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COGNITIVE BEHAVIORAL INTERVENTION FOR CHILDREN WITH
DISRUPTIVE BEHAVIOR DISORDERS IN RESIDENTIAL TREATMENT:
APPLICATION OF THE WEXLER PRISM MODEL

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Kathryn Joanne Morin Silva


June 2000

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ABSTRACT

Increasing numbers of children being referred for mental health services are exhibiting problematic behaviors that can be subsumed under the category of Disruptive Behavior Disorders. This study with its foundations in a post-positivist approach was designed to explore treatment effectiveness of cognitive behavioral intervention applied to adolescents at Oak Grove Institute, a residential treatment facility. This study hypothesized that Wexler's PRISM Model, with its integration of affect, would be instrumental in modifying disruptive behavior as measured at Oak Grove Institute. Although the small sample size precluded statistically significant findings, there were interesting results with respect to two dependant variables. Findings approached significance on measures of impulsivity and verbal aggression. That is, impulsivity and verbal aggression scores were lowered.

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TABLE OF CONTENTS

ABSTRACT	iii
ACKNOWLEDGMENTS	iv
LIST OF TABLES	viii
CHAPTER ONE	
Introduction	1
CHAPTER TWO	
Literature Review	9
Etiology, Symptomatology, and Prevalence of Disruptive Behavior Disorders	9
Etiology	14
The Role of Biology, Family, and Culture in DBD	16
Treatment Considerations for Disruptive Behavior Disorders	18
The Role of Theory in Treatment	24
The PRISM Model at Oak Grove Institute	25
CHAPTER THREE	
Methods	30
Description of Sample	30
Procedure	33
Data Collection	35
Instruments	36
Protection of Human Subjects	37

Data Analysis	37
CHAPTER FOUR	
Results	38
Survey Responses	42
CHAPTER FIVE	
Discussion	46
Limitations	48
Implications for Social Work	52
APPENDICES	
A. Consent Forms	55
B. Surveys	59
REFERENCES	63

LIST OF TABLES

Table 1. Description of Sample by Age, Gender, and Ethnicity	32
Table 2. Descriptive Statistics.	40
Table 3. Behavioral Scores by Age and Gender	41
Table 4. Participants' Perception of Cohesiveness	43
Table 5. Perceived Effectiveness of PRISM Model	44

Chapter One

Introduction

Whether through tantrums, non-compliance, aggression, or impulsivity, individuals considered to evidence disruptive behavior disorders (DBD) are described as "acting out" or externalizing their feelings (Routh, 1994). Quay and Hogan (1999) attest a range of disorders are subsumed under the canopy of DBD, such as Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). However, it is important to note other diagnoses also display these troublesome symptoms. For instance, Tourette's Syndrome and Intermittent Explosive Disorder often present with recurrent problems of impulsivity and aggression (Bruun and Bruun, 1994; Greene, 1998; Breen and Altepeter, 1990).

In addition, disruptive behavior can be witnessed in certain affective disorders like depression and anxiety (Barkley, 1998; Fieve, 1989; Lieberman, 1979; Meichenbaum, 1976; Oaklander, 1978; Stark, Brookman & Frazier, 1993). Previous research indicates the significance of disinhibition and problems with impulse control in ODD, CD, ADHD and other disruptive behavior disorders (Barkley, 1998; Dumas, 1992; Quay and Hogan, 1999; Routh, 1994; Wood,

1999). Many neurologically based disorders, including traumatic brain injury, can present symptoms of aggression, impulsivity and non-compliance (Teeter, 1995; Bruun and Bruun, 1994).

By the end of 1999, three out of four of the estimated three million children receiving mental health services will be diagnosed with a disruptive behavior disorder (Quay and Hogan, 1999). This population is more likely to be referred for mental health services because of the high visibility and negative impact of their behavior on others. It is not only the concern of others and the increasing number of referrals that factor into the urgency in early interventions for these disorders, but the ultimate cost in distress that individuals with disruptive behaviors incur (Breen and Altepeter, 1990; Ilg, Ames, & Baker, 1981; Pipher, 1996). Severe assaults on self-efficacy, self-determination, and self-esteem are just a few areas of psychological development affected by DBD. The sense of self-efficacy, in particular, has been linked to psychological resilience. Studies indicate a child with a strong sense of self-efficacy is better able to cope with life's ordeals. The concept of self-efficacy can translate to achieving therapeutic goals. Therapy can help a child

build a sense of self-efficacy one task at a time.

Treatment outcomes can be determined by 1) how efficacious a child perceives the treatment to be in relation to him or her self and 2) how confident a child feels in implementing therapeutic tasks (Oaklander, 1978). This concept follows along the lines of the placebo effect; if we think it works, it works (Glasser & Horne, 1994; Greene, 1998).

Long histories of poor performance often leave these children feeling unsuccessful. Their sense of failure cycles into further poor performance leading children to perceive themselves as, in my terms, "un-helpable" (Bruun & Bruun, 1994; Greene, 1998; Barkley, 1998). The perception of being "un-helpable" increases the likelihood of self-defeating behavior. Given enough time these behaviors become entrenched leading to a lifetime of various forms of dysfunctional interactions. Such dysfunctional patterns are evidenced later in life in a variety of ways: individuals with disruptive behaviors often struggle with earning a stable income, maintaining intimate relationships, coping with personal stress, and battling with substance abuse (Barkley, 1999; Routh, 1994).

The impact of non-compliance, impulsivity, and aggression is extremely profound on the individual, his or

her family, school, and the community. Social and familial concerns stem from recent studies indicating an increasing fear that early behavior disorders may lead to criminality (Kellerman, 1999; Raine, 1995; Walsh, 1987). Higher incidences of property crime, physical aggression, and personal harm are found in children displaying disruptive behaviors (Barkley, 1998).

Successful therapeutic interventions may alleviate suffering for many individuals struggling daily with these disorders. Research findings indicate early intervention with these children can offset dysfunctional patterns of thinking and relating that lead to troubled lives (Barkley, 1998; Ilg, Ames, & Baker, 1981). Early intervention can reverse a child's perceived sense of being "un-helpable." The majority of studies on treatment strategies indicate the effectiveness of cognitive-behavioral interventions (Beckham & Watkins, 1989; Breen & Altepeter, 1990; Fiedler & Guttman, 1994; DeGuisepe, 1989).

Aaron Beck and Albert Ellis provide effective treatment strategies that address how unaware these children are of the link between their thoughts, feelings, and behaviors. Ellis' Rational Emotive Therapy (RET) and Beck's "Cognitive Schemas" provide the client with the

tools to slow down and recognize "faulty thinking" (Wexler, 1991; Freeman & Reinecke, 1995). One such model based on the theories of Ellis and Beck is the PRISM Model designed by Dr. David Wexler. **Program for Innovative Self-Management** (PRISM) has its philosophical basis in the belief that children with problematic behaviors usually attempt to do their best with what skills they have. Even when their decisions lead to dangerous or destructive results, these children try to deal with difficult situations in their environment as effectively as they knew how.

