A STUDY OF THE EFFECTS OF A JUVENILE ALTERNATIVE PROGRAM ON ADOLESCENT CONDUCT DISORDERS

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Chapter One

INTRODUCTION

Conduct disorders cover a broad range of activities, such as aggressive behaviors, theft, vandalism, fire setting, lying, truancy, and running away. Many different terms have been used to refer to conduct disorders including acting out, externalizing behaviors, anti-social behaviors or conduct problems, and delinquency. For the purposes of this research the term "conduct disorder" will be used. The particular conduct disorder targeted for this assignment is aggressive behavior. The purpose of this study is to examine the effects of juvenile alternative programs on conduct disorders, specifically aggressive behavior. Aggressive behavior can be linked to a number of disorders (i.e., schizophrenia, bipolar disorder), however it is most common among conduct disorders. The characteristic definition of aggression is, "the intentional use of physical or verbal force to obtain one's goal during a conflict."\(^1\)

From this definition of aggression it can be implied that there are two forms of aggression, verbal and physical. Verbal aggression can consist of intentional yelling, screaming, threatening or similar approaches to achieve a goal in a conflict. Physical aggression, on the other hand, usually includes hitting, kicking, throwing objects, or using a weapon.

Bandura found socialized aggressive behavior to have "functional value for the user."\(^2\) By using aggressive behavior verbal or physical, an individual can attain important means, alter rules to fit their own needs, establish control over and secure submission from others, reduce


situations that unfavorably affect their well being, and remove obstacles that hinder or hamper fulfillment of desired goals. Thus, behavior that is punishing for the victim can for a brief period, be rewarding for the aggressor.

Aggressive behavior is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as conduct disorder defined as, a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal Norms or rules are violated.3

Conduct disorders are categorized by two types: (1) childhood onset type and (2) adolescent-onset type. In the childhood-onset type children, typically male, quite often display physical aggression toward others and have troubled peer relationships. In the adolescent, a fewer number of males than females, tend to display mild aggressive behavior and peer relationships appear to be customary, although conduct problems usually occur within a group.

The characteristic behaviors of childhood-onset type and adolescent-onset type are: "aggressive conduct that causes or threatens physical harm to other people or animals. Non-aggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules."4 Three (or more) of these characteristic behaviors will have had to be present during the past 12 months, with at least one behavior present in the past six months.

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4 Ibid.
SIGNIFICANCE OF THE PROBLEM

According to Kernberg and Chazan "the incidence of conduct disorder is at 74 percent among a clinic population of primary school children."\(^5\) Another study (Rutter et.al. 1976) concludes that conduct disorders occur in 4 percent of a general population of children ten and eleven years old. "These children are all at serious risk for the development of adult psychopathology: Thirty-seven percent of them will be diagnosed antisocial as adults. Other common adult diagnoses include psychoses, nonaggressive personality disorders, and anxiety disorders.\(^6\) Other problems that are often associated with conduct disorders include attention deficit disorder, reading disabilities and social skills deficits. These findings reflect the need for intervention and treatment of adolescents who have conduct disorders. To better understand the development of conduct disorders Kernberg and Chazan traced the earliest manifestations of aggression in the life of a child. "Earliest aggression is not negative in its intentions. It is neutralized aggression, or assertiveness, that is part of the organism's program to survive."\(^7\)

Another early form of aggression can be seen in the infant's urgent crying and screaming which communicates panic, extreme discomfort, and what seems like intense resentment. Aggression, therefore is a normal stimulus, however, when parents or guardians fail to teach children how to communicate their frustration in a way to "surmount" or overcome the barrier, aggression begins to take a deviant path and become counterproductive.

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\(^6\) Ibid.

\(^7\) Ibid.
"It is because of this failure in integration between positive and negative states, or synthesis, that these children exhibit a lack of connectedness between cause and effect and a lack of continuity in their relationships with other people."\(^8\) Along with conduct disorders (aggression) being traced back to infancy, Kazdin identified several other factors that predispose children and adolescents to the problems of conduct disorders. Parental factors is one such category. Kazdin stated that "the risk for anti-social behavior in the child is more specifically related to the presence of such behaviors in either parent."\(^9\) Of the stronger and more consistently demonstrated parental factors that increase the child's risk for conduct disorder is criminal behavior and alcoholism of the father. The father's level of aggressiveness during his adolescent years is a good predictor of how aggressive the child will be. "In general, a previous history of antisocial or aggressive behavior in one's family places children at risk for these behaviors."\(^10\) The other category that Kazdin identified was that of school related factors. The school setting has been studied as contributing to the risk of antisocial behavior. For example, elementary or primary schools that are in poor physical conditions or that have a low teacher-student ratio have higher rates of delinquency.

