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ABSTRACT

Programs for adolescents with severe behavior disorders (BD) in Illinois are examined in terms of existing psychoeducational models of BD programs. Research is reviewed on the definition and etiology of BD, and the historical and theoretical background of educational treatment for this group is offered (including a description of several models for programing). The evaluation involving 230 public school administrators and staff and 40 private school administrators in the state is considered in terms of canvassing for the sample, developing and administering the questionnaire, and planning for analysis of the findings. The questionnaire describes programs along the following dimensions: psychodynamic vs. behavioral philosophy, administrative vs. student control of the program, existentialism, biophysical strategies, and ecological perspectives. Among other factors to be measured are student and program characteristics, counseling and education strategies, vocational education, parent involvement, and evaluation. The authors suggest that programs using psychodynamic approaches will have a low degree of administrataive control and those with behavioral approaches will have high control. (The questionnaire is appended.) (CL)

The Effects of PL 94-142 on School Services to Adolescents with Behavior Disorders in Illinois

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Introduction

For most adolescents, high school is a time and place of discovery, growth, accomplishment, and some confusion. For a small, but very significant and troubling minority of adolescents, high school means frustration, fear, drugs and alcohol, disruption, and rejection. This latter group, the adolescents with severe behavior disorders (BD), has long presented a major problem to educators, parents, and society. Special education services designed to treat behavior disorders have traditionally been emphasized in elementary schools and neglected in secondary schools. This is accounted for in part by the increased emphasis on independence in high schools (e.g., departmental studies), an independence for which a certain proportion of children are unprepared.

Appropriate attention to the problems of BD adolescents has been limited in part because high school teachers have traditionally viewed themselves as subject area specialists rather than as counselors and were poorly trained in dealing with BD students. As a result, a common school policy was to suspend and, finally, expel students who exhibited disruptive behaviors. In fact, it was often unnecessary to expel the problem students because they so seldom came to school anyway. Thus, by ignoring the problem, it often went away.

The formal exclusion policy (if not the informal one) is no longer a consideration because of the Education for All Handicapped Children Act of 1975, Public Law 94-142, which mandates that all children with handicaps (including mental disorders), be provided an appropriate, free education in the least restrictive environment. PL 94-142 has made explicit the formerly implicit responsibility of the schools to treat children and adolescents with mental disorders.

Statement of the Problem

In 1975, Public Law 94-142, the Education for All Handicapped Children Act, mandated that all children with handicaps be provided an appropriate, free education in the least restrictive environment. Previous to PL 94-142, many schools commonly failed to provide services for many handicapped children, especially those with behavior disorders. Since 1975, then, alternative school programs for adolescents with severe behavior disorders have or should have sprung up throughout the country in response to the mandate of PL 94-142. A review of the literature via computer searches of Psychological Abstracts, Dissertation Abstracts, and the Educational Resources Information Center (ERIC) revealed: (1) that no program evaluation of a scope beyond the single program has as yet been done, and (2) that there exists very little research describing the nature of a range of BD programs. The descriptive studies which do exist contain demographic data but very little, if any, data describing the nature of the counseling and educational programs.

In regard to the existence of studies of theoretical models of BD programs, Sabatino and Mauser (1978) said, "In searching for programs, the professional literature was exhaustively reviewed. Simply stated, there are not many viable programs. The current literature is depleat (sic) of any organized means of examining the high school curriculum to account for chronic disruptive youth" (p. 40).

Clearly, the effectiveness of PL 94-142 in creating better programs and treatment for BD adolescents is unknown. Indeed, it is not even clear what types of school BD programs exist. It is reasonable to assume that some communities have developed effective treatment

strategies and programs while others have not. The problem is: first, to identify the types of strategies and programs which currently exist; and secondly, to identify those programs which are more effective in treating BD adolescents.

Therefore, this investigator concludes that there is a need for descriptions of the nature of BD programs. Such research will provide a baseline of data useful for policy development as well as for program planning, implementation, and evaluation. The delineation of the characteristics (modeling) of various school programs can serve the following purposes:

1. It can aid communication among programs by providing a survey of the various services, facilities, strategies, curricula, etc. currently in use. This sharing of ideas can promote program development and improvement.
2. The delineation of program models can provide a basis for the testing of relative effectiveness between competing models or among a variety of models.
3. The development of a survey technology can provide a means of obtaining information useful for the allocation of attention and resources to areas found to be underserved.
4. The survey can provide descriptive information about the effects of PL 94-142 in providing services to BD adolescents.

Specifically; this study intends to delineate the demographic characteristics, the program characteristics, and the locus of program control of BD programs as they currently exist in Illinois. Therefore, this research asks the question: What kinds of psychoeducational models are being employed in Illinois schools to treat and educate adolescents

with severe behavior disorders. Additionally, this research will examine the relationships between various program models and outcomes such as attendance, cost, and percentage of students retained in the program beyond age 16.

Definition

Who are adolescents with severe behavior disorders? To obtain a general idea of the characteristics of this population, it is useful to digest the diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). The DSM-III criterion most closely related to "severe behavior disorder" is "conduct disorder." Examples of the characteristics of individuals with conduct disorders include:

A. A repetitive and persistent pattern of aggressive conduct in which the basic rights of others are violated, as manifested by either of the following:
   1. physical violence against persons or property (not to defend someone else or oneself), e.g., vandalism, rape, breaking and entering, fire-setting, mugging, assault
   2. thefts outside the home involving confrontation with the victim (e.g., extortion, purse-snatching, gas station robbery)

B. A repetitive and persistent pattern of nonaggressive conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by any of the following:
   1. chronic violations of a variety of important rules (that are reasonable and age-appropriate for the child) at home

or at school (e.g., persistent truancy, substance abuse)

2. repeated running away from home overnight

3. persistent serious lying in and out of the home

4. stealing not involving confrontation with a victim

C. Failure to establish a normal degree of affection, empathy, or bond with others

Under PL 94-142, "seriously emotionally disturbed" is defined as follows:

> 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.
>
> 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 (U.S.D.H.E.W., 1977, p. 42478).

