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NONVIOLENT RESISTANCE: HELPING CAREGIVERS REDUCE PROBLEMATIC BEHAVIORS IN CHILDREN AND ADOLESCENTS

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In this review, the principles of nonviolent resistance (NVR) and studies examining its acceptability and efficacy are reviewed. Originating in the sociopolitical field, NVR has been adapted for numerous settings including parents of youth with externalizing and other problems, foster parents, teachers and school personnel, and caregivers of psychiatric inpatients. NVR has also been applied to reduce accommodation of highly dependent adult children and to improve novice driving habits. The principles of NVR include refraining from violence, reducing escalation, utilizing outside support, and maintaining respect for the other.

Nonviolent resistance (NVR) is a systematic approach for helping parents, teachers, and other caregivers cope with violent and self-harmful behaviors by strictly nonviolent and nonescalating means (Omer, 2004). The method is an adaptation of the doctrine of NVR in the sociopolitical field (Sharp, 1973). This social background is central to NVR as a treatment method, because violence always has a profound social significance, even when its apparent locus of manifestation is the home. One of the peculiarities of NVR is its ability to address this social nexus of violence explicitly, making it a central element of the therapeutic process. In this way, the parents' resistance is cast as part and parcel of society's struggle against violence. An important implication of this understanding is that children's violence, no less than the violence of adults, is never a strictly private event. Clinical experience indicates that this principle contributes to the appeal and wide acceptance of NVR.[1] Parents, teachers, and other caretakers feel that resisting violence and self-destructive behaviors is much more than a therapeutic issue. This insight lends them a sense of legitimacy and mission.

Previous publications have described NVR applications in a variety of specific areas. The current article aims to provide the first comprehensive review of this growing body of research, integrating the existing information on the NVR approach, and its various implementations. This article also has another important objective. Although increasingly well known in Europe, the NVR approach is considerably less familiar to clinicians and researchers in the United States. We hope this review may help to change this situation.

REVIEW OF THE NVR LITERATURE: A DIVERSE ARRAY OF IMPLEMENTATIONS

Studies of NVR with families of violent children with a variety of diagnoses were conducted in Israel (Lavi-Levavi, Shachar, & Omer, 2013; Weinblatt & Omer, 2008); Germany (Oleffs, von Schlippe, Omer, & Kritz, 2009), England (Newman, Fagan, & Webb, 2014), and Belgium (van

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Holen, Vanderfaeillie, & Omer, 2015). Those studies demonstrated the efficacy of NVR across a variety of social and cultural settings. NVR was shown to be effective at reducing violence and other externalizing symptoms, as well as parent–child escalation, and parental helplessness. NVR treatment also helped parents to increase their positive and caring gestures toward the child, often in situations in which such positive interactions had become unattainable because of chronic conflict. Treatment feasibility and acceptability were found to be high, as was parental satisfaction (dropout rates ranged between five and twenty percent).

The application of NVR in schools has gained acceptance in several countries including Germany (Lemme, Tillner, & Eberding, 2009), Austria (Steinkellner & Ofner, 2011), and Switzerland, but the only systematic study to date was conducted in Israel (Omer, Irbauch, Berger, & Katz-Tissona, 2006). An NVR based program, including training for school staff in effectively coping with behavioral problems, was implemented in a middle school with 800 youth over the course of 1 year. The program was associated with a significant reduction in violent behaviors in the school, including student-to-student, student-to-teacher, and teacher-to-student violence. Following the program, students reported that they could rely more on their classroom teacher or school director to deal appropriately with violence in the school, whereas at the beginning of the year they had not felt able to do so. In parallel with this rise in confidence, students' readiness to report on violence also rose considerably. Besides schools, the NVR approach has also been implemented in other institutional settings, such as inpatient psychiatric units for children or adolescents with psychotic disorders (Goddard, Van Gink, Van der Stegen, Van Driel, & Cohen, 2009). Implementation of an NVR program on several such units in a large hospital was associated with a dramatic reduction of more than half in the use of physical restraints or seclusion by hospital staff. Hospital staff also reported feeling increased confidence in their professional ability and a greater sense of team work, following the one-year program (Table 1).

