THE EFFECTS OF A SCHOOL-BASED COUNSELING PROGRAM ON THE SCHOOL SUCCESS OF EMOTIONALLY DISTURBED CHILDREN

by

Mia Kathryn Schroer-Lundeen

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STATEMENT BY AUTHOR

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APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Betty Newlon
Professor of Counseling and Guidance

Date

April 13, 1994
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ABSTRACT

The purpose of this study was to determine whether a school-based counseling program increases the school success of Emotionally Disturbed (ED) children who participated in the program. A non-randomized pretest-posttest design was employed measuring the dependent variables of perceived quality of students' behavior, perceived quality of family environment and ancillary services. Also utilization of intensive psychiatric placements, such as inpatient hospitalizations and residential treatment centers, was analyzed. The participants in this study consisted of 102 elementary and middle school aged children.

Findings indicated that the school success of ED children in this study was positively affected by participating in a school-based counseling program. Some improvement was noted in the perceived quality of students' behaviors and in some areas of the perceived quality of family atmosphere. Participation of ED children in the school-based counseling program serves as a valuable resource to address their emotional issues and increase their success in school.
CHAPTER 1
INTRODUCTION

Public schools in America are in crisis. Despite significant rhetoric concerning school reform over the past 10 years, little has changed (Kantrowitz, Wingert, Chideya, Springer, Rosenberg, & King, 1993). In fact, because schools are in such turmoil, education has become a permanent fixture on the national agenda. Recent reports continue to sketch a grim picture. Illiteracy is at an all-time high with more than 25 million Americans functionally illiterate (Kaplan, Wingert, & Chideya, 1993). Dropout rates for Caucasians and African-Americans remain at 12.5% (Kantrowitz et al., 1993), while dropout rates among Hispanics are 35.5% (Hispanic Dropout Rates, 1992). This is alarming considering 82% of America's prisoners are high school dropouts (Hodgkinson, 1989). Arizona has the second highest dropout rate for the fifty states, at 13.4% (Hispanic Dropout Rates, 1992).

Moreover, 67% of female high school dropouts are either pregnant or parents (Furstenberg, 1976; Strombino, 1987). Teen pregnancy rates continue to rise. Arizona's rate is 30% higher than the national average (Governor's Office for Children, 1988). Drug and alcohol abuse in schools has risen 25%, with one in 6 teenagers now suffering from a
severe addiction problem (Thorne & DeBlassie, 1985). School crimes, including homicide, rape, robbery, assaults and burglary are dramatically increasing, some by more than 85% (Kantrowitz et al., 1993).

Clearly, many of these school problems appear to be personal and interpersonal in nature. This is reflected in student attacks on themselves (e.g., abuse of alcohol and drugs, unplanned pregnancies, etc.), their peers and school staff (e.g., homicide, rape, robbery, etc.) and property (e.g., burglary, vandalism, etc.).

It is not surprising that 25% of students fear school grounds (Dade County Public Schools, 1976; Lalli & Savitz, 1976; Wayne & Rubel, 1982), especially considering that students are by far the most frequent victims of crime in the schools (Baker, 1986; U.S. Dept. of Justice, 1987; Christopher, Kurtz, & Howing, 1989). This is significant because students who report feeling afraid were found to receive lower grades and were more likely to rate themselves as below average in reading ability (Wayne & Rubel, 1982). Other studies have revealed that exposure to high levels of stress can cause damaging effects on memory, school performance and learning (Pynoos & Nader, 1988; Wayne & Rubel, 1982).

Although many educators and politicians have proposed a return to the “Basics” of reading, writing and arithmetic, it seems that the role schools now hold in our society is no
longer simply one of teacher. Schools have become police, parent, healthcare worker, friend, social worker and counselor because of the problems students bring with them to the school grounds. Today’s youth face a myriad of issues which interfere with their school performance because their emotional development is often not at a level to handle the severity or multitude of these issues.

Moreover, a majority of children now come from single-parent households which have increased by 200% since 1970, from 4 million to 8 million homes (Adler, 1994). The recession has compelled some children into the labor force to help their families survive. More than 5 million children between the ages of 12 and 17 now work, some more than 20 hours per week (Waldman & Springen, 1992). Studies have shown that students who work longer hours earn lower achievement scores, are more likely to use cigarettes and alcohol, get less sleep and are more likely to be truant (Waldman & Springen, 1992).

The stressors today’s youth must brave is astounding. Undeniably, even "normal" youth require a higher level of personal, psychological, social and intellectual development than ever before to successfully cope with the complexity of today’s school and world (Comer, 1980). While present-day adolescents report more problems than their parents or grandparents did during their teenage years, growing evidence reveals that they may be receiving less social and
emotional support than did adolescents in previous
generations (Christopher, Kurtz, & Howing, 1989).
Obviously, youth need much more help in interpreting,
integrating and utilizing the intensity of their environment
than ever before (Comer, 1984).

Most educators recognize that teaching and learning
cannot take place unless the harmful psychological and
behavioral effects of these problems are dealt with and
reduced (Comer, 1980). Some studies have reported slipping
standards by parents, teachers and schools because they
recognize the stresses on these children (Waldman &
Springen, 1992) which contributes to lower achievement.
Thus, if schools are to succeed in their mission, students’
social and psychological development must receive equal or
greater emphasis than coursework, especially if that is the
front-end cost of returning attention to academics in the
future (Comer, 1980).

Emotionally Disturbed Children

An emphasis on children’s social and emotional
development is particularly important for Emotionally
Disturbed (ED) children. These children are not as
developed socially and emotionally as other children their
age and their functioning levels are usually severely
impaired in regards to their role performance, thinking,
behavior toward others and themselves, and moods or
emotions. Typically, ED childrens’ behavior is so
inappropriate that it limits their ability to profit from a
regular classroom experience and can significantly hinder
other children from learning (Chandler, Weissberg, Cowen, &
Guare, 1984). Thus, ED childrens' school success is
generally poor.

Extensive research has demonstrated a relationship
between children's social and emotional competencies and
their positive learning functions (Rose, 1986; Strother &
One study found that if the emotional and interpersonal
difficulties are not addressed, a "spiral" can occur in
which others' perceptions of a child's behavior and the
child's self-perception interact, enhancing the likelihood
of the child's expecting and experiencing social failure
(Amerikaner & Summerlin, 1982). These children may then
feel frustrated, confused and angry (Novato, 1977). Because
these children are not particularly socially and emotionally
competent, these feelings may surface in other ways at other
times. The result may be violence, crime, substance abuse,
depression or self-destructive behaviors (Ellenburg, 1985;
McHolland, 1985; Renfron, 1985), all of which are of great
cost to the individual and to society.

Omizo and Omizo (1987) found that learning disabled
children continue to have difficulty in social and emotional
areas even after their academic performance improves. They
concluded that academic improvement tends to diminish over
time because of the continued social and emotional
difficulties. Thus, the need for school programs to help
children with emotional and social developmental problems is
justified both by research demonstrating associations
between school dysfunction and later mental health problems
(Cowen et al., 1973; Robins, 1979; Waldron, 1976; Werner &
Smith, 1977) and by the heavy financial and human costs of
later problems (Cass & Thomas, 1979).

Group Counseling

Professional counseling literature strongly advocates
the use of group counseling for the treatment of students
with special needs (Shechtman, 1993). The supportive
climate of the counseling group encourages self-disclosure
and sharing of feelings (Schaefer et al., 1982; Schiffer,
1984; Yalom, 1985) which are often lacking in poorly
adjusted children and which are essential to their well-
being (Widra & Amidon, 1987). Group counseling processes
are also linked to the enhancement of social competence,
intimate friendship and self-esteem (Shechtman, 1993).
Moreover, group counseling has been linked with positive
adjustment to school (Shechtman, 1993), by reducing problem
behaviors (Cobb & Richards, 1983) and improving children’s
attitudes toward school (Day & Griffin, 1980; Gerler, 1980).
With such benefits, group counseling may be one of the most
effective methods of helping children deal with their
problems (Ohlsen, 1970).
Many schools employ counselors to address these aspects of children's lives. With caseloads of 500 to 1000 students, however, school counselors quickly become overwhelmed in developing disciplining programs, in disciplining troubled students, and in performing liaison services between school, family, police, probation officers, etc. School counselors appear to have little time to provide counseling to even the most needy students. In fact, in one less troubled urban middle school, it was found that 10% of the students took 65% of the counselors' time (Comer, 1980). Thus, ED students' emotional problems are not addressed, they fall further behind academically which adds to their frustration and anger, which increases problem behaviors and perpetuates the cycle in which help will come only if a serious crisis develops.

Moreover, our political, social and economic institutions tend to expect the public schools to take on all these missions without adequate back-up resources (Comer, 1980). The Federal Government contributed 6.1 percent of the funds spent on kindergarten through twelfth grade education in 1989-90, a percentage point less than it provided in 1983 (Kantrowitz et al, 1993). This has increased the burden on states and local districts during a time when the recession, new immigrants and poor children have strained their resources.
Because the primary mission of schools is to teach academics, however, ED children have been placed in special classrooms, but with little or no therapeutic interventions until a significant crisis develops. With the passage of the Education for All Handicapped Children Act in November 1975, public schools must provide appropriate education in the least restrictive environment, an environment as close to the regular classroom environment as possible (Association for Advanced Training, 1990). This includes education for ED students.

**Interagency Collaboration**

Additionally, it would seem that large infusions of new funds for educational or social programs are not forthcoming from any level of government. That being the case, schools must now get more mileage out of the resources they have. Research indicates that emotional problems can be treated less expensively and more effectively on an outpatient basis (Kiesler & Sibulkin, 1987) especially group counseling which lends itself to the efficient use of increasingly restricted resources (Collins & Collins, 1994). If all current funding dollars were re-allocated through a decrease in inpatient services and directed toward consultation and education efforts in community, a much greater percentage of those requiring services would have access to appropriate alternatives (Werner & Tyler, 1993). Thus, a more comprehensive range of children’s services would be
established (Christopher et al., 1989). The cycle in which children who do not receive services and, as a result, require higher intensity and frequency of services because of their more serious psychological problems would partially be curbed.

One avenue some schools are taking to stretch their dollars and meet their students' need is interagency collaboration. These projects are becoming more widespread because of their successes (Goodman & Kjonaas, 1988; Hodgkinson, 1989). Interagency collaboration seems particularly well-suited for schools and mental health agencies because their individual endeavors overlap. For instance, even though the school and the family are separate systems, there does exist a relational aspect between them: the child is a part of both systems. Therefore, a dysfunction in either system is likely to be felt in the other through the child (Cimmarusti, James, Simpson, & Wright, 1988). Indeed, improvements in one area can actually improve other areas simultaneously (Hodgkinson, 1989).

Thus, although schools' primary mission is education, they now have a greater interest in the social and emotional well-being of children because without some level of social and emotional competence, learning cannot occur. On the other hand, mental health agencies are primarily concerned with the emotional well-being of children, but have an
interest in helping reach children at an early age to deal with school maladjustment and behavior problems.

Additionally, school- and clinic-based counselors working in concert may have a chance to improve treatment outcomes by coordinating interventions across school and home settings (Conoley & Conoley, 1981). Several studies report that appropriate coordination of services has several beneficial results which may include a decrease in recidivism and rehospitalization (Jemerin & Philips, 1988). Moving from agency to agency and service to service the client may lose gains made in one program as new goals and approaches are implemented without adequate transition (Werner & Tyler, 1993).

Additionally, if counseling can take place at school and during school hours, children are more likely to receive the services they need. Often, families find it difficult to participate in counseling services because of geographical accessibility, transportation problems, costs, child care and time constraints. Therefore, these problems would be less likely to interfere with the delivery of services to the child.

A School-Based Counseling Program

One such school-based counseling program has been implemented on a comprehensive basis in one county in the southwestern United States. It is designed to provide a variety of therapeutic interventions to ED children, their
families and teachers during school hours at local schools. Services include individual, group and family counseling, assessment and evaluation, home-based services, parenting classes and teacher consultation. The goal of the program is to improve the social functioning in the school and home environments, to improve peer relationships, to improve the ability to learn, and to prevent the necessity for more intensive levels of care. Individualized treatment plans are devised for each student to improve the chances of their success.

This integrated approach ensures a greater percentage of children will be able to receive services prior to more serious psychological problems developing. Because this is the first year of the program, it is especially important to determine the overall level of success and to gather information that may be used to modify the program in the future to increase its effectiveness.

Purpose of the Study

The purpose of this study was to determine whether a school-based counseling program implemented in local elementary and middle schools, increased the school success of ED children who participated in the program.

Hypotheses

The following research hypotheses were tested in this study:
Hypothesis 1: The children participating in the school-based counseling program will demonstrate a significant improvement over a five month period in their behavior as perceived by their teachers (as measured by the Behavior Rating Profile-2/Teacher Rating Scale).

Hypothesis 2: The children participating in the school-based counseling program will demonstrate a significant improvement over a five month period in their behavior as perceived by their parents/guardians (as measured by the Behavior Rating Profile-2/Parent Rating Scale).

Hypothesis 3: The children participating in the school-based counseling program will demonstrate a significant improvement over a five month period in their behavior as perceived by themselves (as measured by the Behavior Rating Profile-2/Student Rating Scale).

Hypothesis 4: The parent or guardian of the children participating in the school-based counseling program will demonstrate a significant improvement over a five month period in the perceived quality of their family environment (as measured by the Family Environment Scale).

Hypothesis 5: Utilization of intensive psychiatric placements, such as inpatient hospitalizations and residential treatment centers, will decrease during a three month period compared to the same three month period in the previous year.
Significance of the Study

Because a large infusion of new funds for social programs do not appear to be forthcoming from any level of government, agencies need to get more mileage out of the resources currently available. In the present study, schools, mental health funding agencies, mental health service providers and schools teamed together to ensure that mental health services were more readily available to ED children. This project, if successful, can stretch dollars in both arenas while working towards achieving their individual goals. If children deal with emotional issues in less restrictive settings and prior to more serious psychological problems develop, mental health costs decrease (Cass & Thomas, 1979). Also, if children deal with emotional issues, learning can occur. Thus, it is potentially a "win-win" solution for school, mental health agencies, and most importantly, the children.

The need for school-based programs is justified both by research demonstrating associations between early school dysfunction and later mental health problems (Cowen et al., 1973; Robins, 1979; Waldron, 1976, Werner & Smith, 1977) and by the heavy financial and human costs of later serious problems (Cass & Thomas, 1979). By offering group counseling during school hours to ED children, more serious mental health problems may be prevented from developing later on in these children's lives (Chandler et al., 1984).
Assumptions

In this study, it was assumed that:

1. The participants voluntarily completed the questionnaires.
2. The participants answered the questionnaires candidly and objectively.
3. The participants can read, write and understand English.

Limitations

The limitations of the study were:

1. The sample was not a national sample and was limited to a specific population in the Southwest.
2. Results of this study may not be generalizable to other ED children.
3. Because of ethical standards requiring parental and adolescent permission, the representativeness of the sample may be jeopardized.

Definitions

The following terms will be used throughout the study and are included for clarification and explanation.

Child and Adolescent Functional Assessment Scale (CAFAS): Children are screened for eligibility for either case management or case monitoring services on the Child and Adolescent Functional Assessment Scale (CAFAS) (Appendix A) which assesses the functional impairment, rated as severe, moderate, mild or average. The CAFAS scores role
performance, thinking, behavior toward others/self, moods/emotions, substance abuse, caregiver resources/basic needs, and caregiver resources/family social support. If any one item listed under a category of impairment describes the youth's functioning, the youth qualifies for a rating in that category. Depending on the rating of severe, moderate, mild or average, a youth scores points of 30, 20, 10 or 0.

