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ABSTRACT

Alternatives is a project designed for youngsters, ages 11-15, who display serious conduct problems and severe learning deficiencies. The primary goal of the project is to prevent the development of a chronic antisocial orientation among youngsters who are at high risk for such an outcome. The interventions employed at Alternatives are based on the available literature regarding the psychosocial and educational needs of learning deficient youngsters, the causes and correlates of delinquent behavior, and the nature and consequences of the inner city poverty context from which all project participants come. Project interventions are designed to be comprehensive so as to influence the adolescent's attitudes, aspirations, and behavior as well as the adolescent's key systems, which include the peer context, the school, and the family. Interventions include a problem-solving component, a parent management component, an educational remediation component, a daily life component, a weekend recreational component, and a case management component. The treatment's effectiveness was gauged by selecting a sample of 18 youngsters who had been in treatment for at least 3 months and rating them on 37 problem behaviors. Two-thirds of program participants demonstrated a noticeable lessening of problems and one-third continued about the same level of problems. The treatment evaluation form is appended. Contains 30 references. (JDD)

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Alternatives
Project Description

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Alternatives: Project Description

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Alternatives is a project designed for youngsters, ages 11 to 15, who display both serious conduct problems and severe learning deficiencies. The primary goal of the project is to prevent the development of a chronic antisocial orientation among youngsters who are at high risk for such an outcome. Project participants tend to be highly disruptive at home and at school, and to regularly oppose authority. Many have committed status offenses, offenses such as truancy and running away, which would not be considered violations of the law if committed by an adult. A smaller percentage have committed a non-violent criminal or index offense such as auto theft or drug sales. All have a chronic history of school failure and have been placed in special education classes.

Since academic deficiencies and the experience of school failure have been central considerations in conceptualizing the interventions, the literature describing the relationship between school failure and problems of an externalizing nature is briefly presented. A detailed description of the treatment rationale and the specific interventions employed is then provided.

School failure, learning disabilities, and delinquency

An extensive literature indicates that a strong association exists between difficulties in academic achievement, school failure, and behavior problems of an antisocial nature such as delinquency (Hinshaw, 1992; McGee, Share, Moffitt, Williams & Silva, 1988). In general, the poorer the youngster's grades, the lower his or her standardized educational test scores, the higher the number of grade retentions, and the greater the dislike of school, the more likely the youngster will be delinquent (Henggeler, 1989; Hinshaw, 1992, Wilson & Hernnstein, 1985). For example, studies carried out in the 1920's focusing on the educational status of institutionalized delinquents found 86 to 95% of the sample to be educationally retarded (Silberg & Silberg, 1971). Similarly, a longitudinal study conducted at about the same time, found that 54% of youngsters who developed a delinquent pattern were achieving below grade level, compared to only 24% of the youngsters who did not develop a delinquent pattern (Wolfgang, Figho, & Sellin, 1927).

More recent longitudinal and cross-sectional studies have produced comparable findings. In a longitudinal study examining youngsters who did and did not develop a delinquent orientation prior to second grade, over 25% of the delinquent group failed to acquire basic skills in reading, spelling, and writing relative to the nondelinquent group. By second grade, 45% of the delinquents were delayed in reading and 36% in writing. By junior high school, 50% of the delinquent group was delayed in all academic areas relative to about 18% in the nondelinquent

group. In addition, youngsters in the delinquent group were more frequently retained in the same grade at the end of the year (Meltzer, Levine, Karniski, Palfrey, & Clarke, 1984). Severe academic deficits were also found in a cross-sectional study of 2,000 urban delinquents who were on average 14 years old and in the eighth grade. Academic achievement scores in reading, vocabulary and math ranged from the mid-third grade level to the early 4th grade level (Zagar, Arbit, Hughes, Busell, & Busch, 1989).

When delinquency and the prevalence of learning disabilities specifically have been studied, a wide variation in prevalence rates has been reported, ranging from 12% or less (Bullock & Reilly, 1979; Lenz, Warner, Alley, & Deshler, 1980; Morgan, 1979; Pasternak & Lyon, 1982), to 30% to 50% (Broder, Dunivant, Smith, & Sutton, 1981; Duling, Eddy, & Risko, 1970; Dunivant, 1982; Podboy & Mallory, 1978; Robbins, Beck, Pries, Cags, & Smith, 1983; Young, Pappenfort, & Marlow, 1983; Zimmerman, Rich, Keilutz, & Broder, 1979), to 70% or greater (Berman, 1974; Wilgosh & Partich, 1982). The use of differing, often imprecise definitions of learning disability, along with the use of differing assessment criteria, techniques, and instruments, seems to underlie this extreme variation (Brier, 1989).

