A Test of the Effectiveness of Two Treatment Modalities for Adolescent Residents of an Intermediate Care Facility

Paul David Warner

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A TEST OF THE EFFECTIVENESS OF TWO TREATMENT MODALITIES FOR ADOLESCENT RESIDENTS OF AN INTERMEDIATE CARE FACILITY

by

Paul David Warner

A dissertation submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Psychology

UTAH STATE UNIVERSITY
Logan, Utah

1976
ACKNOWLEDGEMENTS

To all those who believe that education—like medicine—must hurt
to be good; may you read and weep.

Special thanks go to Dr. William Dobson, Dr. Morris K. Morgret,
Robert Moran, Poll Oakey, and to my dear wife Sherry.

Paul David Warner
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ABSTRACT

A Test of the Effectiveness of Two Treatment Modalities for Adolescent Residents of an Intermediate Care Facility

by

Paul David Warner, Doctor of Philosophy

Utah State University, 1976

Major Professor: Dr. William Dobson
Department: Psychology

This study attempts to test the effectiveness of two treatment modalities for adolescent residents of the Intermediate Care Facility at St. Anthony, Idaho.

The study was conducted at the Intermediate Care Facility (ICF) at St. Anthony, Idaho. The St. Anthony ICF is a separate yet distinct part of the Youth Services Center in the same area.

The participants of this study were 20 emotionally disturbed adolescents who were randomly assigned to two treatment groups (10 participants in each group). The participants of both groups were shown to be homogeneous with regards to severity of emotional disturbance, family background, race, sex, age, and offense leading to institutionalization.

Both groups of subjects were observed for 7 days during both baseline and data line observation periods by pairs of trained observers. These observers monitored the frequency of occurrence of nine specific misbehaviors which fell into three general categories of behavior, i.e., category one:
passive-withdrawal, category two: overt-hostility, and, category three: manipulation. The reliability between pairs of observers for base line and data line observation period ranged between .82 and .98.

During the 6-week treatment phase of the study, one group of subjects (E1 group) received intensive individual, group, recreational and vocational therapy, while the second experimental group (E2 group) received intensive individual, group, recreational and vocational therapy coupled with self-monitoring plus a 5-day training in the recognition of inappropriate behaviors.

Both the E1 and E2 group participants showed a significant overall decrease in the frequency of misbehaviors for all three categories combined when each group was considered separately on base line and data line observations. However, when the three general categories were considered separately for each experimental group, the E1 group participants showed a significant reduction in only one of the three categories--category one, passive-withdrawal. Whereas, the E2 group participants showed a significant reduction in the frequency of misbehavior in all three categories when base line and data line frequencies were compared. When the E1 group is compared with the E2 group for the greatest amount of reduction of misbehaviors after treatment, the treatment modality applied to the E2 group was significantly more effective in reducing the frequency of misbehavior than was the treatment modality which was applied to the E1 group participants.

The results of this study seem to indicate that for this sample, a treatment modality which combines intensive individual, group, recreational
and vocational therapy with self-monitoring plus training in the recognition of inappropriate behaviors is significantly more effective in reducing the frequency of misbehaviors than is a treatment which employs only intensive individual, group, recreational and vocational therapy techniques.
CHAPTER I

Introduction

This research study was conducted in St. Anthony, Idaho, at the newly developed Intermediate Care Facility (ICF). Its purpose was to determine the effectiveness of one treatment modality against another. In order to understand completely the outcome of this research project, it is important to understand the overall nature, philosophy, objectives, goals, and types of treatment related to the ICF.

Philosophy, Objectives, and Goals of the ICF

The purpose of the ICF is to provide an intensive care program for youth who are involved in social and psychological adjustment problems. The problems encountered by these youth frequently involve strained relationships with family, school, local authorities and, often, their peers. The families from which these young people come are very often multiple-problem families and are suffering from many interrelated difficulties. Emotional problems, medical problems, unemployment, divorce, alcoholism, and familial estrangement are common. The families have minimal parenting skills and few social abilities to pass on to their children. This combination of factors is usually socially and psychologically disastrous for the child and frequently results in low self-esteem and a poor sense of self-worth. This lack of self-worth,
along with poor parental modeling, makes the child vulnerable to negative peer and other pressures and quite often leads into crime, anti-social acts, and/or poor school and authority relationships previously mentioned. These types of relationships are further damaged by negative expectations from family, school, and other authorities. Consequently, the result is a child with serious problems such as crime, hostility and anger, anti-social behavior, uncontrollability, and associated psychological problems.

