CHOICE THEORY: AN INVESTIGATION OF THE TREATMENT EFFECTS OF A CHOICE THEORY PROTOCOL ON STUDENTS IDENTIFIED AS HAVING A BEHAVIORAL OR EMOTIONAL DISABILITY ON MEASURES OF ANXIETY, DEPRESSION, LOCUS OF CONTROL AND SELF-ESTEEM

by

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ABSTRACT

SCOTT D. REEDER. Choice theory: An investigation of the treatment effects of a choice theory protocol on students identified as having a behavioral or emotional disability on measures of anxiety, depression, locus of control and self-esteem. (Under the direction of DR. JOHN R. CULBRETH)

Existing research reveals that students who have a behavioral or emotional disability is a growing population within special education. Special education law and counseling organizations both agree that these students would likely benefit from counseling services at school. Research also reveals that this does not typically happen, that the interventions used in schools tend to have little beneficial effect and that these students are more likely than any other subgroup within public schools to drop out before graduating. This research was designed to assess what, if any, effect a tested treatment modality (Choice Theory) developed and used with children in juvenile detention centers has on students identified as having a behavioral or emotional disability in public school. This research utilized a true experimental design and assessed treatment outcomes on affective measures of Locus of Control, Anxiety, Depression and Self-Esteem in middle and high school aged students with a behavioral or emotional disability. Two groups of 15 students were randomly selected and randomly assigned to either a control or experimental group; the experimental group participated in a 6-week Choice Theory protocol. Both groups were administered the BASC-2 Self-Report at the beginning of the treatment and both groups completed the same instrument at the end of the protocol. Four two-way ANOVA's with one between subjects and one within subjects effects was used to examine differences between the groups on all four of the dependent variables. First, the measure of Locus of Control was examined and revealed a significant difference within

subjects and between subjects effect. In addition, there was a significant interaction demonstrating that students in the experimental group experienced a greater sense of power over their internal world relative to external stimuli after the implementation of the protocol when compared to the control group. Second, the measure of Anxiety was examined and revealed no significant difference within subjects, or interaction, but there was a significant between subject effect. Third, the measure of Depression was examined and revealed that there was a significant difference both within and between subject effect as well as a significant interaction, revealing that students in the experimental group reported experiencing less depressive symptoms than did the control group after the implementation of the protocol. Last, the measure of Self-Esteem was examined and revealed that there was no significant within subject effect, but there was a significant between subjects effect and interaction, revealing that students in the experimental group reported more positive feelings of self worth and efficacy after the implementation of the protocol than did the student in the control group.

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Angel City Outcasts	Anti-Flag	Bad Brains	Bad Religion
Bastards Choir	Billyclub	Blood or Whiskey	Blue Collar Special
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Dag Nasty	Dropkick Murphy's	Enemy You	Flogging Molly
Goldfinger	Madcap	MM Bosstones	MxPx
Naked Raygun	NOFX	One Short Fall	Oxymoron
Pennywise	Pipes and Pints	Pressure Point	Rise Against
Street Dogs	Strung Out	Sugarcult	Ten Foot Pole
Ten Pints In	The Briggs	The Bruisers	The Filthy 42's
The Forgotten	The Gaslight Anthem	The Lillington's	The New Breed
The Offspring	The Real McKenzie's	The Turbo AC's	Tiger Army
Useless ID	Vanilla Muffins	Whiskey Rebels	Ziggy Marley

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CHAPTER 1: INTRODUCTION

There is a growing body of research that suggests that there is a profound need for school based counseling services for all students, particularly those with severe emotional problems (Baumberger & Harper, 1999; Maag & Katisyannis, 1996). According to the Surgeon General's report on the mental health of children (U.S. Department of Health and Human Services, 2000), it is estimated that about 1 in 10 children suffer from a mental health disorder that is severe enough to interfere with normal social and academic development. Because 90% of the children who fall under the age of eighteen attend public schools (U.S. Census, 2002), it logically follows that there are significant numbers of children who warrant the application of psychosocial intervention.

Often, students who exhibit behavior in school that is characterized as dangerous, persistently maladaptive, and so negative that it interferes with theirs and others ability to learn are identified as having a behavioral/emotional disability (BED). Of all of the areas that are identified as educationally relevant disabilities, BED is one of the most challenging and fastest growing categories (Kaufmann, 2001). Generally, the student referral process that precedes the actual identification and placement requires multiple behavioral interventions that inevitably fail (ergo, the referral for testing and eventual testing), which often leaves teachers, parents and students more frustrated than when the process first started (Kaufmann, 2001). Frustration can often act as a catalyst for many of

the behaviors that define the BED label, which further emphasizes the need for school based therapeutic services.

There can be significant consequences associated with failing to adequately address the needs of students with severe emotional problems. Specifically, children with emotional problems are at increased risk for academic failure, continued mental disability and increased risk for placement in juvenile detention facilities (Bilchik, 1998; Kaufmann & Ryan, 1993; Puig-Antich, Willcutt & Pennington, 2000). Some research suggests that these outcomes could be avoided should students identified as BED receive therapeutic school-based services (American Psychiatric Association, 2004). However, fewer than half of these students are likely to receive agency based supportive services for their identified problems, and fewer still are likely to receive these services within the school environment (Costello, Angold & Burns, 1996).

While there have been initiatives designed to increase the service delivery of therapeutic services to students with severe emotional problems (Brener, Martindale & Weist, 2001), these services appear to be inconsistent in availability, with the greatest disparity exhibited between rural and urban school districts (Brener, et al., 2001). The Add Health Study of school administrators found that fewer than half of the public high schools in the United States have school based mental health services, and that one of the biggest problems associated with service provision to students was the fragmentation of the mental health service delivery system (Slade, 2003). Consequently, students with severe emotional problems are underserved in the environment in which they spend most of their time.

Within the school environment there are typically arrays of professionals who have expertise within the area of mental health. These include school social workers, school psychologists and school counselors. While school psychologists often have the knowledge to work with students who have severe emotional problems, they are typically utilized as mechanisms for identification of cognitive, behavioral or emotional problems that may affect school performance (National Association of School Psychologists, 2004). School social workers are generally given the professional role of acting as a liaison between the school and the primary care provider as well as connecting students with outside agency support (National Association of School Social Workers, 2004). Not only are both the psychologist and social worker charged with activities that do not include direct counseling services to students, their numbers in schools are not nearly as high as those of school counselors who can be found in more than three quarters of public schools in the United States (American School Counselors Association [ASCA], 2004). Furthermore, the school counselor's role within the school generally includes direct services to students, particularly those students who are experiencing difficulty coping with school (ASCA, 2004).

The Individuals with Disabilities Education Act (IDEA) stipulates that students with disabilities have the right to the same free and appropriate education as same age non-disabled peers (IDEA, 1997). This legislation also states that students with disabilities should be provided accommodations that are relevant to their disability and are designed to elicit positive educational outcomes (IDEA, 1999). In some cases, these services are referred to as a "related service." For example, a child with a learning disability who also has fine motor problems may have occupational therapy as a related

service because this support is believed to promote academic success in a way that a special education teacher could not provide. IDEA does not require that counseling be provided to students who are identified as having a severe emotional disability, but counseling as a related service is often identified in the child's Individual Education Plan (IEP). Indeed, it is difficult to understand how the emotional and behavioral needs of a child with an identified emotional or behavioral disability could be met without the therapeutic support provided by competent counseling.

Overview

Several researchers have identified school counselors as the professionals best suited for meeting the needs of students with behavioral disabilities in schools (Maag & Katsiyannis, 1996; Wood, Dunn & Baker, 2002). However, both the No Child Left Behind Act of 2001 and the Education Trust Initiative (1999) emphasize minimizing the disparity of test scores between low and high performing students, allocating resources and data collection for reporting purposes, all of which take time away from the counselor from providing direct services to students. This is noteworthy because students with behavioral and emotional disabilities are often among the lowest performing students in school (Maag & Katisyannis, 1996). Consequently, Thompson (2002) suggests that in order to increase the likelihood that students with behavioral and emotional disabilities measurably improve in academics, they must be socially and academically ready to learn. This can be accomplished through therapeutic interventions from a school-based counselor. Hence, counseling services are an important part of meeting the criteria outlined in the NCLB Act and the Education Trust Initiative.

There are nearly 6 million students served under IDEA in the U.S. and the behaviorally and emotionally disabled category is second only to specific learning disabilities in terms of size (U.S. Department of Education, 2002). Students served as BED are often diagnosed as having oppositional defiant disorder (ODD), conduct disorder (CD), attention deficit/hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD) and/or generalized anxiety disorder (GAD). Often, these diagnoses are co-morbid, with a particularly high association between anxiety disorders with PTSD and ODD/CD. Also, ADHD is a secondary diagnosis to both ODD/CD and PTSD (Erk, 2004).

Some of the most noteworthy diagnostic criteria for these diagnoses include aggression, destruction of property, hostile behavior, serious violations of rules, a persistent state of fear, inability to concentrate, difficulty sitting still for long periods of time and difficulty articulating feelings (DSM-IV TR, 2000). These criteria are significant because they all preclude a child's ability to learn efficiently (Erk, 2004). While the IEP for a student identified as BED must have behavior goals, these are often designed to minimize overt behavior within a classroom (Maag & Reid, 1994), which means that they are not designed to address the underpinning reasons for the behavior.

As mentioned earlier, counseling as a related service for students identified as BED is not a required part of the IEP. Although school counselors are often part of an intervention team that develops classroom based interventions prior to a formal psychoeducational evaluation, they are typically not a part of the IEP team that develops and is responsible for implementing the components of the IEP (Wood, Dunn & Baker,

2002). Consequently, counseling is frequently not a part of the IEP for students identified as BED.

This is compounded by the fact that school based counselors report that they do not perceive themselves to be well versed in the pathology of students identified as BED to be effective with them in a therapeutic role (Scarboro, 2002). This is unfortunate because it would appear that this perception is based on some confusion surrounding the terminology of special education law and not technical expertise associated with psychological functioning and development in students (Scarboro, 2002). Indeed, Maag (2002) states that the school based counselor is likely to be the most qualified person to work with students identified as BED.

Of the students who are identified as having a severe emotional or behavioral disability, there is a wide array of therapeutic approaches that have been used with varying degrees of success. Some interventions that can be implemented within the classroom without the involvement of the counselor include behavior contracting and social skills training. These interventions have not been found to be particularly useful in reducing problem behavior or increasing academic success, particularly because the teacher (the one responsible for implementing the plan) is too busy working with other students to intervene consistently and does not understand the motivation of the behavior as described by Maag & Webber (1995).

Other approaches show more promise with regard to efficacy, but require the involvement of a school-based mental health professional. Specifically, cognitive problem solving strategies, family systems therapy, Choice Theory and cognitive behavioral therapy have been found to elicit positive behavioral and academic outcomes

(Maag, 2005). A comparative analysis revealed that there were no significant differences between family systems therapy, cognitive problems solving strategies and cognitive behavioral therapy, and Choice Theory when looking at client outcomes (Lambert, 2004).

Statement of the Problem

One of the largest, most challenging and fastest growing populations within special education is that of students identified as BED (Kaufmann, 2001). While the underpinning pathologies generally associated with this population of students have largely been named and several therapeutic approaches have been found to be effective (Lambert, 2004), there is a lack of literature that looks at counseling outcomes with students identified as BED when the counselor works at the school and the counseling takes place within the school.

The American School Counselor Association's position statement clearly states that school counselors should be providing counseling services to students in special education, particularly those identified as BED (ASCA, 2000). This research seeks to begin to verify the assertion Maag and Katsiyannis make: That school counselors are the best suited and most qualified to deliver counseling services to students identified as BED. More specifically, this study hopes to determine whether or not school counselors, using a Choice Theory model, can be effective in supporting students identified as BED in managing many of the behaviors that make them eligible for the label

Need and Purpose for the Study

In sum, it appears that counseling services within the school for students identified as BED have been scarce and of poor quality (Hutton & Kinnison, 1991). This is a population of students who exhibit a resistance to traditional intervention methods

carried out within the classroom as evidenced by the frequency with which they are expelled from school, drop out before graduation or are committed to juvenile detention facilities (Office of Special Education, 2003; Department of Education, 2004; Randall, Henggler & Pickrel, 1999). Last, as Scarboro (2002, p. 52) points out, "no information is available in the literature about current status of service delivery, referral sources and outcomes of school counselors working with students with BED." Consequently, researching the efficacy of an established therapeutic approach such as Choice Theory with students with severe emotional needs within the context of a school building appears warranted.

Research Question

This study will investigate the efficacy of a Choice Theory based therapeutic protocol with middle and high school students identified as BED. The following question was developed for investigation in this study:

Is there a difference between a group of students identified as BED receiving a Choice Theory protocol and a group identified as BED who are not receiving a Choice Theory protocol on measures of (a) anxiety, (b) locus of control, (c) depression, and (d) self-esteem?

Delimitations

The delimitations imposed by the researcher on this study include the following:

1. Only one school counselor, licensed in South Carolina, will provide services to the students.
2. Only students identified as BED attending public school in three small counties in upstate South Carolina will be a part of this study.

3. The sample used in this study will be a convenience sample randomly assigned to either the treatment group or the control group.

Operational Definition of Terms

Aggression is defined as overt physical or verbal behavior directed toward others with the specific aim of causing physical or emotional harm (Reynolds & Kamphous, 1992).

Anxiety is defined as behavior that is characterized by excessive worry, phobias, fears or self-deprecation.

Behavioral emotional disability (BED) is an educationally relevant disabling condition which is characterized by pervasive anger or aggression, property destruction, an inability to make or maintain friendships or behavioral responses that are not appropriate for the setting or situation. The behavior must occur over an extended period of time and be different enough from appropriate age, ethnic or cultural norms that they adversely affect educational performance. The behavior(s) must occur across settings, one of which must include school, and persist despite interventions implemented within the school setting. While the term BED has been used interchangeably with "emotional disorder", "emotional handicap", behavioral disorder" and "emotional behavioral disorder" the condition is noted in the law as "seriously emotionally disturbed".

> The term means a condition exhibited by one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect the educational performance: (a) an inability to learn which cannot be explained by intellectual, sensory or health factors; (b) inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behaviors or feelings under normal circumstances; (d) a general pervasive mood of unhappiness; (e) a tendency to develop physical symptoms or fears associated with personal or school problems. The term includes students who have schizophrenia. The term does not include children

> who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed (Federal Register, 1981, p.1)

Choice Theory is defined as a therapeutic intervention designed to support participants in identifying how life choices help determine how the participant perceives self, others and their environment.