Further, the PRISM Model is guided by concepts stating that when children learn new coping skills, recognize basic emotional states, and are treated empathetically they will be able to increase their self-esteem, control their behavior, and minimize symptoms of anxiety and depression (Wexler, 1991). One goal of this study was to explore group members' sense of self-efficacy with respect to treatment interventions. One way to accomplish this was by surveying their opinion of the PRISM Model's effectiveness in helping them learn new coping strategies and manage their behavior.

There are three primary theoretical sources for the PRISM Model: the self-psychology principles of Dr. Heinz Kohut, the cognitive-behavior techniques of Drs. Aaron Beck

and Albert Ellis, and the strategic hypnosis-based approach of Milton Erickson (Wexler, 1991). The direct influence of the above-mentioned theories on the principles of practice for the PRISM model will be explored later in this study.

Despite the extensive literature on the efficacy of cognitive-behavioral interventions and the PRISM Model's secure grounding in this theoretical approach for adolescents with disruptive behaviors, this treatment model has not been empirically documented at the time of this study. It was with this goal in mind that the PRISM Model was implemented at Oak Grove Institute, a Level 12 residential treatment facility. The model was implemented in the manner of an adjunct therapy group, similar to many already underway at this institution. Oak Grove provides a suitable venue for this study as Wexler originally designed the program for adolescents in residential treatment (Wexler, 1991a, 1991b).

This study addressed the effectiveness of the group therapy model (PRISM) when applied to children diagnosed with any of the above-mentioned disorders in residential treatment at Oak Grove Institute. Although this model was utilized several years ago at Oak Grove Institute, the opportunity to empirically evaluate its effectiveness did

not present itself. It was the goal of this study to evaluate the efficiency of the PRISM model in modifying behavior as it pertains to the residents of Oak Grove Institute.

As a residential treatment facility, Oak Grove provides a 24-hour therapeutic program of in-patient hospitalized care with a non-public school on site. Individual, group, and family therapy are offered in conjunction with ancillary therapies and services. The institute utilizes cognitive-behavioral interventions and operates from a social learning model, all within the framework of a therapeutic milieu (Brochure).

This residential treatment facility works with a diverse population of children (ages 8-18) who are currently unable to successfully live at home or attend public schools. Residents have been appointed to this institution by courts, local school districts, or upon request of the family members. Their disruptive behaviors have led them into difficulties within the educational or legal systems. Residents of Oak Grove may struggle with a broad range of emotional and behavioral problems stemming from long-term medical, neurological, or psychological origins (Brochure).

The goal of this study was to implement a cognitive-behavioral group intervention with a select group of Oak Grove Institute residents who struggle with DBD behaviors of non-compliance, impulsivity, and aggression. The goal of intervention was to decrease the maladaptive behaviors while increasing the pro-social behaviors of positive peer interaction, asking for help, and appropriate verbalization of feelings.

The group, containing six children (aged 10-18), learned and applied strategies set forth in Dr. David Wexler's PRISM workbook. Wexler's (1991) cognitive-behavioral model addresses issues of impulse control, anxiety, and psychophysiological disturbances with which the majority of Oak Grove residents struggle.

It was important to evaluate how effective the cognitive-behavioral based PRISM model was in reducing negative target behaviors (non-compliance, aggression, and impulsivity) and increasing targeted positive behaviors (e.g., asks for help, assists peers). The intervention was evaluated when utilized within the context of group therapy measured daily on point sheets used as part of regular daily procedures at this institute.

Chapter Two

Literature Review

Etiology, Symptomatology, and Prevalence of Disruptive Behavior Disorders

A variety of researchers (Quay and Hogan, 1999; Barkley, 1998; Greene, 1998) have explored the etiology, presentation, and treatment of Disruptive Behavior Disorders. The symptomatology usually falls within categories of "hyperactive/inattentive behavior, aggressive or hostile/defiant behavior, and delinquent or antisocial behavior" (Barkley, 1998). Children suspected of having a DBD often act out their inability to express their fear, frustration, and confusion over being out of control. Such externalized acts of non-compliance, aggression, impulsivity, and tantrums are often diversions for this unexpressed fear (Breen & Altepeter, 1990).

Since the mid-1970's, hundreds of professional publications have targeted the issues surrounding disorders often first diagnosed in childhood such as ADHD, CD, and OD. Despite the prevalence of research into this group of behavior disorders, pertinent and reliable assessment continues to elude the clinician (Breen & Altepeter, 1990).

The problem seems to arise from differing definitions of what constitutes disruptive behavioral symptoms. Although research continues to reveal inconsistency in identifying samples, selection criteria, and measurement scales, specialists in the field have worked diligently to establish parameters for assessment (Hartmann & Wood, 1990). It is safe to say that a variety of diagnoses can be subsumed under the auspices of a "Disruptive Behavior Disorder" category (DSM IV, 1994). Regardless of definition, the common thread remains that the behaviors subsumed under DBD are severe enough to mitigate serious hampering of daily life and interpersonal relationships.

Barkley (1998) claims that many experienced clinicians in the field of child psychology have drawn parallels between DBD's and developmental disorders. Similarities established include: symptoms appearing at an early age, the disorders hampering the capacity to function successfully in the social milieu, and a chronic nature to the disorder to the extent it affects the long-term adjustment of the adult (Barkley, 1998).

Barkley (1998) and other specialist's in DBD, claim that the most comprehensive method of assessing DBD's is all-inclusive utilizing a collection of behavior rating and

assessment scales. Barkley states that the complex endeavor requires a minimum of a three-hour assessment (not including pediatric and psychological testing) and a gathering of information from multiple sources (parents, child, teachers, and doctors). Careful examination of the Diagnostic and Statistical Manual of Mental Disorders [IV] (1994, p.94) to establish differential diagnoses is of course of primary concern to any clinician working within the venue of children's problematic behavior. In addition Breen and Altepeter (1990, p.166) would include in assessment

- examining developmental issues
- interviews with child, parent(s), and teacher
- utilization of "well standardized, multifaceted [questionnaires] that allow for "statistical and normative comparisons []by age and gender."
- in school/clinic observations by clinical expert in field of childhood behavior disorders
- applying well standardized measures (normed

for age) to assess impulse control and attention

- assess for general cognitive functioning and academic ability (e.g., Wechsler Intelligence Scale for Children and Woodcock-Johnson)
- use of specialized self-report questionnaires when necessary (e.g., Beck Depression Scale)

The most significant consideration is to map consistencies in behavior across a variety of environments and situations. A child may have difficulties in school but do fairly well at home or with neighborhood playmates.

It is critical for a research study to be able to accurately operationalize the behavior behind the assessment. Clinicians depend on current research to aid in their focus of assessment and treatment. It is imperative that research studies develop a consistency in identifying and treating this population. Although inconsistency continues to plague research criteria, a few outstanding researchers have effectively isolated behaviors that could be used to illustrate DBD (Achenbach, 1991; Barkley, 1998; Routh, 1994).

