy where they are working within the individual system only to return to a home environment where the individual system is not addressed with the same intensity. When a child is placed in residential treatment but the home environment has not changed, or the family has not sustained the changes, the problem behaviors eventually return (Painter, 2010). It is then imperative to support the child and family in developing systemic changes and skills that will provide long-lasting implications. This is where the natural transition to MST occurs. However, a reduction in direct work within the individual system for 4–6 months throughout MST in order to create change within the other systems provides an avenue to which an integration of MST and expressive techniques (ETs) can occur. The integration of expressive arts in MST allows the therapist to simultaneously work within the individual system while making direct change within the surrounding systems.

ETs and art among adolescents allow the individual to express and experiment with the developmental process in creating an identity. The desire to create a personality separate from the parents for the development of autonomy is established within ETs by having authority over the art, which leads to less resistance in therapy (Riley, 1999). The ability for adolescents to have an outlet of autonomy is important to continue development while transitioning between residential treatment and the community. Furthermore, art aligns with the population of adolescent females in order to decrease resistance and increase identity development through validation and self-awareness (Hartz & Thick, 2005).

The purpose of this article is to present a retrospective case analysis of the integration of MST and ETs with adolescents with severe emotional disturbances not being supported by the juvenile justice system. This article will review the existing literature of two mutually exclusive practices to provide justification of the integration, limitations, and future research considerations. The institutional review board (IRB) was consulted to which the IRB determined this case has been analyzed retrospectively and therefore no IRB approval was needed.

MST

MST, using the foundation of social ecological theory (Henggeler et al., 1998), analyzes the known risk and protective factors of the ecological systems that directly and indirectly contribute

to delinquency and substance abuse in order to reduce these behaviors (Schoenwald & Rowland, 2002). The social ecology systems consist of micro-, meso-, exo-, and macrosystems (Bronfenbrenner, 1979) at which MST has defined as individual, family, community, school, and peers (Henggeler & Shaeffer, 2016). The treatment engages in a multicultural approach through utilization of the community system as a representative of the overarching culture (Pane, White, Nadorff, Grills-Taquechel, & Stanley, 2013) in addition to the other proximal systems the behavior is functioning (Henggeler & Shaeffer, 2016).

In-home treatment models have been consistently viewed as viable approach to address adolescents exhibiting at-risk behaviors. In order for the counselor to completely conduct the analysis of the behavior, this observation and treatment must be conducted in the environment at which the youth resides (Germain & Bloom, 1999). This allows the clinician to obtain the full picture of the cause and outcome of the targeted behavior. The clinician will gather multiple perspectives from individuals of the various systems as well as a history from the family (Henggeler et al., 1998). However, while the social ecological model emphasizes that life events occur, the perception of the event determines the individual's response. MST does not place emphasis on life events in the same manner (Germain & Bloom, 1999). While MST builds off the strengths of social ecology and empowers the caregiver as the agent of change (Henggeler et al., 2009), this leaves the individual system of the youth treated minimally.

The overall goal of MST is to support a decrease in antisocial (Painter, 2010) and at-risk behaviors such as substance abuse, delinquency, and reducing risk of out-of-home placement (Curtis, Ronan, & Borduin, 2004). It is through the work of MST that action-oriented interventions are applied to the target risk factors among multiple domains. For example, parenting practices of the family members may be a targeted risk factor at which the intervention may be applying skills to link to the teachers and counselors from the school system to the caregiver (Henggeler & Schaeffer, 2016). Other factors between systems may be a lack of consistent communication between the school and the family, lack of prosocial activities to connect the youth to the community supports, or lack of links between parents of positive peers and the parent of the identified youth. Intervention strategies utilize the strengths and skill sets of the family to address the needs of the youth through a combination of empirically based, problem-focused components (Henggeler et al., 2009) at which cognitive–behavioral techniques, parent management training, and systemic family therapy interventions are incorporated (Henggeler, Pickrel, & Brondino, 1999). Although family preservation services have been empirically supported for emotionally disturbed youth, a lack of evidence with families that exhibit multidimensional problems remains (Lindsey, Martin, & Doh, 2002).

Treatment Principles

The theory of change within the MST model is through the empowerment of the caregiver to create an environment at which the child can then be successful through supporting positive behaviors rather than negative peer influence or deviant behaviors. The parent is the key to sustaining the change after treatment through linking the parent to informal supports, obtaining skills and resources for effective parenting, and increasing caregiver competencies (Henggeler & Schaeffer, 2016).