The Etiology of Behavior Disorders in Children

The case of behavior disorders in adolescence presents an intriguing situation in regard to its etiology. Freud and the so-called "second revolution" in psychiatry presented a formidable body of theory

suggesting that, at least, the nonpsychotic mental illnesses originated quite early in life. Rutter (1972) found that childhood experiences do not categorically give birth to adult psychiatric morbidity, but it is not clear how strong an influence early experiences do have. Robins (1966) reports that it is probably true that some types of nonpsychotic disorders, especially the most severe, do persist into adulthood. It may also be true that the major psychotic disorders, most of which become recognized clinically in adolescence and early adulthood have important etiologic determinants in premorbid childhood experiences.

Research has shown that learning disorders, if they persist into late childhood and adolescence, generally lead to serious emotional and behavioral disturbances. Such disorders represent the major single cause of school dropouts. They also represent one of the major problems observed in children and young people who have been referred to clinics and juvenile courts (NIMH, 1975).

Research in this area continues to be hampered by the lack of objective means of classifying the numerous types of learning deficiency. There has been a tendency to confuse classification with what is inferred to be cause. But research over the last half dozen years points to many causes, different combinations of them operating in different cases. Included are genetic defects, prenatal and perinatal complications, postnatal brain trauma and infection, inadequate teaching, cultural deprivation, sensory defects, emotional problems, and the complexities of English orthography (NIMH, 1975). Since the classification of a child with a reading disability or other learning handicap may well affect both their treatment and their psychological development, inferential diagnosis is a grave matter.

Children categorized as antisocial or as exhibiting an antisocial behavior disturbance or disorder may be defined as those who repeatedly show resistance to authority. They fail to attend school or complete assignments; they stay out beyond the time allowed by parents; they address those in authority in ways that appear disrespectful. As they grow older, they may engage not only in acts acceptable for adults but considered inappropriately precocious for children, such as smoking, swearing, drinking, and sexual activity, but also in criminal acts--theft, assault, and rape. They prolong, beyond the ages at which it is sometimes tolerated in small children, behavior such as damaging property and lying.

Antisocial behavior disturbance is a common childhood psychiatric disorder. In fact, a recent epidemiological study by an English investigator found that, of all the childhood psychiatric disorders in the area studied, it was the most common. It accounted for 68 percent of psychiatrically disturbed boys and 32 percent of psychiatrically disturbed girls (NIMH, 1975).

Antisocial children include a large proportion of those given other labels--delinquent or predelinquent, hyperactive or hyperkinetic, and underachiever. They also include many children with specific learning disabilities.

Among possible explanations offered: antisocial children (a) fail to feel the anxiety that inhibits the acting-on-impulse of normal children; (b) are unable to fantasize the future and thus foresee consequences of their behavior; (c) have higher pain thresholds, which reduce their ability to learn from experience; (d) have a deep underlying depression, which makes the future look so bleak that regard for personal safety is

irrelevant; and (e) have delusions of invulnerability. These possibilities have not been systematically studied (NIMH, 1975).

NIMH reports the following findings in regard to prevention and treatment of antisocial behavior disorders:

1. Stimulant drugs given to children labeled hyperactive or hyperkinetic improve behavior at home and in school--by reducing hyperactivity, distractibility, and impulsiveness--on at least a short-term basis, and enhance performance on a number of cognitive-motor tasks.
2. Treatment in conventional child-guidance clinics or in residential educational centers or by conventional psychotherapy has shown little or no advantage over no treatment. Behavior modification techniques appear to be more effective than psychotherapy; they have not been sufficiently tested to know whether or not they will work over the long haul.
3. Some forms of treatment appear to be worse than no treatment at all. Children who have committed offenses that could require appearance in juvenile court seem less likely to be recidivists if they somehow avoid contact with the courts, and particularly if they avoid being sent to a reformatory. However, carefully controlled studies of the effect of diversion of delinquents from the juvenile courts system have not been done (NIMH, 1975, p. 202).

NIMH research findings to date suggest that offspring of seriously disturbed parents should be considered at higher risk for a variety of psychopathological conditions, and not only for the particular problems that afflict their parents. For example, NIMH supported studies have identified difficulties with socialization, activity level, and anxiety,

as well as with depression, in the children of depressed parents. A number of different kinds of problems have been identified when considering infants as being at high risk. Many of the difficulties have to do with the infants themselves. These can include being born underweight, having physical distress after birth, and manifesting problems in growth/development during the early months. Some difficulties can relate to parental status. For instance, the offspring of an unmarried teenage girl with limited resources relevant to mothering might well be considered at increased risk for mental health problems.

Background of the Problem

To understand the need for studies of programs serving BD adolescents, a discussion of the historical and theoretical background will be helpful.

In 1975, PL 94-142, the Education of All Handicapped Children Act, mandated that all children with handicaps be provided an appropriate, free education in the least restrictive environment. Previous to PL 94-142, schools commonly failed to provide services for many handicapped children, especially those with behavior disorders. Addressing this issue in their review of Bureau of Educationally Handicapped (BEH) funded personnel preparation programs in emotional disturbance, Brown and Palmer stated, "Programs focusing on the skills and competencies necessary for setting up quality educational programs at the secondary level simply do not exist in most areas of the country" (Brown & Palmer, 1977, p. 173). It was the goal of PL 94-142 to change this situation by mandating appropriate treatment for handicapped children including emotionally handicapped children.

A Brief Psychohistory

The educational system has long been regarded as a means for socializing deviants (e.g., in the form of migrants from other countries). The philosophical foundation of the system was the English Protestant ethic. Therefore, in the reformatories for children "the values of sobriety, thrift, industry, prudence, realistic ambition and adjustment were taught" (Rhodes & Paul, 1978, p. 23) with a strong emphasis on individual responsibility. In the Twentieth Century, the elevation of science and of social scientists as social pattern interpreters and gatekeepers transformed the Puritan ethic into a mental

ethic for the nation (Rhodes & Paul, 1978).