Although a variety of these behaviors are evidenced in residents in placement at Oak Grove Institute, it is a premise of the behavioral therapist to limit behavior modification to no more than three target behaviors (Krasner, 1990). Converting broadly defined checklists to three operationalized behaviors, as defined at Oak Grove Institute, are demonstrated below:

1. *Disobedience or non-compliance* would operationalize to entail refusing to respond to request after 3 prompts.
2. *Fighting or physical aggression* could be operationalized to include hitting, slapping and kicking.
3. *Verbal aggression* could be operationalized to include screaming, swearing, or overtly cruel remarks directed to another.
4. *Irritability or impulsivity* may be operationalized as rapid escalation to tantrums of crying, whining, screaming, and/or non-directed swearing. Impulsivity can be further evidenced in boundary violations, such as: unsolicited touching and intruding into another's personal space.

Etiology

A survey of current research indicates a broad range of theories for etiology and treatment of these problematic behaviors. Such scholarly disciplines as Education, Psychology, and Medicine have contributed to understanding the etiology of these disorders.

In the field of Education, Goodman and Poillion (1992) discuss the over-labeling of students' "normal" behavior as a dysfunctional diagnosis. They discuss the premise that many disruptive behaviors are developmentally "normal" and parents and educators need to explore if their reactions are just "impatience" for high spirits in this overachieving, fast paced culture.

These studies provide important background for the current research by aiding in exploring how we perceive behavior. A current question among families and educators is "When does it become crucial to intervene?" Again, the general consensus seems to indicate when the behavior inhibits successful functioning at home or school. How parents, teachers, and the children themselves perceive the behavior is instrumental when making the initial assessment and planning treatment.

Psychologists Hallowell and Ratey (1994) discuss etiology, differential diagnoses, therapeutic approaches, and the impact of DBD's with respect to age and gender. These authors illustrate how vital the roles of family and environment are in the success of intervention with these clients.

Although the literature discusses the etiology of DBD as including parenting styles and environmental factors, it stresses the involvement of biological and neurological components. Due to the disparity in defining DBD, prevalence is considered to range from 1% to as high as 20% (Breen & Altepeter, 1990). As a rule, a measurement of 2 standard deviations from the mean on any given rating scale is necessary to make a diagnosis. Ideally, Breen and Altepeter (1990) believe this statistical significance would be evidenced across multiple questionnaires (i.e. parent, teacher, clinical, and self-report). It is believed that about 5% of those children diagnosed with ADHD have a neurological basis. (Barkley, 1998; Breen & Altepeter, 1990; Hallowell & Ratey, 1994).

The field of medicine claims the significance of a neurological basis for DBD cannot be underestimated as the implications are that psychotherapeutic approaches alone

could be less than effective. The most successful intervention would entail the use of medications in conjunction with psychotherapy in minimizing symptomatic behavior (Barkley, 1998; Teeter, 1995; Breen and Altepeter, 1990; Wood, 1999; Bruun and Bruun, 1994).

Treatment considerations are similar as so often the evolution of ADHD and CD are parallel. With respect to the prognosis, it is estimated that as many as 65% of individuals diagnosed with DBD will maintain problematic symptoms throughout adulthood (Breen & Altepeter, 1990).

The Role of Biology, Family, and Culture in DBD

Allen-Meares (1995) writes from a social work perspective in addressing the needs of children and adolescents. Allen-Meares explores the role of family and culture in contributing to emotional and behavioral disorders. The implications for social work are that rising divorce rates, alternative lifestyles, and economic change play a significant part in reforming family structure (Allen-Meares, 1995, p.10). This change creates an unstable environment which can exacerbate acting out behaviors among children with a DBD.

Developmentally, children and adolescents are in a constant state of flux. Frequent and rapid shifts in

physical and emotional states create feelings of being out of control of their own bodies. These conditions often create feelings of intense anxiety. In an attempt to allay this anxiety they strive for a sense of stability. They seek out the foundations for who they are among family, friends, neighborhood, and pop culture. However, when their relationships and environments are in turmoil, they often exhibit this increased anxiety through externalized behaviors, or "act out" in overt ways (Pipher, 1996).

The feminization and juvenalization of poverty, as defined by the U.S. Department of Health and Human Services in 1993, in addition to reduced services, has blocked scores of individuals from attaining educational, financial, and mental health resources. Fewer, at-risk youth are receiving intervention. Unfortunately for many, the alternative to early intervention has been an escalation of disruptive behaviors such as, petty crime, gang involvement, and violent exhibitions of frustration and anger (Allen-Mears, 1995).

Friedman and Clayton (1996) explore the roles of biology, multiculturalism, and neuropsychological assessment in educational attainment of inner-city youth. These researchers evaluated the role of neuropsychological

assessment with academically challenged students. The approach was significant in evaluating the differences between biologically based difficulties and emotional or behavioral disorders (Friedman and Clayton, 1996, p. 293).

Of note was the epidemiological data indicating a decreased use of mental health resources in disadvantaged populations. This translated to lack of assessment, diagnosis, and treatment among at-risk populations.

Treatment Considerations for Disruptive Behavior Disorders

A survey of current research indicates a broad range of theories for etiology and treatment of DBD. Once it is apparent that the child or adolescent is not functioning successfully in their home or school environment and a diagnosis of a disruptive behavior disorder had been made, treatment options are fairly straightforward. Of note is the almost universally held belief among researchers and clinicians that the roles of family and environment are vital in creating success of any intervention with these clients.

The participation of parents is so essential in treatment that Barkley (1997) designed a clinician's manual for assessing and training parents with "defiant children." Many others have followed this example and designed

treatment approaches that involve the families directly in the treatment of the child exhibiting DBD patterns.

Another pertinent philosophy of contemporary professionals in the field of child psychology is the importance of empowering clients to "educate and treat" themselves. The chance for permanent and relevant change can be enhanced if formal treatment intervention is approached as a lifetime process.

The PRISM Model employs multi-modal interventions that offers supports group members can "bring home" and apply. The model consists of 4 components to aid the subjects in learning to comprehend and control external behavior. The four components addressed in group therapy are self-talk, assertiveness, body control, and visualization (Wexler, 1991).

The review of research studies for various interventions for DBD is often subsumed under the specific diagnosis of ADHD, OCD, ODD, Intermittent Explosive disorder, impulse control disorders, and Tourette's Syndrome (Breen & Altepeter, 1990; Barkley, 1998; Greene, 1998).

