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ABSTRACT

Fourteen papers from a 1980 institute on the educational needs of seriously emotionally disturbed children focus on issues regarding eligibility, services, and programing. The following titles are represented: "Preschool Children with Severe Emotional or Behavioral Disorders: Program Directions and Unmet Needs"; "Adolescents with Severe Behavioral Disorders in the Regular Secondary Schools"; "The Influence of Personal, Social, and Political Factors on the Labeling of Students"; "Social Validation: Evaluating the Effectiveness of Interventions with Behaviorally Disordered Pupils"; "Placement and Reintegration Information for Emotionally Disabled Students"; "Exclusion of the Socially Maladjusted from Services Under P.L. 94-142"; "Autism: Teacher Preparation Issues"; "Policy Issues in Providing Psychotheray and Counseling as Related Services"; "Teacher Consultation and the Resource Teacher: Increasing Services to Seriously Disturbed Children"; "Alternative Schools for Troubled Youth: Bridging the Domains of Education and Treatment"; "The Elmwood Center: Alternative Programing for Secondary Behaviorally Disturbed Students"; "Music, A Therapeutic Intervention for Emotionally Disturbed Youth"; "Directive/Process Consultation with Parents of Behaviorally Disordered Adolescents"; and "Effectiveness of Developmental Therapy for Severely Emotionally Disturbed Children." (CL)

PERSPECTIVES FOR A NEW DECADE:

Education's Responsibility for Seriously Disturbed and Behaviorally Disordered Children and Youth

Frank H. Wood

Editor

Selected Papers Based on Presentations from the CEC/CCBD National Topical Conference on the Seriously Emotionally Disturbed, August 13-15, 1981, Minneapolis, Minnesota

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PREFACE

More than 1200 persons from 46 states and Canada gathered in Minneapolis, Minnesota in August of 1980 for a series of institutes, workshops, and presentations focused on ways for better meeting the educational needs of seriously behaviorally disordered and emotionally disturbed students. The institutes were coordinated by Peter Knoblock of Syracuse University, while Lyndal Bullock of the North Texas State University planned and chaired the conference as a whole with the assistance of The Council for Exceptional Children's Conventions and Training Unit staff.

The high registration and full participation that characterized the conference sessions reflected the intense interest of special educators in programing for this group of students. Recognizing this interest, the program advisory committee planned this publication, which includes papers selected from those presented at the conference. Many excellent papers were contributed, and the editor has faced a difficult task in choosing from among them. Thus, the criteria for selection included not only the quality of the papers, but the current and future relevance of the content.

The editor wishes to express his appreciation to the following persons who assisted him in the review process: Bruce Begin, Tanis Bryan, Donna Eyde, Karen Greenough, Judith Grosenick, John L. Johnson, Peter Knoblock, Nicholas Long, Robert McCauley, Rosemary Sarri, Richard Shores, Carl R. Smith, Thomas Stephens, Luanna M. Voeltz, and Richard Whelan. However, the editor assumed final responsibility for decisions concerning inclusion. It is hoped that those selected will have continuing value.

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SECTION 1

OVERVIEWS

The first two papers in this volume provide a broad perspective on the "state of the art" of providing special education to seriously behaviorally disordered and emotionally disturbed students. They describe the needs and present programing for two age groups that are currently of special interest because they have been relatively underserved in the past: preschool children (Wood, Dodge, Pendleton, Perras, Stone, & Swap) and adolescent youth (Quetzloe & Cline). Together, these papers give us a sense of developments on the growing edges of our field.

PRESCHOOL CHILDREN WITH SEVERE EMOTIONAL OR BEHAVIORAL DISORDERS: PROGRAM DIRECTIONS AND UNMET NEEDS

Mary M. Wood
Gordon R. Dodge
V. M. Pendleton
Donald F. Perras
Nancy W. Stone
Susan Swap

Conservative estimates place the number of preschool handicapped children (birth to age 5) at about one million in 1980. With approximately 350,000 receiving some type of public or private service, about 65% of the preschool handicapped are currently not receiving needed services (Smith, 1980). If we use a 2% prevalence figure for the severely emotionally disturbed, about 13,000 severely emotionally disturbed preschool children below the age of 5 remain unserved. Using a 12% figure, the number of unserved emotionally disturbed preschool children jumps to 78,000.

The National Needs Analysis Project (Grosenick, 1980) found that 6,736 severely emotionally disturbed preschool children (ages 3 to 5) were reported by the states as receiving services in 1979. An additional 4,300 were reported to be "underserved" and another 6,200 were estimated to be "unserved." The severely emotionally disturbed preschoolers reported served represents 3% of all handicapped preschool children served that year.

There are numerous reasons for this critical lack of services to the nation's preschool disturbed: problems of definition and labeling; screening and assessment issues; society's concern for parental rights; federal child counting procedures; the varying states' mandatory education age restrictions; the exclusion of mandatory preschool services from Public Law 94-142; and the limited funding of such programs under the preschool incentive grant program (currently reported to be only $100 per child served) (Smith, 1980).

To illustrate how these many problems merge at the state and local levels, consider services to preschool disturbed children in Minnesota, a state long committed to full services for preschool handicapped children. Minnesota, and many other states, allow for the noncategorical grouping of preschoolers. Locally, many children are determined eligible for services based on a classification such as developmentally delayed or special learning and behavior problems. A review of the December 1978

categorical child count from school districts throughout Minnesota (which requires that districts use the categories specified by P. L. 94-142 regulations) indicated that only 122 of the approximately 4,000 handicapped preschool children were classified as emotionally disturbed. This constitutes approximately 3% of the preschool handicapped population as compared with a national handicap incidence estimate of children with emotional disorders as constituting approximately 17% of special education children (Dodge, 1980).

Figures from Head Start records regarding the number of preschool children classified as emotionally disturbed in the state of Minnesota display quite a similar pattern. Of the approximately 570 handicapped children being served in Head Start in Minnesota in the school year 1978-1979, 26 were classified as emotionally disturbed. This constitutes approximately 4.5% of the handicapped population. The figures by school district and by Head Start program also show considerable variation and no relationship to what might be considered general estimates of incidence. A number of programs which do use emotional disturbance as a diagnostic category indicate preschool prevalence figures as high as 20% in that category, while the vast majority of programs around the state do not list any of their preschool handicapped children as emotionally disturbed.

Federal child count reporting, however, does not have a noncategorical preschool classification, nor does it have a classification for behavioral problems. Consequently, where preschool systems are serving emotionally disturbed children, local administrators need to count them as emotionally disturbed, learning disabled, or even, in some cases, as language handicapped. The labeling process for federal child count, however, does not usually (nor does it need to) impinge on the child or parental and staff perceptions of the child. The extent to which the local education agency makes use of categorical classifications in discussions and planning for preschool children (as opposed to relying primarily on child descriptions of developmental lags, behavioral difficulties, etc.) appears to be determined on the basis of whatever policies and professional opinions exist locally.

PROBLEMS OF DEFINITION

The difficulty in determining what constitutes emotional health or disturbance in a preschool child to a considerable extent reflects problems of definition. In addition, each professional person's theoretical orientation influences the approach to definition. Consequently, emotional disturbance may be viewed as a problem of adjustment, a learned behavior, a developmental lag, a dysynchrony between parent and child, failure to achieve social competence, emotional deprivation, or an ecological imbalance.

Historically, in the field of mental health, theories about child development and emotional problems focused principally on the child; emotional problems were explained in terms of the characteristics of the child (i.e., intrapsychic dynamics or their behavioral expressions).

The effects of interactions between child and parent were understood as occurring in only one direction, from the parent to the child. Consequently, if the child had problems, it was believed that the parent's failures had caused them. Current research indicates that this was an oversimplification, and in many instances, an inadvertent disservice to both parents and children.

Mussen, Conger, and Kagen (1969) were among the first to emphasize that the emotional adjustment of children is a process for meeting the demands of life with a reasonable degree of balance between personal needs, feelings, and adult expectations. A child's struggle to achieve or maintain this balance is the process of adjusting. In so doing, a child mobilizes available resources--senses, muscles, cognition, communication, attitudes, values, emotions, motivations, and interpersonal skills--in response to external demands. When a child is coping successfully, these resources are functioning well. In contrast, when these resources are not functioning successfully, unmet needs continue to disrupt the balance between the child's needs and the demands of life. The behaviors seen in emotionally disturbed and behavior disordered preschool children are products of just such an imbalance.

This emphasis on the dual elements in social-emotional development--a child's uniqueness and the surrounding environmental conditions--is also a focus for Zeigler and Trickett (1978). They argued that *social competence* should be our concern in early childhood education, and suggested two basic outcome measures that reflect social competence: (a) the success of the child in meeting societal expectancies; and (b) the personal development of the child.

These theories about the development of young children have been influenced by the field of ecology, the study of the relationship between individuals and their environment. Ecologists define normality as behavior which meets the expectations of the social system in which the individual is functioning (Kessler, 1966). The term *system* is used to refer to a set of elements in interaction, the state of each element being constrained by that of the other elements in the system. The importance of matching educational demands to child capabilities and developmental levels has long been known to special educators. Only recently have we begun to recognize that the ecological match, the compatibility of child and environment, is as necessary for emotional as it is for cognitive development. For example, if you are a teacher of a very active aggressive child, the child's behavior is unlikely to meet your initial expectations, and there is little question that you will be constrained by this child. To some degree, your functioning and that of each child will be affected by all of the other children in the classroom system, including those who meet your expectations and those who do not.

Recently, the field of ethnology (the scientific study of the behavior patterns of animals) has also influenced both methods of study and theories about emotional development in infants. One outcome of this work has been our present understanding of the bidirectionality of effects of interactions between child and caregivers. Not only does the parent or teacher influence the child, but the child also influences the

parent or teacher and the characteristics of their interactions. Thus, because of the unique characteristics of a particular child, difficult/maladaptive patterns of interaction can occur between a child and caregivers who have functioned very capably with other children. For example, in some handicapped infants, it has been found that the emergence of attachment behaviors is delayed or diminished (Stone & Pendleton, 1978). As a consequence, the mother does not receive comminication cues which she is able to understand, and she does not receive reinforcement for her efforts to parent (Randolph, Stone, & Pendleton, 1979). When she picks up her infant, the baby becomes stiff or physically unresponsive instead of snuggling. When she smiles at him, the baby does not smile back, or even look at her. This can be devastating to an insecure or inexperienced mother.

Currently, there seems to be general agreement that emotional development and emotional disturbance are psycho-sociocultural phenomena. Moreover, emotional development or disturbance contributes in a profound way to subsequent development, successes, and failures in every child. We now recognize that severe emotional and behavioral problems occur in the presence of a continuous malfunction in the organism-environment transaction over time. Initial contributions to the malfunction may arise in child behaviors which do not serve to cue and reinforce the caregivers. In order to cope with both biological and environmental demands, such children require parenting and teaching which is unique in nature or in degree. Another potential mismatch may occur between the temperaments of child and caregiver (one caregiver's active, curious, independent youngster is another caregiver's hyperactive, defiant little monster). Still another source for malfunction may originate from caregivers who need too much personal support to provide the emotional support and socializing assistance needed by a child. Thus, the problem behavior or emotional expression represents the child's unsuccessful effort to meet his or her own needs.

Translating these ideas into workable, administrative definitions is a difficult task. For example, Project Head Start addresses the problem rather than the desired outcome by defining emotional disturbance as follows (Transmittal Notice, 1975):

> A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include but not be limited to the following conditions: dangerously aggressive towards others, self-destructive, severely withdrawn and non-communicative, hyperactive to the extent that if affects adaptive behavior, severely anxious, depressed or phobic, psychotic or autistic.

The definition contained in the regulations implementing Public Law 94-142 is similar (*Federal Register*, 1977):

94-142 121a.5 Handicapped Children

(8) "Seriously emotionally disturbed" is defined as follows:
(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(ii) The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed. (p. 42478)

PROBLEMS OF SCREENING AND ASSESSMENT

The subjectivity of the Head Start and P. L. 94-142 definitions of the severely emotionally disturbed, as well as the inadequacy of current preschool screening and assessment alternatives, make the problems of assessment enormous. Recognition of the limitations in present instrumentation dictates that behavioral observation must take precedence over traditional psychological assessment. However, behavioral assessment must be made in more than one setting and with more than one informant.

Screening

Social service and mental health agencies are the most common sources for allocating preschool children with emotional and behavioral disorders, although public health programs and family physicians may also be significant referral resources. Public schools and Head Start programs which serve a large number of emotionally disturbed children seem to have close working relationships with mental health facilities. Some of the Head Start programs, in particular, not only have close referral relationships with mental health programs, but contract for consultation and observational services, often working jointly with them in providing services for an emotionally disturbed child and that child's family.

Unfortunately many current preschool screening programs fail to include a component for the identification of emotional difficulties. Perhaps one of the problems is that most of the preschool screening programs, whether operated by the public school system, Head Start, or a public health system, do not involve mental health personnel, day care teachers, school psychologists, or social workers to any significant

degree in the screening program. Where occasional exceptions to this trend have occurred, there has been an increase in screening for and identification of emotional difficulties.

As a screening tool, the Rutland Center Developmental Therapy Project (Wood, 1972) prepared the following handout containing a list of 16 behaviors to be used by teachers of young children to identify those who may have social-emotional problems. The teacher is asked,

> Have you noticed a child who seems to have a harder time in school than others? Have you noticed children who seem to need something special to help them along? Is a child's behavior making things so hard for the child and others that he/she is not progressing? Sometimes a child's problem may be one you can see easily. But for other children a problem may be hidden. If a child in your class has any one of these characteristics listed below, you may need to provide "something special."
>
> SHORT ATTENTION SPAN; UNABLE TO CONCENTRATE:
> - not able to pay attention long enough to finish an activity.
>
> RESTLESS OR HYPERACTIVE:
> - moves around constantly, fidgets; does not seem to move with a purpose in mind; picks on other children.
>
> DOES NOT COMPLETE TASKS; CARELESS; UNORGANIZED APPROACH TO ACTIVITIES:
> - does not finish what is started; does not seem to know how to plan to get work done.
>
> LISTENING DIFFICULTIES; DOES NOT SEEM TO UNDERSTAND:
> - has trouble following directions; turns away while others are talking; does not seem to be interested.
>
> AVOIDS PARTICIPATION WITH OTHER CHILDREN OR ONLY KNOWS HOW TO PLAY BY HURTING OTHERS:
> - stays away from other children; always plays alone; leaves a group of children when an activity is going on; bites, hits, or bullies.
>
> AVOIDS ADULTS:
> - stays away from adults; does not like to come to adults for attention.
>
> REPETITIVE BEHAVIOR:
> - does some unusual movement or repeats words over and over; cannot stop activity himself.
>
> RITUALISTIC OR UNUSUAL BEHAVIOR:
> - has a fixed way of doing certain activities in ways not usually seen in other children.

RESISTANT TO DISCIPLINE OR DIRECTION (impertinent, defiant, resentful, destructive, or negative):

- does not accept directions or training; disagreeable; hard to manage; destroys materials or toys deliberately; temper tantrums.

UNUSUAL LANGUAGE CONTENT (bizarre, strange, fearful, jargon, fantasy):

- very odd or different talk with others or in stories.

SPEECH PROBLEMS:

- rate (speech that is unusually fast or slow).
- articulation (difficulty making clear speech sounds).
- stuttering (difficulty with flow of speech; repeating sounds, words, or phrases; blocking words or sounds).
- voice (unusually loud, soft, high, or low; scratchy).
- no speech (chooses not to talk or does not know how to talk so that others can understand).

PHYSICAL COMPLAINTS:

- talks of being sick or hurt; seems tired or without energy.

ECHOES OTHER'S SPEECH:

- repeats another person's words without intending for the words to mean anything.

LACK OF SELF-HELP SKILLS:

- unable to feed self; unable to dress self; unable to conduct toilet activities unaided or to carry out health practices such as washing hands, brushing teeth, etc.

SELF-AGGRESSIVE OR SELF-DEROGATORY:

- does things to hurt self.
- says negative things about self.

TEMPERAMENTAL, OVERLY SENSITIVE, SAD, IRRITABLE:

- moody, easily depressed, unhappy, shows extreme emotions and feelings.

The project encourages teachers to follow up the identification of potentially delaying problems with referral for indepth assessment of social-emotional behaviors.

Observational information obtained during screening is an essential part of the information-gathering process. Experienced screening staff are aware that the screening setting may be a unique experience for the child, and consequently the behavior demonstrated there can in no way be assumed to be typical. With that caution in mind, cut-off criteria must be defined carefully. Some developmental screening tests already have such checklists and criteria for emotional indicators, such as D.I.A.L. (Mandell & Goldenburg, 1972) and C.I.P. (Zehrbach, 1976), whereas others such as the Denver Developmental Screening Test (Frankenburg & Dobbs, 1970) lack such items. One large suburban school district in Minnesota uses the Developmental Profile (Alpern & Boll, 1972). This particular

screening instrument does not have a scale specifically designed for emotional behaviors. However, because the screening process consists of a sustained interview with the parent, sufficient rapport can be established to elicit parents' concerns regarding their child's emotional behavior.

It is perhaps best to think of a screening system as a filtering process. Consequently, a careful design of the entire screening process has to be developed. If a local agency is screening for emotional disorders as part of its overall preschool child screening, a follow-up assessment system for emotional disorders also has to be established. Then the components of the actual preschool program to serve emotionally disturbed children must be designed. Outside mental health resources need to be established and a system to monitor the effectiveness of services needs to be in place. Only with a clear understanding of the processes and services available subsequent to the screening can the local educational agency adequately design its screening program.

A determination also needs to be made of the personnel needed for screening for emotional disorders. Personnel may have several levels of involvement in the screening system, and decisions regarding personnel should be made with reference to those various levels of involvement. For example, consultation may be provided by various personnel in the development of the screening system itself. Consultation may also be provided on individual cases seen during the screening process. A more extensive level of involvement, of course, is direct participation in the screening, both in child observation and testing and in parent interviews.

A school system will have varying professional resources within its own staff and may need to reach outside of its agency either on a contractual basis or an informal sharing of responsibility with other agency staff. Typically, the school psychologist and school social worker can participate in one or more of the above levels of involvement. The speech clinician and school nurse may also have some specialized skills in certain aspects of emotional disorders. Utilization of mental health center staff and county or other agency social service staff may also be necessary.

Assessment

Because of the variability in approaches to defining behavioral and emotional disturbance in early childhood, as well as the need for information from parents regarding their child's behavior, it is recommended that an assessment model for preschool emotionally disturbed children include three basic components. These components are (a) an informant's (parent's) inventory, (b) testing, and (c) an observational period of significant duration. It is further recommended that these procedures to the greatest extent possible, be of a standardized and quantifiable design.

Behavioral and developmental checklists can be useful in the quantification of observations of the preschool child. Also useful are adaptive and self-help scales which emphasize functional independence and building and maintaining relationships with others. Preschool assessment should result in:

1. A determination of the child's need for special assistance.
2. An accurate appraisal of the specific difficulties and assets of the child.
3. Identification of the type of assistance needed to assure continuing development.
4. Analysis of what is sustaining the child's aberrant behavior.
5. Identification of the child's strengths and motivations as the platform upon which to build.

There are a number of parent inventories currently on the market which are appropriate for use with the preschool emotionally disturbed child. A recent review of parent report measures (Humphreys & Ciminero, 1979) may be of interest to the reader in this regard. For example, three parent inventories are the Burks' Behavior Rating Scales (Burks, 1977), the Minnesota Preschool Inventory (Ireton & Thwing, 1979), and the Personality Inventory for Children (Wirt, Lachar, Klinedinst, Seat, & Broen, 1977). These not only allow for parental input but also invite comparison of the parent's view of the child with that of other persons involved.

The difficulty encountered with the Minnesota Preschool Inventory is that it was normed primarily for children who would be entering kindergarten in the upcoming school year; i.e., those who would be 5 years old by September 1. Much of the preschool screening is now being directed at the population of children below this age. The Burks' Scales are normed on a small, selective population. However, they can be used with 3 and 4 year olds. An additional appeal of these scales is that they have considerable face validity with parents, and the manual provides general intervention recommendations based upon the individual child's test profile. The Personality Inventory for Children is somewhat longer than the others and has a number of test items referring to school related behavior. This may cause a negative reaction from some parents. However, in circumstances where the parents are willing to complete a lengthy true/false test, the results obtained from this test can be beneficial for diagnostic determination and program planning.

The amount of information available to the staff conducting the assessment will vary depending upon whether a child has been referred through a screening procedure, referral from another agency, or through a parent contact. Consequently, the amount of background information which must be obtained will also vary accordingly. Certain premises are important to a general understanding of the assessment process as it relates to young children with possible emotional disturbance. The most important premise is that emotional behavior, especially at this age, is highly variable with regard to time, circumstances, relationships, and roles. Therefore, an adequate assessment must reflect an awareness of these forces. This premise seems even more important in assessing emotional behavior than in other areas of development, such as cognitive, gross and fine motor, and speech and language.

Variability with regard to time suggests that several samplings of behavior are important, perhaps at different times of the day. Variability in circumstances suggests that the child may perform quite differently when he or she is rushed, hot, tired, hungry, in an unfamiliar room, or with unfamiliar people, than would otherwise be the case. Consequently,

noting the variation that exists under differing circumstances is important. Variability in behavior may also be influenced by existing relationships. Children may perform quite differently depending upon whether they are relating primarily with mother, father, teacher, sibling, or with someone totally unfamiliar. Again, noting not only what a child is able to do, but with whom, is crucial. The roles which the child takes (in the assessment process) also should be noted.

A traditional assessment model, still found in many diagnostic agencies as well as in some school system assessment teams, usually takes the following format. A case history is obtained, including referral information, background information from the parent, and developmental and biological information. Phenomenological information is the other major sphere of a traditional assessment model. For the preschool child, this is basically a mental status examination which includes a diagnostic interview with the child or with the child accompanied by the parent. In addition, psychological testing is usually incorporated, as well as some limited observational procedures. Traditional emotional/psychodiagnostic methods with a 3 or 4 year old often include the Children's Apperception Test (CAT) or Thematic Apperception Test (TAT), a Rorschach, and drawings. Many psychologists also prefer including an individual intellectual assessment and some testing of organicity for a more comprehensive battery, even if the initial referral did not suggest any intellectual or organic deficit. New diagnostic instruments for the assessment of emotional disturbances in children have proliferated over the past several years. Unfortunately, most of these have not been developed sufficiently for valid general use, and the majority concentrate their focus on children ages 5 and up (Hirt & Genshaft, 1976; Katz & Jacobson, 1978; Walker, 1973).

Thorough assessment for the preschool emotionally disturbed child must include an extended observation. School systems and Head Start programs do have this opportunity typically, either through the actual establishment of a diagnostic classroom or through the incorporation of that process into one of their regular preschool classrooms. There are several advantages to incorporating a diagnostic observation period into the assessment process. First, it permits observation of the child over a period of time. Behaviors which may have been unique to earlier testing situations may not be seen during continued placement in an observational program. Second, an observational placement for as much as 3 to 4 weeks can allow assessment of the child's emotional difficulties in group interpersonal settings. This sort of information cannot be obtained through either informant or psychological assessment methods. Third, the diagnostic classroom placement allows the parent to observe and take part in the assessment so that a much more refined and participatory assessment can be accomplished.

Most observational methods in preschool classrooms are informal. Staff often make note of outstanding emotional behaviors, compare findings with other staff members, and chart variations in those behaviors across settings and time.

There are also a number of more formal preschool observation measurement systems (e.g., Aaronson & Schoefer, 1973; Pastor & Swap, 1978; Wolfgang, 1977). One such procedure is the Developmental Therapy Objectives

Rating Form (DTORF) (Wood, 1979), which provides for the assessment of a child's social-emotional development from birth to age 16. Although the instrument was developed specifically for use with the severely emotionally disturbed, a particular advantage is that the items represent sequentially ordered milestones of normal social-emotional development. Following assessment, the DTORF items are used as the basis for a child's IEP program planning, and the assessment procedure is criterion referenced to the curriculum a child subsequently receives (Wood & Swan, 1978).

Assessment procedures should be designed to facilitate the documentation of children's progress. In several programs this is done by (a) using a series of assessment procedures to evaluate initial social-emotional-behavioral status; (b) scheduling reassessment on some measure(s) at 6 to 10 week intervals; and (c) using the repeated measures for periodic formative and summative evaluation (Huberty & Swan, 1975; Perras, 1980; Wood, 1979).

PROGRAM DESIGNS: PREVENTION OR INTERVENTION?

Two issues are currently of major concern to those designing programs for severely emotionally disturbed preschool children. First, should the program be based in public schools? Second, should the program be a *prevention* program integrated into existing programs for all preschool children, or an *intervention* program designed specifically for the treatment of severe emotional disturbance?

The answers certainly are not in yet for either question. In a recent study of 18 model projects for handicapped preschool children, Swan (1980) reported that 13 of the programs had funding relationships with the local public schools but only 5 were actually based in the schools. Perhaps the limitations in the states' mandatory and permissive education age requirements are central to the question of location in the schools. Another element limiting integrated services may be the general lack of preparedness in most existing preschool programs for effective assistance to children with extreme forms of social-behavioral deviancy.

Here are two examples of program responses to these issues. The first is the Head Start Child and Family Mental Health project (Randolph, Stone, & Pendleton, 1979) which addresses *prevention*, including at-risk populations. The second is the Rutland Center-Developmental Therapy project (Wood, 1972, 1975) which provides therapeutic *intervention* for severely emotionally disturbed and autistic children (Bachrach, Mosley, Swindle, & Wood, 1978).

Head Start

Head Start, a comprehensive child development program for 3 to 5 year olds, is concerned about ways to promote and develop social and emotional competencies, coping skills, and positive self concepts. The Child and Family Mental Health (CFMH) project was funded in 1977 by the Office of Health and Human Services to address this concern, and is beginning its fourth year of operation in 14 Head Start programs across the country. The CFMH project reinforces the concept that a program for each child

must be designed to match the abilities of the child, support the child's self esteem through successful encounters with classroom tasks, and assist the child in developing coping skills (Stone & Pendleton, 1978). An additional objective is to deliver services that enhance interactions between the child and the significant adults in the child's environment.

The conceptual framework for this approach is the ecosystem model (Shurley, 1979; Swap, 1974; Wilkinson & O'Connor, 1977). The ecosystem includes social and physical environments, including the Head Start staff, the classroom, and the family unit. The CFMH project emphasizes the degree of match between the teacher and the child. It recognizes that just as parent and child experience problems because of different temperaments, activity levels, and so forth, so too might this present problems in the teacher-child relationship.

An obvious problem occurs when the demands placed on the child do not match the level of development the child has achieved. Another potential problem occurs when the teacher is under so much stress that he or she is unable to respond to the needs of the classroom. The support provided through the CFMH project attempts to address the teacher's perceptions and expectations before the child's functioning reaches the level at which it is identified as a problem by the teacher. Assistance is provided to develop an environment which is facilitative and supportive for the child and for the teacher.

It is expected that as a result of the activities implemented as part of the CFMH project, children enrolled in the program will rate significantly higher than nonparticipating children in the following categories: self esteem; classroom adjustment; peer relations; positive resources for coping with stress resulting from pain, anxiety, frustration or sudden loss; ability to cope and adjust to varying adult demands; empathy for the feelings of others; and adaptability in post Head Start settings.

Rutland Center-Developmental Therapy

Serving a somewhat more severely emotionally disturbed population is the Rutland Center-Developmental Therapy program. Operated as a psychoeducational center by the state of Georgia and the local school district, Rutland Center serves children from birth to 18 years of age. It is one of a network of 24 such centers in the state, designed as alternatives to residential placement. Concomitant mainstreaming is an important aspect of the program, so that children enrolled in the Rutland Center typically also participate in a regular education program for part of each day. The model was validated in 1975 by the Joint Dissemination Review Panel, Department of Education, as a model with documented evidence of effectiveness.

The Rutland Center-Developmental Therapy approach for severely disturbed preschool children involves intensive, stimulating, pleasurable group experiences using all sensory channels to communicate that the world can be a pleasure and that adults help bring pleasure and success. Adult roles are carefully defined to meet the developmental needs of the

children, and a sequence of social-emotional goals and objectives is used to guide teachers and parents to help the children accomplish particular developmental tasks associated with social-emotional development.

The conceptual framework for this approach draws upon various theories, in particular, ego development (A. Freud, 1973; Loevinger, 1976; Mahler, 1968); moral-ethical development (Kohlberg, 1976; Piaget, 1965); cognitive development (Piaget, 1967); and social-interpersonal development (Bandura, 1977; Erikson, 1963; Flavell, 1968; Selman, 1976). The model operationalizes many of these theories with procedures for identifying each child's social-emotional level of development. On the basis of developmental status each child's IEP is designed to promote social-emotional growth on a series of specific milestone objectives.

CURRICULUM FOR EMOTIONALLY DISTURBED PRESCHOOL CHILDREN

A growing number of behavioral scientists believe that many emotional problems are acquired defects in social interactions and social participation (Bandura, 1977; Kessler, 1966). If such is the case, then it would appear from an educational perspective that the social and emotional curriculum for the preschool age child is of critical importance. However, one of the questions that ultimately arises is, just how deeply can you really deal with the emotional and social development of 3, 4, and 5 year olds? Should it be a part of the traditional preschool curriculum? Should it extend beyond the traditional teachings?

Curricula designed for preschool children with emotional, behavioral, and social problems are a relatively recent development in the special education field, although this movement is rapidly expanding in anticipation of program expansions forecast for the 1980's (Bailey, 1976; Findlay, 1976; Mears, 1976). Examples of such curricula are the Learning Accomplishment Profile (LAP) (Sanford, 1974); Developmental Therapy (Wood, 1975); Peabody Early Experiences Kit (PEEK) (Dunn, Chun, Crowell, Halevi, & Yackel, 1976); *My Friends and Me* (Davis, 1977).

Activities

Typically, preschool classes for emotionally disturbed children are designed to provide an intensive early intervention experience by using individualized and small group training to foster the development of behavioral, affective, preacademic, psychomotor, social, and communication skills. Particular emphasis is placed on the development of affective and social skills, since each child usually demonstrates moderate to severe deficits in these areas. Problems include the inability to (a) recognize feelings, (b) label emotions, (c) express affection to adults, (d) use appropriate situational emotions (e.g., laugh while playing), (e) participate, (f) respond to discipline, and (g) develop social competence. Because these affective problems usually represent the predominant needs of the children, considerable curriculum activity is directed toward their remediation. Puppetry, creative arts (including music and movement therapy), story telling, "feeling" pictures, modeling, direct questioning, and group games are employed to promote this growth.

The week-long unit (theme) approach is widely used to assist children in organizing and integrating the common elements in a series of related activities. The unit is an effective way to build sequential skills and experiences which enhance success. Preschool children feel comfortable with the familiar elements and develop a functional vocabulary related to the theme, thereby stimulating communication and socialization.

Materials and Schedules

Materials should have an intrinsic quality to attract a young child's attention and encourage active exploration and individual experimentation. Ideally, materials should also provide a satisfying outcome so that dependence is not exclusively upon an adult for reward and feedback. Most curriculum experts also recommend that some materials included in programs for the preschool disturbed contain human emotional elements to serve as symbolic vehicles for expression and resolution of fears and fantasies. Puppets, teacher-made storybooks, make-believe play, and creative story telling are examples of such materials and activities.

Following are two examples of typical schedules used by the Family School (Perras, 1980).

Nursery Class Schedule
(2 to 4 year olds)

9:30 - 10:00	Opening and Snack
10:00 - 10:30	Art (Mon. & Wed.) Gross or Fine Motor (Tues. & Thurs.)
10:30 - 11:00	Readiness (Mon. & Thurs.) PEEK Lesson (Tues.); Affective (Wed.)
11:00 - 11:30	Play
11:30 - 12:00	Language Group (Mon. & Wed.) Music (Tues. & Thurs.)
12:00 - 12:30	Lunch
12:30 - 1:00	Nap
1:00 - 1:20	Play
1:20 - 1:30	Closing

Pre-Kindergarten Schedule
(4 to 6 year olds)

9:40 - 10:00	Opening Exercises (calendar, rules, weather, sharing time)
10:00 - 10:20	Fine Motor/Readiness (individual activities)
10:20 - 10:40	Snack
10:40 - 11:10	Gross Motor (outdoor play and structured activities)
11:10 - 11:30	M-Group Language; T-Self Help; W-Affective; Th-Self Help; F-Affective
11:30 - 12:00	Free Play and Lunch Preparation
12:00 - 12:45	Lunch in room (M & F with nursery class)
12:45 - 1:00	Story
1:00 - 1:15	Rest
1:15 - 1:30	Group Readiness
1:30 - 2:00	M-Art; T-Music; W-Art; Th-Music; F-Group games with readiness class
2:00 - 2:20	Closing (count points, discuss day, closing song)

Teacher Techniques

Various teacher strategies are used to enhance social-emotional development, including active listening, personalizing interaction, modeling appropriate affect, and role playing. Modeling affect is a significant technique to teach social behavior as teachers demonstrate appropriate responses to situations. Modeling also teaches children to modify behaviors that are potentially negative to others. Role playing provides practice in verbal and nonverbal communication skills. Teaching a child to react to a variety of events promotes the generalization of newly learned competencies and facilitates adjustment to different interpersonal contacts. Such procedures are designed to ultimately teach each child to identify and express feelings in a socially responsible manner.

Emphasis is placed on building adult-child relationships in most preschool programs for the disturbed. Some of the techniques used to enhance relationships include (a) reflecting a child's participation as well as accomplishments; (b) using positive statements rather than negative ones; (c) setting expectations which each child knows he or she can meet; (d) making psychological contact (e.g., eye, touch, words, etc.) with each child every few minutes; and (e) intervention with redirection in order to avoid a crisis or a failure situation.

PARENTAL INVOLVEMENT

Administrators developing services for the preschool disturbed often ask, "How important is parental involvement in the program?" and "What form should the involvement take?" One study which provided a fairly clear answer to the first question is a longitudinal work by Thomas and Chess (1977). They followed 95 children from lower socioeconomic status Puerto Rican families and 141 children from middle and upper middle class predominantly Jewish families in New York over a 20 year period. In this study, children were grouped according to their behavioral style, their temperament. Later, severe problems were found more frequently (but not always) in those children who in infancy had the characteristics of the "difficult child." Thomas and Chess reported that their observations indicated that deviant development was the result of the interaction between a child's individual style of functioning and significant factors in the environment. In no case were later behavioral or emotional problems explained by temperament alone. Observations of child-parent interactions showed that when parents were able to use the guidance that was provided to alter their parenting expectations and practices, in later years the problems improved in some instances and disappeared in others. In contrast, when observers rated parent functioning as failing to show modification, later findings were that no children in this group showed marked improvement or recovery from their problems.

Another study (Werner & Smith, 1977) reported that children whom home visitors rated as having adequate emotional support in the home setting were only one-seventh as likely to show emotional problems at age 10 as those children whom raters considered not to have adequate emotional support at home. The presence of *persistent* mental health problems

(defined as requiring mental health services for 6 months or longer), remedial education, and physical handicaps at age 10 were powerful predictors of the presence of persistent mental health problems at age 18.

Alternative Parent Services

Recognizing that the family is the primary social system for the young child, preschool programs for the emotionally disturbed typically offer an array of services to a child's family. However, variations in the extent of parental involvement and type of service delivery are numerous. One distinctly different program is the Regional Intervention Project (RIP) in Tennessee (Hester, 1977; RIP, 1976), in which parents themselves are the service providers. Another project advocates parental participation as co-therapists (Schopler & Reichler, 1971).

Making parental participation a mandatory requirement for serving a child is questioned by many preschool professionals. On the one hand, it is argued that without parental involvement significant progress for a preschool child is doubtful. The opposing argument is that the children most desperately in need of assistance are those whose parents will not or cannot become involved.

By offering a full array of parent services, a program can usually provide for the needs of parents seeking assistance as well as those who are not. For example, the Rutland Center (Wood, 1972) offers five types of parent services.

1. *Parent Conferences:* Weekly appointments to discuss the child's progress at school, home, and center. These conferences can serve to facilitate the partnership aspect of the treatment program. Both the treatment team and the parents share information to the end that the child's development will be enhanced in both settings.

2. *Parents' Auxiliary Association:* An organization of Rutland Center parents which meets in the evening once a month at the center. All parents are welcome. This program offers parents an opportunity to meet and get to know other parents whose children are enrolled in the Rutland Center program. Information may be shared, programs to help the center may be planned and implemented, and the feeling of isolation which may be felt by the parents of an emotionally disturbed child may be reduced at these meetings. The group also is involved in a number of helping activities. Parents report that this is a significant way that they reciprocate and "do something for the center."

3. *Observation:* Learning about the Rutland Center program by observing the class through a two-way mirror with staff who are also working with the child. For many parents, observing may be their first opportunity to actually see their child interacting successfully in a group situation. Observation may be of help to a parent who wants to see a particular objective being implemented. Also, observation provides parents the opportunity to really know what is going on with their children at Rutland Center.

4. *Home Program:* The monitor and parents plan new management routines for parents to use at home. Often these planning sessions are conducted in the home. It is difficult for a staff person to understand the home situation of which parents speak until he actually sees the family members on their own ground. Parents may feel that the home contact is the best way to explain themselves. In this case, the Home Program may be chosen.

5. *The Parent Training Program:* Parents learn the skills used by the Rutland Center staff by working as a support teacher with a treatment team at the center. The amount of time required will depend upon the parents' time and interest. This program carries the observation program a step farther. It can be very useful to the parent who feels the need to actually use Developmental Therapy techniques and wants to learn them in a monitored situation. The feedback on the parents' progress is then immediate.

These programs are chosen by the parents according to needs, interests, and the availability of their time. Often programs are combined. For instance, parent conferences and observations often are scheduled jointly.

The Family School (Perras, 1980) in Connecticut also emphasizes parental involvement, encouraging parents to observe their child through an observation room to assist them in learning to set limits, become consistent, provide rewards and punishments correctly, and develop skill at expressing feelings. Educational programing on child development, behavioral techniques, and other child rearing strategies is provided at a monthly group session meeting.

To begin the family therapy process, the therapist arranges a series of family diagnostic sessions to assess the family's relationship structure, its communication patterns, its developmental stage, its current stresses and support systems, and its problem solving skills. Structural family therapy and a communications model are applied to facilitate change. Behavioral goals are defined and tasks assigned to realign the family's relationship structure and establish appropriate boundaries within the various subsystems (parental, marital, and sibling). Open alliances are promoted and pathological alliances reduced (Minuchin, 1974).

To promote more efficient communication, the model developed by Bandler, Grinder, and Satir (1976) is adopted because of its emphasis on improving clarity in sending and receiving messages, coordinating verbal and nonverbal transmissions, expressing desired changes, and enhancing different styles of self expression. Teaching parents to negotiate problems and conflicts should make effective communication more realistic and beneficial. The therapist determines the number of family sessions, the frequency of those sessions, the format, and the number of participating members; families not attending according to their personal contract are given special consideration to improve their participation, with the ultimate leverage being their child's continuation at the Family School.

Parent-Professional Communication

In the ecosystem model, the family unit is an essential system in delivering effective services to the emotionally disturbed preschool child. Rather than viewing the child as the center of the problem, the mutually interactive forces of teachers' and parents' skills, expectations, temperaments, and attitudes become the focus. Dynamic involvement between parents and professionals is essential; effective and ineffective styles of communication become of paramount importance.

Clearly, parents of handicapped children must now be involved in any evaluation or program decision for their child. This federal mandate has created new opportunities for effective parent-professional communication, but it has also highlighted significant barriers to communication which interfere with successful relationships. Parents of young children with emotional problems face special difficulties. Accurate identification and diagnosis of young disturbed children is very difficult. This population is severely underserved, and negative stereotypes about their parents among professionals are common and strong. Professionals themselves may be struggling with lack of training in communication skills, or they may lack information about ways of involving parents in preschool programs. Many teachers in "least restrictive environments" have not had the training or experience to meet the needs of disturbed or disturbing children.

All of us have had the experience of communicating effectively--and ineffectively--with another. Principles of good communication are consistent, whether the participants be members of a committee, members of an educational team, a husband and wife, or a parent and professionals. Knowledge of our own experiences and skills in communication is the cornerstone for future work on collaboration.