There are nine MST treatment principles at which the master's-level therapist and teamwork within for the framework of administering the treatment. The first principle is finding the "fit" at which a functional analysis is completed to identify the context at which the problem behavior occurs within the systems. The second principle is maintaining a strength-based approach that utilizes the strengths and skill set of the family and the youth to (the third principle) increase responsibility of all family members throughout treatment. The fourth principle states that interventions are to be action-oriented and present-focused to support the family in applying the intervention and skills they have learned by identifying the "drivers" or causes of behavior (the fifth principle). All interventions are to be developmentally appropriate (the sixth principle), continuously applied (the seventh principle), and consistently evaluated throughout treatment for accountability and efficacy (the eighth principle). Lastly, the ninth principle states that interventions and skills obtained are designed to be generalized across family needs, so the family can then continue to drive the change process after the MST treatment (Henggeler & Schaeffer, 2016). Henggeler and Schaeffer (2016) have reported that intervention fidelity is inversely correlated with youth rearrests after treatment, and therefore, these principles remain important to the fidelity of the model.

Analytical Process

The analytical process within MST resides in a sequence of steps listed in Appendix Table B1. The analytical process begins by identifying problem behaviors as specified by the perspectives of key stakeholders within the systems (i.e., caregiver, teachers, school counselors, or community supports; Henggeler & Schaeffer, 2016) in order to create desired outcomes and goals for the youth and family. The MST therapist would then conceptualize and "find the fit" based on the ecological factors that seem to be driving the behavior (Henggeler & Schaeffer, 2016). These steps are identified in Appendix Table B1 as Steps 1–4. Next, the MST therapist would prioritize a "driver" of the behavior with specified intervention strategies that incorporate the empirically supported interventions to be delivered to the family (Henggeler & Schaeffer, 2016), as reflected in Steps 5–7. Examples of identified drivers may include lack of home–school link or lack of rules, rewards, and sanctions, to which the intervention is employed. The effectiveness of the intervention is then monitored continuously from multiple perspectives within the ecology. If the goal is not met, the driver is then reconceptualized and the intervention is modified (Henggeler & Schaeffer, 2016) until the goal of behavior reduction has been met (i.e., Step 9 in Appendix Table B1).

Outcome Research

MST holds a breadth of literature around its effectiveness of interventions (Henggeler & Sheidow, 2011); however, there are limitations to be considered among outcome research. These limitations include inconsistent results during follow-up studies, lack of independently conducted research, and limited research of noncourt-ordered adolescents (Painter, 2010; Pane, White, Nadorff, Grills-Taquechel, & Stanley, 2013). Rowland and colleagues (2005) identified a significant reduction in internalizing behaviors and fewer days in out-of-home placement as well as an increase in social support for caretakers among adolescents with severe emotional disturbances. However, since Rowland et al., researchers have primarily focused on the cost-

effectiveness of MST and have not continued with adolescents with internalized behaviors (Pane et al., 2013).

Other outcomes of MST follow up studies to compare effectiveness to psychiatric hospitalizations. While settings reduced emotional distress, youth reported that the hospitalization was significantly more effective on improving self-esteem (Henggeler et al., 1999). Overall, the research reports significant findings of immediate benefits that are superior to other evidenced-based treatments; however, there is a significant decline in MST benefits over time with high-risk populations such as individuals with severe psychiatric illness, history of hospitalizations, and chronic illnesses (Pane et al, 2013).

Scholars, both independent and MST founders, researching the model remain inconsistent in both long-term results, internalized behaviors, and psychiatric illnesses (Painter, 2010; Pane et al., 2013). The adaptation of the model for psychiatric illness (Henggeler et al., 2003) yielded a reduction in youth-reported suicide attempts but did not show significant change among caregiver reports of youth suicidal ideations, depression, or hopelessness (Huey et al., 2004). Further, few studies have investigated the experiences of the youth and the individual system which calls for further investigation (Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012; Paradisopoulos, Pote, Fox, & Kaur, 2015).