The role of a neurobiological basis for a disruptive behavior disorder must be factored in when designing

treatment. If, as mentioned earlier, between 1-20% of all DBD diagnoses are believed to be biological in origin, then psychotherapeutic approaches alone could be less than effective. The most comprehensive treatment plan for children identified as having DBD often includes pharmacology, psychotherapy, education, and behavioral interventions (Breen & Altepeter, 1990, p.164). This is often the case in examples of extreme behavior. The utilization of medication can de-escalate the symptomatology enough to allow the child to be receptive to therapeutic interventions. However, due to the disparity in assessment and diagnosis and fear of psychotropic medications, not all children and adolescents are recognized as candidates for multi-modal treatment.

The literature indicates treatment strategies for DBD's are usually, but not always, covered under a specific diagnosis (i.e., CD, ODD or ADHD). Within these diagnoses, a variety of treatment modalities are offered such as cognitive-behavioral, pharmacological, psycho-educational, interpersonal, and family therapy. This is in keeping with the preponderance of empirical research indicating that several treatment modalities within a cognitive-behavioral format are most efficacious in decreasing dysfunctional

behaviors and replacing them with more adaptive strategies (Krasner, 1990; Kazdin, 1990; Fiendler and Guttman, 1994; Hayes and Follette, 1995; Kellerman, 1999).

Research indicates multi-modal interventions are the most efficacious in treating disruptive behavior disorders. Controlled studies that have demonstrated effectiveness include interventions utilizing cognitive behavioral strategies, medication, and psychoeducational approaches such as social and living skills training (Fiedler and Guttman, 1994; Glasser and Horne, 1994).

One of the most acknowledged experts in the field of disruptive behaviors of disinhibition is Russell Barkley. Barkley is the most frequently quoted source for other researchers in the field. Barkley's handbook for the diagnosis and treatment of ADHD is the most comprehensive literature on etiology, comorbidity, prognosis, assessment and treatment to date (1998). Although his treatment perspective is strongly cognitive-behavioral for this population, this expert clinician recognizes the importance of a multi-modal approach in treatment. Barkley (1998) writes extensively on pharmacology, problem solving, coping skills training, and behavior modification within the venues of family, school, and the larger community.

Wood (1999) coins the term "Dysinhibitor Syndrome" and draws on over twenty years of medical social work and personal experience to understand and treat impulsivity and aggression in children and adults with diagnoses ranging from disorders of mood, attention, and impulse. Wood is particularly helpful in evaluating triggering events such as increased stress or change in routine. This author stresses the understanding of the 'involuntary nature' of this syndrome in developing treatment and the necessary supports for the individual to maintain control.

Reid (1997) discusses the history of group work and its application as a social work method. Many of the program activities are cognitive-behavioral based and similar with respect to principles of practice to Wexler's (1991a). Of note was the information on activities utilized in an institutional setting. Reid mentions the relevance of activities of daily living in forming "opportunities for the client's growth, socialization and treatment" (p. 223).

Reid includes the important role the social worker has in matching the institutions broad guidelines to his or her group treatment method. If the institutional guidelines emphasize strengthening social skills, the therapist has an obligation to creatively incorporate such exercises into

treatment. This worked particularly well with respect to the PRISM model and Oak Grove Institute's social learning model. This model's interventions consistently employed role-play, therapist demonstrations, and "homework" in the real world to aid group members in learning through observation and doing.

The dovetailing of the PRISM program to Oak Grove's treatment guidelines, as recommended by Reid, is evident in the strong cognitive-behavioral based techniques and activities (Wexler, 1991a). The concept of the group as part of the larger community in residential treatment is factored into the PRISM method through exercises that strengthen the ability to negotiate differences with authority figures and recognizing the differences between situations, thoughts and emotions (Wexler, 1991b).

Treatment for disadvantaged populations is of particular concern among social workers. As mentioned earlier in studies by Friedman and Clayton (1996), the use of mental health resources is not constant across social economic status or ethnicity. Whether children in lower socio-economic schools are not being recognized and referred or if parents are unable or unwilling to seek

outside help, the fact remains these at-risk youth are unlikely to be served in the mental health milieu.

The decreased use of mental health resources in disadvantaged populations means early intervention for children with DBD is less likely to occur. This increases the likelihood that the behavior will result in serious harm to either the individual or a member of his or her family or community. Furthermore, the later the intervention the poorer the treatment outcome.

The Role of Theory in Treatment

This review would not be complete without an examination of the literature on group and cognitive-behavioral theory in working with youth displaying disruptive behavior. Freeman, Simon, Beutler, and Arkowitz (1989) offer the most illuminating and thorough handbook on Cognitive Therapy. In Comprehensive Handbook of Cognitive Therapy (Freeman, Simon, Beutler, and Arkowitz, 1989) chapters by Ellis on the history of Cognitive-Behavioral Therapy (CBT) and Rational-Emotive Therapy (RET), by Goldberg and Shaw (1989) on clinical and research applications of measurement of cognition in psychopathology, and by Beckman and Watkins (1989) on

process and outcome of Cognitive Therapy provided a foundation of knowledge for the current study.

Social Learning Theory is a major theoretical premise for treating troubled youth and is the model of choice at Oak Grove Institute. Taken from the model utilized at Boystown, USA, children with DBD are perceived as operating from skills deficits (Boystown, 1986). The model works on building skills and offering consequences for dysfunctional behavior. Much of the Social Learning Model's foundations are found in the writings of Albert Bandura. This social learning theorist wrote extensively on the importance of operant conditioning and modeling in shaping behavior (Kazdin, 1990). Exercises in the PRISM model utilize role-play, modeling, and feedback in order to help internalize change.

The PRISM Model at Oak Grove Institute

Although the PRISM Model was previously implemented at Oak Grove Institute, the opportunity to evaluate its effectiveness did not occur. This study would fill the gap by empirically studying the model's effectiveness through an experimental design. With this goal in mind, the PRISM Model was implemented at Oak Grove Institute in the manner of an adjunct therapy group.

The adjunct therapy group addressed issues other than pure behavioral management for overt symptoms of DBD. Research indicates the importance of addressing "soft symptoms" as well. Lowered self-esteem, mood lability, and poor social skills are considered "soft symptoms" associated with DBD. These so called "soft symptoms" often result in the individual's isolation from others. It is considerably important to address these associated symptoms when designing or implementing an intervention strategy. To neglect the "soft symptoms" is to avoid issues that directly impact the individual's potential for recognition of self and ability to internalize change (Barkley, 1998; Breen & Altepeter, 1990; Greene, 1998; Hallowell & Ratey, 1994; Routh, 1994).

As a cognitive-behavioral approach, the PRISM model addresses these behaviors through organizing and applying interventions in a systematic manner. Group members are encouraged to organize their thoughts, feelings, and behavior in a manner that facilitates understanding linkages within DBD's.

To briefly illustrate the model, the 16-program sessions are grouped into quadrants of four sessions each. The first quadrant addresses the issue of self-esteem and

non-compliance through the examination of negative self-talk which can shape how individuals perceive and respond to their world. The second quadrant, by teaching the resident to apply basic communication skills to enhance self-efficacy, assists in diminishing frustration that can lead to aggression. The third quadrant deals with impulsivity and disinhibition by teaching body awareness and relaxation strategies to enable members to build self-mastery. Finally, the last quadrant builds on self-mastery and pro-social skills by practicing integration of problem solving, visualization, and impulse control techniques learned throughout the program (Wexler, 1991).