Depression is defined as behavior that is characterized by a pervasively dysphoric mood, sadness, suicidal ideation and/or withdrawal (Reynolds & Kamphous, 1992).

High school aged is defined as a student currently enrolled in grades 9, 10, 11, or 12 in a South Carolina public school.

Impulsivity is defined as an inability to sustain attention over extended periods of time, being easily distracted, and engaging in inappropriate behaviors despite repeated attempts at redirection (Reynolds & Kamphaus, 2004).

Individuals with Disabilities Education Act is a federal education law designed to ensure that students with disabilities are provided a free and appropriate public education with same age non-disabled peers. The disability must be reevaluated every three years and screening and diagnosis must be provided by a multi-disciplinary team.

Individualized Education Plan (IEP) is an academic and behavioral plan that addresses the unique needs of a student. The plan outlines what academic, behavioral and other services that are to be provided to the student, who is to provide them, where they are to be provided and methods of evaluation of the students' progress toward specific goals. The IEP should be developed by a multi-disciplinary team that includes the primary care provider and cannot be implanted without their consent.

Locus of Control is defined as a person's perception of his or her perceived control over external events (Reynolds & Kamphaus, 2004)

Middle school aged student is defined as a student who is currently enrolled in grades 6, 7, or 8 in a South Carolina public school.

School counselor is a counselor with at least a master's degree in the field of counseling who is licensed by the state in which they work to provide services to students in public school. They are knowledgeable about fundamental skills and theories that are applicable to students in school and other settings (Meyers, 1995).

Self-Esteem is defined as a person's sense of self-reliance and self worth (Reynolds & Kamphaus, 2004), and as one being competent to cope with the basic challenges of life and being worthy of happiness (Branden, 1969). The properties of self-esteem as articulated by Branden (1969) are that it is, a) a basic human need, i.e., "...it makes an essential contribution to the life process", b) "...is indispensable to normal and healthy self-development, and has a value for survival", and c) self-esteem as an automatic and inevitable consequence of the sum of individuals' choices in using their consciousness something experienced as a part of, or background to, all of the individuals thoughts, feelings and actions.

Assumptions

In an effort to determine causal relationships, a true experimental design is the optimal methodology (Patton, 2000). While the sample for this study was one of convenience, the participants will be randomly assigned to either the experimental or control groups. It is assumed that this is the best method for the purposes of analyzing and interpreting the treatment outcomes of the study.

Summary

Chapter one has outlined the need and purpose for the study described. Chapter two will present a more complete review of existing and relevant literature relevant to the study described. Chapter three will present the method in which the data will be collected, analyzed and interpreted. Chapter four will present the results of the data analysis, and Chapter five will present the overall significance of the study, relevant implications and areas that are revealed as needing further investigation.

CHAPTER 2: REVIEW OF LITERATURE

This literature review includes a focus on (a) diagnostic criteria set forth by the Individuals with Disabilities Act (IDEA) for student eligibility as Behaviorally Emotionally Disabled (BED); (b) the common psychopathologies associated with BED, specifically, depression, anxiety, locus of control, social problems and problems with self-esteem; (c) the role of the school counselor within the school setting to work with students with disabilities; and (d) a review of Choice Theory therapy treatment outcomes with students who have been identified as having one or more of the above mentioned pathologies.

I. Eligibility Criteria for Students with BED
    a. Federal guidelines under IDEA
    b. South Carolina guidelines
    c. Prevalence of BED in the U.S. and South Carolina
    d. IEP requirements for students identified as BED
II. Associated Pathology for Students Identified as BED
    a. Locus of Control
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IV. Choice Theory Therapy Treatment Outcomes Associated with Students Identified as Having BED

a. Description of Choice Theory

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e. Highlighting the lack of research in school settings

V. Summary of the Literature

First, this review will examine the criteria for identifying a student as having a behavioral/emotional disability (BED) under federal and South Carolina education law, the prevalence of the disability both nationally and within the state of South Carolina, and mandated school based services for students identified as BED. Second, this review will examine the characteristics of students identified as having a BED, including gender, ethnicity, and grade-level and exiting data. Also, this section will include recommended models of support for students identified as BED, focusing on research emphasizing the need for service delivery. Third, will be an examination of the role of counseling as it relates to providing services to students with disabilities in public school. Fourth, this review will investigate research that examines theoretical models of counseling that have shown positive outcomes when applied to students identified as having BED. Last, the results of the review will be used to support the implementation of the current study.

Eligibility Criteria for Students Identified as BED

It should be remembered that the identification of BED is not an actual psychiatric diagnosis, but an educational term that implies pathology. Special education eligibility for BED is defined as:

> … a condition exhibited by one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect the educational performance: (a) an inability to learn which cannot be explained by intellectual, sensory or health factors; (b) inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behaviors or feelings under normal circumstances; (d) a general pervasive mood of unhappiness; (e) a tendency to develop physical symptoms or fears associated with personal or school problems. The term includes children who have schizophrenia. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed (Federal Register, 1981, p.1)

While this is the federal definition provided by the Office of Special Education Programs (OSEP) it is also the definition by which South Carolina identifies students as having a BED. In addition, eligibility for services due to a BED must be established via assessing all areas of suspected disability. These can include, but are not limited to " health, vision, hearing, social and emotional status, general intelligence, academic performance, communication skills, adaptive behavior in home and school settings, motor skills, vocational aptitudes and post-secondary interests and preferences" (South Carolina Department of Education, 2008). Furthermore, a student being considered for a BED designation must exhibit educational performance that is significantly diminished when compared with other students and have limited access to general education opportunities as a result of the disability (South Carolina Department of Education, 2008). Last, the eligibility specifically excludes social maladjustment which is defined as,

> Students who are socially maladjusted (or more precisely Oppositional Defiant or Conduct Disordered) typically display a persistent pattern of willful refusal to

> meet even minimum standards of conduct. Their behavior and values are often in conflict with society's standards. They exhibit a consistent pattern of antisocial behavior without genuine signs of guilt, remorse, or concern for the feelings of others. These students often engage in simulations of these behaviors but typically display them only when there is an immediate consequence for the absence of such displays. Their antisocial behavior is most frequently seen as resulting from their tendency to place their own needs above those of all other people and the immediate gratification that such behavior brings them. These students are not in chronic distress (one of the criteria for emotional disturbance under the law) although they can exhibit situational anxiety, depression, or distress in response to certain isolated events - particularly facing the consequences of their own actions. These students do not typically respond to the same treatment interventions that benefit emotionally disordered students (EHA Regulations, 1989, 300.5 (80)).

Clearly, there is some confusion over identification issues related to suspected BED students. Indeed, there is a wide variation between states' identification rates which range from .1% of the general student population to 1.74% of the general student population (Coutinho, & Denny, 1996). This may be due, in part, to states often misinterpreting or completely eliminating the social maladjustment clause from their eligibility criteria for a BED (Coutinho& Denny, 1996) South Carolina has an eligibility rate that is at about 1% of the general student population, which has been a consistent ratio for the past 7 years (OSEP, 2008). South Carolina is also a state that includes the social maladjustment exclusionary component to identification of a BED within its regulations, although there is no data available that describes how this component is interpreted, measured or determined.

Of the 50 states, South Carolina ranks 24th in population size and 24th in terms of students enrolled in public school (U.S. Census, 2007). However, it ranks 21st in the total number of BED students served and 11th in the number of students with a BED that are removed from school for more than 10 days as a result of behavior (OSEP, 2008). This means that South Carolina identifies a disproportionate number of students as having a

BED when compared to other states and it is disproportionately more likely to remove these students from school for an extended period of time as a result of the child's behavior.

South Carolina's general education population is comprised of 55% Caucasian, 42% African American, 2% Latino, and 1% Asian/other (South Carolina Department of Education, 2008). Nationally, Caucasian students represent about 61% of the general education population, African Americans represent 17%, and Latinos represent 16%, Asian/Pacific Islanders represent 4% and Native Americans represent just over 1% of the general education population (U.S. Department of Education, 2008). Nationally, African American male students identified as BED comprise about 1.4% of the special education population and Caucasian male students identified as BED comprise about .7% of the special education population. In South Carolina, African American male students identified as BED comprise about 1% of the special education population while Caucasian male students identified as BED represent .46% of the special education population. Even taking into account the differences between national averages and the demographics of South Carolina, African American males are overrepresented within the population of students identified as BED in South Carolina (South Carolina Department of Education, 2008; U.S. Department of Education, 2008; OSEP, 2008).

There are likely to be reasons for the data regarding ethnicity, the BED label and national versus South Carolina disparities. The reasons are likely complex; comprising myriad variables including differing processes for referring a student suspected of a disability, general geographic differences in demographics, state directed special education policy as well as within state/district/school staff demographics and attitudes.

However, addressing these issues is not within the scope of this research. Instead, its focus takes place after identification has been made.

Once a student is identified as having a BED an Individualized Education Plan (IEP) is developed by an interdisciplinary team that must include the child's parent or primary care provider, a classroom teacher who knows the child, a special education teacher qualified to provide services in the suspected are of disability, a school administrator, a person who can interpret and discuss the educational implications of the results of the evaluation (traditionally the school psychologist, although this is not specifically stated in the federal regulations), the child when appropriate, and any other person the parent(s) wishes to invite or persons within the school with expertise in the suspected area of disability including related services providers as appropriate (IDEA, 2004). Usually the meeting in which the child is identified as having met the eligibility criteria for services as BED is also the meeting in which the IEP is introduced. While this is not explicitly forbidden via legislation it is generally not regarded as following best practices (NASP, 2004). The reason for this is that it is difficult to write a complete IEP before getting input from the multidisciplinary team, which might include related services and/or a meaningful behavior plan, particularly for students identified as having behavioral problems.

The IEP must address the student's educational needs in that the goals must be designed to meet the child's needs that would provide them more opportunities to participate and make progress in the general education curriculum (IDEA, 2004). Goals must be written in such a way that they account for present levels of performance and provide for sequential, measurable and comprehensive instruction and services designed

to provide access to general education settings (IDEA, 2004). In addition to these requirements, related and supplementary services are also addressed. Related services are supportive services that are required to assist a child with a disability to benefit from special education (IDEA, 2004). Supplementary services are designed to improve a child's access to learning, to the greatest extent possible, with same age, nondisabled peers within the general education environment (IDEA, 2004).

Both federal and South Carolina state law do not explicitly state that students identified as having a BED need counseling as a related or supplementary service. Indeed, when reviewing student files for the purposes of this research there were no students who had formal counseling goals, although all of the students had behavioral goals. Based on this, it would appear that the public school system fails to acknowledge a direct link between internal thought processes and observable, external behavior. Put another way, the public school system conceptualizes how students view, experience and internalize their world as a discreet, different and unrelated phenomenon to how students behave in the world in which they live. Teaching students to identify feelings, understand what they mean and how these influence behavioral choices is not a relevant educational process. Consequently, counseling will not provide greater opportunities for students identified as having a BED to engage or be included in general education settings.

Characteristics of Students Identified as BED

Current research estimates that about 1 in 5 children suffer from an emotional, developmental or behavioral problem (U.S. Department of Health and Human Services, 2006). Of course, not all of these children will be identified as having a severe enough behavioral or emotional problem to warrant services in special education. Indeed, OSEP

(2008) estimates that about 1% of the public school population served are students with BED. However, some researchers have suggested that there is a significant population of students who would benefit from these services and have not been identified, and that of those who have been identified most are not receiving the level of care that would enable them to experience success in school (McLaughlin & Leone, 1997). Of the students who have been identified as BED, most are boys and there is a disproportionate representation of African Americans (OSEP, 2008; OCR, 2008).

Students who have been identified as BED are among the fastest growing populations in special education and are regarded as the most challenging group with which to work because they exhibit violent, arbitrary and aggressive behavior (Haring & Barckley, 1990). Estimates range from between 50% to 60% of those identified as BED will not complete high school (Carson, Stilington & Frank, 1995). One qualitative study that was done found that many of the students who dropped out of school reported a lack of support and antagonism from teachers, administrators and other school staff. Further, they reported that they perceived leaving was not only something that they wanted to do, but was preferred by the school faculty as well (Kortering, Braziel & Tompkins, 2002). Indeed, there has been a correlation between teacher turnover and students who are aggressive, verbally abusive, and fail to make adequate progress, which are all characteristics of students identified as BED (Nelson, 2001).

It should be remembered that the identification of BED is not an actual psychiatric diagnosis, but an educational term that implies pathology as defined by the U.S. Department of Education (Federal Register, 1981). However, there are facets of pathology described in the *DSM-IV* (APA, 2004) inherent in the definition, and is often

used for assessing the functioning of students undergoing evaluation in schools. Aggression, anxiety, depression, poor locus of control and low self-esteem are have been included within the identification of students with BED, all of which are *DSM-IV* (APA, 2004) diagnoses, or criteria for diagnosis (Achenbach & McConaughy, 1996). What follows is a brief description of some of the more prevalent psychiatric disorders associated with students identified as BED according to Achenbach & McConaughy's (1996) work.

Aggression is behavior that can be manifested verbally, physically, or both, and is generally a learned or adaptive response to a perceived threat (Perry, 1995). Although not a stand-alone diagnosis, aggression is part of the diagnostic criteria for oppositional defiant disorder, anxiety disorders, attention/hyperactivity disorders and conduct disorder (APA, 2004). The most significant areas related to the development of aggressive behavior are the child's home and school, with abuse, family disruption and dysfunction, anti-social parents and violent interactions with siblings the greatest predictors of school-based aggression (Laub & Lauritson, 1998). Perry's work (1995) supports this research, indicating that there is a fundamental neurodevelopmental process where the fear and terror states become traits in children who live in unstable, unpredictable, non-nurturing and violent environments. These traits lead to a pervasive state of hyperarousal and hypervigilance, both of which create an internal dynamic where small and seemingly innocuous stimuli result in behavior that can quickly escalate to aggressive behavior (Perry, 1995).

Males are more likely to be aggressive than females, and they are more likely to be aggressive toward other males (Laub & Lauritson, 1998). Data about students

identified as BED reveals that African American males are the most likely to be disciplined for aggression (OSEP, 2008), and this is the case even when their disproportionate presence within this category is considered. Of note, Caucasian males are more likely to be disciplined for weapons violations than any other ethnic category (OSEP, 2008). Aggressive acts generally appear to be associated with retaliation, perceived rule violations and territory (Laub & Lauritson, 1998). Again, students identified as having a BED are generally not provided counseling services as a part of their IEP, which limits the educational support to that of behavioral goals. Failure to make progress toward these goals will generally result in retention or disciplinary action (OSPE, 2008; IDEA, 2004).