Gradually, NVR was adapted and applied to other conditions in which caregivers face aggressive or violent behaviors. Children with anxiety disorders, particularly obsessive-compulsive disorder (OCD), often exhibit coercive and disruptive behaviors aimed at imposing symptom accommodation on family members (Lebowitz, Omer, & Leckman, 2011; Lebowitz, Vitulano, Mataix-Cols, & Leckman, 2011). An adaptation of NVR (under the acronym [name blinded for peer review]) was shown effective in dealing with children with anxiety disorders who refused therapy (Lebowitz, Omer, Hermes, & Scahill, 2014) and with children with OCD (Lebowitz, 2013). The [name blinded for peer review] treatment was effective in reducing the symptoms of anxiety, the family's accommodation, and the child's coercive behaviors.

With the dissemination of NVR and its growing application among parents of youth, parents of adults started applying for help. These parents felt helpless, confronted by adult children who were not working or studying, and usually continued living in the parental home. The parents were expected (or forced) to supply many or all of their needs, and they felt frustrated, with no end in sight. The term *adult entitled dependence* was coined to characterize this condition (Lebowitz, in press; Lebowitz, Dolberger, Nortov, & Omer, 2012) and provided the impetus for the development of an NVR application for working with parents of those individuals. In a review of 27 such cases, parent treatment with NVR brought about a pronounced reduction in violence on the part of the adult children, parental helplessness, and provision of excessive or inappropriate services by parents. In a substantial number of cases, the dependent young adults started working or studying and/or moved to independent lodgings (Lebowitz et al., 2012). A special element in the treatment, which is now also implemented with adolescents, focuses on helping the parents cope with suicidal threats (Omer & Dolberger, 2015).

An important development to come out of NVR is the concept of *vigilant care*, which refers to parents' ability to stay continuously alert, "with an ear to the ground," regarding their child's potentially dangerous activities (Omer, 2011, 2015). The vigilant care model was developed in response to criticisms to *parental monitoring*, a model that has been found to lead in some cases to negative consequences such as increased parent–child conflict, "overparenting" or "helicopter parenting," and excessive parental control (Racz & McMahon, 2011). Vigilant care, in contrast to parental monitoring, emphasizes gradations of parental vigilance, from open attention, through focused attention, to active protection, with parents moving between different levels of involvement in response to danger signals they detect from the child. As in other NVR models, parents

Table 1
Applications and Implementations of Non Violent Resistance in Various Settings and Challenges: Results from Clinical Trials

	Population/sample	Age range	Methodology	Main findings	Treatment modality
Weinblatt & Omer, (2008)	Youth with behavioral problems. $N = 41$; 68% males.	4–17	Randomized waitlist-controlled trial.	Reduced maternal helplessness. Externalizing symptoms significantly reduced in the treatment group.	Five weekly individual sessions + telephone support.
Oleffs et al. (2009)	Youth with behavioral problems. $N = 52$; 66% males.	11–18	Aggregate data from sites that compared NVR to waitlist or active control (Triple P).	Significant improvement in externalizing symptoms and parental coping in NVR treatment groups. Improved parental depression and helplessness in both NVR and active comparison treatment.	Six individual weekly sessions (6–8 sessions in Triple P).
Lebowitz et al. (2012)	Adult children highly dependent on parents with extreme demands for services. $N = 27$; 85% males.	18–47	Open trial.	Significant reduction in parental provision of age-inappropriate services. Significantly improved functioning and increased employment of adult children.	15–25 individual sessions.
Lavi-Levavi et al. (2013)	Youth with behavioral problems. $N = 46$; 77% males.	Mean=12	Randomized waitlist-controlled trial.	Significantly reduced parental helplessness in the treatment group. Power struggles with the youth were also reduced and parents reported fewer negative feelings toward the youth following treatment.	4–10 weekly individual sessions+ telephone support.
Lebowitz (2013)	Treatment refusing youth with obsessive-compulsive disorder (OCD). $N = 6$; 75% males.	10–13	Open trial.	Reduced OCD symptoms, family accommodation and coercive disruptive behaviors following treatment.	Ten weekly individual sessions.