By 1921, with a national conference on the Prevention of Juvenile Delinquency, the young criminal element had been analyzed by the new behavioral sciences as a source of social infection which could, and should, be subjected to early identification and scientific cure. This was the medical model of diagnosing and curing mental diseases.

Gradually, the problem of emotionally disturbed and deviant children came to be viewed as being within the domain of psychological research. The best interventions were regarded as one to one (or small group) discussions, therapist to client(s), with the client's past being the principal focus. Sociologists recognized that the individual's environment or ecology was greatly responsible for their behavior but they lacked viable models for causing change. Education directed its focus to normal children, allowing deviants who could not function in the regular school system to fall by the wayside, with the result that many were serviced by the mental health and correctional systems or not treated at all.

The medical model held sway until the Sixties with the Community Mental Health Act of 1963, the Civil Rights Act of 1964, the questioning of the model American type, attacks on the "tracking" concept and psycho-educational measurement, and a profound public recognition of all sorts of discrimination and segregation practices culminating in PL 94-142.

As a result of the new way in which deviance has lately come to be regarded, there has recently been a proliferation of alternative schools for those who are dissatisfied with or unable to conform to traditional public schools. This proliferation has been aided by recent special

education litigation and legislation. PL 94-142 actually mandates a restructuring of the teacher-student contract giving parents or child, where appropriate, authority in approving the individual educational plan. In effect, it makes the schools responsible not only for education, but also for mental health care and corrections.

The Mental Health Needs of Children and Adolescents

The exact number of children and adolescents in need of mental health services in the United States is not known. The reasons are complex. They include the lack of a uniform definition for such terms as "mental illness" and "emotional disturbances," the use of different diagnostic categories and instruments to measure incidence and prevalence, and various limitations in current methodology.

The incidence and prevalence of behavior disorders in children are extremely difficult to estimate with precision, but there is a growing recognition that the severity of behavior problems among children and adolescents is increasing. For example, Coleman, Hoffer, & Kilgore report that, "Discipline in schools is regarded by many as the most important problem in American education. In a yearly Gallup Poll concerning education, the general public has for a number of years ranked discipline as the most important problem in schools. And superintendents, principals, and teachers complain bitterly about constraints on them, legal and otherwise, which they regard as preventing them from imposing and maintaining order in their schools (Colemen, Hoffer, & Kilgore, 1981, pp. 136-137). Although it is difficult to find reliable, recent statistics on this matter, Cook County States' Attorney Richard Daley contends that the rate for violent juvenile crime in Cook County jumped 36.6 percent from 1977 through 1980

and continued to rise through 1981 and the first months of 1982. The Chicago Police Department's Youth Division reported that 60,010 juveniles were arrested in 1981; a third of those arrested for Part 1 offenses, which include murder, rape, robbery, theft, burglary, and aggravated assault. A particularly alarming statistic is that more than 14,000 of those arrested were "tender age" children, 13 and under. These numbers represent a jump over 1980, when 53,381 juveniles were arrested (Emmerman, Chicago Tribune, 1982).

Existing data suggest that the need for services far outweighs our ability to provide services. The data show, for example, that 14 percent of the 1,499 mental health catchment areas in 1974 had no mental health services of any kind, that available services are unevenly distributed geographically, that there is not enough manpower to meet the needs, and that monies have not been adequate to meet the service needs of children and youth (NIMH, 1981).

The Joint Commission on Mental Health of Children (1970, p. 25) estimated that 2 to 3 percent of children suffer from severe mental disorders and that another 8 to 10 percent suffer from emotional disturbances that require some intervention. The President's Commission on Mental Health (1978, Vol. 2, p. 39) estimated that 5 to 15 percent of the child population needs some kind of mental health treatment. Regarding services to this population, the Commission stated that it was: "particularly troubled by the lack of people trained specifically to work with children, adolescents, and the elderly. These groups comprise more than half the Nation's population, but they are among those receiving the fewest mental health services" (1978, Vol. 1, p. 38).

If the prevalence of disturbed children is really 5 to 15 percent, it is clear that with 65 million individuals under 18 years of age, at least 3 million and as many as 10 million children and adolescents require mental health care. In 1975, 655,036 children and adolescents were admitted to the mental health system as defined by the combination of community mental health centers, free standing out-patient clinics, state and county mental hospitals, and private psychiatric hospitals. Thus, as few as 6 percent of the potential service population were actually being served by the mental health system (statistics from NIMH, 1981).

Hobbs has noted recently that although Comprehensive Community Mental Health Centers have been the centerpiece of the Nation's mental health programs, they have been repeatedly criticized for neglecting children and youth (Hobbs, 1982, p. 6). At the same time Hobbs states that the public school probably is the institution that serves most mildly and moderatedly disturbed children, simply because that is where most of the children are. In fact, since 1975, alternative programs for adolescents with behavior disorders (BD) have sprung up throughout the country in response to the mandate of the Education of All Handicapped Children Act (Public Law 94-142). At present, PL 94-142 provides services in the schools for approximately 150,000 disturbed children, ages 3 to 21 (Hobbs, 1982, p. 9).

Indeed, it appears that the trend in public alternative education is away from education for the gifted and toward education for the disturbed. Hess notes that alternative schools for problem students appear to be the most feasible of these programs for most districts (Hess, 1979).

For example, a study by the Cook County Board of Education examined the form and availability of public alternative education programs in suburban Cook County, Illinois and found the following student characteristics leading to placement in an alternative program:

1. behavior problems--50% (including social-emotional learning needs disruptive behavior, extremely objectionable and chronic/severe)
2. truancy--14%
3. have not been successful in regular school setting--14%
4. potential dropouts--29%

The State of Program Evaluation and Research

PL 94-142 states in selected parts that: (1) "a free appropriate public education will be available for all handicapped children between the ages of 3 and 18" ... (2) "all children residing in the State who are handicapped regardless of the severity of their handicap, and who are in need of special education and related services are identified, located, and evaluated, and that a practical method is developed and implemented to determine which children are currently receiving needed special education and related services and which children are not" ... (3) "Each plan shall ... provide for procedures for evaluation at least annually of the effectiveness of programs in meeting the educational needs of handicapped children" ....