In order to meet eligibility for case management services, a child must have a principle diagnosis on Axis I and meet either:

1. Total CAFAS score of 90 or higher; or
2. a. Axis IV score of 3 or higher; and
   b. Axis V score of 50 or less; and
   c. The child requires an intensive level of behavioral health treatment in order to prevent decompensation or restore adequate level of functioning.

In order to meet eligibility for case monitoring services, a child must have a principle diagnosis on Axis I and a CAFAS score of below 90.

Counselor: Counselor refers to a person who has attained a master's degree in counseling, or a related field and who is trained to facilitate the group counseling process with children in the school-based counseling program defined below. This person helps these groups of children gain self-understanding and understanding of others
in order to solve problems more effectively and resolve conflicts in everyday living. The counselor will utilize a variety of interventions and modalities described more fully in the definition below.

**Non-Severely Emotionally Disturbed (Non-SED) Children:**
Non-SED children are those diagnosed as having significant emotional problems which slow their learning abilities and impair their functioning level. These emotional problems are not severe enough to qualify these children for case management services. These children receive case monitoring services, a less intensive monitoring program. In order to meet eligibility, a child must have a principle diagnosis on Axis I and have a total CAFAS score of below 90.

**School:** School refers to public elementary and middle schools.

**School-Based Counseling Program:** School-based counseling program refers to a collaboration effort between school districts, mental health funding agencies and mental health service providers. This program has been implemented by the mental health funding agency, in which community services providers go into local elementary and middle schools and provide group, individual, family and parenting classes primarily to severely emotionally disturbed children who qualify for funding for such services through the Arizona Health Care Cost Containment System (AHCCCS). However, as a service to schools, providers agreed to
include other children who teachers believed were in need of mental health services as a free service. Parenting seminars were a free service provided by the service provider also.

**School Success**: School success is measured by three types of data: behavior data, family data and utilization of intensive psychiatric placements, such as inpatient hospitalizations and residential treatment centers.

1. The Behavior Data will be collected using the Behavior Rating Profile-2 (BRP-2) and measures a child's behavior from three perspectives: the teacher, the parent and the child. If the program is successful, the following changes should be evident at posttest: the scores of participants should be closer to the normed average, and fewer problem behaviors should be identified by parents and teachers.

2. The Family Data will be collected using the Family Environment Scale (FES). This data should provide insight into whether a program designed to improve the school success of ED children will also have positive effects on the family environment.

3. The utilization of intensive psychiatric placements data will be reviewed to provide insight into whether a school-based counseling program has decreased the need for more intensive treatment. If the program is successful, the following trend should
be seen in the psychiatric placements: participants should require less intensive psychiatric intervention.

Severely Emotionally Disturbed (SED) Children:
SED children are those diagnosed as having significant emotional problems which slow their learning abilities and impair their functioning level. In order to meet eligibility for case management services, a child must have a principle diagnosis on Axis I and meet either:

1. Total CAFAS score of 90 or higher; or
2. a. Axis IV score of 3 or higher; and
   b. Axis V score of 50 or less; and
   c. The child requires an intensive level of behavioral health treatment in order to prevent decompensation or restore adequate level of functioning.

Summary

The purpose of this chapter was to provide a basis for the hypotheses under consideration. The need for school-based programs is justified both by research demonstrating associations between early school dysfunction and later mental health problems and by the heavy financial and human costs of later serious problems. By offering group counseling during school hours to ED children, their school success may increase and more serious mental health problems may be prevented from developing later on in these children’s lives.
CHAPTER 2
REVIEW OF THE LITERATURE

This chapter begins with a brief discussion of the need for school programs designed to increase the school success of Emotionally Disturbed (ED) children by fostering their emotional and social development. A review of the literature concerning the effects of group counseling on ED children is presented. Next, literature which discusses the effects of group counseling effects on academic performance, the family, and behavior, is reviewed.

Introduction

Today's children are faced with a highly complex and technological society. To successfully cope with that complexity, they require a higher level of personal, psychological, social and intellectual development than any generation before them (Comer, 1980). However, evidence reveals that youth are receiving less emotional and social support than children in previous generations (Christopher et al., 1989) in part because of the disintegration of the family. However, even though today's children are no more mature than in the past, they are forced to make many more decisions about their conduct and purpose than children did in the past.

With such high levels of stress, many young people respond in ways harmful to themselves and society as they
try to make it in our complex world with insufficient emotional, psychological, and social support systems (Comer, 1980). Drug abuse, unplanned pregnancies, violence and crime are just some of the many harmful ways that children are responding to life's complexities.

These responses become problematic for our schools because teaching and learning cannot take place unless the psychological and behavioral effects of these responses are dealt with (Comer, 1980). In fact, the majority of children who "act out" in the classroom are ED children or those children who are experiencing serious emotional problems. This behavior often disrupts entire classrooms and hinders the learning of the ED child as well as his/her classmates (Rose, 1986; Strother & Barlow, 1985; Wade, 1984; Warnache, 1981; Wittrock, 1986).

ED children are often segregated in special classrooms, but receive little, if any, counseling to deal with their serious emotional problems. With no treatment, their problems only worsen and the result may be continued ineffective responses (Ellenburg, 1985; McHolland, 1985; Renfro, 1985), delayed academic achievement (Omizo & Omizo, 1987), and more serious psychological dysfunction later in their lives, possibly developing a chronic mental illness. Undoubtedly, it becomes increasingly important that schools develop programs to improve the emotional and social development of ED students if they are to improve the
education of all their students and to reduce the more serious behavior problems such as drug abuse, violence and crime.

**Group Counseling**

Professional counseling literature strongly advocates the use of group counseling for the treatment of students with special needs (Bowman, 1987; Larrabee & Terres, 1984; Schaefer et al., 1982; Schiffer, 1984). Gottlieb (1983) found that group counseling enhances the health and adjustment of maladjusted students by lowering physical arousal and counter-balancing the effects of stress. According to Rose (1985), group counseling facilitates the coping responses of these students as well.

Poorly adjusted children often lack the comfort and ability in sharing feelings and in self-disclosing. The group counseling process provides a supportive climate in which these children are encouraged to self-disclose and to share their feelings (Schaefer et al., 1982; Schiffer, 1984; Yalom, 1985). Consequently, recent research has linked group counseling to the enhancement of social competence, intimate friendship and self-esteem (Anderson & Bauer, 1985; Omizo & Omizo, 1988; Rose, 1985; Shindi, 1988). With such benefits, group counseling is one of the most effective methods of helping children deal with their problems (Ohlsen, 1970).
Group counseling also lends itself to the efficient use of increasingly restricted resources (Collins & Collins, 1994). Using the group process, more children who need services can receive treatment for less cost (Werner & Tyler, 1993). Additionally, evidence exists which indicates that children seen years earlier in a group counseling intervention for children experiencing school adjustment problems were found to have maintained initial intervention gains (Chandler et al., 1984). This evaluation included teacher ratings of children's school adjustment problems and competencies, a self-report measure of perceived competence, and academic achievement indexes (Chandler et al., 1984). Clearly, utilizing group counseling as preventative or early intervention treatment is justified because it can break the costly cycle in which ED children develop more serious psychological problems, which in turn creates more "acting out," less learning, and a need for more intensive, more costly interventions.

Moreover, when group counseling is provided at school during school hours, children are more likely to receive the services they need because family problems, such as transportation and time constraints, are eliminated. In fact, treatment outcomes will improve when school- and clinic-based counselors work together to coordinate their services (Conoley & Conoley, 1981).
Obviously, the group counseling process is a vital part of the treatment for ED children. Its advantages include cost effectiveness, long-term gains for the children, the increase of self-esteem, the development of coping and social skills, the improved coordination of services between agencies, and the prevention of serious psychological problems such as chronic mental illness.

School Success

School success is a function of many factors. Lazarus (1985) has argued that learning and cognition are affected by what happens in all domains of the whole human functioning. He delineates the domains with the acronym "BASIC ID," which stands for behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology. Research has shown that to promote cognitive development and success in school, students should be provided with classroom experience that stimulates growth in a variety of these domains (Gerler, 1990).

Additional research has supported those findings. School success has been increased through affective education (Wirth, 1977), interpersonal communication training (Asbury, 1984), imagery/relaxation training (Danielson, 1984; Omizo, 1987) and self-esteem training (Gerler, 1990). Determining school success can be measured in multivariate manners as well. In this study, three domains were chosen to determine school success of ED
children: academic performance, family and behavior. It is believed that these three factors are the fundamental elements for school success.

Academic Performance

Extensive research has demonstrated a relationship between children’s social and emotional competencies and their positive learning functions (Rose, 1986; Strother & Barlow, 1985; Wade, 1984; Warnache, 1981; Wittrock, 1986). Thompson (1987) studied the academic performance of underachievers. According to her, school learning is a function of several factors, including motivation, ability, intensity of instructional focus, amount of instructional focus, the social-psychological climate of the classroom, and the stimulation of the child by parent(s) in the home environment. However, she believed that motivation is the fundamental condition necessary for learning and that increasing other factors, such as the amount of instruction, will be useless if motivation remains at low levels.

As a result of this multidimensional definition, in her study, intervention strategies were used to deal with all of these factors except the home environment. Underachieving students in the treatment group participated in multidisciplinary intervention strategies. The findings indicated that students who participated in the treatment group demonstrated a significant improvement in grade point
average and attendance at the p<.006 level when compared with the control group (Thompson, 1987).

Wilson (1986) reviewed professional counseling literature to evaluate the effects of counseling interventions on the grade point average (GPA) of underachieving or low-achieving students in elementary, middle and high schools. In her review, underachievers were those students who demonstrated a discrepancy between their ability and academic performance as measured by standardized tests and GPA. Low-achievers were those students who failed at least one academic course and were referred by their teacher.

Wilson (1986) summarized her findings of programs associated with improved achievement. Characteristics of these programs included group rather than individual counseling, lengthy rather than brief treatment, directive and behavioral rather than person-centered approaches, voluntary rather than non-voluntary participation, and parental involvement. Research supporting her conclusions include studies which found significant improvement in the GPA of students who participated in experimental groups (Altmann, Conklin & Hughes, 1972; Esters & Levant, 1983; Ladouceur & Armstrong, 1983).

Achievement scores have also been shown to improve for children who exhibit disruptive behaviors at least once daily which interferes with their own learning or the
learning of others (Downing, 1977). Sixth-graders who participated in groups for one hour weekly for ten weeks showed significant improvement in their achievement scores at the p<.05 level when compared to the control group.

Another study examined the effects of small-group therapy on school performance, specifically achievement in learning functions (Shechtman, 1983). Poorly adjusted children who participated in this study were Israeli, elementary students who had been referred by faculty owing to a variety of emotional, social, behavioral, or learning difficulties. Characteristics of these children included inattentiveness, restlessness, unmotivation, aggression, all which posed many disciplinary problems.

The counseling intervention was based on a developmental model that emphasized interrelations. The treatment group shared personal difficulties, addressed interpersonal group conflicts, and discussed out-of-group problems involving peers, teachers, and family. Self-expressiveness and self-disclosure were highly encouraged, and communication skills for the provision of support, empathic understanding, and constructive feedback were deliberately promoted. Group counseling lasted 45 minutes, one time per week, for seven months.

Results indicated that grades in reading comprehension and mathematics improved significantly (p<.01) in the experimental group. Additionally, teachers thought that, in
comparison with the control group, the students in group
counseling had gained in mental ability. Improvement in
reading scores in the experimental group were almost
significant, whereas grades in English tended to decrease in
both groups. Shechtman (1993) explained this decline in
English scores as the tendency of teachers to be generous
with grades at the beginning of the school years, so as to
encourage effort in mastering a new language.

Many disabled readers exhibit evidence of emotional
maladjustment (Divine, 1975; Hammer, 1970; Simonds, 1974),
similar to ED children, including poor self-concept and
excessive levels of anxiety. The role of emotional
maladjustment as a cause or effect of reading disability,
however, is non-conclusive (Lewis, 1984). In one study,
reading disabled third-, fourth-, fifth-, and sixth-graders
participated in structured or nondirective counseling groups
for a total of eight 40-minute sessions over a period of 4
weeks (Lewis, 1984). Lewis (1984) found that the structured
program did produce significantly greater gains in reading
comprehension than the non-directive program. Positive
gains in self-concept, trait-anxiety and state-anxiety were
also found, though these were not significant.

Another study designed to study academic performance in
disturbed children used developmental play as its group
counseling method (Brody, Fenderson, & Stephenson, 1976).
Developmental play is a program designed to help children
who are experiencing personal detachment and other emotional, social or learning difficulties by the development of positive, loving interactions and attachments with important adults. They found an increase in these children's intelligence scores by an average of 7 points. SED children have also demonstrated a significant improvement in their self-perceptions of academic competence as well (Lavoritano & Segal, 1992).

Thus, the review of the literature demonstrates that school-based group counseling is successful in improving GPA, grades, achievement scores and intelligence test scores in maladjusted or ED children. The literature also emphasizes that many modalities are effective in increasing the academic performance of SED children.

Family

Many of the families of ED children, and the children themselves, tend to be isolated and without functional support systems while dealing with a myriad of stressors (Egeland & Aber, 1991). Family relationships are often unstable, chaotic and/or dysfunctional. Many of these families are impoverished and have life circumstances which make it difficult for their children to acquire the skills necessary for success in educational settings (Egeland & Aber, 1991). Many parents have to focus their energies on the attainment of basic needs with little time to
However, the involvement of parents in their children's education is essential to effective schooling (Comer, 1991). When the family-school link is strong, this link helps the child to develop academically and socially. When such ties are absent, which is true for many ED children, children are at a disadvantage (Comer, 1984; Egeland & Abery, 1991). Only when these two institutions work together are the best results achieved.

Systemic theories of psychotherapy assert that the family maintains the symptoms of its members, and, in fact, is maintained by the symptoms (Gunn & Fisher, 1989). For example, if a child is depressed and withdrawn, a family therapist would view this as a family problem. According to family therapists, symptoms develop when family patterns of interaction are dysfunctional and help the family maintain its homeostasis.

Under this theoretical perspective, an appropriate intervention would be to break this continual cycle where the symptom is maintained by the family and vice versa at any point in the chain. Thus, if the child is provided with group counseling to reduce his/her depression and withdrawal, the family will readjust and the family members' ability to function in the new context can be experienced. It is most effective in alleviating a symptom to break the
chain at as many points as possible. For instance, in the above example, a child would receive the group counseling, while the parents attend parenting classes and the entire family participates in family counseling.

Therefore, making changes in one system surrounding a troubled child can cause resultant changes in other systems surrounding that child. Esters and Levant (1983) found that when parents of children attended one of two types of parenting groups, their children demonstrated significantly higher GPAs than for children in the control group. Thus, a change in the parents seems to cause resultant changes in the children.

Polirstok (1987) found significant differences in self-concept scores at the p<.05 level for students whose parents participated in a project designed to include a home intervention component, a school-based support group component, and a community component. It appeared that lessening aversive interactions between parents and their children resulted in diminished negative self-referent statements made by target children and improved their overall self-concepts. Moreover, project children also differed significantly at the p<.05 level in terms of attending school regularly.