The approach of the St. Anthony ICF is to provide the necessary intensive help required to meet these medical/social/psychological problems. The problems are dealt with in a variety of ways including medical treatment, extensive group and individual psychotherapy, drug counseling, education, recreational therapy, and structured living experiences.

Objectives. The primary overall objectives of the ICF are to help stabilize each resident socially, medically, psychologically, and to enable him (he or him will be used to indicate both male and female gender) to return to a useful and successful role in society.

Goals. Several goals can be spelled out objectively; they are as follows:

(1) To help improve feelings of self-worth for each resident of the ICF through a clarification of his personal identity and the development of concepts of self-value.

(2) To help develop a sense of responsibility within each resident by clarifying the reality of one's own behavior, by clarifying the relationship
between one's behavior and the reaction of others, by clarifying the relationships between one's behavior and the subsequent events which follow, and by developing within each resident an overall sense of reality.

(3) To improve the ability of each resident of the ICF to relate to one's self, to one's family, and to one's peers.

(4) To improve each resident's basic self-help skills including self-care, self-education, and the ability to deal with others.

**Definition of an Intermediate Care Facility**

The ICF is an institution made possible by the Department of Health and Welfare (DHW) by way of the Medical Assistance Program established by law. An Intermediate Care Facility is defined by state law (Volume 39, No. 12, Part II) as follows:

It meets fully all requirements for licensure under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

**Characteristics of Residents Accepted into the ICF**

One of the most critical and stringent requirements placed on the professional staff of the ICF is that of determining which of the many referrals made to the ICF are appropriate for residency within the ICF. The ICF is aimed at serving youth between the ages of 14 to 18. By the nature of the staffing pattern, facility, and ICF regulations, the facility cannot be considered
to be a psychiatric hospital or an institution for the profoundly mentally retarded. The institutional design and the staffing pattern of the ICF is aimed toward serving those youth who are having emotional difficulties or emotional disturbances which are interferring with their abilities and functioning in their home or community. This type of youth probably would not have home as a resource due to his emotionally maladjusted behavior, and he would probably be having difficulty in school and the community in general.

It is the attempt of the ICF to best serve the type of youth who could benefit greatly by a stay outside the home and community, in an institution in which social and psychological treatment would be both available and intensive. This category of youth could easily include mood disorders, personality disorders, severe neurosis, with an emphasis on behavior and social maladjustment.

The ICF was also designed to serve youth with psychological/social problems which are combined with a drug and/or alcohol problem since these are frequent in this age group.

Several stringent and significant restrictions are placed upon the admissions policies of the ICF by state regulations:

(1) Maternal patients/residents shall not be admitted to the facility.

(2) The facility shall not knowingly admit an individual with a communicable disease (as defined by the Department of Health and Welfare).

(3) No patient/resident shall be detained in a facility against his will, nor shall a minor be detained against the will of his parent or legal guardian.
This ruling would strongly imply that only minimum security risks be referred to the ICF.

The staffing pattern, program, and facility also preclude the acceptance of severely handicapped, blind, and non-ambulatory clients since these types of clients would not be well served by the St. Anthony ICF.

The residential ICF facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. Admission to the ICF shall occur only when it is determined to be the optimal treatment plan available.

A primary emphasis of the regulations governing the ICF are strongly oriented towards effective functioning. The ICF is intended to be used to improve and maximize the effective functioning of any individual placed there. Only those individuals are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. As changes occur in the physical or mental condition of an ICF resident necessitating service or care which cannot be adequately provided by the facility, residents are transferred promptly to hospitals, skilled nursing facilities, or other appropriate facilities.

