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AUTHOR Bernes, Kerry
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ABSTRACT

In response to increasing demands that Canadian school boards provide behavior adaptation programs to counter the effects of disruptive home environments, school violence, and victimization, this paper explores definitions and diagnostic criteria for the following behavior disorders: attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, juvenile delinquency, and antisocial personality. The paper outlines how these disorders can be placed on a continuum from least problematic to most problematic. A brief literature review summarizes effects of interventions currently employed to treat youth with behavior disorders. Difficulties associated with current treatments are highlighted and an integrated approach to treatment is provided. The proposed model targets youth diagnosed with conduct disorder ages 13 through 17 by providing them with male and female leaders and a group revolving around an educational/remedial framework. Activities are arranged to challenge students intellectually, physically, and emotionally, in order to form, challenge and extend self-concepts held by group members. (Contains 27 references.) (PB)

Behavior Disorders: The Need for Multiple and Integrated Treatment Activities

Kerry Bernes

University of Calgary

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Running head: BEHAVIOR DISORDERS

Abstract

School boards are increasingly being required to provide behavior adaptation programs to counter the effects of disruptive home environments, school violence, and victimization. In response to this problem, definitions and diagnostic criteria are examined for the following behavior disorders: attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, juvenile delinquency, and antisocial personality. This paper outlines how these disorders can be placed on a continuum, from the least problematic to the most problematic. A brief literature review summarizes the effects of interventions currently utilized to treat youth with behavior disorders. Difficulties associated with current treatments are highlighted and, finally, an integrated approach to treatment is provided.

Behavior Disorders: The Need for

Multiple and Integrated Treatment Activities

In recent years, there has been increased concern on the part of educators regarding students' misbehavior in the classroom. Coincident to this has been a steady decrease in financial resources available to school boards. Continuous staff and program cutbacks have consequently led to fewer and fewer services being offered for exceptional students. For example, the law insists that children under 16 years of age attend school. In reality, attendance counsellors are hard-pressed to find the time necessary to work with those nonattenders under 13 or 14 years of age. Service gaps such as this one are alienating our youth, depriving them of a sense of significance, competence, power, and virtue. Accordingly, these youth at risk are increasingly turning to gang involvement, prostitution, drugs, alcohol, and crime as a means to create belonging, mastery, independence, and generosity.

In response to this problem, the writer will examine the diagnostic criteria and definitions of the following behavior disorders: attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, juvenile delinquency, and antisocial personality. It will be shown that these disorders can be placed on a continuum from the least to the most problematic. With these definitions and diagnostic criteria in mind, a case will be made for the importance of treating students with behavior disorders. A brief literature review will summarize the effects of interventions currently utilized and difficulties associated with treatment will be highlighted. Finally, the writer will propose a series of activities for youth with conduct disorders. These activities will represent an integrated approach to treatment.

Definitions and Diagnostic Criteria

Disruptive Behavior Disorder

The classification of disruptive behavior disorder is used by the American Psychiatric Association's (1987) Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) to categorize the misbehavior of children and adolescents. The manual defines disruptive behavior disorder as ". . . behavior that is socially disruptive and is often more distressing to others than to the people with the disorders" (American Psychiatric Association, 1987, p. 49). Subclassifications under disruptive behavior disorder include attention-deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder.

Attention-deficit hyperactivity disorder. Attention-deficit hyperactivity disorder is characterized by ". . . developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity" (American Psychiatric Association, 1987, p. 50). A list of criteria must be observed more frequently in a child relative to most people of the same mental age in order to be diagnosed as having attention-deficit hyperactivity disorder. The diagnostic criteria for this disorder are presented in Appendix A. The prevalence of this disorder is estimated at 3% of children. The age of onset is between four and the first few years of school (American Psychiatric Association, 1987).

Oppositional defiant disorder. Oppositional defiant disorder is defined as ". . . a pattern of negativistic, hostile, and defiant behavior without the more serious violations of the basic rights of others that are seen in conduct disorder" (American Psychiatric Association, 1987, p. 56).

> Typically, symptoms of the disorder are more evident in interactions with adults or peers whom the child knows well. Thus, children with the disorder are likely to show little or no signs of the disorder when examined clinically. Usually the person does not regard himself or herself as oppositional or defiant, but justifies his or her behavior as a response to unreasonable circumstances. (American Psychiatric Association, 1987, p. 56)

Again, a list of criteria must be observed more frequently in a child relative to most people of the same mental age in order to be diagnosed as having oppositional defiant disorder. The diagnostic criteria for this disorder are presented in Appendix B. DSM-III-R does not report the incidence of this disorder; however, the onset is expected to begin between age eight and early adolescence.