It is natural for anyone who has been involved in unpleasant, conflict-ridden discussions with another person to blame that individual for the problem. An ecological perspective suggests that there are barriers to parent-professional communication which are culturally determined. For example, although effective communication is characterized by good relationships and frequent opportunities to communicate, schools generally provide infrequent opportunities for parent-professional communication and those occasions which do exist are ritualized or crisis based.

Effective communication is enhanced by shared goals, but the goals of parents for their children are generally focused on the child's individual happiness, while a teacher must concern herself with a child's socialization and achievement as a member of a group. We need to consider how our roles (as teachers, parents, administrators) affect how we interact and how we are perceived by others. An appreciation of the constraints of another's role may make us somewhat less likely to blame an individual for unpleasant confrontation, and provide a basis for future collaboration. Open, reciprocal respect between members of a family unit and professionals is essential for effective intervention with the emotionally disturbed preschool child.

CONCLUSION

Perhaps one of the most profound changes for young children entering the preschool environment is that they must become members of another social group. They must join in play with other children, share, take turns, and take some responsibility for their actions. In this setting they also are expected to substitute verbalizations for physical behaviors, to control feelings and emotions, to find alternatives for certain behaviors, to participate in new situations, to obtain as well as accept help and support, and to recognize the rights and feelings of others. Just as young children have learned to negotiate their home environments, so they must learn to negotiate this new school environment.

One of the problems many children experience early in their effort to negotiate the school environment is their lack of ability to interpret the behaviors of different adults. This problem arises when teachers and parents use very different styles in relating to the child. In the classroom one often sees children who have difficulty in discriminating and attending to the teachers' messages and cues, in particular those that relate to them.

A great deal is being asked of children entering this new setting. Some situations children are competent at handling; other situations may be totally out of their repertoire of experiences. The possibility for developing serious adjustment problems is present. The degree to which a child will be able to adapt successfully to the new environment will greatly depend on the insight, intelligence, flexibility, and objectivity of those adults who make up the early world of the child.

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ADOLESCENTS WITH SEVERE BEHAVIOR DISORDERS IN THE REGULAR SECONDARY SCHOOL

Eleanor Guetzloe
Ralph Cline

Adolescents with severe behavior disorders have traditionally presented a major problem to educators of exceptional children. For many years the emphasis in exceptional student education has been placed on programs at the elementary school level, while the area of secondary education has been comparatively neglected. Because the secondary school has generally tolerated very little deviant behavior, the problem adolescent has usually simply been excluded. The failure of the educational mainstream to deal effectively with the delinquent or disturbed adolescent has been reflected in national statistics on school dropouts (Kauffman & Nelson, 1976). The regular secondary school has been traditionally oriented toward content rather than academic skills or processes, and there has been very little support, environmental control, or individualization for the deviant youngster.

As a result of recent federal mandates, there is considerable professional interest in the provision of educational programs for the behaviorally disordered adolescent. Exclusion is no longer even debatable. The law requires that a continuum of educational placements be made available, that the student be educated in the least restrictive environment, and that the handicapped child participate with nonhandicapped children to the maximum extent possible in extracurricular and nonacademic activities. The implementation of these regulations places a great deal of the responsibility for the education of handicapped children upon regular educators, few of whom feel competent to assume the burden. An additional problem is presented by the fact that the student with a severe behavior disorder, especially at the secondary school level, is considered by many educators to be the most difficult of all handicapped children to integrate with normal peers.

In establishing educational programs for adolescents with behavior disorders, the usual direction within exceptional student education has been toward the formation of special schools and self contained classes which have afforded very little, if any, interaction with normal students. The issue confronting educators of behaviorally disordered

youth is not the advantages or disadvantages of segregated placement, but rather the establishment of an appropriate program which meets the requirements of the federal mandate. Students with behavioral disorders must have available a full continuum of alternative educational placements, ranging from regular classrooms to hospitals and residential institutions.

Providing the least restrictive environment does not necessarily require integration with normal peers. Mainstreaming is not the mandate. Placement, according to the law, must be made on an individual basis. Selection of the least restrictive environment for any handicapped child must be based upon the individualized education program (IEP) and may lead to placement in a setting along any point on the continuum. Inclusion in the regular classroom is not appropriate for all students with behavior disorders. For students who cannot benefit from such placement, segregated classrooms must be provided. The rules and regulations of Public Law 94-142 state that if a child is so disruptive in regular classroom that the education of other students is significantly impaired, such placement is inappropriate (*Federal Register*, 1977). Further, the mere establishment of a class for behaviorally disordered students on the grounds, or within the building, of a regular secondary school constitutes neither mainstreaming nor the least restrictive environment.

In some instances, the federal law may be used as an excuse for providing a lesser program merely because it may be expedient both logistically and financially to place all handicapped children of appropriate chronological age in the regular secondary school. Yet Public Law 92-142 requires that consideration be given, in the selection of the least restrictive environment, to any potential harmful effect on the student. Placement closer to the mainstream may not be made if such placement would be detrimental to the child's educational program. It is therefore reasonable to assume that the specialized support services needed by the student with behavioral disorders (such as counseling, group therapy, academic remediation, and vocational education) will be made available within the context of the regular school.

Mercer (1974) has suggested that the *why* of mainstreaming is to be understood in the perspective of history; the *who* is in large part a decision of the courts; but the *how* is the current challenge of public education. It should be recognized that educators of exceptional children already know *how*. The problem in providing the least restrictive environment is *where* and, of even greater significance, *with whom*. The success of any educational program depends upon the knowledge, skills, and personality of the adult in charge. The responsibility for the successful implementation of programs in the mainstream rests upon those who already have the necessary qualifications. Exceptional student education must also assume this responsibility.

A review of the current literature reveals a relative paucity of information concerning secondary education for children with severe behavioral disorders. Further, most of the programs reported have operated in a segregated setting. There are, however, certain components or elements which are common to many of the projects cited as effective.

With some degree of modification, these components can be implemented in the regular secondary school.

It should be expected that any program for students with behavior disorders will emphasize improvement in basic academic performance. Individual instruction in tool subjects will therefore be assumed and will not be included in this discussion.

BEHAVIOR MANAGEMENT SYSTEMS IN THE SECONDARY SCHOOL

Perhaps the single most critical factor contributing to the success of a program for students with behavior disorders in the regular secondary school is the planning and implementation of an appropriate system of behavior management. As suggested by Reinert (1980), clear-cut theoretical models are generally nonexistent in the reality of the public school. Most successful programs have therefore used intervention strategies based on a combination of theoretical approaches.

The Behavioral Approach

The efficacy of the behavioral approach in the education and training of students with severe behavioral disorders has been adequately demonstrated in self contained classes, special schools, and institutions (Cullinan, 1978; O'Leary & O'Leary, 1977; Shea, 1978; Swanson & Reinert, 1979). The programs cited, however, have generally operated in settings where a great degree of control could be exercised over the learning environment. In a less restrictive placement, it may be very difficult to devise a system which will offer a consistent approach to dealing with the student's behavior in any setting within the school. Several relatively simple behavioral techniques seem particularly suitable for use in a regular secondary school. These include (a) a token economy, (b) behavioral contracting, and (c) reinforced modeling.

The Token Economy. The token reinforcement system is among the most commonly used behavior management systems in programs for severely disturbed or delinquent youth, and its effectiveness has been demonstrated in a variety of educational settings (Cullinan, 1978; Hobbs & Holt, 1976; O'Leary & Drabman, 1971; Phillips, Phillips, Fixsen & Wolf, 1971). In setting up a token reinforcement system in a regular secondary school, it is essential that the procedures used be kept as simple as possible and that the total faculty be aware of, and receive training in, the techniques involved. The implementation of such a system requires the participation, cooperation, and commitment of all personnel involved, including, as suggested by Graubard (1976), the students themselves.

An example of such commitment by a total school community has been reported by several authors (Davis, 1979; Jury & Jury, 1979). An entire middle school in Gilman, Vermont, adopted a token economy. The tokens, called thalers, resemble Monopoly money and are worth one penny each, backed by appropriations from the school board, community donations, and money raised by the students themselves. The system was developed in an effort to teach economics, capitalism, and private enterprise while combating student apathy, vandalism, and discipline problems. The

result is an intricate social, legal, and economic system, including a Bill of Rights and Code of Laws adopted by the student body. Students hold jobs, pay taxes, and enforce their own rules. Both adults and students involved attest to the success of the system (Jury & Jury, 1979).

Behavioral Contracting. Behavioral contracting has been cited as a successful intervention in community, public school, home based, and institutional programs for behaviorally disordered adolescents (Cullinan, 1978; Jesness & DeRisi, 1973; Stuart, 1971; Stuart & Lott, 1972). Rules and guidelines for the implementation of behavioral contracting have been outlined by a number of authors (Homme, Csanyi, Gonzales, & Rechs, 1969; Jones, 1980; Reinert, 1980; Shea, 1978) and examples of behavioral contracts suitable for use with adolescents have been described by Cullinan (1978), Shea (1978), and Rutherford and Edgar (1979). Using behavioral contracts with disturbed adolescents requires no procedural changes, but parent participation in the agreement might enhance the possibilities of success. Initial contracts could therefore be written during the meeting held for the purpose of developing the individualized education program, since all interested parties, including the student, should be present.

Reinforced Modeling. Reinforced modeling (Alexander & Parsons, 1973; Bandura, 1973) has been successfully employed as an intervention technique with a number of patterns of maladjustment such as rejection of authority, inability to resist peer pressure, unwillingness to accept blame, failure to complete tasks, inability to express assertion without anger, inability to ask for assistance, and inability to accept criticism (Cullinan, 1978). The four separate components of the reinforced modeling technique are as follows:

1. The specific behavioral skills required for successful performance are determined and stated explicitly by the trainer.
2. The skills are demonstrated by live models, film, or videotape, and a rationale for each is explained.
3. The student participates in guided practice under safe conditions with reinforcement of successive approximations.
4. The skills are practiced, corrected, and repracticed, with approval or other reinforcement for correct performance in more realistic situations.

It is possible to use this technique in a regular secondary school by first demonstrating and then arranging guided practice sessions in the special education setting. Skills could be further practiced and reinforced by other school personnel in regular classrooms and other settings throughout the school.

Although, as suggested by Cullinan (1978), behavior modification procedures alone can bring about changes in deviant behavior, intervention programs often use behavioral techniques in combination with other approaches. Another strategy, with which behavioral procedures can be made compatible, is that of therapeutic group discussions.

Group Oriented Interventions

In the traditional secondary school, very little opportunity is provided for students to engage in supervised experiences in communication. While most adolescents have acquired some skills in establishing interpersonal relationships with peers, the seriously disturbed child generally exhibits an inability to perform appropriately in social situations and needs structured practice in this area. There is also some evidence that the influence of the special class group may adversely affect classroom behavior (Graubard, 1976). This author contended that the peer group must consciously legitimize learning so that members of the group may participate in classroom activities without fear of loss of status. He cited the need to be aware of the power of the group and to negotiate its support for the system of classroom rewards.

The effectiveness of therapeutic group as an intervention strategy with behaviorally disordered students has been cited by a number of authors (Anderson & Marrone, 1979; Berkowitz, 1972; Copeland, 1974). Copeland, in discussing group psychotherapy for adolescents, suggested that the formation of peer groups for therapeutic purposes can be very effective. He stressed, however, the need for experience and skill on the part of the leaders or co-leaders, and further suggested the addition of a sufficient number of co-therapists to keep the group moving in the right direction, especially if there are more than eight in the group or if members of the group show antisocial tendencies.

Classroom Group Meetings. Group meetings as part of normal classroom procedure have been suggested by several authors (Glasser, 1971; Jones, 1980; Vogel & Smith, 1974). According to Glasser, there are three types of classroom meetings:

1. Open-ended meetings for the purpose of increasing thinking skills and encouraging students to relate what they know to a topic.
2. Educational-diagnostic meetings for the purpose of evaluation of instruction.
3. Problem-solving meetings for the purpose of finding solutions to problems of school living.

Vogel and Smith (1974) proposed the option of an open meeting which may be called by any member of the group for the purpose of expressing frustration and which is usually conducted by a peer. Jones (1980) described a number of strategies, ranging from informal to highly structured, that may be employed by teachers to assist adolescents in the development of communication skills. These activities, according to the author, have been successfully used in groups of up to forty students and should therefore be suitable for the regular classroom in which behaviorally disordered students may be placed.

Therapeutic Group in the Regular School. Anderson and Marrone (1979) have developed a model for therapeutic group discussions that has proved successful in the regular school setting. Mental health professionals were employed to work directly in the classroom with both students and teachers. A psychiatrist or clinical psychologist met with each class once a week at a regularly scheduled time ranging from 45 minutes for

younger children to 60 minutes for older students. On the secondary level, the group meeting time was determined according to the schedule, avoiding those periods in which students were mainstreamed. There were also pre- and post-group meetings with the teacher lasting from 10 to 20 minutes. Within the group, emphasis was placed on appropriate communication and improved interaction among group members.

While this program used a psychiatrist or clinical psychologist as group leader, it would be possible for any person well trained in group procedures to conduct the group discussion. Several benefits of this approach were cited, including the opportunity for the therapists to train teachers and aides in therapeutic techniques, and for the teachers to train the therapists in group educational procedures. These authors have commented on the problems encountered by others who have attempted to replicate their therapeutic group model. They caution that, in order for such a program to be successful, there must be a firm commitment of all concerned, particularly the administrators, to providing group experience as a vital part of the educational experience.

Communication as Intervention

In addition to the implementation of a token economy and other classroom management systems, it is necessary to plan with the entire staff for a method of communicating with the disturbed student. This plan should insure that the response to any problem behavior will be essentially consistent from any adult with whom the student comes into contact outside the classroom.

Secondary school personnel involved with mainstreaming emotionally disturbed students have questioned, "What do we do when they act up in the hall?" "What should we do if the child is involved in a disturbance and refuses to go to the dean?" A dean has asked, "Isn't there something else to do besides sending him to me?" A simple technique, easily mastered by the entire school faculty, has proved effective in such situations. If the student is involved in a dispute away from the special education classroom, he is simply asked to return to the special teacher: "Are you Mr. Hall's student?" "Please go to Mr. Hall's room now." Normally, the student will consider his classroom a haven and will return readily to his special teacher. If, upon entering the room, he responds appropriately to directions, and returns to task, no further action should be necessary. If he continues to be disruptive and/or refuses to follow directions, the options of time out or seclusion in the dean's office must be available to the special class teacher. If the student is told to return to the special education setting from a general classroom, his assignment should be sent with him. Problems arising in the halls or on the grounds should be simply and quickly settled as described in order to provide the least possible disruption of the student's schedule. Rules must be clearly defined, explicitly stated, and consistently applied, but traditional secondary school punishment should be avoided if at all possible. In the event of actual or threatened physical violence, there must be a procedure for providing immediate assistance to the individuals involved. A signaling device must be available for the purpose of calling for help, and one or more staff members should be constantly on call to assist in such crisis situations.

ADVOCACY WITHIN THE SCHOOL

It is to be expected that the adolescent with a severe behavior disorder will have specific problems and needs requiring accommodation in the regular secondary school. There is a great need for a concerned individual within the school who will assume the responsibility of coordinating the efforts of faculty, parents, and others involved in the delivery of services to the student.

A Teacher as Advocate

In a discussion of factors adversely influencing interaction between secondary teachers and parents of adolescents, Rutherford and Edgar (1979) included the following:

1. The student's responsibility to several teachers.
2. The shift in emphasis from academics toward career and vocational goals.
3. The increasing influence of peers, as opposed to that of teachers and parents, upon the student's behavior.

While it may be assumed that the severely disturbed adolescent would be involved with only a few general classroom teachers, communication might be facilitated if one person were designated the school contact. These authors have suggested that the assignment of a single teacher as liaison between home and school would provide a solution to the problem of sharing vital educational information. They further suggested that, as students who are able to cope with the normal curriculum are mainstreamed into regular classes, the resource teacher may be expected to assume other roles previously neglected in the regular school, including that of advocacy for the handicapped students. If the resource or special classroom teacher has a large number of students, however, the assumption of the additional role as advocate might prove extremely burdensome.

A Special Counselor for the Handicapped

A solution to this problem might be the assignment of a single counselor to serve the handicapped population of the regular secondary school. This counselor could then act as both advocate and case manager for the student, facilitating accommodation within the school and coordinating services provided by school support personnel and other social agencies. Ideally, such an individual would possess not only the skills necessary to counsel and advise students, but also the ability to interpret assessment information to both teachers and parents and to make meaningful recommendations concerning the student's individualized education program. Other services that might be performed by the counselor/advocate include communication with feeder schools, new student and family orientation, scheduling a program in which the student can succeed, recommendations concerning teacher selection, and assisting with crisis intervention.

ALTERNATIVES TO THE STANDARD CURRICULUM

In order to meet the needs of the handicapped students who will be mainstreamed, certain modifications to the existing curriculum are necessary. There should be alternative routes to graduation for those students who do not fit the mold of the traditional college preparatory courses. Since federal law will support schooling for handicapped students until the age of 21, why should the handicapped child be expected to complete high school in four years? A degree of flexibility is necessary in the accumulation of the units required for high school graduation. As suggested by Kelly (1978), there is nothing sacred about requiring lockstep completion of a specified number of secondary level units. This author further contended that there is no inherent value in maintaining a standard 5 to 7 hour instructional day for all students. While his discussion centered on the problem of overcrowding, the suggestions are pertinent to the problems of providing flexibility in scheduling for the behaviorally disordered student.

Alternatives to the Traditional Curriculum

Several alternative secondary programs have been described by Sinner and Sinner (1978). At Union High School in Hinesburg, Vermont, seven specific programs are offered to all students on a voluntary basis. Do Unto Others (DUO) is a program in which students may earn school credit for experiential learning in community service and apprenticeship in a number of occupations. Boy's Life and Girl's Life are self contained, autonomous programs conducted in community buildings in which students may earn the equivalent of 18 Carnegie Units toward a diploma. Summer Challenge is a 25 day experience similar to Outward Bound. The Summer Site Betterment Project was a single summer DUO experience in school building improvement. Peer Counseling involves students, trained by the local youth services bureau, who make themselves available as counselors for other students. Finally, the Learning Place, in which students have a significant voice in program design, staff selection, evaluation, and governance, is an off-campus program for nonachievers. The Learning Place involves counseling, academic and experiential learning, and use of the community as a learning resource.

Another alternative to the traditional curriculum has been reported by Young (1976). This author described the John Adams High School in Portland, Oregon, in which eight "schools-within-a-school" have been established. With 1200 students divided into units of approximately 150 students and 7 teachers each, each unit offers educational programing for different goals. Included are traditional college preparatory courses (two schools), academics combined with work experience (two schools), a college exploration school, a school for specialized vocational instruction, a school for career exploration, and an evening school for dropouts and students who must work at daytime jobs. This organizational pattern, according to the administrators, has made closer interaction possible between teachers and students and has rendered both truancy and violence almost nonexistent.

Some curricular modifications would not require a total school reorganization. For example, provisions could be made for a student to study for a high school equivalency examination while attending a special program within the regular high school.

Additions to the Curriculum

Certain additions to the curriculum could be used as reverse mainstreaming strategies, in that normal students could be allowed to enroll in these courses as electives. Such special topics courses could include study skills, communication skills, sex education, use of leisure time, personal health (including diet and medication), drug education, and environmental education. It would also be possible to have content specialists from regular education teach an adapted general education class in a segregated setting, or to have the special class or resource teacher provide a course for normal students in which behaviorally disordered youth could be placed.

Meeting Special Needs in the Regular Classroom

The placement of a behaviorally disordered student in the general classroom for any academic subject implies that the student will be able to succeed in that setting, achieving a passing grade. It is to be expected, however, that some adjustment of requirements must be made in order to meet the needs of the handicapped student. Among the accommodations that can be made by the regular classroom teacher in cooperation with the special education teacher are the following, as suggested for adolescents with learning disabilities (Marsh, Gearheart, & Gearheart, 1978):

1. Selection of special textbooks and instructional materials.
2. Provision of course objectives, requirements, and schedule.
3. Continuous monitoring of the student's progress.
4. Provision of a glossary of technical terms for student use.
5. Provision of taped or written summaries of abstract concepts.
6. Modification of homework or testing requirements.

The special class or resource teacher, in return, should assume the responsibility for the teaching of study skills the student may need in order to succeed in the regular classroom. Such skills may include:

1. Planning an appropriate environment for studying.
2. Notetaking and using a tape recorder.
3. Keeping a record of assignments.
4. Finding main concepts and facts.
5. Taking tests.
6. Using reference materials.
7. Changing reading rate according to purpose and material.

Career Education, Vocational Education, and Vocational Rehabilitation

Educators of exceptional students have long recognized the advantages of combining meaningful vocational experience with formal education. Career and vocational education have been suggested as essential components of

educational programs for the behaviorally disordered student (Kauffman & Nelson, 1976; Northcutt & Tipton, 1978), as having the potential for accommodating handicapped students in the mainstream (Brolin & D'Alonso, 1979), and as an alternative to the traditional secondary curriculum (Colella, 1973; McDowell & Brown, 1978).

A recent review of federal legislation affecting vocational education and future employment of handicapped students (Razeghi & Davis, 1979) emphasized the intent of the mandates that these opportunities be made available and accessible. As reported by these authors, an interbureau agreement has been developed jointly by the Bureau of Education for the Handicapped and the Bureau of Occupational and Adult Education which provides for coordinating the activities of the two bureaus in areas of shared responsibility. Further, the Office of Education has entered into an agreement with the Rehabilitation Services Administration to plan and implement cooperative efforts in providing services to handicapped students. The authors cautioned, however, that special educators may need to provide the initiative in implementing these cooperative efforts, especially at the local level.

Vocational education as an alternative program. McDowell and Brown (1978) have proposed a career and vocational program for emotionally handicapped adolescents as an alternative to the traditional college preparatory curriculum. The program would be housed within the regular secondary school plant in order to facilitate integration of special students into the regular school program whenever possible. Completion of the program would result in graduation with a regular high school diploma.

The Vocational Instructional Program (VIP) at Riviera Middle School in St. Petersburg, Florida, is a working example of such a model. Located in a separate shop and an adjacent classroom within the regular school, the unit houses 30 students with two teachers. Established for disruptive students, VIP has been extremely successful, according to evaluations by teachers, administrators, parents, and the students themselves.

A vocational program for severely disturbed adolescents which serves as an alternative to institutional placement has been developed by Black and Black (1979). The program is made available through cooperation between the New York City Board of Education, the Bronx Children's Psychiatric Center, the Rehabilitation Center (of the adult mental hospital), and the New York State Office of Vocational Rehabilitation. Two vocational classes offer a choice of basic clerical skills or horticulture and ground maintenance. Part time work experience is made available through the Office of Vocational Rehabilitation. The authors recommend a highly structured setting with no more than ten students in a group. They contend that the severely disturbed adolescent requires a therapeutic milieu with behavioral support and controls in the vocational education setting.

The Pinellas Marine Institute is a highly successful vocationally oriented program for adjudicated youth in St. Petersburg Beach, Florida. The program is made available through cooperation between the Pinellas County Public Schools, the Office of Youth Services, and a private corporation, the Associated Marine Institutes. An outstanding feature of the vocational education program is that vocational training is directed toward marine-related occupations that are both desirable and socially acceptable. Subject areas include basic engines, dock building, seamanship, instruments, communication, scuba diving, marine and ocean science, and underwater photography. Students may also earn a high school equivalency diploma. The instructional program is highly structured and based upon a token economy. While courses offered at the institute are particularly suitable for a waterfront community, some components could be implemented in any geographical area.

Modifications in vocational education program. A number of problems may arise in providing vocational education and work experience for the severely disturbed adolescent which require modification of the school program. For example, the vocational plans and choices of the adolescent with a severe behavior disorder may often be somewhat unrealistic. Parents and teachers must cooperate in sharing accurate information concerning the student's actual potential as well as his or her preferences for a possible future vocation.

In traditional vocational education classes, skills may often be taught in isolation, in the form of work samples. The disturbed student may, for example, learn how to write a charge with a credit card. He may learn to work the machine, fill in the blanks correctly, add the bill, and check to see that the signature is correct. These activities, however, are carried out within the comfortable and familiar confines of the classroom. On the job, however, these routines must be performed in an anxiety-producing situation, with customers clamoring for assistance. The disturbed student needs intensive practice in work settings which more closely approximate the real world. He needs practice in managing frustration.

The behaviorally disordered student, after a brief period of work evaluation, is often placed on the job in an unfamiliar environment, with co-workers he does not know, with a supervisor he does not trust, and with infrequent visitations by any liaison person available. The student is expected to model co-workers, respond appropriately to the supervisor, and become comfortable in the new environment while learning the skills required for the job itself. The change is too abrupt for the emotionally disturbed student who actually needs over-training. Skills should be thoroughly ingrained, after which the tasks themselves can contribute to emotional comfort, acting as a crutch in an unfamiliar setting. There should also be gradual, sequential steps from the extremely structured classroom to actual job placement. A sequence of such steps might include:

1. School-based group work experiences with token pay, such as shop, landscaping, and kitchen or lunchroom work.
2. Paid group work experiences, under supervision, perhaps including socially relevant occupations related to helping others.
3. A continuum of placements for part time work--well supervised, structured for gradual increase in social demands, and with a limited amount of time spent in each placement.

At the present time, vocational education and training are often offered as part of the special education program. It should be possible to establish special classes and resource rooms within the vocational schools and institutes, from which youngsters could be mainstreamed to whatever extent possible, while engaging in vocationally oriented activities in the special classes. There should also be established, within the framework of vocational education, a sheltered workshop for those who cannot be successfully mainstreamed, in which management techniques would more closely approximate those that are employed successfully in special classrooms.

ADMINISTRATIVE CONSIDERATIONS

Vital to the success of a program for behaviorally disordered students are the skills and attitude of the faculty and administrative staff. The support of the building principal is particularly crucial. Principals who administer successful programs for these children must be extremely flexible. They must be willing to alter rigid rules that have been made for normal children. The principal must support a special budget, interpret the program to regular faculty, and present himself as a program advocate to his superiors.

Teachers and other professionals within the building are greatly influenced by the value the principal places upon a program. For example, the physical location of the class is the responsibility of the principal. The principal should understand that the nature of the behavior of these students requires much more than the typical square footage per pupil. Traditionally, these youngsters have been forced into the smallest room in the building, a practice which only adds to their overt behavior problems. Bearing in mind the special need for enhancing self image, the special class probably should not be placed in some outlying building on the campus, but within the usual boundaries occupied by the regular students.

Delivery of the proper educational program to behaviorally disordered youth on the secondary level requires the cooperation of many adults, both in the school and the community. In the school it is now necessary to maintain a rather permanent cadre of professionals for the purpose of identification, placement, and educational planning for handicapped students. This cadre generally consists of a guidance counselor, a social worker, a school psychologist, a representative of the special education

department, teachers (both the referring and receiving teachers if possible) and, by law, parents of the child being considered. The principal should designate from his staff a person whose responsibility it is to coordinate and conduct meetings of these individuals.

The principal must also provide a direct line of communication with the parents of students with behavioral disorders. Many active, intelligent, and supportive individuals are forming parent groups as a result of the federal mandate for parent involvement in the educational process. If such parents are included in the planning process, they often become valuable allies. Conversely, if the principal does not make the necessary effort to include them, these groups are likely to become adversaries.

Promotion, Retention, and Graduation

In recent years many states have instituted rather rigid criteria for promotion, retention, and graduation which apply to all students in the secondary school. If handicapped students were expected to achieve according to a rigid set of standards in the middle school and lower high school years, the failure and retention rate would be astronomical. To avoid the practice of retaining students in the same grade for unconscionable lengths of time, some systems limit the number of times a student may be retained. Some states have formulated a battery of tests to determine the type of diploma a student receives upon graduation. Students failing such tests in the eleventh grade are placed in smaller classes for compensatory education. Following such assistance, tests are administered at least a second time. If, in the judgment of local education officials, the student has not mastered the basic information covered by the tests, he is then granted a "certificate of completion." On the other hand, if he satisfies the demands of the tests, he is granted a regular high school diploma which connotes a higher degree of academic performance.

The implementation of such functional literacy testing creates many questions in the minds of those dealing with students whose behaviors do not contribute to outstanding, or in many cases, even average academic achievement. If handicapped students are forced through the same program in lockstep with their normal peers, many or perhaps most of them will be destined to receive the second-rate diploma. Solutions to some of these problems may be found through the proper use of the IEP.

Evaluation of Student Progress in Nonacademic Areas

Any educational determination affecting children with behavior disorders must consider the severity of the handicap. If the professional staff decide that the student is capable of mainstreaming only in the nonacademic areas (i.e., physical education, music, art), then any evaluation of his progress should be accomplished primarily by use of the IEP. Statements in the IEP regarding the extent of participation of the severely disturbed student in nonacademic mainstreamed areas should be agreed upon by the regular teacher and the special teacher. (The more severe the handicap, the more educational control must be maintained by special education personnel.)

Evaluation in Regular Academic Classes

A decision by the staffing team to place a student in a regular academic class calls for yet a different set of procedures. The IEP is the key to the success or failure of the mainstreaming concept. The process of writing the IEP includes most of the sound procedures now known for planning educational experiences for students with behavior disorders. All available data pertaining to the student are gathered and analyzed by a group of professional educators. The results of deliberations during the construction of the IEP simply must reflect realistic goals for the student. If these plans are appropriate, it is reasonable to expect the handicapped child to function in the selected academic areas according to the same standards as other students. On this basis, the mainstreamed youngster should receive grades on a comparable level with the regular student. If this situation results in failure, then the IEP must be rewritten and the team must conclude that their original decision to place the student in a regular class was in error.

Testing and Promotion

When regular students are promoted or retained by measured performance on a predetermined set of criteria, the severely handicapped student will suffer by comparison. A special assessment instrument should be constructed for use with these special children. Flexibility must be built in to such an instrument, taking into account such variables as vocabulary, setting, questioning techniques, and recording of answers. Modifications should be made to the standardized tests to allow for the known deficits of the handicapped student. Any movement or significant change in the program of a handicapped student should, however, be the result of an extensive staffing rather than performance on a standardized test. These movements and changes include the decision either to promote or retain.

CONCLUSION

No single discussion could include all of the factors essential to the success of a program for adolescents with severe behavior disorders. There are a myriad of problems which have not been addressed, including the skills and characteristics of the faculty. Assuming, however, the presence of qualified and concerned personnel, the implementation of the components discussed should prove to be successful in the regular secondary school.

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SECTION II
ELIGIBILITY AND SERVICE ISSUES

Papers in this second cluster address different aspects of defining the population to be served and its needs. Who are these students whom we refer to as behaviorally disordered and emotionally disturbed? On what basis do we apply these labels to them? What services are appropriate for them, and how are they to be provided?

The papers by F. H. Wood; Cullinan, Epstein, and Reimers; Zabel, Peterson, Smith, and White; and Neel and Rutherford focus directly on these questions. The papers by Wood and by Neel and Rutherford take a broad look at present practice and call for change. Those by Cullinan, Epstein, and Reimers, and by Zabel and his colleagues suggest some specific ways to make assessments more valid and useful. Smith's paper is a pointed critique of proposals that the school be responsible for providing psychotherapy for pupils labeled seriously emotionally disturbed. Smith states his argument strongly, and while none of the individual papers submitted for possible inclusion constituted a clearly representative view, Smith makes it clear that he intends his paper to be viewed in light of the ongoing debate on this issue.

The paper by Webber, Gilliam, and Davis focuses most directly on the competencies needed by teachers for those seriously behaviorally disordered children considered to be autistic. Ultimately, however, their discussion also traces back to a definitional issue: the designation of a particular group of behaviorally disordered students as sufficiently different from the larger population to require unique skill training for those who would teach them. We need to think carefully about the implications of such specialization within the field of education of the behaviorally disordered. Are our abilities to define and describe well enough developed to permit or require further differentiation in our training so as to match the special needs of other subgroups of the disordered and disturbed population? The recent decision by the Office of Special Education to report the number of autistic students being served under the category of other health impaired, removing them from the category of the seriously emotionally disturbed, does not resolve the issue of the skills needed by those who teach them.

THE INFLUENCE OF PERSONAL, SOCIAL, AND POLITICAL FACTORS ON THE LABELING OF STUDENTS

Frank H. Wood

Most of the discussion about the effects of labeling on people focuses on the social implications of negative labels. Little concern is expressed about the self fulfilling prophecy implications of labeling Fred "handsome" when he is actually only "average" in looks according to an objective standard, or of labeling Mary "superior in mathematics" after she answers correctly to nine out of ten questions on basic addition facts. However, our concern *is* aroused when someone labels Jimmie "behaviorally disordered" or "emotionally disturbed," if we feel that his behavior is not that disturbing to us.

THE VALUE CONFLICT IN LABELING

Our preoccupation with the harmful effects of negative labeling is an appropriate reflection of our optimistic belief in the potential for positive growth inherent in all people, a potential that must be nurtured and shaped without harsh trampling. Labels such as "emotionally disturbed" do have strongly negative effects on those so labeled, on how they perceive themselves, and more importantly, on how others perceive and act toward them.

But—are not some people *really* "emotionally disturbed"? "It is all well and good to be enthusiastic about people's potential for positive growth, but look at Jimmie's teeth marks on my arm," a teacher says. "Give me a positive label for that behavior in a 12 year old!" We face a dilemma about what labels to use in talking about that real world in which beautiful little children scream and tantrum, kick and bite others, and hide fearfully under beds or in closets. While an analysis of the labeling process often used by special educators will not—and should not—make us more comfortable about using negative labels, it can help us use them in ways that are professionally responsible.

To Label or Not to Label

Is there indeed something negative and hostile in the definition or classification of children as "handicapped" and deserving of special treatment by professionals in educational and caretaking roles? If so, why do we do it? And furthermore, why do we persist in focusing on one person (nearly always the child) as the "locus of the disturbance" when, as Rhodes (1970) has argued persuasively, the real locus is the "encounter point between the child and the microcommunity or microcommunities which surround him" (p. 310). The viewpoint expressed here is that while there is inevitably a negative and hostile aspect to the naming and valuing of behavior as "disturbing, disturbed, or disordered," there is frequently also something positive and well intentioned. It is this duality of valence in our definition of others as being in need of special services that sparks the continuing debate about its morality. When the positive aspect is weak or missing, the process of defining slips into mere labeling. We cannot fully understand the ethical dilemma we face as special educators unless we recognize the mingling of both positive and negative elements in any act of definition.

In a 1970 article, Rhodes drew from ethological and sociological literature to support his argument that labeling of "different" behavior as "deviant" or "disturbed" is aggressive. Analogizing from Lorenz' observations, he compared the extreme arousal of rat colonies to the presence of a strange rat (often leading to the killing of the "stranger") to the disturbance created in human groups by the presence of one whose behavior is perceived as intolerably different from the norm. Our response to disturbing behavior includes actions of controlling, restraining, and even punishing that are clearly aggressive. From a social learning viewpoint, such behavior will be reinforced in the aggressors (or in observers of the aggressive behavior) if it leads to a cessation of the disturbance, which would help explain why the punishing behavior Rhodes has protested continues to occur.

However, certain aspects of human behavior toward those whose differentness is disturbing remain unexplained by the aggression hypothesis alone. First, unlike rats, humans seldom aggress so violently against the individual viewed as the focus of the disturbance as to kill him. Second, in many instances, and notably in those where the behavior of individual children and youth is regarded as disturbed or disturbing, we describe our defining and intervening behavior to ourselves and others as succoring, nurturing, or "caretaking." Rhodes may be correct in suggesting that the patterns of behavior aroused by deviant individuals have some determinants that are deeply biological rather than purely cultural in nature; but these responses may include caring as well as aggressive behavior toward the disturbing others. The research of various sociobiologists and ethologists as summarized by Wilson (1975, 1978) provides support for such a hypothesis.

Both response tendencies must be taken into account if we are to understand the behavior of caregivers in our society, for our response to the "deviant" individual is complex. Our aggressive responses conflict with our nurturing responses, both being deeply rooted in our

biological makeup and strongly, if differentially, reinforced by society. This helps explain why behavior in one situation is inferred to be aggressive, while in another it may be inferred to be caretaking.

Ambivalence about Defining and the Behavior of Special Educators

As a step toward applying these ideas to an understanding of the deviance-defining activity of special educators, we can begin with an analysis of different responses by people in differing roles to the variant behavior of individuals and how their responses may influence the treatment of those individuals. The explanation offered begins with the well established observation that complex dominance hierarchies are characteristic of all human societies. While these dominance hierarchies are relatively stable, they show changes related to time and setting. Factors yet not fully understood seem to produce a balance between the stability needed for social survival and the flexibility necessary for social vitality.

Humans have developed socialization techniques for training the members of their groups to respond in age-appropriate ways to common social situations. When a group member is "not developing normally," i.e., is failing to show age-appropriate behavior, the sense of disturbance in the group is pervasive. The "community" as well as the family responds with concern. Failures to learn the complex behaviors associated with the dominance system are especially disturbing. These include not only failures to respond appropriately to the dominant behavior of social superiors, but also failures to respond as expected to nurturing behavior and to situations where resistance to the aggression of dominant individuals or competition for dominance is considered "normal." These failures disturb not only the individuals who are the variant's superiors, but his or her peers and subordinates as well.

Critics of labeling have tended to defend the rights of individuals to be "deviant" and have suggested that aggressive efforts to change their behavior in the direction of greater conformity to the group norm result from their perceived threat to the existing power structure of the society. If one accepts the hypothesis that human caretaking behavior includes both nurturing and aggressive elements, this seems an oversimplification.

Interventions to change the disapproved or inappropriate behavior tend to be made by dominant members of the group, or at least are directed or sanctioned by them. When a group is disturbed, dominant individuals are expected to respond so as to help the group contain and quell the disturbance, and to continue to respond until the disturbance ceases. Depending on the severity of the disturbance, the group will sanction their use of varying degrees of aggressiveness in this process. Dominant individuals serve as well as direct the group, however, and they are simultaneously expected to express the group's nurturing impulses toward the variant individual, who is viewed ambivalently as "hurt" and in need of succor as well as "deviant" and in need of correction. Dominant individuals must strike a balance between selfishness and altruism with which their group feels comfortable or risk displacement from their position in the dominance hierarchy. Ignoring the group's disturbed state is seldom an acceptable response.

Critics of current caretaking procedures (Rhodes, 1967, 1970; Szasz, 1961) play an important role in generating the social pressures that restrain aggressiveness in the socializing behavior of caretakers. In actuality, those in critic roles may also be members of the dominant group in the society. In Figure 1 it is suggested that the response of dominant individuals to the group's disturbance appears to be broken down into a number of discrete "roles," any one or all of which may be filled at different times by the same individual. At one end of the continuum are roles in which individuals who are themselves well up in the dominance hierarchy of their own social group express the group's concern that the dominant "they" are not behaving toward the variant individual as "we" would wish. At the other end of the continuum are roles in which dominant individuals act out "our" desperate need to have the disturbing variant behavior controlled or stopped, lest it destroy the stability of the social system. Most of us run the range of this continuum at one time or another.

If we relate this continuum to special education programing, we will place those who criticize the present system as too harsh and repressive at the more nurturing end. Child advocates and those who develop alternative schools are also among those stressing the need for society to be more accommodating to the "different" behavior of some students. Advocates of mainstreaming and many special educators fill roles in the middle ground, seeking to balance their use of strong interventions by simultaneous efforts to promote more accommodation to individual differences. Most regular educators probably fill a more strongly socializing role, reflecting a social consensus of what constitutes "safe," age-appropriate behavior in their expectations of pupils and strongly rewarding conformity to those expectations. Occurring less often in the schools, but tolerated under certain conditions, are the punishers of nonconformity. The author hypothesizes that the distribution of individuals along this continuum at any one time is markedly skewed to the left. Empirical data are needed to support this statement, however.