One theory that attempts to explain this phenomenon is the fight vs. flight and bend vs. befriend threat assessment model (Goldstein, 2008). This theory suggests that males are more likely to engage in the fight or flight phenomenon when confronted with a threat. In contrast, females are more likely to bend (conform to whatever is perceived as expected) or befriend (rely on a social network in order to cope) when confronted with a perceived threat. Perry (1995) suggests that females are more likely to dissociate (withdraw, become excessively passive or faint) in a threatening situation.

What are often only tangentially related to aggression in research are the suspected origins of the behavior itself. Specifically, the question, “Where does the aggressive behavior come from?” is only occasionally asked. Perry (1995) certainly articulates that there is a move from state to trait with regard to fear and anxiety, which can result in aggressive behavior. In these cases the behavior is goal directed in that it is

designed to eliminate or minimize a perceived threat. Essentially, the aggression is a coping mechanism designed to elicit some element of control over ones environment.

Another *DSM-IV* (APA, 2004) diagnosis that is often associated with students who are identified as BED is anxiety. Anxiety disorders are among the most common diagnoses in children under the age of 18 (Hollander, Simeon & Gordon, 1999), with estimates that range from 5% to 18%. Anxiety can be characterized as excessive and difficult to control worry which results in feelings of edginess, difficulty concentrating, irritability and impulsivity. The source of the feelings of anxiousness cannot be easily identified or articulated and interfere with social interactions and (school)work performance (APA, 1994). Anxiety disorders can often render children so fearful that they exhibit gross manifestations of the startle response: fight or flight (Perry, 1995). In either case, the child suffering from anxiety can appear hyper-aggressive or hyper-kinetic or they may appear highly withdrawn and slow to respond to questions or directives, with males exhibiting more of the "fight" symptomology and females more of the "flight" symptomology (Perry, 1995). According to Perry (1995), there appears to be a direct link between the sources of aggression and anxiety. Put simply, the very things that are predictors of aggression in children are often the same stimuli that result in pervasive states of worry or anxiety. Learning becomes difficult because the emphasis for the child becomes one of addressing immediate perceived needs and threat assessment rather than on the topic of the class (Goldstein, 2007). Again, behavior goals address only the observable, which appear as distractibility, impulsivity, inattentiveness and/or aggression.

Another area of psychological dysfunction associated with students identified as having a BED is depression. Although there is little epidemiological data regarding the

prevalence of major depressive disorders among children, estimates range from 14%-25% with higher rates among females than among males (Kessler & Walters, 1998). In addition, comorbid diagnoses often associated with depressive disorders in children include anxiety and disruptive disorders (Pine, Cohen, Gurley, Brook & Ma, 1998). Depression is one of the least recognized pathologies in terms of service delivery within public schools, with data revealing that students may be served in a group setting for environmental issues that may result in depression (i.e, divorce, transition, bullying or poor social skills), but not specifically for depression (NASP Bulletin, 2007).

As with anxiety and aggression, there appears to be a link between family dynamics (parenting styles, low involvement by the father, relational quality among family members and depressive disorders among other family members) and depression (Gotlib & Hammen, 1992). Essentially, a comprehensive review of the literature addressing depression in young people universally finds links between depression and other pathologies in addition to familial dynamics. Thus, students identified as BED are far more likely to be experiencing depression than nondisabled students. However, there are no provisions within the student's IEP that specifically address depression, ostensibly because one cannot observe and measure it effectively and, therefore, it does not meet the criteria necessary for a related service because there is no educationally recognized link between academic achievement and depression,

Locus of control issues are frequently seen in students identified as BED. Indeed, part of the eligibility criteria specifically references an inability to make or maintain relationships among peers and adults (IDEA, 1997). Locus of control problems can be described as a child's lack of belief that they have any control over what happens in their

lives, particularly in areas of considerable importance to the child (Evans, Marsh & Owens, 2005). It would seem self-evident that any student who exhibits poor locus of control might experience anxiety, anger, depressive behavior. However, these social deficits are generally not viewed within the context of a wider array of psychopathology, and students are often provided "social skills training" in order to address this issue (Costello, 2001).

Social Skills Training (SST) has been a widely researched methodology for providing support for students identified as having a BED. Gresham,Cook, Crews, & Kern, (2004), provides a meta-analysis of 35 studies that involved SST and concludes that it is a viable model for social and cognitive skill development among students identified as BED. Maag (2006), also conducted a similar meta-analysis of SST research, but the conclusions reached in this article are significantly more reserved with regard to the efficacy of SST among students identified as having a BED when compared with Gresham's (2004) conclusions. Both authors recognize the need for more refined operational definitions of behavior to be addressed through SST, and both agree that the people involved should be adequately trained with a clear conceptualization of what the outcomes of the SST should be. Additionally, Gresham (2004) and Maag (2006) identify the school counselor as a person who could identify the need, train and collaborate with other school personnel in the implementation of SST. However, Maag (2006) sees this is potentially problematic given the myriad responsibilities school counselors already have.

Further, teaching social skills fails to address the real issue that underpins the origins of behavior, and could arguably exacerbate it *because* of the failure to address the real issue. To that end, Granger, Weisz & Kauneckis (1994) were among the first

researchers to identify a link between cortisol levels, social stress and external locus of control in adolescents. Their findings reveal that children who perceive themselves as having little or no control over their environment are more likely to exhibit poor self-control, higher levels of stress, anxiety and depression than children with a greater sense of control over their environment and themselves. These feelings and behavior are likely to become more profound when children believe that their needs are being willfully ignored by relevant adults and peers. Further, their findings revealed that cortisol levels, a hormone associated with stress, anxiety and depression, were higher in children with locus of control problems (Granger, Weisz & Kauneckis, 1994). These results support Perry's (1995) research and suggest that the longer psychosocial needs remain unmet, the more difficult it becomes for the child to change their belief about control and subsequent feelings and behavior. This clearly dovetails well into Glasser's (1998) assertion regarding choices, control and basic human needs.

It should be noted that, again, social skills training is embedded within the child's IEP as a goal and not as a related service. Thus, the symptom of an existing problem is treated while the underlying problem itself is left untended.

In summary, students who have been identified as having a BED exhibit an array of psychosocial problems. While there is substantial research highlighting relationships between neurological functioning (academic achievement for the purposes of this research) and psychopathology, public schools have generally failed to address this within a student's IEP. As a result, the academic plan that is designed to elicit positive educational outcomes is essentially designed to fail before it is implemented.

Role of the School Counselor

Maag and Katisyannis (1996) suggest that school counselors are among the best suited personnel within a school to provide therapeutic services to students identified as BED. Their work also highlights that although the school counselor should be able to provide these services, they are usually left out of the special education process, including the delivery of services outlined in the IEP, in spite of the fact that school counselors have expertise in identifying and understanding basic tenets of child development and behavior, as well as having the ability to effectively mediate between the primary care providers of children and school based personnel (Baumberger & Harper, 1999). While Maag and Katisyannis suggest that the school counselor should be providing services to children identified as BED, Baumberger and Harper (1999) appear to agree albeit with a caveat: school counselors need more training in the area of special education, with an emphasis on professional development that emphasizes establishing clear roles and responsibilities with this population of students. Scarboro's (2002) research supported Baumberger and Harper (1999), demonstrating that school counseling has evolved over a long period of time. Specifically, this research helped establish the competencies that school counselors have that are consistent with the needs presented by children identified as BED. However, her research also suggests that the expectations placed on school counselors by school administration via testing policies and state and federal legislation have rendered the role of the school counselor to one that mirrors that of an administrator rather than clinician (Scarboro, 2002). Specifically, school counselors are often the person in any given school who is responsible for creating student schedules, overseeing end-of-course testing throughout the school, gathering and

disseminating data to school staff regarding student performance, dealing with discrete behavioral infractions, coordinating school/community events, acting as a liaison between transfer students and other schools, and teaching whole class character lessons (Scarboro, 2002).

One of the reasons for this disparity is the lack of training that counselor's receive in their graduate programs. While they tend to get ample training in theory, development and pathology, there is a distinct lack of information provided about students with special needs (Baumberger & Harper, 1999). This could be due to the ambiguous nature of the way that special education law reads with regard to the provision of services to children identified as BED. The IDEA stipulates that children with disabilities should receive supportive services that address their disabling condition in a manner that increases the likelihood that they will experience academic and behavioral success in school. These services include supplementary aids and services (IDEA, 2004). Supplementary aids and services can also be defined as related services, which can include, but are not limited to occupational therapy, speech therapy, physical therapy, counseling services and assistive technology (IDEA, 2004). Counseling as a related service is not specifically mandated for students identified as BED, although it can be implied based on the nature of the disability. Indeed, some researchers and state departments of education have interpreted the way this regulation reads as a requirement that counseling as a related service be provided to students with BED (Maag, et al., 1996; Scarboro, 2002; South Carolina Department of Education, 2000).

While the American School Counselor Association (ASCA, 1999) has changed its position statement on service delivery to students with special needs to include

counseling both parents of and children with special needs, and special education law (IDEA, 2004) has recommended that school counselors be a regular part of school based multidisciplinary teams, there is still a disconnect between what legislative or organizational sources state are the intended duties of the school counselor and what the school counselor actually does. Indeed, the child's IEP rarely reflects school based counseling as a related service, or the service is relegated to someone other than the school counselor (Maag, et al., 1996). Consequently, students with specific emotional or behavioral problems are not provided access to the person within the school building who has the most codified training designed to best meet the needs of the student.

Clark and Crandall-Breman (2009) suggest a tiered support system within schools for students with behavioral and/or emotional disabilities. This model encourages counselors to work with other stakeholders, such as teachers and parents, in an effort to provide appropriate therapeutic services to students within the classroom. Essentially, counselors could work with the entire class, small groups, or individual students (thus the tiered nature of the support) without removing the student(s) from class. This approach has the potential to alleviate the "accessibility to counselor" problem that has been identified by other researchers. It may also provide school counselors a better understanding of how children with BED engage with teachers, other students, and curriculum. Further, it has the potential to meet the academic and social/emotional needs of students simultaneously, as well as promoting collaboration among stakeholders regarding student needs.

In summary, research highlights the underutilization of school based counselors assuming intervention, supportive and clinical roles with BED students. Instead, they are

often used as an administrative functionary, fulfilling a more bureaucratic role for the students who attend the school in which they work. Baumberger (1997), Scarboro (2002) and Maag (2006) have all identified ancillary roles that are played by school counselors, and reasons that may explain some of this. In addition, there is very little research that has been conducted within a public school setting that assesses the effectiveness of counseling by a school counselor with a student in need of some form of therapeutic support. Maag (2006) emphatically highlights this issue, suggesting a self-limiting paradigm: empirical evidence is needed in order for school counselors to advocate for providing counseling services, but school counselors are so over extended with other duties that it is difficult to generate any empirical evidence. Thus, they continue to be unable to provide substantative counseling services. Clark and Crandall-Breman (2009) offer one tenable solution to this with their proposed tiered support model.

Choice Theory as a Treatment Modality for Children Identified as BED

Ryan and Deci (2000) suggest that all people have innate psychological needs which underpin motivation and the integration of personality. Further, they state that meeting these needs is essential for the purposes of personal growth, social development and well being (Ryan & Deci, 2000). Glasser (1998) identifies these needs in five discreet categories, (a) power, (b) belonging, (c) freedom, (d) fun, and (e) survival. The assumption is that, however irrational the behavior might appear, it is designed to meet one of these five basic needs (Glasser, 1998). When viewing pathological or dysfunctional behavior, the irony is that many of the behaviors designed to meet a need create new circumstances that increases the difficulty of actually meeting the identified need.

The psychiatric disorders described previously are varied, and there have been numerous different therapeutic approaches suggested for each of them. In addition, as previously stated, school counselors have complex and demanding jobs that generally have little to do with counseling students. If it were at all possible for school counselors to assume more of a clinical role within schools, it would seem prudent to identify a theoretical approach that addresses a wide array of needs, and is fairly easy to integrate into a counselor's existing theoretical competence. Consequently, commonalities among therapeutic approaches for the described diagnoses was sought in order to find theory that may be effective for a broad spectrum of children and does not require school counselors to dedicate extensive time for additional training, paradigm shifting for individual students, or defining problems and developing meaningful goals with students.

An extensive review of literature was completed in order to find material that related to counseling methodology in public school settings. While alarmingly limited, there were some data that is briefly summarized in the following paragraphs. What the research reveals is a pattern that appears to avoid actual counseling as it is generally conceptualized. However, there are facets of the research that support the proposed efficacy of implementing a Choice Theory approach.

One study that was found reviewed the effects of a long term multi-component intervention that utilized token economies and response cost lotteries (Musser, Bray, Kehle & Jenson, 2001). While the results indicated that overt unwanted behavior reduced by 10% overall, the subjects were not provided feedback about anything other than overt behavior. Maag (1995) criticizes this method arguing that it leads children to develop, or reinforces, an external locus of control and does not require the child to spend any time

reflecting on what led to the behavior. Inherent in this weakness is a failure to train children to take ownership of their feelings, behaviors and subsequent consequences, which would minimize the learned response to rely on outside sources for feedback. It is the inherent weaknesses in this research that inadvertently supports the utilization of Choice Theory in terms of power (ownership of feelings and behavior) and freedom (poor choices limit freedom via response/cost).

Several articles reviewed suggested that group counseling take place for students, ostensibly for social learning outcomes and in order to maximize time utilization (Maag & Webber, 1995; Webb & Myrick, 2003; Collins & Collins, 1994). Again, the outcomes showed promise in that many of the children under investigation exhibited fewer problem behaviors. However, other authors explicitly stated that individual counseling should be the preferred counseling methodology, particularly with children identified as having attention deficit hyperactivity disorder combined type (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD) because children with these pathologies tend to distract each other during sessions (Erk, 2004; Hoise & Erk, 1993). Most notable was the counseling approach which relied heavily on social skills training and avoided addressing the internal dialogue people have before, during and after any observable behavior. Again, the inherent weaknesses in this research reveal the worthiness of Choice Theory as a tenable alternative (social skills training is designed to address issues of belonging and, as a byproduct, fun).

Several pieces of research were located that were designed to help eliminate the need for intensive counseling of students identified as BED while attempting to improve behavior. Dupual and McGoey (1997) presented findings of the use of peer tutors in

helping students identified as BED successfully engage in mainstream classrooms (classrooms that do not contain a majority of special education students). Their findings suggested that peers, along with the support of the teacher, could significantly reduce behavioral problems experienced by the child identified as BED. What was worthy of note were the procedures involved, two of which required self-evaluation on the part of the BED student with the assistance of the teacher or the peer. This self-evaluative process is consistent with tenets of Choice Theory, which Glasser (1998) defines as a method by which people make decisions about how much power and control are given to others, whereby changes can be made which allows for changes in affect and behavior. However, this procedure was limited to overt behavior and not inner precipitators of behavior beyond which the BED student could identify independently.