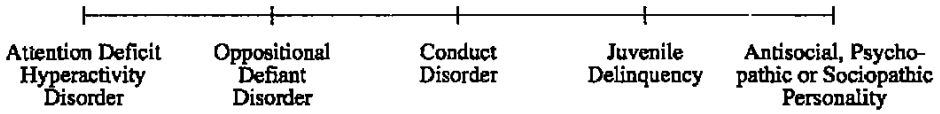
Conduct disorder. Conduct disorder is characterized by

> . . . a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. The behavior pattern typically is present in the home, at school, with peers, and in the community. The conduct problems are more serious than those seen in oppositional defiant disorder. (American Psychiatric Association, 1987, p. 53)

DSM-III-R lists three types of conduct disorder: the group type, the solitary aggressive type, and the undifferentiated type (American Psychiatric Association, 1987). The distinction here is whether or not aggressive acts are carried out with a group of peers or as an individual. The undifferentiated type has no definite preference. The diagnostic criteria for conduct disorder are represented in Appendix C. The incidence of conduct disorder is estimated at 9% for males and 2% for

females under the age of 18. The age of onset is generally before puberty (American Psychiatric Association, 1987).

These subclassifications of behavior disorders can be placed on a continuum from the least to the most problematic (American Psychiatric Association, 1987; Coleman, Butcher, & Carson, 1984; Shamsie & Hluchy, 1991). The continuum is often depicted as follows:



Juvenile delinquency. Juvenile delinquency is actually a legal term and it does not exist as a classification in the DSM-III-R (Coleman et al., 1984). However, it does possess value as a position on the continuum because it utilizes the descriptors under conduct disorder and takes them one step further. Here the individual has not only shown the behaviors described under conduct disorder but has also had definite legal involvement as a result of these maladaptive behaviors.

Antisocial personality disorder. The final step on the continuum is reserved for those over 18 years of age. It is shown on the continuum and is described in this paper to illustrate the importance of treating youth with behavior disorders before they reach 18 and are possibly diagnosed with antisocial personality. The terms 'psychopathic personality' and 'sociopathic personality' are synonymous with antisocial personality.

Antisocial personality disorder is characterized as

> . . . a pattern of irresponsible and antisocial behavior beginning in childhood or early adolescence and continuing into adulthood. For this diagnosis to be given, the person must be at least 18 years of age and have a history of conduct disorder before the age of 15. (American Psychiatric Association, 1987, p. 342)

"These people fail to conform to social norms and repeatedly perform antisocial acts that are grounds for arrest, such as destroying property, harassing others, stealing, and having an illegal occupation" (American Psychiatric Association, 1987, p. 342). Of utmost importance is that these people generally have no remorse about the effects of their behavior on others and they may even feel justified in having hurt or mistreated others (American Psychiatric Association, 1987). The incidence of antisocial personality is estimated at 3% for American males and 1% for American females (American Psychiatric Association, 1987). The diagnostic criteria for this disorder are presented in Appendix D.

The Need for Treatment

The continuum of behavior disorders referred to in the previous section shows the increasing severity of the disorders. It also attempts to illustrate the potentially devastating movement a student can make when treatment is not implemented and/or effective in the earlier and milder stages. In fact, Shamsie and Hluchy (1991) suggest that ". . . up to 40% of those who had been diagnosed as having conduct disorder in childhood continued to have serious psychosocial disturbances in adulthood" (p. 405). There is some indication that those who do not go on to develop antisocial personality often become substance abusers. "There also appears to be an association between

conduct disorder and later psychiatric disorders such as mania, schizophrenia, and obsessive-compulsive disorder" (Shamsie & Hluchy, 1991, p. 407). Along with predicting other psychiatric disorders, conduct disorder is often connected to other adult problems such as unemployment, financial dependency, poor interpersonal relationships, and marital conflict (Shamsie & Hluchy, 1991).

Behavior disorders in general, and conduct disorders, juvenile delinquency and antisocial personalities in particular, exact a heavy toll on society. These effects are observed in the costs associated with institutionalizing offenders, property damage, and assaults on innocent victims (Shamsie & Hluchy, 1991).