In response to this mandate, alternative programs for BD adolescents have sprung up throughout the country. A review of the literature has revealed that no quantitative research of a scope beyond the single program has as yet been done to study these programs and the students they serve. Conversations with university special education professors, State of Illinois special education specialists, and directors of BD

programs have yielded a lack of knowledge about the existence of research designed to evaluate special education programs, in general, and BD programs, in particular. One authority stated colloquially, "For all we know, we might as well be pouring money down a rat hole." Although evaluation is mandated as a condition of receiving funds for these programs, the focus of the "evaluations" is not on value or effectiveness but on compliance with minimal standards and regulations.

A review of the literature on programs for emotionally disturbed and behavior disordered adolescents was conducted via computer searches of the Educational Resources Information Center (ERIC) and Psychological Abstracts and a search of the Education Index. This review revealed few controlled (employing random assignment) studies of different alternative high school program models and few quasi-experimental studies of different alternative high school program models. Program evaluations typically consisted of pretest/posttest assessments of change within a single program (Fineberg, et al., 1982; Maher, 1981). Brown (1980) was able to conduct a controlled experiment of a psychoeducational program in a community mental health setting, but his subjects were adults.

White and Snyder (1979) conducted a very small study which evaluated a behavior modification program for delinquent adolescents in a residential treatment center. The cognitive self-instructional program attempted to change behaviors by changing internal, cognitive processes. A study was conducted in which 15 subjects were randomly assigned to three treatment groups, a cognitive self-instructional treatment, a placebo condition plus an operant program, and an operant program alone. The cognitive self-instructional strategy was found to

have statistically significant effects on improved behavior (e.g., class attendance, social and self-care responsibilities, impulsive behavior, etc.). The study may be criticized for its small scale and the failure to control for reactive arrangements such as resentful demoralization of the untreated groups and unintentional testing effects (White & Snyder, 1979).

Probably the best evaluation of a BD program was conducted by Weinstein on a Project Re-ED program called Cumberland House. In this study, emotionally disturbed (ED) children (6 to 12 years old) attending a Re-ED school were compared with children whose principals identified them as requiring help for behavioral and emotional problems to determine the effectiveness of Re-ED schools. The Re-ED school provided short-term residential care to approximately 40 ED children. The program stressed educational rather than psychodynamic strategies and focused upon parents, schools, and communities as well as the children. After leaving the residential setting, Re-ED children were found to have better self-concepts, more internal controls, and greater improvement in behavior than other subjects. Children who were achieving poorly improved academic performance and acting out children exhibited less motor and cognitive impulsivity. However, no changes in the acceptance of Re-ED children by their peers appeared.

Therefore, it is apparent that existing studies are few and scattered. It is a fact that more comparative studies (experimental or quasi-experimental) will need to be conducted if we are to gauge the relative effectiveness of different models of education and therapy for adolescents with behavior disorders (see Cook & Campbell, 1979; Boruch, et al., 1978). If these studies are to be useful in determining the

relative effectiveness of different program models, it will be necessary to specify the intended program model and to measure its implementation.

Modeling Theories of Mental Disorder

Steven J. Apter (1982) drawing upon the work of Rhodes and Tracy (1972) and Morse, Smith, and Acker (1978), has depicted the major theories in emotional disturbance on a field (Figure 1) in which Internal Forces (needs, drives, innate patterns, biological urges, physiological conditions, etc.) interact with External Forces (stimuli, reinforcers, punishers, social rules, mores, taboos, cultural patterns, social conditions, etc.). While all of the major theories (psychodynamic, behavioral, biophysical, and sociological) recognize this interaction of forces, they differ significantly over which, internal or external, has the more powerful causal effect. Psychodynamic theorists and biophysical theorists would tend to see mental disorder as caused principally by internal forces, whereas behavioral theorists and sociological theorists would tend to emphasize the influence of external forces as causal agents. In this schema, the ecological orientation stresses the importance of examining the entire field or "life space" (Apter, 1982, p. 16) for the sources of disturbance.

The schema is not only useful in conceptualizing the etiology of mental disorders, but also in conceptualizing their treatment. Programs which adhere to a psychodynamic theory emphasize the influence of early childhood events in determining personality, and stress the idea "that abnormal behaviors are symptoms of unconscious conflict" (Newcomer, 1980, p. 38). As a result, these programs would hold that children should discuss the past and express their feelings. The teacher's role

would be to provide environments which do not repress the child's symptoms but which allow opportunities to express the underlying conflicts.

The psychodynamic model. This approach originated with Freud and has been developed and elaborated by numerous others, but the following characteristics are common. The psychodynamic model holds that children have basic needs (love, security, belonging, success, etc.) that must be met in order to develop a healthy personality. The approach stresses the importance of the feelings and the quality of the emotional relationship a child has with his/her family (Apter, 1982).

The psychodynamic model also holds the following:

1. Behaviors that reflect a state of emotional disturbance are caused primarily by internal psychic pathology.
2. Both biological forces and early environmental influences contribute to the pathological condition.
3. Etiology must be identified if effective treatment is to be undertaken.
4. The individual is not consciously aware of the source of the problem.
5. Changing overt behavior is less important than dealing with the underlying conflicts that cause the behavior, since surface treatment only results in symptom substitution.
6. Treatment involves changing the person by providing insight into past conflicts unearthed from the unconscious.
7. Treatment through psychoanalysis can reverse certain pathological behaviors, but the process is long and difficult (Newcomer, 1980, p. 39).

The behavioral model. In contrast, the behavioral model holds to a quite different set of assumptions, which include:

1. All behavior is learned and can be unlearned through the application of principles of learning.
2. Inappropriate behaviors can be altered (extinguished and/or replaced by more acceptable alternative behaviors) through the use of reinforcement procedures.
3. It is possible to predict and ultimately to control behavior if all the pertinent environmental characteristics are known.