Glasser studied his approach within the context of juvenile detention facilities and special schools designed to support children with chronic behavioral problems (Glasser, 1976). His work indicated that these children could learn to assume responsibility for their choices and their feelings associated with the choices made. Preliminary findings indicated that these children were more likely to meet discharge criteria more quickly than other children not receiving this treatment modality, and that recidivism rates were lower among children who had worked with Glasser under his treatment approach when compared other children not receiving Glasser's approach. Unfortunately, this approach has not been implemented in a public school setting.

Choice Theory has also been found to be an effective agent of change in children suffering from anxiety disorders (Kendall, Chu, Pimental & Coudbury, 2000). In this population, Choice Theory is used to help children restructure events or memories,

ongoing self-statements, how experiences are processed, and attributions that result from the previous items. The Choice therapy treatment teaches new skills, including new methods of processing events that challenge dysfunctional thinking (Kendall, et al., 2000).

Bums, Vance, Szadokierski and Stockwell (2006) provide some preliminary work in substantiating the validity of the five needs originally proposed by Glasser (1998) via their creation of psychometric instrumentation. Their findings support the proposition that high school aged children rated belonging, power, fun and freedom as among the most important facets of their lives, and any interference with the acquisition of these causes distress (ratings of survival were not significant). Further, their results suggest that many students are unaware of how to adequately identify needs or ways to effectively meet them (Bums, et al.).

While not addressing the BED population specifically, Loyd (2005) found that presenting a Choice Theory based counseling approach to high school students elicited favorable and significant results on students' ability to better meet their needs related to fun, power and freedom. Unfortunately, the study did not identify specific variables that might be important such as race, academic standing, perception of social connectedness (popularity) or the perceived importance or rank order of importance of the five identified needs.

Mellons and McGraw examined the perceived outcomes of choices made by people when making behavioral decisions designed to either (a) minimize unpleasant outcomes or (b) enhance pleasant outcomes. Their findings suggest that people more willing to take risks reported greater levels of pleasure as a result of their choice(s).

Further, an unexpected result was that unpleasant outcomes were generally not as profound as people expected them to be. While this study was not designed to assess anything related to Choice Theory (i.e., Glasser and Choice Theory were never cited), the results are consistent with Glasser's propositions in that people make choices based on what they expect to happen and the feelings associated with the behavior are internally defined rather than being mediated by external influences.

Summary

To summarize, literature that promotes child progress across pathologies, that does not require the school counselor to wear too many hats, or to have to coordinate multiple schedules in order to engage in counseling, is a Choice Theory approach. The studies that were reviewed generally sought methods that did not require actual counseling in order to elicit positive behavioral outcomes. In doing so, the research either demonstrated the veracity of a Choice Theory approach based on pieces of the process being examined (Dupual, 1997), or through what was clearly lacking in the research methodology (Musser, 2001).

Choice Theory has been identified as a long standing and efficacious approach in working with students who exhibit extreme aggression and conduct disorder (Hollon & Beck, 1994). Kazdin, Bass, Siegel and Thomas (1987) found that a Choice Theory approach was significantly more effective than an attention placebo and parent management training in helping students recognize their thinking, likely behavioral outcomes, and possible behavioral alternatives.

Again, there are several pathologies that are often associated with children identified as BED. While there is no "magic bullet", there are approaches that for myriad

reasons may not be the modality of choice. Consequently, a review of literature was conducted in order to find something that might be of value across pathologies, which yielded Choice Theory as among the most tenable approaches that would meet the needs of individual students and the practitioner with whom the child is working. What was interesting was the utter lack of scholarly work done within the context of a traditional school setting using Choice Theory as the therapeutic modality. Clearly, current research supports Choice Theory as a tenable approach for adolescents. Indeed, Glasser developed the approach after working with children who were, at the time, referred to as delinquent (children who would likely have been identified as BED had there been the classification at the time). Therefore, examining the use and effectiveness of Choice Theory within the context of a traditional public school with students identified as BED will provide much needed information regarding service delivery needs and anticipated prognosis of children being served in special education who fall within this category.

CHAPTER 3: METHODOLOGY

The primary purpose of this was to determine if there is a difference between a group of students identified as behaviorally/emotionally disabled (BED) receiving a Choice Theory (Glasser, 1998) Therapy protocol and a group identified as BED who are not receiving a Choice Theory (Glasser, 1998) protocol on measures of (a) anxiety, (b) locus of control, (c) depression, (d) self-esteem. This chapter will provide the study methodology, including the sample, procedures, instrumentation and data analysis.

This study was conducted as a true experiment in that it consisted of middle and high school aged participants identified as BED from a suburban school district in upstate South Carolina randomly assigned to either an experimental or control group. The experimental group received a 6 week counseling protocol that implemented core principles of Choice Theory, and both groups participated in a pre/posttest measure of specific affective and behavioral characteristics which, in part, define the students' special education designation. While there is research that supports the efficacy of Choice Theory with this population of students (Glasser, 1978; Glasser, 1998; Maag, 2004; Ryan & Decci, 2000), there is no empirical data that reflects student psychosocial outcomes using this modality within the public school forum. Indeed, students who are not being served in a sequestered environment such as a hospital or therapeutic group home spend the majority of their time either at home or at school (Maag, 2004). Consequently, this study is a logical addition to the existing body of literature regarding Choice Theory.

Sample

In order to test the effectiveness of a Choice Theory approach with these students a convenience sample of middle and high school students identified as BED was gathered from a medium sized school district in upstate South Carolina. The school district tracks the number of students being served through their special education program, the specific disability for which they are receiving services, as well as the age, gender, ethnicity and Medicaid eligibility of each student. Students involved in this study were selected from these lists based on disability and age; gender, socioeconomics and ethnicity were not part of the selection process. The students were assigned to one of two groups: the treatment group, which received the Choice Theory (Glasser, 1998) protocol, and the control group, which received no treatment. Assignment to either group was done randomly. Both groups consisted of 15 students, and the treatment group was divided into smaller groups of 3-5 students. Each of these groups was given the Choice Theory (Glasser, 1998) protocol on the same day (albeit different times) each week. Inclusion in the study was voluntary with parental permission given in cases where the subject was under the age of majority (18 years of age in South Carolina), and all subjects were treated in accordance with the ACA code of ethics (American Counseling Association, 2005).

Procedure

The primary researcher was the only counselor involved in administering the Choice Theory (Glasser, 1998) protocol in order to minimize extraneous variables that may affect the outcomes of the study. The counseling consisted of small groups of students (3-5) and they were not segregated according to race or gender. Each session

was one hour in duration, weekly, for a total of six weeks. The sessions were done within the schools that the students attend.

The protocol, developed by the researcher, was designed to utilize the core concepts associated with Choice Theory (Glasser, 1998) over a six week period. Students in the experimental group met with the researcher in small groups during that time and there were no absences due to illness or behavioral infractions (i.e., suspensions, expulsions or alternative setting assignment). On several occasions the researcher had to get permission from a school administrator in order to retrieve a student from an in-school suspension program. In some of these cases, students were given an out-of-school suspension following the treatment. In other words, school staff assisted the researcher in keeping students in the school building until after the treatment had occurred. In all cases, these students had completed the out-of-school suspension before the start of the next session. There were no recommendations for expulsion for any of the students in both groups during the research process.

A standard small group intervention model was used for the majority of the proposed study. Small group interventions have exhibited some positive outcomes associated with students identified as having significant behavioral or emotional problems (McLean, 1994). Through the proposed small group intervention the author (a) offers a place for students to test self-perceptions, (b) reveals distorted self-perceptions and wrong assumptions about behavior, (c) provides a setting of support to address identified problem behavior, (d) provides an opportunity for students to increase skills in reducing problems behaviors and increasing knowledge of other behavioral/emotional choices, and (e) provides a place where students can interact in a manner that increases

social interest. Choice Theory (Glasser, 1998) was the theoretical model under which the protocol (see Appendix A) was developed.

Each of the participants in the experimental and control groups were administered the BASC-2 Self-Report prior to the implementation of the Choice Theory group (Glasser, 1998) and then again at the conclusion following the last group session. Only the items associated with the specific domains being analyzed (Depression, Anxiety, Locus of Control and Self Esteem) were administered. This instrument was given to each of the participants individually in order to minimize error due to a misunderstanding of the directions, and to attempt to establish some rapport with the students prior to the implementation of the protocol.

The University of North Carolina at Charlotte Institutional Review Board procedures were followed to obtain permission for research approval after the dissertation committee approved the proposal of this study. A cover letter was given to all of the subjects (both the experimental and control group participants) and their primary care providers that contained information relative to informed consent, anonymity and Human Subject contact information for this research, as well as a brief description of the protocol and time involved on the part of the student. Cover letters were provided to school principals of the schools in which the students attend and to the district superintendent and the district special education director delineating the focus, purpose, and use of the data collected and perceived contribution of this research. Subject behavior ratings from the BASC-2 were gathered after having received permission from both the subject and his or her primary care provider when appropriate. Following the intervention, all of the participants were debriefed in order to clarify the purpose of the research, answer any

questions that the participants had and allow for critical feedback from the participants. When the experimental group protocol was completed and the data had been gathered the same procedures were followed for the control group. Specifically, they engaged in the six session Choice Theory (Glasser, 1998) protocol.

To restate the basic tenets of Choice Theory, Glasser (1998) identifies basic human needs in five discreet categories, (a) power, (b) belonging, (c) freedom, (d) fun, and (e) survival. The assumption is that, however irrational the behavior might appear, it is designed to meet one of these five basic needs (Glasser, 1998). When viewing pathological or dysfunctional behavior, the irony is that many of the behaviors designed to meet a need create new circumstances that increases the difficulty of actually meeting the identified need.

Treatment sessions were conducted during school elective times rather than core academic times. Given the nature of the students' disability, their schedules are more flexible than students in general education, making these arrangements much easier to meet. During the first session, students were introduced to the researcher and the core concepts of basic human needs based on Glasser's theory (1998). They were also encouraged to articulate something about themselves that others might not know and to give some thought to the reasons for sharing certain information while keeping other information private. After having students sit in their preferred places the author welcomed the group. Following that there was a general discussion of thoughts, beliefs and attitudes toward school in terms of academic and social issues. Next, each student in the group was asked to tell their "story" in terms (a) who they are, (b) where they come from, (c) self-perceptions about how they are as students, friends, and outside interests,

and (d) perceptions of their role within the school (how they perceive that others perceive them). The purpose of this exercise, as it relates to Choice Theory (Glasser, 1998) was to expose the students to what the treatment was about, what is was supposed to do and normalize thoughts, perceptions, feelings, and behavior among the group members. The session concluded with a summary of what had been discussed as a group and the students' understanding of their introduction to Choice Theory (Glasser, 1998).

The second session started with a recap of what was discussed during the previous session and a request for feedback regarding accuracy and understanding. Next, the topic of control was discussed. Specifically, students were asked to discuss the parts of their lives over which they felt they had control and what aspects they felt that others controlled. When students identified something that they reported controlling, but were, in reality, in a reactive state, they were challenged to define how this was control versus a reaction to an outside influence (i.e., teacher, friend, parent). Through this dialogue, students were challenged with regard to some of their core beliefs. Namely, that they believed that they could control what other people did even if they did not want to do it, and that other people could control how the students thought, acted and felt. Also, they were challenged in their belief that it was their right to coerce people into getting them to do something they did not want to do (Glasser, 1998). The session concluded with a discussion that asked students to attempt to discern between things (stimuli) that "make" them think, believe or act in certain ways versus stimuli that, instead, presented cognitive, behavioral and/or emotional options from which the students chose. They were given this as "homework", too, where they were asked to try to differentiate between times when

they were “made” to do, think or feel something and times when they chose to do, think or feel something.

To summarize, the second session was designed to help students define the concept of control for self; differentiate between control and choice; conceptualize the effect stimuli has on the student and the relationship between choice and control. Additionally it addressed student concerns regarding behavioral action/reaction between themselves and others (people and other stimuli).

Session 3 began with a recap of what had occurred in session two and the author asked for feedback regarding accuracy and understanding. Next, students were asked about their homework and if they were able to identify times during the past week where they differentiated between times that they attempted to control or felt controlled versus actively making a choice to think, act or feel a certain way. Using this discussion as a springboard for further exploration into Choice Theory, the author integrated the concept of power into the context of student self-perception and the concept of control versus choice.

Again, the assumption made is that people enjoy the feeling of power when it is theirs and dislike the feeling associated with “giving” power to others (Glasser, 1998). Consequently, students were asked two main questions: (a) can they think of a time when they felt they had power and what that felt like, and (b) can they think of a time when they “gave” power to others and what that felt like. Through the responses, both sides of power are explored. First, the students were asked to elaborate on how giving power to others results in hurt feelings, anger, frustration, and sometimes aggression. The students were also asked to elaborate on feelings associated with exerting power on others, such as

exhilaration, contentment, happiness, and sometimes aggression. The students were also asked to attempt to explain how they balance their feelings when giving power to others and then exerting power on others. When students made excuses for exerting or giving power they were reminded of the difference between choice and control.

In summary, the third treatment session asked students to attempt to define power and different times that they either experienced giving power to others or attempted to use power to control others. Also, students identified feelings associated with both situations. Further, the treatment session asked students to attempt to address empathy through comparing the giving and exerting of control, and to work on metacognitive tasks in order to more consistently make choices about feelings rather than giving control to others.

Session 4 began with a welcome from the author and a brief recap of the previous session. Students were encouraged to identify times during the past week in which they could remember both giving or exerting control and what they did (if anything). When students were able to identify specific times in which they chose to think or act differently than they generally would have in the past, they were asked to expand on this, identifying the thought process, the outcome and thoughts or opinions on the outcomes. For students who reacted to giving or exerting control similarly to how they have reacted in the past, they were asked to expand on the same issues as the others; identifying the thought process, the outcomes and thoughts or opinions on the outcomes.

Next, students in the group were introduced to the concept of their quality world (Glasser, 1998). In this process, the students are asked to define the people with whom they most want to be, the things that they most want to have, and how their belief system

governs their behavior. While students were able to identify the people they like to be around and the things that they want to have, it was difficult to conceptualize a belief system. People often behave in ways that violate their quality world (Glasser, 1998), but fail to recognize the incongruity or the resulting outcomes because they have never fully articulated what they believe. This was not an exercise in morality or right vs. wrong, but an honest appraisal about what students believe about who they are and what they expect from themselves rather than espousing what they perceive other people expect from them. The session ended at this point and the students were asked to give some thought to what kinds of things happen when they choose to behave in ways that violate their quality world (being with people they do not want to be with, wanting things that do not serve the interests of their quality world or behaving in ways that contradict their self beliefs or expectations).