ETs Integration

Art as therapy focuses on the sublimation of conflicts to strengthen the ego (Ulman, 1986). However, this is not to be confused with art psychotherapy which is a cognitive approach to employ verbal processing of the art for consciousness rising (Ulman, 1986). However, creativity in counseling is a term used generally for practices that typically include various therapeutic approaches such as art-based approaches (Rosen & Atkins, 2014). For the purposes of this article, the term ETs denotes creativity in counseling (Eberhart & Atkins, 2014; Knill, Levine, & Levine, 2005) and the use of creative modalities (Rosen & Atkins, 2014) but not the distinct discipline of expressive arts therapy as no formal treatment modality or training within expressive arts therapy has occurred.

Throughout generations of counselors, the arts have been used to transcend verbal language as an expression of the full range of human emotions and experience (Gladding, 2011). As the child develops their own self-concept and self-esteem, affection, emotional support, and verbal approval are among the contributing factors to such development (Canfield, 1989; Sanford & Donovan, 1984). Furthermore, it is through the cultivation of self-esteem within the individual system that increases self-awareness and creates appreciation for strengths and weaknesses (Johnson & Ferguson, 1990). This is also achieved within the practices of MST when the individual's strengths are used in action-oriented interventions. MST youth identify the ability to have personal responsibility for change and choice within the treatment develops a sense of personal agency (Paradisopoulos et al., 2015).

Additionally, a systemic role is taken in the development of self-esteem through both authoritative parenting and positive role models. (Berk, 1996). It is noted that even one relationship to one nonexploitative adult provides a positive correlation to self-esteem and a

decrease in risk factors (Office of Juvenile Justice and Delinquency Prevention, 1998), a teacher's positive encouragement (Simmons & Blyth, 1987), positive peer relationships (Harter, 1990), and the child's connection to the community (Rosenberg, 1979). It is easy to then connect the importance of the child's self-esteem as a consideration within MST as the systems directly contribute to this development through the youth's ability to recognize the impact of behavior and raising self and other awareness. Furthermore, youth who have discharged successfully from MST identify the formation of an identity (Paradisopoulos et al., 2015). For decades, art has promoted the development of self-esteem in adolescents across various researchers (Hartz & Thick, 2005). It is through the art and empowerment of expression that one discovers their own uniqueness and serves as a catalyst for the development of self-esteem (Rhyne, 1973). Art among adolescents is utilized to express and experiment with the developmental process in creating an identity separate from the parents (Riley, 1999).

The integration of art and MST comes when an individual system driver is identified from the fit circle in the analytical process (i.e., Step 4 in Appendix Table B1). An example of an individual system driver may be lack of coping skills or poor communication skills. Family system drivers can additionally be targeted through art as expressive activities shift the individual from a cognitive frame to an emotive frame (Long & Brecke, 2003, p. 28) in order to promote new understanding of identity and relationships (LeBaron, 2002, p. 139). When a family system is in need of fostering and rebuilding relationships, art creates a "we-space" (Maiese, 2016) to collaborate the needs and expectations of both the parent and child within their roles. The child is then able to communicate outside of verbal expression to express need and confrontation within the family. ETs provide an avenue for individuals to influence one another's affective states and point of views to build trust, empathy, and new pathways of interaction (Maiese, 2016). If an identified strength of the adolescent is art and desire to use art, integration maintains the fidelity of the MST principles when targeting a driver from the functional analysis.

Retrospective Case Analysis

The first author was introduced to this client while conducting MST for a national, nonprofit agency in the Southeast United States. Leslie (name has been changed) is a 15-year-old, Caucasian female whom was referred for MST services after a recent discharge from a psychiatric residential treatment facility. Leslie presented with a history of hospitalizations, self-harming behaviors, verbal, and physical aggression. Leslie's ecology presented issues throughout all five systems. Leslie started treatment when she was beginning her first year at a new high school after she had been away from her peers in out-of-home placement for almost 1 year. Leslie had no current or history of legal involvement outside of isolated incidents at which police intervened but no charges had been made. Leslie had no prosocial activities and difficult dynamics of parent–child relational issues as well as parent–parent relational issues within the home. Prior to residential treatment, Leslie had been hospitalized after an outburst led to physical and verbal aggression in the home. Leslie resided in her biological family home with her mother, father, an older sister, and a younger disabled brother.

There were other significant factors presented within the family and individual system that contributed to treatment. At the beginning of treatment, I was informed that the two parents were no longer romantically involved but were simply living under the same roof and legally married

for financial reasons. The mother was residing in the dining room that had been converted into a bedroom, while the father slept nightly in the master bedroom. The older sibling identified as transgender but had not disclosed this identity to the mother and father but only to Leslie. The younger brother was permanently disabled and resided in a hospital bed in the family living room. These multidimensional pieces significantly contributed to Leslie's behavior.