There are three residential units within Oak Grove Institute. Dorm A is comprised of female adolescents with a range of disorders involving issues of substance abuse, body image, disruptive behavior, and mood lability. Dorm B houses children aged 8-18 with disorders involving traumatic brain injury, affective disorders, ADHD, Tourette's Syndrome, Pervasive Developmental Disorder, Asperger's , Schizophrenia, and other neurological based disorders. Dorm C residents are adolescent males who also struggle with issues similar to residents on Dorm A but

display higher incidents of CD, ODD and ADHD (Brochure; OGI Inservice).

Oak Grove Institute's assessment process is cross-disciplinary in nature with evaluations involving medical doctor/ psychiatrist, psychologist, social workers, nursing staff, teachers, and parents and relatives. The assessment is crucial in establishing treatment goals and, as such, updated quarterly to provide the best possible treatment plan for the individual. Oak Grove Institute has established procedures to assess and measure problems specific to each child as they follow the intake process. Target goals and treatment interventions are established including adjunct group therapies that would best aid the child in developing more functional behaviors. Each child carries a daily point sheet that charts hourly incidents of exhibited behavior. The point sheets are tallied each evening and enable the child to move up a ladder of increasing responsibility and privilege. It is within this venue that the PRISM Model will be practiced.

Daily tallies form the summation for weekly reports that, in turn, are compiled to establish monthly totals indicating increases or decreases in behavioral incidents. Doctors, therapists, program director, nursing, and line

staff in redefining problem goals in the treatment team meetings utilize the monthly totals from the Treatment Plan Progress Reports (TPPRs). The TPPRs were a major source for 1) choosing the experimental group participants, 2) establishing a behavioral baseline, and 3) evaluating behavior after group intervention.

Chapter Three

Methods

Description of Sample

The study sample consisted of 12 children (boys and girls, ages 13-17) chosen from the population of sixteen who reside in DORM B. The participants exhibited behaviors consistent with DBD as indicated on the Treatment Plan Progress Report (TPPR). From these twelve, six were randomly chosen to function as a control group while the remaining six comprised the experimental group participating in the PRISM model for self-management.

The sample consisted of twelve children who exhibited frequent incidences of either non-compliance, physical or verbal aggression, or impulsivity. The ages ranged from 13 years to 17 years, with a mean age of 15 years. The ages ranged fairly evenly across the sample with two or three participants represented in each age group from 13 years to 17 years (see Table 1).

The sample included 4 females and 8 males, a breakdown of approximately two-to-one. The breakdown of ethnicity showed whites to be represented similarly, with 8

Caucasian, 2 Hispanic, and 2 of bi-racial African-American and Caucasian ancestry. There was no category for length of time in placement.

The experimental group consisted of 2 females, aged 13 years and 17 years, and four males aged 13 years, 14 years and 15 years. The control group consisted of 2 females aged 14 years and 17 years, and 4 males aged 14 years and 16 years.

Table 1. Description of Sample by Age, Gender, and Ethnicity (N = 12)

Group	Frequency	Percent
Gender		
Male	8	66.5
Female	4	33.5
Ethnicity		
Caucasian	8	66.6
Hispanic	2	16.7
Bi-Racial	2	16.7
Age		
13 years	3	25.0
14 years	3	25.0
15 years	2	16.6
16 years	2	16.6
17 years	2	16.6

Procedure

A group evaluation using an experimental design was conducted to evaluate the effectiveness of a group intervention with Oak Grove Institute residents with DBD symptomatology.

Twelve subjects exhibiting DBD symptomatology were chosen from Dorm B at Oak Grove Institute. They were randomly assigned to the experimental and the control groups of 6 subjects each. A 30-minute cognitive-behavioral group intervention was offered twice a week for seven weeks. No subjects of the study were denied treatment. Members of the control group were offered the same treatment immediately following the experimental group.

The evaluation involved: 1) a pre-test of the experimental and control groups to establish baselines of behavior, 2) attendance by the experimental group in group therapy, and 3) a post-test of the experimental and control groups to measure any modifications of behavior. Specifically, this involves measuring both maladaptive behaviors such as *impulsivity, aggression, and non-compliance*, and adaptive behaviors (*pro-social skills*).

The model chosen for the group therapy intervention is the *Program for Innovative Self-Management* (PRISM). PRISM

is a cognitive-behavioral based intervention designed by Dr. David Wexler for residential treatment. The model consists of 4 components to aid the subjects in learning to comprehend and control externalized behavior. The four components that were addressed are self-talk, assertiveness, body control, and visualization.

All measurement and data collection was drawn from existing Treatment Plan Progress Reports (TPPR) utilized by the treatment team at Oak Grove Institute. The TPPR provides monthly percentages of behavioral incidents for each resident.

This researcher gathered the percentage totals of the TPPR for 12 subjects from DORM B. The percentages were recorded for the month of November. In January, the PRISM model of group intervention was implemented by this researcher and another Oak Grove Institute MSW intern (co-therapist) for the experimental group. The intervention consisted of applying the PRISM model for 30 minutes, twice weekly for seven weeks.

When the intervention was complete, this researcher and another co-therapist provided the intervention for the control group for the next seven weeks. The TPPR percentages for March were compared to the November

percentages to evaluate any modifications in subject behavior.

With respect to administration of the surveys regarding perception, this researcher arranged a time convenient to staff and subjects to explain and administer surveys at termination of the intervention.

Data Collection

Levels of DBD and Pro-social behavior were measured and documented. Modifications in behavior were indicated by comparing differences in TPPR scores from November's pre-test and March's post-test. Variables of age, ethnicity, and gender were documented from client records.

The following behaviors were measured and recorded:

1. *Non-compliance* - repeated failure to follow through on instructions or to complete assignments.
2. *Physical aggression* - spitting, hitting, shoving, or throwing objects at another.
3. *Verbal aggression* - screaming, swearing, or making racial comments.
4. *Impulsivity* - difficulty waiting turn in group situations, blurting out answers before questions are completed, frequent intrusion into others' personal business, and violations of personal space.

5. *Pro-social skills* - positive behaviors such as asking for help, supporting or helping out a peer, and working cooperatively with others.

The control for personal bias was constantly monitored since point sheets are charted by many observers throughout the day. The only limitation is that behavior must be witnessed (difficult to do with 5 or more children to one child care worker).

In an attempt to recognize personal bias, data were also collected from two informal surveys administered to group and staff members: one survey tested subjects' *perceptions* of group cohesiveness, morale, and effectiveness; and another given to teachers and senior milieu staff for their *perceptions* of modification in DBD behaviors.