The position that we take in any discussion of definitions of behavior disorders will be determined in part by our role on the continuum. In situations where we fill the role of a "critic" or "reformer" and demand that the group be more nurturing toward those whose behavior is deviant, we are likely to be critical of the entire effort to define, rejecting it as punitive labeling and refusing to become involved. Those of us at the extreme change-advocating end of the continuum may even seek to halt group efforts to discuss definitions or, failing that, disrupt them as much as possible. Those who press forward to discuss alternative procedures for defining and related interventions also frequently divide into contending groups, but in this case the disagreement focuses on the verbal adequacy and usefulness of the definition under discussion. When "critics" are present during such a discussion, they often become allies of those arguing the technicalities of a given definition. Indeed, those who oppose a particular definition will often shift to the critic role and begin to argue against the defining process itself. Our previous discussion has suggested how strongly determined the impulses that contribute to these behavior patterns may be. An awareness of how they interact can help us understand what is going on in some of our own meetings.

SOCIAL CRITICS ... REFORMERS ... RECONCILERS ... SPECIAL & REGULAR EDUCATORS ... DEFENDERS OF STATUS QUO ... PUNISHERS

"Society must be more nurturing."
"Accept 'deviance' as normal, even healthy."
"Change the society."

"Society is too tolerant."
"Standards must be maintained."
"Change the deviant."

PRESSURES FOR NURTURING

PRESSURES FOR AGGRESSION

FIGURE 1: The dynamics of social ambivalence about labeling.

This tension has been reflected in the history of special education over the past 25 years. Arising from a sense of disturbance over failures to adequately socialize certain "exceptional-variant" children and youth, programs continue to be directed for the most part by models that stress changing the deviant individual to fit the expectations of the group rather than the reverse. Our definitions have stressed the "disordered" and "disturbed" aspects of the individual's socially disapproved behavior without giving sufficient attention to its interpersonal context. The result has been frequent lapses from description and classification into the negatively valenced labeling behavior so rightly criticized as more punitive than therapeutic in intent. But justifiable criticism of labeling and of the pro-majority bias of *any* definition of behavior disordered/emotionally disturbed behavior does not guide us to more appropriate description and classification procedures. To attain that goal, some of us must be able to try new procedures again and again, chastened but not immobilized.

The Appropriate Use of Negative Labels

Ideally, labels that define others as "ill" or "defective" should be used only in ways that stimulate a therapeutic, healing response. Using them to hurt or demean others, or to deprive them of their rights or property, is not ethical professional behavior. But there's the dilemma again. One cannot use these negative labels to obtain help without simultaneously hurting those to whom they are applied. And these labels do hurt, sometimes so much that people will give up the opportunity for treatment rather than accept the label. As a prisoner said to a judge in refusing to accept a plea of insanity made on his behalf by his lawyer, "I may have robbed and beat up some folks, but I sure as hell ain't crazy." As an adult, he could protest that label. The children and youth with whom we work often lack even that right.

There is no simple rule to guide us in our use of the power to label negatively. Simple rules describe relationships between objectively defined variables. Appropriate labeling involves professional judgment about the best obtainable balance between healing and hurting. Exercise of that judgment, despite our training and experience, is a matter of personal subjective valuing. *We* are the labelers.

Several possibilities exist for limiting the injury inflicted when we apply negative labels. One strategy is to keep the label remote from the student who is labeled, thus avoiding the negative side effects. For example, in theory this is done in the child count procedures used by school systems to qualify for funds available under the provisions of Public Law 94-142. The count data, although presented in terms of special education's traditional categories of disability, are anonymous—a list of numbers rather than a list of names. In another example, at the building level, classes, rooms, and teachers are given general labels such as "special," or untranslated acronyms such as SLBP or EH. But people are not fooled by such procedures for long. Students invent their own negative labels for their peers who attend such classes, like "mental" or "stupies." *Negative labels do not stay remote if they serve as the basis for some action.* Appropriate management of the effects of negative labeling requires that we face the problem more directly. To do this, we must

understand the social and political implications of the labeling procedure at a deeper level. We must understand exactly what we are doing when we, as teachers, assess the social and personal adjustment of others, as we describe, value, and label.

STEPS IN LABELING BEHAVIOR AS DISTURBING, DISORDERED, OR DISTURBED

We are constantly evaluating the behavior of others as pleasing or disturbing to ourselves. Figure 2 (Steps 1-6) summarizes a general procedure teachers might follow in labeling student behavior as "disturbing, disordered, and/or disturbed." (Note that throughout this paper the word "teacher" is used. The same procedures are used by other professionals with a few modifications.) While we may often so overlap and jumble the process that such steps are not clearly differentiated, listing them in this way provides a guide to assist us in observing, understanding, and monitoring our own behavior.

Despite guilt-arousing statements to the contrary, we have a right to be disturbed by the behavior of others (Step 2). There is nothing wrong about not liking to have someone hit or shout at us, or worrying when someone sits quietly in a corner watching the movement of light patches on the wall for long periods of time, not returning the social greetings of others.

Sometimes, however, the feeling of disturbance is only momentary and quickly drops from our consciousness with no action on our part (Step 3). In such situations, this feeling does not lead to direct action against the source. Perhaps we do not feel it our duty to act; or, because our social authority is not clear, we feel insecure about acting; or we feel impotent to act effectively. Usually, in such circumstances, we escape the stimulus for disturbance by walking away or waiting until it ends, or less happily, by simply trying "to live with it."

The dynamics change when the disturbed person is a teacher and the disturber is a student assigned to that teacher's class or school. Instead of being a loosely structured situation involving persons of undefined or more or less equal social status and power, school situations where disturbance arises involve persons with well defined differences in social authority. Schools are sociopolitical institutions in which persons in authority roles (teachers, administrators, psychologists) have accepted the power invested in those roles to make decisions about what is appropriate or inappropriate behavior from those in subordinate roles (students). This ordering of the school is implicitly accepted by most teachers and students. Thus, while both teachers and students disturb each other by their behavior, teachers much more frequently initiate action against students than vice versa. Students who act against teachers in spontaneous defense of themselves usually find little support from peers and the community.

However, this does not mean that teachers act with equal degrees of energy to label the behavior of students who differ in social status in the school and the community (Step 4). The labeling process as it unfolds in schools is much more influenced by subtle social and political

Step 1: Teacher's attention is attracted to the behavior of a student.

Step 2: Teacher decides whether behavior is pleasing or disturbing.

(Continue if teacher finds student behavior disturbing.)

Step 3: Is teacher disturbed sufficiently to take some action to change or stop the disturbing behavior?

(Continue only if teacher finds behavior sufficiently disturbing to take action. This can be the result of accumulated instances of being disturbed. If teacher is not sufficiently disturbed to take action, his or her awareness of the disturbing behavior usually begins to lessen.)

Step 4: Teacher wishes to take some action to bring an end to the disturbance. What alternatives exist?

A salient factor to be considered is the interpersonal power characteristics of the situation. Based on appraisal of social and political factors, the teacher may decide to do nothing, to act immediately, to seek alliances with others who will support taking action to stop or change the student's behavior, or to escape from the situation through transfer or resignation.

(Continue if teacher's decision is to take action, alone or in alliance with others.)

Step 5: Teacher's first action is to have student's disturbing behavior labeled publicly as disordered, disruptive, or problem. Often, at the same time, an additional label suggesting the perceived severity of the problem is attached by the labelers: mild, moderate, severe.

(Continue if labelers wish to make or can make inferences about the causes of the disordered behavior.)

Step 6: Teacher (by now usually acting in alliance with social workers, psychiatrists, psychologists, and others who lend political authority to the labeling process) infers that the student's disturbing behavior is a function of past learning and present environmental factors. Preferred label: behaviorally disordered. Preferred interventions: behavioral.

AND/OR

Teacher infers that the student's disturbing behavior is a function of past experiences and present inner emotional state. Preferred label: emotionally disturbed. Preferred intervention: psychodynamic.

FIGURE 2: How teachers influence the labeling of student behavior as behaviorally disordered/emotionally disturbed.

factors than many teachers realize. For example, as Levine (1976) has pointed out so effectively in discussing the development and use of standardized tests in the school, "The intelligence test and the achievement test were constructed and validated by methods that ordered not only individuals but, inadvertently, social classes..... In each instance, test findings supported the positions of dominant groups in the society" (pp. 230-231). Tests or other assessment procedures which lead to the classification of substantial numbers of upper and middle socioeconomic status students as "below average" or "deviant" in achievement; intelligence, or behavior, are simply not used in this nation's schools. On the other hand, measures of "general intelligence" on which culturally and linguistically different students do not score well continue to be used in most states, despite court decisions that underline their fundamentally discriminatory effects. As a matter of fact, the opinion of the teacher and administrator of the referring school, supplemented perhaps by a statement from a school social worker or school psychologist, is usually sufficient to establish the "need" for special programing for behavioral reasons of a low socioeconomic status student. By contrast, outside support in the form of a full clinical report may be necessary in the case of his or her higher socioeconomic status classmate.

Other factors also have an effect on our action when we are disturbed by the behavior of another. Cultural and language differences, related to ethnicity or religion, may be a factor. In most cases, the power equation favors the teacher, but not always. For example, students are sometimes able to mobilize support from their home and community by stressing the "bias" in the behavior of the teacher. Advocacy organizations may also come to the support of the student. When this happens, an adversarial situation develops in which both teacher and student, disturbed by the behavior of the other, label each other's behavior as "disturbed." Occasionally, the outcome of such confrontations may appear to an impartial observer to be unfair to the teacher. In most cases, the teachers' status will be sufficient to enable them to reject the efforts of students and their allies to label them. However, the end result will almost always be the labeling of someone as the principal bearer or the problem. This pattern, we may note, generally describes what happens in actual practice. The accuracy of Rhodes' (1967, 1970) description of disturbance as fundamentally a problem of the social system rather than an individual is not being contested. In practice, however, school people are not acting from an ecological perspective. In the end, it is an individual, usually the student, who is labeled the "behavior problem" (Step 5).

The bearer of the disturbing behavior has now been given his or her first negative label. The behavior, and by implication, the behaver, will now be openly described as a "problem" or as "disordered." To the extent that this labeling is public, the student becomes the focus of the attention from others who are looking to see what and how much is wrong with his or her behavior. Judgments of the severity of the disturbed behavior quickly become attached to the original label: mildly disordered, moderately disordered, severely behaviorally disordered. The process does not necessarily stop here.

Human beings like explanations about the reasons for events they observe. Some of these explanations are based on scientific knowledge; many are only plausible, sanctioned by popular opinion rather than solid fact. The question about why a person's behavior is disturbing and disordered has been answered in many different ways over the years. Foucault (1973) and Szasz (1961) are among the recent writers who have reviewed the history of explanations of disturbing behavior. Rhodes and Paul (1978) have discussed a number of the current views which stress (singly or in combination) genetic, physiological, interpersonal, and societal factors that may contribute to disturbing behavior. The two hypotheses most often used by teachers and school personnel are (a) the "behavioral" view," which stresses the importance of environmental factors in the shaping of behavior, and (b) the "psychodynamic" view, which stresses the importance of thoughts and feelings internal to the behavior. Neither view is solidly based in fact in all particulars. The concept of "emotional disturbance" as the explanation of the observed, disordered behavior requires an inference about the inner state of disequilibrium and conflict in the individual. Such inferential assessment fits the theoretical constructs associated with the psychodynamic view. Because P.L. 94-142 requires that students be labeled "seriously emotionally disturbed" in order to be eligible for the funding it provides, this terminology with its implicit hypothesis about the causation of disturbing, disordered behavior is generally used in the schools. However, many who use this label for reporting purposes make only the most superficial inferences about inner disturbance. Those who work from a behavioral perspective actually resist the idea that inferences about covert behavior are valid. They use the label "emotional disturbance" only because it is required by the law.

The label "emotionally disturbed" brings with it associated folk beliefs about the causation of disordered behavior such as parent-child conflict, inherited mental disease, "craziness," etc., which make it a particularly negative label for students and their families. Parents who will accept from school personnel an assertion that their child's behavior is "disordered" may resist the application of the label of "disturbance" because of these associations. At present, this resistance often leads school personnel to compromise on the label used. Students whose major problems are in the area of social behavior may be served under the label "learning disabled" if their academic achievement is sufficiently retarded to justify the use of this label. Even though all parties may recognize the social nature of the student's difficulty, this label is more acceptable to parents because it is less frequently associated with family conflict or poor child rearing practices.

One result of the avoidance of the labeling and classification of students as "seriously emotionally disturbed" is the comment of many special teachers trained to work with learning disabilities that they are expected to work with too many students with behavior problems. Here again, we have an instance where the social and political aspects of the labeling process demonstrate their potency. As an aside, it might be noted that if the principle of serving the student in the "least restrictive environment" were broadened to a concept of serving the student under the "least negative label," what actually takes place

is very defensible. The problem thus becomes one of changing teacher expectations and helping them acquire the skills they need to teach a behaviorally challenging class of students.

EMOTIONAL DISTURBANCE VS. SOCIAL MALADJUSTMENT

The definition of "seriously emotionally disturbed" presented in the regulations implementing P.L. 94-142 (*Federal Register*, 1977) includes a phrase specifically excluding students whose behavior is labeled "socially maladjusted but not emotionally disturbed" from the group eligible for service under the law. The regulations do not elaborate on the criteria to be used in differentiating the socially maladjusted from the emotionally disturbed. This discrimination, with its obviously important impact on the educational programing provided to some students, provides a useful illustration of the critical role played by personal value judgments in the application of a label. Figure 3 has been drawn to clarify aspects of Figure 2 important to this discussion.

Two value judgments are made in labeling a student as "emotionally disturbed" or "socially maladjusted but not emotionally disturbed." The first is made on the basis of our observations of a student's behavior. This is our professional judgment that the behavior is "disordered" as well as disturbing to us. The second value judgment is not made directly on the student's behavior, but on our subjective inferences about the student's inner emotional state as inferred from observations of his or her behavior. We and our fellow professionals may disagree about whether the observed behavior is indeed disordered rather than an appropriate response to a difficult situation. We are even more likely to disagree about the relevance and meaning of our inferences about the behaver's inner emotional state at the time the disturbing behavior occurred.

The phrase "social maladjustment" is generally interpreted as referring to antisocial behavior by children and youth that brings them to the attention of police, the courts, and the related correctional system. There are some interesting differences between the courts and the schools concerning the role played by inferences about emotional disturbance in the decision making process. In schools, if a student's behavior is judged by professionals to be disturbing or disordered, the student "qualifies" for disciplinary action but not for attempted therapeutic educational programing. In the courts, if a student's behavior is judged to be indicative of disturbance as well as being disturbing, disordered, and criminal, he or she may be assigned to therapeutic treatment and returned to the community instead of being punished or given corrective rehabilitation. Critics of both systems challenge the authority of professionals to make such judgments. For example, at the 1980 annual convention of the American Psychiatric Association, Thomas Szasz, a well known critic of his own profession, is reported to have charged (Newlund, 1980) that "psychiatrists are guilty of 'crude intellectual sleight of hand' when they testify in support of an insanity defense" (p. 7B). Szasz argued that criminal behavior is criminal behavior and refers to the inferences made by defense psychiatrists as

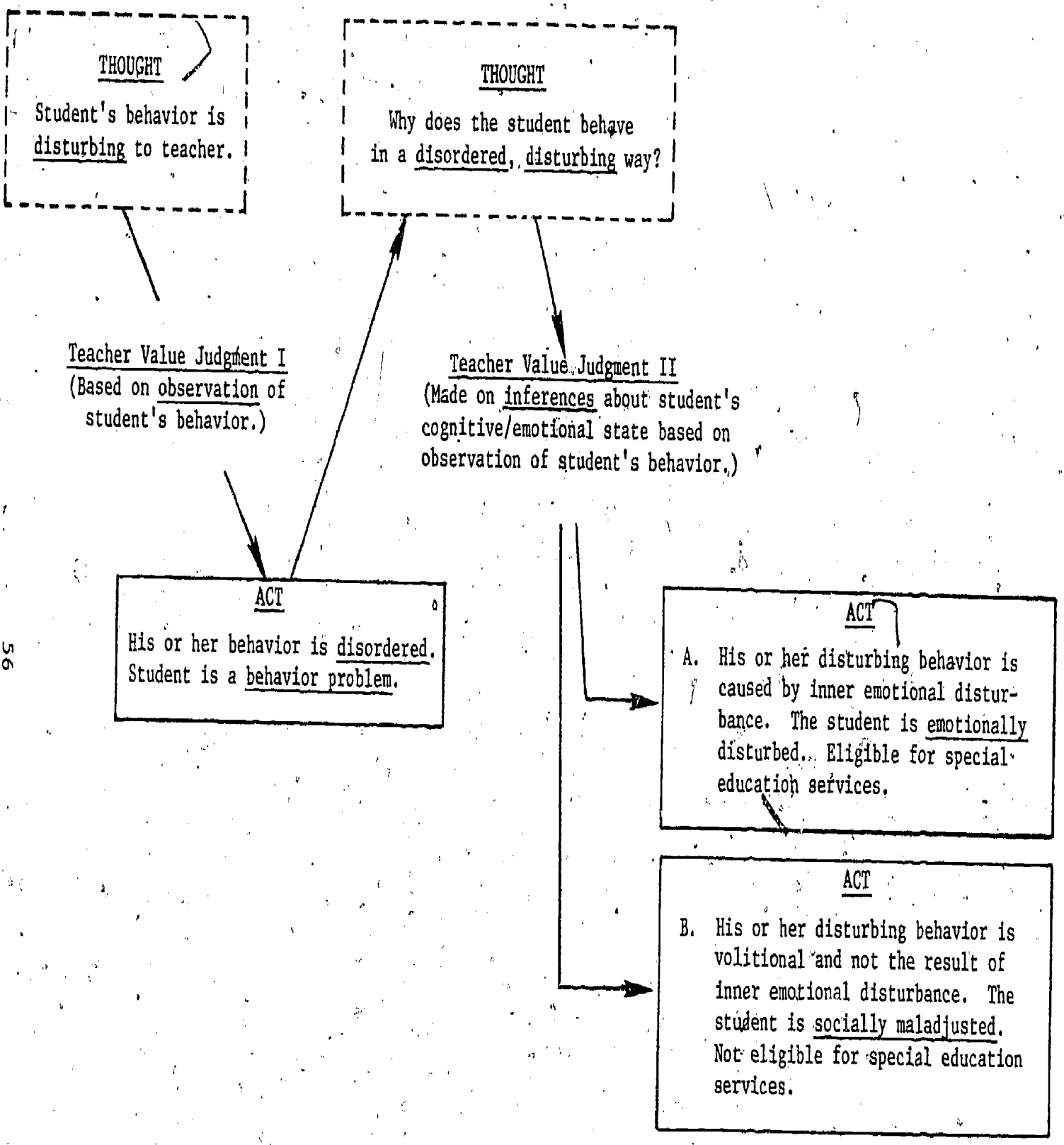

FIGURE 3: The process of deciding if a student is emotionally disturbed or socially maladjusted.

"fantasies legitimized by the courts as expert medical testimony" (p. 7B). In like manner, educators are encouraged by P.L. 94-142 to attempt the reverse discrimination—to deny special programing consideration to students on the basis of inferences that the behavior of those students, while disturbing, is "only socially maladjusted" and not indicative of emotional disturbance.

Professional value judgments are required to make any special educational system work. Such judgments are professional in the sense that they are made by persons who are skilled in gathering relevant information on which to base them and who understand what is being done in valuing that data, *but they are also personal, subjective, and influenced by social and political factors.* Sensitive professionals should always remain a bit uncomfortable about this aspect of their work. A few who are made too uncomfortable by their participation in the present system may seek relief by withdrawing from it completely, or by becoming critics while developing some personal compromise with the system, as Szasz has done. The important thing is to be sensitive to and honest about one's own position and to demand similar sensitivity and honesty from one's fellow professionals.

LABELING AND ASSESSMENT

How does the application of labels as a social and political procedure relate to our attempt to describe good professional practice for special educators of the behaviorally disordered and/or emotionally disturbed? How can we minimize the intrusive effects of bias related to social status and cultural difference? The first step, as already mentioned, is to understand that it is indeed that kind of process. The second step is to introduce into the record for each student as detailed and objective a description of his or her behavior as possible. Despite the inevitable reliance, at critical points of the process, on private value judgments by individuals whose personal as well as professional backgrounds affect their decisions, the record can contain a substantial amount of written descriptive material related to each decision. The third step is to be certain that labeling decisions are group rather than individual decisions, and are made by groups that include persons familiar with aspects of the student's background, language, and culture that influence his or her behavior.

As professionals we need to be able to say for the record (and that means publicly if necessary), "This is the behavior that disturbs me," and then go on to describe that behavior in its social and physical context as completely and objectively as skill and available resources permit. The professional can say, "The behavior described here is that which I am calling 'disordered,'" and relate the observed frequency, duration, and intensity of that behavior to whatever information is available about the range of similar behavior in the student's classroom peer group as well as in local and national samples. Finally, the professional can say, "This is the behavior that I believe indicates an underlying, internal condition that warrants the label 'emotional disturbance.'" Good professional practice, then, combines descriptive

information about the student with public value statements ("I" statements) based on those descriptions. Also, accepting the assumption that professional judgments are inevitably biased by personal and social factors, it is clearly important that the final step of decision making be taken by groups that provide checks and balances for the biases of individual participants. Students whose behavior is influenced by their socialization in culturally and linguistically different communities must be represented in these decision making groups by professionals qualified by personal experience to sensitize their colleagues to these important background factors. Most parents, regardless of their community status and educational background, lack the professional status and technical expertise to fill this group role effectively.

The professional practice issue is that of description and assessment, of openness about value judgments, and the acceptance of a professional responsibility to monitor one's own biases in decision making. Here, there has been some improvement in practice in special education during the past decade. Special educators of the behaviorally disordered/emotionally disturbed have moved from heavy reliance on status measures such as personality tests and behavior checklists to the use of procedures for recording behavior observed in classrooms and other natural settings. Measurement procedures that meet an ecologist's criteria for validity are so complex and comprehensive that they are difficult for teachers to use. However, there are a number of simpler procedures that yield data that can be interpreted from an ecological perspective, although they focus on individual students in interaction with teachers and peers. Wood (1980) has discussed some of these that seem appropriate for use by classroom teachers. Other good sources of information about procedures for more accurate assessment can be found in sources such as Hewett and Taylor (1980), Rhodes (1975), Smith and Grimes (1979), Walker (1979), M. M. Wood (1979), and Weinberg and Wood (1975). Regardless of the method chosen, the professional responsibility of the special educator is to choose a method for describing behavior that will withstand public review. The information recorded and the behavior described should be shown to be the basis for the value judgments made by an informed, sensitive group in the classification of any student labeled "behavior disordered" and, perhaps, "emotionally disturbed."

RELATING ASSESSMENT TO INTERVENTION

Because sound assessment is the foundation on which the rest of a special education program is based, it has been stressed in this paper. However, unless assessment leads to therapeutic intervention, it is irrelevant. As earlier stated, the only justification for negative labeling is to mobilize a healing, therapeutic response. At one time, teachers relied too much on psychologists and other professionals to assess their students. As a result, many clinical assessments by other professionals were felt by teachers to have little relevance to educational planning. As teachers began to assert their needs more aggressively and to develop on their own the needed assessment skills, social workers, psychologists, and psychiatrists began simultaneously to move

out of the clinic and into the school. As a result, we have begun to develop a number of good models in which assessment is related to educational programing procedure. Hewett and Taylor (1980), Walker (1979), and M. M. Wood (1975) are examples of the models for practice becoming available to special educators.

One important feature of the assessment procedures used by special educators is their adaptability for use in monitoring student progress. In general, other professionals see special students only periodically. Thus, they are satisfied with status measures obtained at long intervals. While such status measures may reveal long term changes in student behavior, they are not adequate to guide daily instructional planning. Teachers need to become proficient in assessment procedures that lend themselves to repeated measures. Such procedures are discussed in several of the sources cited.

An Action Plan

Our present procedures for assessing and classifying students as disturbing, disordered, or disturbed are unsatisfactory to professionals, parents, and students. Here is a suggested action plan to change this situation, beginning with a change in perspective on how we function as labelers of the behavior of others.

1. We must develop awareness of the ways in which personal, professional, social, and political factors influence our labeling of students with special needs as disturbing, disordered, or disturbed.
2. We must develop our skills as observers and describers of the behavior of students and teachers in school situations.
3. We must develop descriptions of the range of typical student/teacher behavior in school situations to replace our old descriptions of "average" or "normal" behavior. These descriptions must give appropriate recognition to situational and cultural factors
4. We must develop our skill in analyzing the differences in the behavior of individuals across situations, both in and out of school.
5. We must require that decisions about the labeling of student behavior be group rather than individual decisions, and that decision making groups include professional persons who from personal experience can sensitize other group members to the significance of unique cultural and linguistic factors in understanding a student's behavior.
6. We must develop skill in isolating the key interactive factors that make a difference in student learning so as to increase our personal and professional competence in assessment, placement, and instruction.

Special educators still have much to learn about assessment, educational decision making, and the implementation of intervention. It will be a long time before we can meet the stringent criterion of using negative labels only in ways that stimulate a therapeutic, healing response from the student's ecosystem. But the evidence is strong that we are making progress toward this goal. Acknowledging the personal, social,

and political influences on our decisions about whether students are behaviorally disordered, emotionally disturbed, or socially maladjusted will take us a good step along the way. While it will be helpful for raising the general level of professional practice to have principles like those just presented made school policy, the responsible special educator will apply them to her or his professional behavior without waiting to have them mandated by others.

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SOCIAL VALIDATION: EVALUATING THE EFFECTIVENESS OF INTERVENTIONS WITH BEHAVIORALLY DISORDERED PUPILS

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Constance Reimers

Applied behavior analysis can be defined as the application and experimental evaluation of procedures for changing socially important behaviors within applied settings. Attention to several important considerations is required in applied behavior analysis (Baer, Wolf, & Risley, 1968; Kazdin, 1975). First, as an empirical science, applied behavior analysis is concerned with measurable phenomena, chiefly observable behavior patterns that are to be changed (target behaviors). Target behaviors have to be defined carefully enough so that their occurrence can be reliably determined. Additionally, for the duration of a behavior change project, repeated observation and recording of target behaviors takes place, usually according to conventional behavior assessment procedures (see Repp, 1979). Data thereby produced are used to guide various decisions; for instance, the record of target behavior arising from an initial period of assessment-only ("baseline") is examined for implications affecting the selection of a behavior change technique (Sulzer-Azaroff & Mayer, 1977). Third, following baseline, an intervention is applied to change target behavior. Applied behavior analysis interventions involve altering specific environmental events that influence target behaviors, usually consequences for behavior or consequences plus behavior antecedents such as rules, requests, demonstrations, or instructions. Details of the growing body of demonstrably effective behavioral interventions are available from numerous sources (Axelrod, 1977; Sulzer-Azaroff & Mayer, 1977).

These three practices--providing an operational definition for each target behavior, regularly recording it over time, and applying an intervention--permit the teacher or other professional to determine the extent of behavior change by comparing behavior records during baseline to those during intervention. However, modifications in behavior cannot be attributed to the intervention with much confidence unless they are evaluated through the use of some experimental design. Single subject research designs, including reversal, multiple baseline, changing criterion, simultaneous treatment, and other varieties of single case experimentation are preferred in applied behavior analysis (Cullinan, Epstein,

& Kauffman, in press; Hersen & Barlow, 1976). Verification of a functional relation between intervention and modification of target behavior, then, is the fourth major aspect of applied behavior analysis. Further, while reliable behavior change in a predicted direction, even though small in magnitude, may have theoretical value, applied behavior analysis is concerned with improvement that is substantial and evident soon after intervention is begun (Baer et al., 1968).

When is "substantial improvement" sufficient to be of real value to the person whose behavior changes and to the community setting in which she or he exhibits the behavior? Recently, increased attention has been directed toward the need for social validation of behavior change--the need to develop criteria for judging the relative importance of behavior changes achieved through behavioral interventions. The concept of social validation was suggested early in the history of applied behavior analysis (Baer et al., 1968), and illustrations of this concept have occasionally appeared in the literature since that time. However, there is now renewed interest in developing applied behavior analysis practices through which to achieve social validation (Kazdin, 1977; Wolf, 1978). This trend has a good deal of relevance to special education for children with behavior disorders.

TWO METHODS FOR SOCIAL VALIDATION

Kazdin (1977) described two methods for social validation of the effects of an intervention, both of which are attempts to determine how well obtained behavior changes actually bring an individual's functioning into line with standards or expectations for appropriate performance. These two methods--social comparison and subjective evaluation--are described below with particular reference to special education for behaviorally disordered pupils.

Social Comparison

Purpose and procedures. The intent of the social comparison method is to contrast, with respect to one or more target behaviors, a pupil identified for intervention with a pupil (or group of pupils) not in need of intervention. Once the target behaviors and recording strategies have been decided upon, the teacher should select a comparison pupil to whom the identified pupil can be appropriately compared. The comparison pupil is selected on the basis of two criteria: (a) his or her functioning on the target behavior is judged to be within normal or appropriate limits; and (b) he or she is essentially similar to the identified pupil in most other ways, such as status variables (age, sex, and so on), level of academic achievement, or other important characteristics that will vary from case to case. Next, target behavior assessment is carried out on both the identified pupil and the comparison pupil. Data points based on the comparison pupil's behavior are assumed to represent appropriate (or at least acceptable) functioning, since the comparison individual had not been identified for intervention on the target behavior.

Several variations of this basic social comparison procedure are possible. For example, different comparison individuals may be assessed on succeeding days. Alternatively, the behavior of several comparison individuals may be assessed daily, with the comparison level of target behavior for any day based on the lowest, highest, or median data point from this group; this would require a prior decision as to which data point most accurately represents appropriate behavior. Another variation would use data collected on the behavior of several comparison pupils each day or on selected days, to generate a "band" of normal target behavior based on either the range of data points, the mean plus or minus the standard deviation, or some other convention. Again, the primary purpose of each variation of the social comparison method is to identify a level of appropriate behavior with which the target behavior of the identified pupil can be contrasted.

Uses. Several helpful functions of social comparison data are apparent. First, they add an objective dimension to the judgment of whether the identified pupil's behavior is markedly different from "normal." If target behavior recording indicates that the behavior is not, in fact, significantly different, intervention for that target behavior may not be indicated. The teacher would have to consider several possibilities: (a) the recording strategy chosen may have assessed aspects of the behavior problem other than those the teacher had in mind when the pupil was identified for intervention; (b) perhaps a totally different target behavior needs to be selected; or (c) conceivably, the teacher's reasons for identifying the pupil need to be reexamined.

Second, social comparison data strongly suggest some intervention goals. That is, the teacher may decide to change the level of target behavior of the identified pupil so that it closely resembles that of the comparison pupil. Thus, a realistic criterion for educationally important behavior change is inherent in the social comparison method.

Following intervention for the identified pupil, social comparison data can indicate how closely the obtained behavior change approaches "normal" functioning. This information may be very helpful in making decisions related to withdrawing intervention, switching to an intervention program intended to maintain behavioral improvements, reducing special education teacher contact and increasing regular teacher contact with the pupil, and so on. When the target behavior of the identified pupil closely approaches that of the comparison pupil (an appropriate or normal level), a strong case can be made that the intervention has been successful and may be reduced, changed, or withdrawn.

Examples. At the Center at Oregon for Research in Behavioral Education of the Handicapped, Walker and his associates have used normative peer data to socially validate several intervention programs for children with behavior disorders (Walker & Hops, 1973; Walker, Hops, & Johnson, 1975; Walker, Mattson, & Buckley, 1971). In one study, Walker and Hops (1976) worked with three groups of pupils who displayed low proportions of appropriate classroom behavior (e.g., following instructions, attending to task). Observations of the identified students were made first in the regular classroom prior to intervention, then in an experimental

classroom both before and during intervention, and finally during followup in a regular classroom. Data on each behaviorally disordered student's classroom peers were collected throughout each phase of the study. Following nontreatment baseline conditions, the intervention conditions were instituted; these consisted of token and social reinforcement for appropriate academic and social responding. An experimental design showed that this intervention improved the disordered pupils' levels of appropriate behavior in the experimental classroom. More to the point, social comparison data indicated that their appropriate behavior reached a level that fell within normal limits, when they were mainstreamed into the regular classroom. Further, followup comparisons between the treated pupils and their normal comparison peers, made at 7 to 12 week periods, showed that these changes were successfully maintained.

Additional social comparison treatment procedures to evaluate intervention programs have been reported by Patterson (1974), Patterson, Cobb, and Ray (1972), and Patterson, Shaw, and Ebner (1969). In one report, Patterson (1974) evaluated a home and school treatment program for conduct problem boys. Home intervention, consisting of training parents in behavioral principles, was provided to 27 families. The training consisted of (a) reading a programed text on child management; (b) defining, tracking, and recording deviant and/or prosocial target behaviors; (c) modeling and roleplaying appropriate behavior management strategies; and (d) writing contracts that specified contingencies and problem behaviors. For school intervention, a contingency management program was introduced whereby pupils received reinforcement for displaying nondisruptive behaviors or task oriented "survival skills." When the disruptive classroom behavior was brought under control, more natural consequences and reinforcers for peers were introduced. Home and school observations were made during baseline, intervention, and 12 months of followup. A social comparison evaluation was made by contrasting treated children to a closely matched group of children who had not sought treatment. Assessment of these children's behavior in home and school served to determine the degree of conduct problem of members of the referred group, and to establish treatment goals. By the time the home-school intervention was terminated, the total deviant behavior of treated children in home and school was within the range of normal functioning peers, a result that was maintained throughout a 12 month followup period.

Subjective Evaluation

Purpose and procedures. The subjective evaluation method calls for value judgments about the importance of obtained improvements in target behavior. Persons may be chosen to make these judgments because of close interaction with the pupil or because they are considered expert with regard to the target behavior and overall goals of intervention. After direct assessment data clearly show that target behavior has improved, rating or other assessment procedures are used to structure the judges' opinions as to the quality and importance of the identified pupil's performance. These judgments help determine the extent to which improved behavior functioning approaches realistic standards for appropriateness or competency.

Examples. The subjective evaluation method was used for social validation of a project to modify the composition-writing skills of behaviorally disordered secondary school pupils assigned to an adjustment classroom (Brigham, Graubard, & Stans, 1972). Intervention consisted of tokens contingent upon increases in total number of words, number of different words, and number of new words used by the pupils. In addition to the usual assessment of target behaviors, the importance of behavior change was gauged by submitting pupil compositions completed during baseline and intervention phases to college students. These judges rated each composition on several specific dimensions, including mechanical aspects, vocabulary, fluency, and development of ideas. The compositions written during treatment phases were consistently rated higher than those completed prior to intervention. This subjective evaluation procedure not only complemented the target assessment data, but also permitted overall quality assessment of a complex human performance that was only approximately defined by the target behavior assessment procedures.

Subjective evaluation as a method for validating treatment effects has also been used extensively at Achievement Place (Phillips, Phillips, Fixsen, & Wolf, 1972; Phillips, Fixsen, Phillips, & Wolf, 1979), a community based treatment program for delinquent and/or behaviorally disordered adolescents. In several research projects, the subjective evaluation method was used to assess the social importance of interventions for conversational skills (Maloney, Harper, Braukmann, Fixsen, Phillips, & Wolf, 1976), parent-youth interactions (Willner, Braukmann, Kirigin, Fixsen, Phillips, & Wolf, 1977), and police interactions (Werner, Minkin, Minkin, Fixsen, Phillips, & Wolf, 1975).

Other applications. Determining the effects of intervention is a major area in which subjective evaluation can be useful to the special educator, but there are additional implications of this method. Wolf (1978) suggested that subjective evaluation could serve to clarify the significance of intervention goals and the acceptability of intervention practices. Concern for the significance of treatment goals means that the objectives of a specific intervention or an overall treatment program often ought to be jointly formulated and negotiated between, for instance, those whose behavior is to be changed, those who will manage behavior change, and those who will evaluate the program. Although Wolf was primarily addressing researchers, subjective evaluation has obvious implications for socially validating progress toward individualized education program (IEP) objectives. Pupils, parents, and other interested parties who participate in the IEP planning and progress meetings provide a ready supply of judges who can be asked to take part in subjective evaluations of objectives and goals.

The issue of acceptability of intervention practices similarly refers to the need to consider input from consumers of educational procedures (pupils, parents, community persons, etc.). Just as universities typically have committees to review proposals for medical, psychological, educational, and other research in which humans will serve as subjects, and just as institutions for handicapped people have review committees to examine potentially objectionable treatment procedures, so the method

of subjective evaluation may be useful in providing a formal means by which pupils and their parents help determine educational practices used to achieve IEP objectives.

PROBLEMS IN USING SOCIAL VALIDATION

Several problems and cautions in the use of social validation need to be addressed as professionals explore this tool. Potential problems with the social comparison method generally involve the issue of determining which individual or group will be assessed to yield comparison target behavior data. For many problems exhibited by children with behavior disorders, it makes good sense to select a nondeviant peer as the comparison pupil. This is because he or she is likely to be similar to the identified pupil in important ways, except for showing "normal" levels of the target behavior, unlike the identified pupil. However, in some cases the use of peers could provide an undesirably low standard. This might be so if the target behavior were "remaining on task," yet the majority of pupils in a classroom acted out uncontrollably; or if the target behavior were demonstration of grade-level reading comprehension, yet class members were reading several years below grade expectation. The likelihood that problems of this sort would occur seems to be increased in special class settings and resource rooms for the behaviorally disordered, especially if the students spend little or no time in regular classes.

On the other hand, the use of peer behaviors to define behavioral standards in the social comparison method could also produce unrealistically high levels of appropriate or competent behavior. For example, there would rarely be merit in performing social validation of treatment outcome based on comparisons between a seriously disturbed pupil and a normal peer. Educational and other treatment programs for incarcerated juvenile delinquents might be another example in which it is not exactly clear who could appropriately be selected to provide desired social comparison behavior. Clearly, research is needed to explore the applicability of the social comparison method for judging the importance of behavior changes in difficult situations such as these.

Several potential problems arise with regard to the subjective evaluation method as well. For one thing, ratings and other judgments are behaviors that may be influenced in unknown ways, or even manipulated, by numerous situational variables such as observer expectancies and characteristics of the rating instrument and procedures themselves (Gronlund, 1971). Thus, those who use the subjective evaluation method must try to minimize measurement problems associated with observer reporting. They must also be aware of validity, reliability, and other psychometric assessment issues relating to instruments that utilize subjective ratings to produce data (Kazdin, 1977).

Another problem can arise if judges respond to aspects of a child's performance that are not measured through the behavioral target assessment procedures. Conceivably, subjective evaluations may indicate child improvement even though target assessment indicates little or no change

in behavior, and vice versa. The likelihood that this problem will occur may be reduced if the intended use of the subjective evaluation method is taken into account in the planning of a behavior change project; thus, target behaviors can be selected which may be appropriately measured by the subjective evaluation method.

Finally, although it is probable that the opinions of those who make subjective evaluation judgments can be valuable in determining the importance of goals, intervention practices, and outcomes, the teacher or researcher cannot afford to abdicate responsibility for the project. Input from others must be carefully analyzed for merits and shortcomings. Some issues are probably better determined on the basis of a professional's training, experience, and other expertise than by majority consensus of nonprofessionals.

IMPLICATIONS OF SOCIAL VALIDATION

Aside from their value in evaluating the importance of pupil behavior changes, social validation procedures have implications for other contemporary issues in the delivery of special education to pupils with behavior disorders. For instance, a continuing source of confusion in this area has been the definitions of pupil behavior disorders. Attempts to operationally define certain important aspects of available definitions, such as severity of a disorder or deviation from normality, are hindered by problems of measurement (Cullinan & Epstein, 1979). Social comparison procedures suggest a possible solution to some of these problems, since normative data on relevant varieties of pupil behavior problems could perhaps be collected locally, within a single grade, school, or district (Nelson & Bowles, 1975). Such data could serve as reference points in decisions concerning the degree to which a pupil's behavior is deviant and his or her need for special education. The feasibility of such data collection is in need of research attention.

A related issue pertains to the desirability of bringing more objective criteria to bear on decisions related to the selection, placement, educational treatment, and reintegration of behaviorally disordered pupils. For instance, social comparison data could provide valuable perspectives on where a pupil should be placed, or how to group pupils in special education situations. When reintegration into a regular classroom is deemed appropriate, collecting data on the levels of various behaviors in several regular classrooms could permit a more objective decision as to which classroom affords the pupil the greatest chance of behaving acceptably.