Attention Deficit Disorders, deficient verbal skills, and negative attitudes toward school are variables that are likely to contribute to the high concordance between school failure and delinquency. Studies of populations of learning disabled youngsters have found that fifteen to eighty percent of subjects had Attention

Deficit Disorders, with the extreme variability explained, in part, by the variability in definitions and measurement methodologies used (Frick, Kamphaums, Lahye, Loeber, Christ, Hart, & Tannenbaum, 1991; Brier, 1989; Lampert & Sandoval, 1980). Studies of delinquent populations are somewhat similar in showing that about one-half of the youngsters meet the criteria for an Attention Deficit Disorder (Lillenfeld & Waldman, 1990; Moffit & Silva, 1988). The lack of self-regulation that constitutes a central element of an Attention Deficit Disorder is likely to interfere with academic success and to contribute to noncompliance and impulsivity, central aspects of a delinquent orientation.

Deficient verbal skills, a common attribute of learning impaired youngsters, seems to be another link between school failure and delinquency. Roughly two-thirds of delinquents have been found to have problems with verbal skills compared to the general population (Quay, 1987). These verbal skill deficiencies may contribute to a delinquent outcome by negatively effecting youngsters' moral reasoning, problem-solving, and perspective-taking abilities (Arbuthnot et. al., 1987) and by interfering with their ability to engage in adequate "self talk" or reflection (Hinshaw, 1992). Finally, negative school attitudes, frequently found among poor achievers, also seem to contribute to the association between school failure and delinquency by increasing the likelihood of truancy. Truancy, in turn, has been linked to elevated rates of delinquency (Murphy, 1986; Rutter & Giller, 1984), in part, due to an increase in unsupervised time and an increase in negative peer contact that follows.

Project rationale and goals

The interventions employed at Alternatives are based on the available literature regarding the psychosocial and educational needs of learning deficient youngsters, the causes and correlates of delinquent behavior, and the nature and consequences of the inner-city, poverty context from which all project participants come. In particular, the interventions follow from studies which show that association with deviant peers is the strongest predictor of an antisocial outcome, that parent involvement and discipline skills are critical protective factors, and that poor academic skills and a lack of bonding to school as noted, increase the risk of an antisocial outcome.

Given the multidetermined nature of the problems to be effected, project interventions are designed to be comprehensive so as to influence the adolescent's attitudes, aspirations and behavior as well as the adolescent's key systems, which include the peer context, the school, and the family. Because of the chronic, often overwhelmingly chaotic nature of these youngsters' lives, the interventions are also intended to be long-term, problem-focused and pragmatic so as to impact as much as possible on the everyday world the adolescent lives within.

The primary outcomes sought for the youngster as a result of project interventions include: a decrease in disruptive, challenging behavior at home and school; a decrease in negative peer influences concomitant with an increase in exposure to prosocial peer models; an improved relationship between the youngster and his or parent; an increase in self-control and in interpersonal

problem-solving skills, and a decrease in negative attitudes and behavior towards learning. For the parent, the primary outcomes sought include: an increase in parents' sense of agency, that is, the belief that they can influence situations and individuals that effect their lives; an increase in their use of nonaggressive, planned discipline practices, and an increase in the number of positive, affectionate interactions they have with their youngster.

Specific Interventions

While the interventions employed are curricula-based, that is, designed and presented in a planned, systematic, and relatively uniform fashion, an attempt is made to adapt the program, whenever possible, to the youngster and his or family's unique needs. In order to accomplish this goal, a series of assessments are carried out prior to the implementation of the interventions. The assessments attempt to: determine the particular causes of the youngster's disruptive behavior and the contextual pressures effecting the youngster and his or her family; the nature and influence of the peer group; the nature and quality of family relationships; the level of the youngster's intelligence and academic skills, and the nature and degree of any psychological distress present.

The interventions include: a problem-solving component, a parent management component, an educational remediation component, a daily life component, a weekend recreational component, and a case management component. The problem-solving component is carried out in a group format two-times-a-week, supplemented by individual sessions on an as needed basis.

Modules within the problem-solving component focus on: a) improving the ability to delay impulsive actions, particularly in regard to anger, b) increasing self-esteem and positive aspirations, c) increasing such social-cognitive skills as perspective-taking, moral reasoning, consideration of consequences, and cause-and-effect thinking, d) improving conflict resolution skills and the ability to deal with anger in a flexible, situation-appropriate, nonviolent manner, e) increasing the ability to successfully deflect overtures from deviant peers to engage in antisocial behavior, f) increasing peer acceptance and the ability to engage in cooperative, reciprocal social interactions, and g) increasing the ability to identify distressed feelings, to recognize how they are currently being coped with, and to learn adaptive alternatives when necessary.