In congruence with these assumptions, the behavioral treatment strategies include: reinforcement, punishment, extinction, time out, level systems, task analysis, modeling, etc., all aimed at reshaping maladaptive behaviors so that they conform to general societal norms.

Under the behavioral model are classed Pavlovian conditioning (stimulus-response conditioning), Skinner's operant conditioning (positive/negative reinforcement), instrumental learning (goal directed or avoidance learning), freeing of the emotions, Systematic Desensitization, and behavior modification (an amalgam of the aforementioned). Behavior modification is the strongest current and, possibly, future trend. It uses operant conditioning techniques such as token economies to change deviant behavior.

The biophysical model. The biophysical approaches to explaining the origin and nature of behavior problems in children emerged from specialized study concerned with the behavioral consequences of brain dysfunctions. Maladaptive behavior is explained, in psychoneurological terms as the psychological consequences of central nervous system dysfunction. Although the biophysical model has a great many adherents

and powerful implications for the treatment of children, it is not commonly employed in the schools but in hospitals and mental health centers.

The sociological model. Sociological approaches regard disorder as resulting from the effects of social forces on individuals especially as agents in the social system come to label children as deviant or disordered. This model is useful in understanding mental disorders, and it implies that it is necessary for treatments to consider and change the institutions which influence and label children.

Labeling refers to the public designation of a person as a deviant. Labeling theorists postulate that one does not become a deviant by breaking rules. Rather, one must be labeled a deviant before the social expectations that define the deviant role are activated. Labeling theory stresses the role of agents of social control; e.g., police, the court system, psychiatry, teachers, and parents. The agents of control invoke the labeling process, a process which is often carried out under the rubric of treatment or rehabilitation. Labeling theory emphasizes the contributions of the agents of social control, but tends to ignore any contributions of the rule breaker.

The ecological model. The ecological point of view is concerned with the adaptation between the organism and the environment. As applied in the field of child variance, the ecological point of view shifts the focus from the child and his/her personality, psychic make-up, and behavior, to the problem of mutual adaptation between the child and his/her community (Rhodes & Paul, 1978).

Clearly, there exists a broad variance of opinion in regard to the explanation and treatment of childhood disorders. This variance must be

accommodated in any attempts to model programs for BD adolescents.

Therefore, there is a need for an approach which unifies and gleans the most effective contributions of these various theories. Actually, the ecological perspective does this in that it recognizes the influences of internal forces interacting with the influences of external forces in causing mental disorder (Faris & Dunham, 1960; Levy & Rowitz, 1973). The ramifications for treatment are that the ecological model would employ components of all of the theories. For example, it would employ reinforcement schedules without eliminating discussions of past life events in an effort to reshape the deviant child while exploring internal causes. It would work in harmony with various institutions and agencies such as law enforcement, employers, hospitals, mental health centers, families, etc. in attempting to fit the child and the environment.

Project Re-ED

One of the most prominent porponents of the ecological approach to treating disturbed children is Nicholas Hobbs, the founder of Project Re-ED. Hobbs notes that two ideas are central to his ecological approach. First, the role of insight in psychotherapy as a source of behavior change and increased personal integration was questioned (Hobbs, 1962). It followed that health, happiness, and self-worth "must grow out of a life that is lived, not out of life as it is talked about in the context of some fragile theory of personality (Hobbs, 1981, p. 14). The second idea was that emotional disturbance arose not as a symptom of individual sickness, but was a symptom of a malfunctioning human ecosystem (Rhodes, 1967).

In practical terms Project Re-ED meant the following preferences:

for a vocabulary of everyday life over a vocabulary of pathology; for the idiom of education; for cost-effective solutions; for a staff with natural talents for work with children; for using psychiatrists, and other mental health specialists as consultants, thus extending the application of their knowledge; for involving families in programs; for making normal socializing agencies work; and for settings attuned to the needs of children for affection, play, adventure, learning, and a sense of the future as possibility (Hobbs, 1981, p. 17).

Methods

The need to study models of programs for adolescents with BD arises out of the need to evaluate the effectiveness of PL 94-142 in providing service to this population. How do we evaluate these programs? One way would be to evaluate all types of programs looking only at outcomes (ie., viewing all BD programs as a black box). This was done with compensatory education (Westinghouse Learning Corporation/Ohio University, 1969) with the result that thirteen years later it is still unclear whether effects were positive, negative, or nil. Of course, the problem with the black box evaluation is that programs with positive outcomes may be mixed together with programs having no effect and negative effects, thereby diluting the effect size if not eliminating it entirely. To restate, the problem with the evaluation of a black box is that it reveals no information about the various treatment models which are intended to cause the outcomes. Additionally, it tells nothing about the implementation of the intended treatment models; that is, it fails to address the question: is the intended treatment model actually being implemented as intended?

Therefore, it is the intention of this research to get inside the black box; that is, to describe and differentiate existing BD programs in regard to their philosophy and methods of treating and educating adolescents with severe behavior disorders. The methodology of this study borrows from the work of Harnischfeger & Wiley (1978), Moos (1974), Walberg (1979), and others who have developed methods of measuring classroom and program environments. It is unique in that it attempts to assess program environments via a mail survey of on-site administrators. One advantage of this strategy is that it can

capitalize on the intimate knowledge of program directors. A threat to the validity of the results is that the administrators may respond with socially desirable answers.

This study will delineate models of programs for adolescents with behavior disorders along three dimensions, i.e., philosophy, type of control, and program characteristics, using an instrument constructed specifically (See Appendix A.) for this purpose. The philosophy of a program will be characterized on a scale (strongly disagree, disagree, agree, strongly agree) which measures a psychodynamic vs. behavioral orientation. The type of control employed in the program will be assessed on a scale (strongly disagree, disagree, agree, strongly agree) which measures the strength of behavior control (high or low). Program characteristics will be delineated with a survey designed to assess components including: students, staff, facilities, curriculum, parent involvement, and evaluation. Although it is not the principal purpose of this study to relate program processes to inputs and outcomes, an attempt will be made to obtain information about cost and student attendance in an effort to get a rough idea of how program models differ on these policy relevant variables.