Additional research in family therapy has also found positive results. Juvenile delinquency and family therapy has been extensively studied by James Alexander (Alexander &
Parsons, 1973; Klein, Alexander, & Parsons, 1977; Parsons & Alexander, 1973). Families treated using functional family therapy improved significantly in communication and showed a lower rate of recidivism (26% than other treatment modalities (47% for client-centered, 50% for untreated persons, and 73% for dynamic-eclectic therapy approaches).

Patterson (1982) studied conduct disorders involving aggressive behaviors (e.g., physically violent) and nonaggressive behaviors (e.g., stealing) utilizing parenting groups. Results indicated significant changes in both child classroom and in-home behaviors.

Therefore, the literature supports the systems theoretical perspective which asserts that a change in the school system in which a child is a part, affects his/her family as well, and may improve family functioning. Thus, if a child is symptomatic and is provided with group counseling which eliminates that symptom, the family should experience a change in functioning.

Behavior Problems

Children who are labeled as ED often demonstrate serious emotional and behavior disorders, including hyperactivity, distractibility, impulsivity, emotional lability, low self-esteem and poor social skills (Bryan & Bryan, 1977; Leviton & Kiraly, 1979; McCarthy & McCarthy, 1970). Such disruptive behavior in the classroom is a continual source of frustration and stress for students,
teachers and administrators, and adversely affects these relationships. In fact, some studies suggest that aggressiveness correlates with inadequate school adjustment and low academic performance (Coopersmith, 1959; Wittmer & Myrick, 1980).

ED children who display inappropriate behaviors in the classroom often do so as a result of feeling frustrated, confused and angry (Novato, 1977). Children are often punished for such behaviors, but are not provided with a means of coping with their angry feelings. But punishment does not make the feelings disappear. Their feelings will often surface in other ways and at other times (Omizo, Hershberger & Omizo, 1988).

Omizo et al. (1988) developed a group counseling intervention strategy to assist children in coping with anger. Fourth-, fifth- and sixth-graders participated in ten sessions which lasted 50 minutes each. These groups incorporated cognitive, behavior techniques, role playing, and positive reinforcement. Omizo et al. (1988) found that children who participated in the counseling had significantly decreased their aggressive and hostile behaviors as rated by their teachers on the Aggression and Hostile Isolation Subscales of the School Behavior Checklist (Miller, 1981). Additionally, the principal reported that children in the experimental group were sent to the office
for disciplinary actions less often as well (Omizo et al., 1988).

Amerikaner and Summerlin (1982) studied the effects of group counseling on the classroom behavior and self-concept of learning disabled first- and second-grade students. Learning disabled students often demonstrate many of the same behavior problems as ED children (Bryan & Bryan, 1977; Leviton & Kiraly, 1979; McCarthy & McCarthy, 1970). In their study, two group counseling approaches including social skills and relaxation training. They found the subjects who participated in the relaxation group received lower "acting-out" scores than other subjects. Subjects who participated in the social skills group demonstrated higher social self-esteem scores. Clearly, children's group experience has beneficial effects in terms of the classroom teachers' perception of their behavior.

Children's disruptive behaviors and their self-esteem were also studied in a seven week play group for third-graders (Bleck & Bleck, 1982). Participants showed a significant improvement in their behavior and self-esteem.

Teachers often find themselves expending considerable amounts of time correcting children's inappropriate behavior and losing instruction time. As mentioned previously, Downing (1977) studied sixth-graders who exhibited disruptive behaviors. Pretest data was collected including achievement scores, a summary of the child's attendance
records, and a teacher's report of the classroom behavior. Results indicated that children involved in the treatment program attended school at the rate 6% higher than did the control group and teachers reported all children who participated in the treatment group improved in their social behavior in the classroom. The measured achievement levels of the treatment group were significantly better than the control group, as well.

Self-esteem and locus of control can also be positively affected by group counseling (Omizo & Omizo, 1987). In their study, groups were designed to eliminate self-defeating behaviors, which were defined as any thought, feeling or action that is ineffective and recurring. The purpose of their study was to evaluate how eliminating self-defeating behaviors would affect self-esteem and locus of control in learning disabled children who often possess low self-esteem and an external locus of control (Bryan & Bryan, 1977; Cruickshank, Morse, & Johns, 1980; Leviton & Kiraly, 1979). A more internal locus of control has been shown to be related to many other variables of positive adjustment (Omizo & Omizo, 1988). This is especially important for learning disabled children who believe they do not have much control (Omizo & Omizo, 1988). Omizo and Omizo (1988) found that subjects in the treatment group showed significant improvement in their self-esteem and had a more internal
perception of locus of control than did control group subjects.

Gerler and Anderson (1986) studied the effects of classroom guidance on children’s classroom behavior, their attitudes toward school and achievement in language arts and mathematics. Results indicated that children in the treatment group improved significantly on classroom behavior and on a measure of attitude toward school as compared to the control group. However, no significant differences in language and math grades were indicated between the treatment and control groups.

Another study mentioned above (Shechtman, 1993) examined the effects of small-group therapy on school adjustment, including school performance, attitudes towards peers, and behavior, as observed by teachers (Shechtman, 1993). Results indicated that children who underwent such counseling were viewed more positively by teachers and displayed improved relationships with peers and teachers alike. Furthermore, clear progress was made in their overt behavior and was significant when compared to the control group. Most impressive was the reduction in the number of behavioral problems or symptoms by more than half the children after experiencing group counseling. Aggression, disciplinary problems and absenteeism were all reduced.

Thus, the literature strongly supports group counseling as a way to significantly decrease problem behaviors in ED
children. Most of these studies have measured the decrease in those behaviors, as rated by their teachers and principals. Behaviors which were decreased included aggressive behaviors, detentions and acting out. Consequently, the literature also supports group counseling as a way that these children will also experience higher self-esteem, a better attitude about school and their peers, and will develop a more internal locus of control. Research also indicates that children who participate in these groups will attend school at a higher rate.

Summary

This chapter began with a discussion about the need for school programs which improve the school performance of ED children by fostering their emotional and social development. Literature concerning group counseling and its effects on ED children was then reviewed. Last, a review of the literature concerning the effects of group counseling on academic performance, the family and behavior was presented.
CHAPTER 3

METHODOLOGY

The purpose of this study was to determine whether a school-based counseling program implemented in local elementary, middle and high schools, increases the school success of Emotionally Disturbed (ED) children who participated in the program. This chapter discusses the methodology of this study and includes a description of the participants, procedures, research design, instrumentation and data analysis.

Introduction

ED children are often placed in special education classrooms because they possess a variety of emotional, social, behavioral or learning difficulties which often interfere with their ability to remain in mainstream classrooms. Although these children are labeled as having emotional problems, they are not routinely provided with therapeutic interventions because of limited funding for counseling within school districts. Those children who have been referred to the public mental health sector often drop out of services due to a variety of reasons including poor geographical locations of clinics, their limited hours of operation, a family's lack of resources, including money and transportation, and their lack of motivation.
In the past, children have not been provided with appropriate interventions until a crisis situation develops, necessitating the use of intensive interventions such as inpatient hospitalization. Not only is this a costly intervention, such an intervention also interferes with a child’s school attendance which may cause the child to fall further behind in his/her learning, thus adding to the stress a child may experience.

The school-based counseling program in this study was designed to make mental health services more readily available to ED children by offering a variety of therapeutic interventions to these children and their families during school hours at local schools. The program was developed by the Regional Behavior Health Authority (RBHA) for Pima County, in Southern Arizona, a non-profit corporation designated by the Arizona Department of Health Services to provide or arrange for the provision of behavioral health services to eligible populations within the county (Appendix B).

This "front-loaded" approach was designed to decrease the utilization of costly, intense services, such as inpatient hospitalization or day programs. It was also designed to reach needy children prior to the onset of more serious problems while alleviating behavior problems in the classrooms which interfered with teaching and learning. The
RBHA and local school districts agreed that this collaboration effort would be mutually beneficial.

**Participants**

The participants for this study consisted of elementary and middle school aged children who were labeled as ED, had been placed in special education classrooms, and whose parents or guardians consented to treatment in the school-based counseling program. Thirty-five elementary aged children (34 boys and 1 girl) and 62 middle school aged children (58 boys and 9 girls) participated. Because of the multi-dimensional definition of "school success" used in this study, participants also included at least one of the children’s primary caregivers (e.g., parent or guardian) and their Special Education teachers.

All children and their parents or guardians were screened for eligibility for special funding. Regardless of financial eligibility, however, all referred students were given the opportunity to participate if their parents or guardians consented to treatment.

As part of the initial screening, demographic information was gathered about the children and their families at the pretest assessment point. The data included the children's age, sex, education level and ethnicity, as well as the family income.
Procedures

Initial contact was made with the school districts and approval for the study was obtained from the Human Subjects Committee of the University of Arizona (Appendix C). An appropriate parent Consent Form (Appendix D) and student Assent Form (Appendix E) were developed.

At the time when parents were initially screened for eligibility, a brief description and explanation of the study was given. It was also explained to the parents that all information on the questionnaires would be confidential and anonymous. The questionnaires were numerically coded and the parents were provided with envelopes in which to seal their questionnaires to guarantee confidentiality and anonymity.

The Behavior Rating Profile-2 (BRP-2)/Parent Rating Scale (Brown & Hammill, 1990) (Appendix F) and a modified version of the Family Environment Scale (Moos, 1974) (Appendix G) were self-administered by the parents. The total time for completing both questionnaires was 20-30 minutes.

Prior to treatment, the children and teachers were presented with the same description and explanation of the study. It was explained to the students that the information on the questionnaires would be confidential and anonymous. The questionnaires were numerically coded and the participants were provided with envelopes in which to
seal their questionnaires to guarantee confidentiality and anonymity.

The BRP-2/Student Rating Scale (Appendix H) was administered to the students by their teacher. The total time for the students to complete the questionnaire was 20 minutes. The BRP-2/Teacher Rating Scale (Appendix I) was self-administered by the teachers. The total time for the teacher to complete the questionnaire was 5-10 minutes for each student.

Treatment then began. The counseling program utilized in this study was provided by two, large mental health clinics which contracted with the RBHA to provide services within the schools. These services included intake assessment and evaluations, group therapy, individual therapy, family therapy, and home-based services. Children and their families were able to participate in the interventions as needed. In addition, the providers agreed to offer teacher consultation as needed and monthly parent training seminars for all parents within the school, not limited to parents of ED children.

Although not all participants received identical therapeutic interventions, all participants took part in group therapy. The goal of the groups was to improve social functioning in the school and home environments, to improve peer relationships and the ability to learn, and to prevent the necessity for more intensive levels of care. Groups
were designed to address the behavioral and emotional problems manifested by the students, including issues such as poor impulse control, anger management, emotional withdrawal, social isolativeness, physical and verbal aggression. Groups included a variety of interventions such as role play, art therapy, therapeutic games, as well as process to address issues.

All groups were facilitated by master's level therapists. Groups were made up of no more than 8 students. Teachers were encouraged to participate in the group process to help provide information and to be interactive.

After five months of treatment, the parents were re-administered the Family Environment Scale and the BRP-2/Parent Rating Scale when they attended parent-teacher conferences. The students and teachers were re-administered the BRP-2/Student Rating Scale and BRP-2/Teacher Rating Scale respectively.

Again, it was explained to the participants that the information on the questionnaires would be confidential and anonymous. The questionnaires were numerically coded. The participants were provided with envelopes in which to seal their questionnaires.

Research Design

The research design utilized in this study was a non-randomized pretest-posttest design (LoBiondo-Wood & Haber, 1990) as follows:
This quasi-experimental design differs from a true experimental design in that random assignment of subjects to groups does not occur. LoBiondo-Wood and Haber (1990) suggest that the quasi-experimental design is often the best choice when random assignment is not possible. In the present study, random assignment was inappropriate because the RBHA did not want to deny services to any of the referred children and participants were self-selected.

Instrumentation

The instruments used for this study were the BRP-2/Parent, Student or Teacher Rating Scales and a modified Family Environment Scale (FES). The BRP-2 was appropriate for this study because the overt behaviors of ED children provide an excellent index of the students' personal and social adjustment. Most behavior checklists focus on a single environment in which the child functions - usually
school - and ask a single respondent to complete the checklist - usually a teacher.

The BRP-2, however, is a norm-referenced battery of six instruments designed to evaluate students' behavior at home, school and in interpersonal relationships, and solicits the varied perspectives of parents, teachers, peers, and the target students themselves. It is designed to assess children aged 6 1/2 through 18 1/2 years. Five of the instruments are rating scales: the Student Rating Scales for Home, School and Peer; the Teacher Rating Scale; and the Parent Rating Scale. The sixth instrument is a Sociogram, but was not utilized in this study.

The BRP-2/Student Rating Scale. The Student Rating Scale is a 60-item instrument in which students are asked to describe their own behavior by responding "True" or "False" to each item. Each item is a sentence describing behaviors of the student. This scale is inclusive of the three 20-item scales for home, school and peer. Scores indicate an estimate of a child's personal and social adjustment in the home, school and interpersonal arenas.

Norms for the Student Rating Scale were based on a total of 2,682 students aged 6 1/2 through 18 1/2 years of age in 26 states. The normed samples included people from a variety of ethnic backgrounds.

The BRP-2/Teacher Rating Scale. The Teacher Rating Scale is a 30-item scale which is usually completed by one
or more of the instructors who have the target student in their classes. Each item is a sentence describing behaviors that may be observed at school. The respondent classifies each item as "Very Much Like the Student," "Like the Student," "Not Much Like the Student," or "Not At All Like the Student." Scores indicate an estimate of a child's personal and social adjustment.

Norms for the Teacher Rating Scale were based on a sample of 1,452 classroom teachers in 26 states. The normed samples included people from a variety of ethnic backgrounds.

The BRP-2/Parent Rating Scale. The Parent Rating Scale is a 30-item scale which is completed by the child's primary caregivers, usually the parents. Each item is a sentence describing their child's behaviors that may be observed at home. The respondent classifies each item as "Very Much Like My Child," "Like My Child," "Not Much Like My Child," or "Not At All Like My Child." Scores indicate an estimate of a child's personal and social adjustment.

Norms for the Parent Rating Scale were based on a sample of 1,948 parents in 19 states. The normed samples included people from a variety of ethnic backgrounds.

Reliability and Validity

Using Cronbach's Coefficient Alpha (1951), the internal consistency of the subscales exceeded the .80 level. The stability reliability of the BRP-2 scales ranged from .78 to
.91 over a two week period of time (Brown & Hammill, 1980). Ellers, Ellers and Bradley-Johnson (1989) found test-retest reliability for the BRP-2 scales ranged above the .80 level for the same period of time.

Three studies correlated BRP-2 scores for 4 groups of public school students with the mean age of 11 1/2: a group of "normal" students; a group of learning disabled; and a group of emotionally disturbed. The fourth group consisted of emotionally disturbed students being served in an institutional setting. Walker (1976) correlated scores from the BRP-2 with the Walker Problem Behavior Identification Checklist. Walker reported that 20 coefficients ranged from .46 to .95, with 10 coefficients exceeding .80, providing evident of the BRP-2 scales' validity. The correlations associated with the normal students are the only ones that failed to reach significance (Brown & Hammill, 1990).

Quay and Peterson (1987) correlated the same scores for the Behavior Problem Checklist and reported 20 coefficients range from .52 to .95, with 13 of the coefficients exceeding .80. Doll (1965) correlated the same BRP-2 scores, with the Vineland Social Maturity Scale and reported 20 coefficients ranging from .70 to .92, again providing further support of the scales' validity.