Table 1
Continued

	Population/sample	Age range	Methodology	Main findings	Treatment modality
Goddard et al. (2009)	Inpatient psychiatric units. Four child and two adolescent units.	Child<13 Adol.>12	Open trial of NVR implementation in the units.	Use of seclusion and restraint was significantly reduced on all but one unit. Staff feelings of confidence and team work increased. Staff on adolescent units reported decreased sense of helplessness.	NVR was implemented on the units for 1 year.
Lebowitz et al. (2014)	Treatment refractory/ Treatment refusing youth with anxiety disorders. $N = 10$; 50% males.	9–13	Open trial.	Reduced anxiety and family accommodation after treatment. Increased youth motivation for individual treatment.	10–12 weekly individual sessions.
Newman et al. (2014)	Youth with behavioral problems. $N = 24$	8–17	Open trial.	Reduced youth behavioral problems and improved functioning following treatment.	12 weekly group sessions.
Omer & Dolberger, (2015)	Youth and young adults with threats of suicidality.		Pilot implementation	Reports of reduced suicidality. No systematic comparisons available.	10–25 weekly individual sessions.
Shimshoni et al. (2015)	New young drivers. $N = 217$	17–22	Randomized controlled trial.	At risk youth showed better driving behaviors in the NVR-based training group.	Six months of feedback on driving behavior ± 90 min NVR-based training and access to telephone support.
van Holen et al. (2015)	Children in foster care with externalizing problems. $N = 62$; 52% boys.	Mean=12	Randomized controlled trial of NVR or TAU.	NVR treatment associated with more child-monitoring and more use of social support than TAU. No significant differences in child behavior outcomes.	10 weekly in-home sessions + telephone support

Table 1
Continued

	Population/sample	Age range	Methodology	Main findings	Treatment modality
Omer et al. (2006)	Students in one middle school and one high school. $N = 800$	12–7	Open trial	Reduced youth behavioral problems in school. Improved staff coping with behavioral problems.	Training and support for teachers and school staff + parent outreach over one school year.
Golan, Shilo & Omer, (2016)	Young adult with high functioning autism. $N = 4$; aged	20–26	Open trial.	Reduced parental distress and increased hopefulness.	10 weekly individual sessions + telephone support

Note. NVR = Non-Violent Resistance; TAU = Treatment as usual.

learn to prevent and reduce escalation, exercise self-control and avoid invasive and controlling messages. However, they are also helped to act decisively when clear signs of danger are forthcoming. The approach has been applied with parents of youth with a variety of problems that require parental vigilance including, delinquency, diabetes, computer misuse or addiction, alcohol abuse, and school absenteeism (Omer, 2015). One special field in which the model has proved effective is that of aggressive driving by novice drivers (Shimshoni et al., 2015). In this study, a brief 90-min parent training, in the presence of the young driver, was shown to reduce aggressive driving, as measured by an in-vehicle recording device. Importantly, the intervention was well received by parents and youngsters alike, adding to the feasibility of this potentially life-saving intervention.

CENTRAL CONCEPTS AND RELATED MODELS

Helplessness

Parents of violent, aggressive, or otherwise domineering children often view themselves as having less power than the child, *even when they are violent themselves* (Bugental, Blue, & Cruzcosa, 1989). Some parents vent their frustration through harsh and ineffective punishments, others submit to the child's demands, and others oscillate between lashing out and giving in, leading to an exacerbation of the child's aggressive behaviors. This interactional pattern has been cogently described in Patterson's *coercion theory* (1982). Training in NVR reduces parental helplessness, submission, and violence, thus helping the families to break away from the cycle of coercion (Lavi-Levavi et al., 2013; Weinblatt & Omer, 2008).

Escalation

Violent behaviors are fueled by *complementary escalation* in which parental submission increases the child's demands and outbursts, and *reciprocal escalation*, in which hostility begets hostility. NVR was specifically designed to counter both kinds of escalation. In the sociopolitical arena, emphasis is placed on training the activists in how to withstand violence and provocations without reacting in kind. Similarly, in NVR for the parents of violent children, the ability to withstand provocations and aggression, without lashing out or giving in, is carefully cultivated (Omer, 2004).

The focus on preventing escalation and modifying negative cycles of interpersonal behavior and communication links NVR to other systemic and family oriented approaches and therapies. For example, strategic therapists (e.g., Madanes, 1991) use both direct assignments and reframing to help families break out of negative cycles of behavior. Cognitive behavioral family therapists (e.g., Epstein, Schlesinger, & Dryden, 1988) target family related cognitive schema that impact interpersonal feelings and maintain negative family dynamics, and interventions targeting substance abuse urge family members not to respond in kind to inappropriate or violent behaviors (Meyers, Miller, Hill, & Tonigan, 1998; Piercy & Frankel, 1989).