Functional Analysis

Beginning with the MST analytical process, the target behavior in Figure C1 is identified as verbal aggression. MST primarily begins with the behavior that potentially contributes to safety issues within the systems, but for the case analysis, the interventions being proposed were in correspondence with verbal aggressive behaviors. In considering all of the systems within Leslie's ecology, the drivers were identified through a functional analysis and sequencing techniques. Based on Appendix Table A1, drivers are targeted through interventions utilizing the family's strengths in order to indirectly or directly reduce the behavior.

Leslie identified that she lacked coping skills and de-escalation skills when she is angry or experiencing an outburst. Leslie also identified that when she comes home from school, she is often frustrated from the bullying that she experiences which, at times, leads to verbal aggression in the home and school setting. A lack of communication skills was identified as a driver within the family system due to quick escalation, poor listening, and verbal aggression often displayed by other members within the home. The family identified verbal altercations could also be contributed to parent–child relational issues, parent–parent relational issues, and lack of parent–parent communication. Within the school system, it was reported that Leslie did not identify many friends or supports and therefore verbal aggressive incidents occurred when she felt attacked or criticized by peers or teachers due to the lack of support. Within the community system, it was identified that the older sister did not have the support of a trans-community and therefore relied on Leslie to maintain her identity from the parents which shifted into a polarizing dynamic.

Interventions

Soundtrack activity

I began my work of targeting verbal aggression with Leslie and the family by prioritizing the lack of coping skills. Through connecting the systems, Leslie was able to identify pro-social activities within the school and community setting that would serve as an outlet and means of support for her outside of the home. Leslie joined the high school drama club, choir, and a video game club through the local library that allowed Leslie to obtain informal supports, positive peers, and coping skills outside of the home. As I worked within the systems, Leslie and I needed to work on her individual coping skills in order to prepare to target the lack of communication within the home. It was hypothesized at this time that the family communication would spark conversations that elicited a need for independent coping skills and clear communication.

The first intervention was created to support Leslie in finding her strengths and mood stabilization. Leslie and I began our work with her love for music. Leslie aspired to be a

YouTube star through her music interests at which I utilized to build coping skills based on her talents. Leslie identified songs that she could listen to when she was experiencing different emotions that either validated her feelings or supported a shift in her mood. Leslie and I created a soundtrack that would be utilized for support when she needed to step away from the family dynamics to self-regulate and stabilize. Leslie and I shared the soundtrack with her family to encourage the positive behavior and develop shared interests among the family. Leslie later utilized the sound track in the school setting when she was allowed to listen to music while completing her work or to de-escalate herself when she was upset in the school setting.

In a study conducted by Porter and colleagues (2017), music therapy did not show a significant outcome in treatment but a significant difference in self-report of communication improvement. However, this activity allowed Leslie to identify her emotions and articulate what she needed each moment, validation and encouragement through music. Additionally, the intervention was used and supported across systems to promote coping in various settings.

Stoplight communication activity

Once Leslie felt confident in her coping skills, she and the family were ready to target the drivers of poor communication within the home that led to verbal aggressive behaviors. As a family, Leslie, her sister, and her mother created a conversation stoplight. Leslie began with a green card of construction paper that represented when Leslie was in a good communication mode. Leslie then identified how she knew that she could easily communicate by identifying her signs of good communication. Leslie identified that her signs of good communication were a good mood and a calm voice at which she wrote on the green card. Leslie and I then worked to identify what skills are used in order to maintain the green level of communication. Leslie identified her skills of listening to her positive music and singing her favorite songs that support her positive mood.

The second card was a yellow card, which was identified as a card of caution. Leslie and I identified that the card of caution would be used when she began to feel uncomfortable, targeted, and frustrated with the conversation. Leslie identified what her signs for herself and others would be when she is in a caution stage of communication at which she wrote on the card. Leslie then identified what coping skills could be used to bring her from the yellow card back to the green card, which was then written on the card.

The last card was the red card, which indicated that Leslie was not ready or able to communicate effectively or positively. Leslie identified that her signs of being within the red card were escalation, yelling, and cursing. Leslie and I identified that she would need to leave the conversation for 15 min to return to a yellow caution stage before returning to the conversation.