The correlations between the Test of Early Socioemotional Development (Hresko & Brown, 1984) and the
BRP-2 were computed for students ranging in age from 3 to 7 1/2 years. The TOESD is similar to the BRP-2 in that it has student, teacher and parent rating scale components. Correlations between the two Teacher Rating Scales were .98, as were the correlations between the two Parent Rating Scale. The correlations between the TOESD Student Rating Scale and the Student Rating Scale: Home, was .87. The TOESD Student Rating Scale correlated at .42 and .44 with the Student Rating Scale: School and Peer, respectively.

Brown and Coleman (1988) correlated the BRP-2 with the Index of Children’s Personality Characteristics. Of the 45 coefficients reported, they range from .50 to .87. The highest correlations are those involving the IPC Acting In and Acting Out scales, which make up the behavioral dimension of the IPC; their items are most like the items on the BRP-2 scales.

McCarney, Leigh, and Cornbleet (1983) correlated the BRP-2 Teacher Rating Scale with the Behavior Evaluation Scale. The correlation was .64 which indicates a significant relationship between the two teacher-rating instruments.

Other studies have shown a pattern of rating showing students tended to rate their own behavior most positively, followed by their teachers; ratings, with the parents'
giving the lowest behavioral ratings (Residberg, Fudell & Hudson, 1982; Sebring, 1984; Buckley; 1982; Smith, 1985; Senning-Brown, 1982; Johnson, 1981).

Brown and Hammill (1990) intercorrelated standard scores for the BRP-2 and reported 40 coefficients ranging from .49 to .96, with 24 coefficients ranging above the .80 level. Based on the above-information, the BRP-2 demonstrates sufficient consistency and validity for its use in this study.

The Family Environment Scale (FES). The FES was designed to assess a family's social climate. The FES addresses the environment of the family on a number of dimensions: relationship, personal growth and system maintenance. The Relationship dimensions assessed include: the degree of commitment, help and support family members provide to one another; the extent to which family members are encouraged to act openly and to express their feelings directly; and the amount of openly expressed anger, aggression, and conflict among family members. The Personal Growth dimension assesses the extent to which family members are assertive, are self-sufficient, and make their own decisions; the extent to which activities are cast into an achievement-oriented framework. The System Maintenance dimension assesses the degree of importance of organization and structure in planning family activities and the extent
to which set rules and procedures are used to run family life.

While this scale contains 10 subscales, 8 of the subscales were used for the purposes of this study. Those included Cohesion, Expressiveness, Conflict, Independent, Organization, Control, Achievement Orientation and Active-Recreational Orientation. The remaining 2 subscales were excluded from use in this study because they were inappropriate. The subscales excluded from use were the Intellectual-Cultural Orientation and the Moral-Religious Orientation. The modified FES was a 63-item inventory which asked respondents to describe their family environment by responding "True" or "False" to each item.

The modified FES was appropriate for this study to determine whether parents' perceptions of their conjugal or nuclear family environment change in the course of a child's treatment. Of special interest was whether their perceptions of family environment changed if ratings of the child's behavior had been noted.

Several studies have found that families of delinquent or uncontrollable adolescents are characterized by poorer family relationships and less social connectedness (Fox, 1983; Haddad, 1985; Kirst-Ashman, 1984; Malin, 1981). In general, these families score lower on Cohesion and Independence and higher on Conflict and Control scales (Fox, 1983; Haddad, 1985; Kirst-Ashman, 1984; Malin, 1981).
Parents from families with a history of physical or sexual abuse tend to report significantly more family Conflict and less Cohesion, Expressiveness and Recreational activities than demographically matched nonabusive families (Davis & Graybill, 1983; Perry, Wells, & Doran, 1983). Alcoholic patients entering a residential treatment facility and their family members tend to report less Cohesion, Expressiveness, and Organization, and more Conflict than the normative sample. They also report less emphasis on Independence and Recreational pursuits (Filstead, McElfresh, & Anderson, 1981). Studies with adults and children in families of alcohol abusers have shown comparable results (Moos & Billings, 1982; Moos & Moos, 1984; Petersen-Kelley, 1985).

Norms for the FES were based on 1,125 normal and 500 distressed families selected from all areas of the United States. The normal families included single, two parent and multigenerational families from a variety of ethnic backgrounds. The distressed sample included families of alcohol abusers, general psychiatric patients and those with a child in a crisis situation.

Using Cronbach’s Coefficient Alpha (1951), the internal consistency of the subscales ranged from .61 to .78. Test-retest reliability falls in the acceptable range with individual scales ranging from .68 to .86. Profiles have been shown to be consistent for up to 1 year (Moos, 1981).
In regards to construct validity, Sandler and Barrera (1984) found that persons who saw their family as more cohesive reported receiving more supportive behaviors from family members. The FES Cohesion scale was correlated at .83 with the Procidano-Heller indices of perceived support from family members and friends (Swindle, 1983), the Locke-Wallace Marital Adjustment Scale (Waring et al., 1981), and the Spanier Dyadic Adjustment Scale (Abbott & Brody, 1985).

Brown, Yelsma, and Keller (1981) found that individuals who handled conflict constructively were likely to report low family conflict. Also, Schaefer and Olson (1980) noted that 18 of 20 associations between five aspects of partner intimacy and six conceptually comparable FES subscales were significant as predicted. The couples' perceptions of high family cohesion and expressiveness and lack of conflict were significantly related to their reports of their emotional, social, and sexual intimacy.

Jensen (1983) developed a Family Routines Inventory that measures 28 observable behaviors that involve two or more family members that may occur with predictable regularity in daily family life. High scores on the Family Routines Inventory were related to high family cohesion, organization, and control and low family conflict.

Methods of Analysis
In order to address the research hypothesis of this study, the following statistical procedure was used. First,
the five subscales of the BRP-2 and the seven subscales of the FES were scored separately.

Second, all posttest scores were compared with all pretest scores on all 12 measures. To do that, a one-way repeated measure analysis of variance (ANOVA) was generated between the group means of the posttest and pretest in all instances where complete data was available.

Summary

This chapter discussed the methodology utilized in this study. It included the purpose, participants, procedures and research design of the study. The reliability and validity of the two instruments were considered and the methods of data analysis was reviewed.
CHAPTER 4

RESULTS

The purpose of this study was to determine whether a school-based counseling program implemented in local elementary and middle schools, increased the school success of Emotionally Disturbed (ED) children who participated in the program. School success was measured by three types of data, including behavior, family and utilization of intensive psychiatric placements. Five research hypotheses were generated to address each of these variables.

This chapter begins with a description of the participants and a demographic description of the children who participated. The results of the data analyzed for each of the five research hypotheses follows. Tables are included to further explain the findings.

Participants

The participants in this study consisted of 35 elementary school aged children (34 boys and 1 girl) and 67 middle school aged children (58 boys and 9 girls) who were ED, had been placed in special education classes and whose parent or guardian consented to their participation in a school-based counseling program. Participants also included one of the children’s caregivers (e.g., parent or guardian) and their Special Education teacher.

Demographic data were available for those children who
were enrolled with the Regional Behavioral Health Authority (RBHA), thus receiving case management or case monitoring services. This included 83 of the total 102 children who participated. The other 19 children had either not yet been enrolled with the RBHA or did not meet the RBHA’s eligibility criteria, but met the school district’s criteria to be placed in an ED classroom.

The demographic data selected to describe these children included the child’s age, gender, ethnicity and psychiatric diagnosis. The demographic data for the children is presented in Table 1.

The range of ages of children participating in this study was 6 to 16 years. The mean age of the children was 12.12 years. The participants consisted of 92 boys and 10 girls. There were 36 Caucasions (Non-Hispanics), 32 Hispanics, 9 African-Americans, 2 Native Americans and 4 who described themselves as other.

Seventy children were diagnosed with more than one disorder, while 13 were diagnosed with only 1 disorder. Forty-two children were diagnosed with Oppositional Defiant Disorder (DSM-III-R 313.81). Attention Deficit Disorder (DSM-III-R 314.00 or 314.01) was the next most common disorder, with 28 children diagnosed and 19 children were diagnosed with Dysthymia (DSM-III-R 300.40). Nineteen
Table 1. Demographic data for ED children (n = 86) enrolled with the RBHA.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of Children (n = 86)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Range 6 - 16 years</td>
<td>12.12 years</td>
</tr>
<tr>
<td>Mean 6 - 16 years</td>
<td>12.12 years</td>
</tr>
<tr>
<td>6 years old</td>
<td>1</td>
</tr>
<tr>
<td>7 years old</td>
<td>3</td>
</tr>
<tr>
<td>8 years old</td>
<td>4</td>
</tr>
<tr>
<td>9 years old</td>
<td>4</td>
</tr>
<tr>
<td>10 years old</td>
<td>12</td>
</tr>
<tr>
<td>11 years old</td>
<td>4</td>
</tr>
<tr>
<td>12 years old</td>
<td>13</td>
</tr>
<tr>
<td>13 years old</td>
<td>13</td>
</tr>
<tr>
<td>14 years old</td>
<td>15</td>
</tr>
<tr>
<td>15 years old</td>
<td>13</td>
</tr>
<tr>
<td>16 years old</td>
<td>2</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>76</td>
</tr>
<tr>
<td>Girls</td>
<td>7</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian (Non-Hispanic)</td>
<td>36</td>
</tr>
<tr>
<td>Hispanic</td>
<td>32</td>
</tr>
<tr>
<td>African American</td>
<td>9</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td><strong>Severity of Emotional Disturbance</strong></td>
<td></td>
</tr>
<tr>
<td>SED</td>
<td>35</td>
</tr>
<tr>
<td>Non-SED</td>
<td>51</td>
</tr>
<tr>
<td><strong>Level of Service</strong></td>
<td></td>
</tr>
<tr>
<td>Group only</td>
<td>42</td>
</tr>
<tr>
<td>Group in conjunction with ancillary services</td>
<td>41</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Number of Children</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>(n = 86)</td>
</tr>
<tr>
<td><strong>Psychiatric Diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>Major Depression (296.21)</td>
<td>1</td>
</tr>
<tr>
<td>Psychotic Disorder (298.90)</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety Disorder (300.00)</td>
<td>2</td>
</tr>
<tr>
<td>Dysthymia (300.40)</td>
<td>19</td>
</tr>
<tr>
<td>Functional Encopresis (307.70)</td>
<td>1</td>
</tr>
<tr>
<td>Adjustment Disorder (309.00, 309.30, 309.40)</td>
<td>3</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (309.89)</td>
<td>5</td>
</tr>
<tr>
<td>Organic Personality Disorder (310.00)</td>
<td>1</td>
</tr>
<tr>
<td>Depressive Disorder (311.00)</td>
<td>4</td>
</tr>
<tr>
<td>Conduct Disorder (312.00, 312.20, 312.90)</td>
<td>5</td>
</tr>
<tr>
<td>Impulse Control Disorder (312.39)</td>
<td>1</td>
</tr>
<tr>
<td>Avoidant Disorder (313.21)</td>
<td>1</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder (313.81)</td>
<td>42</td>
</tr>
<tr>
<td>Attention Deficit Disorder (314.00, 314.01)</td>
<td>28</td>
</tr>
<tr>
<td>Developmental Reading Disorder (315.00)</td>
<td>3</td>
</tr>
<tr>
<td>Mild Mental Retardation (317.00)</td>
<td>2</td>
</tr>
<tr>
<td>Parent-Child Problem (V61.20)</td>
<td>19</td>
</tr>
<tr>
<td>Other Family Circumstances (V61.80)</td>
<td>12</td>
</tr>
<tr>
<td>Diagnosed With More Than One Disorder</td>
<td>70</td>
</tr>
<tr>
<td>Diagnosed With Only One Disorder</td>
<td>13</td>
</tr>
</tbody>
</table>
children were diagnosed with Parent-Child Problems (DSM-III-R V61.20) and 12 children were diagnosed with Other Family Circumstances (DSM-III-R V61.80).

Data Analysis

The following is a discussion of the data analysis utilized in this study.

Hypothesis 1: The first hypothesis stated that the children who participated in the school-based counseling program would demonstrate a significant improvement (p < .05) in their behavior over a 5 month period as perceived by their teachers (as measured by the Behavior Rating Profile-2/Teacher Rating Scale).

A total of 74 pre- and post-test scales were completed by teachers. Reasons for incomplete data included a student's relocation or lack of teacher motivation in completing the data. Test scores of participants who did not complete all data were not included in the final analysis.

A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores for the pre- and post-test scores were significant for the main effect of group participation $F (1, 71) = 4.12, p < .05$. The pre- and post-test mean scores for the Teacher Rating Scale are presented in Table 2. The means are presented in BRP-2 standard scores which range from 1 – 20 with a standard deviation
Therefore, Hypothesis 1 was supported. Children who participated in the school-based counseling program significantly improved their behavior over a five month period as perceived by their teachers.

Table 2. Mean Scores for BRP-2, Teacher Rating Scale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Rating</td>
<td>6.5 (SE = 1.6)</td>
<td>7.1 (SE = 1.6)</td>
</tr>
</tbody>
</table>

Hypothesis 2: The second hypothesis stated that the children who participated in the school-based counseling program would demonstrate a significant improvement ($p < .05$) in their behavior over a 5 month period as perceived by their parents (as measured by the Behavior Rating Profile-2/Parent Rating Scale).

A total of 45 parents/guardians completed both the pre- and post-test data. Reasons for incomplete data included a family’s relocation, a child’s placement in a different classroom, lack of motivation, disinterest and/or having negatives feelings associated with the nature of the data.
being collected. Test scores of participants who did not complete all data were not included in the final analysis.

A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were significant for the main effect of group participation $F (1, 42) = 33.57, p < .000001$. The pre- and post-test mean scores for the Parent Rating Scale are presented in Table 3. The means are presented in BRP-2 standard scores which range from 1 - 20 with a standard deviation of 3. Therefore, Hypothesis 2 was supported. Children who participated in the school-based counseling program significantly improved their behavior over a five month period as perceived by their parents.

Table 3. Mean Scores for BRP-2, Parent Rating Scale

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Rating</td>
<td>4.7 (SE = 1.3)</td>
<td>6.4 (SE = 1.3)</td>
</tr>
</tbody>
</table>

Hypothesis 3: The third hypothesis stated that the children who participated in the school-based counseling program would demonstrate a significant improvement
(p < .05) over a 5 month period in their behavior as perceived by themselves (as measured by the Behavior Rating Profile-2). The BPR-2 Student Rating Scale is comprised of three subscales. These included home, school, and peer. The results of each subscale are presented.

**Student Rating Scale/Home.**

A total of 59 students completed both the pre- and post-test for the Student Rating Scale/Home. Reasons for incomplete data included a student's relocation, lack of motivation or disinterest. Test scores of participants who did not complete all data were not included in the final analysis.

A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were significant for the main effect of group participation $F (1, 56) = 7.88$, p < .0069. The pre- and post-test mean scores for the Student Rating Scale/Home are presented in Table 4. The means are presented in BRP-2 standard scores which range from 1 - 20 with a standard deviation of 3.
Table 4. Mean Scores for BRP-2, Student Rating Scale/Home.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Rating Scale/Home</td>
<td>8.6 (SE = 2.3)</td>
<td>9.8 (SE = 2.3)</td>
</tr>
</tbody>
</table>

A total of 59 students completed both the pre- and post-test for the Student Rating Scale/School. Reasons for incomplete data included a student's relocation, lack of motivation or disinterest. Test scores of participants who did not complete all data were not included in the final analysis.