Social validation may also have relevance to the building of bridges between research and practice. Historically there has been relatively little real relationship between these areas; research has had too little influence on how behaviorally disordered pupils are educated, and researchers have not always addressed the needs of practitioners. Social validation procedures can be expected to bring research and practice into a more harmonious and productive association because of a common interest in social appropriateness and the practical effects of behavior change.

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PLACEMENT AND REINTEGRATION INFORMATION FOR EMOTIONALLY DISABLED STUDENTS

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As a child who is considered emotionally disabled moves from one level of the continuum of special education services to another, decisions regarding placement and educational programing should be made on the basis of relevant information about that child's academic and behavioral functioning. For emotionally disabled students, as for most identified exceptional children, a variety of information is routinely collected in the process of identification, during initial and subsequent comprehensive evaluations, and throughout placement in special education programs.

The purpose and justification for collecting such information is, of course, to provide data that helps educators make decisions regarding placement in the least restrictive environment and most appropriate program. Recent professional opinion has advocated using multiple sources of data (O'Leary & Johnson, 1979), and Public Law 94-142 also stresses the use of multidisciplinary teams and multiple sources of data in both determining handicaps and in making program decisions. However, little is known about the types or usefulness of information that are typically available to teachers of emotionally disabled students. State guidelines for assessment of this population vary and frequently do not specify types of information that are especially appropriate for this population. In addition, it is not uncommon for teachers of emotionally disabled students to complain about a dearth of useful information for decision making. For these reasons, the authors decided to investigate the availability and perceived value of different types of information for teachers of emotionally disabled students in decision making related to initial placement and later reintegration.

SAMPLE

In the winter of 1980, all teachers of emotionally disabled students, as well as a random sample of special education resource teachers, from three states (Iowa, Kansas, and Nebraska) were mailed a questionnaire concerning the reintegration of students into regular programs. Of these,

683 (54.3%) responded to the rather lengthy survey that sought information on the numbers and types of emotionally disabled students who were being served, the numbers and types whose placement had changed during the last 2 years, the procedures used for making placement and programing decisions, factors involved in reintegration, and a variety of other issues. Delivery models of the respondents included those in resource (40.0%), self contained (40.1%), residential (5.9%), and other (14.0%) types of programs. Grade level responsibility of the respondents was fairly evenly divided between those primarily at either the elementary (43.5%) or secondary (38.9%), with another 17.6% indicating level as "other" than either of these.

PROCEDURE

The teachers were first asked to indicate whether or not each of 15 different types of information is typically available to them at the time an emotionally disabled student is placed into their programs. This list of items (see Table 1) was based on the responses to a similar question in an earlier study (Smith, White, & Peterson, 1978; White, Smith, & Peterson, 1979). Teachers were also asked to rate the usefulness of each type of information for designing and implementing an appropriate program. Ratings were made on a Likert type scale (1 = unimportant; 7 = essential).

Later in the questionnaire, the teachers were asked to indicate whether each of 15 types of information (listed in Table 2) is typically available at the time a decision is made to reintegrate a student into a regular program and were again asked to rate the usefulness of each type of information for making reintegration decisions.

RESULTS

Table 1 summarizes responses regarding the availability of the 15 types of information at the time an emotionally disabled student is *placed* into a special program. Items are ranked according to availability. Mean ratings of usefulness of each type of information for designing educational programs are also included in Table 1.

The percentage of respondents indicating the availability of each type of information at the time of *reintegration* and the mean ratings of the usefulness of each are presented in Table 2.

DISCUSSION

It is apparent from this data that a variety of information is typically available for making educational decisions at the time an emotionally disabled child is placed into a special program. Of the 15 types of information included in the questionnaire, 10 were reported as available by at least 50% of the respondents. It is notable, however, that some of the more available types of information were considered less useful than some that were less available. Conversely, some types of information

Table 1

Type of Information Available at Time of Placement

Type of Information	Percent Available*	Rank	Mean Rating of Usefulness**	Rank
IQ scores and reports	92.1%	1	4.736	13
Standardized achievement test scores	91.7	2	4.899	12
Clinical/psychological reports	90.4	3	5.813	2
Vision/hearing/language screening	84.2	4	5.269	9
Health history/family information	83.9	5	5.083	11
Teacher's assessment of behavioral status/anecdotal records	67.7	6	5.703	4
Criterion referenced academic evaluation/informal tests	64.1	7	5.288	8
Statement of student's educational/ behavioral goals	61.4	8	5.861	1
Subjective evaluation (i.e., "I think it's necessary")	61.5	9	4.462	15
Statement of intervention techniques already attempted	56.4	10	5.715	3
Expected date for achieving goals	48.2	11	4.520	14
Behavior rating scales/checklists	47.9	12	5.469	6
Description of regular class expectations/requirements	47.0	13	5.293	7
Formal behavior observation data	45.8	14	5.575	5
Sociometric/self concept data	33.2	15	5.225	10

*Number of respondents ranged from 516 to 547 on individual items.

**Number of respondents ranged from 484 to 531 on individual items.

Table 2

Types of Information Available at the Time of Reintegration

Type of Information	Percent Available*	Rank	Mean Rating of Usefulness**	Rank
Achievement of behavioral/academic goals	94.7%	1	6.105	1
IQ scores and reports	94.5	2	4.318	15
Clinical/psychological reports	94.1	3	5.067	11
Teacher's assessment of behavioral status	93.0	4	6.056	2
Standardized achievement test scores	91.1	5	4.740	13
Vision/hearing/language screening	90.6	6	4.909	12
Subjective evaluation ("readiness")	90.3	7	5.646	5
Health history/family information	89.7	8	4.624	14
Statement of interventions attempted	87.9	9	5.893	4
Criterion referenced academic information	84.7	10	5.308	8
Arrival of expected date for achievement of goals	79.4	11	5.114	10
Description of regular class expectation/requirements	74.1	12	6.049	3
Formal observation data	68.5	13	5.548	6
Behavioral ratings/checklists	67.3	14	5.513	7
Sociometric/self concept data	53.7	15	5.122	9

*Number of respondents ranged from 456 to 473 on individual items.
**Number of respondents ranged from 425 to 455 on individual items.

considered more valuable were among those reported as less available. For example, three of the five most available types of information—health history/family information (83.9%), standardized achievement test scores (91.7%), and IQ scores and reports (92.1%)—were also among the five receiving the lowest mean ratings for usefulness. Some of the "more valuable" types of information—formal observation data, behavior rating scales and checklists, and description of regular class expectations—were reported typically available by fewer than one-half of the respondents. A statement of student's educational/behavioral goals, which received the highest mean rating of usefulness and is required in individualized education programs, was reported as available by only 61.4% of the respondents.

The reported availability of all types of information increased during a child's placement in a special program. Those types of information reported most often available at time of placement also tended to be those that had been most often available at time of reintegration. Information reported as less available at placement again tended to be that with the lower rankings for availability at reintegration, yet by this time all types of information were reported as typically available by at least one-half of the respondents. In several instances (expected date for achieving goals; sociometric/self concept data; description of regular class expectations; statement of interventions attempted; statement of educational/behavioral goals; formal observation data) availability increased by more than 50% between placement and reintegration.

Based upon the respondents' judgments of the usefulness of information, it appears that all types were considered valuable both at placement and at reintegration. The lowest rating of usefulness at placement was for teacher's subjective evaluation of the necessity of the placement ($\bar{x} = 4.462$). At reintegration, the lowest rating was for IQ scores and reports ($\bar{x} = 4.318$). There were some statistical differences in mean rating of usefulness at time of placement and at time of reintegration. In order to assess the statistical differences in mean ratings of usefulness t-tests were utilized. Several types of information were found less useful for making reintegration decisions than they were for making program decisions at placement. These were: IQ scores and reports ($t = 6.15$; $p < .001$), clinical/psychological reports ($t = 11.84$; $p < .001$), standardized achievement test scores ($t = 3.50$; $p < .001$), health history/family information ($t = 8.32$; $p < .001$), and vision/hearing/language screening ($t = 6.08$; $p < .001$). Types of information considered more useful at reintegration were: teacher's assessment of behavioral status/anecdotal records ($t = -5.44$; $p < .001$), description of regular classroom expectations/requirements ($t = -11.17$; $p < .001$), statement of student's educational/behavioral goals ($t = -7.12$; $p < .001$), teacher's subjective evaluation ($t = -14.67$; $p < .001$).

An additional observation that could be made regarding judgments of the usefulness of information is that, both at placement and reintegration, those types of information considered more valuable were those that are typically provided by teachers themselves (e.g., statement of behavioral/academic goals; regular class expectations; teacher's assessment of behavioral status), while types of information typically provided by school psychologists and other nonteaching personnel (e.g.,

IQ scores and reports; health history/family information; standardized achievement test scores) were not rated so useful. The lone exception to this pattern was the relatively high rating given to clinical/psychological reports, which obtained the second highest mean rating of usefulness at time of placement.

CONCLUSIONS

The results of this study indicate that (a) a number of different types of data are typically available at both time of placement and reintegration of emotionally disabled students; (b) all types of information tend to be more available at reintegration than at placement; (c) all types of information are viewed as being useful at both placement and reintegration; (d) information provided by teachers themselves tends to be considered more useful than that provided by others, especially at time of reintegration; (e) some of the more available types of information are not considered as useful as some of the less available information, and conversely, some of the less available types of information were considered more useful; (f) some types of information were more useful at placement; others at reintegration. These conclusions suggest that nonteacher members of the multidisciplinary teams involved in placement and reintegration decisions involving emotionally disabled students should make greater efforts to demonstrate the value of the kinds of information they provide and should also make greater efforts to ensure that some of the "more valuable" types of information are made more available to teachers.

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EXCLUSION OF THE SOCIALLY MALADJUSTED FROM SERVICES UNDER P.L. 94-142

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The definition of the socially maladjusted is vague and open-ended. Because we are unsure who are the socially maladjusted, and who should serve them, a substantial number of children and youth systematically are excluded from the free and appropriate education mandated under the Education for All Handicapped Children Act of 1975 (Public Law 94-142).

The definition of seriously emotionally disturbed cited in P.L. 94-142 "does not include the children who are socially maladjusted, unless it is determined that they are also seriously emotionally disturbed." (*Regulations*, 1978, p. 10). Although frequently used to describe children whose behavior is considered socially inappropriate, social maladjustment has seldom been defined. Educational definitions are essentially nonexistent. Smith and Neisworth (1975) defined social maladjustment as involving behavior problems which create disruptions for others, are unaccepted by society, and usually violate cultural norms. These problem behaviors frequently include disobedience, disruptiveness, defiance, and/or incorrigibility. Others consider social maladjustment a synonym for delinquent behavior, and attempt to rationalize the social and legal descriptions of behavior (Suran & Rizzo, 1979). Still others consider all maladjustment as a product of our society's systems which continue to increase the percentage of maladjusted youth as well as the number of treatment options (correctional, educational, mental health, and social welfare) (Rhodes & Tracy, 1974).

REASONS FOR EXCLUDING THE SOCIALLY MALADJUSTED FROM SERVICES UNDER P.L. 94-142

The socially maladjusted were not excluded from services without reason. Several possible explanations come to mind. Examining each in turn demonstrates that exclusion of these children reflects neither the spirit nor the letter of P.L. 94-142.

One explanation for exclusion is that socially maladjusted children are not handicapped in the true sense of the word. Rather, they are children who are undergoing a temporary conflict that will cure itself with the passage of time. Many people feel that socially maladjusted children merely lack the proper motivation and guidance. Given the right direction and insight, either through discipline or juvenile correction, they will see the error of their ways and "cure" it themselves. Thus, it is the consensus of these persons that the problem is not that such children *can't* behave, it's that they *won't*.

Nothing could be further from the truth. Socially maladjusted children fail to act in socially preferred ways because they lack the social skills required. Most of these children have a few, highly generalized undesirable behaviors that they use in a wide variety of situations. Because their repertoire is limited, they are unable to exhibit the more preferred alternatives required for success in the school and community without special education.

All social skills are learned skills. They are informally taught in a variety of settings through a complex socialization process. The socially maladjusted child has failed to learn the social skills necessary to adapt to his or her environment. Repeated exposure to the same learning atmosphere produces relatively little change. A brief glance at national recidivism rates should demonstrate that "more of the same" is not an appropriate education for these children. Instead, they need specialized education to teach them the skills others learn informally. This makes them no different from other handicapped children.

A second rationale for excluding these children is that they can be better served under other existing handicap labels. This viewpoint regards social maladjustment as a secondary condition resulting from another, more readily identifiable, handicap. To be sure this is sometimes true. In the majority of cases, however, it is not. It also follows from this viewpoint that the alleviation of the primary handicapping condition will alleviate the social maladjustment as well. This is not often the case. Social maladjustment can be observed independent of other handicapping conditions and should be treated as a separate phenomenon. Because social maladjustment exists in children who have no other handicapping condition, it cannot be considered solely as a subset of another handicapping condition. True, there are children who are socially maladjusted and deaf or socially maladjusted and blind. These children, however, should be treated as multihandicapped, not as special subpopulations.

In actual practice with socially maladjusted multihandicapped youth, the social maladjustment is often regarded as the primary condition. Success or failure with these children is often determined by the ability of their teachers to provide specialized instruction designed to teach socially adaptive skills. The child's progress is not predicated upon the teacher's knowledge of how to teach children who are deaf, blind, retarded, or learning disabled, but rather, on the ability to enable these children to operate successfully within the school setting. Unless these skills are taught, all the best planned instruction will never succeed.

A third explanation for the exclusion of socially maladjusted children is that their needs are better served elsewhere. This argument maintains that they would be better served in the general school population or through the juvenile justice system. After all, this is where they have been "served" in the past. In fact, the record of "service" is appalling. The major interventions of the school systems are corporal punishment, suspension, and expulsion, none of which teach new socially adaptive behaviors (Rutherford & Neel, 1978). Corrections programs are all too frequently designed to control rather than teach. The few skills that are learned frequently don't generalize to the natural environment to which these children return. Far too often, the reported "success" of these juvenile justice programs disappears when the children are released. Other youth are maintained in the system until they matriculate to the adult system.

This situation is not entirely the fault of the juvenile justice system. The repeated failure of such programs rests with the failure to recognize that social maladjustment is a handicap requiring specialized instruction. For these children to be able to participate in our school systems, they must be specifically taught how to adapt *to* these systems *in* these systems. Appropriate education must include the teaching of social skills relevant to their natural environments. If this training does not occur, then these youth will, in all probability, continue to fail to behave acceptably. They did not learn how to adapt on their own, nor did they learn to adjust by the vague informal way that the majority does. If a child cannot learn to read using standard techniques, few would argue that he or she should not receive special help. Should the child who cannot adapt to the social system in which he or she lives be afforded any less an opportunity? Definitely not!

A final rationale for excluding socially maladjusted children is that there is no clear definition of the term, and that the criteria used to identify these children are vague, arbitrary, and sometimes capricious. In its most extreme form the argument runs as follows: the definition is too vague to pin down; school districts will abuse the category; there will be hundreds of thousands of children identified; the costs will be excessive; therefore, exclude the children. Such arguments violate the intent of P.L. 94-142. The socially maladjusted should come under the same mandate for services as any group of exceptional children and youth who "need some form of special education--part time or full time, for short or long periods--at some stage in their sequence of schooling" (Reynolds & Birch, 1977, p. 9).

No clear definition exists because of the confusion between legal, social, and educational parameters. Definitions have been a problem in many areas, not just with regard to the socially maladjusted. A similar problem has plagued those who try to identify learning disabled children. Definition cannot be the real complaint. Lack of successful intervention strategies may be the real reason for the reluctance to include socially maladjusted children under P.L. 94-142. If social maladjustment is acknowledged as a handicap, then these children would have to be served. They could not be excluded or expelled from schools. Thus, the school would be required to provide programs, and many districts are not sure they can. It is easier to include these children, to rely on the intervention of exclusion

IMPLICATIONS OF INCLUDING SOCIALLY MALADJUSTED AS A HANDICAP

The major question is whether or not social maladjustment is a handicap. If it is, and we believe it is, then children who are socially maladjusted must be served. Once this is a recognized fact, the problems of definition, eligibility, curriculum, and service delivery models become problems to solve, not reasons for exclusion. It is beyond the scope of this paper to propose specific solutions to each of these problems, but several tentative parameters can be put forth.

Definition

Wood (in press) has presented an educational definition of seriously emotionally disturbed that relies on a social referent to establish the quality and quantity of behaviors that are considered disturbed. A similar model with its inclusion of both social and academic behaviors, age and grade references, and socially relevant definitions of excess could be used as a starting point for defining social maladjustment. Wood limited his judges to teachers and other school personnel. This would need to be expanded to include parents and other community members, since the behaviors of socially maladjusted children impact all areas of their life. Schools will need to extend their parameters outside traditional limits, and form cooperational programs in the community (Neel & DeBruler, 1979).

Such changes will definitely run against the status quo. Problems of funding, territoriality, accountability, regulations, and conflicting legislation will require immediate attention. These problems cannot, however, be more difficult than others we face daily in implementing a free and appropriate education for all handicapped children. Nor can their solutions be more costly to the children or society as a whole than the current strategies that are repeated and repeated in the face of overwhelming data indicating their ineffectiveness.

Curriculum

Teaching socially maladjusted children will require two major changes in the curriculum. We have a growing body of technology that shows we can change children's behaviors. Unfortunately, much of what we have changed is insignificant to the learners. What is needed is to apply the growing technology to significant problems. These children need to learn how to make friends, solve social dilemmas, interpret mood changes, and generate new tactics when external conditions change. They need to learn how to express anger appropriately and how to absorb hostility without fighting or running away. Instead, they are taught to make their bed or keep their toilet paper rolls neat (Philips, 1968). These early demonstrations of technology were necessary and valuable, but it is time for the curriculum to leave the laboratory and roam the streets.

A second needed change is for all of us to stop viewing misbehavior as an interruption that needs to be eliminated. Social behaviors, approved or not, are the behaviors of concern. Too often we feel they interrupt our math or reading programs and need to be stopped so we can get on with the important tasks. Group tasks are relegated to odd times of the day, or "when the work is done." A majority of classrooms individualize their

programs and reinforcement systems to improve academic performance. Improved performance is achieved, however, at the cost of social interaction. Unfortunately, it is poor social interactions, not poor academics, that handicap these children. The result is that we teach the wrong things and inadvertently assure a continuing problem. Social curriculum needs to be elevated to a parity level with academics. More work needs to be done in articulating social curriculum that produces real change in the lives of socially maladjusted children.

Delivery Systems

Reynolds and Birch (1977) present an instructional cascade of educational services from the least to the most restrictive placements for exceptional children. The aim of placement for socially maladjusted youth should be the same as for any group of exceptional children and youth. That is, educational placement should be in diverse regular educational environments whenever possible; in diverse educational environments with special education support when necessary; and in specialized and limited educational environments only when more open and less restrictive environments are not feasible.

Many socially maladjusted children spend a part of their lives in limited educational settings. While specialized educational environments are designed only for educational purposes, limited educational environments are those where placement is made based on other than educational considerations. In these environments, control of socially maladjusted or delinquent behavior is of primary importance while education is often of secondary concern. What is suggested here is that the role of education should be elevated to equal status. Perhaps the "right to treatment" issue raised in the *Wyatt* v. *Stickney* (1971) case will facilitate a sharing of responsibility between those in the legal-correctional and the educational systems for the treatment of socially maladjusted youth. As Reynolds and Birch (1977) pointed out, educators ought to be involved in ensuring the appropriateness of educational programs in all settings and providing careful coordination with other school programs. Rutherford and Bower (1976) have demonstrated one way such an interaction might work.

ONE FINAL NOTE

Idealistic rhetoric is easy. As Dunn (1980) so aptly reminded us, constructive criticism that expands an idea is much more difficult, but is, in the long run, more likely to be creative. To ignore the socially maladjusted is unconscionable. To refuse to provide services because the problems are too vast flies in the face of the letter and spirit of the law. What is suggested instead is to recognize social maladjustment as the handicap it is and then focus resources and energies on the problems inherent in that recognition. P.L. 94-142 is an idea that needs to be expanded. It has been the intent of this paper to describe some of the beginning steps.

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AUTISM: TEACHER PREPARATION ISSUES

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The Education for All Handicapped Children Act of 1975, Public Law 94-142, has dictated a new framework of requirements for teachers, and, in the process, created issues and concerns which need to be addressed by teacher education. "Attempts to implement the law already have revealed in practice what was evident and predictable in advance: The level of professional preparation simply is not adequate for the new conditions" (Reynolds, 1979). One of these conditions is the immigration of severely handicapped children, previously served by private or state institutions, into public schools. Autistic children, as members of this group, have gained particular attention due to the extreme learning and behavior problems characteristic of their conditions.

The mandate to mainstream these children has placed teachers in a new position of responsibility without providing adequate preparation. The focus of this chapter, then, will be to address issues and considerations in this critical area of teacher preparation in the field of autism. Specifically, the author will:

1. Discuss the characteristics of autism and current concerns in the field.
2. Discuss the state of the art in teacher preparation for teachers of autistic children.
3. Offer recommendations for teacher preparation.
4. Provide a model of recommended competencies and characteristics for teachers of autistic children.

AUTISM: CHARACTERISTICS AND CONCERNS

Autism is a devastating behavioral disorder which affects approximately 4 in 10,000 people (Wing, 1974). Autistic children are characterized by severe problems in communication and behavior, and an inability to relate to people in an appropriate manner. The etiology of the disorder

is unknown and its effects are lifelong (Ritvo, 1976). Specific educational concerns in the field of autism center around identification and intervention.

Identification and Diagnosis

Traditionally the identification and diagnosis of autistic children has been the responsibility of the medical profession. Medically trained psychiatrists, using interview and observation techniques and a large measure of clinical judgment, have made their diagnoses somewhat subjectively. This approach to diagnosis often results in inconsistency of identification (Rimland, 1971) and is dependent upon individual interpretation of behavior. Now, the responsibility for identification of autistic children is falling on public school personnel. In Texas, Delaware, Louisiana, New York, North Carolina, and Michigan autism is a special education category separate from emotional disturbance or multiple handicaps. As a consequence, special education placement committees will be responsible for autistic children.

Identification is of particular concern when one realizes that public school personnel have not been trained to identify autistic students and have been provided, at best, ambiguous guidance. In addition, many of the instruments available for assessment of autism are neither readily available, valid, nor effective. As a result, some children may be mislabeled as autistic while others who are autistic may be improperly diagnosed and not receive adequate services.

Placement and Treatment

Exactly what constitutes adequate and effective services for autistic children is also a source of controversy. A cursory review of the literature reveals that many different types of treatment are advocated. For instance, Bettelheim (1967) advocated a psychodynamic approach, based on the assumption that unresolved subconscious conflicts have arrested the child's emotional development. A teacher's primary goal would be to therapeutically facilitate the child's conflict resolution. In contrast, Lovaas (1976) has completed extensive research using behavioral therapy. A teacher using behavioral techniques assumes that the child has learned inappropriate behavior and, therefore, can learn appropriate behavior. Emphasis is placed on changing old behaviors and teaching new behavior through the use of reinforcement and punishment techniques. Wood (1975) recommended a developmental approach, which takes into consideration the developmental stages of children before setting performance expectations. As with most treatment controversies in education, no one approach appears to have all the answers.

Disagreement also exists concerning which types of placements and treatment procedures are most desirable, and by whom they should be administered. Fenichel (1966) wrote that autistic children are better off at home. However, some professionals believe that these children require more consistent, controlled environments (e.g., institutions or residential facilities) in order to achieve maximum learning (Gilliam, Unruh, & Haley, in press). Research into the treatment of autism is multidisciplinary. Medically trained people (Ritvo, 1976; Rutter, 1968),

psychologists (Lovaas, 1976; Rimland, 1964), and educators (Arick & Krug, 1978) are all interested in effective treatment, but there is some disagreement concerning which discipline should have primary responsibility for this treatment. The school system, however, is the only system mandated by law to serve autistic children, and research into effective educational intervention has become critical.

Assuming that teachers have a key role in the treatment of autistic children, questions arise concerning personnel selection, necessary competencies, and the ultimate role and responsibility of teacher preparation. Answers to questions about identification and treatment in the field of autism are slowly emerging, but teacher educators cannot afford to wait. Issues regarding the preparation of teachers must be addressed now, for the progress of autistic children may often depend directly upon the success of failure of their educational programs.

STATE OF THE ART IN TEACHER PREPARATION

Currently there are many issues concerning the training of teachers to work with autistic children. The glaring reality is that many teachers now in classrooms for autistic children are not adequately trained (Smith, 1977). In addition, many public school administrators are desperately searching for qualified personnel to staff classrooms for autistic children. Few teacher preparation institutions provide programs for this specialized training; certification requirements and state guidelines for required competencies are often nonexistent; and, even among experts, the skills and characteristics necessary for teaching autistic children have not been delineated.

Traditionally, special education teacher preparation programs follow categorical models. Teachers are trained to work fairly exclusively with children who are either emotionally disturbed, learning disabled, mentally retarded, or have other specified handicapping conditions. This system tends to produce teachers who are proficient in only some of the skills necessary for the education of autistic children. For example, teachers trained in the area of emotional disturbance usually receive training in behavior management, affective curricula, and psychology, but not functional retardation or language acquisition. Many teacher preparation institutions using categorical systems have been reluctant to add "autism" as a separate entity because autistic children constitute a fairly low incidence population; there is often a lack of trained faculty in this field; and there is also disagreement among teacher trainers as to how different the skills necessary for teaching autistic children are from skills included in the existing categorical programs. Consequently, teachers trained in categorical programs may be lacking skills necessary for teaching these exceptional children.

Teacher training based on a generic model attempts to prepare teachers to deal with all handicapping conditions. However, teachers are usually trained to deal with only the mild to moderate range of cognitive, language, and behavior disorders. Unfortunately, autistic children often exhibit severe behavior and language disturbances, leaving the

generically trained teacher ill prepared to cope. This inadequate preservice training in programs based on either model requires teachers to receive extensive inservice training for deficit skill areas.

Inservice trainers are required to decide which skills are necessary for teaching autistic children, and must also individualize training to compensate for inadequate preservice preparation. Although surveys (Gilliam & Dollar, 1978; Smith, 1977) have reported that behavior management, curricula content, parent consultation, and interaction skills are of primary concern to teachers of autistic children, few inservice trainers are adequately qualified to train in all those areas.

The general lack of agreement as to which skills and competencies are necessary for teachers of autistic children causes a dilemma for both preservice and inservice trainers. It is generally agreed that there is a need to delineate specific competencies that are effective with autistic children in various settings.

Due to the lack of agreement among experts concerning teacher competencies and the general lack of preservice preparation for teachers of autistic children in teacher training institutions, state education agencies have been slow to mandate certification standards. As a result, individual school districts are often forced to determine their own qualification policies for hiring teachers to staff classrooms serving autistic children, and to decide what specific inservice training may be needed once personnel have been selected.

To summarize briefly at this point, many teachers are not adequately prepared to teach autistic children. Among the factors contributing to this situation are a lack of preservice training programs, qualified teacher trainers, agreement on competencies and skills necessary for the teachers, and state certification requirements. These issues are addressed in the following recommendations.

RECOMMENDATIONS FOR TEACHER TRAINING

Teacher educators can no longer ignore the fact that public schools are now serving autistic children, and personnel preparation has become a critical issue. Preservice options need to be increased. Categorical programs could be expanded to include training in skills necessary for serving populations exhibiting extreme behavioral and communication problems. For instance, a specialized endorsement area for severe behavior disorders might include training for dealing with the educational needs of autistic children. This type of program could offer specific courses dealing with research, legal and ethical issues, assessment, curricula development, instructional strategies, and behavior management as it pertains to autistic students. Other endorsement areas could offer different coursework for teachers of severely retarded and severely language disordered students.

Generic programs could also be broadened to include courses specializing in the education of the severely-profoundly handicapped. For example, assessment strategies for a severely-profoundly handicapped

population depend on observational techniques and the identification of small increments of development rather than academic achievement. Other courses might include parent interaction, teaming skills, alternative communication systems, and consulting skills, in addition to curricula development and instructional strategies successful with severely impaired children.

Faculty members in teacher preparation institutions need to expand their expertise to include current research, methods, and curricula in the field of autism. Field placements for student internships need to be reexamined. A very important component of field placement is adequate supervision and feedback as new teaching skills are learned. Since large populations of autistic children are seldom available, alternative field placements in institutions for the mentally retarded or mentally ill could be considered. Often there are misdiagnosed clients in these settings who are autistic or exhibit autistic symptoms. With only minor adaptations, many of the skills necessary for teaching autistic children and adults can be mastered with these populations.

Inservice programs should be designed to meet the individual needs of the teacher. Assuming preservice programs have provided instruction in basic skills such as language development, general assessment techniques, and basic classroom management, inservice training should concentrate on the refinement of these skills and emphasize the teacher's personal growth and rejuvenation. Due to the difficult problems autistic children bring to the classroom, many teachers "burn out" after 1 or 2 years. Often these teachers have mastered specialized teaching skills and are valuable to the progress of their students. Therefore, inservice programs might also emphasize stress management and the formulation of both personal and professional support systems so that good teachers remain in the classroom.

In addition, supervisory personnel in the public schools should become familiar with the content of preservice programs and offer input into the organization of field placements. A cooperative effort between teacher preparation institutions and public schools in teaching courses, supervising field placements, and delivering inservice activities would provide the most complete training program for teachers.

All of these recommendations depend upon the identification of skills and competencies necessary for teachers of autistic children. Since the literature reports little research in this area, the following section will describe a model of desirable competencies and characteristics based on the authors' classroom experience with autistic children and informal surveys conducted during teacher inservice training over a 5 year period.

RECOMMENDED COMPETENCIES AND CHARACTERISTICS FOR TEACHERS OF AUTISTIC CHILDREN

The model (Figure 1) was formulated in order to illustrate a comprehensive collection of competencies and characteristics necessary for effective teaching in classrooms for autistic children. The model is not a

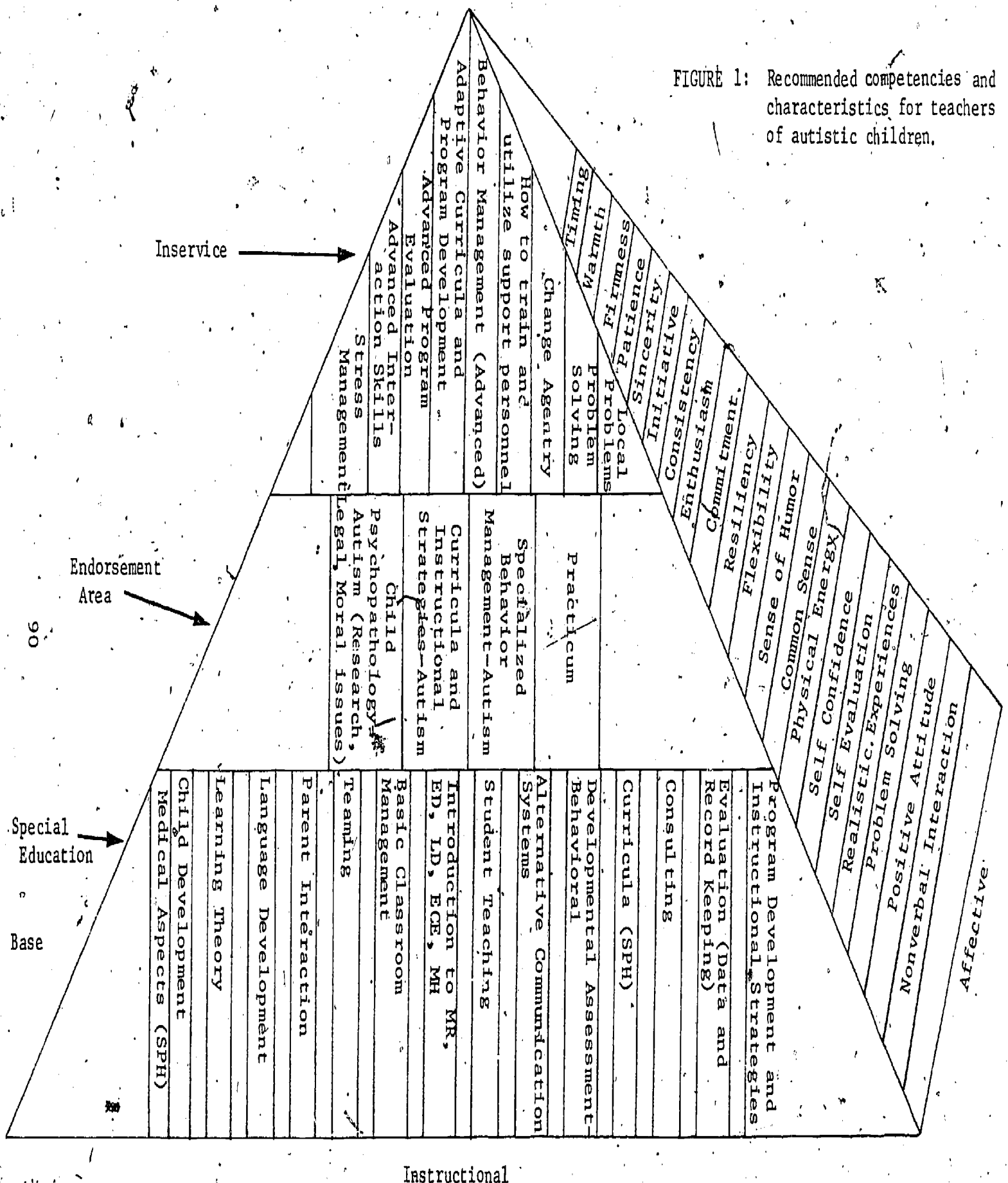

FIGURE 1: Recommended competencies and characteristics for teachers of autistic children.

complete listing but is designed to provide a framework to which skills may be added or subtracted as new research data is discovered, and can be adapted to fit the needs of individual instructional arrangements.

Base Program

Basically, the model illustrates a three level training program. The base is a 4 year certification program specializing in courses necessary for teaching any severely-profoundly handicapped population such as the severely retarded, the severely language disordered, and the severely disturbed. Content in this program will deal with functional retardation, language acquisition, medical and physical problems, behavioral assessment, and adaptive curricula and methods. Field experiences should be encouraged in settings serving severely handicapped populations and the program should include at least one semester of student teaching in a classroom with one of these populations.

Endorsement Level

The second level is the essential training for teachers of autistic children. This level, in the form of an endorsement area, would include courses specific to the field of autism. The first course should be an overview of research issues, characteristics, ethical questions, and resources related to autism. Since Kanner (1943) first described the syndrome of autism, many theories and myths have been perpetuated concerning its etiology, incidence, and treatment. None of these myths (i.e., "refrigerator mothers" cause autism) are based on solid research, but many caregivers in the field believe them to be true (Gilliam & Coleman, 1980). The basic course should provide a solid foundation in facts and research and formulate a structure for a specific skills series.

The next two courses should deal with specialized curricula, instructional strategies, and behavior management. Teachers in the field of autism must be prepared to teach students ages 3-21, who exhibit an extremely varied functional level and a wide range of behaviors. The literature shows five major problem areas of the autistic which interfere with the educational process (Rincover & Koegel, 1977). These areas are (a) physically disruptive behavior, (b) self stimulatory behavior, (c) motivation, (d) stimulus overselectivity, and (e) generalization and maintenance of treatment gains.

The instructional strategies found most effective in dealing with these problem areas require teachers to demonstrate skills in (a) appropriate presentation of instructions, (b) effective use of prompts and prompt fading, (c) shaping successive approximations to the target behavior, (d) delivery of contingent and effective consequences, and (e) inclusion of distinct intertrial intervals. In addition, teachers need to learn to adapt curricula for individual needs in the areas of language (e.g., how to remediate mutism, echolalia, and perseveration), cognition (e.g., how to cope with uneven cognitive development), and sensory discrimination (e.g., what methods to employ to remediate over- and underselectivity).

In both the Michigan survey (Smith, 1977) and Texas survey (Gilliam & Dollar, 1977) behavior management was listed by teachers as a major emphasis area for further training. Autistic children often exhibit extremely deviant behavior such as self mutilation, biting, screaming, hyperactivity, tantruming, opposition, and fecal smearing. Teachers must be able to decelerate these behaviors in the classroom and train others to decelerate the behaviors in other settings. The behavior management course at the endorsement level may be the one most critical to the success of the teacher in classrooms for autistic children.

The final course at the model's endorsement level is a full semester practicum including as much student contact time as possible. The teacher trainees need to be able to try their specialized techniques on children with communication and behavior disorders, receive feedback, adjust the techniques, and try them again. Inherent in this field placement should be an emphasis on creativity, problem solving, and initiative. Perhaps the necessity for emphasizing these qualities might best be illustrated through a description of a hypothetical classroom scene.

A self contained classroom in a public elementary school is occupied by five autistic-like students, a teacher, and an aide. A new child is introduced into the classroom and even though she stays in her seat she refuses to respond to any teacher activities. The teacher provides the opportunity for the child to roam the room while the other children are on the playground with the aide. Soon the teacher notes that the child has picked out a puzzle and seems compelled to put all of the pieces in place. The child concentrates on the puzzle for more than 10 minutes. As a result of this observation, the teacher solves the student's motivation problem by using the unfinished puzzle as a reinforcer. The teacher gives the child an empty puzzle board and only upon completion of a task is she given a piece of the puzzle. Since the child is very insistent that the puzzle be finished, she may be induced to perform many learning activities in order to "earn" puzzle pieces. This is an example of a creative solution to a potentially difficult problem.

Although qualities like creativity and initiative cannot always be taught, they are recognizable and, at this point in the preservice program, may be used as a basis for screening and determining which teachers will be most successful in classrooms for autistic children.

Inservice Training

The third level of the pyramid contains skills that might be taught through inservice training. Once teachers are actually in the classroom, they should have mastered basic teaching skills and be ready to move to more complex skills. For example, the teacher may find himself or herself in the position of having to train and utilize volunteers, aides, and parents in the classroom. At this point, skills in supervisory techniques might be helpful. If a teacher should become a student advocate, he or she may need some information about changing systems and parent interaction skills. Inservice on updated techniques, materials, and resources in the field of autism could be valuable. Finally, skills involving interaction techniques such as assertiveness are extremely

useful for teachers already in the classroom. Autistic children are found in many different settings (i.e., public schools, state institutions, private residential facilities, and day treatment centers.) These treatment situations often require teachers to work with psychiatrists, psychologists, social workers, parents, child care workers, speech therapists, principals, teachers, nurses, and other support personnel. Effective interaction skills for facilitating group decision making and interdisciplinary coordination will allow maximum treatment for the child and more support for the teacher.

Affective Characteristics

All of the skill areas listed on the three levels of the model's instructional face can presumably be taught and measured. However, some characteristics which may not be trainable or measurable seem requisite for all successful teachers, and particularly for teachers of autistic children.

The second face of the pyramid delineates affective characteristics desirable in teachers and implies that these characteristics interface with all of the instructional categories. For example, even if a teacher is skilled in behavioral assessment, he or she must also be flexible. Often standard assessment procedures are not successful with autistic children, for these students may not respond to the suggested instructions or might show inconsistency in their responses over a period of time and in different settings. Improvisation and divergent thinking are also crucial teacher characteristics. These affective characteristics might be useful in screening prospective teachers and for training or evaluation. All too often, teachers who seem to have mastered the necessary teaching skills fail in the classroom. Perhaps the cause of this failure could be a general lack of a sense of humor, an inability to relate nonverbally, an inability to set realistic expectations for himself or herself or for the children, or some other aspect of the teaching personality related to the affective domain. Even though the affective domain is ambiguous, it is worth examination in the area of teacher preparation.

SUMMARY

Until recently, autistic children have been excluded from public schools due to their severe behavioral and learning handicaps. Public Law 94-142 has mandated that all children be provided a public education. However, school personnel, specifically teachers, are not adequately prepared to receive these very difficult children. The training of these teachers has been hampered by controversies among experts in the field of autism; a lack of preservice programing for teachers of autistic children; few state guidelines in the matter; and disagreement on skills and competencies necessary for teachers to possess in order to be effective with autistic children. Recommendations include suggestions for programs in teacher preparation institutions; suggestions for possible state certification procedures; and a model delineating competencies and characteristics necessary for teachers of autistic children at three different training levels.