Treatment Modalities Used for Remediation of Emotional Disturbances

Upon admission to the ICF, the youth has been preceded by a complete diagnosis and medical evaluation obtained in the home community. This
diagnosis and medical information are combined with direct interviews with the resident psychiatrist and psychological administrator. The admissions staffing board is convened for that particular youth, and during that staffing, the board considers all of the diagnostic and medical information brought with the youth. This information is scrutinized as are the treatment and release plans of the service worker who has referred the youth to the institution. Combining all of this information, the staffing board proceeds to write a basic treatment plan for the youth and to assign him or her to a cottage. In the cottage, the therapy technician and group supervisors are fully informed regarding the treatment plan of the youth. Beginning at this time, these individuals make critical cottage-life observations of the youth's behavior:

**Student performance appraisal.** As each youth enters the cottage, he is observed by each cottage worker who watches for the following specific behaviors:

1. **Response to supervision:** (a) When asked to do an assignment, the patient responds in an appropriate and positive manner;
   (b) when a change in assignment is made, the student understands that the change was necessary and finds out what he needs to do, what equipment or materials he needs to complete the assignments, etc.; (c) when mistakes are made the student attempts to correct them; (d) the student participates in activities designed to improve behavior; (c) the student is knowledgeable regarding
the program, including changes and/or additions; and, (f) the student completes assigned tasks.

(2) Social behavior: (a) The student is aware of and sensitive to thoughts and feelings of others; (b) the student provides help to others when needed; (c) the student cooperates and participates in group related activities; (d) when engaged in activities with members of the opposite sex, the student is behaving appropriately without continual supervision; (e) the student accepts social interactions; and, (f) the student initiates pro-social interactions with others.

(3) Personal and group hygiene: (a) The student pays attention to dress standards and dresses accordingly; (b) the student attends to personal appearance; (c) the student is courteous towards others regarding their personal appearance; and, (d) the student attends to his living environment making sure that it is clean and neat at all times.

(4) Personal skills: (a) The student is able to delay receiving gratification of needs; (b) when observed, the student is generally involved in activities appropriate for that time and place; (c) when at fault, the student admits it and takes steps to correct or make up for what he did; (d) the student is willing to do work without continual reminders or supervision; and,
(e) the student is careful to understand what is wanted before doing it.

(5) Interest and motivation: (a) Given the time and opportunity, the student volunteers to participate in extra assignments; (b) the student uses behavior ratings (self-monitoring) and other program information as guides to improve his behavior; (c) the student is attentive to the suggestions of staff; and, (d) the student is courteous towards the staff.

As the cottage staff makes critical evaluations of the student's behavior within the above mentioned areas, he begins to observe patterns of misbehavior which, when communicated to the psychologist (prime therapist), provide needed information in deciding what direction therapy should take for each individual resident.

**Individual therapy.** As a major and primary element in the therapy of each youth, individual counselors are assigned. Each of the therapy technicians and group supervisors that work directly in the cottages is assigned a caseload of youth in his unit. They (therapy technicians and group supervisors) work in very close conjunction with one of the members of the professional staff or psychologists. Each youth in the ICF is seen in individual therapy sessions on a basis of at least two and possibly three times per week by one of the psychologists or psychiatrists. In addition to these therapy sessions, the youth is, on a more informal basis, involved in counseling with therapy technicians and group supervisors. This provides an intensive
therapeutic community at a level rarely seen in institutions. The psychologist assigned to each individual is responsible for determining which "method" of therapy intervention is to be used with each patient. He also is responsible for informing others who are involved of the type of intervention to be employed with each patient.

**Group therapy.** An organized group is held at least once a day. The aim of this group is to develop in each youth a sense of responsibility, not only for himself but also for all members of his group. The groups as perceived in this approach, are not geared toward the uncovering of "deep-seated psychological problems." They are not traditional in this way and are more in line with a reality therapy approach (Glasser, 1965). Although these problems do come to the surface quite often, they are worked on in such a way as to alleviate the tension and anxiety that they tend to elicit in the individual.