A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were not significant for the main effect of group participation $F (1, 56) = .28, p > .60$. The pre- and post-test mean scores for the Student Rating Scale/School are presented in Table 5. The means are presented in BRP-2 standard scores which range from 1 - 20 with a standard deviation of 3.
Table 5. Means Scores for BRP-2, Student Rating Scale/School.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Rating</td>
<td>8.6 (SE = 2.1)</td>
<td>8.8 (SE = 2.1)</td>
</tr>
</tbody>
</table>

The Student Rating Scale/Peer.

A total of 59 students completed both the pre- and post-test for the Student Rating Scale/Peer. Reasons for incomplete data included a student's relocation, lack of motivation or disinterest. Test scores of participants who did not complete all data were not included in the final analysis.

A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were not significant for the main effect of group participation $F (1, 57) = 2.21, p > .14$. The pre- and post-test mean scores for the Student Rating Scale/Peer are presented in Table 6. The means are presented in BRP-2 standard scores which range from 1 - 20 with a standard deviation of 3.
Table 6. Mean Scores for BRP-2, Student Rating Scale/Peer.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Rating</td>
<td>9.3 (SE = 2.0)</td>
<td>9.8 (SE = 2.0)</td>
</tr>
</tbody>
</table>

Therefore, Hypothesis 3 was supported in part. The children who participated in the school-based counseling program significantly improved their perception of their behaviors at home over a five month period. These children did not significantly improve their perceptions of their behaviors at school or with respect to their peers.

**Hypothesis 4:** The parent/guardian of the children participating in the school-based counseling program will demonstrate a significant improvement over a 5 month period in the perceived quality of their family environment (as measured by the Family Environment Scale).

The FES is an instrument comprised of ten separate subscales. For the purposes of this study, however, seven of the subscales were utilized to assess the impact of the group on family environment. These subscales included Cohesion, Expressiveness, Conflict, Independence, Organization, Control and Achievement Orientation. The
results of each subscale are presented.

A total of 39 parents/guardians completed both the pre- and post-test data. Reasons for incomplete data included disinterest, lack of motivation, a family's relocation, and/or having negatives feelings associated with the nature of the data being collected. Test scores of participants who did not complete all data were not included in the final analysis.

**FES/Cohesion Subscale.** A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were significant for the main effect of group participation $F (1, 36) = 13.17, p < .0009$. The pre- and post-test mean scores for the FES Cohesion Subscale are presented in Table 7. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.

Table 7. Mean Scores for FES, Cohesion Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means (SE = 10.1)</th>
<th>Post-test Means (SE = 10.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Cohesion Subscale</td>
<td>44.0</td>
<td>52.7</td>
</tr>
</tbody>
</table>
FES/Expressiveness Subscale. A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and posttest scores were significant for the main effect of group participation $F(1, 35) = 7.52, p < .01$. The pre- and posttest mean score for the FES Expressiveness subscale are presented in Table 8. The means are presented in FES standard scores which range from 1-80 with a standard deviation of.

FES/Conflict Subscale. A one-way ANOVA was used to analyze whether significant differences existed between the pre- and posttest mean scores. The overall mean scores of the pre- and posttest scores were not significant for the main effect of group participation $F(1, 36) = 1.54, p > .22$. The pre- and posttest mean score for the FES Conflict subscale are presented in Table 9. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.

Table 8. Mean Scores for FES, Expressiveness Scale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Expressiveness Subs</td>
<td>44.3 (SE = 10.1)</td>
<td>51.0 (SE = 10.1)</td>
</tr>
</tbody>
</table>
Table 9. Mean Scores for FES, Conflict Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means (SE = 6.5)</th>
<th>Post-test Means (SE = 6.5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Conflict Subscale</td>
<td>58.2</td>
<td>56.3</td>
</tr>
</tbody>
</table>

**FES/Independence Subscale.** A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were not significant for the main effect of group participation F (1, 38) = .61, p > .44. The pre- and post-test mean scores for the FES Independence subscale are presented in Table 10. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.

Table 10. Mean Scores for FES, Independence Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means (SE = 11.6)</th>
<th>Post-test Means (SE = 11.6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Independence Subscale</td>
<td>40.7</td>
<td>38.7</td>
</tr>
</tbody>
</table>
**FES/Achievement Subscale.** A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were not significant for the main effect of group participation $F (1, 36) = .34, p > .56$. The pre- and post-test mean scores for the FES Achievement subscale are presented in Table 11. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.

Table 11. Mean Scores for FES, Achievement Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Achievement Subscale</td>
<td>49.9 (SE = 7.8)</td>
<td>51.1 (SE = 7.8)</td>
</tr>
</tbody>
</table>

**FES/Organization Subscale.** A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were not significant for the main effect of group participation $F (1, 37) = 1.1, p > .31$. The pre- and post-test mean scores for the FES Organization subscale are presented in Table 12. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.
### Table 12. Mean Scores for FES, Organization Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Organization</td>
<td>48.9 (SE = 7.2)</td>
<td>50.6 (SE = 7.2)</td>
</tr>
</tbody>
</table>

**FES/Control Subscale.** A one-way ANOVA was used to analyze whether significant differences existed between the pre- and post-test mean scores. The overall mean scores of the pre- and post-test scores were significant for the main effect of group participation $F (1, 36) = 3.9, p < .05$. The pre- and post-test mean scores for the FES Control subscale are presented in Table 13. The means are presented in FES standard scores which range from 1-80 with a standard deviation of 10.

### Table 13. Mean Scores for FES, Control Subscale.

<table>
<thead>
<tr>
<th>Source</th>
<th>Pre-test Means</th>
<th>Post-test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES/Control</td>
<td>55.8 (SE = 7.2)</td>
<td>52.5 (SE = 7.2)</td>
</tr>
</tbody>
</table>
Significance ranged from $p < .05$ to $p < .0009$, with Cohesion being highest at $p < .0009$ to control being lowest at $p < .05$. Therefore, Hypothesis 4 was supported in the areas of Cohesion, Expressiveness and Control and was not supported in the areas of Conflict, Independence, Achievement Orientation and Organization.

**Hypothesis 5:** The fifth hypothesis stated that the children who participated in the school-based counseling program would demonstrate a significant decrease in intensive psychiatric placements during a three month period compared to the same three month period in the previous year.

Utilization data for inpatient psychiatric hospitalizations and residential treatment centers was collected for a total of 2,209 ED children enrolled with the RBHA. Analysis for the period January, February, and March of 1993 and 1994 is presented in Table 14. Therefore, Hypothesis 5 is partially supported. The average daily census of intensive psychiatric placements for ED children enrolled with the RBHA did not significantly decrease. The average length of stay for these children utilizing intensive psychiatric placements did significantly decrease.
### Table 14. Utilization of Inpatient Hospitalizations and Residential Treatment Centers by ED Children.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Average Daily Census (N = 2209)</th>
<th>Average Length of Stay (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitalization</td>
<td>4.00</td>
<td>4.07</td>
</tr>
<tr>
<td>Residential Treatment Center</td>
<td>17.31</td>
<td>19.61</td>
</tr>
</tbody>
</table>

**Summary**

This chapter presented the results of the statistical analyses performed to test the five general research hypotheses. A one-way repeated measure analysis of variance (ANOVA) was employed to identify changes in the pretest and posttest mean scores. Significant ($p < .05$) changes were observed on the measures of student behavior as perceived by parents and teachers, and students themselves on the home subscale. No significant changes were observed on the measures of behavior by the students on the school and peer subscales.

Also, significant ($p < .05$) changes were observed on the measure of family atmosphere on the Cohesion and Expressiveness, and Control subscales. No significant
changes were observed on the family environment subscales of Conflict, Independence, Achievement or Organization.

The utilization of intensive psychiatric placements indicated that the average daily census for both inpatient hospitalizations and residential treatment centers did not decrease significantly. The average length of stay decreased significantly, especially for residential treatment centers.
CHAPTER 5

SUMMARY, IMPLICATIONS, RECOMMENDATIONS

This chapter summarizes the study and discusses previous related research along with conclusions and recommendations for future study. The purpose of this study was to determine whether a school-based counseling program increased the school success of Emotionally Disturbed (ED) children who participated in one such program, examining its effect on several variables.

Summary

Participants

The participants for this study consisted of 102 elementary and middle aged school children who were ED and who participated in a school-based counseling program in Southwestern Arizona. These children consisted of both Severely Emotionally Disturbed (SED) children and Non-SED children. Participants also included their parents or guardians (N = 85) and their Special Education teachers (N = 74).

Assessment Instruments

Two instruments were utilized in the study. The Behavior Rating Profile-2 (BRP-2) consists of 5 subscales: the Parent Rating Scale, the Teacher Rating Scale, and the Student Rating Scale for Home, School and Peer. A score was generated for each subscale. This instrument provides an
estimate of children's personal and social adjustment. The BRP-2 was completed at pretest and posttest measurement points.

The other instrument utilized in this study was a modified Family Environment Scale (FES). This instrument assessed the quality of the family environment. The FES is comprised of 10 subscales, 7 of which were utilized in this study. These include the Cohesion, Independence, Control, Conflict, Expressiveness, Organization and Achievement subscales. A score was generated for each subscale. The instrument was completed at pretest and posttest measurement points.

Hypotheses

Five general research hypotheses were generated to assess the effects of participation in the school-based counseling program on 3 dependent variables. The dependent variables examined in this study included the perceived quality of students' behavior (as perceived by teacher, parent and student) and the perceived quality of the family environment (as perceived by parents or guardians). The utilization of intensive psychiatric placements, such as inpatient hospitalizations or residential treatment centers, by RBHA enrolled ED children, was also analyzed.

The first hypothesis addressed the variable of perceived quality of students' behavior as perceived by the teacher. It was hypothesized that children who participated
in the school-based counseling program would demonstrate a significant improvement in their behavior as perceived by their teachers (as measured by the Behavior Rating Profile-2/Teacher Rating Scale).

The second hypothesis addressed the variable of perceived quality of a students' behavior as perceived by their parents. It was hypothesized that the children who participated in the school-based counseling program would demonstrate a significant improvement in their behavior as perceived by their parents (as measured by the Behavior Rating Profile-2/Parent Rating Scale).

The third hypothesis addressed the variable of perceived quality of a students' behavior as perceived by themselves. It was hypothesized that children who participated in the school-based counseling program would demonstrate a significant improvement in their behavior as perceived by themselves with respect to home, school and peer ecologies (as measured by the Behavior Rating Profile-2).

The fourth hypothesis addressed the variable of perceived quality of family environment as perceived by parents. It was hypothesized that parents of children who participated in the school-based counseling program would demonstrate a significant improvement in their perception of the quality of their family atmosphere (as measured by the Family Environment Scale).
The fifth hypothesis addressed the variable of the utilization of intensive psychiatric placements. It was hypothesized that the utilization of these placements would significantly decrease during a 3-month period compared to the same 3-month period in the previous year.

**School-Based Counseling Group Treatment**

The school-based counseling group was designed to provide a variety of therapeutic interventions to ED children, their families and teachers during school hours at local schools. The goal of the program was to improve the social functioning of ED children in the school and home environments, to improve peer relationships, to improve the ability to learn, and to prevent the necessity for more intensive levels of care.

Groups were designed to address the behavioral and emotional problems manifested by the students, including issues of poor impulse control, anger management, emotional withdrawal, social isolativeness, and physical and verbal aggression. Groups included a variety of interventions, such as role play, art therapy, therapeutic games, as well as process to address issues. Master's level counselors facilitated these groups which were made up of no more than 8 students.

**Results**

The data collected in this study were analyzed using a one-way repeated measure analysis of variance (ANOVA). The
factor examined for hypotheses 1-4 was group participation. The factor examined for the fifth hypothesis was the utilization of inpatient hospitalizations and residential treatment centers.

The first hypothesis addressed changes in students' behavior as perceived by teachers. For the Teacher Rating Scale, significant differences ($p < 0.05$) were noted between the pretest and posttest mean scores for the main effect of group participation, thus supporting the hypothesis.

The second hypothesis, addressing changes in students' behavior as perceived by parents, was also supported. For the Parent Rating Scale, significant differences ($p < 0.000001$) were noted between the pretest and posttest mean scores for the main effect of group participation.

The third hypothesis, addressing changes in students' behavior as perceived by themselves with respect to home, school and peer ecologies, was partially supported. For the Student Rating Scale/Home, significant differences ($p < 0.0069$) were noted between the pretest and posttest mean scores for the main effect of group participation. For the Student Rating Scale/School and Peer, however, no significant differences ($p < 0.60$, $p < 0.14$, respectively) were noted.

The fourth hypothesis, addressing changes in perceived family environment, was supported for 3 of the 7 subscales. The analysis of the Cohesion, Expressiveness and Control
subscale scores indicated significant differences 
\( (p < .0009, p < .01, p < .05, \text{ respectively}) \) between the 
pretest and posttest mean scores for the main effect of 
group participation. For the Independence, Achievement, 
Conflict and Organization subscales, no significant 
differences between \( (p > .22, p > .44, p > .56, p > .31, \text{ respectively}) \) 
the pretest and posttest mean scores existed 
for the main effect of group participation.

The fifth hypothesis, stating that utilization of 
inensive psychiatric placements during a 3 month period as 
compared to the same 3 month period in the previous year, 
received partial support. Although the average daily census 
for these intensive psychiatric placements did not 
significantly decrease, the average length of stay decreased 
significantly, especially in the utilization of residential 
treatment centers.

Implications

In this study, significant findings were identified for 
the main effect of group participation for several subscales 
in each of the measurement instruments. These include the 
Teacher, Parent and Student/Home Rating Scales of the BRP-2, 
as well as the Cohesion, Expressiveness and Control 
subscales of the FES. This indicates the combined group 
mean scores were significantly different.

Since all participants had already been dealing with 
the emotional disturbance of their children, their students
or themselves for an extended period of time, it would not be expected that the combined group would change significantly during the period of this study because of a sudden increased ability to make changes measurable by the instruments. Thus, the significant differences noted for the main effect of group participation may have resulted because participants were affected by the testing procedures/instruments. Participants may have responded differently simply because of repeated exposure to their measurement instruments. Another possibility is that participants changed their behavior (resulting in changes in the dependent variables) after becoming sensitized to the variables assessed by the testing procedures. Thus, the threat of the testing effect to internal validity may account for the significant differences found in the main effect of group participation.

Another explanation for the significant differences noted for the main effect of group participation is that an interaction between various threats to this study's internal validity (e.g., maturation or history) and group participation in combination produced a change in the dependent variables. Thus, the ED children would have obtained higher scores on the posttest even if they had not participated in the school-based counseling program and would have improved their behaviors and scored higher on the instruments. Thus, an interaction effect may account for
the significant differences found.

It is also possible that the significant differences were a result of the tendency of extreme scores on any measure to regress toward the mean when the measure is readministered. Thus, the significant differences may have resulted because of the participants’ extreme status on the dependent variables. However, in this study, participants were not chosen based on their extreme scores. The pretest scores of many participants were within the normal range. Additionally, if statistical regression were to occur, it would be expected on all measures, not just 3 of the 5 BRP-2 subscales and 3 of the 7 FES subscales.