The Sample

When it was determined that a statewide survey was to be taken, the Illinois State Board of Education (ISBE) was contacted in order to obtain any information available about high school BD programs and students. All public and private educational facilities receiving any state or federal funds for education must report descriptive data to the ISBE.

While the ISBE was unable to provide any data about particular

programs or data which were specifically related to high school students it did provide the following data which were useful in classifying and organizing our sample.

1. A list of 89 special education joint agreement areas which included the names, addresses, and phone numbers of the directors, as well as the counties and districts served by each.

2. Descriptive data on each joint agreement area which described area of exceptionality, race, age, least restrictive environment, and related services. This gave the investigators a general notion of the numbers of BD students and programs in different areas of the state.

3. A list entitled "1981-82 Approved Eligible Non-Public Facilities" was obtained which names and describes the ages, populations, and addresses of private special education facilities across the State of Illinois.

A telephone canvas of the entire state was carried out with the goals of (1) obtaining a description of how each special education joint agreement area serves its high school BD students, and (2) creating an accurate and complete list for each agreement area of all the administrators of BD programs consisting of at least one self-contained classroom.

Descriptive data from the ISBE were reviewed before calling each agreement area. This was done so that the caller would be familiar with the area being called. Each agreement area was then called and asked for a description and listing of all BD programs starting with the largest and going to the smallest. That is, programs that served more than one district were listed first, then district-wide programs that

served more than one school, then school-based programs with self-contained and resource rooms. This process often required several phone calls. In compiling the list of sample subjects, the target respondents were administrators or appropriate administrative staff who were in daily contact with the program. In the case of most agreement areas, the director of the special education joint agreement was not the appropriate respondent, but, rather, an on-site coordinator, principal, etc.. On the other hand, where only one classroom existed or where no administrator was in close contact with the program, the teacher was considered the appropriate respondent. Names and addresses of subjects were recorded for all programs with at least one self-contained classroom. All joint agreements were called. Some had no programs, or resource room programs only, and were not included in the survey.

The final sample was composed of 230 public school program administrators and staff obtained through the telephone canvas, and 40 private school program administrators obtained from the "1981-82 Approved Eligible Non-Public Facilities" list. The respondents represent every area of Illinois including large and small urban, suburban, and rural areas. The investigators consider this sample to cover comprehensively the population of on-site program directors and teachers of BD programs having at least one self-contained classroom.

The Questionnaire

The questionnaire employed a four point scale (strongly disagree, disagree, agree, strongly agree) to describe programs for adolescents with behavior disorders primarily along the following dimensions: psychodynamic vs. behavioral philosophy and administrative vs. student control of the program. It was expected that a psychodynamic

orientation would correspond with student control and that a behavioral orientation would correspond with administrative control and that these constructs would be at opposite ends of a single continuum. In addition, items were included to gauge the orientation of programs on the dimensions of existentialism, biophysical strategies, and ecological perspective. These items were expected not to correlate with the psychodynamic/behavioral and control dimensions. Therefore, they would provide a measure of the discriminant validity of these scales (Table 1).

In addition to the four point scale items, a questionnaire was designed to measure the following characteristics of the BD program: (1) student characteristics, (2) program characteristics, (3) counseling and education strategies, (4) vocational education, (5) parent involvement, and (6) evaluation (See Appendix A for the entire questionnaire).

Statistical Analysis

In addition to descriptive statistics, a factor analysis will be performed in which it will be expected that programs will be characterized by their program philosophy (psychodynamic or behavioral), their degree of administrative control (low or high), and the extent to which the program affects the various systems (ecology) of students' lives. It is expected that psychodynamic approaches will have low control and that behavioral approaches will have high control. It is to be tested which will have the strongest ecological orientation.

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Figure 1. Major theories in emotional disturbance (Morse, Smith, & Acker, 1978)