Instruments

This researcher used the monthly TPPR (already in use at Oak Grove Institute) containing summary hourly and daily scores from two other point sheets (compiled by childcare workers). Additional data were collected from two surveys administered to subjects, teachers, and senior milieu staff before and after the intervention (see Appendix B).

Protection of Human Subjects

Issues of confidentiality were respected and names were safeguarded from appearance anywhere in this study. Permission to participate in the study was gathered from the appropriate agency, parents, social workers, and residents (see Appendix A).

All subjects were assigned a number that corresponded to the instruments utilized. All personal information (consent forms, surveys, and key to number assignment) was kept in a locked file in this researcher's home. The information will be kept for five years then shredded.

Data Analysis

Quantitative measures were used when analyzing the data. Statistical frequencies and paired T-Tests were run. Qualitative measures were used to describe demographic information and survey responses.

Chapter Four

Results

Quantitative measures were used when analyzing the pre-test and post-test data from the Treatment Plan Progress Reports (TPPRs). In addition, qualitative analysis was used to examine the surveys from group members, staff and teachers. Initially descriptive statistics were examined for the mean, standard deviation, and standard error of the mean. T-Tests were used to examine the difference in means for pre-test and post-test behavior scores as indicated on the TPPR (see Tables 2 & 3).

Both the experimental and the control groups were measured on the targeted behavior of non-compliance. Incidences of non-compliance were measured hourly by teachers, child-care workers, therapists, and milieu staff. These tallies were then compiled to form totals recorded on the Treatment Plan Progress Report (TPPR).

With $N = 5$ for the category of non-compliance in both control and experimental groups, non-compliance for the experimental group had a mean of 48.66 incidences for a 30 day period before the treatment intervention (pre-test). The post-test mean for non-compliance on the experimental group indicated 33.26 incidents within the 30-day period

following the treatment intervention (post-test). The results did not indicate statistical significance. The $t(4)=1.308$, $p= .261$.

Pre-tests for physical aggression among experimental group participants indicated a mean of 3.84 incidences and a post-test mean of 1.0 incidences. No statistical significance was apparent. The $t(3)=1.222$, $p= .309$.

Verbal aggression for the experimental group's pre-test bore a mean of 13.7, while post-test mean for verbal aggression was 7.5. The $t(5)=1.954$, $p= .108$ and also did not attain statistical significance but was nearer attainment.

The mean for impulsivity among experimental group participants was 17.0 for pre-test measures and 9.5 on post-test results. The $t(5)= 2.169$, $p= .082$ and did not reach statistical significance but was intriguing given the small sample size.

The experimental group demonstrated a pre-test social skills mean of 78.8% and a post-test mean of 89.7%. The $t(2)= -1.300$, $p= .323$. The indications were of no statistical significance.

Table 2. Descriptive Statistics (N = 12)

	Experimental Group			Control Group		
	Mean	S.D.	S.E.M.	Mean	S.D.	S.E.M.
N=5				N=6		
Pre- N/C	48.66	24.99	11.17	34.11	13.87	5.66
Post-	33.26	16.93	7.57	44.53	22.24	10.30
N=4				N=5		
Pre-P/A	4.80	7.61	3.80	2.08	3.35	1.50
Post-	1.00	1.41	.70	1.35	.94	.42
N=6				N=5		
Pre-V/A	13.71	15.57	6.35	14.76	14.09	6.30
Post-	7.50	10.66	4.35	24.95	23.01	10.29
N=6				N=4		
Pre-IMP	17.00	11.27	4.60	14.15	13.14	
6.57						
Post-	9.51	11.13	4.54	9.19	8.48	
4.24						
N=3				N=6		
Pre-S/S	81.00	13.00	7.50	75.80	21.98	
8.97						
Post-	89.66	1.52	.88	81.33	9.11	
3.72						

Key: Descriptive Statistics for the pre-test (Pre-) and post-test (Post-) scores for the dependent variables of targeted behaviors. Target behaviors were Non-Compliance (N/C), Physical Aggression (P/A), Verbal Aggression (V/A), Impulsivity (IMP), and Social Skills (S/S).

Although scores across all five dependent variables were not statistically significant due to small sample size, there was an overall decrease among mean scores for

disruptive behaviors and an increase in the mean scores for positive behaviors. The control group indicated no significance at all among any of the five variables (see Table 3).

When comparing behaviors by gender, figures indicated that females consistently scored lower incidents per 30-day period than their male counterparts (see Table 3).

Table 3. Behavioral Scores by Age and Gender
N=12.

Pre-Test & Post Test Results for Females

N/C		PA	VA	IMP	AGE			
na	na	0	Na	0	0	3.0	2.8	13
38.6	73.0	0	0	na	na	.40	.33	17
9.5	16.25	na	Na	2.5	1.0	4.0	1.7	14
19.5	8.0	na	Na	1.2	0	na	Na	17

Pre-Test & Post Test Results for Males

N/C		PA	VA	IMP	AGE			
72.6	32.25	3.0	1.0	34.8	15.7	24.8	16.0	15
46.0	61.5	0	0	30.0	25.5	29.4	29.5	14
47.0	30.0	0	0	0	0	25.2	4.25	15
68.2	26.3	16.0	3.0	15.0	2.8	16.4	2.8	13
21.8	40.5	8.0	1.7	15.2	19.25	16.0	3.7	16
42.2	57.0	.2	.75	12.8	52.25	28.0		14
27.0	23.5	1.4	2.0	6.6	7.7	8.8	14.7	16
55.6	65.2	.8	2.25	38.0	45.5	31.4	18.0	16

Key: 0= Zero incidents of targeted behavior for past 30 days. na= Never or no longer a targeted behavior. NC = Non-Compliance, PA = Physical Aggression, VA = Verbal Aggression, IMP = Impulsivity, and Age.

The results indicate that the numbers (t's), approach significance in at least two categories, verbal aggression and impulsivity.

Survey Responses

Qualitative measures were used in exploring participant survey responses. Results between surveys were fairly consistent. The comparisons between the Cohesiveness and Effectiveness surveys indicated predominantly favorable ratings. It is within individual survey responses that variety is witnessed. The individual responses within the Effectiveness Survey demonstrated careful selection. Rarely were all positive or all negative answers given.

The responses were mostly varied within each questionnaire. For instance, one participant's vote of "not very supportive" was contradicted by the perception of peers as "friendly" and "would enjoy" having these peers in another group. Another participant circled all middle categories (i.e. "would enjoy") and yet another all high positives (i.e. "would enjoy very much"). One participant responded "would not enjoy" and had hand written "kind of" before the "Friendly" and "Supportive" categories (see Table 4).

Table 4. Participants' Perception of Cohesiveness
N=5

Peer Support

- (1) Not very supportive
- (2) Supportive
- (2) Very supportive

Peer Friendship

- (0) Not very friendly
- (4) Friendly
- (1) Very friendly

Peer Enjoyment

- (1) Would not enjoy
 - (2) Would enjoy
 - (2) Would enjoy very much
-

Note: Numbers in parentheses indicate the number of participants marking that response.