Each session begins with the group leader reading a story that is designed to facilitate interest, involvement, and identification, and to illustrate key aspects of the problem-solving skills to be taught. After the story is read, role-playing, guided peer interactions, didactic presentations, and games are used to highlight the skills to be focused on. Throughout the session, the group leader gives corrective feedback, trying whenever possible to emphasize the positive benefits of using the skill and of self-regulated behavior more generally. Between sessions, youngsters are asked to practice the skills through homework assignments.

The parent-management component is also carried out in a group format, one-time-per-week, and is supplemented by individual sessions on an as needed basis. Didactic instruction, group problem-solving, modelling, and role-playing are used to

help the parent or guardian to: a) set expectations and rules for the adolescent, b) increase their competence in monitoring and enforcing the rules, once set, including the use of clearly defined positive and negative consequences, c) increase their use of negotiations and compromise in resolving family conflicts, and eliminate the use of harsh, inconsistent and/or physical punishments, d) strengthen cohesion and support among family members, increasing expressions of empathy, perspective-taking, affection, and the amount of enjoyable interactions, and e) provide support and encouragement to persevere, in part, by helping to organize family tasks and by assisting in the arrangement of such concrete services as health care, clinical services for other family members, and child care.

While a formal curriculum is used which focuses on the parental skills to be learned, the parent's own need for nurturance and own longing for a secure attachment is continuously kept in mind and directly addressed when appropriate. Thus, each session tends to start with a formal presentation or a discussion of how to manage a crisis that is "live" for a particular parent. Attempts are then made to provide the support and encouragement needed and to nurture the parent, modelling the positive attachment behaviors many of these parents have never personally experienced.

The educational component is carried out in small groups of three to five youngsters from two to four times a week, depending on the youngster's needs. Based on information obtained from the youngster's school, ongoing diagnostic assessment, and trial-teaching, an attempt is made to: a) encourage attitudes and

behaviors necessary for academic success, including the belief that wanting to achieve is positive, that accomplishments can be made if effort is expended, that frustration can be tolerated, and that perseverance is necessary, b) improve attention and concentration, and c) improve academic competencies.

While the content of each session focuses either on aspects of the youngsters' school-based curriculum or their homework, the major thrust of the educator's efforts are directed at helping the youngster develop an "I can do it feeling" in regard to learning, and an increase in the importance of education and school attendance. Concurrent with these attempts, school staff from the youngsters' schools are invited to form a partnership with the youngsters, their parent and/or guardian and project staff to make their school experience maximally successful and the bond to school the strongest it can be.

The daily life component is an outgrowth of the overwhelmingly violent environment these youngsters live in, and the primary adaptions of either withdrawal and isolation on the one hand, and a lack of restraint and a tendency to join with peers in dangerous and antisocial activities on the other. Carried out dyadically with the adolescent and his parent or guardian, the clinician, in a once a week meeting, reviews the youngster's current daily life activities in regard to the nature of his peer associations and the presence of situations which place the youngster at risk for antisocial behavior. The clinician then tries to: increase the youngster's involvement with prosocial peers in structured, enjoyable activities that include adult role models, such as organized sports, volunteering, and part-time

employment, increase the amount of time the youngster spends in situations that are free from danger, and increase the parent or guardian's involvement with, and ability to monitor, the youngster's activities and associates.

The weekend recreational component of the project is held once a week on Saturdays. As noted, given the frequent isolation of these youngsters and their lack of opportunity to engage in positive peer interactions, recreational activities are provided in an attempt to: a) have fun so as to maintain the youngster's willing participation and bonding to the program; examples of fun activities include model building, board games, and photography, b) provide opportunities for interactions with adult, male, prosocial mentors, c) through cooperative, rule-bound activities, encourage the view that rules are necessary and potentially helpful, and that legitimate ways exist to change rules if necessary, and d) create opportunities to practice the skills acquired in the more structured components of the project in this more relatively naturalistic setting so as to facilitate their generalization.

The case management component is the final element of the project. Because a failure to comply with rules is central to the youngster's adaptive difficulties, a staff person is assigned to each youngster to: a) monitor adherence to the program's requirements, b) assess goal attainment and the nature and degree of any obstacles to program success, and c) serve as a liaison between the project, the youngster and his or her family, and other agencies attempting to provide services to the youngster. Parents and guardians have often been found to have as much trouble with compliance as their youngsters, so that a fair percentage of the

case managers' time is spent trying to contact the parent or guardian and obtain their maximal participation.

Preliminary Evaluation Data

Demographically, approximately one hundred youngsters have been referred to the project from the time of the project's inception in January, 1993 through February, 1994. With respect to race, age and sex, about fifty percent of referred youngsters were Black and about fifty percent Hispanic; males outnumbered females in roughly a three-to-one ratio, and the average age of referred youngsters was fourteen. About two-thirds of the youngsters live in single parent families and about one-quarter were cared for by someone other than their biological parent. The majority of families are on public assistance.