> Since most of these young people have no serious disabilities and are of average intelligence, they have the potential to grow up to become normal adults. By not taking steps to prevent the early damage and effectively treating them afterwards, we condemn ourselves to bear the cost of looking after these youth for most of their lives, and condemn them to a life of crime and despondency. (Shamsie & Hluchy, 1991, p. 405)

The costs and growing public alarm at increasing violence among youth makes treatment a necessity. Thus, the writer will now turn to a literature review of potential interventions now being utilized for youth with maladaptive behaviors.

Review of the Literature

A review of the literature, along with the writer's experience in this field, suggests that many different interventions are currently used to treat behaviorally disturbed youth. These interventions include: drama and play therapy (Mosley, 1988), social skills training (Verduyn, Lord, & Forrest, 1990; Lowenstein, 1989; Elias &

Branden, 1988; Zarragoza, Vaugh, & McIntosh, 1991; Singh, Deitz, & Epstein, 1991), experiential education (Tritt, 1991; Cohen & Sovet, 1989; Welds, 1986; Marx, 1988), work experience (Welds, 1986; Marx, 1988), cognitive-behavioral approaches (Fling & Beck, 1984; Salend & Lamb, 1986; Elliot, 1986; Fantuzzo, Polite, Cook, & Quinn, 1988), family therapy (Shamsie & Hluchy, 1991), anger management (Shamsie & Hluchy), and martial arts training (Fuller, 1988; Richman & Rehberg, 1986; Skelton, Glynn, & Berta, 1991; Trulson, 1986; Konzak & Boudreau, 1984; Nosanchuk, 1981; Nosanchuk & MacNeil, 1989).

Verduyn et al. (1990) evaluated a school-based social skills training program. They found significant improvement in social activity, parental report of social behavior, and self-esteem in treatment groups as compared with control groups. Lowenstein (1989) suggests that the peer group should be used to facilitate social skills training and behavioral change. Lowenstein (1989) found that three social skills training techniques were effective in enhancing self-esteem: (1) confronting young people with the results of their behavior; (2) creating a sense of shared decision-making and responsibility between young people and those who care for them; and (3) finding alternatives to negative patterns. Elias and Branden (1988) suggest that social skills training would be helped by improving coping skills, social support, self-esteem, increasing supportive resources in the schools, and providing opportunities for students to enact a wider variety of social roles than is presently encouraged in schools.

Zaragoza et al. (1991) examined 27 studies that used social skills training as an intervention for behaviorally-disturbed students. They found that social skills

interventions have been successful in yielding changes in self, teacher, and parent perceptions but peer perceptions seemed more resistant to change. Singh et al. (1991) reviewed 28 outcome studies that dealt with social behavior deficits or inappropriate social responding of children and adolescents. They found that the social skills training procedures were used unsystematically. They also report that, although the ". . skills-deficit model has been used in the great majority of social skills training studies with adults, its validity with this population has yet to be established" (Singh et al., 1991, p. 74).

Mosley (1988) describes the use of drama therapy in treating behavior problems. She suggests the use of behavior contracts coupled with role play as an effective remedial technique.

Experiential educational interventions are generally based on the assumption that, in any learning event, one's self-concept is being formed, challenged, extended, and threatened (Tritt, 1991). The goal is to permit alternative and flexible self-conceptions so as to alleviate negative self-fulfilling prophecies and to promote risk-taking. Such risk-taking activities hopefully produce more adaptive behaviors by challenging existing perceptions of the student as learner. Cohen and Sovet (1989) define experiential learning as learning that is ". . . characterized by changes in judgement, attitude, or skills acquired through direct participation in a series of events" (p. 117). Welds (1986) believes that experiential educational programs should foster questioning, collaborative learning, team building, discussion groups, and decision making. She outlines how these elements were included in an experiential sailing program. Students conducted classes on the boat as they saw the world. Cooperation

was necessary to satisfy their day-to-day needs. The travelling experience worked to enhance each learner's capacity for self-direction and intellectual responsibility.

Many outdoor adventure programs are found throughout the literature. These programs, like the one Marx (1988) describes, tend to challenge students physically, mentally, and emotionally. The goal is to move students from acting-out behavior to emotional verbalization. In this manner, students, in effect, teach themselves self-control and self-discipline techniques.