Conduct disorders in children and adolescents is a serious problem in the practice of social work. Social workers are tasked with controlling this behavior before the disorder continues on into adulthood. Studies have shown that delinquent or clinically referred

\(^8\) Ibid.


\(^10\) Ibid.
antisocial behavior identified in childhood or adolescence predicts a continued course of social dysfunction, problematic behavior, and poor school adjustment. Several studies are available that attest to the breadth of dysfunction of conduct-disordered children as they mature into adulthood, therefore it is necessary that the problem of conduct disorders is identified and treated early in the adolescent's life.

Purpose of the Study

The purpose of this study is to determine the effects of juvenile alternate programs to detention on adolescents who experience conduct disorders. The study will attempt to show how early intervention can controvert the course leading to antisocial behavior.
Chapter Two

REVIEW OF LITERATURE

The literature review is organized in the following manner: (1) Origins of Aggressive Behavior, (2) Significant studies about the effects of alternative programs on aggressive behavior, (3) The treatment of aggressive behavior, and (4) Theoretical framework.

Origins of Aggression

The frustration aggression theory adopted by J. Dollard explains that aggression is a learned response to frustrating situations, and that aggressive behavior is reinforced insofar as it proves successful in overcoming frustrations that prevent the satisfaction of biological drives of learned motives. Frustration, as Bandura states it, "is the occurrence of conditions that prevent or delay the attainment of a goal response."¹ Frustration can be seen as early as infancy. The frustration that an infant encounters is primarily due to the delay in the satisfaction in his/her bodily needs and results from his/her helplessness and inability to care for him/herself. When a child is hungry or in some other form of discomfort it (the child) can do nothing else except emit motor or vocal responses which let the parent know that something is wrong. "The crying, restlessness, and the flailing of limbs seen in infants seem in fact to be the precursors of later verbal and physical responses that would unhesitatingly be classed as aggressive".² Therefore the conditions for development of aggressive behaviors is present in every infant, however, the child's responses lack the characteristics of aggressive acts. Bandura states that,


²Ibid.
"it is only when the child has learned to attack persons or objects in his environment in such a way as to injure or damage them that he can be described as aggressing."³

Thressen contends that aggression is a form of competition. He states that in order to survive competition among individuals, populations, and species must exist. Thressen goes on to define aggression as "any behavior which has evolved to enhance competitive ability."⁴

Patterson argues that aggressive behavior in children and youth result from inconsistent ineffective parental discipline.⁵ He referred to this discipline practice as the "negative reinforcement trap." This "trap" consist of parent-child interactions in which both individuals are reciprocally reinforced through oversize-coercive behavior. In aversive-coercive behavior, "the parent gives a command (aversive event) and the child responds coercively (whines, argues, yells) followed by the parent withdrawing the command (removal of aversive event)."⁶ Decreased parental nurturance and warmth has long been known to be associated with aggressive behavior in children and youth. This is a behavior more common in families of low social-economic status.

Bandura points out that another form of displacement simultaneously takes place under the pressure of anxiety about possible punishment or disapproval. Bandura goes on to point out that the primary socializing agents are the parents. When parents impose physical restraint

³Ibid.
⁶Ibid.
or punishment on the child, they (the parent) have a very potent weapon in their ability to threaten the child with withdrawal of their affection and approval. As a result aggressive impulses are aroused and are often displaced to other persons and even to non-human objects.

Significant Studies on Alternative Programs and Aggressive Behavior

In an effort to show the effects of prevention programs on aggressive behaviors Vitaro and Tremblay studied 104 aggressive boys aged 8 to 9 years old. 46 boys were randomly assigned to the PV(Prevention) group and 58 boys were included in the CO(control) group at the beginning of the study. The prevention program employed in this study included parent training, social skills training, and cognitive problem-solving skills training with the children. The prevention program was conducted over a two year period. At age 10, the subjects in the two groups answered a 27-item Self-Report Delinquency Questionnaire asking them to report if they had ever been involved in a variety of delinquent behaviors. At age 11 and 12 years, the children answered the same 27-item questionnaire but with reference to the last 12-month period only. The questions addressed misbehavior in the home and outside the home (e.g., fighting, theft, vandalism). The children answered whether they had never (scored 1), rarely (scored 2), sometimes (scored 3), or often (scored 4) engaged in each described act. A total scale score was computed by adding the scores on the individual items. The total delinquency score could range from 27(no delinquency to 108 high delinquency). The results showed that after the two year period those 46 boys who were part of the prevention group were rated less aggressive than the control group subjects. PV subjects were less likely to report vandalism and stealing compared to their CO counterparts. Boys who participated in the prevention
program associated with less disruptive friends at ages 10 and 12 years compared to control subjects.