Therapists using NVR also help families break out of destructive, escalating cycles by targeting both cognitive (e.g., beliefs, attitudes, thoughts) and behavioral patterns, as described below under Treatment Steps, and in particular under *antiescalation training*. A unique feature of NVR is that prevention of escalation, which is usually viewed as a supplemental skill, is a defining characteristic of the NVR approach.

Power and Control

The philosophy of NVR postulates that a person or group that desists on principle from actively resisting violence ultimately contributes to its perpetuation. Therefore, those who witness or experience violence have a responsibility to struggle against it. The struggle, however, should be rigorously nonviolent**.** The nonviolent resistor must learn to avoid any form of physical or verbal attack and refrain from actions or expressions which humiliate or insult. In NVR, parents aim to *resist* rather than *control* the child's destructive behaviors. It is unrealistic to expect that because parents or other caregivers adopt an NVR approach, and implement its corresponding tools, their wards will immediately desist from all violent behavior as well. NVR stresses that that is actually the caregiver who is the first beneficiary of the approach, as the sense of helplessness diminishes and their self-worth is restored. Only gradually is the behavior on the "other side" likely to change,

as escalation is reduced and violence is curtailed on all sides. For this reason, the message of the NVR therapist to parents is that they "don't have to win, but only to resist," promoting a longer term view of the effects on NVR on the system as a whole.

Presence

The appeal and relevance of NVR to parents faced with difficult interactions with their children lies in part in the emphasis on increasing parental presence. Rather than choosing between decreased presence and less contact with the child on the one hand, or increased escalation and more violence on the other, parents are offered the possibility of actually increasing their presence and augmenting the contact with the child, while refraining from aversive escalation and violence.

In the sociopolitical arena, the practical operationalization of this principle takes the form of various tools such as civil disobedience, protest marches, or the "sit-in." These tools emphasize the activist's engagement and presence in the political discourse, rather than increased disenfranchisement and isolation, while providing the tools to exercise the presence in a nonviolent manner that obstructs the mechanisms of oppression and injustice. For parents, the ability to actually increase their relevance to the child's life and challenges is crucial, as maintaining or increasing their distance puts the child at risk and is typically at odds with their goals as parents. The practical operationalization of this principle in the family sphere includes, for example, choosing to be physically present in situations and locations where the child is at risk for destructive or high-risk behaviors. Parents can perform their own version of the "sit-in," to express their commitment to fulfilling their parental responsibility. Through these actions, parents are sending a strong message to the child that they will not abdicate their responsibility, and cannot be discarded, ignored, or paralyzed. Crucially, they send this message while rejecting authoritarian practices based on fear or physical force. The distinction is of particular importance in the context of violent youth who tend to respond negatively to fear-based messages and who often elicit in parents the instinct to retreat and create more distance between themselves and the child.

Support, Openness and Transparency

Another key aspect of NVR, that distinguishes it from more clandestine resistance movements, is the commitment to openness and transparency. By rejecting secrecy and acting in an open and public manner, NVR creates strong counter pressure to the violence, which often thrives most under a veil of secrecy. The publicity of the parents' actions also helps to commit them more fully to following through on their statements and abstaining from violence themselves.

Parents are encouraged to involve people in the situation and to enlist the help of friends and relatives from outside the home, providing them with crucial support and reducing their sense of isolation. This feature of NVR links it to other systemic models such as multisystemic therapy (e.g., Henggeler, Melton, & Smith, 1992) and multifamily therapy (Asen & Scholz, 2010).

External supporters also exert positive influences on the child, by strengthening intrinsic motivation to refrain from violence. NVR posits that within the child there exist multiple inner voices, both maintaining and opposing the violent behavior. Supporters, who are not the parents with whom the behavior is habitually manifested, serve to strengthen the positive voices opposing the violence. Involving outside supporters is a daunting choice for many parents, and good deal of persuasion on the part of the therapist is often necessary before they are willing to overcome their doubts and apprehension. But ultimately this can be achieved in the majority of cases, with immeasurable gain to both the parents and the child as the secrecy and isolation are removed. A strong counter argument to the notion that involving supporters violates the child's privacy is the idea that violence is never private and that maintaining secrecy actually increases the likelihood of it continuing. The supporters themselves can address the child's resentment or indignation at the parents' "betrayal" by expressing their support in a positive and empathetic manner that acknowledges the validity of the child's feelings while opposing the unacceptable actions.