Mill and Walter (cited in Shamsie & Hluchy, 1991) illustrate that helping offenders find jobs and keep them reduced their chances of being arrested again. They attribute this success to ". . . factors such as working with employers, the shaping of pro-employment behavior in the adolescent, and the pay received at the end of the week" (Shamsie & Hluchy, 1991, p. 409).

Cognitive behavioral approaches aimed at solving this problem have been met with mi :d reviews. For example, Fling and Black (1984) describe their attempt to teach relaxation and covert rehearsal skills to fourth graders. Unfortunately, acquisition of these skills did not show significant behavioral improvement. On the other hand, Salend and Lamb (1986) found that the use of a group-managed response-cost system mediated by free tokens worked to decrease inappropriate behavior. The use of peer pressure coupled with group ownership seemed to enhance generalization and maintenance of improved behavioral patterns.

Elliot (1986) states that ". . . children should be involved in decisions about treatment for their own misbehavior and that, in general, children can make valid judgements about treatment procedures" (p. 23). Similarly, Fantuzzo et al. (1988)

evaluated 26 studies that directly compared teacher- versus student-managed interventions.

> It was found that student-management interventions resulted in greater treatment effect sizes than those of the teacher-management interventions, and there was a significant positive relationship between the number of intervention components that were student managed and the treatment effect size. (Fantuzzo et al., 1988, p. 154)

Using behavioral systemic family therapy (in which principles of systemic and behavioral approaches are combined) has also shown positive results. Similarly, providing parent skills training has also resulted in the behavioral improvement of children (Shamsie & Hluchy, 1991).

Wolf, Braukmann, and Ramp (cited in Shamsie & Hluchy, 1991) report the applicability of anger management training. This multimodal, psychoeducational intervention for assaultive, hostile adolescents has shown a decrease in the number and intensity of antisocial behavioral incidents for institutionalized youth.

Providing traditional martial arts training for behaviorally disturbed youth has consistently shown positive results (Fuller, 1988; Richman & Rehberg, 1986; Skelton et al., 1991; Trulson, 1986; Konzak & Boudreau, 1984; Nosanchuk, 1981). An exception to this is when the training is not grounded in the traditional concepts of respect, self-discipline, and self-control. Traditional training emphasizes respect for others, building confidence and self-esteem, the importance of physical fitness, patience, perseverance, humility, honesty, honor, and responsibility (Trulson, 1986). Furthermore, there is a strong emphasis on using techniques only for self-defence, to

protect oneself, one's family, the weak, and one's country. In fact, students are generally required to sign a pledge stating that they will use their skills only for the above-mentioned purposes (Trulson, 1986). The majority of nontraditional clubs do not require such a pledge and they typically only teach fighting and self-defence techniques. Trulson (1986) suggests that this type of training ". . . enhances the negative personality traits of people who are already delinquent" (p. 1137).

Skelton et al. (1991) examined the effect of tae kwon do training on the level of aggression of 68 six- to 11-year-old tae kwon do students. "A significant inversive relationship was found between the children's tae kwon do rank and their aggression" (Skelton et al., 1991, p. 179). Measurements were formulated with the use of the Revised Child Behavior Profile.

Trulson (1986), in his article titled, "Martial Arts Training: A Novel 'Cure' for Juvenile Delinquency," summarizes the results of his study consisting of three samples.

> Group 1 received training in the traditional Korean martial art of tae kwon do, Group 2 received training in a modern version of the martial art that did not emphasize the psychological/philosophical aspects of the sport, and Group 3 served as a control group for contact with the instructor and physical activity. (Trulson, 1986, p. 1131)

Each group received training for one hour, three times weekly, for six months.

> Group 1 showed decreased aggressiveness, lowered anxiety, increased self-esteem, increased social adroitness, and an increase in value orthodoxy. Group 2 showed a greater tendency toward delinquency on the Minnesota Multiphasic Personality Inventory (MMPI) than they did at the beginning of

the study, a large increase in aggressiveness, and general opposite effects of Group 1 on the Jackson Personality Inventory. (Trulson, 1986, p. 1131)

Konzak and Boudreau (1984) claim that karate training serves as an excellent means of resocialization. They found that higher-ranking karate participants showed a distinct personality profile characterized by higher scores on intelligence, emotional stability, and relaxation as compared to lower-ranking participants.