To address the issue of violence (which can be viewed as aggressive behavior) author Judith Ross, in a brief abstract, suggest that, "schools are the obvious places to interact with children and to study, identify, treat, and prevent youth violence and its causes." Ross goes on to state that, "school based and school linked clinics present important opportunities for social workers to connect with a vital initiative and to help children and their families cope with a vast array of social and emotional problems that contribute to violent acting out behavior."7

In an abstract entitled, "12 points for breaking the cycle of violence, an anonymous author states that more prisons and 17 year olds on death row are symptoms of our collective frustration and fear, but they do not solve the problem of youth violence. The author goes on to state that "punitive solutions to youth violence are breaking the economic back of the nation."8

To address the causes of violence while dealing with the growing problems at hand, the author suggests the following strategies:

1) Provide prenatal and early childhood programs for at-risk populations.

2) Expand parent education and family support programs.

3) Enforce zero tolerance for the possession of guns in schools. It is estimated that students carry 270,000 guns to school everyday.


4) Support programs that reduce violence in the family as a way to curb youth violence by making homes safer for mothers, children, and ultimately, all family members.

In their study of aggressive and resistant youth, Davis and Boster state that the nature of the violent client is complex and interactive, and that "interventions with violent clients cannot afford the illusionary parsimony of single approaches."\(^9\) The authors go on to state that a "multidomain" intervention model is required. To treat the individual and ignore the dysfunctional environment of that person will only doom the intervention to failure before it is begun. Violence (aggression) is generally a lifelong difficulty, often resulting from perceived threat on the part of individuals who need to learn consistency in their lives. The authors state that "accordingly, modification of violent behavior is not a rapid process, and involves commitment on the part of the clinician and the client."\(^10\) The relationship formed with the aggressive client is crucial. The clinician must accept the individual while rejecting the violent behavior.

In their 1992 study of resistant and aggressive youth, Davis and Boster go on to state that, “In relation to cognitive interventions the violent client is likely to have a very narrow band of imaginative thought and is likely to habitually appraise situations in an aggressive manner and ruminate upon violent fantasies or self-perceptions. Accordingly, cognitive therapy should, with due consideration given to the fragile self-esteem of the violent client, focus upon alternative appraisal mechanism.”\(^11\)

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\(^10\) Ibid.

\(^11\) Ibid.
In individual cognitive therapy, the use of a logbook of perceptions can help in recording thoughts and reinforcing non-violent appraisals of the environment. In the group setting, art therapy techniques such as cartoons without captions can be quite useful to the same end. "Clients should be given a non-violent framework to counter learned perceptions. A lifeline drawn out using the Erikson stages of development can help clients make sense of what they perceive as generally chaotic early life experiences."\textsuperscript{12}

**TREATMENT OF AGGRESSIVE BEHAVIOR**

A lot of episodes of aggression happen within the school structure leaving educators to face this increasing phenomenon. Precise reasons for increased student aggression and violence are difficult to pinpoint. However, Simpson et al. in a 1991 study offered three possible explanations. First, they observed that there has been an overall increase in societal aggression and violence. School-age children are exposed to aggressive and violent acts with such frequency that these events become socially acceptable models of behavior and students become desensitized to their significance. Simpson et. al.\textsuperscript{(1991)} also observed that increased public school inclusion of seriously disturbed and socially maladjusted students, including those with histories of aggression and violence, is correlated with an overall increase in school aggression and violence. Whatever the reasons for increased student aggression and violence in schools, it is clear that educators must be prepared to deal with these incidents when they arise.