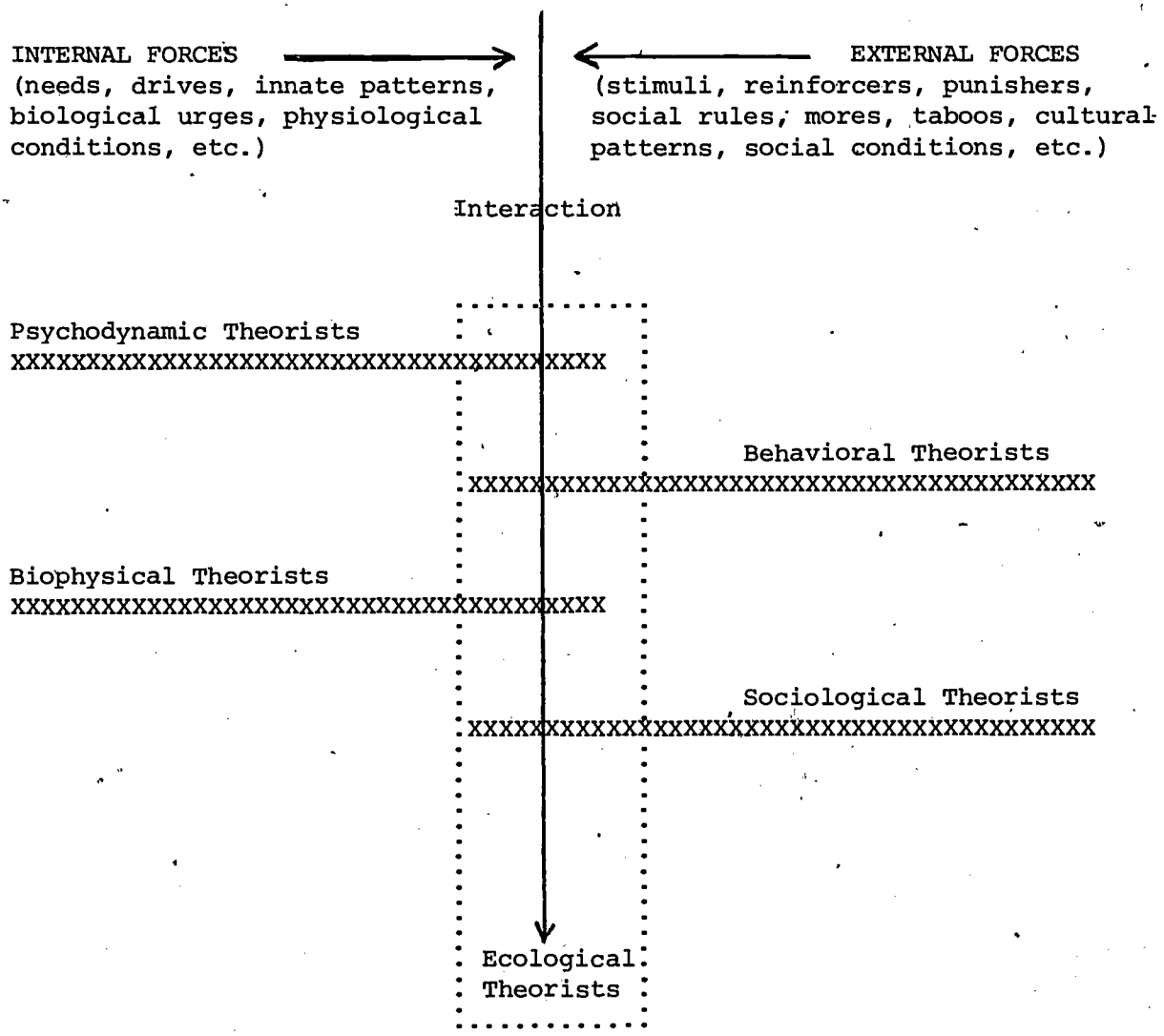

Table 1
The Scales of the Behavior Disorders Program Questionnaire

Scales and Sample Items	N of Items
1. Psychodynamic Orientation: The program emphasizes changing the inappropriate behaviors of students through discussing them. There is a great emphasis placed on learning about students feelings.	7
2. Behavioral Orientation: Teachers give points or tokens for appropriate behavior. All problem behaviors are learned and can be unlearned.	7
3. Student Control: Students have freedom in choosing their class schedules. Students are expected to take leadership here.	10
4. Administrative Control: Students stick closely to a routine which is defined by the administration. Students need permission to go to the washroom.	9
5. Existential Orientation: The major responsibility for the child's behavior resides with the child.	3
6. Ecological Orientation: Behavior disorders are primarily caused by a bad fit between the particular child and the environment.	3
7. Biophysical Orientation: Drugs are administered as part of the school program.	2

Office Use Only

APPENDIX--A--1

Study of School Programs for Adolescents with Behavior Disorders

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PLEASE CIRCLE ONE ANSWER FOR EACH QUESTION UNLESS OTHERWISE INDICATED.

1 = SD, strongly disagree
2 = D, disagree
3 = A, agree
4 = SA, strongly agree

	SD	D	A	SA
1. The program emphasizes changing the inappropriate behaviors of students through discussing them.	1	2	3	4
2. If students become violent or uncontrollable, they are sent home.	1	2	3	4
3. Students have freedom in choosing their class schedules.	1	2	3	4
4. Behavior problems are principally a result of a lack of responsibility for one's behavior.	1	2	3	4
5. Changing problem behaviors is a process which takes years to accomplish.	1	2	3	4
6. Students may leave school any time they want without obtaining permission.	1	2	3	4
7. This program encourages student control of the school environment.	1	2	3	4
8. Teachers give points or tokens for appropriate behavior.	1	2	3	4
9. Teachers are expected to be models of appropriate behavior.	1	2	3	4
10. Students stick closely to a routine which is defined by the administration.	1	2	3	4
11. This program demands that students assume personal responsibility for their behavior.	1	2	3	4
12. Treatment for behavior problems should provide insight into past conflicts.	1	2	3	4
13. This program emphasizes changing the child's environment outside of school.	1	2	3	4
14. All problem behaviors are learned and can be unlearned.	1	2	3	4
15. Teachers take away privileges of students for inappropriate behaviors.	1	2	3	4
16. Staff rarely give in to pressure from students.	1	2	3	4
17. Students get to school any way they choose.	1	2	3	4

	SD	D	A	SA
18. Students are sometimes kept after school as a consequence of inappropriate behavior.	1	2	3	4
19. There is a smoking area for students in the school building.	1	2	3	4
20. This program primarily relies on peer pressure to control student behavior.	1	2	3	4
21. Students are free to determine their own daily routine.	1	2	3	4
22. Students are not allowed to move about the classroom without asking permission.	1	2	3	4
23. Students are not forced to go to classes.	1	2	3	4
24. The major responsibility for the child's behavior resides with the child.	1	2	3	4
25. Staff are trained in methods of physical restraint.	1	2	3	4
26. Students need permission to go to the washroom.	1	2	3	4
27. This program focuses on changing problem behaviors before dealing with internal psychological processes.	1	2	3	4
28. This program has a high degree of control over student behaviors.	1	2	3	4
29. This program employs locked isolation rooms.	1	2	3	4
30. Students are expected to take leadership here.	1	2	3	4
31. If students behave inappropriately, they can be suspended from school.	1	2	3	4
32. There is a great emphasis placed on learning about students' feelings.	1	2	3	4
33. Staff must win all power struggles with students.	1	2	3	4
34. Staff members will sometimes ignore students in order to manipulate their behavior.	1	2	3	4
35. Behavior disorders are primarily the result of physiological factors.	1	2	3	4
36. Teachers sometimes control students by restraining them.	1	2	3	4
37. Changing a child's behavior is less important than dealing with the underlying conflicts which cause the behavior.	1	2	3	4

	SD	D	A	SA
38. Behavior disorders are primarily caused by a bad fit between the particular child and the environment.	1	2	3	4
39. The arts, including music and dance, are important components of the therapy program.	1	2	3	4
40. Drugs are administered as part of the school program.	1	2	3	4
41. Before children can be successfully treated, it is necessary to know the cause of their problem.	1	2	3	4

Student Characteristics

42.a. In your own words, what is the principal reason for students being assigned to the program?

b. What percentage of students have been in trouble with the law (i.e., involvement with the legal system stemming from delinquent or criminal activities)? _____

43. Below is a listing of reasons for assignment to a BD program. Please rank them from 1 to 7 according to which is the most frequent reason to which is the least frequent reason that students are assigned to your program (i.e., 1 = most frequent, 7 = least frequent).