The responses to the Effectiveness Survey were in keeping with the responses to the Cohesiveness Survey. In the evaluations, two respondents answered all high positives ("very helpful"). A single respondent answered all mid-positives ("maybe, a little helpful"). Two respondents answered with a variety of responses ranging from "No, not helpful" to "Yes, very helpful."

The descriptions of responses to the perceived helpfulness of specific lessons within the PRISM Model are

seen in Table 5. Briefly, they indicate the majority of participants perceived the lessons in "Faulty Self-Talk," "ABCDEs of Behavior," and "The Supportive Observer/Ally," as either moderately helpful or very helpful in learning self-management skills. Participants indicated they found the group sessions helpful in aiding them to "work their program" at Oak Grove Institute.

Table 5. Perceived Effectiveness of PRISM Model
N=5

Faulty Self-Talk

- (2) Yes, very helpful
- (3) Maybe, a little helpful
- (0) No, not helpful

ABCDEs of Behavior

- (2) Yes, very helpful
- (2) Maybe, a little helpful
- (1) No, not helpful

Supportive Observer/Ally

- (2) Yes, very helpful
- (3) Maybe, a little helpful
- (0) No, not helpful

Overall

- (3) Yes, very helpful
 - (2) Maybe, a little helpful
 - (0) No, not helpful
-

Results of the Senior Milieu staff survey demonstrated that disruptive behaviors (i.e. non-compliance, verbal or physical aggression, and impulsivity) for each group member had decreased. In addition, the overall response indicated an increase in peer cooperation.

In summary, the quantitative results indicated the numbers approaching significance on the dependent variables of verbal aggression and impulsivity. The qualitative results of surveys evaluating participants' perceptions of group cohesiveness and helpfulness of the PRISM model demonstrated moderate to favorable responses overall. The surveys completed by staff and teachers indicated that they perceived the majority of participants had a decrease in disruptive behaviors and an increase in pro-social behaviors.

Chapter Five

Discussion

Taking into consideration that the sample size was small and the short duration for the PRISM intervention, it was intriguing to see how near statistical significance the experimental group reached on the dependent variables of verbal aggression and impulsivity. Overall, the PRISM Model appeared successful both by statistical and qualitative measures. Teachers, staff, and group members seemed to find the intervention helpful in managing behaviors necessary to complete treatment goals.

Ideally, the study would have evaluated group members on completely matched dependent variables. This is particularly true with respect to gender. As noted in Table 3, this was not possible for several reasons.

First, as addressed in the literature review, females rarely exhibit DBD symptomatology to the degree and duration of their male counterparts. This was evidenced in only one female with a target behavior of verbal aggression.

Second, although a female participant may have entered Oak Grove with verbal aggression or non-compliance as a targeted behavior, the goal to eliminate the behavior may have been attained fairly quickly. The reasons for this

are beyond the scope of this paper. Nevertheless, explanations could lie in the cultural conditioning of females being more compliant and cooperative. It is also possible that the behavior was not firmly entrenched from the beginning.

Third, is the shift in goals of the treatment plan. For example, one female was near discharge and had actually transferred to the higher functioning atmosphere of Dorm A. If no incidences are recorded for 90 days, the goal is considered accomplished and a new goal established.

How all individuals *perceive* the effectiveness of the intervention was equally relevant to the study and this researcher. The problem for children with DBD is not in recognition of their behaviors, it is in controlling them and accepting responsibility. How well they are able to control their behavior is often a result of self-efficacy.

As addressed in the literature review, the power to implement change can be found in the subjects' perception of their self-efficacy. It is crucial that they perceive the intervention to have helped in enabling them to control their impulses and move toward self-management.

Evaluating effectiveness of treatment on dependant variables required observing the client utilizing the

skills and supports that are modeled during treatment. For example, charting incidents when the resident demonstrates following through with tasks assigned by teachers, parents, childcare workers, or therapists (compliance). Observation and tally of the resident's demonstrated ability to control anger and impulsivity (by diminished acts of aggression and intrusion) helped reflect the impact of intervention on the dependant variable.

Limitations

The small sample size of 12 participants for both the control and the experimental groups was constrained by the total population from which to draw a sample. The entire population of Dorm B consisted of 16 residents at the time of the study.

Further limitations involved the movement of participants from the Dorm B program to either the adolescent male Dorm C or the adolescent female Dorm A. The move constituted more than just physical relocation. Programs are specific to not only the individual resident but to the population as a whole. Certain behavioral goals are designed for a more mature population. Whereas impulsivity may be a targeted behavior on Dorm B, it is

replaced with "able to appropriately express needs with peers" on Dorns A and C. This created a difficulty in comparing pre-test and post-test scores for transferred residents, evidenced with some categories remaining unmarked for post-test scores.

Further limitations involve discerning intervening variables affecting behavior. It cannot be assumed that the PRISM Model alone accounted for the numbers approaching statistical significance. This researcher needed to identify intervening variables that might have influenced behavior such as, areas of additional support.

The added attentions of a child-care worker, favorite relative, or teacher will all impact the child's behavior. Some important questions to ask when evaluating the results are as follows: Did the participant gain a particularly supportive new child-care worker? Did the participant begin a new adjunct therapy group or social activity? Were there new residents on the unit influencing participants' behavior either positively or negatively? Was there a change in medication at any time during the intervention?

These are just a few of the multitude of questions that could be asked when examining behavior. With respect to Oak Grove Institute, all of the above-mentioned

questions could be answered with a resounding "Yes!" These events, and more, took place as the participants progressed through the PRISM program.

Another factor to consider when reviewing the results is length of treatment. Did the length of treatment influence effectiveness? Many cognitive-behavioral group interventions last only 8-10 sessions. Despite the fact, some of the literature suggests longer, more consistent levels of treatment are necessary to successfully alter behavior. This was a factor in choosing to implement the PRISM Model. Fourteen sessions of one hour each in the PRISM Model allowed for a slow assimilation of cognitive restructuring, a kinesthetic awareness of behavioral change, and time practicing new behaviors. However, agency and population constraints translated to half-hour meetings. That extra half-hour would allow for a more leisurely pace to introduce and implement interventions.

The difficulty of evaluating behavior interventions stems from the multitude of interacting conditions that influence behavior. Self-perception, perception of others, learned reactions to specific stimuli, personalities of the individuals involved in an interaction, and the biochemical

condition of the individual exhibiting the behavior are just some of the influencing factors.

To complicate matters further, general system's theory illustrates how an alteration in any one factor can have an exponential impact on one, some, or all of the other factors. Despite the daunting nature of studying behavior, researchers have continuously tried to design clearer and more accurate measures.

Some constraints in measuring observations are the subjective nature of the process of observation. The observer selectively chooses what will or will not be noticed based on personal attitudes and experiences. We often overlook contradictory evidence when making observations. For example, Johnny is working co-operatively with another student building and noisily destroying block constructions. However, the observer, alerted to the child's ADHD, may only see how Johnny is behaving in a "noisy" and "destructive" manner.