Teacher educators must fulfill their responsibility in the quality preparation of teachers. Quality teachers enhance educational programing which is critical to the welfare of autistic children. "The provision of appropriate educational programs for these children is not a manifestation of public generosity, but rather a reflection that these children, too, have a clear right to an appropriate education" (Gallagher & Wiegerink, 1978).

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POLICY ISSUES IN PROVIDING PSYCHOTHERAPY AND COUNSELING AS RELATED SERVICES

Carl R. Smith

This topic presents a dual edged sword. On the one hand, there is the need to be quite careful, even legalistic, in the choice of words, phrases or statements of hypothesis; it seems that the area of policy issues in providing psychotherapy and counseling is being determined by due process proceedings and by the courts rather than by us, as professionals, arriving at what could be collectively agreed upon as best professional practices. On the other hand, there is a need to almost free associate the perceived implications of this current and important topic.

Perhaps the best way to resolve this dilemma is to give a brief background of the writer. I am neither an attorney, a judge, a hearing officer, nor a legislator, and even shudder at the curse of being referred to as an administrator. Rather, I consider myself a professional who works for a state education agency, attempting to be an advocate for the development of appropriate programs and services for those youngsters referred to in Public Law 94-142 as "seriously emotionally disturbed." I participate in both leadership activities and administrative tasks.

Because of this background, I am appropriately humble when it comes to stating terms legally or predicting what either our courts, hearing officers, or legislators might be inclined to do. Such humility, however, tends to taper off a bit when it comes to stating opinion or how I think things should be!

DEFINITION OF TERMS

The title of this paper includes several key words or phrases which merit definition. Some are defined in P.L. 94-142, while others are not mentioned in that document. Those which are not defined in federal statute or concept papers, I will take considerable liberty in defining.

The term "seriously emotionally disturbed" refers to a group of handicapped pupils defined in P.L. 94-142. Although both this choice of terminology in describing behaviorally deviant students and the definition

itself have provoked considerable professional criticism (Yard, 1977) it is nevertheless the current standard. It reads as follows (*Federal Register*, 1977):

> A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree: an inability to learn which cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms, or fears associated with personal or school problems. The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted but are not emotionally disturbed. (p. 42478)

At least two studies (Epstein, Cullinan & Sabatino, 1977; NASDE, 1978) have verified that states are, despite this federal definition, using a variety of terms and definitions to apply to this population. However, at this time, it appears that such variations have been deemed acceptable and consistent with federal statute.

"Related services" is also defined in P.L. 94-142 as follows (*Federal Register*, 1977):

> The term 'related services' means transportation, and such developmental, corrective and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children. (p. 42479)

Related services are further defined in 45 C.F.R. 121a.13. In that section "counseling services" means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

The differentiation of "counseling" from "psychotherapy" is a difficult and perhaps impossible task. For the purposes of this paper no such differentiation will be presented. This stance is consistent with Patterson (1966) who states:

> The difficulty in, or impossibility of, separating counseling and psychotherapy is apparent when one considers the definitions of each offered by various authors. The definitions of counseling would in most cases be acceptable as definitions of psychotherapy, and vice versa. There seems to be agreement that both counseling and psychotherapy are processes involving a special kind of relationship between a person who asks for help with a psychological problem (the client or the patient) and a person who is trained to provide that help (the counselor or the therapist). The nature of the relationship is essentially the same, if not identical, in both counseling and psychotherapy. The process that occurs also

does not seem to differ from one to the other. Nor do there seem to be any distinct techniques or group of techniques that separate counseling and psychotherapy. (p. 1)

Implications

From the review of definitions and terminology found in present federal statutes, it appears that the door has been left open to the provision of counseling services to handicapped children. As brought forth in such recent court decisions as *"A" Family* vs. *State of Montana* (1979), the interpretations of the right to such services seem to be extending to the purchase of psychotherapy services from professionals outside the educational structure. It is my contention, however, that such a movement is not necessarily going to lead to improved services for seriously emotionally disturbed students, and may, in fact, be of negative consequence for some. Eysenck (1953) states:

> To the specialist engaged mainly in therapeutic work, the bad effects of education are most obvious and he is likely, therefore, to have a poor view of training in education. The educator, on the other hand, as the authorized agent for perpetuating accepted values and traditional ways of culture, is likely to value more highly the importance of his calling. This difference in attitude easily leads to charges by the clinician that the educator is brutal and sadistic, and to the countercharge by the educator that the clinician is idealistic and unrealistic. . . . There does seem to be a distinct tendency in contemporary culture for the educator to be replaced by the clinician, not because of any conscious and deliberate policy or because there are any facts showing the superiority of the one approach over the other, but rather for nonrational and emotional reasons. (pp. 211-212)

Although this quote is certainly dated, I would contend that the basic premises are still valid. A more recent proposal by Szasz (1979) in his book titled *The Myth of Psychotherapy* brings to light an even more frightening possibility, given the direction of our current movement.

> Most people now believe that it is a good thing that the state defines what is sickness and what is treatment and that the state pays for whatever treatment people need. What most people do not understand, indeed seem disinclined to understand, is that the state may, and therefore will, define as sickness whatever the people might want to do for themselves; that it may, and therefore will, define as treatment whatever the government might want to do to the people; and that it may, and therefore will, tax the people for "medical" services that range from denying Laetrile to those persons who want it to imposing psychiatric imprisonment on those who do not want it. Clearly, the future scope of such "services" promises to include an array of therapeutic prohibitions and prescriptions of truly Orwellian proportions. (pp. 198-199)

PROPOSITION

As a result of such global concerns, I would like first to make a proposal and then to elaborate on several points of rationale in relation to this proposal.

BE IT RESOLVED: that counseling and psychotherapeutic services are only to be provided to selected handicapped pupils who can be shown to be in need of such services in order to progress within an educational structure.

BE IT FURTHER RESOLVED: that such services are only to be delivered by education employed personnel; are to be delivered typically within the school building; and, in most cases, are to be implemented within the student's special or regular classroom.

BE IT FURTHER RESOLVED: that such services must have specified, written goals and objectives and evaluation criteria.

BE IT FURTHER RESOLVED: that such services are not, in any manner, appropriate for all children and adolescents identified as "seriously emotionally disturbed."

Rationale #I: The Myth of Psychopathology

Achenbach (1978) stated:

> Lacking objective criteria for discriminating normality from pathology, mental health workers may be overly sensitive to signs of pathology. This is especially true where children are concerned, because they may become anxious, constricted, impulsive, or withdrawn when brought to mental health settings, which they view as mysterious, threatening, or punitive. Clinical settings are thus likely to highlight signs of pathology, and the effect of pathological biases on clinical judgments on even the most normal children have been well documented. (p. 766)

This quotation points out one of the major dangers we face in our field today--that is, assuming pathology within the population we serve when such pathology may not exist. Likewise, we are often placing our students in settings where pathology is expected. Perhaps we are even disappointed if we do not see it! Rhodes (1979) alluded to this when he stated, "Deviance is in the eye of the beholder. What you see is what you get" (p. 1). Rosenhan (1973) dramatically illustrated this point when he, along with seven other copatriots, had themselves admitted to private and public mental health institutions and found themselves held for 7 to 52 days with initial diagnoses of schizophrenia and discharge diagnoses of schizophrenia in remission.

Engel (1972) also dealt with the perception of pathology by classroom teachers in viewing their students. She pointed to an additional problem in this process when she concluded:

> The relationship between parents' views of maladjustment of their children and teacher's judgments is high and statistically significant *if* the social class of the children is taken into account. The correlation is quite high (.90 in one study) between parents and teachers of middle class children. With lower class children the correlation drops (.17 in one study). (p. 34)

When I was in training to be a teacher of behaviorally deviant students, much of the emphasis of the training program dealt with the distinction between educational and therapeutic interventions with students. We were being taught in accordance with a view described by Rhodes and Paul (1978): "When the child was 'cured' and only then, he or she could be educated. 'Reasonableness and nonreasonableness were mutually exclusive human qualities" (p. 274). This viewpoint was exemplified in my training program through a heavy emphasis on child psychiatry literature, including the use of case histories from child psychiatry journals as a primary training tool. We were studying how to deal with deviant behavior in the classroom on the basis of what had been reported as being clinically successful with similar children.

More recently our profession has shifted in the direction of training our teachers to realize that our primary goal is to provide an appropriate educational program for youth whose behavior is deviant in the classroom. We are now also concerned with a student's academic progress because we realize that such progress may play a very important role in whether or not the student returns to the regular classroom. We have also become aware that a student's self-perceived and actual competence as a student may have a very important bearing on his or her behavioral adjustment. Finally, we have begun to realize that those pupils with overt clinical characteristics represent only a portion of all students served in such programs.

Algozzine, Schmid, and Connors (1978) described two types of students found in programs for the "seriously emotionally disturbed." One type of student manifested behaviors which may be problematic in school but not at home, and may be very responsive to environmental management strategies. The second type of youngster (clinical) manifests deviant behavior across home and school settings and does not appear responsive to environmental management strategies, suggesting that the problem may be related to organic inadequacies within the child.

One of the obvious problems with the Algozzine, Schmid, and Connors study is that it lacks a data base to support the hypotheses. Recently, in a study in which I participated (Peterson, Zabel, Smith, & White, 1980), teachers of the seriously emotionally disturbed in three midwestern states were asked to estimate how many of their pupils were actually emotionally disturbed with clinical implications versus how many were behaviorally disordered. Tentative results of this study indicated that a greater number of behaviorally disordered pupils are perceived as being in such programs, especially the less restrictive models. Grosenick and Huntze (1980) summarized the sentiments of many professionals in the field of behavior disorders:

> The label "seriously emotionally disturbed" tends to focus on children and youth with disturbances of behavior that are psychiatrically defined and/or intra-psychic. While these children and youth are appropriate for services by public education, they are only a small portion of the types of serious problems that public schools face. Many of the most serious school concerns involve behaivor that has no psychiatric overtone. (pp. 22-23)

It is my own contention that, with the increased emphasis on related services such as counseling and/or psychotherapy, we must be cautious not to add to the prevalence of the myth of psychopathology in relation to the entire population of those children and adolescents included in the federal count of "seriously emotionally disturbed." I would further contend that the efficacy of traditional counseling and psychotherapy with both clinical and nonclinical populations has been questioned. I believe we must work hard to avoid contributing to a situation similar to that reported by a Ralph Nader task force (Chu & Trotter, 1974) in relation to the Community Mental Health Centers Act of 1963:

> Psychiatric domination of the program meant that centers would inevitably regard the problems and needs of clients from the narrow perspective of a sickness requiring medical attention from medical personnel. Nowhere is this perspective more evident than in the program's outlook toward state hospitals. The framers of the center's program assumed that state mental hospitals were primarily treatment institutions; that the individuals residing in or sent to state hospitals suffered from "mental illness"; that mental health professionals and psychiatrists in particular were the most appropriate personnel to help these individuals; and that psychiatric intervention was truly effective in dealing with such problems. Without questioning these assumptions . . . the program's originators simply proceeded to design another system of psychiatric treatment institutions. They believed that constructing more buildings and hiring more mental health professionals was the appropriate and effective strategy for meeting the needs of state hospital inmates. (pp. 21-22)

Rationale #2: The Question of Efficacy

Before addressing this rationale, I wish to reiterate a primary personal bias. I believe that an appropriate educational program for a behaviorally deviant child goes as far as, and perhaps farther than, most related services in meeting the affective needs of such a student. My bias also leads me to believe that social and academic competence begets a mentally healthy child or adolescent. Further, I believe that any productive counseling service is aimed at creating freedom as defined by Rollo May (1975):

> Human freedom involves our capacity to pause between stimulus and response and, in that pause, to choose the response toward which we wish to throw our weight. The capacity to create ourselves, based upon this freedom, is inseparable from consciousness or self-awareness. (p. 117)

Counseling techniques which are easily within the competence realm of classroom teachers of the "seriously emotionally disturbed" or school based support personnel, such as school psychologists or school social workers, would seem to address such student needs. Techniques such as life-space interviewing, relationship building, or the various self control curricula available would certainly seem to fit the bill.

But others may cry that psychotherapy and counseling must go far beyond such humble parameters to meet the needs of some children. They might present as examples autistic or psychotic children, or extreme cases of family psychopathology. It is true that the psychotic or autistic student may need more than the pragmatically based counseling approach described above. However, I would contend that the efficacy of more depth oriented approaches has yet to be shown. This finding, for example, has led such parent dominated groups as the National Society for Autistic Children to laud the value of a well structured, skill oriented educational program as compared to more traditional psychiatric treatments. Obviously there are families who have needs which extend beyond the need for a school program. However, as I will discuss later, I believe there are definite limitations to what the school should do in dealing with such tragic circumstances.

Another side effect of what appears to be the common perception that something must be done with the family in order for a "seriously emotionally disturbed" child's behavior to improve is again a perception of pathology which may or may not be present. Walker, Hops, and Johnson (1975) contrasted the behaviors of behaviorally deviant children in the classroom versus the home setting as part of a study dealing with the generalization and maintenance of classroom treatment effects. This was done by using objective observers in both settings. According to these authors:

> Children who exhibit high rates of deviant behavior in school do not necessarily show similar difficulties at home. . . . These findings taken together would seem at least to call into question the not infrequent practice of referring parents for counseling because of their child's behavior problems in school. Furthermore . . . it would appear likely that improved behavior in relation to the family would not have any necessary impact on the child's behavior in the classroom. (p. 198)

The question of "setting generality" or the influence of operations performed in one setting or the child's behavior in other settings has also been addressed by Wahler (1969). Home based behavioral programs established for two children were followed up to see the effects of such programs in both the home and school settings. Similar to the conclusions drawn by Walker et al. (1975), Wahler found that the children's behavior in the school setting was unaffected by the home operations. Only when similar operations were applied in the school did changes show in both home and school settings.

By looking at these empirical studies as well as others (Johnson, Bolstad, & Lobitz, 1974; O'Leary & Drabman, 1971; Meichenbaum, Bower, & Ross, 1968; Skindrud, 1972) we find that behavior appears to be situationally bound and to some extent independent of other settings. Thus, we should

be capable of designing appropriate management programs in the school setting which lead to positive change in this setting regardless of what is taking place elsewhere--including the home. This statement should not be misconstrued to mean that we should not be interested in providing support to the homes of the pupils with whom we deal, especially through the services of such professionals as the school social worker. However, to hesitate in intervening educationally in the life of a youngster because of perceptions of the "home situation" may in fact be selling ourselves short regarding what can be done.

I am not attempting under this rationale to cast doubt on all forms of counseling or psychotherapy. Rather, I believe there are many efficacy questions concerning such approaches which have yet to be answered. Before we rush out of the schools to take all of our diagnosed "seriously emotionally disturbed" children and their families to the local psychiatrist or mental health agency, we had best pause and look at these issues. Again quoting from the Nader report (Chu & Trotter, 1974):

> Throughout our report . . . appear such questions as "What can psychiatrists do that no one else can do?" and "How do they know that what they do does anyone any good?" Admittedly, these questions are enormously difficult to answer, but they do raise issues that have been too long ignored by psychiatry. Furthermore, the very lack of response we have received to these questions indicates that many psychiatric claims to "expertise" are based on imputed knowledge and assumed effectiveness rather than on factual evidence. (p. xix)

Rationale #3: The Limitations of the Educational Structure

My final rationale for this proposal deals with a very simple notion. Excuse me if I sound like a conservative, but I do believe that there are limitations to those services which should be provided in our public schools.

Public Law 94-142 is a sweeping mandate to provide a free appropriate public education for handicapped learners. When our legislators were drafting and voting on this piece of legislation, I wonder if any debate centered on purchasing ongoing psychiatric services for our nation's children and adolescents. In the definition of related services originally proposed, medical services were specifically limited to diagnostic and evaluation purposes.

Special education is in the fortunate position today of being a mandated program. Our colleagues in mental health services generally do not have the capability, at present, to reach the general school age population, as we do. We must be cautious in protecting an educational mandate from being used by others to get programs and services. In our rush to provide mental health services promoted by the myth of psychopathology, I fear that precious resources will be taken away from providing adequate educational programs for students who seem to need them.

WHEN REASON DOES NOT PREVAIL!

Despite the points made above, there does seem to be an increased effort by some in our field to expand the mandate to directly pay for psychiatric services under the guise of "related services." Among the areas which will have to be dealt with are (a) the specific credentials required of those delivering mental health services; (b) the specific process by which the need for such services is determined; and (c) supervision of such services.

In addition, there is the question of accountability. With the initiation of P.L. 94-142 and a myriad of comparable state legislative changes, we have all been forced into greater accountability in our instructional programing for handicapped students. Such accountability takes many forms, including the inclusion of parents in decision making, the presentation of collected data upon which decisions are made, and the annual review process.

If the public schools enter into increased activity in the form of counseling or psychotherapy services, then it is incumbent that such services be held just as accountable as are instructional services. Such questions as these must be addressed:

- What is going to be the content of such services?
- How will they be delivered?
- By whom?
- What are the annual goals and short-term objectives of such services?
- What will be the specific behavioral changes which will be observed in the pupil?
- How will such changes be evaluated?

In the past, such human change services as psychotherapy have appeared to function under a cloak of secrecy. Some may have contended that the lay public simply could not understand such complex procedures. This rationale has certainly been criticized within the therapeutic professional community (Drummond, 1979; Szasz, 1979).

With the movement of such services closer to the public school structure, such ill defined procedures and fluid accountability cannot be tolerated. If the public is obligated to pay for such services, then these services must be explained. A reported outcome such as "Johnny feels better about himself" will not suffice as a comprehensive outcome of such services.

In these days of so-called "limited resources," there are also a number of funding issues which must be addressed. If increased counseling or related services are provided from within our educational structure, then obviously one of two directions will have to be taken. Either increased personnel will have to be employed, or other previously delivered services by these professionals will have to be eliminated. With financial restraints being applied, it appears that the latter direction will have to be followed.

If such services are to be purchased in systems outside the educational structure, additional questions will have to be faced, such as (a) who pays?, (b) who establishes the cost?, and (c) who determines the need?

The crux of this matter rests, perhaps, with who determines the need for such services. As earlier implied, I am quite concerned over our society's uninformed consumerism in relation to mental health services. And I am also concerned about who will be making the decisions regarding need. It seems highly probable that staffing teams dominated by mental health professionals, for example in residential care settings, will readily see the need for such services. As Weatherly and Lipsky (1977) reported in a review of the implementation of special education in Massachusetts:

> The kinds of disorders identified through screening were directly related to the specialty of the person doing the screening. For example, System B, which relied much more heavily on speech specialists to conduct screening than the other two systems, referred more than twice as many children because of speech problems. (p. 184)

SUMMARY

This paper has reviewed many of the concepts related to the provision of counseling and psychotherapy services to pupils identified as "seriously emotionally disturbed." I have intentionally advocated a very conservative approach to these services. We may, however, be faced with a dramatic increase in such services in light of recent court decisions and the reported direction of some thinking at the federal level. It is incumbent upon us, as a professional community, to voice our concerns regarding such a direction.

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SECTION III

PROGRAMING

This final group of papers, including those by Conoley, Apter, and Conoley; Brendtro and Mitchell; Dembinski, Rossi, Valenti, and Chambers; Reter; Rutherford and McGlothlin; and Kaufman, Paget, and M. M. Wood, describe special programs and programing options. Here again, this selection stresses programs where our field is currently faced with the need for rapid development; those dealing with adolescence, consultation with teachers and parents, and the need for a curriculum that goes beyond the 3 R's. The final paper in this set (Kaufman, Paget, & Wood) discusses and illustrates the evaluation of program effectiveness.

If we are to attract continued support for education programs for the seriously emotionally disturbed during this period of fiscal retrenchment, we must be able to show that our programs make a difference in the personal development and social behavior of students. Kaufman and his coauthors describe how the Developmental Therapy Program of the Rutland Center in Athens, Georgia, has responded to this challenge.

TEACHER CONSULTATION AND THE RESOURCE TEACHER: INCREASING SERVICES TO SERIOUSLY DISTURBED CHILDREN

Jane Close Conoley
Steven J. Apter
Collie W. Conoley

A continuing dilemma in the treatment of behavior disordered and emotionally disturbed children is that the treatment provider has only limited direct service time and, therefore, only partial control over the events that affect the children's daily lives. For children with severe problems, such limits in treatment may be costly. On the other hand, the desire to normalize the children's environment to approximate that of their peers leads us to remove them from situations which might provide a complete and consistent therapeutic milieu.

Discomfort on the horns of this dilemma has caused some to suggest the use of consultation as a way for child oriented professionals to increase their impact without removing children from typical age appropriate settings.

Consultation is one of those words, however, that means everything and, therefore, nothing to most who hear it. Some define *consultation* as telling somebody something, or providing specialized diagnostic skills. Medical doctors consult by inviting specialists to give input into or take over a difficult case.

Another view of consultation is that it is a process as complex as therapy between two peer professionals from slightly differing fields (Caplan, 1970). The *consultant* (e.g., special education resource teacher) leads the *consultee* (e.g., regular education teacher) through an examination of *client* (e.g., emotionally disturbed child) issues, always delicately avoiding the interfering intrapsychic conflicts which are often the real cause of the difficulty between consultee and client.

Still other perspectives do not rely on intrapsychic explanations of behavior, but do see the process of consultation as more than mere information sharing. It is viewed as a complex human interactional event (e.g., Gallessich, 1974; Meyers, Parsons, & Martin, 1979).

The explanation of the existing models of consultation--behavioral, process, mental health, ecological, and advocacy--can be found in a number of sources (e.g., Bergan, 1977; Caplan, 1970; Conoley, 1981; Kelly, 1970; Schein, 1969; Walton, 1969). An appreciation of each model is a necessary first step to effective consultation. It is important to remember that no one model is the correct view. They are all useful depending on the situational variables surrounding the consultation. In fact, just as we develop and prescribe the individualized programs for special needs children, so too must we use individualized prescriptive approaches in working with the significant other caregivers in children's lives. The need for such individualization has been overlooked when dealing with peer professionals.

This chapter will describe some of what we know about the prescriptive use of consultation in educational settings and describe a model of teacher training that sees consultation as one of the necessary skill areas for resource teachers. Consultation definitions will be expanded, a rationale for the use of consultation given, consultant and consultee characteristics as they affect outcome will be discussed, and the actual process of consultation will be explored using research findings and portions of an actual consultation transcript. Finally, some of the nitty-gritty problems facing special educators who attempt to implement consultation programs to support the regular class placement of behavior disordered and emotionally disturbed children will be highlighted. Suggestions for overcoming obstacles are offered. Our purpose is to provide resource teachers, other special educators, and school psychologists with information useful for increasing their positive impact in their work settings.

WHAT IS CONSULTATION?

The most generic definition of consultation comes from Caplan's (1970) pioneering work:

> ...a process of interaction between two professional persons--the consultant, who is a specialist, and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized competence. (p.19)

Historically, the specialist consultant has been a psychiatrist working with public health nurses, a psychologist working with teachers, or a person perceived as having some needed expertise by school, mental health, government, or business organizations.

Despite the diversity of professional specialists and host organizations represented, the common thread defining consultation is help offered to another enabling that person to do a better job. If "help" could simply be giving right answers, the consultant's work would be simple indeed! Unfortunately, human interaction involves sharing information, persuasion, motivation, and positive rapport. In addition, most problems which have stumped consultees are complex enough to defy a simple right answer.

Consultation should be seen, therefore, not as the more knowledgeable consultant giving answers to a puzzled consultee. Rather, it must be viewed as a collaborative problem solving process during which the consultant facilitates the creative, coping skills of the consultee and learns from the consultee about the unique aspects of the problem and the consultee's situation.

A RATIONALE FOR RESOURCE TEACHERS AS CONSULTANTS

The role of resource teacher has been identified as an increasingly critical staff position for the delivery of special education services to seriously troubled children in today's schools. For example, a recent minisurvey of 21 resource teachers in the Syracuse, New York area (Apter, 1978) indicated that most of the students involved in those resource programs were labeled emotionally disturbed and nearly all of them were perceived by their teachers as having behavior (sometimes in addition to academic) problems.

The resource teacher can provide direct services to children, both individually and in groups of various sizes, but also may serve as consultant to the other adults who work with children with special needs. Thus, in a given school, the resource teacher can typically interact with children, parents, classroom teachers, specialists, administrators, and members of the surrounding community and can become a critical link in the planning and implementation of successful educational programs. The resource teacher, parents, classroom teacher, specialists, administrators, and members of the community are all part of the child's learning system or ecology.

When viewed from an ecological perspective, the role of resource teacher carries great potential both for delivering appropriate direct services to disturbed children and for effecting necessary changes of the surrounding components through a variety of more indirect service functions (e.g., consultation, inservice education).

Unfortunately, the often overwhelming need for service and the frustrations produced in classroom teachers, administrators, and special educators who deal with disturbed children, have combined to create a "clinical press" that strives to find solutions to the complicated problems of troubled youngsters by offering more and more direct services. Frequently, this turns out to be a self defeating process for a number of reasons:

1. The overemphasis on direct service to the exclusion of other impactful components of the learning systems can be short sighted. More services to children might be provided today, but there is little evidence to indicate that children served in this limited way will be much better off tomorrow.
2. Equally important is the evidence that indicates there will never be enough trained personnel to meet the needs of the number of disturbed youngsters in our society. In other words, no matter how much direct service is provided to troubled children by resource teachers, there

will always be more youngsters waiting in line for their opportunity.

3. A direct-service-only model makes it impossible for resource personnel to become involved in what may turn out to be the most critical professional activity related to emotional disturbance in youngsters: *prevention*. This is especially frustrating because of the critical position of resource teachers at the interface of so many of the system components that impinge on the lives of disturbed children.
4. It must also be recognized that the problems enumerated above are magnified by the ineffectiveness of our typical direct services only approach. In fact, the provision of effective service to troubled children is a very difficult enterprise that hardly guarantees success. As more and more seriously impaired youngsters move into public school programs, we can only expect the task to become even more difficult.
5. The direct service only model increases the likelihood that resource teachers will fall into the "expert trap," the focus of client expectations for "magical" cures to very difficult problems. While not diminishing the need for expert services, an ecological perspective for resource teaching emphasizes the importance of coordination functions in the effective implementation of programs for troubled children.
6. An ecological model of service delivery is also more in keeping with the "least restrictive setting" philosophy. Such a perspective focuses on the whole child in the context of the natural setting in which he or she lives; in school and out, strengths as well as weaknesses, affective as well as cognitive domains, prevention before the fact in addition to treatment later on, coordinated with instead of separate from regular education, and comprehensive assessment rather than narrow diagnosis. The purpose of such a focus is to fully utilize all the health producing elements within a child's environment.
7. The push toward mainstreaming really demands that a coordination function become a central aspect of the resource teacher role. Figure 1 depicts possible resource teacher roles. As Meisgeier (1976) has stated:

> If our expectation is that 1-hour daily sessions in the resource rooms will magically or pervasively eliminate children's learning problems without concomitant efforts to teach children in a healthy learning environment the other four hours of each day, we are surely going to be disappointed. The process must be a cooperative effort between regular, alternative and special education to be called a mainstreaming effort. (p.259)

Program planning for a behaviorally disordered child in any educational setting requires an understanding of the variety of elements within each youngster's system, their relationships to each other, and their effects on the child's functioning. The role of resource teacher offers great potential for developing such understanding and for effecting necessary changes in public school service delivery models.

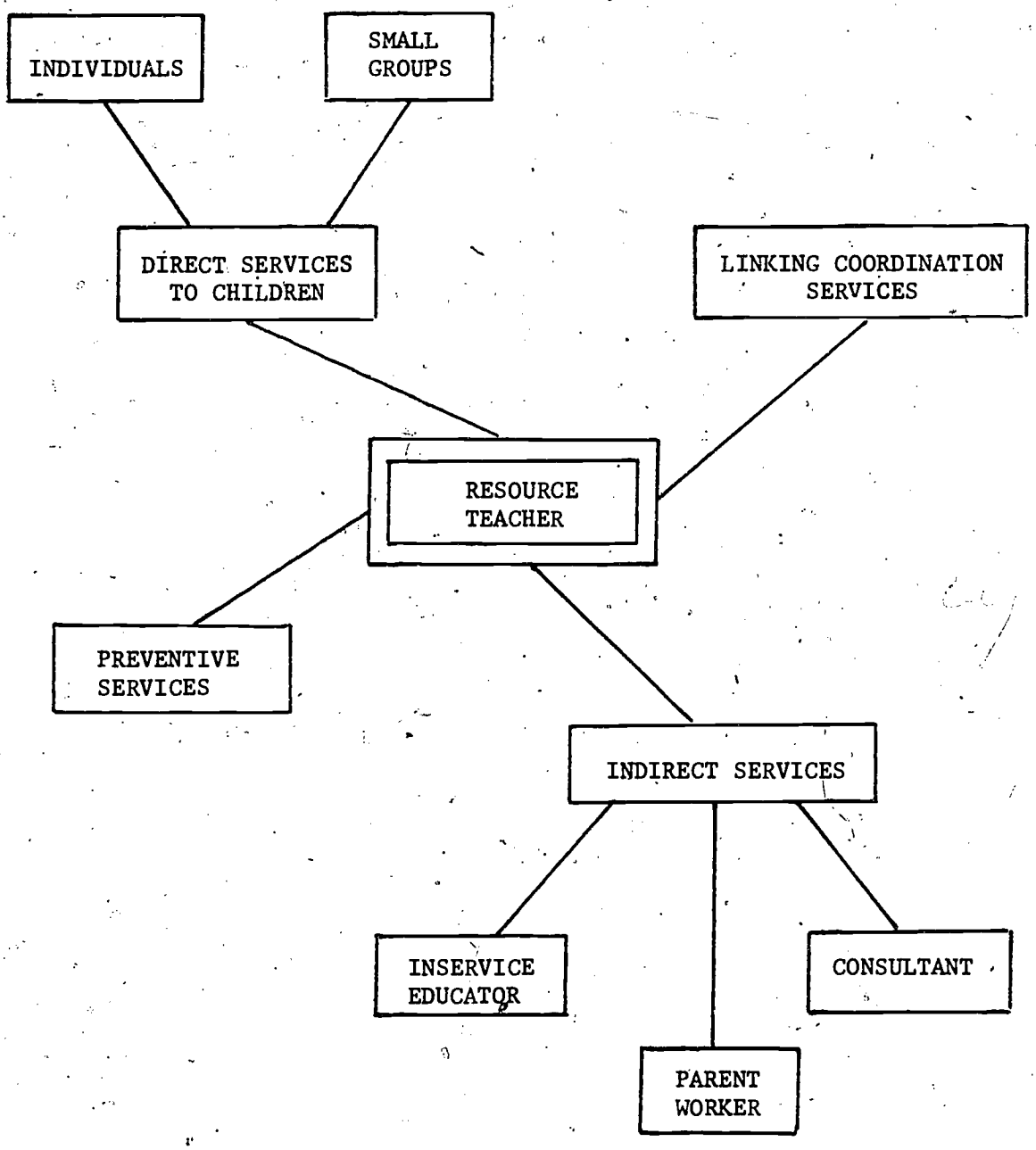

FIGURE 1. Roles of the systems-oriented resource teacher.

A good resource teacher can effect planned change regardless of presenting problem or nature of client system. This requires the ability to assume a variety of roles and to engage in innovative direct and indirect service programs and activities. Specifically, at Syracuse University, systems oriented resource teachers are prepared to function in five roles. The resource teacher delivering direct services to children assumes the role of teacher-counselor. In the realm of indirect service, the resource teacher assists colleagues by assuming four different roles --consultant, inservice and community educator, and parent worker.

We have emphasized consultation in this chapter because we see it as having a particularly critical role. Consider the following quote (Wiederholt, Hammill, & Brown, 1978).

> The emphasis that we give to the consulting role in the resource program model is long overdue in special education. Most teacher-training institutions have been slow to include such skills among their competencies; until the advent of the resource programs, public schools had no practical instructionally oriented arrangement that lent itself conveniently to providing consulting services to teachers. In any event, the schools in which the resource teachers are permitted to perform only two duties (to assess and to remediate children's problems) are overlooking a profitable avenue for improving the education of both students and teachers. In fact, in selecting resource teachers, one primary consideration might be their ability to implement tactfully the consulting aspects of the resource program. (pp. 32-33)

In an interview in which he discussed both the move to an ecological point of view in work with disturbed children and the role of the resource or helping teacher, Morse (1977) said (with reference to resource teachers for troubled children), "They need a lot more training in consultation and working with both teachers and systems to figure out how they can change some of these fundamental elements that cause or accelerate problems" (p.163).

Resource teachers themselves have expressed their needs in this area; 76% of the participants in the Syracuse survey referred to earlier emphasized a desire to incorporate more indirect service (defined primarily as consultation) into their roles. Evans (1980) reached similar conclusions; resource teachers, classroom teachers, and principals in her study agreed that resource teachers could productively *double* the amount of time they spent doing consultation.

There may even be some evidence that consultation can improve the likelihood of successful integration for a seriously troubled child. Wixson (1980) found that while 30% of a sample of disturbed pupils receiving direct services from the resource teacher were able to return to regular classrooms, 57% of the youngsters receiving indirect services (defined as resource teacher consultation and classroom teacher implementation) made successful returns to full and unaided classroom participation.

Finally, with regard to the preparation of all teachers for increased integration of disabled youngsters into the mainstream of public school life, Reynolds (1979) recommended:

> It is essential now that all teachers have opportunities to master the knowledge and practices involved in effective consultation and other forms of professional communication. Every teacher should have instruction and practicum experience leading to assured capability in these areas as part of preservice preparation. (p.14)

We are painfully aware that the model we describe is not a reality in most areas of the country. We feel, however, that special education professionals are in a position to facilitate such a reality, especially if they can adopt an ecological perspective in the delivery of services in which consultation is one of the key elements.

BEGINNING CONSULTATION: WHAT TO CONSIDER

Consultation requires a constructive, supportive relationship between the resource teacher consultant and the consultee. The consultee may be anyone who has influence over the clients/students the resource teacher consultant wishes to serve.

To facilitate a match between consultant and consultee some interactional issues between the two should be considered. Is this consultee lacking skills or knowledge? Will direct input or modeling help? Is this lack of skill a source of defensiveness on the part of the consultee? How much rapport building is necessary before the consultee can safely share personal concerns and accept consultant input? Is the presented problem similar to others that have been raised so that the consultant recognizes a theme? Why isn't the consultee using information or skills in this case that were successfully used on prior consultation cases? What organizational forces are facilitating or inhibiting the work of the consultee? What are the emotional issues around and in the consultee which make successful functioning difficult with this client or this type of client?

All of these issues are considered by the good consultant during the initial moments of a consultation interaction. Consultation strategies change accordingly. The specialized skills or information possessed by the consultant will be of little value if successful relationships with consultees are not established. The most elegant plan to support regular class placement for emotionally disturbed or behaviorally disordered children will falter if a significant implementer (e.g., regular education teacher) is not invested in its success.

WHO BEST CONSULTS WITH WHOM?

A growing body of literature tells us about characteristics of successful consultants (e.g., Gilmore & Chandy, 1973; Iscoe, Pierce-Jones, Friedman, & McGehearty, 1967). Teachers like, work with, and follow more recommendations of consultants who respond quickly to their requests, give them help in defining exactly what the problem is, are collaborative and friendly, give relevant advice, and seem interested in them as people. Despite the impression this list may leave, one need not be perfect to be a good consultant. In fact, consultees prefer to work with someone who shows some human frailties and acts nondefensively when discovered to be in error.

Consultants report greater success with younger, less experienced teachers (Martin, 1978) who are open to suggestions and are in touch with the social, emotional, and academic needs of children (Alpert, Ludwig, & Weiner, 1979). It seems ironic that we like to work with those who appear to need us least. Awareness of this tendency may help us be available to and seek out all potential consultees, *not* just those who are of like age, religion, ethnicity, or values. Dissimilar people deserve attention, too. In fact, as all special educators know, different people may require a special effort!

With limited consultation time available, however, a consultant should try to work with those who hold the greatest potential for success, at least initially. Early success experiences will facilitate work with other teachers within the consultation model.

THE PROCESS OF CONSULTATION: OR HOW DO YOU DO IT AND WHAT DO YOU SAY?

The process of what actually goes on during consultation and how that is related to effectiveness is a critical area. Unfortunately many questions are as yet unanswered. Process elements include stages of consultation, group versus individual consultation, level and kind of verbal activity by consultant and consultee, and affective levels apparent during consultation sessions.

We know, for example, that numerous writers describe a sequence within a consultation session that resembles typical problem solving steps: rapport building, problem identification, alternative generation, selection of a plan, implementation plans, plans for followup (Robbins & Spencer, 1968). Bergan and Tombari (1976) have determined that when using behavioral consultation the most important phase is problem identification. Consultants and consultees who can arrive at a shared understanding of *exactly* what is causing consultee distress have a 95% chance of solving the problem. When this phase is not successful it is unlikely that consultant and consultee will work together on a special needs child; direct service delivery to the child is the more likely alternative.

Other issues about phases remain to be studied. For example, how much catharsis should be facilitated by the consultant? Most of us believe that it's good to let consultees "blow off some steam." How much is enough? Is the possibility of anger escalation as great as anger reduction? We surely don't want to be involved in reinforcing consultees for saying negative, nontherapeutic things about children. At the same time, we are most effective when people can trust us to keep their shared feelings confidential and trust us enough to say what they feel. By prolonged focus on negative consultee emotions, consultants can find themselves in the uncomfortable position of not feeling able to "turn off" a consultee's experience of anger, hopelessness, or confusion.

Some researchers (e.g., Tobiessen & Shai, 1971) have looked at group versus individual consultation. There are several very positive aspects to the consultant meeting with groups of consultees. It is a more efficient use of time; creates many cues or ideas upon which the consultant and group members can elaborate; establishes a structure for problem solving about disturbing children (instead of just complaining); increases rapport, cohesiveness, and support among consultees as they realize the comparability of their concerns; and makes multiteacher cooperation in dealing with a special needs child more likely.

Disadvantages or limitations also exist. These include the difficult time underassertive group members may have in joining group process; difficulties in sharing confidential or self disclosing information; the need for the consultant to possess group process facilitation skills in addition to problem solving skills; and scheduling problems (i.e., how does everyone get free to meet at the same time?).

Consultants often find a mix of group and individual consultation helpful, needing always to be flexible in their formats. Some groups will simply *not* jell. Altrocchi, Speilberger, and Eisdorfer (1965) described such a group of principals who could not admit problems in front of each other. Their concerns were more readily met using an individual consultation approach. A guideline, however, is not to hesitate in facilitating naturally occurring supportive alliances (or engineering unnatural ones) among consultees.

Whether in a group or with an individual, consultants who can elicit information, action, and task adherence from consultees are most likely to be effective and to be seen positively (Bergan & Tombari, 1975; Wilcox, 1977). Consultation is a more active, directive, problem solving process than is therapy or counseling. There is a need to radiate energy and positive expectations so as to motivate consultees to take on new responsibilities with a child, or try new strategies, or just accept how a child is going to be.

Finally, some interesting though limited evidence (Meyers, Friedman, Gaughan & Pitt, 1978) about affective levels during consultation suggests that consultee anxiety about a problem should not be completely reduced by the consultant's reassuring manner. It may be that a moderate amount of concern about a child is energizing and should be maintained. This can be accomplished by stressing the consultee's

continuing responsibility for the case and the complexity of the problem, and by avoiding quick superficial answers or an offer to take over case responsibilities.

For example, a teacher may want an emotionally disturbed child to receive additional resource help. The consulting resource teacher will be wise not to give the referring teacher the impression that with 60 extra minutes per week the problem will be solved. It may be far better to contract together about joint activities with the child and to make clear the limitations of the direct service model than to elicit a profound, but shortlived, sigh of relief from the regular education teacher.