Therefore, it is the aim of this therapy approach to handle the immediate needs of individuals and groups. These groups are usually open ended, that is youth come and go at varying times depending upon their admission and release. When a patient enters the group, he tells something about himself and is introduced to the group. It is the responsibility of older youth in the group to acquaint a new patient with the basic group procedures which are in effect. The new member of the group has the responsibility of telling his own "life story." This usually entails disclosure of those sets of circumstances and behaviors which got him into trouble. After the group is reasonably established, calling a meeting is a responsibility of any member of the
group. Frequently, happenings that occur during the day are brought up and discussed in the group. If a member of the group does not want to bring these up, other members of the group have the responsibility of applying modest pressure in order to get these events and feelings brought up. By bringing up everyday happenings and discussing the causes and consequences of these events, the group will learn something that is appropriate to their own functioning (Clements, 1968).

There are several problem areas that are dealt with quite frequently in these groups. The first is the problem of authority. This is a predominant problem among institutionalized youth. Examples of this are the youth who is easily talked into going along, who yields to the authority of peers, or the youth who has difficulty dealing with the authority of others around him in his everyday functioning. Second is the problem of stealing and the consequences or such activities. Third, lying. Fourth, drinking or other drug involvement. Fifth, inconsiderateness subdivided into being inconsiderate to others and being inconsiderate to oneself (self-abuse). Sixth, flaunting or putting on a mask of some characteristic thought to be socially desirable. Seventh, the temper problem or the easily aggravated youth, subdivided into those who aggravate themselves and those who aggravate others. Eighth, insignificant feelings or feelings of insecurity towards one's self. Other problems which frequently arise in this type of group are family problems. When these come up, each youth is in a position of seeing similarities between his own functioning in his home and the functioning of others in their respective homes.
Again, a major point in this approach is that it is aimed at attitudinal changes rather than simply overt behavioral changes. Emphasizing only overt behavioral changes without underlying attitudinal changes is to put the youth in the position of needing to "con" (Rose, 1970). The second major point is that the group has responsibility for any individual or group of individuals if something goes wrong during the day. It is the group's responsibility to discover what went wrong, why it went wrong, to call a group on it and to come up with possible outcomes, consequences, and therapeutic approaches.

**Family therapy.** Since parents are often responsible for the unhappiness of their children, one way of changing the child's environment is to change the parent or parents responsible. For this reason, the ICF is geared toward encouraging, wherever possible, that the parents be involved in family therapy with their child. Most family therapy will be done by the psychologist who is responsible for the treatment of the adolescent in the ICF, and he will include as many of the family members as is deemed necessary to improve the milieu of home so that it becomes a resource for the adolescent when he leaves the ICF. There are certain limiting factors which may impede the use of family therapy, even though the adolescent may strongly need such therapy intervention. These limitations would include:

1. Parents living too great a distance from the ICF to economically and practically facilitate family therapy.
(2) Serious disinterest on the part of the parent/parents towards their child, such that home is not a resource to the child upon release from the ICF.

(3) Death, separation, divorce, and estrangement, or situations in which the family experience dissolution to the extent that the family unit no longer exists as such.

(4) Severe psychological disturbance on the part of parents which could not be adequately treated outside the facilities of an institution.

Parents have two broad and overlapping kinds of problems. First, the parent may have anxieties and problems not strictly related to the child's but which are passed on to the child through attitudes of tension, emotional inconsistency, strictness, thoughtlessness and the like. In such cases, the procedures are the same as for adult counseling, but with efforts to help the parent understand the affects of his or her behavior on the child. Second, the parent may be well-intentioned but inadequate, through ignorance of the developmental perspective, to understand that everyone passes through certain physical, mental and emotional phases in growing from infancy to adulthood. This knowledge is usually very reassuring to parents and helps them anticipate and meet problems of development with more confidence.

Goals of counseling the parents of the adolescent at the ICF include helping them to channel their child's feelings into constructive activities and to understand his behavior. The parent is often reassured to learn that rebellions
behavior is a necessary part of growth. This phase of development can be less painful for parents and adolescents if awareness of the growth process is gained before serious misunderstanding develops. Essentially, the primary goal for family therapy at the ICF is to center the therapy process on feelings rather than past actions, and to help both parents and adolescents develop self-discipline instead of a reliance on external controls.

In situations where it is impossible for the parents and family to be involved in therapy with the child at the ICF, every effort is made to coordinate with the local mental health facilities located near the residence of the parents to insure that the family does receive psychological services and that these services relate to the treatment of the child at the ICF. It is intended that this type of coordinated effort between community services and the ICF will improve the environment of the home and increase the possibility of positive adjustment to the community upon release from the ICF.