Respect and Reconciliation

Leaders like Gandhi and Martin Luther King Jr. did not settle for the absence of violence alone: They demanded that acts of resistance be accompanied, as far as humanly possible, by respect for the adversary. This stance is based not only on a moral, but also on a strategic premise:

The idea that the "opponent" is not made entirely of one cloth. Acts of respect and reconciliation serve to strengthen positive voices among the aggressors. In contrast, eschewing such acts, or engaging in actively humiliating behaviors, would actually strengthen the violent voices and is therefore counterproductive. In the context of parent–child relations, this argument is particularly valid. Our basic assumption is that positive feelings exist on both sides, even if they are sometimes buried under the abrasive conflicts. Parental acts of respect and reconciliation (that do not include surrender) are thus based on mutual feelings, increasing the likelihood that these feelings may be expressed and thus feed positive interactions. The most common conciliatory steps are verbal or written messages of appreciation, small symbolic gifts, proposals of pleasurable joint activities, offers of small unrequested services, reminders of *positive* events from the past (without contrasting them to the more bleak present), and expressions of regret or reparation for past mistakes (Omer, 2004). Jakob (2014) argued that such gestures help to renew the "dialogue of care" that had previously been obstructed by the hardships of parenting a violent child.

TREATMENT STEPS

Establishing a Working Alliance

The parents are the clients. They are the ones that come to therapy and manifest interest in changing the situation. Their motivation usually stems both from their concern for the child, and from their own stress and suffering. However, their attitude toward therapy may be ambivalent, partly out of fear that they may be blamed for the child's condition. This fear is often linked either to previous experiences with treating agencies, or to their own sense of guilt. These concerns are addressed in the initial sessions. The therapist makes it clear that in NVR, the family is not viewed as a circle with one center – the child – but rather as an ellipse with two centers – the parents and the child. To fulfill the child's needs, the parents' needs must be filled as well. The therapists also expresses empathic understanding for the fact that parents may be afraid of attacks, worn out by conflicts, or overwhelmed by anxiety. By showing the parents that addressing those conditions is a central goal of treatment, the therapist becomes the parents' ally.

Antiescalation Training

Situations of escalation are examined and reactions that express self-control are formulated and rehearsed (Omer, 2004; Weinblatt & Omer, 2008). We have coined three phrases that illustrate the nonescalating stance of NVR, which parents should keep in mind: (a) "Strike the iron, when it is cold!"; (b) "You can't control the child, but only yourselves!"; and (c)"You don't have to win, but only to persist!" The first phrase is designed to help parents overcome the urge to react immediately to the child's violent behaviors. The rationale is that immediate reactions come about at the height of arousal and increase the risk of escalation. Parents learn to take a deep breath, postpone the temptation for immediate action, and develop planned ways to resist the violence and the inappropriate demands that are linked to it. The second phrase aims to modify dominant attitudes that often turn the parent–child relationship into a zero-sum game. In NVR, the compulsion to control is replaced by the duty to resist. The third phrase is actually a synthesis of the other two: It unites the factor of time with the abandonment of a controlling stance. The message of persistence is a good antidote to the sense of total urgency that exacerbates violent interactions. In treatment, the parents are helped to develop a time span that arches over days, weeks, and months, instead of minutes.

The Announcement

During the first few sessions, parents are helped to prepare a semi-formal "announcement," in which they declare to their child that they will resist the violence, and will no longer keep it secret. The announcement serves several purposes: (a) it constitutes an opening event or a rite of passage to a new phase in the family's life; (b) it introduces the parents to a new kind of interaction, in which they state their position in a self-controlled manner, independent of the child's agreement; and (c) it tells the child that the parents will no longer keep the problem secret.

The parents rehearse how to deliver the announcement and how to develop nonescalating responses to the child's reactions. Thus, if the child refuses to listen or read the announcement, the

parents can leave it on the table. If the child tears the page, parents can say: "We do not expect you to agree. We are giving you this to be fair with you, so that you may know what we are going to do." When parents succeed in delivering the announcement in this spirit, they are already on the way to becoming nonviolent resistors.