Nosanchuk (1981) attempted to identify whether or not the concepts of self-control, self-assertiveness, self-esteem, or self-confidence played an intervening role in the inverse relationship between increased training and decreased aggressiveness. He found no evidence to suggest that these variables demonstrated any kind of intervening potential.

With a review of the literature complete, the writer will now discuss some of the problems associated with treatment.

Problems Associated with Treatment

Fortunately, a review of the literature reveals that many types of interventions achieve positive outcomes. Typically, the research attempts to measure the effectiveness of an individual treatment method against client outcomes. Even in practice, programs typically operate on the basis of one type of intervention and rarely are interventions combined as activities under an overriding psychological theory or theoretical context. Instead, approaches maintain their distinctiveness and separateness from one another. A simple example of this are programs designed to provide behaviorally disturbed students with work experience training. Limited rationales claim that behaviorally disturbed youth are disinterested in school and require skills for

the work force. The entire program is limited by offering only one activity or intervention to precipitate behavioral change. Learning theory in general, and learning styles in particular, tell us as educators that this type of single intervention strategy is, at best, an ad-hoc guess at what is the most suitable form of treatment for individual students. Ultimately, the treatment may reach some and miss others. This is true of all modalities; however, as educators and psychologists we need to understand that a combination of activities designed for a specific group of participants under a particular theoretical rationale and context would be the most effective. Shamsie and Hluchy (1991) state that with many new approaches, it is now possible to individualize treatment plans and that a careful assessment and formulation should point to a mix of approaches that would best serve a particular youth.

Current programs for the behaviorally disturbed frequently utilize the idea of social interaction as a privilege when, in fact, it should become a basic component of the curriculum. Thus, many of these students are lumped together and then excluded from outside contacts and social experiences. This segregative approach may be accounted for by society's tendency to take a punitive rather than rehabilitative attitude toward aggressive youth. Coleman et al. (1984) suggest that such punitive actions work to intensify rather than correct the behavior. Long (1991) attempts to solve this dilemma by stating that there are clearly no winners in a power struggle with aggressive students. Long (1991) goes on to state that

> . . . what's surprising about this aggressive conflict cycle is that even if the student loses the power struggle and is suspended or physically restrained, the

> aggressive student's basic assumptions that adults are hostile and that he has a right to be angry or "to get even" are reinforced. (p. 47)

Long (1991) suggests that adults need to learn to control and take ownership of their counter aggressive feelings. In this manner, the cycle is broken and the adult gains the neutral position of being able to help the student understand the root of his/her feelings. This understanding is crucial since the aggressive child has never learned to tolerate normal amounts of frustration, disappointment, or anxiety (Long, 1991). "Instead of owning these feelings, he gives them away by attacking or depreciating everyone in sight" (Long, 1991, p. 47). If the adult acts in a counter aggressive manner, the conflict escalates. This escalation is what Long (1991) calls the aggressive conflict cycle.

Another problem associated with treatment is that knowledge about the developmental nature of conduct disorders, the aggressive conflict cycle, and behavior therapy is generally lacking in the staff that provide treatment for behaviorally disturbed students. This is because it is typically the least experienced staff that work with behaviorally disturbed youth (Colyar, 1991; Long, 1991; Shamsie & Hluchy, 1991). The annoying behaviors and the lack of progress made by these youth lead to low morale and frequent staff turnover. Ultimately, this hinders treatment effectiveness.

Another problem associated with treatment is that programs are typically very short-term in nature. The writer has found it to be very rare for treatment to last longer than three months; most programs operate on the basis of one month or 20 school days. Extremely disturbed students are continuously moved from one treatment

to the next. Shamsie and Hluchy (1991) state that ". . . in most cases from the time the first symptoms appear at preschool age to late adolescence, ten to 12 agencies have been involved, with repeated assessments and no systematic ongoing treatment plan" (p. 409). Shamsie and Hluchy (1991) also suggest that these ". . . transitions sometimes lead to setbacks in the progress achieved during treatment" (p. 411). Similarly, effective treatments such as behavioral systemic family therapy are often unable to be used because of a lack of familial involvement (Shamsie & Hluchy, 1991).

Other treatment problems revolve around the lack of evaluations conducted by facilities and the financial necessities of having to lump youth suffering from other diagnoses into the same residential programs as youth with behavior disorders. "This often results in those with conduct disorder mistreating patients who are psychotic, depressed, or have a dual diagnosis, disrupting programs and demanding an inequitable amount of attention from the staff" (Shamsie & Hluchy, 1991, p. 411).