After setting up the cards, Leslie and I practiced using the cards during session in order to identify warning signs and coping skills needed for family conversations. The cards were also used in Child and Family Team Meetings at which each member of the meeting would have their own set of cards during the communication. As treatment and family sessions continued, the cards were used less often in session as the verbal aggressive behavior decreased within the home and school setting.

Conflict resolution through expressive activities support facilitating communication where each individual can try to adjust to the other person's cognitive and affective perspectives potentially shedding light on unnoticed considerations (Maiese, 2016). Through this activity, Leslie was able to communicate her emotions through the cards while supporting her own needs of coping throughout the dialogue.

Other ETs that were integrated into treatment include constructing behavioral plans with art. For example, the family constructed their behavior plans for the family with collaging and drawing to be used in the home. The MST therapist took the treatment modality of the MST model and utilized creation and art to reframe the behavioral work within the family.

Discussion

The purpose of integrating ETs into MST is to identify a vehicle of expression and build autonomy within the individual's system that is neglected within the MST model. The target outcome of the integration is to support the transition from an inpatient, individually focused treatment modality with an ecological intensive modality. ETs have been found to support the development of self-esteem in most participants (Goodkind & Miller, 2000) at which establishing mastery in the creating of self-esteem promotes awareness of the individual's capabilities (Berk, 1996). Adolescents whom are actively seeking or have achieved self-esteem have a higher self-worth (Berk, 1996) as opposed to those whom have lower self-value have more adjustment problems (Archer & Waterman, 1998; Erikson, 1968; Marcia, 1988).

Overall, the integration of MST and the ETs was successful in supporting the family in building communication and coping skills in both the youth and the family. Leslie remained under the care of medication management with the psychiatrist but was able to reduce treatment to outpatient therapy at the conclusion of MST services. Additionally, Leslie engaged in activities such as theater, choir, and school and community advocacy activities.

Limitations

Limitations for this proposed integration include a lack of empirical support to back the integration when utilizing MST and ETs with emotionally disturbed youth. Additionally, the arts bypass the defense of the consciousness at which strong emotions can arise and be accessed rapidly (Rosen & Atkins, 2014). Such access to emotions need to be facilitated with a licensed professional and therefore should be conducted with guidance. It is also important to maintain the fidelity of the MST model in order to develop parenting skills to de-escalate or support the youth in coping with emotions that arise. Solely focusing on the individual system would not maintain fidelity of the MST model and would be counterproductive to the overall treatment. Future research considerations include outcome studies of including ETs within the predominately utilized interventions of MST with emotionally disturbed youth and juvenile offenders. ETs are only one avenue of integration of MST to which other theoretical or creative approaches could take place. Other research considerations include counselor self-efficacy among theoretical integration within MST and their outcome results.

Conclusion

The integration of expressive arts and MST is an innovative approach to incorporating the MST principles in a creative way. Art allows for communication to take place through an avenue that the adolescent controls and builds a working alliance between the MST counselor and the adolescent. This integration potentially makes way to explore new realms of which the functional analysis presents new approaches to target drivers of behavior that are unique to each individual and family's strengths.

Appendix A

Table A1. Expressive Interventions With Multisystemic Therapy Drivers.

Lack of coping skills	• Mood soundtrack: Youth creates a soundtrack of their favorite music specific to their mood; that is, happy track, sad track, and angry track. Be sure to include tracks that will transition their mood. • Mood journaling: Youth creates a mood journal to promote organization and coping skills; can exclude tasks, organization, expression, or processing skills.
Lack of communication skills	• Stoplight communication intervention: Create green, yellow, and red cards. Have the youth identify signs of their mood such as balling of fists, talking faster, pacing, and so on. Next have youth identify what coping skill they can use to move back to green or yellow. Include cards for the whole family to teach all family members their signs and autonomy to share when they are ready to communicate.
Easily triggered	• Tactile objects: Incorporate tactile objects that allow the youth to be distracted while still engaging in interventions; playdoh, pipe cleaners. • Draw the symptom: Have the youth draw what their triggers feel like both internally and externally with craft supplies.
Lack of de-escalation skills	• Create the plans: Have the youth create and draw the plans using magazine cut outs, colors, or pictures. • Put on a show: Have the youth act out and practice the plans based on sequencing or known triggers.
Lack of home-peer link	• Create the plans: Have the youth create a contact sheet of their peer's parents using craft supplies or in their bullet journal.