\textsuperscript{12} Ibid.
Students exhibit a pattern of behaviors before an aggressive or violent act. This pattern can typically be divided into four stages: (a) the frustration stage, (b) the defensiveness stage, (c) the aggression stage, and (d) the self-control stage (Beck 1985). Intervention at early stages often prevents behavior escalation. During the frustration stage, students exhibit specific behavioral changes that may not be indicative of an impending aggressive or violent act. That is, students may bite their nails or lips, lower their voices, tense their muscles, grimace, or otherwise indicate their general discontent. It is easy for teachers to ignore these seemingly minor behaviors, yet these behaviors often indicate a future crisis. To stop future behavior crisis, teachers can use a variety of strategies, such as hurdle help (assistance with difficult assignments or situations), signal interference (nonverbal signal used to communicate awareness of student difficulty), proximity control (teachers' physical positioning employed to reduce negative behaviors), or interest boosting (personal interest of teachers in a student and his or her preferences used as a tool for managing behavior). Interventions at this stage do not require extensive teacher time, but it is wise to understand the events that precipitate such behaviors so that teachers can (a) be ready to intervene early or (b) teach student strategies to maintain behavioral control during these times.

During the defensiveness stage students lash out at or threaten the teacher or other students either verbally or physically; or withdrawing from others either emotionally or physically. The student may challenge the classroom structure or authority by attempting to engage in a power struggle. During this stage, it is imperative that the teacher reach the student without becoming party to a struggle. To best accomplish this task the teacher should restate or remind the student of class rules, routines, and consequences.
If student behavior is not diffused during the frustration or defensiveness stages aggression may occur. During this stage, the student may exhibit a myriad of behaviors, including biting, hitting, kicking, or destroying property. The crisis cycle does not end with the aggression stage. Rather, there is a fourth stage: the self control stage. Without intervention, the student may become sullen, withdrawn, or deny that inappropriate behavior occurred. The result could be another act of aggression or violence.

In their article "Understanding and Preventing Acts of Aggression and Violence in School-Age Children and Youth," the authors Myles, and Simpson list eight strategies for preventing and planning measures for aggressive and violent students:

1) Practice for a crisis.

2) Train staff to respond to students' acts of aggression and violence.

3) Plan for violent and aggressive episodes by dressing appropriately.

4) Remove items of monetary and sentimental value from reach of aggressive and violent students.

5) Work to establish trust and rapport with students including those prone to acts of aggression and violence.

6) Clearly define behavioral expectations and provide consistent and constant consequences for rule compliance and non-compliance.

7) Remain calm and in control during times when students demonstrate aggressive and violent tendencies and actions.

8) Maintain a therapeutic attitude when dealing with children and youth prone to acts of aggression and violence.

The two authors go further to suggest system wide policies and procedures needed to effectively meet the needs of aggressive and violent students:
1) Offer a full continuum of educational, mental health, and other services for aggressive and violent students.

2) Enhance communication across agencies and disciplines involved with aggressive and violent students.

3) Facilitate parent and family involvement and provide maximum family support.

4) Train and empower case managers to coordinate programs and services for aggressive and violent students.

Since students who exhibit aggressive and violent behaviors are increasingly being seen in the general education setting it is important that school based personnel have the ability to plan and apply appropriate interventions for these students. It is also crucial that school based personnel work together to devise and implement policies to meet the needs of these students.

THEORETICAL FRAMEWORK

The Theoretical Framework adopted for this study is the Cue-Elicited Aggression Theory. The theory, which was proposed by Berkowitz, argues that frustration is not sufficient to elicit aggressive behavior. He states that frustration simply produces a state of arousal. The frustration induced arousal creates a "readiness" to respond aggressively. According to Berkowitz, the presence of aggression eliciting cues transforms the "arousal" into overt acts of aggression. "Presumably, any stimulus can acquire the capacity to elicit aggressive responses from aroused persons if they had previously been associated with instigators of "anger" (such as the name of an instigator) or aggression generally (such as a weapon)." Berkowitz stresses emotional and motivational processes and the prepotency of anger-arousing cues. Berkowitz

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ignores or attaches little importance to the roles of cognitive, social, and personality processes.

Berkowicz goes on to argue that aversive events are the root of angry aggression, and that aggressive behavior is mediated by emotional instigation.
Chapter Three

METHODOLOGY

The methodology section is organized in the following manner: (1) Study Design, (2) Case Information, (3) Intervention strategy and plans.

STUDY DESIGN

The “A-B” single system design is used in this study. Bloom and Fischer refer to the basic design as the “workhorse” of evaluative research. 1 The “A-B” design identifies whether there has been a change in target problems due to an intervention supplying both monitoring and evaluation information. 2 Design “A” The Multi-Problem Screening Inventory MPSI, is used for the baseline measurement of the subjects aggression. 3 In an effort to provide additional information, the self-esteem Subscale and Problems with Friends Subscale were administered to measure several of the associated characteristics of aggression in juveniles. Low self-esteem and troubled peer groups have been identified as associated characteristics of aggressive behavior.