With these ideas and considerations in mind, the writer now proposes a treatment program for a specified target population. The type of group used, the theoretical context for it, the role of group leaders, and activities the participants would engage in are all outlined. Program evaluation is also commented upon.

Proposal

This proposal targets youth aged 13 to 18 who have been excluded from the regular school system. The population best suited for this proposal has been diagnosed with conduct disorder. Two leaders (one male and one female) would work with eight students for one full academic year. Although this proposal is geared toward students

with conduct disorder, the writer supports the preventive stance taken by Shamsie and Hluchy (1991).

Type of Group Used

This group would revolve around an educational/remedial framework. Activities would be arranged to challenge students intellectually, physically, and emotionally. The purpose would be to form, challenge, and extend the current self-concepts held by members of the group. Every attempt would be made to guide students toward a sense of mastery, independence, belonging, and generosity. It is believed that this focus, along with the theoretical context and selected activities, would result in a decrease in aggression, criminal activity, and problems with authority figures. Increased self-control, discipline, concentration, respect for self and others, social skills, commitment, and self-esteem would also be intended.

Theoretical Context

Behavioral principles would provide the framework for this program. Concepts such as classical conditioning, extinction, operant or instrumental learning, aversive conditioning, shaping, cognitive restructuring, reinforcement, modelling, treatment contracts, goal setting, behavioral rehearsal, role playing, relaxation training, and self-control would be drawn upon to arrange individualized treatment. Throughout all activities, the overriding philosophy of the program would be to enhance Brendtro, Brokenleg, and Van Bockern's (1990) concepts of belonging, mastery, independence, and generosity. More will be presented about these concepts and the theoretical context in the subsection entitled "Activities".

Role of Group Leaders

The group leaders are expected to be well-versed in the areas of maladaptive behavior, the aggressive conflict cycle, conduct disorders, education, behavior therapy, and the concepts highlighted by Brendtro et al. (1990). The leaders are authoritative but certainly not authoritarian. They act more as elders and leaders facilitating, guiding, organizing, and directing the group through a predetermined set of specified activities. Although members would look to the leaders for instructing, pacing, and sequencing, the group members are not without the power and ability to set their own goals and make suggestions pertaining to alternate activities.

The leaders would prepare objectives prior to each day. Day-by-day plans would specify interventions that could be used to achieve objectives. Group leaders would encourage and serve as models for providing positive and constructive feedback. These messages help group members achieve their goals, and the feedback is a necessary component within the general principle of shaping. Leaders utilize the concepts of reinforcement, extinction, punishment, and modelling to influence desired and undesired behaviors. These techniques would be modelled so that group members could further the therapeutic effects by utilizing the principles with one another.

Activities

The proposed program would follow a schedule beginning at 9:00 a.m. and ending at 4:00 p.m., Monday through Friday. Mock schedules are as follows:

Monday - Thursday	
9:00 a.m. - 10:30 a.m.	Martial arts training
10:30 a.m. - 11:30 a.m.	Life skills training
11:30 a.m. - 12:30 p.m.	Lunch
1:00 p.m. - 4:00 p.m.	Work experience
Friday	
9:00 a.m. - 10:30 a.m.	Group meeting for goal setting, contracting, and program planning
10:30 a.m. - 4:00 p.m.	Experiential education

The martial arts training would be delivered in a traditional manner and would emphasize the psychological/physiological principles of self-control, self-discipline, and respect for self and others. Behavioral principles would be utilized to influence desired and undesired behaviors. A sense of competence in these skills would eventually result in some feelings of mastery and achievement.

Life skills training would attempt to provide remedial and preventative educational experiences. Thus, training in social skills, health, nutrition, career, money management, hygiene, sexuality, and relaxation would be provided. The Career and Lifestyles Management 20 curriculum (Alberta Education) would provide the basis for these activities. Here an attempt would be made to enhance the self-concept of group members and to provide a sense of belonging. Belonging would be enhanced by delivering pertinent social information to students. It is hoped that this information would enhance the quality of group members' relationships, thereby improving each individual's sense of belonging.

