Integration of a Token Economy into a Child and Adolescent Psychiatry Training Clinic

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We developed a token economy pilot program in which reinforcers were provided by a university outpatient child and adolescent psychiatry clinic to address two problems common to psychiatry training programs: 1) psychiatric residents have insufficient opportunity to learn to use behavior modification techniques with outpatients, and 2) many patients and their parents seen in training clinics are poorly motivated and noncompliant with treatment, which leads to psychiatry resident discouragement and frustration. The rationale for the program is presented from the perspective of both the resident and the patient. The implementation of the program with 25 cases is described, including potential and actual difficulties. One case treated by a psychiatry resident is presented in more detail.

In most psychiatry clinics serving children and adolescents, the majority of patients present with behavioral problems at home and/or school. The children diagnosed as having disruptive behavior disorders often fail to respond to conventional play or verbal therapy techniques. Over the past two decades, behavior modification techniques have been used extensively to treat a variety of problems in these children (1). One of these techniques, the token economy, has been shown to be effective when used by families (2–4) and in schools (5). In a token economy, either actual tokens or points are awarded and subtracted, based on a clearly defined list of positive and negative behaviors. The points or tokens are then exchanged for backup reinforcers (privileges or material rewards). Optimal use of this treatment includes teaching parents the principles of operant conditioning and social learning so they can design and execute token programs at home. When token economy programs are used in outpatient clinics, the backup reinforcers are typically provided by the family (6).

Behavioral techniques such as the token economy are considered an essential part of training in both general psychiatry (7,8) and outpatient child and adolescent psychiatry.
However, the few published accounts of behavioral training in residency programs either address only the treatment of adult patients (10,11), describe only briefly the teaching of parent training as part of a more general experiential seminar on behavioral techniques (12), or include children only in the setting of a special school (13). In many programs, residents in general psychiatry or child and adolescent psychiatry lack sufficient supervised opportunities to design and use such treatment programs with outpatients.

Child and adolescent psychiatry outpatient training is frequently conducted in public settings, where there is a mandate to serve all patients who apply or who are referred. Many parents present to the clinic at the insistence of a school or a social welfare agency and have little motivation to participate in a treatment program that requires them to monitor behavior and dispense consequences. Even when parents are willing, they may lack the means to provide material rewards. These families often have the characteristics associated with poor outcome in conventional outpatient behavioral parent training programs: low socioeconomic status, parental depression, marital discord, single parents, and insular families (14,15). The families’ multiple financial, social, interpersonal, and psychiatric problems leave little energy for child-rearing. Discipline is often both harsh and inconsistent. Moreover, school personnel rarely have the interest or resources to provide an alternative source of reinforcement.

Many of the children have little insight into their problems or motivation to change their behavior. These children are action oriented with little interest in, or even opposition to, verbal psychotherapy. Such cases try the patience of even experienced therapists and can be especially demoralizing for psychiatry residents, many of whom are anxious about working with children and their families (16).

In our clinic, although residents were taught and encouraged to use behavior modification strategies, behavioral treatment was often seen by physicians (both residents and faculty) as a therapy restricted to use by psychologists. Resistance among psychiatry residents to learning and using behavior modification techniques, despite their demonstrated efficacy, was increased by the influence of psychiatry supervisors and role models, who recommended either individual dynamic psychotherapy or pharmacologic treatment. Few of the child and adolescent psychiatry supervisors were knowledgeable about behavioral approaches, and some actively disapproved of them. Both residents and supervisors voiced specific objections. Some perceived the token economy to be a form of bribery, which taught children greed. This complaint was also shared by some parents, despite explanations that bribery uses rewards to corrupt behavior, while in a token system, the goal is to facilitate socially appropriate behaviors (17). Symptom substitution was a commonly perceived threat, despite evidence that properly implemented behavior modification does not have this outcome (18). Others protested that behavior modification is too mechanical, is indifferent to emotional factors, or is incompatible with other treatment methods. Some residents resented the additional effort required to plan and implement such a highly structured treatment.

When the residents did attempt to implement behavioral programs in homes or schools, they were often met by active resistance from families who believed that children should not be rewarded for doing what they were “supposed to do.” Other families agreed to a program, but repeatedly failed to record behaviors or to provide contingencies as set out in the contract. Because the child and adolescent psychiatry rotation often plays a major role in recruiting general psychiatry residents into child and adolescent psychiatry career training, it is especially important to avoid an aversive experience for the resident.