This brings up the issue of validity. How can internal validity be ascertained when the dependent variable is so subject to observer bias? One method used to offset observer bias was to have several individuals gathering

data. This methodology was already in place at Oak Grove Institute and worked to offset some, if not all, bias.

Other limitations include the sampling method. The non-probability (convenience) sampling method for this applied research study was less than ideal. Issues of researcher bias can be raised and put into question the study's precision. Even though the sample size was 3/4 of the total population on Dorm B, the participants only numbered twelve. This reduced sample increases the likelihood of sample error.

Implications for Social Work Practice

This study would be of interest to agency and non-agency professionals such as members of law enforcement, educators, and therapists. It is of primary interest to parents of residents that their children can follow through with self-management skills at home and avoid the high-risk behaviors they habitually engage in. Perhaps those individuals to benefit the most from the resulting implications of this study are the PRISM group members themselves. Members were able to recognize group cohesion, evaluate the differences in interventions (lessons), and most importantly, actively participate in treatment evaluation. Group members articulated their satisfaction in

being part of the evaluation process. Could this not be the most significant intervening variable in influencing behavior?

Beyond the children, their families, the agency and staff, society at large might be interested in the outcome of this intervention. Studies indicate individuals with disruptive behavior disorders, who do not receive early intervention, often end up in trouble with the law.

This research would be of interest to the communities where these children live. Vandalism, property damage, and accidents are often a result of impulsivity or aggression on the part of children with DBD. As a matter of note, one study found a significant number of individuals serving criminal sentences (often involving aggressive acts) were diagnosed with ADHD (Kellerman, 1999).

Social workers need to recognize and address the biopsychosocial ramifications of Disruptive Behavior Disorders as addressed in this study. It is crucial that clinicians, child protection services, schools, parents, parents and law enforcement recognize that delay is deadly. Early intervention can teach these children and adolescents the skills they need to self-manage thereby reducing dysfunctional behaviors and increasing pro-social

interactions. The sense of self-efficacy this gives them is priceless.

Recommendations to repeat the study with a larger sample size can be made due to the favorable outcomes of both the survey and the descriptive statistics. The surveys from staff, teachers, and participants indicated effectiveness of the PRISM Model in building group cohesiveness and helping to members to increase self-management skills. Indications of a least two variables (verbal aggression and impulsivity) approaching significance would recommend repeating the study with a larger sample size.

Appendix A

Consent Forms

Informed Consent Form

Your permission for consent is being requested for your child/client to participate in a research study conducted by Jo Silva, a graduate student in the Department of Social Work at California State University, San Bernardino. Jo Silva will be under the direct supervision of project advisor Jette Warka with the guidance of Dr. Rosemary McCaslin, CSUSB, Department of Social Work and Oak Grove Institute Case Manager, Nancy Morningstar, L.C.S.W. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

The goal of the study is to evaluate the effectiveness of a stress management group based on the PRISM program designed by Dr. David Wexler by measuring individual behavior before and after participation in the group. Measurement will be taken from point sheets already in use at Oak Grove Institute.

The study will require the child/client to participate in a 30-minute therapy group that will meet twice weekly for seven weeks. The group focus will be on stress management. The primary goal of treatment will be to enable members to recognize differences in events, thoughts, and emotions. The sessions will demonstrate to members ways to

recognize how thoughts influence behavior, the physical symptoms of stress, and triggering events that create stress. The sessions will close by utilizing relaxation techniques to aid in controlling stress that can lead to problematic behaviors. At this time, members will be asked to answer a few questions regarding the helpfulness of the group from their perspective.

Confidentiality will be fully maintained at all times. After completion, you will have full access to the results of this study.

Participation is voluntary. The child/client may withdraw consent at any time. If you have any questions please feel free to contact Nancy Morningstar and Jo Silva at Oak Grove Institute (ph: 909-677-5599) or Dr. McCaslin at CSUSB (909-880-5507).

Signature/Title

Date

Guardian's Name (printed)

Child's Name

Participant Consent Form

Name: _____

You are invited to attend a stress management group with Social Work Intern, Jo Silva. The group is designed to help you learn skills that will help you relax and increase your ability to focus. If you agree to participate, Jo will meet with you two times a week, 30 minutes each time, for seven weeks.

After the group sessions, you will be asked to fill out a short survey. It will take you approximately five minutes to complete. Your answers to the survey questions will help Jo measure the effectiveness of these group sessions in helping you achieve some of your stated goals at OGI.

Jo will be conducting these groups while under the direct supervision of Nancy Morningstar, L.C.S.W., a case manager of this institution. If you have any questions at any time, feel free to ask either Jo or Nancy!

Consent

I agree to participate in the 14-session stress-management group. I understand that my participation will be completely confidential and that I can drop out of the group whenever I wish. I realize that behavior scores will be used to help evaluate the group's success.

Signature

Appendix B

Surveys

COHESIVENESS SURVEY FOR GROUP MEMBERS

Please circle the answer that best explains how you feel about the question. For example, if you think your peers were not helpful or supportive of you during group sessions then you would circle "Not very supportive".

1. How supportive (helpful/kind) were your peers during the group sessions?

Not very supportive Supportive Very supportive

2. Did you feel a sense of friendship with your peers while in the group?

Not very friendly Friendly Very friendly

3. How much would you enjoy having these peers in another group with you?

Would not enjoy Would enjoy Would enjoy very much

EFFECTIVENESS SURVEY FOR GROUP MEMBERS

"Self-management" is your ability to control what you think, how you feel, and what you do!

Please circle the answer that best explains what you think and feel about the group sessions.

#1. Did you find the session on "Faulty Self-Talk" helpful in learning "self-management"?

Yes, very helpful Maybe, a little helpful No, not helpful

#2. Did you find the session on "ABCDE" helpful in learning "Self-management"?

Yes, very helpful Maybe, a little helpful No, not helpful

#3. Did you find the concept of the "Ally" or "Supportive Observer" helpful in learning "self-management"?

Yes, very helpful Maybe, a little helpful No, not helpful

#4. Did you find the group sessions helpful in working your program here at Oak Grove Institute?

Yes, very helpful Maybe, a little helpful No, not helpful

SURVEY FOR STAFF AND TEACHER

(Please circle best answer)

#1. Prior to participation in the PRISM group, how would you rate the level of *non-compliance* of the resident?

Less compliant Same More compliant

#2. Prior to participation in the PRISM group, how would you rate the level of *verbal or physical aggression* of the resident?

Less aggressive Same More aggressive

#3. Prior to participation in the PRISM group, how would you rate the level of *impulsivity* of the resident?

Less impulsive Same More impulsive

#4. Prior to participation in the PRISM group, what level of pro-social behavior (peer cooperation) have you observed in the resident?

Less cooperative Same More cooperative

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