To summarize, session 4 treatment involved students working on choosing to think and act as well as learning to define their quality world (personal connections, wants, beliefs). In addition, students were asked to address consistency in thinking and behaving relative to choice and learning to articulate the components of their individual quality world, as well as differentiating between morality and beliefs.

Session 5 began with a welcome from the author and a recap of the previous session, with particular attention being paid to the ongoing process of defining each of the students' quality worlds. Specifically, the students were queried about what thoughts they had over the course of the week regarding their quality world. Whom do they really want to spend time with and what is it about these people that make them important? What are the things that they really want? Is it a reflection of pop culture, or is it an

honest internal appraisal that represents their quality world? What are their beliefs and how do these beliefs fit with their personal connections and their desires?

Responses from this dialogue were reconnected with earlier discussions regarding power, control and choices. In other words, was congruity between the articulated quality world and the observable behavior exhibited by the students in the group? Often, people will state that they do not care when, in fact, they care deeply about something within their quality world (Glasser, 1998). This is the part of the group interaction that created the most defensiveness and internal crisis. This was due to the crossroads at which the students found themselves. On the one hand, they could reject what they have learned about themselves, give control to others and continue to engage in self limiting behavior. On the other hand, they could honor their quality world and what that entails and assume the risk of redefining themselves both internally and to their external world. One choice was easy, but results in limited positive long term outcomes. The other choice was harder and uncertain. It was the responsibility of the author to make these distinctions, reminding the students that the decision was ultimately theirs to make.

This session concluded with the students giving an appraisal of their thoughts about the current session. Defensiveness during the session was addressed and validated, as was any indication of fear or anxiety. People are often resistant to change and can react with avoidance and anxiety when challenged to do so (Medin, 2006). Also, any indication of risk taking or growth was addressed and encouraged.

To summarize, session 5 involved students acknowledging and beginning to honor their quality world. They started to recognize that power, control and choice are all pieces that can either facilitate or interfere with this process. Being defensive, fearful or

uncertain was validated by the author and the group. In addition, students addressed the process of change, setbacks and skepticism (from within and without) and learned that freedom is also authenticity, and that practice is necessary throughout the process.

Session 6 began with a welcome from the author followed by thoughts and feedback from the previous session. This session was a conclusion of the work that had been done over the past six weeks. Specifically, the students were asked to share their thoughts on the process, what, if anything, they had learned, what changes, if any, they had made and their ideas on freedom, power, fun, control, and choice.

The students were also asked to articulate goals for the coming weeks and months about choosing thoughts and behavior when confronted with people or events that violate their concept of their own quality world. Further, follow-up sessions were scheduled with each of the students individually. They chose either face to face contact or contact via telephone (or email if they had it). The follow-up sessions took place 3 weeks after the conclusion of the study with an open invitation to the participants to contact the researcher at their discretion via telephone or email after that.

Instrumentation

The BASC-2 Self-Report was administered during the course of this study. The Behavior Assessment Scale for Children—2nd Edition (BASC-2) Self Report edition was used to gather general information about global aspects of behavior. The BASC-2 is designed to aid in the identification and differential diagnosis of emotional/behavioral disorders in children and adolescents. It is multidimensional in that it measures numerous aspects of behavior and personality including positive and negative aspects of each.

The BASC-2 Self-Report yields reliability coefficients of .80 for internal consistency. It yields validity coefficients (concurrent factor analysis) of .63-.89 for the Minnesota Multiphasic Personality Inventory, .30-.46 for the Youth Self-Report, .67-.72 for the Behavior Rating Profile and .60 for the Child Personality Questionnaire (Kaufmann, 2004).

Specific items that relate to subscales that were not analyzed were removed from the BASC-2 protocols for the student edition. Specifically, items associated with withdrawal, somatization and adaptive behavior were not a part of the protocol. Pearson Assessments, the publisher of the BASC-2, will not allow modified copies of the protocol to be created, but will allow specific items to be "blacked out." The BASC-2 examiner's manual lists the protocol statements by subscale, so it was feasible to eliminate the superfluous items from the protocol, allowing the respondents to answer items related to only the subscales being measured for this research.

The BASC-2 Self-Report was completed by the student. This instrument asks the student to rate 140 statements on a Likert scale ranging from "never" to "almost always". Examples from the Student Edition are "I like school," "I have friends," "I cause problems," "My parents have unrealistic expectations of me"; "I am never in control." This instrument yields T-scores that have a standard deviation of 10 and a mean of 50. This instrument assesses the following areas: anxiety, attitude to school, attitude to teachers, atypicality, depression, locus of control, sensation seeking, sense of inadequacy, social stress, somatization, interpersonal relations, relations with parents, self-esteem and self-reliance.

The BASC-2 Self-Report is comprised of two primary scales: Clinical and Adaptive. The measures of Anxiety, Depression and Locus of Control are within the Clinical scales domain. As previously stated, T-scores have a mean of 50 and a standard deviation of 10. Thus, scores from the Clinical domain that range from 60-69 are considered within the "at-risk" range and scores 70 and above are within the "clinically significant" range. Consequently, a drop in the T-score, particularly if they are at 60 and above, is considered a move toward better mental health, and a rise in the T-score in these areas is considered a negative trend. In contrast, the measure of Self-Esteem is within the Adaptive scales domain. Scores that range from 30-39 are within the "at risk" range and scores below 30 are within the "clinically significant" range. Consequently, a rise in a T-score from the Adaptive scales domain is viewed as a move toward better mental health and a drop in the T-score is considered a negative trend.

To summarize, if the Choice Theory treatment is having the desired effect, one would expect to see a drop in T-scores on the measures of Anxiety, Depression, and Locus of Control. In contrast, one would expect to see a rise in the T-score on the measure of Self-Esteem.

Researcher as an Instrument

The author of this research is a part of the instrumentation. He met with the parents, students, teachers and administrators, collecting the data and analyzing and interpreting the data; Patton (1990) states that it is the responsibility of the researcher to report any personal and professional information that may have had an effect on data collection, analysis and interpretation. While this is generally applied to qualitative

research, it is the opinion of the author of this research that readers understand the depth of interaction between the researcher and those being researched.

As an instrument, the researcher's expertise and credibility are provided. The researcher graduated with a bachelor's degree in psychology, followed by a master's degree in psychology and a specialist degree in school psychology. Concurrent with the pursuit of the graduate degrees, the researcher worked as a clinical director for a nonprofit organization which provided services to children and adults with mental and physical disabilities. The researcher developed a program within the company to also provide services to school age children being served through area mental health agencies and juvenile justice agencies due to substance abuse, sexual predation, abuse, neglect and chronic legal infractions. These services included mentoring, counseling and providing academic support for the child, home, school and agency collaboration and parent training (helping parents better understand how to communicate with, set boundaries for and implement consequences for their children). In addition, the researcher was responsible for attending and participating in multidisciplinary team meetings regarding these children.

Following the completion of the graduate degrees, the researcher worked as a school psychologist for 10 years in both rural and urban school districts. Among the responsibilities of the job, the researcher assumed the role of counselor for many students being served as children with emotional and/or behavioral disabilities. Initially, this was done at the request of individual schools and school district administration. However, the researcher began to independently seek out opportunities to work with this population of

students as a result of the positive social and academic outcomes observed in many of the students due, in part, to the interaction between the students and the researcher.

In pursuing a doctoral degree, the researcher has continued to work regularly with this population of students while also teaching at the undergraduate and graduate levels in cognitive and developmental psychology, research methods and behavior intervention and applied behavioral analysis. Additionally, the researcher has provided graduate supervision in the areas of assessment, childhood development, and counseling, which included integrating theory into practice, for students pursuing advanced degrees in psychology and counseling.

Last, the process involved in this research provided additional opportunities for skill development and growth. Specifically, this process involved working with children in small groups, a counseling dynamic in which the researcher has the least amount of experience. Consequently, establishing and adhering to group ground rules, determining appropriate levels of self-disclosure, encouraging group member risk taking (i.e., discussing thoughts, feelings, aspirations, fears, and hopes; all of which can lead to greater personal vulnerability when in the presence of peers) and letting group members disagree, hold each other accountable for behavior, and talk through (problem solve) situations with only minimal input from the researcher were all profound experiential clinical developmental processes in which the researcher was able to engage.

These collective experiences have provided the researcher with both credibility as well as bias. The other instrumentation that is used in this research as well as the statistical analysis of the data should limit the inherent bias the researcher brings to the experiment.

Data Analysis

The Statistical Program for Social Sciences (SPSS) version 18.0 was utilized to analyze the data in this study. The following scales from the BASC-2 were used: anxiety, locus of control, depression and self-esteem. Although there are other scales provided by the BASC-2 (i.e, learning problems, somatization, atypicality, withdrawal and adaptive scales), these were not used given their limited applicability to the BED designation under which the students are being served (IDEA, 2004).

A repeated measures analysis of variance (ANOVA), with one between and one within subjects factors, were used to evaluate the research questions. The between subjects factor was the group assignment (experimental or control) and the within subjects factor was the pretest and posttest. On the between subjects factor, one would expect to see differences (variation) in mean T-scores on pretest and posttest measures, assuming that the treatment elicited the expected outcomes. There should be little variation on the within groups factor. An interaction between the two groups would suggest that the treatment protocol had an effect on the experimental group. There was one independent variable (the treatment) and there were four dependent variables: anxiety, depression, locus of control, and self-esteem, as measured by the BASC-2 Self-Report.

It was anticipated that, based on the treatment protocol, measures of anxiety, depression, and locus of control would go down (a lower T-score), and that the measure of self-esteem would go up (a higher T-score).

Summary

The primary purpose of this research was to study the effect that a Choice Theory (Glasser, 1998) protocol has on a group of middle and high school students identified as

BED. The research sought to identify if there are differences between a treatment and control group with respect to measures of (a) anxiety, (b) locus of control, (c) depression, (d) self-esteem based on subscales assessed by the Behavior Assessment Scale for Children—2nd Edition (BASC-2). If the Choice Theory treatment elicits the desired effects, there should be a drop in the T-scores on the measures of anxiety, depression and locus of control, and there should be a rise in the T-score on the measure of self-esteem.

The BASC-2 is among the most widely used and understood behavior rating instruments used in schools, and among the most researched within education (Kaufmann, 2004). Further, many of the items within the BASC-2 are used for multiple scales. Because this study was an experimental design with a pretest/posttest, multiple two-way ANOVAs with one between subjects and one within subjects effects were used to examine differences between the experimental and control groups.

CHAPTER 4: RESULTS

This study involved one question comprised of 4 subparts: Is there a difference between a group of students who have been identified as having a behavioral or emotional disorder receiving a Choice Theory group intervention protocol and a group of students identified as having a behavioral or emotional disorder not receiving a Choice Theory group intervention protocol in measures of (a) anxiety, (b) locus of control, (c) depression, and (d) self-esteem?

Description of the Participants

Two random samples, 15 students in the experimental group receiving the Choice Theory protocol and 15 students in the control group not receiving Choice Theory protocol were used. The randomization process involved three steps. First, the school district in which this research was conducted provided the researcher with a list of all students grades 5-12 who were identified as having a BED designation. Second, the students were assigned a number and this data was entered into a randomizing program, which was told to randomly assign an equal number of students (15) to one of two groups (experimental or control). Last, the output numbers for each of the groups generated by the randomizing program were compared to the list of names of the students, which enabled the researcher to identify the specified subjects and then comprise the sample used for this research.

The items on the BASC-2 that assess anxiety, depression, locus of control, and self esteem were administered to both groups as a pretest before the intervention began and

posttest after the intervention concluded to measure changes in the affective areas being studied.

Although not part of the research question or design, the following demographics are provided regarding both the experimental and control groups: nine African American students, one Latino student, and five Caucasian students for the experimental group. For the control group there were seven African American students, one Latino student, and seven Caucasian students. After random assignment to either the experimental or the control groups additional demographic information was obtained: The experimental group was comprised of 9 middle school age students and 6 high school age students, and included 8 males and 7 females. The control group was comprised of 10 middle school age students and 5 high school age students, and the group was comprised of 12 males and 3 females (See Table 1).

Table 1

Demographic Profile of the Control and Experimental Groups

	Middle school	High school	Male	Female	African American	Latino	Caucasian
			Control				
Number	10	5	12	3	7	1	7
Percent	67	33	80	20	47	6	47
			Experimental				
Number	9	6	8	7	9	1	5
Percent	60	40	53	47	60	6	33

Age of the student when identified as having a disability, secondary or tertiary disabilities, socioeconomic level, parent level of education, parent employment, type of primary caregiver (i.e., grandparents, aunts, uncles, foster parents, or siblings), social and developmental history were not included in data gathering procedures.

Treatment Fidelity

Treatment fidelity refers to how well the treatment delivery adheres to the original treatment protocol (Institute of Medicine, 2001). This can be achieved through the provision of manuals of the treatment protocol, implementation of training and supervision for those delivering the treatment, checklists designed to assess the adherence to the treatment protocol, replications of the study as well as qualitative feedback from both the participants of the research and those responsible for the treatment delivery (Harchik , 1992 & Hutchings, 2004).

As the sole researcher for this study, the author acknowledges that this research is limited with regard to treatment fidelity. There was no manual of a treatment protocol, nor was any training or supervision provided to third parties who would either engage in the treatment protocol or rate the researcher on his adherence to the protocol. Further, given the preliminary nature of this research, there were no preexisting protocols available that would have better met treatment fidelity criteria.

Although there were no objective measures of treatment fidelity, part of the definition does include the concept of adherence to the protocol. In the case of this research, part of adherence includes the participation of the students who were receiving the treatment. The schools at which the students attended all agreed to adjust consequences for behavioral infractions by eliminating suspensions or expulsion from school for the

duration of the treatment phase. Consequently, all of the students were able to attend all of the sessions. Furthermore, none of the students missed a session due to illness or injury

Analysis of the Data

Repeated measures analysis of variables, with one between and one within subjects factors, were used to evaluate the research questions. The between subjects factor was the group assignment (experimental or control) and the within subjects factor was the pretest and posttest. There was one independent variable (treatment) and there were 4 dependent variables: anxiety, depression, locus of control, and self-esteem as measured by the BASC-2 Self-Report.