Reproduced here are parts of a transcript representing a consultation session between a consulting resource teacher and a regular education teacher. The young regular education teacher is dealing with a child labeled emotionally disturbed. The regular education teacher (T) has requested the consulting resource teacher (C) to observe the child in the regular classroom where the child has health class. The lines of asterisks indicate where we have broken the transcript. In parentheses we describe what went on during that part of the conversation. We have annotated in the margins to point out consultation processes and have edited the transcript slightly to facilitate reading.

C:	Well, Sue I appreciate your inviting me into your class. There are lots of positive things happening. I'm wondering what you see as the top priority problem?	Build rapport, problem identification
T:	Well, Mark is the major problem. He seems to be kind of hyperactive and just kind of antagonizes people. He really disrupts the whole class. You saw him hitting Ermenie, passing notes. If he were out of the class the whole class would calm down.	
C:	Could you describe to me exactly what kinds of disruptive behavior are of major concern to you?	Problem identification
T:	Closing windows, shutting the door. The thing that is really odd about it is that he pretends that he's being helpful to me. He has an excuse for everything. He never raises his hand.	
C:	What have you been trying with Mark?	Plan formulation
T:	I'm trying to be firm. I ask him sometimes, "What's troubling you, Mark?" I want him to know that I care about him. I tell everybody to raise their hands if they want to say something. He hits people. I say to him, "Mark, why are you doing that? The people in here want to learn."	
C:	So you've been trying to give the whole class some more structure and especially show Mark that you care about him.	Reframe plan strategy to include class.

T:	One thing I've been thinking about is re-arranging the desks into a circle or something less rigid than those rows. I think a circle will be more advantageous for discussion.	Reinforce teacher for previous efforts.
C:	That might have a number of good spin-offs. You'd have increased eye contact with all of the kids, they might feel more a part of the discussion, and Mark wouldn't have anyone to poke from behind. That takes away the problem before it can start.	Reinforce teacher and expand on strategy.
T:	That's something I'm big on.	
C:	This Mark. You've described him now as a kid who's disruptive in the sense of moving around a lot and disturbing other kids, and you said he's probably trying to get attention. I wonder if you have any feeling about kids like that? Do you see those kids as happy, insecure, lonely?	Summarize, move to emotional sphere.
T:	Well, I don't really label them as such, because, like I said before, I think almost everybody at one point or another has really kind of acted up in class just because of wanting attention. Maybe they're not getting it at home. Or something went wrong during the day. They want to prove that they can still get people to look at them and maybe be their friends. He is probably pretty lonely to have to act that way.	
C:	So one way to look at the way Mark acts is to see it as a way of making friends. Of course, as adults we know that his behavior won't make friends for him, but obviously he doesn't know it. In other words, he is lacking in certain social skills. I wonder if there is a way for a kid to be taught to be mature and socially skilled. You seem very sophisticated about changing the physical structure of things. Is there some way that the social structure could also be changed? What about a peer tutoring set up?	Change focus from internal pathology to a behavior deficit that can be worked on.
T:	OK. I see what you are saying, and it's a very nice idea. But I don't think that in 45 minutes I can cover material and give some kind of psychological therapy if he's going to be disruptive. I think a kid with his problems should be handled by someone else with specialized skills.	
C.	Yeah, I really didn't mean therapy. I'm sorry I wasn't clear about what I meant. I was comparing the kind of situation you are aiming toward in your class, lots of openness with people sharing ideas, with a similar one in which kids teach each other. We have learned that both kids in an interaction like that benefit. The children feel better about themselves if they see themselves as	One downmanship, clarification, share information.

competent resources to the others. In this way their strong points are emphasized instead of their weaknesses.

T: That's a possibility I never considered. How will I know what his *real* problem is, though? Don't you think I should talk with him to find out what is really on his mind?

C: I think it's great for you to take the time to find out what he's thinking about. But remember that finding out what the problem is doesn't solve it. So you get him to tell you that he acts this way because he's lonely (and that would be quite a feat to get an adolescent to open up to you in that way) you still have to figure out what to do about it. And if you think that part of the misbehavior problem is due to social skill deficits with peers, then building an adult oriented relationship with him may not be the way to go.

Reinforce teacher, elaborate on plan implementation.

T: I see what you mean. My plan doesn't really match what may be going on with him.

* * * (discuss social skills training strategy) * * *

T: If he's going to be disruptive, as far as I'm concerned he can go out. He can go out and be disruptive. I don't need this kind of disruption in my class.

C: I noticed that he was rocking back and forth in your class, but you ignored that.

Ignore punitive teacher verbalization, reinforce positive strategy.

T: I wouldn't have given him the satisfaction, because obviously he wanted my attention.

C: So one strategy to use with some disruptive behavior is to ignore it. You obviously can't ignore everything, but tell me what you think.

Clarify, elicit teacher information.

T: Some kids settle down just because they get tired of doing it with no attention.

C: I wonder how the class would react if you were to say, "This is a place to learn. If we want to get through the lesson, I want us all to ignore these certain behaviors." And then list all the things that you feel can be ignored.

Suggest elaboration of strategy.

T: I think it might help, but I think that it would help the class and not him. I think someone ought to take care of his problem also.

C: You're really concerned about his internal working, aren't you?

Attend to teacher's discomfort with emotionally disturbed label.

* * * (Develop the relationship between educational and therapeutic interventions) * * *

T:	I'm going to speak to the other teachers and what do you think about talking to his parents?	
C:	You'd talk to his parents, too? What would be your goals?	Avoid agreeing. Elicit elaboration and clarification of plan.
T:	Not to tattle tale. But I would ask how Mark spent his time, what his interests are, how they might cooperate with me.	
C:	So you would be looking for his strong points! Knowing a little about him might allow you to individualize some lessons. You might ask him to present a little talk on his interests in order to change him from class clown to class resource.	Elaborate positive outcomes of teacher plan.

IMPLEMENTING A CONSULTATION PROGRAM

You may be thinking that as nice as consultation sounds, it just cannot be done in *your* setting. We have already mentioned the major forces that tend to inhibit consultation from occurring, that is, lack of training and press for direct service. Personal commitment to the use of consultation is, however, probably the most effective predictor to use. Successful service providers are often reluctant to change roles. Listed in Table 1 are some "tips" for people interested in using consultation as a tool.

You begin a consultation program by involving regular education teachers, parents, and administrators in the problem solving steps taken to develop plans for the disturbed child. Plans must contain elements that can be done by people other than yourself. Observing in other classrooms, offering support, stressing preventive procedures in the classroom and in the home are important consultation components.

Your belief in the rightness of what you are doing will iron out some of the implementation difficulties. Others such as scarce administrator support can be achieved by targeting the recalcitrant administrator as a consultee--not as an obstacle. You may have to reeducate an entire school building through workshops, special media events, modeling, interpersonal support, and plain hard work. Begin by reading some of the books listed in the references.

It may also be helpful to remember that the regularities of school life change slowly (Sarason, 1971) but *are* amenable to change. Planned systematic efforts *do* pay off. There are numerous examples in the literature and in the experience of others that support the efficacy of adding consultation to the skill repertoire of child oriented professionals (see especially, Mannino & Shore, 1975; Medway, 1979). The goal of making schools health producing settings seems to depend on certain key professionals sharing their expertise with others. Such a process is by its nature a long term commitment. Such commitments are sorely needed.

TABLE 1

Tips for Resource Teachers Doing Consultation

Getting to Know Consultee

1. Establish proximity (social gatherings, "hanging around," appearing approachable)
2. Schedule meetings (prove that you're friendly, conform to "regularities")

Issues in Relationship Building

1. Relationship building is a directed process ("sit beside consultee," ask enriching questions, get whole story).
2. Foster consultee's self respect (no snap judgments; consultees fear looking foolish).
3. Deal with consultee's anxiety *about the case* (don't reassure; model calm concerned problem solving); *about the consultant* (be prepared for constant testing; don't judge).
4. Consultant as role model (try to demonstrate three Human Service Universals: (a) empathy; (b) tolerance of feelings; (c) conviction that, with enough information, all human behavior is understandable).
5. Clarification of consultation contract.
6. Maintaining confidentiality.
7. "One downmanship" (answer deference by deference; purpose of consultation is to *lighten* load on consultee).
8. Avoidance of psychotherapy (techniques include: prevent situation; ask objective, not personal, questions; discussion of client is safety zone; don't let consultee control with anxiety; beware of generalizations; learn tactful but quick interruptions).
9. Consultation:

   Postulates:

   a. The setting is always part of the problem.
   b. Some obstacle blocks effective problem solving behaviors.
   c. Help must be located near the setting.
   d. Goals and values of consultants must be cor istent with goals and values of setting.
   e. Form of help should have potential for being established on a systematic basis using the natural resources of the setting.
   f. Errors are inevitable.
   g. Efforts will be misunderstood.

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ALTERNATIVE SCHOOLS FOR TROUBLED YOUTH: BRIDGING THE DOMAINS OF EDUCATION AND TREATMENT

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"An alternative school is simply a school accessible by choice, not assignment" (Duke, 1978, p. 4). With such a broad definition, it should not be surprising that a wide variety of programs and philosophies have flown the flag of "alternative school." Typically, early alternatives were homogeneous in social class and racial composition and had in common only the desire to break with traditional public school methods and organization. As many alternative schools have found themselves serving significant numbers of alienated students, there has been a growing interest in wider use of alternative education programs designed for specific populations of troubled youth (Gold, 1978).

With a clearer idea of what they opposed rather than what they proposed, staff and students in early alternative schools were often more preoccupied with "doing their own thing" than with building a viable organization (Deal, 1978). Successful alternative schools frequently have been unable to identify the basis for their success. Thus participants in an exciting free school may believe success is due to abandoning the "rigidity" of other schools, while advocates of a productive back to basics school may attribute success to reasserting discipline and control lost in the "permissiveness" of regular education. If programs espousing contradictory philosophies can succeed--and there is evidence that they do--then perhaps their effectiveness is due to other less salient factors which they have in common.

The literature on alternative schools is not in agreement on the elements essential to viable programs. Various investigators have identified factors such as organizational structure, social setting, or operational issues of time, space, resources, and grouping (Duke, 1978). However, research on successful school programs suggests the need for a wholistic outlook encompassing multiple variables.

Critical variables acting in harmony create a synergistic effect, while the absence of a critical factor has a debilitating effect, according to Clark, Lotto, and McCarthy (1980). In their analysis of

1200 studies on factors related to success in urban schools, they identify a number of salient dimensions including *strong leadership* that creates a climate of *positive expectations*, *reduced child-adult ratios*, *goal specificity*, and high levels of *parental involvement*. Contrary to expectations, they found that within reasonable limits, success was unrelated to the availability of resources or facilities. And, in a conclusion which challenges the philosophy underlying many contemporary alternatives, they suggest that schools serving urban youth were most likely to succeed if they offer a *structured learning environment* such as that provided by diagnostic-prescriptive instruction. Youth who are lacking order in other aspects of their lives seem to need and respond to this structure in school.

Gold (1978) has highlighted the personal characteristics of alternative school teachers as essential to establishing *warm relationships and mutual respect* with students alienated from traditional schools. The importance of developing *positive peer group cultures* has been suggested by others as a crucial variable in programs for troubled youth, although to date rigorous research on the effectiveness of peer group counseling is lacking (OJJDP, 1980; Whittaker, 1979). In summarizing the results of a number of research studies on alternative schools, Timpane concluded that favorable impacts of alternatives can be explained to a considerable degree by their *typically small size* (Carnegie Council on Policy Studies in Higher Education, 1979).

THE DEFINITION DILEMMA

The development of alternative schools serving troubled youth is complicated by confusion over the category of emotional disturbance. As Sarason and Doris (1979) suggested, many of our definitions of *deviance* are really social inventions. Unlike more precise physical handicaps, emotional disturbance is not a concrete condition but is in fact whatever our culture decides it should be. Regulations accompanying Public Law 94-142 attempt to strip from this category children who are "socially maladjusted." Kauffman (1980) pointed out that the addition of this disclaimer makes the concept nonsensical. The definition is inconsistent since it also embraces Bower's (1960, p. 9) long established premise that emotional disturbance is marked by "an inability to build or maintain satisfactory interpersonal relationships with peers and teachers." Such revisionist "newspeak" can only serve to limit the flow of services to children with socioemotional handicaps.

A number of emerging programs offer students and their parents the freedom to exercise special education placement procedures to gain access to alternative schools designed to serve troubled youth, specifically those who could be labeled as *severely behaviorally handicapped* or *emotionally disturbed*. The workability of such arrangements is dependent upon the operating definition of *emotional disturbance* in the particular school district and the willingness of youth and parents to

submit themselves to the labeling process. Since the ambiguous federal definition allows as much range for interpretation as a Rorschach card, school districts may choose to follow either an inclusionary or exclusionary bias, a decision more often made on political than professional grounds.

The creation of alternative schools serving problem youth under the auspices of special education funding confounds traditional assumptions of both special education and alternative education. The past decade has seen bureaucratic regulations transform special education from its original role as an opportunity for children to a "restrictive alternative" from which children should be protected. In contrast, alternative schools offer greater "freedom of choice" to young people and their families, and thus are on the side of the angels in the least restrictive alternative controversy.

THE BEST OF TWO WORLDS: LINKING EDUCATION AND TREATMENT

Most traditional youth-serving organizations are ill equipped to meet the broad range of needs of emotionally disturbed children. Typically, educators and treatment personnel have operated in separate domains with widely divergent philosophies and methods. The result has been a process described by Morse (1979) as the "tacit collaboration of the various professionals to break the youngster into many pieces" (p. 16).

There is growing awareness that interdisciplinary and interorganizational cooperation will be required to adequately meet the complex challenges presented by troubled youth. One such attempt to link philosophies and organizations is the Starr Commonwealth Alternative Education Program. This program is the product of cooperative efforts by a child-care agency, the public schools, and a juvenile court. The program is operated by the Starr Commonwealth Schools, a nonprofit organization serving troubled youth at three campuses in Michigan and Ohio.

In 1979, following an earlier experience developing an elementary day school program in Columbus, Starr Commonwealth embarked on a coeducational secondary alternative day school program at its campus in Van Wert, a city of 12,000 in a rural area of northwestern Ohio. Situated amidst the natural beauty of a wooded 40 acre country estate, the Van Wert campus provides a residential environment for 45 adolescent boys in an atmosphere similar to a small private boarding school. The philosophy underlying Starr Commonwealth's treatment program is that of a total living-learning milieu (Trieschman, Whittaker, & Brendtro, 1969). Starr's adolescent programs have been active in the development of positive peer group treatment methodologies (Vorrath & Brendtro, 1974). The basic staff role in Starr's treatment programs is that of educateur, an interdisciplinary generalist in the wholistic education and treatment of troubled children (Heward & Orlansky, 1980).

The Starr Commonwealth alternative program initially was designed to serve 10 to 12 students from Van Wert County, with application made by school, court, or family. Students must voluntarily elect this placement. Admission is determined subject to the development of an individualized education program (IEP).

Key program staff include a special education teacher, an educateur, and a part time secretary-aide. Starr Commonwealth's residential program provides administrative leadership as well as the services of a resource teacher to the alternative school.

School facilities include academic classrooms, a gymnasium, athletic field, track, tennis courts, Olympic size pool, and resources for arts, crafts, music, and drama. The individualized academic program is based on a diagnostic-prescriptive methodology emphasizing basic communication and math skills. Extensive use is made of community resources and students are involved in outdoor education activities, culminating in a 1 week spring camping trip to the Smokey Mountains.

Program staff fill much broader roles than specialists in larger schools. Thus the educateur serves as individual and group counselor and maintains liaison with the families and community agencies. The teacher is involved in a variety of activities beyond the traditional instruction and the roles of the teacher and educateur often overlap. Although students frequently enter the program with the attitude "I hate teachers," they soon discover a level of intimacy and involvement which is neither typical nor perhaps *allowed* in public schools. Through field trips, parent contacts, and close interpersonal relationships, staff are able to communicate a commitment beyond the call of duty.

The alternative program is designed to achieve structure without rigidity. The elaborate rules common in large organizations are wiped away and the students start fresh in primary group human relationships. The size and informality allows wide flexibility. Cross age grouping, the varied course of studies, and spontaneous access to the community create a highly stimulating and challenging climate. While staff seek to build an *esprit de corps* within the alternative school, they also continually impress on students that this is a temporary alternative and that they must focus on future placement in another school, vocational training, or employment. The average length of stay is 1 year.

Youth admitted to the program are between the ages of 14 and 18 and the ratio of boys to girls is about three to one. Students present a wide range of problems including nonachievement, school and home truancy, severe authority conflicts, drug abuse, vandalism, and other delinquent offenses. While staff were initially concerned that the IEP process might complicate admission, these fears were unfounded. School personnel, families, and students have viewed the alternative school as a resource for problem solving to be freely elected rather than a legalistic screening or labeling process. The obvious problem solving emphasis of the program and its tie to a residential treatment center have to date prevented spurious applications from youth not requiring

this special environment. For youth who were experiencing severe conflict in public school and who already were under the supervision of the court, this program came to be viewed not as a punishment but as an escape. While it is obvious that court involvement could be coercive in the youth's decision to change schools, most youth and their families initially see the alternative school, if not in a totally positive light, at least as a less disastrous option than continued failure in the regular school.

From the onset, full involvement of parents was a principal focus of the alternative school. However, treatment personnel in residential agencies have tended to view parents as either clients or patients, which did not seem proper for this setting. Because of the public school connection, it seemed more appropriate to approach the parents as partners, based upon the radical notion that perhaps we need them at least as much as they need us. Furthermore, the intent was not to presume that the problems of the young person were necessarily of the parent's doing--most parents would feel this responsibility regardless. Should contact with parents lead to family counseling, this is accommodated, but the basic relationship continues to be a partnership. At this time parent groups have not been used even though these are a key element in the residential program. If this is a weakness, it is because parents can learn much from one another.

Many alternative schools provide a major if not controlling role for parents in the governing structure. While alternative school staff were committed to parental input and involvement, the governance of the program was intentionally kept in the hands of professionals. Since students typically stay less than one year, parents in such a program are by nature transient and continuity and permanence depend upon the staff. Furthermore, staff with experience in operating programs for troubled youth were confident of their treatment and educational skills and did not feel that program design and administration were areas in which parents could make the greatest contributions.

The principal formal mechanism for parental contact is a biweekly conference either at the school or in the parent's home. Although the educateur is responsible for this contact, other school staff are in almost continual informal communication with the family. Scarcely a day passes where several telephone contacts are not made between staff and various parents, and parents may be asked to come to the program amidst a problem with a youth if this is seen as helpful. While the educational curriculum operates on a 9 month basis, regular parent contact as well as twice weekly student group meetings continue throughout the summer.

MAKING CARING FASHIONABLE

Students in the alternative program are involved in a peer group treatment process designed to emphasize positive values of caring, helping, and responsibility. Formal group sessions are held for 1 hour daily, with the educateur serving as group leader. The goal is to develop positive peer leadership skills in problem identification and resolution. The structure of group meetings includes identifying specific goals for

change, focusing help on a particular student, and feedback by the adult leader. The helping process is extended beyond the group meeting as youth assist one another in a variety of ways, including support for positive behavior, peer tutorials, and informal relationships in the community. The intent is to create a climate of shared concern where youth provide one another with positive peer reinforcement for pro-social behavior. As young people learn to be of value to others they increase their own feeling of worthiness and build positive self concepts.

Staff must be vigilant to keep the tone positive. The adults must maintain ultimate control within the peer group process to insure that absolutely no license is given for peer punishment or intimidation but only for peer concern. The success of the program is dependent upon building a climate of trust rather than confrontation. In a homogeneous population of troubled youth without the balance of conventional students, there exists a clear risk of creating a negative peer culture. Unless the alternative school is strongly positive and productive, the result will be a destructive environment with all of the problems inherent in segregating, tracking, and labeling deviant youth.

However laudable it might be to create a group climate where students reach out to one another, this is not sufficient. Caring for "your own" is not a mark of distinction but of normalcy. The program seeks to expand this self interest to the world beyond the in-group. Through regular service-learning projects, the helping process is generalized to other citizens in the community at large. Students and their staff have engaged in a wide variety of volunteer activities, typically with senior citizens and smaller children. Thus a group may help an aged couple by chopping firewood or painting their home, or provide recreation for disadvantaged children in a Head Start program. These projects cannot be contrived, artificial, or make-work but must be a genuine response to meeting human needs. In order that service-learning continues to be interesting and reinforcing, staff seek to keep activities spontaneous rather than allowing them to become an institutionalized "helping time."

The thrust of the group program is to involve youth to a greater degree in creating change than in being changed. Rather than hoping troubled young people will come forth with a "cry for help," youth are asked instead to help one another. As caring becomes fashionable, young people learn to receive as well as to give help. In reaching out to another person, the youth create their own proof of worthiness: being of value to someone.

While the alternative and residential programs have been structurally autonomous, it has been neither possible nor desirable to preclude all contacts between these groups of students. Certain schoolwide activities lend themselves to involving both residential and day students. Furthermore, staff and students from residential groups have from time to time been a resource for youth in the alternative program, particularly in the initial development of a positive group culture. There

have been isolated instances where residential students have attempted to enlist day students for drug connections but this has only provided grist for productive problem solving discussions in the respective groups.

For obvious reasons, nonresidential group treatment programs have less control over the activities of youth than is provided by the total environment of residential treatment. While this may be seen as a limitation, in reality, staff in the day program have the opportunity to observe and change behavior in a more natural setting. Furthermore, students do not face as drastic an adjustment in transferring from the alternative school as do those who leave the protection of the residential environment.

The advantages of close proximity to the child's home are obvious. If a student comes to school in a belligerent mood, the teacher or educateur can immediately consult with the parents. Probation workers assigned to students in the alternative school are readily available and can work very closely with school staff. In some instances, new students have exhibited attendance problems and on occasion the group and teacher have, with parental invitation, driven directly to the student's house to encourage the youth to return with them to school. Commonly a student in a regular public school can miss many days without attracting attention or intervention. The personalized concern of peers and staff in the alternative school can have a pronounced impact on a youngster's involvement in the program.

Students have generally known one another prior to enrollment and will continue to have community contact indefinitely. This is a marked difference from many residential groups where the transitory relationships of youth from different communities can offer a protective anonymity. Thus alternative school youth occasionally encounter situations where a particularly embarrassing personal problem, such as sexual abuse, cannot be easily handled in the group format. To meet such needs, individual counseling is always available parallel to the group process.

PROGRAM EVALUATION

Much of the literature on alternative schools is more promotional than data based. However, the Carnegie Council (1979) reported that a number of research evaluations have found such programs to result in improved attendance, achievement, and attitudes. One might question whether these positive findings would hold in an alternative school serving a homogeneous population of troubled youth.

The Starr Commonwealth Alternative Education Program (AEP) employs an ongoing process of evaluation which includes attendance measures, achievement testing, and attitudes as reported by parents. Preliminary information is now available on eight students who have been enrolled in the program an average of 7½ months.

Attendance records were obtained from the students' previous high school for the academic year prior to entry in AEP. The average youth had been reported absent 25.4% of the days school was in session. In contrast, during their time in AEP students were in attendance 94% of the days, with absenteeism at 6%.

Upon entry, the average youth was in the 11th grade with reading and math achievement over 4 years below grade level. Reading achievement increased from a grade level of 6.6 at admission (pretest) to 8.0 at the end of the academic year (posttest) as measured by the Woodcock Reading Mastery Test. Since the typical student had only been achieving an average of 0.6 of a grade level per year in previous schooling, the reading gain of 1.4 grade levels in AEP is more than twice that which might reasonably be expected.

In contrast to the marked gains in reading achievement, scores on the Key Math Diagnostic Arithmetic Test showed minimal gains from 6.9 at pretest to 7.1 at posttest. This lack of measured improvement in math achievement in a course of studies emphasizing math skills raises obvious questions. One possible explanation is that the content of the test items does not reflect the math curriculum which is heavily oriented to practical consumer skills.

Through a questionnaire survey parents were asked to evaluate their experiences with the previous school and AEP, as well as the attitudes of their son or daughter toward both settings. Seven of the eight parents were available to complete the questionnaire. Six of the parents (86%) felt AEP staff understood the problems and needs of their child to a "great extent" or "very great extent," while none expressed this feeling about the regular public school. All of the parents described communication between themselves and AEP staff as "excellent" or "good," while 86% characterized communications with previous school personnel as "fair" or "poor." When asked about their child's attitude toward AEP, 86% indicated it was "somewhat positive" or "very positive," while attitudes toward regular school were described as "somewhat negative" or "very negative" in 71% of the cases. Parents were asked to indicate areas for change in AEP as well as elements of the program they liked best. One parent criticized the program because she felt her child "was not punished enough." A majority of the parents mentioned family meetings as among the most positive aspects of the program.

Although more rigorous research with larger populations of students will be necessary, these preliminary data clearly suggest that alternative schools for troubled youth can result in improvement in attendance, achievement, and attitudes.

THE BOTTOM LINE

In addition to combining concepts from special education and alternative education, the Starr Commonwealth program strives to bridge the domains of teaching and treatment. Public school philosophies of education traditionally have been devoid of treatment constructs. In fact, some

states have refused to include "treatment" services within Public Law 94-142, choosing to identify these as medical rather than educational interventions. As is so often the case, the bottom line is money, and government units are reluctant to augment existing services while their buying power is diminished (Schools Should Provide Mental Health Services, 1980). The funding for AEP combines special education resources with outside community support. The noneducational services have been underwritten by corporate donations with the administrative overhead donated by Starr's residential treatment program. On an annual basis, the per pupil cost, including summer counseling services, is approximately $4,000.

In spite of the fact that local school district contributions are limited to providing special education staff, some community resistance was encountered concerning a program cost significantly exceeding traditional per pupil costs. Some individuals expressed the belief that it would be preferable to send the youth away from the community and let the state handle them. Certain public school teachers voiced the criticism that this large amount of money would be better spent by adding resources to existing school programs. In fact, it is fair to say that the only real controversy surrounding the program has been and continues to be the issue of responsibility for long range funding.

Public schools as well as residential group care agencies are being faced with difficult choices in a time of intensified competition for limited resources. Will they continue to conduct business as usual in the face of demonstrated needs for new alternatives to serve troubled youth? The experience of the Starr Commonwealth alternative school suggests that untapped potential for innovation exists through forging creative partnerships between public schools and child treatment organizations. However, if alternative schools are to serve as a vehicle for reforming traditional youth-serving institutions, then, as Nelsen (1972) suggested, critical organizational issues must be resolved including ongoing funding, cost effectiveness, accountability, responsible community control, and effective linkages with the public school system and other alternative models.

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THE ELMWOOD CENTER: ALTERNATIVE PROGRAMING FOR SECONDARY BEHAVIORALLY DISTURBED STUDENTS

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The development of programs to meet the needs of secondary students exhibiting behavior disorders has been a priority for the past several years. Communities, nationwide, have struggled with vandalism, increasing dropout rates, juvenile arrests, teacher and student assaults, poor achievement, and drug and alcohol use in the schools. The situation in Rockford, Illinois, was typical of large school districts. During the 1973-74 academic year, for example, 130 students between the ages of 12 and 16 were referred out of their regular middle or secondary schools because of their inability to function in the school setting. These students had been exposed to and had exhausted a number of program options made available by the school district. These options included schedule changes, special programing, resource arrangements, and "p.m." and storefront schools. Many of these students were approaching or had reached dropout status, expulsion, or were juvenile parolees. The types of problems exhibited by these students included running away, truancy, potential and actual delinquency, lack of success in school, and social ineptness. These students qualified for categorization in varying combinations under existing state terminology as learning disabled, behavior disordered, socially maladjusted, and educable mentally retarded. These were students for whom the school district and the special education program had no more options.

HISTORY AND PHILOSOPHY

During 1974, the special education staff began to explore new means of programing for those adolescents who were not successful in existing program options. These students constituted an unsuccessful, difficult to manage population. They sought to be independent and "run their own lives." By and large, they refused to cooperate with the educational system and to respond to parental control. Therefore, it was decided to establish a self contained program free from the distractions and peer pressures of a typical urban high school. Due to incorporation, Elmwood Elementary School was to be closed. The school was located in a rural

area just outside of town. The school consisted of six classrooms, a gym, an industrial arts area, and office space. The site and the facilities satisfied the criterion of an isolated, distraction free environment suitable for a population of 50 to 80 students.

It is important to comment on the issue of least restrictive environment at this point. The developers of the program recognized the emphasis on educating students in the least restrictive setting. However, the district was committed to the notion that students be educated in an environment appropriate to meeting their needs. These students had not been successful in a number of less restrictive educational options. It was decided, therefore, that a self contained, special public school was the last remaining least restrictive environment prior to residential placement that the school system could provide. Viewed within the context of a continuum of increasingly restrictive environments, the Elmwood concept seemed appropriate and reasonable.

REFERRAL PROCEDURES

Referrals to Elmwood may be initiated by the district's middle schools, high schools, Evaluation Clinic, Attendance Department, Special Education Services, and outside agencies such as the Juvenile Court. In order to establish a priority among referrals and to determine individual student needs, each referral must include not only a statement of the presenting problem but also a description of the adjustments in the instructional program which have been attempted for the student. Additional information would include intellectual and achievement levels, psychological opinion of personality factors, personal interests and attitudes, health information, attitude toward school, general academic and social strengths and weaknesses, and recommendations. The types of behaviors that typically initiate consideration for placement in Elmwood are presented in Table 1.

Referrals are reviewed biweekly by the Advisory Council of the Special Extension Study Program. The Advisory Council consists of:

1. Director of Special Education or designee
2. Director of Attendance or designee
3. Chief Social Worker or designee
4. Chief School Psychologist or designee
5. Middle School Representatives
6. High School Representatives
7. Behavior Disorders Coordinator

It is important to note the degree to which regular education staff are involved in the diagnostic and programing process for Elmwood clients. This involvement was considered critical in that some of the referred students may be reintegrated into regular programs at some point in the future. Support for the reintegration process is sought at the time that regular educators identify a problem. Their participation in the diagnostic and programing process is conducive to securing support for later reintegration efforts.

TABLE 1

Elmwood Intake Behavioral Profile

I. WITHDRAWAL - Self Involvement

1. Preoccupation--in a world of his or her own (sleeping/daydreaming)
2. Off task, but not disruptive behavior (doodling)
3. Nonparticipation in group activities
4. Generally annoying behaviors (pencil tapping, foot tapping)

II. INTERACTION - Verbal/Physical

1. Interrupts class (blurts out)
2. Interferes with or annoys peers in class
   a. Misleads others
   b. Easily misled
3. Acting out to seek attention (class clown)
4. Pokes, torments, teases classmates
5. Stealing
6. Gambling
7. Lying (students, staff)
8. Using drugs/alcohol
9. Always supports negative point of view (chumps)
10. Stoolie/tattle tale

III. AGGRESSION

1. Verbal
   a. Uses profane language
   b. Hot tempered, easily angered
   c. Extorts other students
   d. Threatens harm to peers/staff
2. Physical
   a. Fights (opposite sex, peers, staff members)
   b. Use or possession of weapons
   c. Throws objects (chairs, books, etc.)

IV. RESISTANCE

1. Verbal
   a. Acts defiant--will not comply with reasonable requests (challenges teacher to confrontation)
   b. Argues with teacher about assignments or procedures; belittles, or makes derogatory remarks about subject matter
   c. Ignores warnings/tests limits
   d. Projects blame
   e. Sneakiness/underhandedness
2. Physical
   a. Runs away from problem (flight)
   b. Seeks way to avoid class (passes to nurse, office, etc.)
   c. Forces physical confrontation with teacher

The Advisory Council reviews all relevant information to decide if all existing regular building program options have been exhausted with no appreciable effect on the student's academic and social behavior. If such is the case, the student is referred to Elmwood.

Upon acceptance into the Elmwood Program, the student is re-staffed by the Elmwood Center Building Team. The purpose of this staffing is to determine appropriate placement and to set a starting and orientation date. Staffings are held each Thursday afternoon. The principal is responsible for setting a time for the student and his or her parent/guardian to visit the school. The principal is also responsible for arranging transportation for the student, collecting relevant materials on each student, and assigning a staff member to oversee the orientation program for the student. A minimum of one day is set aside for assessing the student's academic skills and for orienting him or her to the school.

THE PROGRAM

The program was arrived at through the compilation of existing theories, the expertise and background of the staff, and trial and error experiences of the last year's program. The program is designed to meet the needs of each of the students and not to reflect the biases of a particular staff member or discipline.

The program for each student is twofold. The first and primary objective is to identify and modify the inappropriate behavior that prompted the student's removal from the general academic setting. The second objective is to satisfy the student's academic needs. This objective is realized in two ways. Each student's academic program is individualized. Remedial support is provided for those students exhibiting learning problems. In addition, the staff will explore and develop a vocational program for a student when appropriate.

Each of these objectives is addressed in each of three stages. Briefly the three stages may be described as follows: Stage 1 consists of a daily 2½ hour class session. This session accommodates students who are in need of intense behavioral structuring and academic remediation. Placement is determined at a staffing after all attempts to assist a student in a Stage 2 setting have failed.

Stages 2 and 3 consist of a daily 5 hour program that is in operation from 8:00 a.m. to 1:00 p.m. These programs accommodate those students whose behavior is such that they are being considered for placement in a regular high school program and/or alternative vocational environment. A description of the behavioral, academic and vocational programs follows.

Behavioral Program

The ultimate behavioral objectives are to help each student become responsible for his or her own behaviors and attitudes and to become aware that the choice he or she makes has a consequent result which may help or hurt him or her or others.

The Behavioral Program is divided into three stages: Stage 1 consists of the identification of each student's individual behavioral problem. Token economy strategies are used to diminish negative behavior and reward positive behavior. Stages 2 and 3 consist of a behavior modification/classroom management model enhanced by group therapy sessions. The sessions are concerned with the identification of individual negative behavior and the development of positive alternatives through problem solving techniques.

Academic Program

The Elmwood academic program has two functions. In addition to helping the students achieve success at or near their grade level, the program offers high school credit courses for those students whose improved behavior will facilitate their return to a general education environment. The program consists of an individualized core curriculum in a structured self contained setting.

Stage 1	Suggested Curriculum (Completely individualized)
	Mathematics
	English/Vocabulary
	Crafts
	Individual Counseling
	Other Elective if needed

Stages 2 & 3	Suggested Curriculum (Individualized, with minimal group instruction)
	Mathematics/Science
	English
	Physical Education
	Shop/Crafts/Health
	Vocational Exploration/High School Electives
	Group Therapy
	Job Skills

Instructional levels and academic progress are monitored by means of pretesting and posttesting. Academic progress is closely monitored by the teachers to make certain that each student continues to progress successfully.

Vocational Program

The vocational program is offered to Stage 2 and 3 students only. It has two primary functions. The first is to teach practical skills that relate to the working environment. The second is actual job placement for those students not returning to a general education setting. Vocational direction is determined at a staffing attended by the student, his or her parents, and school personnel.

THE STAGE SEQUENCE

As mentioned previously, the behavioral, academic, and vocational programs are offered within a three stage context. The stages represent levels of academic performance, appropriate behavior, and degree of staff control over student behavior. All students enter Elmwood at the Stage 2 level. Their behavior dictates whether they progress to Stage 3 or are phased into a Stage 2 contract phase, a Stage 2 transition phase, or are placed into a Stage 1 classroom. Figure 1 depicts the program options through which a student may progress. Each stage can be described in terms of its purpose, structure, curriculum, management approach, and schedule.

Stage 1

Purpose
1. To provide the fundamental skills of reading and mathematics.
2. To modify inappropriate antisocial behavior through the formation of acceptable alternatives and options.

Structure This stage consists of a highly structured management program. Placement in the Stage 1 program is only for those students who fail to meet the requirements of Stage 2 behaviors. Placement in Stage 1 occurs only after a student has two opportunities to remain in Stage 2. The two opportunities are provided through a contract arrangement and a reduction in the number of hours attended per school day. Consequences for inappropriate behavior are swift and consistent. Alternative methods of behavior modification, along with token economy strategies, are employed. Students may earn a total of 20 points per day for exhibiting positive behaviors. The three behaviors which are monitored are in seat, quiet, and working on task. Additional behaviors, such as fighting, use of profanity, and forgery, are also monitored. These behaviors are discussed in the Discipline Procedure section of this paper. Upward movement to the Stage 2 program is dependent upon attainment of the following criteria: 80% attendance and 30 good days (17 points or more).

Curriculum Each subject is completely individualized, in accordance with the student's present achievement level. The subject content is altered to fit the particular needs of each student. Mathematics is oriented to studies in consumer buying and budgeting. Communication skills include vocabulary building, writing sentences, and spelling.

Management Approach Each student's problem area is exposed and clarified. Acceptable alternatives to coping with those problems are offered. The students are also provided with an avenue for expression and discussion of their feelings and emotions. At the same time the students are expected to adhere to strict behavior. Individual counseling is provided.

Suggested Schedule Stage 1 classes meet for 2½ hours, 5 days a week. The number of days per week may be altered if a student's behavior is severe enough to cause disruption to the program or harm to himself or herself or others in the building.

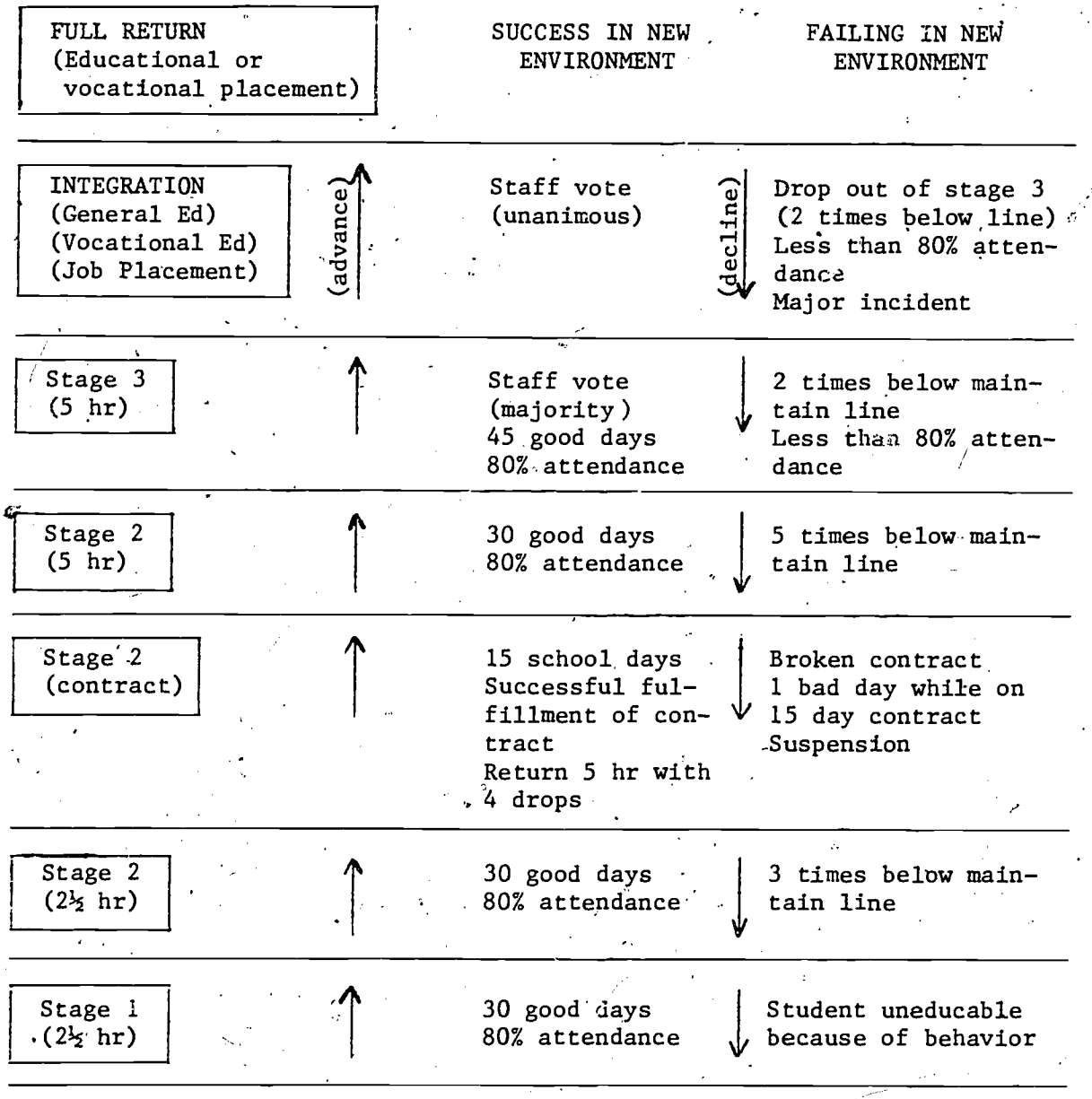

FIGURE 1. Flow chart of student program options.