The Support Group

Whenever possible, a meeting with the supporters is organized by the therapist. Many parents have trouble "going public," because they feel ashamed, concerned it might hurt the child, or fearful of a violent reaction. Dealing with these objections is one of the central tasks of the NVR therapist. In cases where a supporters' meeting is not feasible, supporters can be recruited on an individual basis. Typical supporters include grandparents and other members of the extended family, friends of the parents, the parents of the child's friends, and members of the school staff. The supporters do not have to live nearby, as their help can be made available by phone or text messages. We have often made use even of supporters who lived in other countries, especially with migrant families: help from grandparents or other members of the extended family who call from abroad to talk with the violent child can be very effective.

Resistance Steps

Documentation and involvement of supporters. The very fact that supporters are informed of the violence and that it is made clear to the child that they have been notified and are willing to help, constitutes a significant act of resistance. Few children or adolescents are immune to public opinion, although many try to put up a show of indifference. The parents begin by documenting the violence – in writing or by visual means (e.g., taking photographs of destroyed property). We do not recommend that the parents record the violent behavior as it is occurring, as this often leads to escalation. Writing and photographing are better, as they can be conducted *when the iron is cold*. The documentation is then sent to the supporters, who call or visit the child. It is not necessary that all supporters contact the child: one or two each time are enough. However, it is important that parents tell their child that they are no longer keeping the events secret and that they will send their reports to whomever they feel is appropriate. Supporters are specifically asked to address the child in a positive way, but to make clear that they know what happened, that they view the behavior as violent and unacceptable, and that they believe that the child can overcome it.

The sit-in. The sit-in has come to typify NVR in families, probably because it is emblematic of NVR in the sociopolitical arena. It is important to understand that the sit-in is a measure of resistance and not a disciplinary step geared to changing the child's behavior immediately. In fact, the sit-in affects the parents more than the child: in preparing for the sit-in and staging it in a self-controlled manner, the parents achieve a basic proficiency in NVR. Thus, the sit-in can be viewed as training in the context of real life. In the sit-in, the parents enter the child's room (a single parent may be accompanied by a supporter, in person, or via technology), sit-down, and tell the child: "We are here because we are no longer willing to accept the kind of violent behavior that you displayed today. We will sit here and wait for a proposal as to how the violence might end." After this, the parents stay silent. In preparation, the therapist helps the parents to develop ways of coping with typical reactions, such as physical attacks, attempts to expel them, ignore them, or deride them (Omer, 2004, 2011). The sit-in usually takes between 30 min and one hour. If the child makes a proposal, a dialogue may ensue. If not, the parents are advised not to raise proposals of their own. The success of the sit-in is not a function of the proposals, but of the readiness of the parents to sit through it without succumbing to provocation.

Reparation. In NVR, the perpetrator of a violent act is held accountable and expected to make amends for their behavior. This often takes the form of a clear apology and a symbolic act of compensation. The supporters encourage the perpetrator and offer to help him or her perform reparation in ways that maintain their dignity. If the perpetrator is not willing to do so, the parents, with the supporters' help, declare that the victim will be compensated and that they will decide how the perpetrator will be made accountable. This process, when patiently adhered to, often leads to growing readiness of perpetrators to engage in acts of reparation. This side of NVR has similarities to the procedures of restorative justice, but probably without the cumbrousness that may make some of those procedures hard to implement (Omer, 2011).