Design “B”, the Alternate Plan Program of the Fulton Multi-Service Center, under the auspices of the Department of Children and Youth Services is the intervention used to determine its effect on the subject’s aggression. This program serves as an alternate to jail for young people committed to the State of Georgia. The aim of the program is to offer


2 Ibid.

the juveniles vocational training, one-on-one counseling, peer group counseling and recreational activities. The Multi Problem Screening Inventory is a self report measure that evaluates the individual's problems in 27 different areas of personal and social functioning. Each Subscale yields scores that range from 0 to 100. A low score signifies the relative absence of the problem being measured, and the higher scores indicate the existence of a more serious problem. The Subscale also provides a clinical cutting score of 30. Individuals who acquire a score of 30 and over are considered to have a clinical problem. A score under 30 indicates the individual is unaffected by the measured problem. The exception is the aggression Subscale, which has a clinical cutting score of 15.

CASE INFORMATION

In this section and throughout most of the methodology Chapter, the subject will be referred to as Joseph. Joseph is a 15 year old African American male who resides with his mother in a Southwest Atlanta apartment.

Joseph was committed to the state of Georgia for a number of offenses, one of which was an aggravated assault charge. Joseph spent time in a wilderness program designated by the state but did not successfully complete the program. Joseph has a very aggressive temper, he does not know how to properly handle himself when things go wrong. Instead of thinking his way through things Joseph uses force to get what he wants, either verbal or physical, most often physical force.

\[^{4}\text{Ibid.}\]
In a situation at school, Joseph was confronted by a group of teens who were taunting and teasing him about his appearance. This behavior went on for about a week. On one particular day, Joseph was again confronted by the group of teens. This time instead of walking away, Joseph went after one of the teenagers with a knife. Fortunately, Joseph was restrained by some other teens before he could use the knife.

In the home environment Joseph’s mother states that she cannot do anything with him. She states that he comes and goes as he pleases and that he is in and out of court. Joseph’s other crimes include auto theft, criminal trespass, gang activity, violation of probation, and the list goes on. Joseph is now participating in the Alternate Plan Program of the Department of Children and Youth Services by order of the court. His attendance has been regular, but he is often to himself during program hours. Joseph is now 16 and in a couple of months he will be 17 and considered an adult by the laws of the state. It is the hope of the researcher that Joseph uses the Alternate Plan Program to get himself on the right track.

**TREATMENT HYPOTHESIS**

Participation in the Juvenile Alternative Program will decrease the frequency of aggressive behavior reported by the subject of this study.

**INTERVENTION STRATEGY AND PLANS**

The Alternate Plan Program of the Fulton Multi Service Center is designed to provide treatment and supervision to those youths who are able to reside in the community. Rehabilitation and treatment received by youths in the natural environment (home and community) has been proven to be more effective and long lasting. Incentive
mechanisms are utilized to control and measure positive behavior. These mechanisms may manifest themselves as point, phase, level systems etc. A couple of the goals and objectives of the alternate plan program are:

1) To provide a community oriented program that will maximize the optimal development of each youth during the rehabilitation process.

2) To provide clients with relevant group sessions to assist them in the development of their interpersonal and intrapersonal skills and to educate them about topics that effect their lives.

The Alternate Plan Program is designed for Joseph to participate three days a week, Monday, Tuesday, and Wednesday. One out of the three days a week the Multi Problem Screening Inventory was administered for repeated measures to Joseph during the intervention phase, to determine if the intervention had any impact on the associated characteristics of aggressive behavior (i.e. self esteem and problems with friends).

Each session lasted forty-five minutes to an hour. For four weeks in February - March 1996.

FIRST SESSION

Joseph was given about a week to adjust to the program before the first baseline measure was administered. The reason that baseline information was gathered once a week was because the intervention was the actual Alternate Plan Program, so once a week the researcher could determine if the Alternate Plan Program was having any positive effects on Joseph's behavior.
During the first session, the researcher introduced himself to Joseph and established a rapport with him. The researcher then explained to Joseph what the sessions would entail and what the purpose of the sessions were. Before the first session actually took place, Joseph was asked to explain why he made the choices that he made and what he thought led him to be so aggressive.

Joseph responded to all the questions by saying “I have to take care of myself, ain’t nobody gonna punk me out so I have to show them that I ain’t no busta”.

The session was held right before programming started. Joseph was given the agenda for programming for the day. After the researcher went over the agenda with Joseph, the MPSI was administered. Joseph was asked to only complete the sections on aggression, self esteem, and problems with friends. Joseph was told to read the instructions. After reading the instructions, Joseph was observed taking the test by an observer.