Work experience opportunities would focus in on the interests and goals of group members. While providing members with actual skills, work experience would enhance feelings of independence and autonomy. Feelings of generosity would also be reinforced as members would volunteer their services to the communities they serve. Group leaders would go out to work sites to provide additional reinforcement to group members.

The weekly group meeting serves as a means of obtaining, calculating, and discussing individual and program goals. This would foster a sense of belonging, oneness, and group cohesiveness. Members would work together to set individual and program goals.

Experiential educational activities would be derived from within the group at the weekly meetings. Activities may include educational visits to museums, libraries, occupational sites, planetariums, and post-secondary institutions, or recreational pursuits such as horseback riding, hiking, skiing, swimming, mountain climbing, and rope climbing. An attempt would be made to facilitate the development of a wide variety of activities, thus enhancing a sense of mastery and independence.

Assessment and Evaluation

Behavioral observations, checklists, interviews (with parents, teachers, students), and standardized assessments such as the Minnesota Multiphasic Personality Inventory and the Jackson Personality Inventory will be conducted before and after treatment to establish progress and outcome measures. Interviews will qualitatively focus on determining each student's ability to connect with others and build relationships. An attempt will also be made to assess individual levels of conscience

development, i.e., each student's ability to show guilt or remorse for his or her own actions. Students will be selected for this program based on their diagnosis of conduct disorder and their expected prognosis and motivation for treatment. The prognosis will be based on assessment information gathered prior to student intake.

Medical exams will also be conducted to ensure that there are no physical or organic factors affecting the behaviors. "In cases where organic brain damage is suspected it is important to have neurological tests--such the EEG, CAT Scan, or PET Scan--to aid in determining the site and extent of organic brain disorder" (Coleman et al., 1984, p. 607). Neuropsychological tests may also be required to determine if the underlying brain disorder is affecting an individual's behavior.

Conclusion

Some specific behavior disorders were defined and examined, and a case was made for the necessity of providing treatment for behaviorally disturbed youth. A literature review revealed some problems associated with current treatment modalities. This information led to the proposed treatment program for behaviorally disturbed students. The specification of a targeted population, an outline of the type of group to be used, the theoretical context, the role of group leaders, and an explanation of the activities members would engage in were all outlined. Program evaluation was also incorporated. This treatment program, as compared to others currently operating in the city of Calgary (Alberta, Canada), breeds a better sense of belonging, mastery, independence, and generosity. Its focus on long-term treatment and increased social interaction facilitates the realization of these ideals. Behavioral principles provide an excellent framework for work with behaviorally disturbed students. The program's

theoretical grounding and its emphasis on providing multiple activities vastly improves its likelihood for success.

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Appendix A

Diagnostic Criteria: Attention-Deficit Hyperactivity

Disorder (American Psychiatric Association, 1987, p. 52)

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:
   (1) often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
   (2) has difficulty remaining seated when required to do so
   (3) is easily distracted by extraneous stimuli
   (4) has difficulty awaiting turn in games or group situations
   (5) often blurts out answers to questions before they have been completed
   (6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
   (7) has difficulty sustaining attention in tasks or play activities
   (8) often shifts from one uncompleted activity to another
   (9) has difficulty playing quietly
   (10) often talks excessively
   (11) often interrupts or intrudes on others, e.g., butts into other children's games
   (12) often does not seem to listen to what is being said to him or her
   (13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
   (14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

   Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

Appendix A (cont'd)

C. Does not meet the criteria for a Pervasive Development Disorder.

Criteria for severity of Attention-Deficit Hyperactivity Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis **and** only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe".

Severe: Many symptoms in excess of those required to make the diagnosis **and** significant and pervasive impairment in functioning at home and school and with peers.

Appendix B

Diagnostic Criteria: Oppositional Defiant Disorder

(American Psychiatric Association, 1987, p. 57)

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least five of the following are present:
   (1) often loses temper
   (2) often argues with adults
   (3) often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home
   (4) often deliberately does things that annoy other people, e.g., grabs other children's hats
   (5) often blames others for his or her own mistakes
   (6) is often touchy or easily annoyed by others
   (7) is often angry and resentful
   (8) is often spiteful or vindictive
   (9) often swears or uses obscene language

   Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Does not meet the criteria for Conduct Disorder, and does not occur exclusively during the course of a psychotic disorder, Dysthymia, or a Major Depressive, Hypomaniac, or Manic Episode.

Criteria for severity of Oppositional Defiant Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis **and** only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe".