Prior to running the major analysis, all variables were examined for accuracy of data entry, outliers, missing values, normality of distribution and homogeneity of variance. All data were in acceptable ranges with no outliers found (i.e., greater than 3 standard deviations away from the mean), and there were no missing values. A visual inspection of the distribution for each group and the values for skewness, which were all less than the absolute value of 1.0, suggested a reasonably normal distribution.

The means and standard deviations by the control and experimental groups on the measure of anxiety are reported in Table 2. There was no statistically significant within subject effect [$F(1, 28)=91.27$, $p=.188$] or interaction [$F(1, 28)=52.27$, $p=.316$]. There was a statistically between subjects effect [$F(1,28)=10.17$, $p<.05$]. A graph is contained in Figure 1.

The means and standard deviations by the control and experimental groups on the measure of depression are reported in Table 2. There was a statistically significant within subject effect [$F(1, 28)=4.39$, $p<.05$] and interaction [$F(1, 28)=4.97$, $p<.05$]. There was a

Table 2

Means and Standard Deviations for the Control and Experimental Groups for the Measures of Anxiety, Depression, Locus of Control, and Self Esteem on the BASC-2 Self-Report

	Control				Experimental			
	Pretest		Posttest		Pretest		Posttest	
Scale	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Anxiety	56.4	8.37	55.8	8.04	50.4	9.68	46.07	7.37
Depression	58.53	7.01	58.67	5.11	54.67	6.73	50.33	7.56
Locus of Control	60.33	7.53	60.27	6.24	63.93	5.99	58	5.33
Self Esteem	38.27	5.04	37.2	6.6	37.13	6.93	42.27	7.5

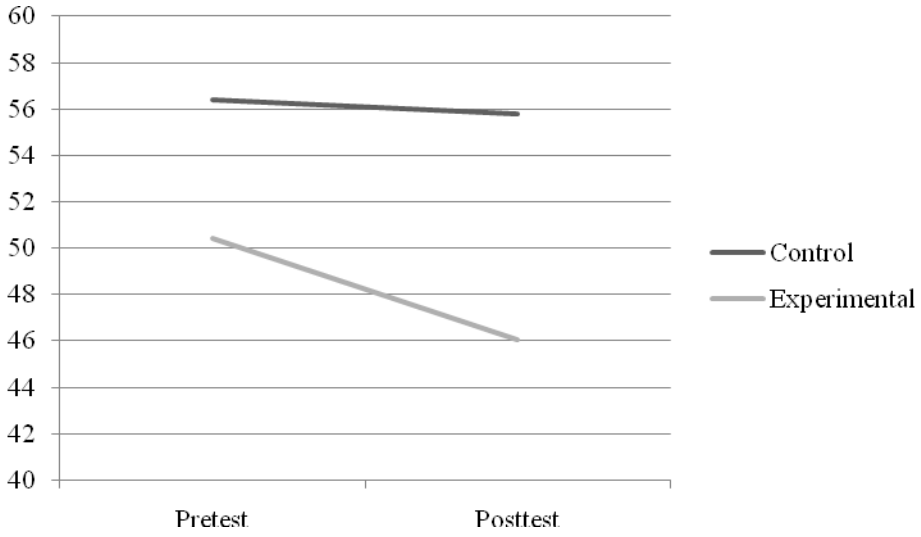

Figure 1. An illustration of the treatment effects of the Choice Theory protocol and students in the control and experimental groups on the measure of Anxiety.

statistically significant between subjects effect [$F(1,28)= 7.56$, $p<.05$]. A graph is contained in Figure 2 which suggests that students in the experimental group reported a greater reduction in feelings of depression associated with their external environment after the implementation of the Choice Theory (Glasser, 1998) protocol than did students in the control group who did not receive the treatment.

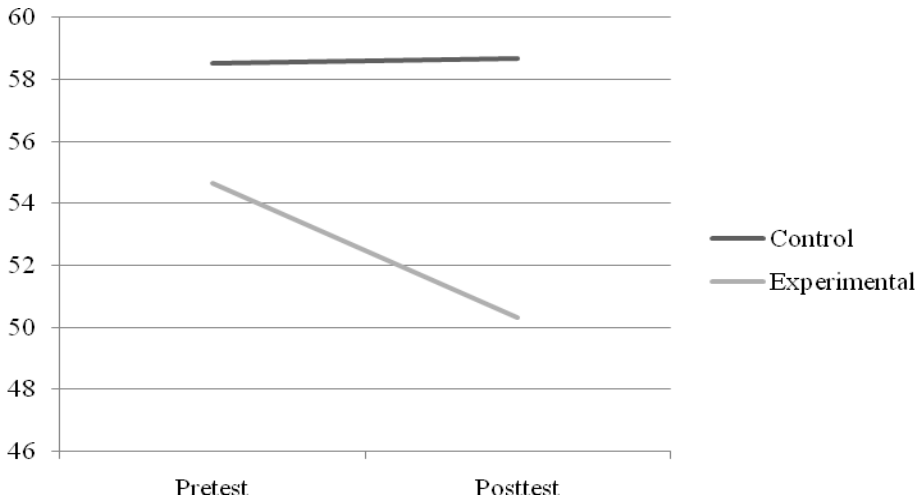

Figure 2. An illustration of the interaction between the treatment effects of the Choice Theory protocol and students in the control and experimental groups on the measure of Depression.

The means and standard deviations by control and experimental groups on the measure of locus of control are reported in Table 2. The results of the repeated measures ANOVA revealed a statistically significant within subject effect [$F(1, 28)=13.17$, $p<.05$] and interaction [$F(1, 28)=12.96$, $p<.05$]. There was no statistically between subjects effect. A graph of the interaction is contained in Figure 3. The interaction suggests that students in the experimental group reported feelings of greater internal control over their external environment after the implementation of the Choice Theory (Glasser, 1998) protocol than did students in the control group who did not receive the treatment.

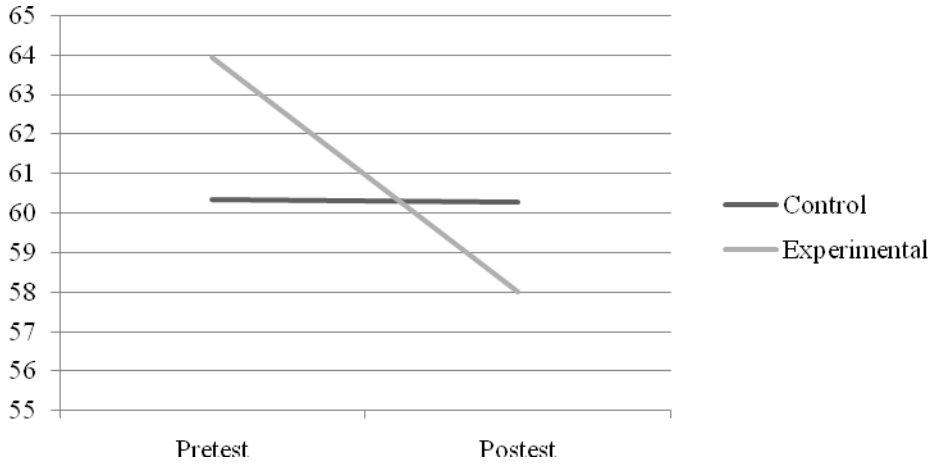

Figure 3. An illustration of the interaction between the treatment effects of the Choice Theory protocol and students in the control and experimental groups on the measure of Locus of Control.

The means and standard deviations by the control and experimental groups on the measure of self-esteem are reported in Table 2. There was no statistically significant within subject effect [$F(1, 28)=3.03$, $p=.09$], but there was a significant interaction [$F(1, 28)=7.04$, $p<.05$]. There was no statistically between subjects effect [$F(1,28)=.88$, $p=.36$]. A graph of the interaction is contained in Figure 4, in which the interaction suggests that students in the experimental group reported a greater increase in their sense of self worth after the implementation of the Choice Theory (Glasser, 1998) protocol than did students in the control group who did not receive the treatment.

Summary

The students who comprised this study were from a moderate sized school district in upstate South Carolina. Members of both the control and experimental groups were randomly assigned. Both the experimental and control groups consisted of students who ranged from middle school aged to high school aged students.

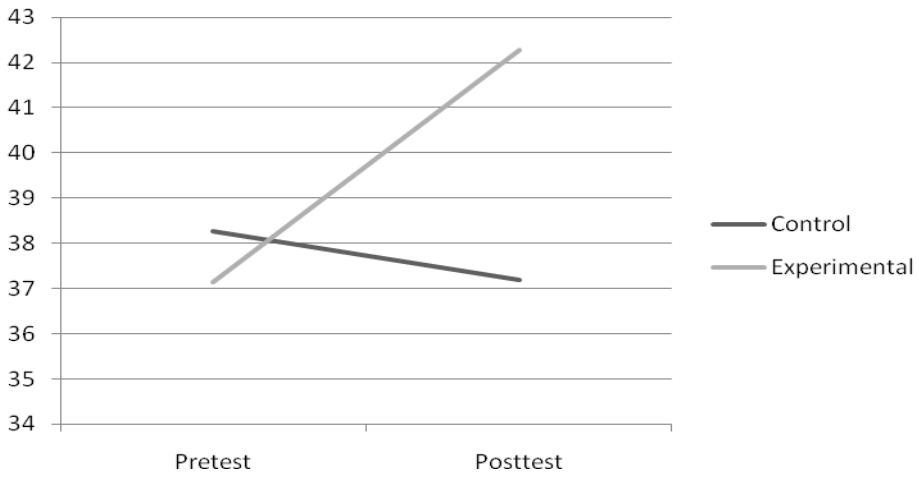

Figure 4. An illustration of the interaction between the treatment effects of the Choice Theory protocol and students in the control and experimental groups on the measure of Self-Esteem.

Of the four dependent variables that were under investigation (locus of control, anxiety, depression, and self-esteem), three showed significant changes after the Choice Theory protocol when comparing pretest and posttest results between the experimental and control groups. Members of the experimental group reported significant improvement in measures of depression, locus of control, and self-esteem. While the measure for anxiety was not significantly different between groups, the experimental group did exhibit a small reduction in feelings associated with anxiety.

The measure of anxiety assesses a student's behavior that is characterized by excessive worry, phobias, fears or self-deprecation. Although there was no statistically significant difference in pretest and posttest scores between the control and the experimental group, there was a slight drop in the mean T-score for the experimental group. Consequently, while not significant, group members did report less prevalent or severe anxious experiences when compared to the control group.

The measure of depression assesses a student's behavior that is characterized by a pervasively dysphoric mood, sadness, suicidal ideation and/or withdrawal. There was a statistically significant difference in pretest and posttest scores between the control and experimental groups, which means that the T-score mean for the experimental group dropped significantly. This suggests that students receiving the Choice Theory (Glasser, 1998) protocol reported less intense and/or frequent feelings of sadness, dysphoria, and/or withdrawal when compared to the control group.

The measure of locus of control assesses a student's perception of his or her perceived control over external events. There was a statistically significant difference in pretest and posttest scores between the control and experimental groups, which means that the T-score mean for the experimental group dropped significantly. This suggests that the students receiving the Choice Theory (Glasser, 1998) protocol reported having a greater sense of control over their lives when compared to the control group. It should be noted that this can appear confusing: A drop in a T-score means an increase in the students' locus of control.

The measure of self-esteem assesses a student's self-reliance and self-worth. There was a statistically significant difference in pretest and posttest scores between the control and experimental groups, which means that the T-score mean for the experimental group rose significantly. Unlike the Clinical Scales, which include anxiety, depression, and locus of control, the self-esteem measure falls under the Adaptive Scales on the BASC-2. This means that lower scores are viewed as being unhealthy and higher scores are considered qualitatively better (the inverse is true for the Clinical Scales).

Thus, the data reveal that students in the experimental group reported a statistically greater sense of self-worth than did the students in the control group.

In summary, the null hypotheses for this research were rejected in three of the four possible cases. The Choice Theory treatment protocol elicited statistically significant results in reducing symptoms of self-reported depression, problems associated with locus of control and increased self-reported feelings of self-worth and adequacy. Anxiety was the sole variable in which there was no statistically significant difference between the control and experimental groups.

CHAPTER 5: DISCUSSION

As an aid to the reader, this final chapter of the dissertation restates the research question and reviews the major methods used in this investigation. The major sections of this chapter summarize the results, discuss their implications, and address the limitations within this particular piece of research.

Overview of the Research

One of the largest, most challenging, and fastest growing populations within special education is that of students identified as BED (Kaufmann, 2001). While the underpinning pathologies generally associated with this population of students have largely been named and several therapeutic approaches have been found to be effective (Lambert, 2004), there is a lack of literature that looks at counseling outcomes with children identified as BED when the counselor works at the school and the counseling takes place within the school. Thus, this study investigated the efficacy of a Choice Theory based therapeutic protocol with middle and high school students identified as BED. The following question, is there a difference between a group of students identified as BED receiving a Choice Theory protocol and a group identified as BED who are not receiving a Choice Theory protocol on measures of (a) anxiety, (b) locus of control, (c) depression, and (d) self-esteem, was developed for investigation in this study.

As discussed in Chapter 1, children identified as having a BED are a growing population (Kaufmann, 2001), who are often resistant to traditional forms of behavior

management (OSEP, 2003), and who are unlikely to receive any counseling as a related service within their IEP (McLaughlin, et al. 1997). Students identified as having a BED tend to be male, African American and high school drop outs, ostensibly because they perceive that school faculty would prefer that they leave school (OSEP, 2008).

ASCA (1999) specifically states that school based counselors should be part of the service delivery model to students with special needs and IDEA (1997) and its subsequent reauthorizations has specified counseling as a related service. However, the role of the school based counselor, a resource trained to engage with students on a therapeutic level, remain conspicuously absent from interdisciplinary teams that develop IEP's (Scarboro, 2002). A caveat to this issue is that school based counselors often report that they are not prepared to work with the BED population, or lack the understanding of this population necessary to be of any substantive use (Maag et al., 2002).

This is an interesting research finding given that children identified as having a BED are, in the end, still children. While science has provided some insight into the development, organization and potential of the human brain, there are still wide swaths of information about the brain yet to be discovered. However, we do know that children have more malleable brains than do adults, that the brain develops in a hierarchical fashion where there are "critical" periods throughout childhood and adolescence, that any interruption in development in one stage will have a profound effect on subsequent stages of development, and that early intervention is generally more effective, decreasing as the child ages (Perry, 1995). Essentially, this means that, while damage cannot be undone, it can be arrested in such a way to minimize the effects of trauma, and that the earlier interventions are implemented the more profound they will be.