Once Joseph finished the test, the observer took the test and brought it to the researcher. Joseph was then asked to report to programming where his activity and behavior was monitored by the researcher. During programming for the first session, Joseph participated, with very little effort, in recreational activities such as pool and ping pong for the first hour after which Joseph was involved in group counseling. The topic of the group for the first session dealt with self esteem.
SESSION TWO

At the start of the second session, the researcher and Joseph went over the previous session. The researcher asked Joseph if he felt that the alternate plan program was beneficial to him, Joseph responded by simply saying that “things are OK”.

Just as in the first session the researcher went over the agenda for the day with Joseph, after which Joseph took the test. As before the observer watched as Joseph took his test and once he was finished the observer brought the test back to the researcher. Joseph was then escorted to programming where he was observed by the researcher.

During programming for this particular session all of the students of the Alternate Plan Program were tested to find out what academic level each student was performing on. As usual for the first hour of programming Joseph participated in recreational activities. For the second part of programming Joseph was given the Wide Range Achievement Test Revision 3 (WRAT 3) by the teacher of the Alternate Plan Program. Joseph’s scores for the test were quite low. In the area of reading Joseph is on the high school grade level, however, for the areas of spelling and arithmetic Joseph scored in the fourth grade level.

On this particular day Joseph appeared very restless. He and another student in the Alternate Plan Program were changing words (fighting words) throughout the whole program, however, there was no incidence of fighting to report between the two during program hours.

After program hours Joseph and the other student was observed walking to the train station. The other student pulled a knife out on Joseph, for fear of his safety Joseph
Joseph said that he took the knife and proceeded toward the turnstile. He “hopped” the turnstile and was apprehended by Marta police officers where he was searched and the knife was found on him. Joseph was then arrested and taken to juvenile court.

After finding out that Joseph was being detained in Fulton County Juvenile Court the researcher went to talk with him. Joseph mentioned that he did not intend to use the knife, but instead he was the victim, and that he was just taking the knife for fear of his safety. Joseph was not able to participate in programming for a couple of weeks because he was being detained.

**SESSION THREE**

Joseph was back for programming after being detained for two weeks. There was a little discussion about Joseph being detained. He did express that he was glad to be out and that he hoped that he did not have to go back.

As in the previous two sections, the agenda for the day was presented to Joseph, and as before, he was given the MPSI to read and then take. Upon receiving the test, Joseph stated that “this is my third time taking this test.” The researcher mentioned to Joseph that he was given the test once a week to measure his level of success in the program. Joseph went ahead and took the test with his answers dropping two or three points from the previous tests that he had taken. At this point, the researcher concluded that Joseph was answering the questions the way the researcher wanted him to, and the researcher figured that there would be no need to administer the test before the last session since Joseph made the comment that he made about the test being the same.
Joseph went ahead and participated in programming for the day. As in the previous two sessions, Joseph spent his usual hour involved in recreational activities. During the group session Joseph was put in the “hot seat”. The purpose of the “hot seat” is to first, call a client on what he or she may be doing that does not fall in line with the program rules (i.e. not going to school, not working, getting into trouble with the law, etc.). Secondly, the “hot seat” gives the client a chance to state those positive things that may be going on in the client’s life. Joseph was being “drilled” about his getting into trouble recently and his lack of participation in the program.
Chapter Four

PRESENTATION OF FINDINGS

The four graphs presented on the following pages represent findings in this study. Figure 1 depicts Joseph’s scores on the aggression Subscale. Figure 2 shows Joseph’s scores on the self-esteem Subscale and problems with friends Subscale.

The graphs depict scores of both the baseline and intervention together. Joseph was given a test at the beginning of each session and afterwards was sent to The Alternate Plan Program. The following graphs only represent the scores after the test was given and not after the intervention. For this research project, the researcher assumed that Joseph could do the baseline phase and then immediately following, the baseline intervention could be administered. The following week in the next session, the scores from the MPSI would determine if the intervention was successful. For sessions 1, 2, and 3, figure 1 depicts scores that are way above the clinical cutting score of 15, showing that Joseph has a big problem controlling his anger.
FIGURE 1

MPSI SCORES ON FREQUENCY OF AGGRESSION
FIGURE 2

MPSI SCORES ON ASSOCIATED CHARACTERISTICS OF AGGRESSION
For the Subscale self esteem and problems with friends, figure 2 represents scores that are way above the clinical cutting score of 30 for each suggesting that Joseph has no real problem in these areas.