Stages 2 and 3

Purpose
1. To provide the academic skills required to successfully complete course work in vocational/general education setting.
2. To identify each student's inappropriate behavior and to assist him or her in identifying a variety of acceptable alternatives through problem solving techniques.

Structure These stages use a point system. This system is used to create an environment that provides the structure, discipline, and consistency each student needs to foster a successful return to a general education or vocational setting. The student is monitored for the following behaviors: appropriate peer interaction, cooperation with staff, and working on task. The student may earn a total of six points per period for the three behaviors being monitored and four points for Break and Lunch. Students may earn 40 points per day for exhibiting positive behavior. Industrial Arts is earned by acquiring 35 points or more on the previous day. Attendance is also monitored. Minimal levels of attendance are set. For example, 80% attendance means no more than four unexcused absences in a four week period. Stage 2 and 3 students are housed in the same classroom. The relationship between Stage 2 and Stage 3 behavior is depicted in Figure 2.

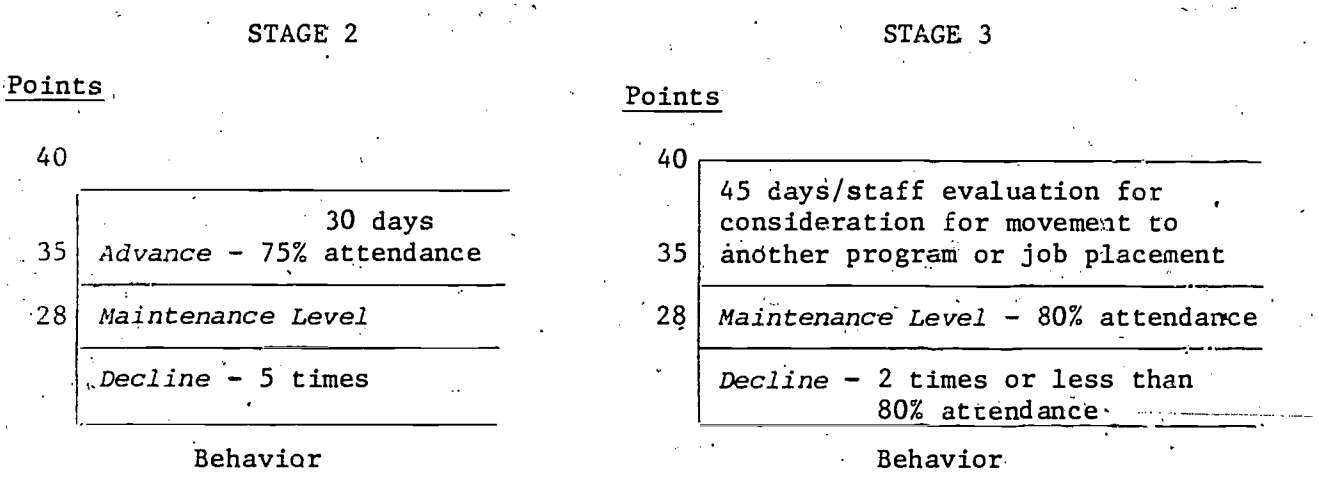

FIGURE 2. Stage 2 v. stage 3 behaviors

Curriculum The recommended core curriculum consists of mathematics/science, English, physical education, industrial arts/creative arts, group therapy/social studies/health, and job skills. Other courses may be substituted at any time in order to meet a student's individual requirements. Each subject is completely individualized in accordance with the student's achievement level.

Management Approach An eclectic approach is used which includes behavior modification, group therapy, reality therapy, peer pressure, contingency contracting, and parental and community involvement. Rap sessions are held as often as needed for all students in both Stages 2 and 3. The purpose of these sessions is to discuss alternatives to inappropriate problem behavior. Outside speakers, films, and a variety of educational materials are used to expose the student to a variety of people, places, and things that may assist him or her in the future. The sessions are under the supervision of the school psychologist.

Suggested Schedule Stage 2 and 3 classes meet for 5 hours, 5 days a week. Each full day consists of three academic subjects, physical education, and industrial arts. Periods are 45 minutes in length. Students are provided with elective subjects that assist them in gaining either a high school diploma and/or appropriate job skills which will aid them in future employment.

Students who fail to meet the 80% attendance and the "maintenance" performance level in Stage 2 are placed on a 15 day contract arrangement related to their inappropriate behavior. A maintenance level is defined as earning a minimum of 28 points per day for the three behaviors previously identified as being monitored in Stage 2. If a student fails to meet the conditions of his or her contract, their program is reduced to a 2½ hour session. During this phase, they must display 30 days of at least maintenance level behavior and maintain an 80% attendance rate. If the student's performance falls below the maintenance level, he or she is placed in a Stage 1 program. Movement upward through Stage 3 to partial and full return programs is contingent upon meeting the requirements specified at the various levels indicated in Figure 1.

PARTIAL INTEGRATION AND REENTRY PROGRAM

The purpose of the integration/reentry program is to establish a structured transition situation for the behavior disordered student who is moving from a self contained school facility to a less restrictive alternative. A variety of alternatives exist within the Rockford School System and the community. These include regular education programs, special education classes in middle and high schools, vocational training, adult education, job placement, CETA, and other community and school options.

Upon successful completion of 45 days of 90% behavioral charting and 80% attendance, the student is eligible to petition the school staff for the opportunity to return on a part time basis to a less restrictive educational setting or job related environment. In some cases, the student

is informed that he or she is under consideration for partial integration. The student is asked about his or her interest in such a move. The interviewer notes any concerns and inflated or deflated expectations that the student has in respect to his or her behavior.

Students under consideration for integration are counseled in the following areas by the Behavior Disorders Facilitator:

1. Student's concerns
2. Realistic interpretation of placement
   a. Permanence and expansion of enrollment dependent upon student's performance
   b. Not an end to Elmwood's involvement, but a continued surge of involvement and concern
3. The need for positive performance in the following areas:
   a. Attendance
   b. Relations with receiving staff and peers
   c. Attention to rules of school and class
   d. Successful completion of tasks

Final staffing for placement consideration includes:

1. Facilitator's report on student interviews
2. Final staff review of student's performance
3. Staff interview with student--to emphasize that continued success in both the Elmwood and alternative phase will result in a more complete integration program
4. Final recommendation

If the final recommendation is negative, the student and parents are given a written report citing the reasons for rejection. The report includes a time line for improvement and other considerations of which the student may need to be aware.

If the recommendation is positive, the Facilitator informs the parents and the student of the options available. When an option is agreed upon, the Facilitator presents the student and his or her credentials at a receiving staffing. Acceptance is dependent upon course offerings, openings, and needs. A final decision is reached at the staffing in the receiving program.

The student is introduced to the following appropriate people by the Facilitator: Counselor, Supervisor, Teacher, Program Administrator, Assistant Principal, and Principal.

The Facilitator is responsible for followup on the student as needed to insure continued success. Upon successful completion of at least 9 weeks of part time placement, the student is eligible to be considered for full time placement in the setting. A staffing is held at both facilities to review progress. If full time placement is appropriate, the Facilitator expedites the placement and continues followup for as long as needed. Followup information is maintained in a log book. It includes information resulting from contacts with the student, parents, building teachers and other appropriate personnel.

COOPERATIVE WORK TRAINING PROGRAM

The purpose of this phase of the program is to help the students secure gainful employment outside of the school setting. Students eligible for this aspect of the program are those who have completed all the requirements of Stage 3 and do not wish to return to a general education setting. The Elmwood Job Placement Coordinator assists the student in acquiring and maintaining employment. Periodic checks with student and employer are made. Students earn one high school credit for successful progress on the job and in school.

DISCIPLINE PROCEDURE

The behaviors displayed by the students enrolled in Elmwood vary not only in type but intensity. In order to establish a consistent response to these behaviors, a discipline procedure was developed. The procedure identifies three classes of infractions, i.e., minor (Class I), major (Class II), and serious (Class III). Behaviors included in each of these classes are listed in Table 2.

A disciplinary procedure is paired with each class of infraction. The staff responds to Class I infractions at Step A of the disciplinary procedure; Class II infractions at Step D; and Class III infractions at Step E.

The steps in the disciplinary procedure are as follows:

A. In-class teacher intervention (e.g., confrontation, moving of desks, etc.) Record in anecdotal record book.

B. Isolation from class with teacher discretion as to the amount of time and what student does while in waiting room. Loss of points for amount of out of class time. Record date, offense, and consequences in permanent file in office.

C. Conference in office with teacher, head teacher, and special services staff. Contact parent to summarize meeting and/or participation if possible.

*D. 1. Letter of suspension sent to the parents stating a 3 day suspension until parental conference can be arranged. Parents are to contact school for appointment.
2. If student must be sent home before the end of the day, notify parents by phone or other means before the child leaves school.
3. Notify superintendent and attendance supervisor with copy of Notice of Suspension form.

E. 1. Letter of suspension sent to the parents stating a 5 day suspension until parental conference can be arranged. Parents are to contact school for appointment.
2. If student is to be sent home before the end of the school day, notify parents by phone or other means before the child leaves school.

* Referral to proper police authorities may be initiated whenever appropriate.

TABLE 2

Classes of Student Infractions

Class I: Minor Infraction

1. Disorderly conduct including profanity and obscene behavior: Conduct and/or behavior which is disruptive to the orderly educational procedure of the school.
2. Defiance of school personnel's authority: Refusal to comply with reasonable requests of school personnel.
3. Verbal abuse of teachers or students.
4. Forgery: Writing and using the signature or initials of another person.
5. Smoking: Smoking in an unsupervised area at an unauthorized time.

Class II: Major Infraction

1. Fighting: Students who engage in physical contact for the purpose of inflicting harm on the other person.
2. Gambling: Participating in games of chance for the express purpose of exchanging money.
3. Extortion: The solicitation of money, or something of value, whether overt or implied, from another student, regardless of the amount, in return for protection, or in connection with a threat to inflict harm.
4. Theft or possession of stolen property: The taking of property not belonging to the student.
5. Destruction or defacement of school property: The destroying or mutilating of objects or materials of the school. Restitution or repair will be made by the offending student.
6. Possession or use of drugs and/or alcohol: The possession and/or use of any illegal drugs or alcohol in any form, on school property.
7. Turning in a false alarm or bomb threat: The reporting of any fire or bomb threat to the school when no such emergency exists.

Class III: Serious Infraction

1. Physical assault: Physical attack of one person, or a group of persons, upon another who does not wish to engage in conflict and who has not provoked the attack. A person who finds himself the victim of an assault has the right to defend himself against the attack in such a manner as to safeguard his person.
2. Possession or use of weapons: The possession or use of any instruments such as knives, clubs, guns, chains, and the like, that can be used to inflict bodily injury to another person.

3. Notify superintendent and attendance supervisor with copy of Notice of Suspension form.
4. In extreme cases, a recommendation for expulsion may be forwarded to the Superintendent of Schools for presentation to the Board of Education.

*F. 1. Letter of suspension sent to the parents stating a 10 day suspension until parental conference can be arranged. Parents are to contact school for appointment.
2. Notify parents by phone or other means before the child leaves school.
3. Notify superintendent and attendance supervisor with copy of Notice of Suspension form.
4. If appropriate, a recommendation for expulsion may be forwarded to the Superintendent of Schools for presentation to the Board of Education.

STUDENT AND PROGRAM EVALUATION

Student Evaluation

Staffings and conferences are held weekly for continuing evaluation of each student's progress. Parents are involved through conferences, progress reports, and telephone conversations.

Teachers are responsible for developing individual behavioral objectives, maintaining observational notebooks and achievement records, and documenting parent contacts.

Since it is not the intent of the program to retain a student permanently, students are directed into a variety of plans which include regular school placement, employment in the community, technical training, and military training (see Figure 3).

Student improvement is monitored in relation to the following factors: less involvement with the law, reduction in acting out behavior, improved peer-adult relations, increased attendance, increased academic achievement, and successful employment experiences.

Program Evaluation

Data on students placed in Elmwood indicate that the program does, indeed, place students in a variety of settings. Table 3 indicates less than 10% of the students served during the 1977-1980 school terms have been reintegrated into total regular school programs. Only 3% of the students are returned to a regular program supplemented by other community services. Approximately two thirds of the students return to Elmwood for a second year. The dropout rate has averaged 15% for the past 3 years.

* Referral to proper police authorities may be initiated whenever appropriate.

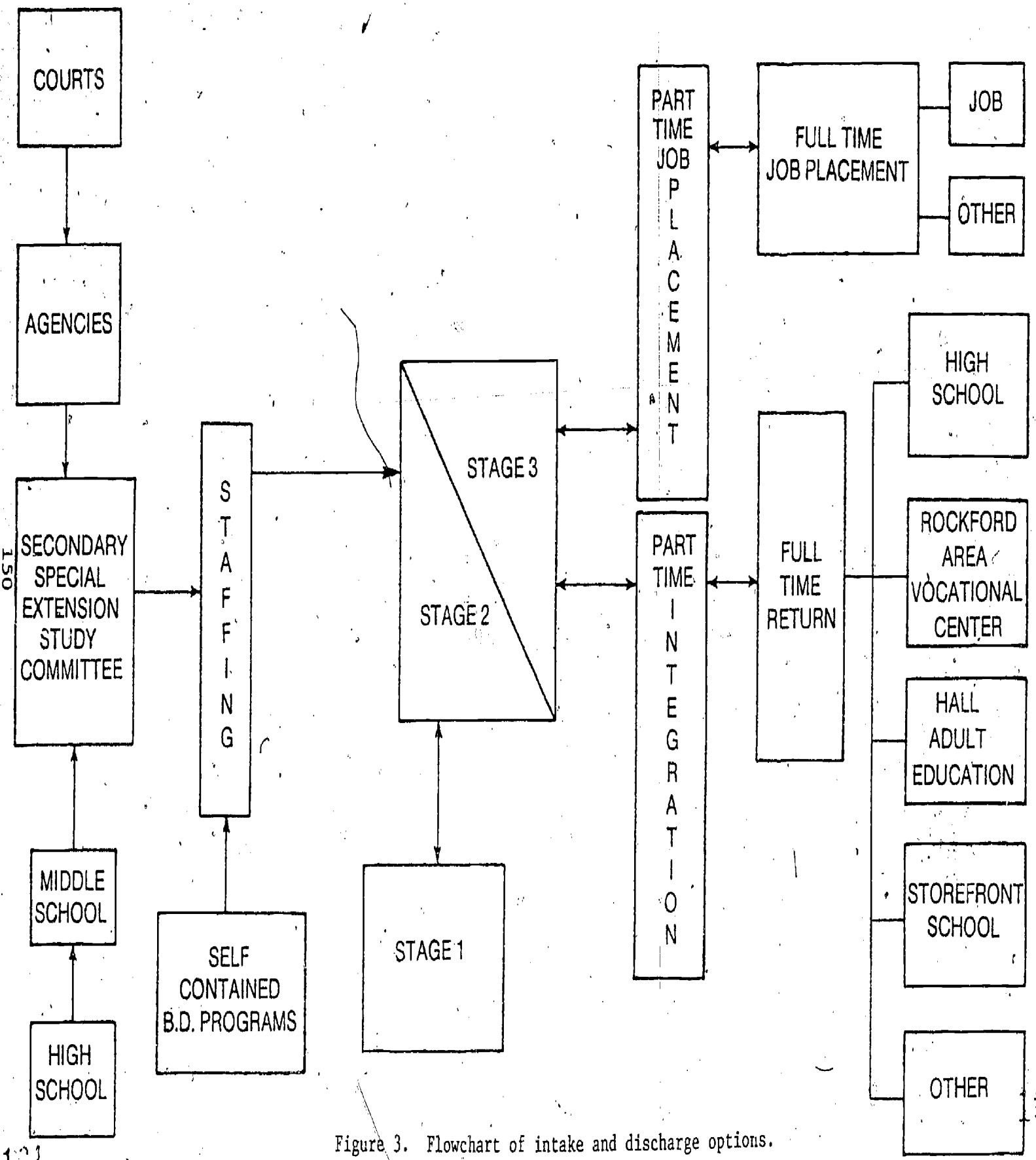

Figure 3. Flowchart of intake and discharge options.

TABLE 3

Student Placement Distribution 1977-1980

Year	Students Served	Reintegrated School		Reintegrated Community Options		Court Placements		Continued Service		Dropout Unknown	
	N	N	%	N	%	N	%	N	%	N	%
1979-80	73	8	10.9	4	5.4	5	6.8	48	65.7	8	10.9
1978-79	82	6	7.3	2	2.4	8	9.7	52	63.4	14	17.1
1977-78	85	7	8.2	2	2.3	11	12.9	50	58.8	15	17.6
Total	240	21	8.8	8	3.3	24	10.0	150	62.5	37	15.4

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At its inception, the staff felt that, given the complex, intense nature of the students' problems, the program would be successful if 10% of the students it served would be able to return and remain in some form of school program. To date, approximately 11% of the students served have remained in some type of school program. By the same token, 10% of the Elmwood students end up in court supervised placements. Combined with the dropout rate, approximately one fourth of the students served at Elmwood continue to have difficulties responding to the social responsibilities facing them.

STAFF

The Elmwood Center staff consists of a minimum of 10 certified staff with a variety of professional backgrounds and teaching certifications. Certification patterns include industrial arts, secondary English, math, science, social studies, and special education in the areas of learning disabilities, behavior disorders, and educable mental handicaps. The variety of backgrounds and certificates is an integral part of the Elmwood program, as some of the students need to be able to assimilate a regular school program if they are to earn credits toward graduating or working in a vocational-technical program.

Supportive staff include a part time program facilitator and job placement coordinator. In addition, a full time psychologist, home social worker, nurse, and home/school counselor and a one-third time vocational counselor and remedial reading specialist are assigned to the program.

REFLECTIONS

Several points are worth noting in respect to the Elmwood program. The development of secondary level programs for difficult-to-manage students is in its infancy. The Elmwood program was a response to the unique problems faced by the Rockford schools. There is a danger that others may choose to model Elmwood without consideration of the needs which Elmwood satisfied. This may be a mistake. The program planner is encouraged to analyze the Elmwood Program within the context of local needs.

Second, the program was based on the notion that what was most appropriate to meeting the students' needs was considered least restrictive. It appears that some schools have initiated programs on the basis of what is least restrictive at the expense of being most appropriate. The Elmwood staff attempts to maintain these concepts in some state of balance in relation to the student population served.

Third, the Elmwood management program was built on the notion that different students will respond to different management techniques, hence the variability in management strategies in Stages 2 and 3. A similar philosophy prevails in relation to academic performance. Rather than engaging in a philosophical debate as to whether students should be exposed to remedial or compensatory skill development, the program opted for both, depending on the response of the particular student.

One aspect of the Elmwood program that has been slow in developing is parent involvement. Monthly parent meetings have typically been held in the school with mixed results. Beginning with the 1980-81 school year, meetings will be shifted to neighborhood settings closer to the students' homes. Likewise, parent involvement in industrial arts projects is planned. It is anticipated that parent response may increase as a result of these innovations.

Lastly, it is imperative that programing at this level necessitates close working relationships with a variety of community resources. The staff at Elmwood has initiated or responded to cooperative arrangements with vocational training centers, CETA, juvenile authorities, and employers. The value of these relationships cannot be emphasized enough. They provide not only reinforcement for Elmwood's philosophy but placement or training alternatives not always available in the public school sector.

MUSIC, A THERAPEUTIC INTERVENTION FOR EMOTIONALLY DISTURBED YOUTH

Mary Jo Roter

Did you know you are being programed in many large supermarkets, department stores, doctors' offices, while driving, and even in business offices where background music is in use? Music is modifying human behavior every day and, as an individual, you are helpless to control some of the behavior the music generates.

The music you hear, even if you are not aware of it, has been programed for specific purposes. By this very subtle means your behavior is affected. In the supermarket, for example, you probably will hear popular or semiclassical tunes with moderate or mildly accelerated tempos Monday through Friday. The reason supermarkets play this type of music is obvious. You will probably move more slowly along the aisles, look at and buy more items, and find that a boring task has been made more pleasant.

In the same store, starting Friday night and running through the weekend, the tempo will be accelerated, the volume level raised a bit to be more intrusive, and the selection of tunes will tend to be short and light. The purpose of this is to keep customers moving more rapidly during the rush hours.

THE POWER OF RHYTHM

The functional use of music--that is, the use of music with a purpose other than the purely aesthetic--is a powerful force. It is powerful because the person hearing the music is forced to have some kind of reaction. Unconsciously, the listener responds because rhythm--the driver and energizer in music--enters the body at the subcortical level and travels to almost every part of the body over the autonomic nervous system. Physiologically, the rate and depth of breathing and even the pulse rate changes with the music. The striated muscles (for example, the biceps of the arm) tense or relax to the music.

It is physically impossible to restrict movement of some part of the body after being immersed in highly percussive music. This was made vividly apparent to the author during an experiment on the subject at the University of Kansas. Electrodes were placed on the skin over some of her striated muscles. The author sat comfortably in a chair while classical music was piped into the room. Because she felt completely relaxed, the results of the experiment were a shock. The paper strip record showed spikes at each cymbal crash, at sudden loud tones, at tempo changes, and at the mood changes.

The early research findings on the use of music therapy (the use of functional music in therapy) were converted by entrepreneurs into popular record albums called "Music for Listening," "Music for Dining," "Music for Romancing," and similar titles. Many of us have had personal experience with this particular use of music. To this day, the author cannot eat in a restaurant where there is loud rock music, tiny and tinny reproducing speakers, and a continuous bombardment of percussive noise. Her stomach rebels. An accompaniment of "dinner music," however, adds to mealtime pleasure.

Football games, pep rallies, and parades are another example of the functional use of music. Trumpets blare, drums beat loudly, and the march music begins. Soon fans are clapping, talking more loudly, or in some other manner releasing the physical tension generated by the musical attack. Esprit de corps exists as the crowd cheers wildly for the team. The entire emotional tone of the event has been heightened by the music used.

In church, by contrast, other music is used to produce specific desired responses. The organ, during the prelude, transforms the individual with everyday worries into a member of the church body awaiting the service. Thereafter, music continues to be used to stimulate desired behaviors--a hymn before the sermon, a musical interlude and response during collections, and a familiar hymn before leaving the service.

THE POWER OF MELODY

The power of rhythm was discussed first because without rhythm there is no music. Melody, however, also plays a major role in music. Melody requires intellectualization. It is the ego (in Freudian terms), a governor that sets the limits on rhythm. Rock music has little melody, much rhythm. In it, both voices and instruments are a mass of short, staccato sounds amplified to very high levels. When one is immersed in this very loud, percussive sound with little interruption, baser human instincts are elicited by the heavy rhythm, and the conduct of the group deteriorates.

On the other hand, the "Big Band Sound" has a good balance between rhythm and melody. With its melody, this type of music is more restful and enjoyable.

The mood of the nation is always reflected in the popular music of the moment. The tension and pressures of world conflicts can be seen in the frenetic percussiveness of music in the early 1940's and World War II, or acid rock and the Vietnam era. When pressures abate, as in the late 1940's and late 1950's, more melodic music returns.

PRINCIPLES OF MUSIC THERAPY

There are a few basic principles in music therapy, including the following:

1. Music is sound without inherent threat.
2. Music immerses one in sound, thus reducing a feeling of aloneness.
3. Music is a highly personal art form. A large group may listen to music, yet each individual will react to the music in a different way.
4. Because music activities can be enjoyed without conflict, music is a good tool for resocialization.
5. Music is a form of communication, a nonthreatening form which often succeeds when other methods fail.
6. Music can elicit the tender emotions (i.e., those based on love). Such feelings often seem nonexistent in a disturbed student, but music may provide a means for the student to develop a more positive view of self and others.
7. Through selection of warm, melodic music, a pleasant atmosphere is created which often helps a disturbed student feel more positive toward the immediate environment.
8. Good reproduction of the music is essential. When reproduced over a poor sound system (i.e., a pocket radio or a poor record player), music can be harmful. A small portable radio with a good FM station is satisfactory, as are school record players with good needles and volume control.
9. Unselected music or poor reproduction equipment should not be used. Either can be quite harmful.

To summarize the principles of the functional use of music, it may be said that music makes life less boring by providing a means for flights of imagination; it makes the lonely person feel part of a group; and when correctly used, it has the power to delay fatigue and relieve tension. Music also contributes to a sense of well being and can help people feel at ease in difficult situations.

GUIDELINES FOR THE USE OF MUSIC THERAPY

Even though an individual may be fully aware of the basic principles of music therapy, some details for its use must be stressed. It is true that moods may be changed by the *correct use of music*, but this means that the music has been selected with some or all of the principles taken into account. However, to alter the mood and/or behavior of a group, or even one person, the existing mood first must be determined. Then music is chosen to match that existing mood.

For example, if a class is "on the ceiling," playing a lullaby might send the group the rest of the way through the roof. Instead, match the hyperactive mood with stimulating music--loud, brassy, syncopated. Then very slowly change records in a way that evolves into a good march rhythm with moderate volume. This will take some time, but it is a subtle intervention in which no one feels "put down."

Matching the existing mood is called the *Iso-Moodic Principle*. This principle may be illustrated by recalling a time when you were late for a meeting or a party. As you tried frantically to dress, someone in another room turned on some lovely "mood music." That act probably brought irritated remarks or a demand to "turn it off." What happened is that your heartbeat was much faster than the beat of the music. Your negative reaction was caused by the contrasting speed of the music and your pulse. Thus, in using the Iso-Moodic Principle the pulse of the music and the pulse of the listener should be matched as closely as possible.

When the author interned as a music therapist in a state mental hospital, tranquilizers were not yet in use. However, ward aides could call the music therapy department and report that the mood of the ward was very low or perhaps becoming highly agitated. Records and tapes in the department were sequenced for raising, lowering, or maintaining moods. On a call from an aide, the therapist would pipe the appropriate music to meet the expressed need into that ward. It was not uncommon to see 10 or 12 men stop pacing and yelling, then sit down quietly without the need of restraints or physical force if allowed 20 to 30 minutes for the mood shift.

APPLICATIONS TO PROGRAMS FOR THE EMOTIONALLY DISTURBED

Considering the principles and guidelines listed, here are some suggestions for the use of music in dealing with seriously emotionally disturbed youth. Many of these ideas have come from methods developed by the author in working with music in special education classes.

Background Music

A good FM radio with the volume set slightly above the threshold level lends a good feeling to a classroom. It should be remembered, though, that background music should be mostly instrumental when any academic work is being done. This applies wherever tasks are largely mental. The obvious exception is during the Christmas season. At this time, familiar carols may be used because students seem to hum along with the tunes without being distracted from the task at hand.

In addition to using the best reproduction system possible, it is also important that breaks from the music--total system silence--should occur in midmorning and midafternoon.

The author has used a small, but adequate quality FM radio in classes of emotionally disturbed children of all ages. It is normal for students to ask for a station playing the "top forty," but this request should be refused. Normally, an "easy listening" station will serve the function best.

It is interesting to note that on several occasions when the radio was deliberately left home following a vacation, it took only a few days for the students to ask that it be returned.

Listening

This is a good activity for all ages. When the author was handling the music in emotionally disturbed classrooms, the junior high school group presented a decided challenge, which should be no surprise. Sessions were 45 minutes long, twice a week, during which the regular teacher left the room.

Guidelines established what volume level could be used and also what other activities the students could do while listening (i.e., puzzles, models, quiet games). Each student was required to choose a record for listening.

After several weeks a leader was selected who would bring records and call on other students to pick specific tunes. Any loud arguments with the leader or between other students caused the listening session to stop. By the end of the semester, though, students were dancing, helping shy class members learn dance steps, singing, and in general having a good time.

Younger children enjoyed music ranging from Disney story records, action records (recorded instructions), to the "Pink Panther Theme" which brought out many creative movements. They also enjoyed records of familiar songs such as those from the movie, "Mary Poppins." The listening sessions always were structured to lead toward resocialization. In listening and singing sessions, a student was never forced to join a group. At the same time, though, he or she was not allowed to interfere with or interrupt the group activity.

The use of the listening technique is a demonstration of music as sound without inherent threat. The student who begins to listen to music, even though not sitting with the group, is dealing with a segment of reality which can be shared with others without disagreement.

A good example of how this works occurred some years ago when the author was asked to work with an autistic student on a homebound program, and was told to "try anything." The student, 14 years old, had different levels of screams which only his mother could interpret.

It was learned that the student liked music, especially nursery rhymes. In desperation, this therapist began to play and sing songs on the "appropriate" level. Soon the student sat on the edge of the piano bench, holding himself rigid and taking great care to avoid physical contact. After several sessions, the author left off the last word of the songs. Very soon the student began to sing those last words clearly.

Finally, after many weeks of using this procedure, the student stopped the therapist from singing one day, sang several songs accurately, and left off the last word. He sat waiting for the astonished therapist to collect her wits and supply the missing words.

This exemplifies the bond of trust which music creates. However, much care must be taken to minimize adult reactions when the student makes some tentative responses. The real trust is in the music; the test by the student is in extending that trust to a person.

Rhythm Bands

This is a good music activity to use with any age. With adults, it has even been used to provide a release from tension. However, it is necessary to provide larger and more sophisticated instruments at the junior high school level and older.

In the author's experience, rhythm instruments were always kept available and often were substituted for a planned activity if the special education teacher reported the students were difficult to "settle down." Care was taken to give students instruments they could not break in order to protect them from attendant guilt.

As such a session progressed some of the more disruptive students finally would gain enough control to play a coveted instrument, such as the tambourine. Single tone bells were also popular with the students and could be used as rewarding activity.

Singing

This activity follows the same kind of pattern used in other forms of music activities. The session should begin with one or two favorite tunes; then one or two new songs should be scattered through the rest of the session.

To improve self image, songs that use the child's name may be used, or a child may be permitted to lead the songs. No child should ever be criticized or left out of a music session by the teacher. There is always one little thing each child can do well. He or she should be praised for that.

Any of the activities suggested can be used by any teacher, even those unsure of singing or playing, by turning to records. Generally, in fact, it would be preferable to use records because this permits the teacher more freedom to observe, encourage, and include all children.

The child who elects to remain apart usually will move closer and closer to the group if he or she does not feel threatened or pushed by the teacher. This, again, reminds one that music is nonthreatening, and it is to this lack of threat that the child relates. The second step is in extending that trust to the teacher.

It cannot be stressed too often that a need for action songs, creative movements, listening, or any other music activity may arise at any point during the day. There should never be any hesitation to try this type of intervention to achieve a goal.

For those students who suddenly seem to be "losing control," the author has used records and earphones. If the need is detected early enough, the

student usually welcomes this help in redirecting his or her thoughts. Choices of records should be made by the student, but checks on the volume level should be made by the teacher. Not only is high volume basically disturbing, but it can also cause hearing loss. After spending 20 minutes or more at the listening center, a student usually is able to return quietly to his or her desk and resume work.

Many students choose to listen to music as an earned free time activity. This may be coupled with working a puzzle or coloring. It is not surprising to discover that a soft drone in the room is coming from a listener with earphones--although this normally occurs late in the year. The listener becomes lost in the pleasant sound and does not realize he or she is humming--often terribly off-key. If the class is not disrupted, humming may be permitted--especially if the teacher sees it coming from a student with sparkling eyes and a smile.

Beauty is essential to the mental well being of all people. Experience has taught the author that many students, in both regular and special classes, are sorely in need of some kind of beauty. Quite often music will fill that void.

In all teaching, structure is reshaped for different activities, but is always present and clearly understood by the students. Whatever the activity, the breakdown of structure is always frightening for students, especially so for special education students.

Whatever the music activity may be, it is imperative that students be in their seats, alert and ready for academics at the end of a session. Needless to say, any special education teacher would be upset to come back from a break to find students every place but where they should be. Likewise, no one should allow students to be stimulated by free listening (no controls) at noon, then expect them to calm down at once when it is time for class.

ONE MUSICAL SUCCESS STORY

Much of the material presented here was used by the author in conducting a pilot study on the functional use of music in 10 classrooms of emotionally disturbed children for the Topeka, Kansas, public schools. The most exciting and surprising conclusion to this study--in fact, one of the most satisfying experiences ever for the author--was the presentation of a one act operetta by approximately 40 very disturbed primary and intermediate age children.

Sets and costumes were made by the parents and teachers of the classes. The lead roles were played by some of the more seriously disturbed children. In some cases, as many as three of the children were assigned to sing one person's solo--an obvious hedge against one youngster being too upset to sing the solo. The children reacted so normally on stage that one forgot this operetta was being done by a special group of students.

Invitations to attend were extended to other classrooms of emotionally disturbed children, parents of the participants, and to the district's

special education administrative staff. At 9:30 one rainy spring morning, the curtain went up for an overflow crowd of nearly 100 people. Parents even left work to see this operetta because they had never seen their children on stage before.

The children performed beautifully--at least to the audience and the author, who was playing the piano out front. Later, teachers and associates reported the students "fell apart backstage," but when they heard the music cueing their parts, they entered the stage poised and happy.

As far as the author knows, this was the first time such an operetta was presented in a public school setting solely by seriously emotionally disturbed children. It was a tremendously rewarding experience for the children, their parents, and their teachers.

For special educators, it would be redundant to detail the positive results of the experiment. But it is obvious that the students' (and the parents') self image improved; performing as a group took place; and a new form of self expression, as well as a feeling of accomplishment and satisfaction, was experienced by the children.

For any class of seriously emotionally disturbed children, a music teacher with a therapeutic background (one who serves the student first and the music second) would be the ideal. But, hopefully, the principles and guidelines set forth here will help *any* teacher adapt music therapy--the functional use of music--to *any* class.

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DIRECTIVE/PROCESS CONSULTATION WITH PARENTS OF BEHAVIORALLY DISORDERED ADOLESCENTS

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Training and consulting with parents of exceptional children has been the focus of tremendous interest in recent years. Parents are increasingly being recognized as crucial contributors to the education and treatment of their children. A number of recent publications call for maximizing "trained" parent input and involvement with children both at home (Cooper & Edge, 1978; Graubard, 1977; Patterson, 1975) and at school (Evans, 1976; Jones, 1980; Kelly, 1974; Kroth & Scholl, 1978).

Many parents of behaviorally disordered adolescents lack both the specific skills and emotional resources necessary to deal with their child. Effective consultation with parents of adolescents with behavior disorders is an often called for (Kroth, in press) yet seldom achieved goal of special education programs. Barriers to effective interaction as well as the lack of a comprehensive consultation model have resulted in a dearth of documented successful consultation efforts with these parents.

Teachers have frequently been designated to fill the role of the parent consultant (Rutherford & Edgar, 1978; Seligman, 1979) without being given the necessary skills to consult with parents. This lack of skill, coupled with the mandate of Public Law 94-142 to maximize parent involvement in the decision making process in the schools, has often led to well intentioned but ineffective and haphazard parent-teacher communication.

The purpose here is to identify parent centered, teacher centered, and adolescent centered barriers to effective parent-teacher interaction. Strengths and weaknesses of directive and process consultation models for working with parents are discussed, and a combined directive/process model is proposed as an alternative. The steps of the proposed model include (a) definition of level of involvement, (b) definition of role, (c) ecological assessment, (d) specification of intervention, (e) intervention, and (f) evaluation.

BARRIERS TO EFFECTIVE COMMUNICATION BETWEEN TEACHERS AND PARENTS

A number of barriers make working with parents difficult and working with parents of behaviorally disordered adolescents even more difficult. These barriers between teachers and parents can be classified as parent centered, teacher centered, and/or adolescent centered.

Parent Centered Barriers

One type of parent centered barrier is parent burnout. In this case, the parent no longer has the will to invest time and energy in attempting to alleviate the problems of the adolescent. Parents may have invested years of emotional and financial support in the adolescent with little or no return. Some parents have reached the point where they have no more to give and cannot be induced to participate in the school program for their child.

In addition, there are some parents who are not able to cope with their child's problems; they are confused and overwhelmed by the severity of the problems encountered. One reason for this inability to cope may be loss of control by parents of the contingencies necessary to control their children's behaviors. The positive and negative contingencies which the parents attempt to employ may not be as powerful as peer and other outside influences.

Another reason for parental inability to cope with adolescents may be the difficulty some parents have in altering their parenting style (Jones, 1980). Being a parent of a 16 year old requires skills different from those needed by a parent of a 10 year old. The adolescent is moving from dependence on parents to independence from parents. If there is the added problem of an adolescent behavior disorder, parents, as well as adolescents, might find adjustment to new adolescent behaviors very difficult.

A third factor which may contribute to the parent's inability to cope with the adolescent, and thus to an inability to work effectively with the school, is that many parents of adolescents may be going through a difficult stage in their own lives. Many parents in their late 30's and early 40's find themselves reevaluating their careers, marriages, and lifestyles (Sheehy, 1976). It may be doubly difficult to deal simultaneously with a child's behavior problems and one's own problems.

The defensiveness some parents feel concerning the behavior problems of their child represents another barrier to effective school-home interaction and cooperation. They often suppose that they are the cause of their adolescent's problems. The carryover from psychoanalytic thought that many emotional disturbances are the result of faulty parenting (Riese, 1962) has left many parents defensive in dealing with the schools and the mental health system. A possible example of this defensiveness is the lack of any formal organized parent advocacy group for behaviorally disordered children and youth. Few parents want to be identified as the parent of a behaviorally disordered or emotionally disturbed youth.

Finally, hostility of parents toward the schools is a barrier that occasionally blocks effective consultation with parents. Either through personal negative experiences with the school, or through a protracted negative history of home-school relationships with regard to their child, some parents have reached a point where any contact with the school is aversive. Parents at this point may be so hostile to the schools that parent-teacher interaction and cooperation are almost impossible to achieve.

Teacher Centered Barriers

While it is easy to place the blame for teacher-parent communication breakdown on parents, there are a number of teacher centered factors which may hamper open communication and effective parent involvement.

First, teachers, like parents, can burn out on a particular adolescent to the point where they have little or no desire to deal with that adolescent. Some behaviorally disordered adolescents' behaviors are so aversive that the teacher will not work with the adolescent, let alone the parents.

Teachers at the secondary level, again like parents, often lack control of the contingencies necessary to influence and change adolescent behavior. Peers, drugs, and cars are frequently more reinforcing than grades and teacher attention. If the adolescent responds primarily to outside variables, teacher and parent efforts to establish control will be difficult at best.

Another teacher centered barrier involves directing hostility or blame toward the parents for the adolescent's problems or for problems in establishing effective consultation with parents. Parents who may be defensive and hostile toward the schools may engender hostility from teachers. It is not uncommon for teachers to view parents as the primary stumbling block to the effective education and treatment of the behaviorally disordered adolescent.

Several school based administrative and logistical barriers hinder effective consultation with parents. First, if the school program in general is inadequate, it will be difficult for the teacher to build a sound school-home program. Teachers have a much better chance of building successful parent involvement if there has been a demonstrated positive effect of the school program on the adolescent.

Another administrative barrier is the possible lack of role definition for parent participation. Although the schools may call for active parent involvement, there may be no specific guidelines for how that involvement may be carried out. There are many ways for parents to be involved in the schools, such as serving as classroom volunteers, co-managing behavior change projects, joining the PTA, participating in particular parent training groups, seeking individual counseling, and monitoring curriculum components. These parent roles and tasks must be defined.

Another major logistical barrier is the lack of time teachers have to actively train and/or counsel the parents of the children and youth they are responsible for educating. It is extremely difficult to

effectively manage the classroom behavior of a group of adolescents and, at the same time, provide their parents with the skills and support necessary to make a teacher-parent coordinated effort feasible. In addition to lacking time, many teachers lack adequate preservice and inservice training in working with parents. Teachers are expected to be able to help parents in a variety of skill areas such as applied behavior analysis, effective communication, assertiveness, and advocacy, and to possess appropriate counseling and therapeutic skills, frequently without any formal preparation in these skill areas or in the techniques for conveying these skills to parents.