Academic problems, poor achievement, learning disabilities . _____

General behavior problems in school ..... _____

Truancy and class cutting ..... _____

Aggression, acting-out, disruption ..... _____

Withdrawal, depression, suicidal tendencies ..... _____

Psychosis, extreme withdrawal, autism ..... _____

Delinquency or criminal activities ..... _____

44.a. Of those students who are in your program, would you say that most are: (Circle one.)

Severely disturbed 1

Moderately disturbed 2

Mildly disturbed 3

b. If you did not circle 1, "severely disturbed," would you describe the facilities which accommodate the severely disturbed students in your area?

Program Characteristics

45. How many BD students are assigned to your program? _____

46. How many of your BD students are female? _____

47.a. How many of your BD students are white? _____

b. How many of your BD students are black? _____

c. How many of your BD students are Hispanic or other? _____

48.a. How many BD students are under 14? _____

b. 14-17? _____

c. 18 and older? _____

49. What is the average length of stay (in months) of students in the program? _____

50. How many students are assigned to each classroom? _____

51.a. What is the per pupil attendance rate (number of days students were in attendance divided by number of days students were enrolled)? Estimate if you do not have exact figures. _____

b. What is the per pupil expenditure? _____

52. What student behavior problem causes the most trouble in the everyday running of the program?

53. How many full-time, self-contained BD classes are there? _____

54. How many resource BD classes are there? _____

55. How many staff are assigned to each classroom? _____

56.a. How many classroom staff members are female? _____

b. How many classroom staff members are male? _____

57.a. How many classroom staff members are white? _____

b. How many classroom staff members are black? _____

c. How many classroom staff members are Hispanic or other? _____

58.a. What is the average length of time that your classroom staff have taught in programs for students with behavior disorders? _____

b. How many years has the program been in existence? _____

59. How many times per month do staff meet for program planning? _____

60.a. Is this a special, separate day school? (If no, SKIP to 61.) Yes No

b. At how many different sites is your program located? _____

61. Is this a residential school? (Does it include a residential school?) Yes No

62.a. Is there a hospital school? Yes No

b. Please describe any other special facilities?

63. What (approximately) is the per family income of the families of students in your program? _____

64. How long is the school day? hours minutes

65. Is the sponsoring agency of your program public? 1

private? 2

66. Which school districts does your program serve? Please list district numbers below.

67.a. Does your program maintain a formal cooperative arrangement with other community agencies or facilities? (If no, SKIP to 68.) Yes No

b. Would you describe this (these) arrangement(s)?

68. Are there any staff who go to the jails or courts on behalf of students (at least once per week)? Yes No

Counseling and Education

69. Do students receive counseling or therapy? (If no, SKIP to 73.) Yes No

70.a. Is participation in counseling voluntary? Yes No

b. What percentage of students participate in counseling? _____

71. Is the counseling program primarily individualized? 1

group administered? 2

other? (Describe.)..... 3

72. How many times per month does the average student participate in counseling? _____

73. How would you classify the treatment approach used in this program?

Behavior modification 1

Psychodynamic 2

Other (Please describe.)... 3

74. Are BD students suspended from school? Yes No

75. Are BD students expelled from school? Yes No

76. If a student is absent without calling the school with a valid excuse, what is done?

77.a. Does the program employ particular procedures to reduce truancy? (If no, SKIP to 78.a.) Yes No

b. Would you describe them?

78.a. Is there a place for time-out? (If no, SKIP to 79.) Yes No

b. Would you describe it?

79. How would you describe the principal focus of the curriculum?

80. Does the educational program include:

a. Occupational therapy Yes No

b. Music? Yes No

c. Art? Yes No

d. Outdoor education? (If no, SKIP to 81.) Yes No

e. Briefly describe the outdoor education program.

81. Does the program include intramural sports or games? Yes No

82.a. Are there extramural sports or games? (If no, SKIP to 83.) Yes No

b. Would you describe them?

83.a. Is there a summer program? (If no, SKIP to 84.) Yes No

b. Would you describe it?

84. Is the school regularly in use on weekends? Yes No

85. Does the program provide 24 hour crisis intervention? Yes No

86. Does the school provide an alcohol or drug abuse program? Yes No

Vocational Education

87.a. Is there career or pre-vocational training at the school? (If no, SKIP to 88.) Yes No

b. Would you describe it?

88. Is there a work study program (e.g., student attends classes in the morning and works at a monitored site in the afternoon)? Yes No

89. Is there a job placement program (school is actively involved in placing students in jobs)? Yes No

Parent Involvement

90. What is the principal method by which the organization communicates with parents?

Written correspondence 1

Telephone 2

In person 3

91.a. Is there a parent counseling program? (If no, SKIP to 92.a.) Yes No

b. Is it for individuals? 1

groups? 2

both? 3

c. What percentage of parents participate? _____

d. How many times per month does the average parent participate? _____

Evaluation

92.a. Are standardized tests administered to students? (If no, SKIP to 93.a.) Yes No

b. How many testings are done each year? _____

93.a. Is there an ongoing system of program evaluation? (If no, SKIP to 94.a.) Yes No

b. Would you describe the system?

94.a. Are there follow-up studies of program impact; that is, are students contacted periodically after they have left the program to see how they have adjusted to society? Yes No

b. Would you describe the (these) study (studies)?

95. Would you be willing to participate in a more thorough study of school programs for adolescents with behavior disorders? Yes No

A study including tests given to students? Yes No

96. What is your job title? _____

THANK YOU FOR YOUR COOPERATION IN THIS STUDY.

If you feel that you would like to send program descriptions or other information in order to provide a more complete understanding of your organization, please send to:

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