When Joseph was asked why he responds to situations so aggressively, he simply responded by saying, "I ain't going to let nobody push me around".

LIMITATIONS OF THE STUDY

Bloom and Fischer cite that in some ways the limitation of the "A-B" design does not provide strong changes nor does it permit control of many alternative explanations for why the results occurred at they did.¹

This study has four limitations. First, self reporting procedures may have been a factor in the outcome of the results, due to the fact the subject may have been reporting what he felt was needed to participate in the study and to please the researcher. Second, because the Subscales were easy to read and comprehend the subject may have given memorized responses. Third because a pretest/post-test was not done, the results of the intervention could not be clearly identified. The more appropriate thing to do would have been to first administer a pretest to determine the subjects level of aggression at the onset of the program. Once the intervention was complete, the researcher should have administered a post-test to determine what affect the intervention had on the subjects aggression. Fourth, the constraints on both the baseline and intervention phases did not allow for a stable pattern of behavior to emerge. An extended time period would have

¹ Martin Bloom, Joel Fischer and John C Orme, Evaluating Practice: Guidelines for the Accountable Professional (Needham Heights, Massachusetts: Allyn and Bacon, 1995), 353-354.
provided a more clear picture on the extent of aggressive behavior and its associated characteristics. An extended time line would also have provided more data on how well the skills taught in the intervention were utilized by the subject.
Chapter Five

CONCLUSION

The goal of this research study was to show the effects of a juvenile alternative program (The Alternate Plan Program) on a specific juvenile’s (Joseph) conduct disorder (aggressive behavior). The study was conducted over a four week period with a session taking place on one day during each week. To measure the subject’s level of aggression the Multi Problem Screening Inventory by Walter Hudson was used. The subject’s scores on the MPSI were above the clinical cutting score of 15 for aggression, suggesting that the subject’s level of aggression was extremely high and needed immediate attention. Throughout the course of the research the subject’s participation was limited. The subject only paid close attention when he knew that he would get something out of the session (i.e. if a court date was about to come up participation was high in an effort to show the researcher that he was serious about changing his behavior in the hope that something good would be said about him in court).

During each session the subject was asked to take the MPSI and complete only those sections that pertained to aggression, self-esteem, and problems with friends. Afterwards, a brief discussion took place between the researcher and the subject to find out what accomplishments may have been made or if Joseph was having problems in the program. After each meeting with the researcher Joseph participated in programming. Programming consisted of recreational activities, groups, counseling sessions, and tutorial and computer classes. The whole idea of programming was to assist Joseph, as well as the other students, in turning their lives around.
Each MPSI that was administered represented the baseline phase of the study. The purpose of the baseline phase was to measure the frequency of aggressive behavior displayed by the subject. The actual program was representative of the intervention phase and was used as a means of lowering the subject’s aggression. Since the intervention was administered soon after baseline data was taken, it can not be clearly concluded that the Alternate Plan Program had a positive impact on the subject’s aggressive behavior.

Although the intervention was not administered correctly, the Alternate Plan Program did decrease the subject’s level of aggression. The subject was able to take advantage of the various components of the program, (i.e. groups, on-on-one counseling, recreational and vocational activities).

**IMPLICATIONS FOR SOCIAL WORK**

Most cases involving aggressive children have been treated by simply sending the child away to some type of detention facility where the child is given time to think about his or her actions. Detention facilities are in fact needed. However, more attention should be focused on programs that teach children how to properly handle their aggression instead of being “locked up” and forced to think about what happened.

To some extent this study has shown that alternative programs can be used with children with aggressive behavior. One of the most important aspects in alternative programming is the active participation of the subject. The subject is given the opportunity to practice and rehearse modeled skills to be adapted in the subjects environment with immediate feedback from the instructors. With descriptive feedback, emphasis can be placed on areas that need the most attention to achieve an effective treatment intervention. Clinicians can
implement alternative programs designed around the needs of the subject with ease and its effectiveness can be quickly observed.

Researchers, in addition, should explore other ways to treat and assist violent and aggressive youth. In addition to alternate programs to jail, programs that focus on the family and programs that focus on the aggressive youth in the school populations should be implemented. The more research that is done the more ways we will have to address this growing phenomenon instead of the traditional way of locking the youth up.

RECOMMENDATIONS FOR FUTURE USE

A recommendation for future use of this intervention would be to administer a pretest/post-test. In this case the researcher would be able to measure the level of aggression before the intervention, and once the intervention is completed, the researcher would be able to determine what effect the intervention has on the child’s level of aggression.