Note. Table includes examples of expressive arts interventions that can be utilized for potential drivers of at-risk behaviors. Drivers are identified through the analytic process to which the expressive arts interventions can be integrated in order to maintain treatment fidelity.

Appendix B

Table B1. Steps of the Multisystemic Therapy (MST) Analytical Process.

Steps of the MST Analytical Process
1. Referral behavior 2. Desired outcomes 3. Identify goals 4. Finding the fit 5. Prioritize a driver 6. Intervention development 7. Intervention implementation 8. Assess 9. Repeat Steps 5–8 until all drivers have been thoroughly addressed

Note. Table includes steps of the MST analytical process to identify drivers that are described throughout this article.

Appendix C

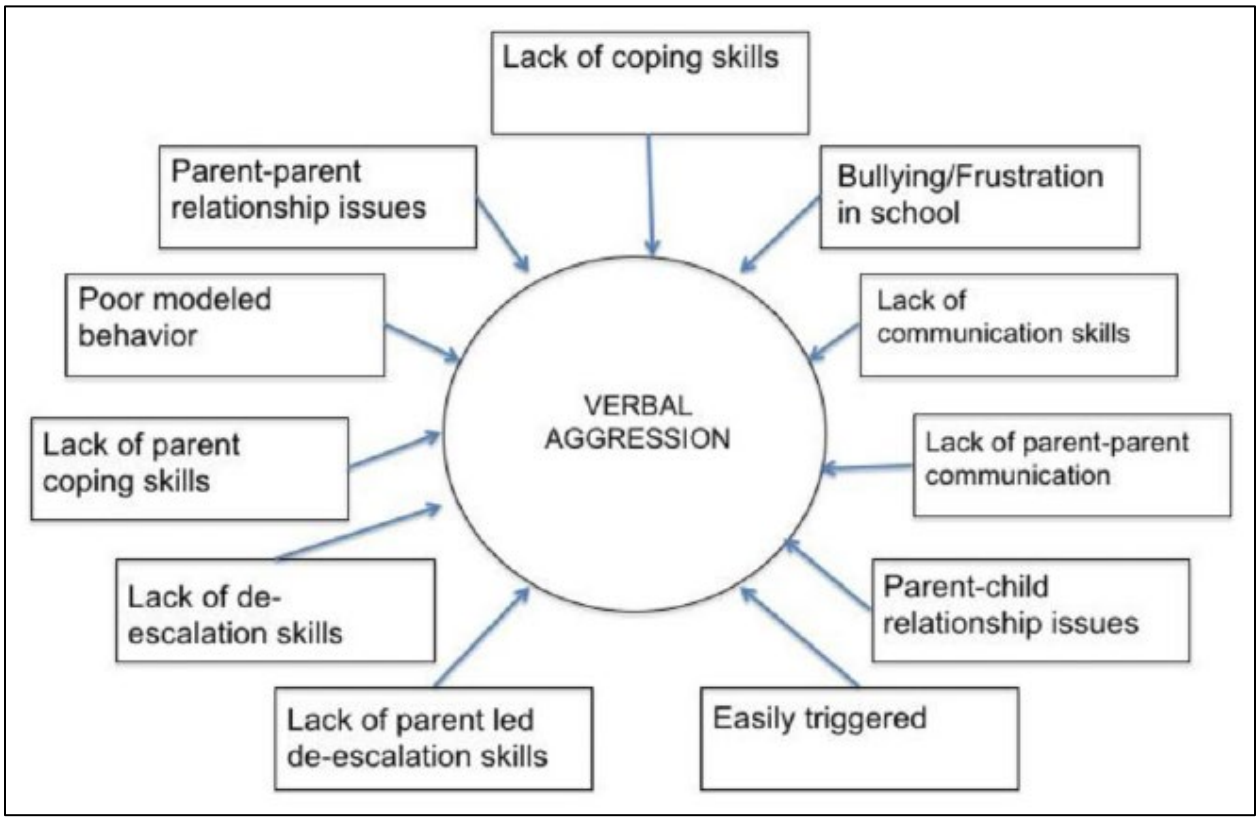

Figure C1. Case analysis fit circle for verbal aggressive behavior. This figure illustrates the fit circle used during the case to analyze factors that contribute to verbal aggressive behavior.

Declaration of Conflicting Interests

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