An alternate explanation for the significant differences is that the changes were noted because of the loss of participants. Many participants in this study did drop out for a variety of reasons, including a family’s relocation, students returning to mainstream classrooms, students forced into alternate placements (e.g., jail or shelters), or lack of motivation. A face review of the pretest scores of these participants was conducted and did not reveal significant differences in scores with regard to their initial status on the dependent variables.

Behavior Rating Profile-2

Pretest and posttest mean scores of the BRP-2/Teacher, Parent and Student/Home Rating Scales increased significantly, suggesting that the personal and social
adjustment of the children who participated in the school-based counseling program was positively impacted. According to Gunn and Fisher (1989), systems theorists believe that a family maintains the symptoms of its members, and, in fact, is maintained by the symptoms. An intervention designed to interrupt the symptom-maintaining sequences, thus changing the family pattern of interaction will move the symptom out of the family dynamics (Gunn & Fisher, 1989).

Additionally, changing an individual's behavior within one of the systems he/she is involved, should change other systems of which that individual is part (Gunn & Fisher, 1989). Thus, one explanation of the significant differences noted is that as the inappropriate behaviors were confronted and changed within the group (1 system), behaviors in the classroom and at home (2 other systems) improved as well. This possibility seems likely because multiple instruments measured multiple behaviors across systems and through multiple perspectives.

Mean scores between the pretest and posttest of the BRP-2/Student Rating Scale for School and Peer yielded no significant differences. This outcome may have resulted from the utilization of group means to assess change. According to Brown and Hammill (1990), in an analysis of their own research and independent research, group means are probably not the most appropriate statistic for reporting self-rating data for emotionally disturbed students,
especially for the School and Peer subscales. It appears that the distribution of scores on these scales typically is bimodal and when averaged, they cancel each other out and yield a misleading group mean (Brown & Hammill, 1990). Therefore, it is possible that the scores in this study were at the low range of this bimodal distribution, thus giving misleading means.

Adler (1979) believed that a major life task is to develop meaningful relationships and that through this socialization process, an individual fulfills their need to attain a sense of belonging. According to Erikson (1963), during adolescence, peers become of primary importance as a child attempts to clarify his/her identity.

A majority of the children who participated in this study were adolescents who are struggling to become adults, but who have not found a sense of belonging either in their families or in regular classrooms. It is this unfulfilled need that makes them such a high-risk population for gang involvement, drug use and chronic mental illness.

Because the children participants individually completed the instruments in a group setting, their motivation to fulfill their need to belong in this group of peers may have increased and they may have completed the questions in a way they believed their peers would answer or in a way they believed their peers might want them to answer. This explanation is feasible given the questions
being asked were about peers and school, the place where they have the most access to their peers. Thus, their heightened awareness of peers in combination with their need to belong, may have motivated them to answer the questions in a way that was socially acceptable within that group of children, but not particularly accurate of their behavior. This seems likely because the pretest and posttest mean scores for the Home subscale were significant, which may mean that the students felt more comfortable answering accurately in relation to their behavior at home.

In the analysis of the BRP-2 scores, parents' ratings are highest, teachers' ratings fall in the middle, and children's ratings are lowest. These findings are contrary to the typical pattern found (Brown & Hammill, 1990). In a review of research utilizing the BRP-2, Brown and Hammill (1990) found that in all groups of students, the students' self-ratings are usually the highest scores with teachers' ratings falling in the middle and parents' ratings the lowest. In this study, the reversed pattern may have resulted because confrontation of inappropriate behaviors is part of the group counseling process and the students may have rated their behavior as inappropriate based on their new awareness and improved emotional development.

**Family Environment Scale**

According to Moos and Moos (1986), families with a delinquent or disturbed adolescent tend to score lower on
cohesion and independence, and higher on conflict and control. Abusive families tend to report significantly more family conflict and less cohesion, expressiveness and intellectual activities (Moos & Moos, 1986). Families of substance abusers tend to report less cohesion, expressiveness and organization, and more conflict (Moos & Moos, 1986). Families with members in counseling tend to report less cohesion and expressiveness, and more conflict (Moos & Moos, 1986). Thus, a change in any of these areas would be particularly encouraging because so many of these children were delinquents and come from abusive families and/or families of substance abusers.

The Cohesion, Expressiveness and Control subscales yielded significant differences between pretest and posttest mean scores. Significantly improved scores on the Cohesion and Expressiveness subscales indicate that parents or guardians believed that the degree of commitment, help and support family members provided for one another and the extent to which family members were encouraged to act openly and to directly express their feelings, increased.

Since group members were encouraged to be supportive of each other during the course of the group counseling, it is possible that these increased feelings of cohesion and expressiveness generalized to the family environment. Another explanation is that as changes in the child’s emotional development were targeted, those changes disrupted
the usual pattern of interaction within these families, thus increasing the functioning level of the family itself.

These outcomes may have also resulted in part because of the ancillary services offered to the families of the ED children. It is possible that because of the additional support they were receiving and because of the encouragement in family counseling to talk openly and directly express feelings, parents or guardians felt more support and openness for expression in their families.

Scores on the Control subscale, which measures the extent to which set rules and procedures are used to run family life also increased significantly. Since students were encouraged to resolve their issues within the group counseling setting, this outcome may have resulted from the students feeling less need to act in a rebellious manner and to follow family rules. Additionally, the utilization of ancillary services may have affected the outcome. In family counseling, rules and procedures may have been addressed, clarified and discussed. This additional support may have helped parents and guardians establish consequences and set firm limits, thus increasing their effectiveness in parenting.

The FES subscales for Conflict, Independence, Organization and Achievement yielded no significant differences between pretest and posttest mean scores. The outcome on the scales of Independence, which measures the
extent to which family members are assertive, are self-sufficient, and make their own decisions, and Conflict, which measures the amount of openly expressed anger, aggression, and conflict among family members, may have resulted from insufficient exposure to the school-based counseling group or to ancillary services for the family (Moos & Moos, 1986). Additionally, it would be expected that conflict in the family would increase in the initial stages of counseling because covert issues are made overt so that changes can be made. Changes in these areas would be expected to take some major restructuring of the family as well as time.

Scores on the Organization subscale, which measures the degree of importance of clear organization and structure in planning family activities and responsibilities, and the Achievement Orientation subscale which measures the extent to which activities are cast into an achievement-oriented or competitive framework, did not significantly change. It seems as though changes in these areas of the family would occur once some of the severity in the other areas are improved. Thus, their priority may be low at this point in the interventions.

Utilization of Intensive Psychiatric Placements

The analysis of the utilization of intensive psychiatric placements found that changes in the daily census of inpatient hospitalizations and residential
treatment centers did not significantly decrease. This may have resulted because the data collected were for all ED children enrolled with the RBHA, many of whom had not yet been involved in the school-based counseling program. Additionally, the program had been implemented for only 2 months when the data began being collected, probably not enough time for significant changes to be expected.

The average lengths of stay did significantly decrease. This may have been partially affected by the availability of the counseling program and ancillary services as well as the RBHA's philosophy to keep children in the least restrictive environment possible. Thus, it is possible that because group counseling and ancillary services were available to ED children and their families at local schools, the need for more restrictive settings may have been lessened because of the additional support that was in place. The children may have been able to maintain a level of functioning that allowed them to remain at home while dealing with their issues.

Conclusion

Participation in the school-based counseling program seems to have resulted in a reduction of inappropriate behaviors by the children, thus increasing their personal and social adjustment. The counseling program also seems to have positively impacted the family environment while ensuring that a greater percentage of children will receive
services. Thus, the cost-effectiveness of limited resources may have increased as well.

Recommendations

A number of recommendations for future research are suggested to address treatment programs for ED children.

1. A series of duplication studies yielding similar findings would further support the research hypotheses.

2. The design of this study could be strengthened in a duplication study in which a control group was compared to a treatment group.

3. Future studies should employ other measures of school success, including academic performance, reducing aggression, and absenteeism.

4. Future studies should focus on the suitability of a school-based counseling program with higher grade levels.

5. Future studies should focus on the impact of ancillary services on ED children and their families.

6. Future studies should focus on the impact of teacher resistance on the school success of ED children.

7. A follow-up study in 2-5 years should be conducted with the original sample population to check for the effectiveness of the program over time and what the children are doing at that time.

Other recommendations for counselors, educators, program directors, and the community:
1. The community should target resources for ED children beginning at the preschool level and continuing throughout the primary and secondary levels.

2. The community should target resources for parenting education, especially for high-risk families.

3. Educators should expand their curriculum to include affective, assertiveness, decision-making and social skills training to improve the emotional development of all children.

4. Counselors should develop intervention strategies and programs which are directed towards increasing the school success of ED children and towards increasing family involvement.

5. Families should be encouraged to become involved in their children’s education and counseling.

Closing Comment

The findings of this study provide a hope for the future of Emotionally Disturbed children. This research supports the contention that a collaborative counseling program between mental health agencies and schools which make resources more readily available to high-risk children and families by incorporating programs into the local school settings can effectively treat the emotional problems of ED children and their families. This may normalize the counseling process for these families, increasing their involvement and change. Thus, the need for more intensive
psychiatric placements will be decreased and will allow children to remain in school, increasing their success in the educational system and their chances for more healthy, functional lives.
CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

The CAFAS is used to assess a youth’s functional impairment, rated as severe, moderate, mild or average. If any one item listed under a category of impairment describes the youth’s functioning, the youth qualifies for a rating in that category. You should indicate all items that apply in that category. Do this by circling the number to the right of the item description. Do not circle any items that apply in lower categories. Rate the youth’s most severe level of dysfunction in the last month.

1. For each sub-scale begin your assessment by reviewing items in the SEVERE category. If any item describes the youth’s functioning, circle all that apply in that category, and write the score “30” in the score box on the left.

2. If none of the items in the SEVERE category describe the youth, proceed to the MODERATE category. If none of the items in the MODERATE category describe the youth, proceed to the MILD category, and so on. If the youth is described by any of the items in a category, then that category will apply to the youth. Always start with the SEVERE CATEGORY AND PROGRESSIVELY PROCEED TO THE AVERAGE CATEGORY, STOPPING AT THE CATEGORY IF THE YOUTH IS DESCRIBED BY ANY ONE OF THE ITEMS IN THAT PARTICULAR CATEGORY.

3. If you believe that the youth should be rated in a category of impairment where no items are circled, write the score in the score box, circle the number corresponding to the “EXCEPTION” box, and explain the reason for your rating in the space labeled “Explanation.”

### Severe

<table>
<thead>
<tr>
<th>Role Performance</th>
<th>Severe disruption or incapacitation (30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to maintain 001 job, school, or family role because of impairment...</td>
<td>Persistent problems 007 at work/school (e.g., frequently in trouble; at risk of expulsion; history of multiple expulsions or suspensions)...</td>
</tr>
<tr>
<td>Extensive 002 management by others required in order to be maintained in the home...</td>
<td>Persistent failure 008 to meet usual expectations in family relations and/or behavior/responsibilities within home (may be at risk for placement out of home due to impairment)...</td>
</tr>
<tr>
<td>Expelled or 003 equivalent from school...</td>
<td>Currently at 009 risk of confinement because of frequent or serious violations of law, delinquent behavior, running away, probation or parole...</td>
</tr>
<tr>
<td>Unable to meet 004 even minimum requirements for behavior in classroom (either in regular or specialized classroom in public school or equivalent)...</td>
<td>Persistent problems 010 in school due to extreme difficulty sustaining attention to tasks...</td>
</tr>
</tbody>
</table>

### Exception 006

**Explanation:**

The CAFAS was modeled after the North Carolina Functional Assessment Scale (NCFAS), which was developed primarily for use with adults.

Could Not Score: 020
<table>
<thead>
<tr>
<th>Severe Disruption or Incapacitation</th>
<th>Moderate Occasional Major or Frequent Disruptions</th>
<th>Mild Significant Problems and/or Distress</th>
<th>Average No Disruption of Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(30)</td>
<td>(20)</td>
<td>(10)</td>
<td>(0)</td>
</tr>
<tr>
<td>Extreme disruption 021</td>
<td>Frequent distortion 226</td>
<td>Occasional difficulty 232</td>
<td>Thought, as reflected by</td>
</tr>
<tr>
<td>Thinking</td>
<td>of thinking (obsessions, mistrust, suspicions)...</td>
<td>in communication or behavior due to thought distortions (e.g., obsessions, mistrust, suspicions)...</td>
<td>communication, is not disordered or eccentric...</td>
</tr>
<tr>
<td>-</td>
<td>Intermittent hallucinations that interfere with normal functioning...</td>
<td>May express odd 033 beliefs, excessive fantasy or, if older than eight years old, magical thinking...</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Frequent confusion 028</td>
<td>Eclectic speech 034 (e.g., impoverished, digressive, vague)...</td>
<td></td>
</tr>
<tr>
<td>Pattern of short term memory loss/disorientation to time or place most of the time...</td>
<td>or evidence of short term memory loss...</td>
<td>Unusual 035 perceptual experiences not qualifying as hallucinations...</td>
<td></td>
</tr>
<tr>
<td>Inability to communicate with others and/or marked abnormalities in nonverbal or verbal communication (e.g., echolalia, idiosyncratic language)...</td>
<td>Unable to comprehend consequences of behavior...</td>
<td>Evidence of persistent and excessive fantasy (e.g., daydreams, artwork, writing samples) with destructive and/or bizarre themes...</td>
<td></td>
</tr>
<tr>
<td>Exception 025</td>
<td>Exception 031</td>
<td>Exception 036</td>
<td>Exception 035</td>
</tr>
</tbody>
</table>

Explanation:

Could Not Score: 039

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<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>Severe disruption or incapacitation</td>
<td>30</td>
</tr>
<tr>
<td>Moderate</td>
<td>Occasional major or frequent disruptions</td>
<td>20</td>
</tr>
<tr>
<td>Mild</td>
<td>Significant problems and/or distress</td>
<td>10</td>
</tr>
<tr>
<td>Average</td>
<td>No disruption of functioning</td>
<td>0</td>
</tr>
</tbody>
</table>

### Behavior Toward Others/Self

- **Behavior consistently inappropriate or bizarre...**
- **Behavior so disruptive or dangerous that harm to self or others is likely...**
- **Expelled from family for reasons related to impairment...**
- **Usable to form/ maintain any age-appropriate close relationships...**
- **Severe destructiveness toward property (e.g., deliberate fire-setting; serious damage to community/school property)...**

#### Exception
- 045

### Moods/Emotions

- **Emotional responses incongruous or inappropriate (unreasonable, excessive) most of the time...**
- **Fears, phobias, worries, or anxieties result in poor attendance at school (i.e., absent more than present) or marked social withdrawal...**
- **Depression is incapacitating at times (e.g., academically, socially) or is accompanied by suicidal intent...**

#### Exception
- 064

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*1990 by Kay Hodges, Ph.D. (Vanderbilt Child Mental Health Services Evaluation Project). The CAFAS was modeled after the North Carolina Functional Assessment Scale (NCFAS), which was developed primarily for use with adults.*
<table>
<thead>
<tr>
<th>Substance Use: (Substances = alcohol or drugs)</th>
<th>Severe Disruption or Incapacitation (30)</th>
<th>Moderate Occasional Major or Frequent Disruptions (20)</th>
<th>Mild Significant Problems and/or Distress (10)</th>
<th>Average No Disruption of Functioning (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle centers on acquisition and use (e.g., preoccupied with thoughts or urges to use substances)...</td>
<td>Uses in such a way as to interfere with functioning (i.e., job, school, driving) in spite of potential serious consequences...</td>
<td>Infrequent excess and only without serious consequences...</td>
<td>No use of substances...</td>
<td></td>
</tr>
<tr>
<td>Dependent on continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms)...</td>
<td>Gets into trouble because of use (e.g., fights with family or friends, in an accident or injured, trouble with teachers, picked up by police, experiencing physical health problems due to use)...</td>
<td>Regular usage (e.g., once a week) but without intoxication or being obviously high...</td>
<td>Has only &quot;tried&quot; them does not use them...</td>
<td></td>
</tr>
<tr>
<td>Failing school or kicked out of school or work related to usage...</td>
<td>Frequently intoxicated or high (e.g., more than two times a week)...</td>
<td>High or intoxicated once a week...</td>
<td>Occasional use with no negative consequences...</td>
<td></td>
</tr>
</tbody>
</table>

If youth is 12 or younger, use these additional categories:

- For 12 years or younger, high or intoxicated once or twice a week... | For 12 years or younger, use regularly (once a week) without intoxication and without becoming obviously high... | For 12 years or younger, occasional use with no negative consequences... | Exception 088 | Exception 092 | Exception 096

Explanation:

Could Not Score: 097

Additional Comments:

Continue onto next page.
<table>
<thead>
<tr>
<th>Caregiver Resources: Basic Needs</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to meet child’s needs for food, clothing, housing, transportation, medical attention or safety, such that severe risk to health or welfare of child is likely...</td>
<td>(10)</td>
<td>(20)</td>
<td>(10)</td>
<td>(0)</td>
</tr>
<tr>
<td>Frequent negative impact on child’s functioning OR a major disruption in the child’s functioning due to problems meeting child’s needs for food, housing, clothing, transportation, medical attention, or safety...</td>
<td>098</td>
<td>100</td>
<td>102</td>
<td>104</td>
</tr>
<tr>
<td>Able to obtain or arrange for adequate meeting of all basic needs so that there is no disruption in the child’s functioning...</td>
<td>EXCEPTION 099</td>
<td>EXCEPTION 101</td>
<td>EXCEPTION 103</td>
<td>EXCEPTION 105</td>
</tr>
</tbody>
</table>

Explanation:

Could Not Score 106

The Family/Social Support Sub-Scale contains ideas and wording adapted from a measure developed by Setterberg, Shaffer, Williams and Spitzer.