Another recommendation would be that future clinicians may want to extend the days of the intervention and implement a maintenance phase to ensure mastery took place. Also, instead of continuous measurement using the test it may be better to measure the aggressive behavior from baseline to termination by counting the frequency of aggressive behavior.
APPENDIX

MEASURING SUBSCALES
The questionnaire is designed to obtain information about a wide range of possible problem areas. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1 = None of the time  
2 = Very rarely  
3 = A little of the time  
4 = Some of the time  
5 = A good part of the time  
6 = Most of the time  
7 = All of the time  
x = Does not apply

You may discover that some of the items do not apply to you or your personal situation. For any such item, please enter an x, but do not leave any item blank.

When you begin to complete the items on this questionnaire you will see that you can very easily make yourself look good or as bad as you wish. Please do not do that. It is extremely important for you to provide the most accurate answers possible even though you may feel embarrassed or uncomfortable. If you provide incorrect or misleading information to those who are trying to assist you, it will be very difficult to provide you with the help that you are seeking.

**SUBSCALE: AGGRESSION**

1. ____ When I have to, I really do not mind punching someone out.  
2. ____ I get into fights.  
3. ____ When I hurt someone physically it really does not bother me.  
4. ____ I am quick to let people know they can not walk all over me.  
5. ____ I push others around before they have a chance to push me around.  
6. ____ People tell me I have a bad temper.  
7. ____ I hurt people before they can hurt me.  
8. ____ I threaten people with a fight.  
9. ____ I like it when others are afraid of me.  
10. ____ If punches are thrown, mine go first!

**SUBSCALE: SELF-ESTEEM**

1. ____ I think my friends find me interesting.  
2. ____ I think I have a good sense of humor.  
3. ____ I feel very self-conscious when I am with strangers.  
4. ____ I feel that if I could be more like other people I would have it made.  
5. ____ I feel that people have a good time when they are with me.
ANSWER KEY
1 = None of the time 5 = A good part of the time
2 = Very rarely 6 = Most of the time
3 = A little of the time 7 = All of the time
4 = Some of the time x = Does not apply

6. ___ I feel that people enjoy my company.
7. ___ I feel I get pushed around more than others.
8. ___ I think I am a rather nice person.
9. ___ I feel that people really like me very much.
10. ___ I feel that I am a likable person.
11. ___ I am afraid I will appear foolish to others.
12. ___ My friends think very highly of me.

SUBSCALE: PROBLEMS WITH FRIENDS
1. ___ I get along with my friends.
2. ___ My friends act like they do not care about me.
3. ___ My friends treat me badly.
4. ___ My friends really seem to respect me.
5. ___ I do not feel like I am “part of the group” with my friends.
6. ___ My friends are a bunch of snobs.
7. ___ My friends understand me.
8. ___ My friends seem to like me very much.
9. ___ I really feel “left out” by my friends.
10. ___ I hate my present group of friends.
11. ___ My friends seem to like having me around.
12. ___ I really like my present group of friends.
13. ___ I really feel that I am disliked by my friends.

SUBSCALE: PROBLEMS WITH SCHOOL
1. ___ I hate school.
2. ___ I enjoy my school work and studies.
3. ___ I put off my studies at school until the last minute.
4. ___ My school work is very boring.
5. ___ School is not for study, it is for parties and play!
6. ___ I study very hard at school.
7. ___ I think I am a good student at school.
8. ___ I think my school work will help my future.
9. ___ I really do pretty shoddy work at school.
10. ___ I feel I learn a great deal at school.
SUBSCALE: FAMILY RELATIONSHIP PROBLEMS

1. _____ There is too much hatred in my family.
2. _____ Members of my family are really good to one another.
3. _____ My family is well respected by those who know us.
4. _____ There seems to be a lot of friction in my family.
5. _____ There is a lot of love in my family.
6. _____ Members of my family get along well together.

ANSWER KEY

1 = None of the time 5 = A good part of the time
2 = Very rarely 6 = Most of the time
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7. _____ Life in my family is generally unpleasant.
8. _____ My family is a great joy to me.
9. _____ I feel proud of my family.
10. _____ Other families seem to get along better than mine.
11. _____ My family is a real source of comfort to me.
12. _____ I feel “left out” of my family.
13. _____ My family is an unhappy one.
BIBLIOGRAPHY


Kashni, Javad H., William Deuser, and John C. Reid. “Aggression and Anxiety: A New Look