Prior to a planned, comprehensive evaluation, treatment effectiveness was gauged by selecting a sample of eighteen youngsters who had been in treatment for a period of at least three months. A rating scale was developed (see Appendix A) to assess the degree to which the problems which led to the youngster being involved with the project improved, worsened, or stayed the same. Thirty-seven problem behaviors divided into five categories were rated. These categories included: disruptive behaviors, negative parenting behaviors, context problems, academic problems, and symptoms of psychological distress. For each youngster, two clinicians most familiar with his or her status during the period of evaluation independently completed the rating scale. Ratings were then compared and any

differences found were resolved through discussion.

Table One
Frequencies and Percentages of Problem Behaviors Noted in Data Set (N = 18)

Problem Category	Frequency of Problems Noted	Ratings of Change					
		Worse		Same		Better	
		Freq.	%	Freq.	%	Freq.	%
Disruptive	80	4	5	21	26	55	69
Negative Parenting	66	0	0	31	47	35	53
Context	19	0	0	6	32	13	68
Academic	67	7	11	35	52	25	37
Psych. Symptoms	48	3	7	16	33	29	60
Cumulative	280	14	5	109	39	157	56

As can be seen from an inspection of Table One, when problem behaviors demonstrated by program participants were grouped across problem categories, more than half of the problem behaviors (56%) noticeably lessened since the inception of treatment. Further, only a very small percentage (5%) worsened. Since most participants were referred at a time when they and their family were in a state of crisis, the prevention of a worsening of problem behavior seems to be a valuable program effect. When problem behaviors were examined by category, a sizable improvement was evident in regard to the disruptive behaviors that were instrumental in leading to program referral (69%) and in the contextual problems that contributed to the disruptive behavior (68%), such as involvement with antisocial peers and social isolation. The majority of psychological symptoms of distress noticeably lessened as well (60%) as did the parent or guardians'

difficulties in communication and discipline (53%). The only problem category in which the majority of problem behaviors remained at the same level involved academic problems (52%). Speculatively, this result was seen as an outgrowth of the severe, neurologically-based nature of the attentional problems contained in the category and an indication, perhaps, of how powerfully, chronic school failure negatively effects academic behavior and attitudes.

When an analysis was made of improvement organized in terms of whether program participants improved, worsened, or stayed the same relative to the majority of their own constellation of problems, two-thirds of program participants (12) demonstrated a noticeable lessening of problems and one-third (6) continued to display about the same level of problems. None of the program participants had the majority of their problems worsen over the course of treatment.

APPENDIX A

ALTERNATIVES

Clinical Ratings of Change

Duration of Rx:_____

PATIENT:_____ Date of Rating:_____

Problem Behaviors Noted in Data Set	PRESENT	WORSE	SAME	BETTER
I. Disruptive Adolescent Behaviors:				
1. Defiant-oppositional at home	____	____	____	____
2. Defiant-oppositional outside home	____	____	____	____
3. Truancy/cutting	____	____	____	____
4. Curfew violations	____	____	____	____
5. Stealing	____	____	____	____
6. Lying	____	____	____	____
7. School suspensions	____	____	____	____
8. Fighting/assaultive	____	____	____	____
9. Running away	____	____	____	____
II. Negative Parenting Behaviors:				
10. Use of physical punishment (but not abusive)	____	____	____	____
11. Withdrawn/uninvolved	____	____	____	____
12. Failing to set rules	____	____	____	____
13. Failing to monitor rules	____	____	____	____
14. Failing to discipline/enforce rules	____	____	____	____
15. Sense of hopelessness/placement being considered	____	____	____	____
16. Physically abusive	____	____	____	____
17. Verbally abusive	____	____	____	____
18. Unrealistic expectations/demands	____	____	____	____
19. Unopen to feedback/advice	____	____	____	____
III. Context Problems:				
20. Social isolation	____	____	____	____
21. Exposed to antisocial peer influences	____	____	____	____
22. Lack of availability of organized social activities	____	____	____	____
IV. Academic Problems:				
23. Fails to participate in the classroom	____	____	____	____
24. Unable/unwilling to focus/attend	____	____	____	____
25. Fails to take initiative in approaching academic tasks	____	____	____	____
26. Fails to control frustration	____	____	____	____
27. Unable/unwilling to complete tasks	____	____	____	____
28. Avoids academic tasks when difficult	____	____	____	____
29. Lacks self-confidence in regard to academics	____	____	____	____
V. Symptoms of Psychological Distress/Problems:				
30. General lack of self-control/impulsive	____	____	____	____
31. Lack of control over anger	____	____	____	____
32. Sense of turmoil	____	____	____	____
33. Closed/guarded	____	____	____	____
34. Depressed	____	____	____	____
35. Low self-esteem	____	____	____	____

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