Adolescent Centered Barriers

The severity of the adolescent's behavioral problems is a factor which most often affects teacher-parent interaction and cooperation. Generally, the more severe the problem, the more difficult and complex the education and treatment of the adolescent will be. As the difficulty and complexity of initiating and maintaining effective intervention increases, teachers and parents often have more difficulty working together to solve problems. If all of the parent and teacher centered barriers are overcome, severity of the problem may still hinder the effectiveness of the teacher-parent dyad.

MODELS OF CONSULTATION

Traditionally, two models of consultation have been used by teachers to impact on the communication barriers encountered in consulting with parents of behaviorally disordered adolescents: the directive model of consultation and the process model of consultation. The stages in effective consultation with parents have often not been precisely matched with appropriate techniques drawn from both models. A discussion of both the directive and the process consultation models follows, including an analysis of the strengths and weaknesses of each. A combined model, where strengths are drawn from both models and matched to intervention stages, is proposed and explained in detail.

The Directive Model of Consultation

In directive consultation the teacher/consultant tells parents what to do to solve problems. The teacher/consultant imparts information, advice, and/or skills that are deemed important by the teacher/consultant. The basic assumption of the directive model of consultation is that if parents acquire a specified set of skills from the teacher/consultant, they will be more effective in dealing with their behaviorally disordered adolescent. An area where the directive consultation model is frequently used is in the teaching of applied behavior analysis or behavior management techniques (Becker, 1971; Mash, Hamerlynck, & Handy, 1976; Patterson & Gullion, 1968; Smith & Smith, 1976). Parents are taught behavior definition skills, observation and recording skills, and intervention, evaluation, maintenance, and generalization skills. In other words, the consultant teaches or trains parents to be effective behavior managers.

The directive consultation is often used in parent training in such diverse a assertiveness (Markel & Greenbaum, 1979), values clarificatio Simon, Howe, & Kirschenbaum, 1972), reality therapy (Glasser, 1965), rational emotive therapy (Ellis, 1975), transactional analysis (Harris, 1969), and other techniques and procedures designed to teach parents new skills in dealing with their adolescents.

A directive consultation approach involves the following assumptions (Demos & Grant, 1973):

1. Emphasis is placed on the adolescent's problems rather than on the process of problem solution.
2. Emphasis is placed on data collected by the consultant rather than data offered by the parents.
3. Concern is for the intellect--for information collection and skill development--rather than the emotions or feelings of the parent.
4. Emphasis is on the scientific approach where new techniques are tried and evaluated as to their effectiveness.
5. Emphasis is on the educational aspects rather than the personal-social aspects of parent training.

The directive consultation model is often effective in imparting specific skills to parents; however, process or personal variables are frequently not accounted for in this approach to working with and training parents. It is assumed that if parents learn and use the skills, they will achieve success with their adolescents. The model frequently does not deal with the dynamics of the parent-teacher interaction or with the dynamics of parental interactions with their behaviorally disordered adolescent. In other words, the directive model often does not account for many of the parent centered, teacher centered, and adolescent centered barriers to effective teacher-parent interaction and cooperation that were mentioned earlier. Without such considerations, attempts at directive consultation frequently fail.

A second major weakness of directive consultation is that, when used alone, it is often ineffective in bringing about real and long-lasting change because parent motivation and commitment may not have been assured and because parents often do not participate in decision making under this model. This weakness results in parents having learned skills they really have little interest in using.

The Process Model of Consultation

A second approach to working with parents of behaviorally disordered adolescents is the process consultation model. This approach assumes that parents will make changes only if they want to. Emphasis is placed on the *process* of problem solving, and consultation is designed to help parents focus on the problem. Schein (1969, p. 9) defines process consultation as a "set of activities on the part of the consultant which help the client to perceive, understand, and act upon process events which occur in the client's environment." In working with parents, a process consultant helps the parent learn to see the problem, share in assessment, and generate a remedy. The process consultant may not be an expert in solving a particular problem, but this is less

important than his or her skills in helping the parents find an appropriate solution. The processes of problem definition and remedy selection are emphasized.

Schein (1969) discussed a number of assumptions underlying process consultation. First, the process consultant assumes that most parents have a constructive intent to improve problem situations but frequently need help in assessing or pinpointing problems. The process consultant believes that parents can be more effective if they learn to assess their own strengths and weaknesses. Parents must identify the problems themselves, then share in finding the remedy. Another assumption is that consultants work with parents because parents usually have the most extensive knowledge of the problem. Finally, parents' feelings are important and must be considered in the change process. The most effective and lasting problem solutions will be generated by parents themselves.

The strength of the process consultation model lies in the consideration it gives to the motivation level and individual intellectual/emotional characteristics of particular parents. Chosen problem solutions are ones with which individual parents are comfortable because they share in the processes of diagnosis and prescription. They are helped through process consultation to identify and solve their own problems (Caplan, 1970).

Process consultation differs in a number of ways from the directive approach to working with parents of secondary students. A major difference is the emphasis placed on joint problem diagnosis. In the directive model, credibility is given to data collected by the consultant, while in a process consultation model, the bulk of the data is volunteered by parents. Similarly, in a directive model, problem solutions are usually consultant generated, while process consultation aids parents in identifying appropriate solutions. Directive consultants focus on intervention skills, while process consultants focus on problem definition. Directive consultants usually impart specific problem solving skills to parents and adolescents, while process consultants primarily facilitate problem definition and solution by helping parents and adolescents work through their feelings and ideas.

Process consultation is often based on the nondirective or client centered counseling approach developed by Carl Rogers (Stewart, 1978). This approach to counseling or consulting holds that people's problems are primarily emotional in nature, and that in most cases, people have the information they need to solve their own problems. The role of the consultant/counselor is to establish a climate of trust or warm positive regard that will enable parents to lower their defenses and gain insight into their problems and appropriate solutions. The goal is positive growth of the individual (Rogers, 1961).

The consultant/counselor in a nondirective encounter must adopt the internal frame of reference of the parent, must display genuine liking for the parent, and must not be evaluative. To accomplish this, the consultant/counselor uses techniques such as listening-in-depth, reflecting on attitudes and feelings, and clarifying (Stewart, 1978).

Despite the strengths of the directive and process consultation models, both have fallen short of enabling educators to avoid failure with parents of adolescents. Both approaches have significant weaknesses. Directive consultation alone is frequently ineffective in bringing about long-lasting change for several reasons. In many cases, parent motivation and commitment have not been confirmed before skills are taught; therefore, skills taught are often never used. Also, parents have often not been involved in diagnostic-prescriptive decision making and so have no real "ownership" of or commitment to the planned interventi

Process consultation has also frequently resulted in a less-than-desired success rate, primarily because it may not give parents the specific skills they need in order to implement an effective intervention. The major portion of consultative time may have been spent discussing the problem. Solution strategies, as well as the skills needed to implement them, may have been neglected.

Directive/Process Consultation

Given the strengths and weaknesses of the directive and process consultation models, considered separately, it is suggested that the optimal way of achieving success in working with parents of secondary students is to combine the two approaches into a directive/process consultation model that capitalizes on the strengths of the models, while avoiding their respective weaknesses. In each intervention stage, care will be taken to correctly match needs with appropriate consultative strategies. Such a combined model emphasizes both the problem itself *and* the process through which it can be identified and rem died. Data are gathered and shared by consultant, parent, and adolescent. Consideration iven to skills needed by parents as well as to parents' and adolescen eelings about the problem and its solution. The combined model stresses kill acquisition and process variables throughout the consultative experience. The steps of the directive/process consultation model are diagrammed in Figure 1.

Definition of level of involvement. The first step in directive/process consultation, following recognition f problem situation, is the definition of level of involvement by par , adol scent, and teacher/consultant. If successful problem solution is to occur, consensus must be reached at this stage concerning each pe on's willingness to participate. The strategies used to achieve t consensus are drawn primarily from the process consultation model. The teacher/consultant facilitates the achievement of cons nsus by establishing rapport with the parent and/or adolescent, by reflecting on ideas and emotions expressed, and by clarifying. Through this process, for example, a truant adolescent (fearful of school failure), the teacher (concerned about the adolescent's truancy), and the adolescent's parents (fearful of increased resistance from their child), could agree that they all wanted to help solve the problem.

Ideally, consensus is reached smoothly in this initial stage. If not, two other considerations are necessary if the potential for success is to be maintained. First, an effort must be made to identify reinforcers which would encourage reaching consensus. In the example above, the teacher/consultant and the parent may have established rapport and

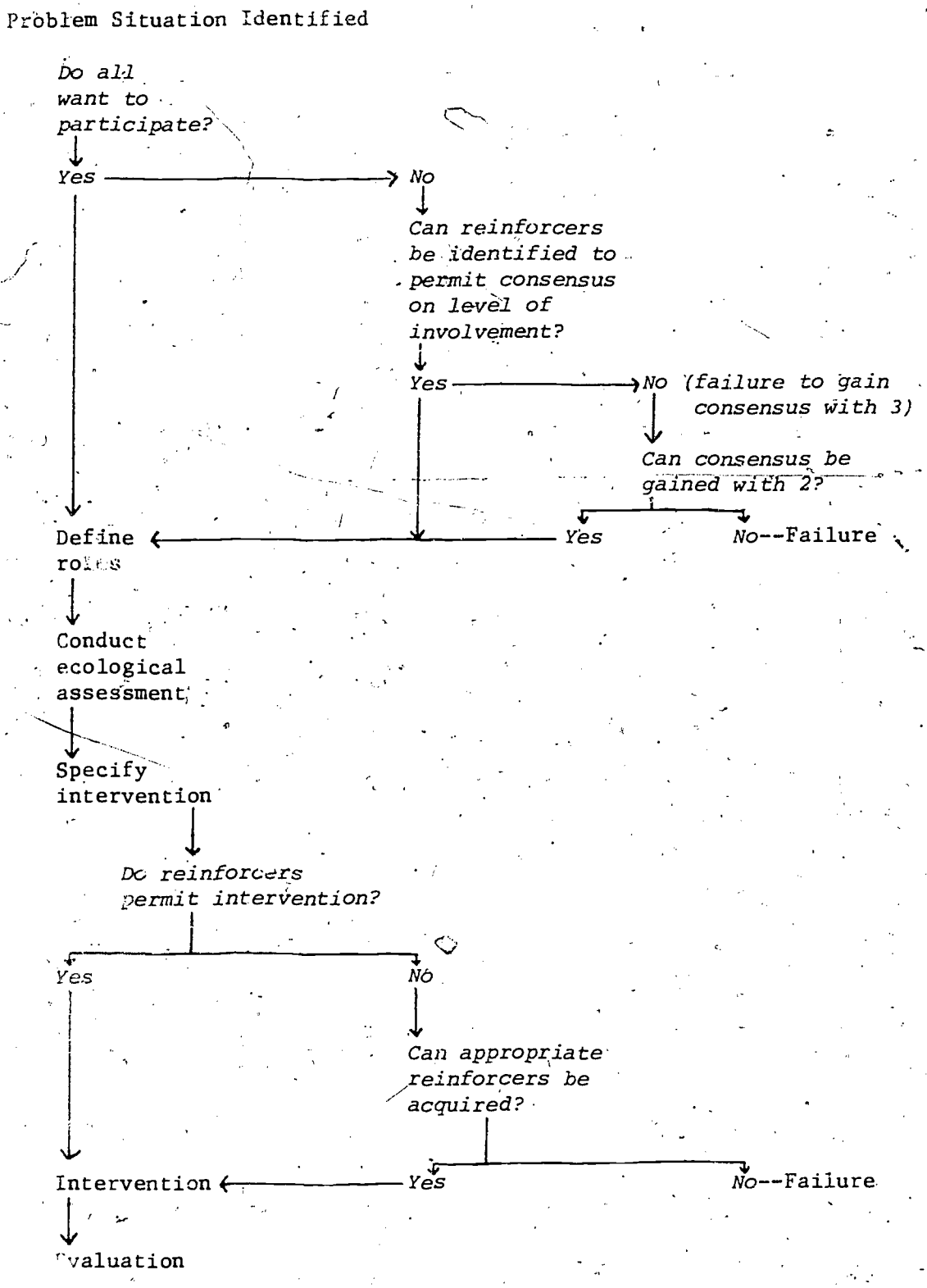

FIGURE 1: Directive/process consultation model.

consensus, but the adolescent may not agree to work with them. If this unwillingness is pinpointed, it may be possible to identify a reinforcer that would make the adolescent more willing to give consensus, thus enabling the continuation of consultation.

If no reinforcer can be identified that will facilitate consensus, a second consideration can be made. At this point, participants who have achieved consensus can consider the possibility of proceeding without the consensus of the third person. For example, if a teacher/consultant and an adolescent establish rapport and agree on their level of involvement in a problem situation, it may be possible for them to proceed without parental participation or support.

If at least two of the principals cannot agree to participate, the consultative effort is doomed to failure and should be discontinued. It is reasonable to assume that some consultative efforts will end at this stage; however, by making the two considerations discussed above in response to initial failure to elicit support from all participants, the teacher/consultant may gather data that will enable success at a later time.

Definition of role. Once a consensus regarding level of involvement is reached with two or more participants, the next step is for all participants to define their roles. In the example already discussed, the adolescent, parent, and teacher/consultant would work together to clarify each person's responsibilities in the processes of assessment, intervention specification, implementation, and evaluation. Role descriptions at this point must be general since specific task responsibilities cannot be decided prior to assessment and intervention planning. It is crucial, however, to discuss roles at this early stage so that each person involved makes a commitment to be an active participant.

Ecological assessment. Following the definition of roles, the participants must conduct an ecological assessment of the problem (Prieto & Rutherford, 1977). The role of the teacher/consultant in assessment is to facilitate the collection of data using procedures drawn from both expert and process consultative models. Data to be collected would include (a) stated expectations of each participant for the other participants' behavior in relation to the problem situation; (b) data showing the current performance of all participants in relation to the problem situation; (c) stated discrepancies between expectation and performance for each participant; (d) chosen reinforcers for each participant; and (e) stated strengths of each participant in relation to the problem situation.

Directive techniques used by the teacher/consultant to aid the assessment process might include (a) administering norm-referenced assessment measures and interpreting evaluative results for parents; (b) collecting observational baseline data through the use of specific observation and recording techniques; and (c) teaching parents to use observation and recording techniques. To continue the example of the truant adolescent, the teacher/consultant might want to administer tests to determine the child's academic performance levels. In addition, the parent could be shown how to keep a simple frequency count indicating

periods or days of school missed. The teacher/consultant would probably also ask the parent and adolescent to complete reinforcement surveys.

Additional data would be gathered using process consultation techniques in discussions among participants. In this process the teacher/consultant might use listening, reflecting, and clarifying to help all participants state expectations. With an adolescent truancy problem, the teacher/consultant might state the expectation that the adolescent would attend class a certain percentage of the time. This expectation would later be compared with baseline data on the adolescent's attendance to generate a statement of discrepancy or need from which an objective could be drawn.

The parent might state the expectation that the adolescent attend school, that the adolescent be trustworthy, and that the adolescent perform satisfactorily in school. The adolescent might state expectations that the school work assigned be fair and appropriate and that parents demonstrate trust.

In addition to eliciting information about expectations of all participants, process consultation can be used by the teacher/consultant to explore self reported strengths of each participant. A truant adolescent might identify a personal strength as his or her concern that the teacher and parent were upset. An additional strength might be that the adolescent liked and did well in some school classes. The teacher's strengths might be a liking for the student and a willingness to individualize programing. The parent's strengths might be a willingness to continue to help the adolescent and a good, although weakened, rapport with him or her.

Specification of intervention. The fourth step in applying a combined directive/process consultation model is the specification of an appropriate intervention. Once the participants have pinpointed the problem, given commitment, defined roles, and assessed, directive and process consultation techniques can be used to facilitate the design of optimal intervention strategies.

In the initial stages of intervention specification, the teacher/consultant would use directive consultation techniques to summarize the evaluative findings for the parent, to help specify objectives, and to list appropriate alternative intervention strategies. With those tasks accomplished, the teacher/consultant would then switch to using process consultation techniques in order to facilitate the decision making process through which parent and adolescent could choose a strategy.

An ecological assessment of the adolescent truancy problem discussed above might show the following:

1. The adolescent is missing an average of 50% of all classes, but only 35% of the participant teacher's classes.
2. The adolescent has significant academic deficits in the area of reading.
3. The parents have been punishing the adolescent for truancy.
4. The parents complain and nag the adolescent during a majority of their times together.

5. The adolescent identifies a guitar, record albums, and concert tickets as possible reinforcers, while the parent feels that the reestablishment of good rapport with the adolescent is sufficient reinforcement. The teacher/consultant chooses the adolescent's renewed class participation as adequate reinforcement.

The use of process consultation techniques could facilitate the participants' decision to intervene through behavioral contracting combined with regular ongoing meetings of all participants to discuss progress. The teacher/consultant, after summarizing evaluative findings and alternative solutions, would help other participants discuss their feelings about various alternatives until they were able to choose one with which they were comfortable.

Intervention. Once an intervention approach is chosen, the teacher/consultant again needs to use directive consultation skills--first, to match appropriate techniques to chosen objectives; second, to teach parents and adolescents how to use those techniques; and third, to assure that appropriate reinforcers are available for intervention. In this case the adolescent and parents would be taught behavioral contracting. The use of both directive and process consultation techniques in designing an appropriate intervention procedure insures that participants will be comfortable with the problem solution chosen *and* that they will have the skills necessary for intervention.

As the agreed-upon intervention is implemented, the teacher/consultant functions as a directive consultant to monitor the performance of all participants and give feedback. The continuation of process consultation is also important throughout intervention, to provide a forum for the emotional and intellectual reactions of the participants.

Evaluation. The final step in directive/process consultation is evaluation of the intervention. Here, as in all previous steps, the teacher/consultant would use a combination of directive and process techniques. Directive consultation techniques would assist the teacher/consultant to analyze participant performance measures to determine whether the intervention had met the criteria for success established when the intervention was designed. In addition to comparing results with these criteria, it is also important for the teacher/consultant to use process consultation techniques to determine the degree to which participants are satisfied with the results of the intervention and to help them choose procedures for adapting, modifying, or maintaining changes made.

In summary, a combined directive/process consultation model for working with parents of behaviorally disordered adolescents has been proposed. This model describes a structure by which teacher/consultants can provide parents with the necessary skills and support to deal effectively with their behaviorally disordered adolescents. Both the instructional and emotional needs of the parent are addressed through this model of consultation.

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EFFECTIVENESS OF DEVELOPMENTAL THERAPY FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN

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Developmental Therapy, a psychoeducational treatment program devised by M. M. Wood (1972, 1975), is now used in over 40 public schools, residential treatment centers, day treatment programs, and day care centers throughout the United States and in other countries as well. Since its inception in 1970, and initial validation by the U.S. Office of Education/National Institute of Education in 1975, a need has existed to further evaluate the effectiveness of this approach to treating severely emotionally disturbed and autistic children. The goal of this investigation was to provide additional validation of the effectiveness of the Developmental Therapy model in reducing the number of severe problem behaviors manifested by severely emotionally disturbed and autistic children, and for maintaining this reduction over time. Results showed that children receiving Developmental Therapy manifested a large and statistically significant reduction in their severe behavior problems, as perceived by their parents.

EFFECTIVENESS STUDIES

Professionals and lay persons alike agree that evaluating the effectiveness of special education programs is vitally important (Semmel & Semmel, 1976). Recent years have seen an increase in effectiveness studies, particularly in light of the emphasis on accountability in Public Law 94-142, the Education for All Handicapped Children Act of 1975. A considerable number of methodological problems arise, however, in designing studies evaluating the effectiveness of treatment for emotionally disturbed children. Most studies have lacked consistent definitions of emotional disturbance, have failed to control for variations in the severity of the children's disturbance, do not detail the methods and practices, or have lacked adequate instrumentation. All too often researchers have relied solely on data from case records which have built-in biases from staff members in the treatment programs (Bowlin, Marchant, Rutter, Berger, Hersov, & Yale, 1973). While some studies have made important contributions, providing data on preadmission and postdischarge

adaptation (Taylor & Alpert, 1973), outcome differences among diagnostic categories (Davids, 1972), and specific variables that relate to successful functioning (Davids & Salvatore, 1976; Garber, 1972), they have not provided systematic descriptions of the actual treatments employed.

Several well controlled studies have demonstrated the effectiveness of behavioral approaches to the treatment of pyschological disorders (Paul & Shannon, 1966). However, when evaluating the effectiveness of a behavioral intervention program for children having both behavioral and academic difficulties, Kent and O'Leary (1976) found that the results of a behavioral approach were short term in their effectiveness. Significantly greater improvement in behavior occurred immediately after treatment for treated than for control children; however, at a 9 month follow-up, the control group had also improved sufficently, resulting in no differences in behavioral adjustment. Quay, Glavin, Annesley, and Werry (1972) also found that changes in behavior obtained during 6 months in a special resource room did not generalize well to the regular classroom. They suggested that their findings indicated a need to change conditions in the regular classroom to support behavior learned in the special classroom.

DESIGN ISSUES

The question of spontaneous improvement of untreated emotionally disturbed children is central to an effectiveness study. In a study of 602 public school children identified as behaviorally disordered but who had received no special help, Glavin (1972) found that about two-thirds of the children improved in the following 4 years. Because there was no categorization of the children's problems according to type, the study loses predictive value; it was not clear which children would be expected to improve and which would not. However, the greatest strength of Glavin's study was that three different ratings of adjustment were provided from teachers, peers, and the children themselves.

While control groups in effectiveness studies control for spontaneous improvement and maturation, ethical and logistical considerations enter into the methodological picture. Certainly it is ethically unsound to condone the mere identification of emotional disturbance with no provision for treatment, particularly in light of due process requirements. Furthermore, the use of subjects from a waiting list for entry into a program causes problems because of attrition of subjects. While one long range followup study (Levitt, 1974) used control subjects who were discontinued from a program and were similar to the clinic population on 26 variables, the use of such a control has been criticized (Eisenberg & Gruenberg, 1961; Hood-Williams, 1960). The point was made by these researchers that individuals discontinued from a program constitute an inappropriate control group because they may be less disturbed individuals who are able to respond favorably to the diagnostic procedure. Many researchers contend that the aim of comparing one program with another should not dominate plans for evaluation. Evaluation should be primarily concerned with the efforts of a particular program under study (Cronbach, 1963).

In the present study, Developmental Therapy was the only treatment under investigation. No control group was used because of the ethical (as well as legal) issues involved in denying treatment to preschool and school age children who are diagnosed by a comprehensive multidisciplinary team as being severely emotionally disturbed and in need of immediate assistance.

THE MODEL FOR EVALUATING PROGRAM EFFECTIVENESS

An evaluation model that combines theory with clinical usefulness is that proposed by Huberty, Quirk, and Swan (1973). The model is particularly useful because it is closely tied to the philosophy and underlying theory of Developmental Therapy (Wood, 1975) upon which the treatment program in this study is based. Working with a problem behavior orientation instead of a mental illness framework, the authors emphasized the need for specific behavioral objectives for treatment planning and measurement. A major strength of the model is that it provides for systematic data collecting. Within the model, data collection is accomplished through (a) completion of problem behavior checklists at the time of entry and termination from the program, (b) observational data, and (c) specification of objectives at the time of entry and every 5 weeks during the course of treatment.

Since Huberty et al.'s (1973) evaluation system has been applied directly to Developmental Therapy, longitudinal data compiled over the years on the problem behaviors of children receiving therapy were available for analysis. These ratings of severely emotionally disturbed children at two or more points in time provided the key in this study for determining whether Developmental Therapy led to a significant reduction in severe behavior problems at the end of the treatment and also 2 years after therapy was terminated.

DEVELOPMENTAL THERAPY

Developmental Therapy is a psychoeducational approach to the education and treatment of severely emotionally disturbed and autistic children from 2 to 16 years of age (Wood, 1975). The theoretical framework of Developmental Therapy is drawn from learning theories and developmental psychology, employing constructs about ego development, social learning, and moral and cognitive development, as well as principles of social reinforcement, task analysis, and structured interventions. Developmental Therapy translates these constructs and principles into educational practice, focusing therapy around a hierarchical series of developmental milestones for social-emotional growth. These developmental milestones are the treatment objectives, and they determine the roles of adults as well as the activities, materials, and techniques used in the therapeutic classroom. With the use of developmental objectives as guidelines, therapy is conducted by a lead and support teacher with a maximum of eight children per class.

The Developmental Therapy curriculum consists of four areas: Behavior, Communication, Socialization, and (Pre)Academics, all of which are carefully defined and described (Wood, 1975, pp. 5-6). Within each of the four curriculum areas the objectives follow developmental sequences. These sequences suggest five distinct stages of social-emotional development. Children of varying ages, with different kinds of emotional problems and socioeconomic backgrounds, are grouped for Developmental Therapy according to the similarity in their stages of social-emotional development. These stages define the general therapeutic goals for each child. For example, the therapeutic goal for Stage 1 children is "responding to the environment with pleasure," while that for Stage 2 children is "responding to the environment with success." Children at Stage 3 in their development learn skills for "successful group participation," while those at Stage 4 learn to "invest themselves in group processes." Children at Stage 5 in their social-emotional development are rarely kept within the Developmental Therapy milieu. The goal at this final stage is "to apply individual and group skills in new situations." This goal is more adequately accomplished in a regular school program (Wood, 1975).

METHOD

The Referral Form Checklist

The Referral Form Checklist (RFCL) (Wood, 1972), which has been described in detail and factor analyzed in a recent investigation (Kaufman, Swan, & Wood, 1979; Kaufman, Swan, & Wood, 1980), was the instrument used in this study to obtain parents' ratings of the behavior problems of their emotionally disturbed children and adolescents. The RFCL comprises 54 items which have been grouped into the four main curriculum areas of Wood's (1972, 1975) Developmental Therapy model: Behavior (24 items), Communication (14 items), Socialization (10 items), and Academics (or Preacademics) (6 items). Sample problems included in each of the four portions of the RFCL are listed below.

Behavior	Socialization
Distractible	Avoids difficult or new situations
Restless, overactive	Irresponsible
Aggressive toward children	Suspicious (distrusts, blames others)
Communication	**Academics**
Speech problem	Reading or reading readiness
Talks excessively	Writing or hand coordination
Listening problems, difficulty comprehending	Spelling

Each of the 54 behavior problems is rated on a 5 point continuum. A rating of 1 signifies a high priority problem whereas a rating of 5 denotes no observable problem.

Factor analysis of the RFCL revealed three dimensions that were highly similar to dimensions isolated in investigations of other behavior problem checklists such as the one developed by Quay and Peterson (1979): (a) a dimension of aggressive hostility, (b) a factor associated with immature and apathetic behavior, and (c) a dimension related to anxiety and withdrawal (Kaufman et al., 1979). This analysis, which excluded the Academic items as well as 10 additional items that lacked sufficient variability, revealed that the three factors cut across the Behavior, Communication, and Socialization areas. Consequently, the factor scores yield information that differs considerably from scores in the separate curriculum areas. For this study, analysis was undertaken for both sets of scores. The factor related scores provide meaningful information because of their empirical foundation and because they correspond to dimensions of behavior that have been isolated in study after study of diverse groups of children, normal and exceptional (Miller, 1972; Quay, Morse, & Cutler, 1966; Quay & Quay, 1965). However, the scores in the areas of Behavior, Communication, Socialization, and Academics are also important because they provide the focus for treating the problem behaviors during Developmental Therapy.

Subjects

For this study, samples were needed which permitted comparison of a child's behavior problems just before entering Developmental Therapy with his or her problems at the end of therapy, and also with the number of problems one or more years after termination of therapy. Obtaining the "before" measure was easy since all referred children have the RFCL filled out by several raters during the intake process (i.e., by parent, teacher, psychologist, educational diagnostician, and sometimes a psychiatrist). However, RFCLs are inconsistently obtained at the termination of treatment because of practical and logistical problems; these problems are especially difficult when trying to track down the children's families one or more years following treatment. Even when follow-up is done, there is a good chance that the raters will not be the same (e.g., mother and father together during intake, but mother alone during followup).

To secure samples for the present study, the records at Rutland Center, a psychoeducational center for the assessment and treatment of severely emotionally disturbed children and adolescents, were combed to find individuals who were rated on the RFCL by the same rater at two or more points in time. Emotionally disturbed children who received Developmental Therapy any time between 1970 and 1977 provided the source for the sample. Although a number of children were identified who were rated two or even three times by their teachers, very few of the children were rated more than once by the same teacher; hence, only ratings by parents proved suitable for analysis in this study.

By going through Rutland Center records, children were identified who were rated twice by the same parent (typically the mother, although in a few instances the mother and father in collaboration). One group contained 37 children who were rated on the RFCL during intake (just prior to the onset of Developmental Therapy) and again at the termination of treatment. A second group comprised 36 children who were rated by the

same parent during intake and also about 2 years after termination of treatment. Consequently, analysis of data from these groups permitted evaluation of both the immediate and long term benefits of Developmental Therapy. Ten children were rated at all three points in time (intake, termination of treatment, and 2 year followup) and were thus included in both groups. For convenience, the group of 37 children rated at termination will be referred to as the Termination sample, and the group of 36 children located about 2 years after treatment ended will be called the Tracking sample.

The Termination sample ranged in age at intake from 3 years, 2 months to 11 years, 5 months (mean age of 7 years, 4 months; SD = 2 years, 2 months). These 37 severely emotionally disturbed children were 65% male and 35% female; there were 62% White children, 35% Black children, and 3% with race unknown; parental annual incomes ranged from $500 to $25,000+, with a median of $6,250; and they were enrolled in Developmental Therapy for anywhere from 2 to 27 months (mean = 11.5 months, SD = 6.3 months).

The Tracking sample comprised an age range of 3 years, 8 months to 12 years, 2 months (mean = 8 years, 3 months; SD = 2 years, 6 months). These 36 youngsters were 65% male and 33% female, and were 50% White, 47% Black, and 3% race unknown. Annual incomes of their parents ranged from $500 to almost $25,000 with a median income of $5,750. The Tracking group received from 3 to 23 months of Developmental Therapy (mean = 10.0 months; SD = 5.8 months). The length of time between termination of the child's treatment and the administration to the parent of the followup RFCL ranged from 7 months to 4 years, 2 months. The mean interval was 2 years, 2 months (SD = 9.2 months), and 70% of the intervals were 2 years ± 6 months from termination of treatment. In view of the 10 months these children spent undergoing Developmental Therapy and the interval of more than 2 years that separated the termination from the followup RFCL, it is evident that an average of 3 years elapsed between the initial and followup ratings on the RFCL for the Tracking sample.

Procedure

The number of severe problems (ratings of 1 or 2 on the RFCL) was tallied for each RFCL obtained for children in the Termination and Tracking samples. For each RFCL, severe problems were tallied for the total instrument (54 items) and also for each of the four curriculum areas that make up the RFCL. In addition, factor scores were computed for each of the three factors described above. To determine which problems were considered to be associated with each factor, the following rule was adopted: Any problem behavior that loaded .35 or greater on a factor in the analysis of parents' responses (Kaufman et al., 1979) was deemed to be a measure of that factor. On that basis, 14 items were associated with Factor I (Aggressive/Hostile), 9 with Factor II (Inadequacy/Immaturity), and 9 with Factor III (Anxiety/Withdrawal). A child's factor score simply equaled the number of severe problems earned on the items constituting each factor. Since no problem behavior had a loading of .35+ on more than one factor, the three factor scores were independent in terms of content.

To determine the significance of the difference between the number of severe problems at termination of treatment and the number of severe problems at intake, correlated t tests (Hopkins & Glass, 1978, pp. 259-260) were conducted for the total RFCL, the four curriculum areas, and the three factor scores. The same procedure was used for the Tracking sample--i.e., correlated t's were computed for the three sets of scores to compare the number of problem behaviors prior to the onset of Developmental Therapy to the number of problem behaviors reported at the tracking followup. Directional hypotheses were used for all comparisons in this study since it was predicted that Developmental Therapy would lead to a significant reduction in problem behaviors when the treatment was completed, and that this reduction would be maintained over time. Consequently, one-tailed t tests were employed for all comparisons.

RESULTS

Table 1 shows a comparison of the severe problems noted for emotionally disturbed children in the termination sample just before and just after receiving Developmental Therapy. For the total RFCL, the mean number of severe problems was more than halved, going from 14.9 to 6.2. Large and statistically significant reductions also were observed for all three factor scores and for the curriculum areas of Behavior, Communication, and Socialization. No reduction was observed for Academics, which is not surprising since Developmental Therapy does not directly treat learning problems and is an affectively rather than a cognitively oriented curriculum.

Results of the t test comparisons were strikingly similar for the Tracking sample (see Table 2). Statistically significant reductions in severe problem behaviors were observed between intake and followup ratings obtained from parents 2 years after treatment was terminated. Again, Academics was the only comparison that failed to produce a significant decrement. Clearly, the substantial reduction in severe problem behaviors that was evident at the termination of Developmental Therapy (Table 1) was maintained for quite some time after the treatment was no longer in effect (Table 2).

Additional analysis adds depth to the picture of the effects of the Developmental Therapy program. Nine of ten children who were rated at all three points in time (intake, termination of therapy, and 2 year followup) showed a drastic reduction in the number of severe behavior problems at termination. Eight of these nine maintained this improvement a full 2 years after treatment. Another analysis indicated that Developmental Therapy seemed to be equally effective regardless of age, parents' income, or length of time in treatment.

DISCUSSION

The results of this study show that severely emotionally disturbed children aged 3 to 12 years who undergo Developmental Therapy show a large, statistically significant decrement in their severe problem behaviors, as perceived by their parents. This reduction is not only evident at

TABLE 1

Comparison of the Number of Severe Problems of Emotionally Disturbed Children Before and Directly After Receiving Developmental Therapy (N = 37)

	Number of Problems BEFORE Treatment		Number of Problems DIRECTLY AFTER Treatment		t of Difference Between Means
	Mean	*SD*	*Mean*	*SD*	
Curriculum Area					
Behavior (24 items)	8.4	4.2	3.0	3.8	7.98***
Communication (14 items)	3.0	2.3	1.1	1.7	5.55***
Socialization (10 items)	2.2	1.8	0.8	1.1	5.01***
Academics (6 items)	1.3	1.8	1.3	1.8	0.09
Factor Score					
I. Aggressive/Hostile (14 items)	5.5	3.4	2.3	3.2	4.33***
II. Inadequacy/Immaturity (9 items)	3.6	2.6	1.2	1.8	7.17***
III. Anxiety/Withdrawal (9 items)	2.2	1.8	0.8	1.2	4.47***
Total RFCL (54 items)	14.9	7.5	6.2	6.2	7.75***

Note: Mean length of treatment equaled 11.5 months (SD = 6.3 months).

***$p < .005$

TABLE 2

Comparison of the Number of Severe Problems of Emotionally Disturbed Children Before Receiving Developmental Therapy and About 2 Years After Termination of the Treatment
(N = 36)

	Number of Problems BEFORE Treatment		Number of Problems 2 YEARS AFTER Treatment		t of Difference Between Means
	Mean	*SD*	*Mean*	*SD*	
Curriculum Area					
Behavior (24 items)	7.0	4.1	3.4	4.5	4.12***
Communication (14 items)	3.0	2.4	1.4	2.0	3.59***
Socialization (10 items)	2.2	1.8	1.0	1.7	3.17***
Academics (6 items)	1.3	2.0	0.8	1.4	1.34
Factor Score					
I. Aggressive/Hostile (14 items)	4.8	3.3	2.3	2.9	4.62***
II. Inadequacy/Immaturity (9 items)	3.4	2.5	1.5	2.5	3.53***
III. Anxiety/Withdrawal (9 items)	2.1	1.8	1.2	1.7	2.41*
Total RFCL (54 items)	13.4	7.8	6.6	8.6	4.23***

Note: Ratings of problem behaviors for this sample were obtained an average of 25.6 months after the termination of treatment (SD = 9.2 months). Since this group was in treatment for an average of 10.0 months the length of time between the two sets of ratings shown here was an average of 35.6 months.

* $p < .05$

*** $p < .005$

the termination of treatment, but is still clearly demonstrated about 2 years after the completion of Developmental Therapy. It is possible that the decrement in problem behaviors could have been due to maturation and/or spontaneous recovery. We cannot know without a control group. However, these alternative explanations do not seem likely for several reasons.

First, children who are accepted for Developmental Therapy have been diagnosed as severely emotionally disturbed by a team of professionals that includes a psychologist, social worker, educational diagnostician, and usually a child psychiatrist. Mildly handicapped youngsters are referred elsewhere or are treated in the schools. Only the referrals with the most severe disorders and the poorest prognosis for improvement in their current school or preschool settings are accepted. Second, in this study only severe problems (ratings of 1 or 2 on the RFCL) were analyzed, which further reduces the likelihood of the children's spontaneous improvement over time. The milder problems that are more likely to self correct (ratings of 3 or 4 on the RFCL) were totally excluded from this investigation. Third, the time in therapy for the Termination sample averaged 11.5 months, with about one-third of the group enrolled for only 2 to 8 months. It seems highly unlikely that so much spontaneous improvement would have occurred over such relatively short intervals in view of both the severity of the specific problems and the severity of the emotional disorders.

Finally, it is typical for about 67% of emotionally disturbed individuals to demonstrate some spontaneous improvement over time in the absence of treatment (e.g., Glavin, 1972). In the present study, 89% of the children in the Termination sample showed a clear reduction in the number of severe behavior problems between intake and termination of treatment, and 81% of the Tracking sample showed reductions in problems 2 years after Developmental Therapy had been completed. Furthermore, three quarters of both samples evidenced a striking reduction in problem behavior.

The present results might also be challenged by people who claim that many parents "fake bad" at intake to get their children accepted in the treatment program. Again, this claim is not likely to be true. A very high percentage of referrals were made by the school, not the home. Whereas some teachers could probably be accused of "faking bad" in some instances to help get a difficult child out of their classroom and into a day treatment program, parents are not as likely to be motivated in that direction. If anything, it is more conceivable that some parents would have tried to "fake good" to keep their child in a full day of regular classes. In any event, the mean number of problems for the Termination sample (14.9) and Tracking sample (13.4) as rated by parents on the total RFCL (54 items) does not seem excessive in view of the severity of these children's disorders, and corroborates the findings of professionals such as psychologists, educational diagnosticians, and psychiatrists. In a sense, the failure of Developmental Therapy to lead to significant decrements in the Academics area serves as a kind of control for the significant reductions in the affective areas. The fact that problem behaviors reduced in these specific target areas of Developmental Therapy (Behavior, Communication, Socialization), but not in

Academics, suggests that the RFCLs were filled out conscientiously. "Faking bad" by parents on the initial RFCL would presumably have led to inflated scores in all four areas and hence to a significant reduction in Academics.

CONCLUSION

This study has presented encouraging evidence that Developmental Therapy is effective for treating the behavior problems of severely emotionally disturbed children. Numerous additional investigations are needed to cross-validate and expand upon the present results. The problems associated with securing a good control group will necessarily limit interpretation of any results, no matter how positive they are. However, lack of a comparable control sample should not deter researchers from continuing to conduct evaluations of the progress of children receiving Developmental Therapy. Other objective indices of improvement might be used for evaluating improvement as a result of Developmental Therapy. The Developmental Therapy Objectives Rating Form (DTORF) (Wood, 1979) which teachers and parents fill out dur therapy to assess children's progress on social-emotional milestones, should be a useful tool for this purpose.

Future research is needed to explore the interaction of length of time in treatment, severity and type of emotional disorder, and reduction in behavior problems. Research also should go beyond parents' ratings since the emotionally disturbed child's environment extends beyond the home. Teachers' ratings of problem behaviors, as well as ratings of psychologists, educational diagnosticians, psychiatrists, and therapists, should be obtained systematically at different points in time. These multiple ratings will help determine whether the striking improvement in the behavior of emotionally disturbed children following Developmental Therapy generalizes beyond the perceptions of the children's parents.

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