* 1990 by Kay Hodges, Ph.D. (Vanderbilt Child Mental Health Services Evaluation Project). The CAFA-S was modeled after the North Carolina Functional Assessment Scale (NCFAS), which was developed primarily for use with adults.
APPENDIX B

REGIONAL BEHAVIORAL HEALTH

AUTHORITY'S BOARD OF DIRECTORS' PHILOSOPHY
In 1992 the Arizona Center for Clinical Management (ACCM) was given the opportunity to become Pima County's official Regional Behavioral Health Authority (RBHA). ACCM develops, funds, coordinates and monitors all public behavioral health services in Pima County. Simply put, we are the focal point for public funding dedicated to behavioral health issues.

For ACCM, this recognition is the result of our continuing and never-ending effort to, first and foremost, meet the needs of Pima County residents seeking behavioral health assistance. This assistance may include: emergency services, evaluation and intake services, prevention efforts, comprehensive case management services for both adults and children, inpatient, residential and outpatient services.

Our philosophy is straightforward: to provide Pima County residents with timely access to appropriate, affordable and effective behavioral and mental health care. At ACCM, the individual is served in a respectful, non-judgmental and non-discriminatory manner. We recognize that behavioral and mental health concerns are often complex and private matters affecting the very core of our personal life experience.

We believe that empowering the individual serves as the very basis for providing the necessary care and service in the most effective and cost efficient manner. In fact, we feel strongly that this philosophy is increasingly important as we approach this time of health care reform and change.
Receiving Care in the ACCM System

We know that the first and often most important measure of the success of any program is the ability of the consumer to get assistance quickly, effectively and efficiently. In other words, to provide an understandable, caring and human entry into our system; to quickly assess the person’s needs; and, utilizing the vast resources of our provider network, deliver quality care and treatment without regard to income.

Should you, a family member or a friend need help and it is an emergency, life-threatening crisis situation, as always, Dial 911. Remain calm and explain the nature of the emergency or crisis.

Should you, a family member or friend need assistance in a non-life-threatening crisis situation, ACCM provides for 24-hour crisis and intervention services through the Southern Arizona Mental Health Center. Call (602) 628-5241. Again, remain calm and explain the nature of the assistance needed. For children who are not in crisis, but need help, call 747-7619. Assistance can also be provided at any intake agency.

Our employees and the employees of our providers are trained, caring individuals who want to help you, your family and friends. We place great emphasis on overcoming the various barriers to getting help like: language, transportation, geographic location, hours of operation and physical accessibility. It is our goal to make the first step to getting help a positive, meaningful and empowering one.

ACCM delivers a wide array of services through a family of affiliated behavioral and mental health care providers. Each of these providers tailors the delivery of service to their particular area of expertise, affording the individual and their families the greatest opportunity to receive precisely targeted, specialized care.

These services are grouped in the following categories to allow our clients to better define their care options.

- Prevention & Early Intervention
- General Mental Health
- Children
- Substance Abuse
- Domestic Violence
- Seriously Mentally Ill

Prevention & Early Intervention

At ACCM, we truly do believe that “an ounce of prevention is worth a pound of cure.” This is especially true in these times of health care reform and change. Keeping someone well and healthy is a far superior strategy for all involved, and is far more cost effective, as well.

Our Prevention & Early Intervention program is a comprehensive effort encompassing needs assessment, development of detailed goals and objectives, and vital linkages with target populations and community groups. Because of this holistic approach, prevention becomes an active process at creating conditions, opportunities and experiences that lead the development of personal attributes which promote the overall well-being of people.

General Mental Health

We live in an increasingly difficult and complex world. A world where poverty, homelessness, suicide, domestic violence and gang activity are becoming all too common. Individuals traumatized by these and other factors, while often not exhibiting severely disabling illness, none the less, display a host of behavioral health disorders requiring treatment.

ACCM believes that by giving these consumers and family members access to appropriate, issue focused services most individuals will resolve these problems relatively quickly, positively and productively. It service is delayed or unavailable, the risk of increasingly severe and serious illness increases, along with the attendant costs, stress and strain on the public health care delivery system.

It is our philosophy to encourage the maximum participation of the individual, family and friends in a treatment program designed to be easily accessible, outcome oriented and sensitive to ethnic and cultural differences, as well as, the special needs of the individual.

Children

Children are our future. Yet, everyday more and more children face ever more challenging and troubling times. Therefore, we must make every effort to help those children who require behavioral health care assistance to improve and correct these problems soon, through early intervention programs, to reduce the likelihood or more severe problems later.

As ACCM, we believe in focusing all child directed care in the least restrictive environment available to preserve normal family and community relationships. Our out-of-home placement in treatment facilities is viewed only as a last resort; to be considered when all other most appropriate and least restrictive options have failed.
RECEIVING CARE IN THE ACCM SYSTEM

We also believe that the early and consistent involvement of the family and other significant people is an integral and essential part of all treatment and service-planning efforts. We believe it is only through this family-based comprehensive approach that children will truly receive the behavioral health care they so richly deserve. For our children and our future.

SUBSTANCE ABUSE

While substance abuse is often a personal and private tragedy; make no mistake, substance abuse is also most certainly a public health problem. Substance abuse can often lead to other public health problems from the spread of contagious disease to community violence. Therefore, when it surfaces, it is a primary condition requiring clear and decisive treatment. Our ultimate goal at ACCM is the prevention and elimination of substance abuse.

Our substance abuse program in place here in Pima County works with the entire community to solve problems associated with substance abuse. Here, as in our other programs and services, we work to support and empower individuals and families in the process of recovery. This system provides for a complete range of services from information and prevention to necessary treatment options. Individuals receive clinically appropriate services tailored to their needs in settings that are accessible and appropriate.

DOMESTIC VIOLENCE

Domestic violence is a pervasive social problem which creates a dramatic and profound impact on all members of the affected family. And it's on the rise. ACCM believes that, time and time again, family members faced with domestic violence require a rapid response, stabilization of the crisis and a safe living environment. The safety of the children and other significant people are also involved in the ACCM system of person-centered services designed to be flexible, accessible and culturally relevant is available to empower the survivors of domestic violence and encourage resolution and treatment, as appropriate.

SERIOUSLY MENTALLY ILL

The Seriously Mentally Ill population treated at more than 2,000,000 individuals at the United States is every day, faced with varied and complex behavioral health issues. In the past several years as the use of institutions has declined, the person with a serious mental illness has seen increasingly formulaic outcomes and care. Once the safety of the individual and their dependents has been achieved, the ACCM system of person-centered services designed to be flexible, accessible and culturally relevant is available to empower the survivors of domestic violence and encourage resolution and treatment, as appropriate.

SERVICES

Everyone receiving care as a consumer in Arizona has rights. At ACCM, we believe strongly that people should be treated with dignity and respect; and that their rights as individuals receiving service must be clearly defined and honored.

It is important to know and understand your rights so that you can exercise and protect them.

► You have the right to request or refuse any or all treatment (unless ordered by a court or in an emergency) to the extent that is permitted by law.
► You have the right to file an appeal regarding your ISP or ITP, file a grievance when you believe your rights have been violated; or, question the need for a guardianship over you.
► You have the right to live your life in the manner that you wish; to marry, divorce, enter into contracts, and enjoy other rights that all citizens have unless you are under the age of 18 or under a guardianship.

These are just some of the many rights guaranteed under Federal and State law, regulations or rules. While it is not possible to list all of your rights here, a complete list of client rights is available at the reception desk of any ACCM provider or treatment site. Please feel free to ask for it.

Should you have a complaint or wish to file a grievance, call your ACCM advocate at (602) 28-9592.

*An individual service plan (ISP) is used for people with serious mental illness. An individual treatment plan (ITP) is used for all other individuals who receive treatment in the ACCM system.
APPENDIX C

LETTER OF APPROVAL
Mia K. Schroer-Lundeen, Master's Candidate  
c/o Betty J. Newlon, Ed.D.  
Counseling/Guidance Program  
Esquire Apartments, Suite 210  
1230 N. Park Avenue (CAMPUS MAIL)  

RE: HSC A93.107 THE EFFECTS OF A SCHOOL-BASED COUNSELING PROGRAM ON THE SCHOOL SUCCESS OF SEVERELY EMOTIONALLY DISTURBED CHILDREN  

Dear Ms. Schroer-Lundeen:  

We received your above-cited research proposal. The procedures to be followed in this study pose no more than minimal risk to participating subjects. Regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)] authorize approval of this type project through the expedited review procedures, with the condition(s) that subjects’ anonymity be maintained. Although full Committee review is not required, a brief summary of the project procedures is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved effective 3 December 1993 for a period of one year.  

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.  

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.  

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.  

Sincerely yours,  

William F. Denny, M.D.  
Chairman, Human Subjects Committee  

WFD:rs  
cc: College/Departmental Review Committee
APPENDIX D

PARENT CONSENT FORM
CONSENT TO PARTICIPATE

I, _______________________________, give my son/daughter, _______________________________, permission to participate in this study about the school-based counseling program by completing 1 short questionnaire prior to beginning the school-based counseling program which will take approximately 15 minutes to complete. My child also has my permission to complete 2 short questionnaires during March 1994 which will take approximately 20 minutes.

By signing this form, I am also agreeing to participate by completing 2 short questionnaires prior to my child's involvement with the school-based counseling program which should take approximately 30 minutes to complete. I also agree to complete 3 short questionnaires in March 1994 which should take about 35 minutes to complete.

My participation is voluntary and I understand that I may withdraw from participation at any point in this study.

I also understand that all information compiled from this study is CONFIDENTIAL. This means that my name and my child's name will not appear in any publication of this research and that we will not be identified in written or public presentations of this study at any time or under any circumstance.

Parent/Guardian ___________________________________ Date ________________

Investigator's Affidavit

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits and risks involved in his/her participation and his/her signature is legally valid. I have also explained the same about the participation of his/her child. A medical problem or language or educational barrier has not precluded this understanding.

Signature of Investigator __________________________ Date ________________
APPENDIX E

STUDENT ASSESSMENT FORMAT
OUTLINE OF ORAL EXPLANATION

TO CHILDREN WHOSE PARENTS HAVE CONSENTED
TO THEIR PARTICIPATION IN THE SCHOOL-BASED
COUNSELING EVALUATION
(ASSENT FORMAT)

I. Introduction
   A. Myself
      1. Name
      2. Working on Master's in Counseling and Guidance at the University of Arizona.
      3. I have a special interest in school-based counseling programs and how they can help children. I would like to study and learn more about how these programs can best help children.

II. Explanation of Evaluation of School-Based Counseling Program
    A. You are all participating in the counseling program. I'm studying whether the program is helping you and whether there are ways to make it better for you.

III. Procedure
    A. By helping me in this study, you will be anonymously completing one questionnaire now and two questionnaires next Spring. It should take about 15 minutes.
    B. All information you give me is confidential. This means that your name will not appear on any of the questionnaires and will not appear in any part of this study. Your teachers, parents or counselors will not see your questionnaires. To make sure of that, I will be giving you envelopes in which I want you to seal your questionnaires so that no one else sees it except for me.
    C. Participation is voluntary. Your parents have already agreed that it is okay if you want to participate. It is your choice. You can withdraw from participation at any point.

IV. Thanks
APPENDIX F

BEHAVIOR RATING PROFILE, PARENT RATING SCALE
PARENT RATING SCALES
RESPONSE BOOKLET

Instructions for Completing the Parent Rating Scales

The Parent Rating Scale is completed by the individuals who are the primary caregivers of the child who is being rated. Usually this is one or both of the child’s parents. It also may be a foster parent, guardian, or houseparent who is responsible for the child.

There are 30 items on the Parent Rating Scale. Each item is a sentence describing behaviors that may be observed at home. All of the items have been worded negatively. This is because these behaviors have been determined to be the best discriminators of students who are and are not experiencing behavioral difficulties or emotional problems at home and in school.

Please complete the items of the Parent Rating Scale. It is important to respond to all 30 of the items. Instructions for completing the scale are printed on the inside of the booklet.

This Behavior Rating Form contains a list of descriptive words and phrases. Some of these items will describe your child quite well. Some will not. What we wish to know is this: Which of these behaviors are you concerned about at this particular time and to what extent do you see them as problems?

Take, for example, item 2, "Doesn't follow rules set by parents." If the child never follows home rules and is willfully disobedient, the rater might check the "Very Much Like My Child" space. If the child is usually disobedient but occasionally follows a rule set by the parents, the rater might check the "Somewhat Like My Child" space. If the child is usually obedient, a check in the "Not Much Like My Child" space might be appropriate. If the child is never willfully disobedient, then the "Not At All Like My Child" space would be indicated. These ratings should reflect your perceptions of the child’s behavior. Please do not confer with anyone else when completing this form.