This is important because it highlights the need for competent mental health intervention and treatment when people are still young (school aged). Knowing the biological nuances of the interaction between environment and genetics is less important than simply understanding that there is one. This was not the point of this research, but one of the reasons to pursue it. Anger, aggression, anxiety, depression, locus of control, self-esteem, withdrawal and hypervigilance can present themselves independently or in combination. They can be the result of chronic trauma or genetic predisposition and expression, or some combination of all three (Goldstein, 2008). Graduate students in counseling programs are given the opportunity to learn therapeutic modalities that address these issues. Thus, it is reasonable to assume that school based counselors do have the necessary expertise to work with students identified as having a BED, but for reasons beyond the scope of this research are led to believe that they do not.

Time considerations are also important when working with children within the school context. Given the emphasis that is placed on student learning and measures of school worthiness (NCLB, 2001), public schools understandably resist allowing students to miss core academic classes in order to get mental health support. Despite the inherent irony with this position, it helps explain part of the reason that this phenomenon is allowed to flourish by virtue of not challenging the status quo. Consequently, a therapeutic process that is both effective and time efficient would likely better meet the needs of both students and the faculty of a school.

The purpose of this research was to determine if Choice Theory would have an effect on certain affective measures of students identified as having a BED. One of the findings of this study is that Choice Theory is a viable treatment option for students in

school who have behavioral or emotional problems. An unexpected finding is that there was not a large time commitment to this approach, making it something that could be of significant use to counselors in schools. Specifically, given the myriad responsibilities that school counselors have, they often report having too little time to devote to clinical service delivery to specific students or groups of students (Maag, 2005). The protocol used in this research required a total of 6 hours of clinical time spent with students (1 hour per week for 6 weeks), which is likely to be seen as more manageable for school counselors who feel overwhelmed with administrative expectations not involving clinical work, but who also are committed to the notion of providing counseling services to students.

In Chapter 2, a review of the literature revealed Choice Theory attempts to address the five fundamental needs that people have (power, a sense of belonging, fun, freedom and survival) and how the manner in which people attempt to meet these needs often exacerbates, as opposed to meeting, the severity of the unmet need(s) (Glasser, 1998). Children who have significant emotional and/or behavioral problems often exhibit behavior that is characterized as aggressive, anxious or fearful, manipulative, depressive and self-limiting (Glasser, 1998; Perry, 1995; Ryan & Decci, 2000). These behavioral characteristics can be objectively measured using an array of psychiatric instrumentation. In this research, the BASC-2 was used in order to assess the likelihood that anxiety, depression, locus of control and self-esteem were having a significant and negative effect within the lives of the children who were part of this research.

Results of the instrumentation and a comparative analysis between a control and experimental group in these areas were discussed in Chapter 4. To restate, the implementation of Choice Theory appeared to have an effect on how the students in the

experimental group were able to manage their internal dialogue, which allowed them to make decisions regarding their affect, subsequent behavior and reactions to their external environment that helped them better meet the five needs outlined in Glasser's work (1998).

While this specific kind of research had yet to be done in a public school setting, the results were similar when compared with research outcomes done in hospital, alternative education and juvenile detention settings, and that were assessing the same or similar dependent variables (Glasser, 1976; Loyd, 2005; & Kendall, et al., 2000). Put simply, the data collected in this research confirms data from other research that states, when people (students) take ownership of their emotions rather than relinquishing this to others they are more likely experience feelings of control (power) and less likely to feel anxious, depressed, angry and worthless. Consequently, their behavior better suits their efforts at identifying and meeting their needs associated with power, a sense of belonging, fun, freedom and survival.

As stated in Chapter 3, this research was preliminary and quantitative utilizing a true experimental method. It was designed to assess responses of students identified as having a behavioral or emotional disability on four relevant variables: anxiety, depression, locus of control, and self-esteem. Students from a medium sized school district in upstate South Carolina who were being served in special education under this identifier were randomly chosen and randomly assigned to either an experimental or a control group.

Students in the experimental group were provided a therapeutic protocol developed using Choice Theory (Glasser, 1998) core concepts. The protocol was used in small groups over the course of six weeks. Students in the experimental group were asked to complete the BASC-2 Self-Report, consisting of only the items that examine the four dependent

variables, both before the protocol began and after it was completed. The students in the control group were also asked to complete the same format of the BASC-2 Self-Report during the same time as the pretest and posttest for the experimental group.

Discussion of the Results

The data collected were comprised of one independent variable, treatment, and four dependent variables, anxiety, depression, locus of control and self-esteem as measured by the BASC-2 Self-Report. Four two-way ANOVAs with one between subjects and one within subjects effects was used to examine differences between the groups on all four of the dependent variables. First, the measure of anxiety was examined and revealed no significant difference within subjects, or interaction. Second, the measure of depression was examined and revealed that there was a significant difference both within and between subject effect as well as a significant interaction, revealing that students in the experimental group reported experiencing less depressive symptoms than did the control group after the implementation of the protocol. Third, the measure of locus of control was examined and revealed a significant difference within subjects and between subjects effect. In addition, there was a significant interaction demonstrating that students in the experimental group experienced a greater sense of power over their internal world relative to external stimuli after the implementation of the protocol when compared to the control group. Last, the measure of self-esteem was examined and revealed that there was no significant within subject effect, but there was a significant between subjects effect and interaction, revealing that students in the experimental group reported more positive feelings of self worth and efficacy after the implementation of the protocol than did the students in the control group.

These findings are generally consistent with research associated with Choice Theory in other settings. Kendall (2000) found that implementing Choice Theory had a profound effect on the reduction of anxiety in children. This research assisted children in learning to restructure memories, change statements about self, and develop skills that would challenge ways of thinking about things that would have a limiting effect on self and others. The students who were a part of this research clearly learned methods of changing self statements as well as defining the attributes of others or their external environment relative to themselves. In other words, the children involved in this research learned that the reactions people had towards them were not necessarily qualitative or, if they were, the children learned that they had control over how to choose to internalize this information and respond to it.

Bums, et al. (2006) demonstrated that high school students have profound needs related to power and freedom. Their work also revealed that these children experience distress when these needs are not met, and that they are often unable to adequately articulate these needs or find ways of effectively meeting them. Again, the students involved in this research required some help in identifying what their "quality world" would look like and useful ways of achieving this. However, they were able to begin this process and, as a result, begin to eliminate some of the self-imposed barriers that helped create feelings of depression and low self-esteem.

Mellons and McGraw (2007) examined the perceived outcomes of choices made by people when making behavioral decisions designed to either (a) minimize unpleasant outcomes or (b) enhance pleasant outcomes. Their findings suggest that people more willing to take risks reported greater levels of pleasure as a result of their choice(s).

Further, an unexpected result was that unpleasant outcomes were generally not as profound as people expected them to be. While this study was not designed to assess anything related to Choice Theory (i.e., Glasser and Choice Theory were never cited), the results are consistent with Glasser's propositions in that people make choices based on what they expect to happen and the feelings associated with the behavior are internally defined rather than being mediated by external influences.

By the end of the six week protocol the students appeared to have formed a kind of alliance, where they were helping each other in the self-talk, control giving and owning responses to external stimuli. In addition, they were initiating discussions about what was wanted and how one might get it. Again, there was humor in these encounters. There were also indications that while the students were beginning to understand empathy, there was considerable room for growth (i.e., choosing to steal because one is prepared to accept the consequences fails to take into account how this behavior affects those being stolen from).

Limitations

As has been stated, this research was preliminary in nature and was designed to answer one question: Does Choice Theory have an effect on students being served as having a behavioral and/or emotional disability in the areas of anxiety, depression, locus of control and self-esteem? The sample was relatively small and comprised of only students from one suburban district in the upstate portion of South Carolina. Consequently, there are some significant limitations to this research, which could be addressed within the scope of future inquiries of a similar nature.

First, this research did not take into account a full spectrum of cultural variability. Certainly, one might expect there to be measurable outcome differences among subjects

when race, socioeconomic level, cognitive skills, parent level of education, parent attitude toward their child's school, and geographic region are among the variables being measured. Because this research did not take any of this variability into account, the data have to be interpreted with caution in terms of its generalizability to all students being served in special education as having a behavioral or emotional disability,

Second, this research utilized the skills of only one counselor. One has to anticipate differences on outcome measures of the variables studied in this research when other counselors engage in a similar treatment plan with other students. There will always be a discreet dynamic between and among children and the people who provide clinical support, even when the theoretical model is the same. Indeed, it is likely that the outcomes of this research would be different should the researcher engage in this exact model with the same students a year from now, or even had it been done a year earlier. The complexities of these kinds of situational and personal variables are extremely difficult to operationalize and then measure, but they exist. Again, when this is taken into consideration, one has to be careful not to make sweeping generalizations about what the data reveal in this research.

Third, there are differences among validity and reliability measures between instruments such as the *one* that was used in this research. One could argue that there would be profound differences on outcome measures of the dependent variables examined in this research depending on the instrumentation that is used. This is important because the current educational zeitgeist is to make "data driven" decisions and implement "research based" educational interventions. Making educational decisions based on the measures of one instrument (albeit one that meets the statistical standards for validity and reliability) should be done with caution, and probably be avoided when possible.

Fourth, this research lacked procedural fidelity in that the author was the sole researcher and administrator of the treatment procedure. As a result, there were no objective measures in place to ensure that the treatment was being conducted consistent with the treatment procedure.

Fifth, the pretest and posttest measures were administered by the sole researcher, which may have had an effect on the results. For example, the respondents of the BASC-2 who were in the experimental group could, conceivably, respond to items in a way they thought would reflect favorably on them and/or the researcher.

Last, primary care givers and teachers were not queried in this research. While the students may perceive changes, the same may not be the case for the adults who work with the students. This research, or any like it, would certainly be more robust if there were separate and independent measures reported on the same variables by different people (i.e., students, parents, and teachers). This research purposely avoided assessing primary care providers and teachers because of the brief duration of the experimental phase of the research. Generally, second parties (primary care providers and teachers) are slower to notice differences than the primary party (the students).

Certainly, using a larger sample size representing a more diverse group of students, involving multiple counselors using the same protocol and measuring outcomes with a broader array of instruments are worthy of consideration for future research. Additionally, the following recommendations are provided for consideration for future research efforts similar to this:

Implications for Future Research

1. Gresham, et al. (2004) and Maag (2006) reach slightly different conclusions about the efficacy of social skills training, but the fact that both authors engaged in a meta-analysis of SST research would suggest several things: First, SST is being heavily researched. Second, part of the reason for this research direction is that it is thought to be a viable support mechanism for students identified as having a BED. Third, SST does not involve the same level of time commitment to one student by one adult within the school (i.e., the school counselor). Last, it involves the participation of other people who are a part of a student's life in school, such as teachers and aides. To that end, Clark and Crandall-Breman (2009) suggest a tiered support system within schools for students with behavioral and/or emotional disabilities. Under this model, school stakeholders (parents, teachers, administrators, and support staff) work together in order to support positive outcomes for students without removing them from the classroom. While their research does not identify a specific therapeutic approach under a tiered support system, Clark and Crandall-Breman (2009) provide a framework through which counselors and teachers could use Choice Theory (Glasser, 1998) principles in order to facilitate emotional and academic growth in students. Part of what this research revealed was students' quick response to Choice Theory (Glasser, 1998) principles and the portability of the treatment, which dovetails with tiered support systems. Additionally, this helps keep the role of the school counselor both relevant and manageable.

2. Using the same instrument(s), researchers should engage in periodic follow-up inquiries regarding the specific variables that were studied in order to make some determinations about how well students are able to generalize the skills they learned during the implementation of the research protocol. Learning implies some form of fundamental and permanent change, so it would be useful to know how much "learning" actually took place as opposed to transient skill acquisition.
3. Related to the first item, it is recommended that similar research be conducted within a similar context using a similar protocol for a significantly longer period in order to determine if this has an effect on the outcome measures.
4. Research should also be done in terms of the differences in perceived change among the children, their parents and their teachers. The Pygmalion Effect is generally recognized as a legitimate and potential behavioral phenomenon, so it might be useful to examine how children see themselves relative to adult perceptions of them, and if these adult perceptions limit or foster growth on the dependent variables examined in this research.
5. Age and gender did not appear to have a significant relationship with the outcome measures in this research. Perry (1995), Goldstein (2008) and others suggest that females and males interact with their environment and subsequent emotions in very different ways. It would be useful to look for explanations that account for the outcome similarities between genders found in this research for the purposes of better understanding this population of students who are provided special education support services.

Summary

As preliminary research, this study helps confirm Glasser's ideas on basic human needs and the ways in which people go about meeting those needs (and how some of those methods are not particularly effective), as well as demonstrating that understanding what control means, where it begins and ends are all useful in promoting the mental health needs of the students involved in this research. Given the limited size and scope of this research, it would be irresponsible to generalize the findings to different groups of children. However, based on the questions that still exist, this research is certainly worthy of expansion in scope, size, and duration.

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APPENDIX A: PARENT CONSENT

Informed Consent for Parents
Scott D. Reeder
School Based Counseling

Purpose of Research

This research is designed to see if school based counseling will help your child decrease depression, anxiety, impulsive behavior, and aggression and improve their ability to get along better with other people.

This research has not been done in traditional public schools before, and the results of this research are designed to help other parents, their children, teachers and counselors in other school districts beyond Rock Hill or Lancaster County schools. Your participation, and that of your child, will help us better understand how to relate to and support other students.

Investigator(s)

This study is being conducted by Scott Reeder, a doctoral candidate within the counseling department of the College of Education at the University of North Carolina at Charlotte and a school psychologist with Rock Hill School District 3. This dissertation is a required part of the doctoral coursework. Jack Culbreth, Ph.D. (Associate Professor, Counseling Departmen,t College of Education at UNCC) is the chair of my dissertation committee and can be reached at 704-687-8973.

Eligibility

Your child is eligible to participate in this research if they (a) are between the ages of 11 and 18, (b) have been identified as having a behavioral or emotional disability, (c) and are being served within special education for this disability, or, in certain cases, if your child is being served as having an other health impairment. These cases are limited to cases where your child has a medical diagnosis of attention deficit hyperactivity disorder combined type.

Your child is not eligible who are younger than 11 years of age or older than 18 years 11 months, who are being served in special education under any other category, or who were once served as having a behavioral or emotional disability but were dismissed or exited from special education services.