Severe: Many symptoms in excess of those required to make the diagnosis **and** significant and pervasive impairment in functioning at home and school and with other adults and peers.

Appendix C

Diagnostic Criteria: Conduct Disorder

(American Psychiatric Association, 1987, p. 55)

A. A disturbance of conduct lasting at least six months, during which at least three of the following have been present:
   (1) has stolen without confrontation of a victim on more than one occasion (including forgery)
   (2) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning)
   (3) often lies (other than to avoid physical or sexual abuse)
   (4) has deliberately engaged in fire-setting
   (5) is often truant from school (for older person, absent from work)
   (6) has broken into someone else's house, building, or car
   (7) has deliberately destroyed others' property (other than by fire-setting)
   (8) has been physically cruel to animals
   (9) has forced someone into sexual activity with him or her
   (10) has used a weapon in more than one fight
   (11) often initiates physical fights
   (12) has stolen with confrontation of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)
   (13) has been physically cruel to people

   Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. If 18 or older, does not meet criteria for Antisocial Personality Disorder.

Criteria for severity of Conduct Disorder:

Mild: Few, if any, conduct problems in excess of those required to make the diagnosis, **and** conduct problems cause only minor harm to others.

Moderate: Number of conduct problems and effect on others intermediate between "mild" and "severe".

Severe: Many conduct problems in excess of those required to make the diagnosis, **or** conduct problems cause considerable harm to others, e.g., serious physical injury to victims, extensive vandalism or theft, prolonged absence from home.

Appendix D

Diagnostic Criteria: Antisocial Personality Disorder

(American Psychiatric Association, 1987, p. 344)

A. Current age at least 18.

B. Evidence of Conduct Disorder with onset before age 15, as indicated by a history of *three* or more of the following:
   (1) was often truant
   (2) ran away from home overnight at least twice while living in parental or surrogate home (or once without returning)
   (3) often initiated physical fights
   (4) used a weapon in more than one fight
   (5) forced someone into sexual activity with him or her
   (6) was physically cruel to animals
   (7) was physically cruel to other people
   (8) deliberately destroyed others' property (other than by fire-setting)
   (9) deliberately engaged in fire-setting
   (10) often lied (other than to avoid physical or sexual abuse)
   (11) has stolen without confrontation of a victim on more than one occasion (including forgery)
   (12) has stolen with confrontation of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)

C. A pattern of irresponsible and antisocial behavior since the age of 15, as indicated by at least *four* of the following:
   (1) is unable to sustain consistent work behavior, as indicated by any of the following (including similar behavior in academic settings if the person is a student):
      (a) significant unemployment for six months or more within five years when expected to work and work was available
      (b) repeated absences from work unexplained by illness in self or family
      (c) abandonment of several jobs without realistic plans for others
   (2) fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest (whether arrested or not), e.g., destroying property, harassing others, stealing, pursuing an illegal occupation

Appendix D (cont'd)

(3) is irritable and aggressive, as indicated by repeated physical fights or assaults (not required by one's job or to defend someone or oneself), including spouse- or child-beating

(4) repeatedly fails to honor financial obligations, as indicated by defaulting on debts or failing to provide child support or support for other dependents on a regular basis

(5) fails to plan ahead, or is impulsive, as indicated by one or both of the following:
  (a) travelling from place to place without a prearranged job or clear goal for the period of travel or clear idea about when the travel will terminate
  (b) lack of a fixed address for a month or more

(6) has no regard for the truth, as indicated by repeated lying, use of aliases, or "conning" others for personal profit or pleasure

(7) is reckless regarding his or her own or others' personal safety, as indicated by driving while intoxicated, or recurrent speeding

(8) if a parent or guardian, lacks ability to function as a responsible parent, as indicated by one or more of the following:
  (a) malnutrition of child
  (b) child's illness resulting from lack of minimal hygiene
  (c) failure to obtain medical care for a seriously ill child
  (d) child's dependence on neighbors or nonresident relatives for food or shelter
  (e) failure to arrange for a caretaker for young child when parent is away from home
  (f) repeated squandering, on personal items, of money required for household necessities

(9) has never sustained a totally monogamous relationship for more than one year

(10) lacks remorse (feels justified in having hurt, mistreated, or stolen from another)

D. Occurrence of antisocial behavior not exclusively during the course of Schizophrenia or Manic Episodes.