(Reprinted with permission of Pro-Ed)
<table>
<thead>
<tr>
<th>My child......</th>
<th>Very Much Like My Child</th>
<th>Like My Child</th>
<th>Not Much Like My Child</th>
<th>Not At All Like My Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is verbally aggressive to parents.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Doesn’t follow rules set by parents.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Overeats, is obese, fat.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4. Complains about doing assigned chores.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Doesn’t follow directions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6. Lies to avoid punishment or responsibility.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. Has associates of which parents don’t approve.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>8. Is not a leader among his/her peers.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10. Is shy; clings to parents.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>11. Is lazy.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. Has no regular, special activities with parents, eg. shopping trips, ball games, etc.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>13. Is self-destructive, pulls out his/her own hair, scratches self to point of drawing blood, etc.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. Is unconcerned about personal hygiene: brushing teeth, bathing, combing hair.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>16. Sleeps poorly; has nightmares, insomnia.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>17. Has too rich a fantasy life.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>18. Takes orders from parents unwillingly.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>19. Is oversensitive to teasing.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>20. Demands immediate gratification, eg. must have the bicycle now, can’t wait.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>21. Talks too little; is non-verbal.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>22. Is unreliable about money; buys compulsively, is not trusted with money.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>23. Tattles on others.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>25. Doesn’t seem to enjoy participating in family recreational activities.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>27. Won’t share belongings willingly.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>28. Doesn’t listen when parents talk.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>29. Demands excessive parental attention.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>30. Cries excessively.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
APPENDIX G

MODIFIED FAMILY ENVIRONMENT SCALE
### FAMILY ENVIRONMENT SCALE

1. Family members really help and support each other.
2. Family members often keep their feelings to themselves.
3. We fight a lot in our family.
4. We don't do things on our own very often in our family.
5. We can't seem to get the best at whatever you do.
6. Activities in our family are pretty carefully planned.
7. Family members are rarely ordered around.
8. We often seem to be bickering at home.
9. We say anything we want to around home.
10. Family members rarely become openly angry.
11. In our family, we are strongly encouraged to be independent.
12. Getting along in life is very important in our family.
13. We generally very neat and orderly.
14. There are very few rules to follow in our family.
15. We put a lot of energy into what we do at home.
16. It's hard to "slow down" at home without spending money.
17. Family members sometimes get so angry they swear.
18. We think things out for ourselves in our family.

| Number | Statement                                                                 | True | False 
|--------|---------------------------------------------------------------------------|------|------
| 1      | Most family members really help and support each other.                    |      |      
| 2      | Family members often keep their feelings to themselves.                    |      |      
| 3      | We fight a lot in our family.                                              |      |      
| 4      | We don't do things on our own very often in our family.                    |      |      
| 5      | We can't seem to get the best at whatever you do.                          |      |      
| 6      | Activities in our family are pretty carefully planned.                    |      |      
| 7      | Family members are rarely ordered around.                                  |      |      
| 8      | We often seem to be bickering at home.                                     |      |      
| 9      | We say anything we want to around home.                                    |      |      
| 10     | Family members rarely become openly angry.                                |      |      
| 11     | In our family, we are strongly encouraged to be independent.               |      |      
| 12     | Getting along in life is very important in our family.                    |      |      
| 13     | We generally very neat and orderly.                                        |      |      
| 14     | There are very few rules to follow in our family.                          |      |      
| 15     | We put a lot of energy into what we do at home.                            |      |      
| 16     | It's hard to "slow down" at home without spending money.                   |      |      
| 17     | Family members sometimes get so angry they swear.                          |      |      
| 18     | We think things out for ourselves in our family.                           |      |      
| 19     | How much money a person makes is not very important to us.                 |      |      
| 20     | It's often hard to find things when you need them in our household.       |      |      
| 21     | There is one family member who makes most of the decisions.               |      |      
| 22     | There is a feeling of superiority in our family.                           |      |      
| 23     | We tell each other about our personal problems.                           |      |      
| 24     | Family members hardly ever lose their tempers.                            |      |      
| 25     | We作文 and go as we want to in our family.                                |      |      
| 26     | We believe in competition and "make the best man win".                    |      |      
| 27     | Being on time is very important in our family.                             |      |      
| 28     | There are set ways of doing things at home.                               |      |      
| 29     | We rarely volunteer when something has to be done at home.                |      |      
| 30     | If we feel like doing something on the spur of the moment we often just pick up and go. |      |      
| 31     | Family members often criticize each other.                                |      |      
| 32     | There is very little privacy in our family.                                |      |      
| 33     | We always strive to do things just a little better the next time.         |      |      
| 34     | People change their minds often in our family.                             |      |      
| 35     | There is a strong emphasis on following the rules in our family.           |      |      
| 36     | Family members really back each other up.                                  |      |      
| 37     | Someone usually you spent if you complain in our family.                  |      |      
| 38     | Family members sometimes hit each other.                                  |      |      
| 39     | Family members always rely on themselves when a problem comes up.         |      |      
| 40     | Family members rarely worry about job promotions, school grades, etc.      |      |      
| 41     | Family members make sure their rules are seen.                            |      |      
| 42     | Everyone has an equal say in family decisions.                            |      |      
| 43     | There is very little group spirit in our family.                           |      |      
| 44     | Money and paying bills is openly talked about in our family.              |      |      
| 45     | If there's a disagreement in our family, we try hard to smooth things over and keep peace. |      |      
| 46     | Family members strongly encourage each other to stand up for their rights. |      |      
| 47     | In our family we don't try that hard to smooth things over and keep peace. |      |      
| 48     | Each person's duties are clearly defined in our family.                   |      |      
| 49     | We can do whatever we want to in our family.                               |      |      
| 50     | We really get along well with each other.                                  |      |      
| 51     | We are usually careful about what we say to each other.                   |      |      
| 52     | Family members often try to one-up or one-do each other.                  |      |      
| 53     | It's hard to be by yourself without hurt. someone's feelings in our household. |      |      
| 54     | "Work before play" is the rule in our family.                             |      |      
| 55     | Money is not handled very carefully in our family.                        |      |      
| 56     | Rules are pretty flexible in our household.                               |      |      
| 57     | There is plenty of time and attention in our family.                      |      |      
| 58     | There is a lot of spontaneous decision-making in our family.              |      |      
| 59     | In our family, we believe you don't ever get anywhere by raising your voice. |      |      
| 60     | We are not really encouraged to speak up for ourselves in our family.     |      |      
| 61     | Usually members are often compared to others as to how well they are doing work or school. |      |      
| 62     | Dishes are usually done immediately after eating.                         |      |      
| 63     | You can't get away with much to say in our family.                        |      |      

APPENDIX H

BEHAVIOR RATING PROFILE,

STUDENT RATING SCALE
Student's Name ________________________________

Date of Rating ________________________________

Instructions for Completing the Student Rating Scales

This booklet contains 60 sentences which describe some of the things that students do at home, at school, and with their friends. Some of these sentences will describe you very well. Other sentences will not describe you at all. If you think a sentence tells about something you do, then fill in the shape under “True.” If a sentence tells about something you do not do, then fill in the shape under “False.” It is important for you to answer all 60 questions. If you do not know the meaning of some of the words in these sentences, ask your teacher or the person who is giving the Student Rating Scales to you.

First, write your name and date in the spaces above. Then, open the booklet and begin completing the items of the Student Rating Scales. Remember to answer all 60 items.

1 Copyright 1990 by PRO-ED, Inc.
My parents 'bug' me a lot.
My parents treat me like a baby.
I think about running away from home.
My parents often get angry with me.
Some of my friends think it is fun to cheat, skip school, etc.
Other students don't like to play or work with me.
Sometimes I get so angry at school that I yell at the teacher and want to stomp out of the room.
I have some friends that I don't invite over to my house.
Other kids don't seem to like me very much.
I argue a lot with my family.
My family doesn't do many things together, like going places or playing games.
I get into too many arguments with people I know.
I sometimes stammer or stutter when the teacher calls on me.
When my parents don't let me do what I want, I get real quiet and don't talk.
My parents don't spend enough time with me.
My parents say that I am awkward and clumsy.
I don't get my way at home.
I am shy around my parents' friends.
Occasionally, I get so upset at things that happen at school that I get sick.
At home I'm always trying to get out of my chores.
I don't like to do chores in the classroom, like erasing the board or running errands.
I often break rules set by my parents.
I never get my way at home.
I am shy around my parents' friends.
I spend too much time playing/workng by myself.
I spend too much time daydreaming in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
I can't seem to concentrate in class.
My teachers don't listen to me.
My teachers don't listen to me.
My teachers don't listen to me.
My teachers don't listen to me.
My teachers don't listen to me.
My teachers give me work that I cannot do.
Other kids say I act like a baby.

True
False
1. My parents 'bug' me a lot.
2. I don't have enough freedom at home.
3. My parents treat me like a baby.
4. I think about running away from home.
5. My teacher often gets angry with me.
6. Some of my friends think it is fun to cheat, skip school, etc.
7. Other students don't like to play or work with me.
8. Sometimes I get so angry at school that I yell at the teacher and want to stomp out of the room.
9. I have some friends that I don't invite over to my house.
10. Other kids don't seem to like me very much.
11. I argue a lot with my family.
12. My family doesn't do many things together, like going places or playing games.
13. I get into too many arguments with people I know.
14. I sometimes stammer or stutter when the teacher calls on me.
15. When my parents don't let me do what I want, I get real quiet and don't talk.
16. I am not interested in schoolwork.
17. My parents don't spend enough time with me.
18. My parents say that I am awkward and clumsy.
19. Other people don't like to share things with me.
20. My parents don't approve of some of my friends.
21. I spend too much time playing/workng by myself.
22. My friends say that I am clumsy.
23. The teacher doesn't choose me to run errands.
24. Other kids don't listen to me when I have something important to say.
25. I don't have enough friends.
26. I can't seem to concentrate in class.
27. My teachers don't listen to me.
28. Usually, I am not interested in what my teachers have to say to me.
29. My teachers give me work that I cannot do.
30. Other kids say I act like a baby.
31. I seem to get into a lot of fights.
32. It is hard for me to make new friends.
33. I have lots of nightmares and bad dreams.
34. I get real angry with the way other kids treat me.
35. My parents expect too much of me.
36. I sometimes play 'hooky.'
37. I have difficulty sitting still in class.
38. Often, I think about getting sick so I won't have to go to school.
39. My parents won't let me spend the night away from home.
40. I don't like it when the teacher tells me what to do.
41. Teachers are often unfair to me.
42. I get teased a lot by the other kids.
43. I rarely get to spend the night with my friends at their homes.
44. People think I'm unattractive.
45. I am dissatisfied with my progress in school.
46. I don't like to do chores in the classroom, like erasing the board or running errands.
47. I often break rules set by my parents.
48. I never get my way at home.
49. I am shy around my parents' friends.
50. Occasionally, I get so upset at things that happen at school that I get sick.
51. At home I'm always trying to get out of my chores.
52. I do a lot of daydreaming in class.
53. I don't tell anybody how I feel.
54. I am rarely invited to a friend's home to eat or play.
55. I can't seem to stay in my desk at school.
56. Other kids are always picking on me.
57. I don't listen when my parents are talking to me.
58. When at home, I spend too much time daydreaming.
59. The things I learn in school are not as important or helpful as the things I learn outside of school.
60. Some people think I am dumb.
APPENDIX I

BEHAVIOR RATING PROFILE

TEACHER RATING SCALE
TEACHER RATING SCALE
RESPONSE BOOKLET

Name of Student Being Rated ____________________________________________

Date of Rating ____________________________

Instructions for Completing the Teacher Rating Scale

The Teacher Rating Scale usually is completed by one or more of the instructors who have the referred student in their classes. Occasionally it also may be given to non-teaching personnel who have regular contact with the student, such as the principal, the librarian, or the school nurse. There are 30 items on the Teacher Rating Scale. Each item is a sentence stem describing behaviors that may be observed at school. All of the items have been worded negatively. This is because these behaviors have been determined to be the best discriminators of students who are and are not experiencing behavioral difficulties or emotional problems at school.

Please take a few minutes before you complete the scale to supply some additional information that will be important in interpreting the results of the Teacher Rating Scale. First, you may be asked by the psychologist or diagnostician to complete the identifying data requested in Section I on the next page of this booklet. Generally, this information is readily available in the student’s cumulative records.

Second, please supply the anecdotal information requested in Section II based on your experience and knowledge of the student. If you need more space to record these comments and observations, please write them on separate sheets of paper and attach them to this booklet.

Third, please complete the items of the Teacher Rating Scale as they are printed in Section V. It is important to respond to all 30 of the items. Instructions for completing the scale are printed directly above the items.

Finally, you also may be asked by the psychologist or diagnostician to score the Teacher Rating Scale. If so, simply tally the raw score as indicated at the bottom of Section V and then convert this raw score to a standard score or percentile rank using the normative table provided on the last page of this booklet in Section VII. The scores then are recorded in Section III. Complete instructions for completing and scoring the Teacher Rating Scale are provided in chapter 2 of the B-RP-2 Examiner's Manual, so please consult the manual if there are any questions about correct procedure.

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Section V. The Teacher Rating Scale Items

This Behavior Rating Form contains a list of descriptive words and phrases. Some of these items will describe the referred student quite well. Some will not. What we wish to know is this: Which of these behaviors are you concerned about at this particular time and to what extent do you see these as problems?

Take, for example, Item 1, "Is sent to the principal for discipline." If the student frequently is sent to the principal's office, the rater might check the "Very Much Like the Student" space. If the student is sent to the principal's office on an infrequent but regular basis, the rater might check the "Somewhat Like the Student" space. If the student has been sent to the principal's office on rare occasions, a check in the "Not Much Like the Student" space might be appropriate. If the student never has been disciplined by the principal, the "Not At All Like the Student" space would be indicated. These ratings should reflect your perceptions of the student's behavior. Please do not confer with other teachers in completing this form.

<table>
<thead>
<tr>
<th>The student</th>
<th>Very Much Like the Student</th>
<th>Not Much Like the Student</th>
<th>Not At All Like the Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is sent to the principal for discipline</td>
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<tr>
<td>2. Is verbally aggressive to teachers or peers</td>
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<td>3. Is disrespectful of others' property rights</td>
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<td>4. Tattles on classmates</td>
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<td>5. Is lazy</td>
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<tr>
<td>6. Lacks motivation and interest</td>
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<td>7. Disrupts the classroom</td>
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<td>8. Argues with teachers and classmates</td>
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<td>9. Doesn't follow directions</td>
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<td>10. Steals</td>
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<tr>
<td>11. Has poor personal hygiene habits</td>
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<tr>
<td>12. Is passive and withdrawing</td>
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<tr>
<td>13. Says that other children don't like him/her</td>
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<td>14. Can't seem to concentrate class</td>
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<td>15. Pouts, whines, sobs</td>
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<td>16. Is overactive and restless</td>
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<td>17. Is an academic underachiever</td>
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<td>18. Bullies other children</td>
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<td>19. Is self-centered</td>
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<td>20. Does not do homework assignments</td>
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<td>21. Is kept after school</td>
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<tr>
<td>22. Is avoided by other students in the class</td>
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<tr>
<td>23. Daydreams</td>
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<td>24. Has unacceptable personal habits</td>
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<td>25. Swears in class</td>
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<td>26. Has nervous habits</td>
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<td>27. Has no friends among classmates</td>
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<td>28. Cheats</td>
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<td>29. Lies to avoid punishment or responsibility</td>
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<tr>
<td>30. Doesn't follow class rules</td>
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</tr>
</tbody>
</table>

Sum of Marks in Each Column = Multiply Sum by 0 1 2 3
Add Products Total Points Scored
REFERENCES


Arizona Department of Health Services. (Not dated). Division of Behavioral Health Services, Checklist for Chronic Mental Illness Determination.


Dade County Public Schools (1976). Experiences of teachers and students with disruptive behavior in the Dade public schools. Miami, FL.