Overall Description of Participation

Your child's participation in this research is completely voluntary. Neither you nor your child is required to participate. Should you and your child decide to participate the following procedures will occur: If included in the research, your child will complete a

rating scale about themselves that is designed to help them and the researcher understand their feelings, attitudes and behavior at school and at home. The rating scale should take about 30-45 minutes to complete. Your child's primary special education teacher will complete a similar scale in order to compare adult perceptions with your child's perceptions. Following the completion of the rating scales, your child will be randomly assigned to either an experimental group of 30 students or a control group of 30 students. If your child is assigned to the experimental group they will engage in a 6 week Choice Theory group (one meeting a week in a small group of 3 to 5 students for approximately 60 minutes each meeting) which is designed to teach your child how choices about behavior affect feelings and attitudes, and that feelings and attitudes are also choices. This approach is designed to give your child a greater feeling of control in their life, which should decrease feelings of depression, anxiety, impulsivity, and aggression and improve how your child relates to other people. Your child will then complete the same rating scale that they completed at the beginning of the group, as will their primary special education teachers. Your child will probably miss some instructional time if you allow them to be a part of this research. They will be given additional time to make up work if they miss any, or they will be excused from the work (whichever the teacher decides). If your child is assigned to the control group they will receive the same treatment as the experimental group at the completion of the research project, although they will not complete the second self rating scale, nor will they be meeting weekly in small groups for the first 6 weeks of the research. If your child is in the control group you will be asked (via phone) if you still give permission for your child to receive the treatment, which will start immediately following the completion of the treatment for the experimental group.

Length of Participation

As mentioned above, the research will take 6 weeks. Your child will meet with the researcher in small groups of 3 to 5 students once a week for approximately 60 minutes each time for 6 weeks.

Risks and Benefits of Participation

Inherent within this type of research is the possibility for psychosocial harm as a result of the treatment. As your child learns new methods of managing stressors and practicing skill sets, they will inevitably make mistakes, which can result in punishment from authority figures or adverse reactions from peers. Your child my try out a new behavior that appears as bad as something they have not before or they may appear to be getting worse before things change for the better (which is normal). Part of the group curriculum addresses these issues specifically. Additionally, emergency contact information (EMS [911], police and community mental health agency emergency information [Rock Hill {803-329-7200}, and Lancaster {803-283-1173}, Catawba Mental Health agency {803-327-2012}]) are provided here should you or your child need immediate assistance. Should it become evident to the researcher, your child or you that further participation could cause harm; your child will be given the choice to discontinue participation in the research immediately. The project may also involve risks that are not currently known.

This research should provide benefits to your child with their ability to manage stress, anger, frustration and disappointment. Additionally, your child should improve assertive skills, ways in which they engage with their environment, and the manner in which they qualitatively define themseleves. Ideally, this research will be implemented on a broader scale with children who have behavioral or emotional disabilities with similar effects.

Volunteer Statement

Your child is a volunteer. The decision to participate in this study is completely up to your child. If they decide to be in the study, they may stop at any time. Your child will not be treated any differently if they decide not to participate in the study or if they stop once they have started. Additionally, if your child refuses to participate in this research, even if you have given permission, they will not be included as a part of the research.

Confidentiality Statement

Any information about your participation, including your identity and that of your child, is completely confidential. The following steps will be taken to ensure this confidentiality: All data collected will be kept in a locked filing cabinet in a locked office when not in the physical possession of the researcher. All computer files with any identifying information is password protected, as are data contained on a flash drive. After a period of 5 years, all data in the form of instrumentation will be destroyed via shredding at the completion of the dissertation defense. All electronic data that can be indentified as a single individual will also be deleted after 5 years

Statement of Fair Treatment and Respect

UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-3309) if you have questions about how you are treated as a study participant. If you have any questions about the actual project or study, please contact my faculty advisor, Dr. John R. Culbreth (704-687-8973, JRCulbreth@uncc.edu), or myself, at sreeder@rock-hill.k12.sc.us.

Approval Date

This form was approved for use on 11/24/2009 for use for one year.

Parental Consent

I have read the information in this consent form. I have had the chance to ask questions about this study and about my child's participation in the study. My questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to allow my child to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study.

_____
Child's Name (PLEASE PRINT)

_____ _____
Parent's Name (PLEASE PRINT) DATE

_____
Parent's Signature

_____ _____
Investigator Signature DATE

In the event that my child is assigned to the control group I voluntarily give permission for my child to receive the same treatment as the experimental group when that group has completed their treatment. I understand that I will receive a phone call from Scott Reeder, the primary researcher, reminding me of this and that I can verbally revoke consent at that time.

_____
Child's Name

_____ _____
Parent Signature DATE

APPENDIX B: PARENT LETTER

UNC CHARLOTTE
College of Education
Department of Counseling
9201 University City Blvd, Charlotte, NC 28223-0001
704.687.8960

Dear _____, Date:_____

My name is Scott Reeder and I am a school psychologist with Rock Hill School District #3. I am also working to complete my Ph.D. in counseling through the University of North Carolina at Charlotte. As a part of obtaining my degree, I am conducting a research study in which your child may be eligible to participate, and that is why I am contacting you. Attached to this letter is something that is called "informed consent". It outlines what my research is about, why I am doing it and why I need your permission in order to do the research that is described. There are contact numbers for me and for Jack Culbreth, the faculty member at UNCC who is overseeing this research. Please feel free to contact either one or both of us if you have any questions after reviewing the informed consent form and before signing it. Also, the principal of the school your child attends is also aware of this research and can also answer some of the questions that you might have. Please know that this research is in no way related to your child's IEP and that no information collected as a part of this research will be included in your child's special education or regular education files. I appreciate your concern and consideration, and I look forward to working with you and your child over the next couple of months.

You can contact me directly at (803)-981-1826 or at sreeder@rock-hill.k12.sc or you can contact my faculty supervisor, Dr. Jack Culbreth, at (704) 687-8973 or at JRCulbreth@uncc.edu. If I do not receive the signed consent forms within 2 weeks of sending them home I will call you directly in order to see if there are any questions you might have or concerns that you would like to discuss.

Sincerely,

_____
Scott D. Reeder
Student Researcher, UNCC

PS
Attached is also a student assent form. Please explain to your child that their signature is also needed. Included in the envelope is a self-addressed stamped envelope. You can return the forms to me in these. Thanks again for your help.

APPENDIX C: STUDENT ASSENT

STUDENT ASSENT FORM
Scott D. Reeder
School Based Counseling

My name is Scott Reeder, and I am from the College of Education, Department of Counseling at the University of North Carolina at Charlotte (UNCC). I am asking you to participate in this research study because you are in middle or high school.

PURPOSE: In this study, I am trying to learn more about school based counseling and how it will affect you in terms of any changes you feel about your own happiness, friendships and relationships with adults such as teachers and parents.

PARTICIPATION: If you want to decide to participate in this project I will have you answer some questions about yourself and your feelings about things like school, friends and family. All of this should take about 30 minutes to 1 hour. The items you respond to will let me know a little bit about how you see yourself, how you believe others see you and how you feel about friends, school, teachers and parents. Later on, you, me and about 4 other students will meet once a week for six weeks for about an hour. In these meetings we will discuss how you make decisions, how these decisions affect you and others, if these decisions are getting you what you want for yourself or from others and other possible ways to make choices.

RISKS & BENEFITS: Hopefully, you will learn to learn how to make decisions that help you without getting into trouble or feeling really angry, hurt, frustrated or sad. You will also learn more about what control you have when interacting with other people and how to keep that control and not give it away. However, like any new thing that you learn, it will take practice to learn it well. You may get bad reactions from your friends when you're trying the things that you've learned because you aren't doing what they expect you to do. Your teachers may get frustrated for the same reasons. While this is something that I expect, you should consider how this may influence your participation before committing to the process.

VOLUNTEERING FOR THIS RESEARCH: I have already asked your parents if it is ok for me to ask you to take part in this study. Even though your parents said I could ask you, you still get to decide if you want to be in this research study. You can also talk with your parents, grandparents, and teachers (or other adults if appropriate) before deciding whether or not to take part. No one will be upset if you do not want to participate, or if you change your mind later and want to stop. You can also skip any of the questions you do not want to answer.

You can ask questions now or whenever you wish. If you want to, you may call me at 704-517-0100 or email me at sreeder@carolina.rr.com. Please sign your name below, if you agree to be part of my study. I will give both you and your parents a copy of this form after you have signed it.

Signature of Participant _____ Date _____

Name of Participant (printed) _____

Signature of Researcher _____ Date _____

APPENDIX D: STUDENT INFORMED CONSENT

Informed Consent for Students
Scott D. Reeder
School Based Counseling

Investigator(s)

My name is Scott Reeder, and I am from the College of Education, Department of Counseling at the University of North Carolina at Charlotte (UNCC). I am asking you to participate in this research study because you are in middle or high school.

PURPOSE:
In this study, I am trying to learn more about school based counseling and how it will affect you in terms of any changes you feel about your own happiness, friendships and relationships with adults such as teachers and parents.

PARTICIPATION:
You will do the following: Answer some questions about yourself and your feelings about things like school, friends and family. All of this should take about 30 minutes to 1 hour. The items you respond to will let me know a little bit about how you see yourself, how you believe others see you and how you feel about friends, school, teachers and parents. If you decide to participate further, we will meet together in small groups (you, me and about 4 other students) once a week for six weeks for about an hour. In these meetings we will discuss how you make decisions, how these decisions affect you and others, if these decisions are getting you what you want for yourself or from others and other possible ways to make choices you may or may not find useful.

RISKS & BENEFITS:
Hopefully, you will learn to learn how to make decisions that help you without getting into trouble or feeling really angry, hurt, frustrated or sad. You will also learn more about what control you have when interacting with other people and how to keep that control and not give it away. However, like any new thing that you learn, it will take practice to learn it well. You may get bad reactions from your friends when you're trying the things that you've learned because you aren't doing what they expect you to do. Your teachers may get frustrated for the same reasons. While this is something that I expect, you should consider how this may influence your participation before committing to the process.

Eligibility

You are eligible to participate in this research if you (a) are between the ages of 11 and 18, (b) have been identified as having a behavioral or emotional disability, (c) and are being served within special education for this disability, or, in certain cases, being served as having an other health impairment. These cases are limited to students with a medical

diagnosis of attention deficit hyperactivity disorder combined type as determined by a licensed medical doctor.

You are not eligible if you are younger than 11 years of age or older than 18 years 11 months, being served in special education under any other category, or were once served as having a behavioral or emotional disability but were dismissed or exited from special education services.

Overall Description of Participation

You do not have to participate in this research. If you decide to participate you will complete a rating scale about yourself that is designed to help you and me to understand your feelings, attitudes and behavior at school and at home. The rating scale should take about 30-45 minutes to complete. A teacher you have who knows you pretty well will complete a similar scale in order to compare how they see you with how you see yourself. Following the completion of the rating scales, you will be put into either an experimental group of 30 students or a control group of 30 students. The students assigned to the experimental group will meet with me once a week in a small group (3 to 5 students for approximately 60 minutes each meeting) which is designed to teach you how choices about behavior influence feelings and attitudes, and that feelings and attitudes are also choices. This approach is designed to give you a greater feeling of control in your life, which should decrease feelings of anger, sadness or getting really frustrated with your parents, friends and teachers. After our meetings end you will complete the same rating scale that you completed at the beginning of the group, as will your teacher. If you were assigned to the control group you will have the opportunity to receive the same treatment as the experimental group at the completion of the research project, although you will not complete the second self rating scale. This means that for the first six weeks of the research you will not be meeting weekly in small groups.

Length of Participation

As mentioned above, the research will take 6 weeks. You will meet with the me in small groups of 3 to 5 students once a week for approximately 60 minutes each time for 6 weeks.

Risks and Benefits of Participation

As you learn new ways of managing stress and practicing new thinking and beahvior, you will probably make mistakes, which might result in getting into trouble with teachers or your friends may laugh at you because you are doing things that don't expect. (i.e., behaving differently than people expect you to, being assertive and not fighting, making decisions that go against what your friends are doing, etc.). Part of what we do in the group session deals with this stuff so that you can, too. Additionally, emergency contact information (EMS [911], police and community mental health agency emergency information [Rock Hill {803-329-7200}, and Lancaster {803-283-1173}, Catawba Mental Health agency {803-327-2012}]) are provided here should you need immediate

assistance. If you or I decide that further participation could cause harm you will be given the choice to stop with the counseling in immediately. The project may also involve risks that are not currently known.

This research should provide benefits to you with your ability to manage stress, anger, frustration and disappointment. Also, you should get better at letting people know how you feel or what you want from them.

Volunteer Statement

You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may stop at any time. You will not be treated any differently if you decide not to participate in the study or if you stop once you have started.

Confidentiality Statement

Everything we do together remains private. You can talk about anything that goes on between us, but I can't. All the information that I have about you is either with me, locked in a cabinet or on an encrypted flash drive and will be destroyed 5 years after we stop working together.

Statement of Fair Treatment and Respect

UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-3309) if you have questions about how you are treated as a study participant. If you have any questions about the actual project or study, please contact my faculty advisor, Dr. John R. Culbreth (704-687-8973, JRCulbreth@uncc.edu), or myself, at sreeder@carolina.rr.com.

Approval Date

This form was approved for use on *11/24/2009* for use for one year.

Participant Consent

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study.

_____ _____

Participant Name (PRINT) DATE

_____

Participant Signature

_____ _____

Investigator Signature DATE

In the event that I am assigned to the control group I voluntarily give permission to receive the same treatment as the experimental group when that group has completed their treatment. I understand that I will receive a phone call from Scott Reeder, the primary researcher, reminding me of this and that I can verbally revoke consent at that time.

_____ _____

Participant Signature DATE

APPPENDIX E: ROCK HILL REQUEST FOR RESEARCH LETTER

July 30, 2009

Dr. Harriet Jaworoski, Associate Superintendent
Rock Hill School District #3
Rock Hill, SC

Dear Dr. Jaworoski,

The purpose of this letter is to request permission to conduct research within the Lancaster County School District. The research for my dissertation is designed to assess students' response to a Choice Theory protocol with regard to anxiety, depression, social problems, aggression and problem solving. The criteria for being selected for this research is that the students must be identified as having a behavioral or emotional disorder as defined by IDEA and they must be of middle or high school age.

The research will follow an experimental design in which students are randomly assigned to either a control or experimental group. Students in the control group will be offered the opportunity to engage in the same treatment as the students in the experimental group. The protocol will be conducted in small groups during the school day. All of the identified students and their teachers will complete a BASC-2 before and after the protocol has been administered in order to assess perceived differences in the identified dependent variables. There will be no cost to the school district.

Thank you for your careful consideration of this research request in your district. Ideally, the research outcomes will help school districts better meet the needs of children who have significant behavioral and/or emotional needs.

Sincerely,

_____
Scott D. Reeder, SSP
School Psychologist, Rock Hill School District

_____ Research Approved Superintendent's Signature_____

_____ Research Not Approved