ILLUSTRATIVE CLINICAL CASE EXAMPLE

Nick, the 16-year-old son of Vivian and Martin, suffered from OCD and imposed a long list of rules and demands on the entire family. The slightest show of unwillingness to comply with his demands was met with violence. Vivian and Nick's two sisters had all been physically attacked and beaten on several occasions. Nick's attempts to control and humiliate the family were not restricted to his OCD symptoms alone. For example, Nick had brought the family computer into his room, which he did not permit anyone to enter. He littered the house with used paper tissues, sprinkled the floor of the bathroom with urine, defecated with an open door, and walked around the house naked, especially when his mother and sisters were around. Seating arrangements at meals and even the ordering of the servings were all rigorously prescribed by Nick. Martin, the father, was in charge of washing Nick's laundry, a task he had to perform according to a number of strict rules: Nick's laundry should not be mixed with that of anybody else, and Martin must take it out and fold it in a special order, putting each piece separately into its own nylon bag. The whole procedure had to be video-taped and dated, so as to make sure that all instructions had been followed to the letter. Nick's food was also purchased especially for him. Martin would take Nick to a supermarket of his choice, but Nick would often fight with the members of the staff, as he took only food from the rear of each shelf, causing a lot disorder. After such a conflict, the father would have to take him to a new supermarket. As all of the supermarkets in the vicinity had been exhausted, the father now had to drive farther and farther away to satisfy Nick's demands. Nick's food had to be kept and prepared according to exact stipulations. When he was not satisfied with the performance, the food was thrown to the garbage and the whole procedure had to be repeated. Martin was in charge of fulfilling the majority of the tasks imposed by Nick. If the day's performance was deemed lacking, Nick would wake up in the middle of the night and prevent everyone in the household from sleeping, sometimes for hours on end.

The parents were divided. Martin felt pity for Nick's difficulties, while Vivian wanted to get him out of the house. Martin's identification with Nick was abetted by the fact that he had also suffered from OCD in the past.

The therapist introduced the concepts of NVR to the parents and told them that it was imperative that the violence be stopped if there was to be hope for either Nick or the rest of the family. The therapist clarified the relationship between family accommodation and the course of OCD, explaining that giving in to Nick's demands might bring momentary relief, but at the price of greater violence in the longer term, and progressive worsening of the disorder.

Martin and Vivian wrote an announcement to Nick and were helped to recognize and avoid their typical escalation patterns. Predictably, Nick reacted negatively to their announcement, tearing it up, and spitting in his mother's face. Both parents remained resolute and stated clearly to Nick that their decision did not depend on his agreement. The next day, they placed a new page with the same announcement on the door of the fridge.

A meeting with ten supporters (all of them members of the extended family) took place in the therapist's office. Vivian feared that her parents-in-law would criticize her and blame her for Nick's situation. To her surprise, the therapist succeeded in convincing the supporters not only not to blame her, but also to actively cooperate. Over the course of 6 weeks, Martin became more and more willing to withstand Nick's commands. He now understood that resisting the impositions was something he undertook for his son and not against him.

Martin no longer bought food for Nick in special supermarkets. Nick tried to attack him, but Martin shut himself in his room and called the supporters. The grandfather who lived nearby arrived and Nick left the house in protest, staying away until late at night. When he returned to the house, he found to his surprise that both the grandfather and the grandmother were waiting for him. They spoke to him kindly, telling him that they did not blame him for obsessive fears but that violence against anyone, including his father was completely unacceptable. This happened again two other times (with the other grandparents and an uncle and an aunt). In each case, one of the supporters also stayed overnight. This led Nick to abstain from his usual punishment of keeping the family awake at night. Gradually, a new procedure was accepted, whereby Nick would get money from his parents and buy his food alone. The demands and impositions regarding the

laundry were also interrupted. There were no more videos, plastic bags, or separate washing. When Nick reacted with violence, the parents performed three sit-ins in his room. The first time an uncle sat with them, the other two times he was present in the house but in another room.

As Vivian had the most difficult relationship with Nick, the therapist encouraged her to perform gestures of reconciliation. It was not easy to convince her to do so, but ultimately she liked the idea that she would bake Nick the cake that he liked the most, leaving it on his night table with a short caring message. She felt that in this way she was showing strength in the very gesture of reconciliation (by entering his room). Nick threw the cake away, screaming at her that he did not want anything from her. She answered calmly that of course she could not force him to eat it, but that she remembered the pleasure that cake had once brought him, and how much she had liked baking it for him. On the third occasion that she did this, Nick protested, but ate the cake all the same. The therapist told Vivian that a piece of mother's cake in a son's stomach performs some good parental work, even if he grumbles.

After twelve weeks of therapy, the violence and the services had diminished considerably. There were no physical attacks, but there was still a lot of verbal abuse. The parents, however, learned to differentiate between the grosser and more humiliating remarks, to which they would react with documentation and involvement of supporters, and the more "normal" curses that would be ignored. The atmosphere at home was still heavy. Nick avoided addressing Vivian directly, speaking to her only through Martin. His OCD was still pronounced, but the family was now largely uninvolved. Martin said that Vivian was more able to acknowledge Nick's positive efforts. Vivian still thought that Martin was too accepting of Nick's negative behaviors, but she was also aware of the improvements. Both felt that they were still far from living like a normal family, but they no longer felt tyrannized.

DISCUSSION

The dissemination of NVR in many countries and its applicability to multiple settings and a variety of problems is possible because the method is a transdiagnostic treatment, resting on a small number of principles that address a common underlying problem (McHugh, Murray, & Barlow, 2009). Although specific treatment manuals have been developed, for example, for anxiety and OCD (Lebowitz, 2013; Lebowitz et al., 2014), violent and risk behaviors (Weinblatt & Omer, 2008), aggressive driving (Shimshoni et al., 2015), adult entitled dependence (Lebowitz, in press; Lebowitz et al., 2012), and foster parents (van Holen et al., 2015), the commonalities are large enough to allow for a relatively easy transition between different conditions. In addition, family therapists who have had a basic training in NVR report that its basic elements can be readily integrated with their own way of doing therapy (Wilson & Smith, 2014). Skills like antiescalation training, mobilization of supporters, the judicious use of transparency and publicity, reconciliation, and reparation steps, as well as NVR's more specific techniques (e.g., the announcement, the sit-in or the telephone round), have been used to enrich the work of therapists that describe their approach as multifamily, multisystemic, or structural. Those "borrowings" are both legitimate and desirable, as are adaptations of the approach to different settings, such as home treatment, institutions, and community. Thus, although NVR is a well-defined method, it is not meant to be a treatment that can only be administered by certified therapists who undergo strict supervision by equally certified supervisors.

We believe there is a common function that is served by NVR with the parents of children, adolescents, and young adults with various diagnoses and presenting complaints. NVR allows parents who are otherwise overwhelmed by the child's reactions to stabilize themselves, achieve better self-control, and become able to withstand the pull of their child's drives. The parents may then become able to fulfill an *anchoring function* (Omer, Steinmetz, Carthy, & von Schlippe, 2013). There is thus a similarity between the ability of parents to withstand a child's aggressive provocations, anxious reactions, or suicidal threats without being drawn into escalating acts or giving in to the pull of overwhelming emotions. The various elements of NVR (antiescalation training, resistance against destructive behaviors, reduction of inappropriate services, and use of a supportive network) allow the parents to anchor themselves in their parental ground and offer the child a stabilizing presence to counter his or her emotional storms.

Learning to focus on the parents' sense of agency, presence, self-control and support may thus be the chief abilities of an NVR therapist. The parents of children in the different conditions that are addressed by NVR are often affected by a kind of "negative hypnosis": Their attention seems to be totally absorbed by the child's adverse behaviors. Their speech is punctured by interjections ("He hits me!" "She screams!" "He panics!") or overwhelming questions ("What do I do if she runs away?" "What if he tries to kill himself?") that all but obliterate the fact that they are also agents in those interactions. When parents learn that they cannot control the child, but only themselves, that there is no immediate solution to crises, but only persistent attitudes that gradually reduce them, and that they cannot solve everything on their own, but can root themselves on their supportive network, the "negative hypnosis" and the problematic reactions diminish.

Thus, all the different elements in NVR lend weight and binding power to the parental anchor. This is not only a theoretical assumption, but a good way of communicating with the parents and unifying their treatment experience. Recently, we have developed a procedure for summarizing each treatment session for the parents with a short message that links the events in the session with the anchoring function. This allows for greater treatment unity, for more synergy between diverse treatment elements, and for the establishment of a common language between the different conditions and settings in which NVR is implemented.

A final caveat regarding the research that we have summarized. Although the number of studies is growing apace, only a few are random control trials. NVR is a relatively new approach and some of its applications (for instance, NVR for the parents of adults with entitled dependence, or with high-function autistic spectrum disorders) can only show a basic kind of evidence, such as assessment and follow-up of series of cases. In this respect, research in NVR finds itself between the early and ripe stages recommended for the development of evidence-based practice (Bruce & Sanderson, 2005). We hope this article may help stimulate research that will advance this evidence base.

NOTE

[1]Originally developed in Israel, NVR is widely known and practiced in many countries, especially in Europe. Dozens of local and four international conferences have taken place involving thousands of participants.

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