Recreational and Social Activities

Appropriate programs of recreational and social activities are provided for all patients for daytime, evenings and weekends to meet the needs of the patients and the goals of the program. Programs are structured to reflect patterns and conditions of everyday life. The programs are planned to aid the patients in exploring the nature of their individuality and creativity, learning motor, cognitive and social skills, and integrating these into a positive sense of self.
Activity programs and groups are planned so that residents have opportunities to interact with residents of different ages and of both sexes and to develop new interests and skills that help them gain self-confidence and acceptance by others. A balance of active group play, competitive endeavors, and quiet solitary activities are sought after. The ICF provides and utilizes outdoor activities whenever feasible. Individual and team sports normal to the ages of the residents are made available. Initiation and termination of participation in any activity are timed in accordance with the resident's individual needs and his ability to tolerate one activity for a period of time.

Participation in parties, dances, and other group social events are planned on the basis of interests and therapeutic considerations, and appropriate staff and support are made available to meet the residents' needs in such activities. There are opportunities for group activities to develop spontaneously, such as group singing, story telling, or listening to records. Each resident's birthday is recognized and celebrated individually within each cottage.

Opportunities are provided for all residents to participate in religious services and other religious activities within the framework of their individual and family interest and clinical status. The option to celebrate holidays in the resident's traditional manner is provided and encouraged.

The facility plans and carries out efforts to establish and maintain positive relationships with general community resources, and the facility staff tries to enlist the support of these resources to provide opportunities for residents to participate in normal community activities, as they are able.
Where necessary, the facility supplies the transportation and supervision required for the maximum usage of general community resources such as movie theaters, amusement parks, and museums, as appropriate. All labelling of vehicles used for transportation of residents shall be such that it does not call unnecessary attention to the residents which would thereby jeopardize their feelings or their sense of dignity.

Vocational/Educational Treatment

Each ICF resident is involved in full time (5 hrs/day) educational/vocational training (the word *vocational* is used for simplicity sake and refers to both educational and vocational treatments since both are geared towards helping the residents of the ICF adjust to the job market upon release).

When a person enters the ICF, educational and vocational aptitude assessments are made. When the determination is made as to the achievement levels and vocational aptitudes of each resident, they are placed in a vocational and educational setting which facilitates productivity within the ICF resident at his present level of functioning.

The ICF resident is encouraged to develop educationally and vocationally so that his skills, both scholastically and vocationally, are appropriate and comparable to persons of his age group. This phase of treatment tends to be very beneficial to each resident and is usually a means whereby each resident can begin to succeed for the first time in either of these areas, hence building internal self-confidence and feelings of self-worth.
Institutional Care as a Treatment

The basic therapeutic process of maintaining a youth in an institution. One of the therapy procedures which must be discussed is the fact that the youth are maintained in an institution. There are several facets that make this a useful form of therapy.

(1) The institution offers opportunities for different sorts of relationships with "parental" figures. It is certainly well recognized that most youth who are sent to an institution such as the St. Anthony ICF are having difficulties of varying degrees with parents. Being in the institution permits the child to maintain a certain amount of "safe" psychological distance from the parental figure. This allows the child to work on the problems without having to face, concomitantly, the family problems.

(2) The institution provides the child with a greater variety of types of parental figures. Each cottage maintains a staff of people involved in varying tasks, and the youth is involved in school work and other work around the campus, which allows him to contact a large number of people. Any one of these contacts might become a surrogate parent and provide a better parental model than the child is receiving at home (Abbot, 1938; Balbernie, 1966).

(3) The institution offers a greater tolerance for all sorts of behaviors that could or would not be accepted in the home or the community. This is not to say that the institution allows acting-out behavior but rather allows a child to engage in withdrawn or otherwise bizarre behaviors that would not be
tolerated elsewhere. It should also be pointed out that the institutional setting allows for some dissipation of hostility, some expression of hostility, without the usual parental and community response (Babell, 1970).

(4) The institution provides an element of stability which is usually not in existence in the child's home, hence, the importance of the structured environment of the institution is maximized. This structure provides a routine that simplifies the child's life and permits him to know with some assurance just where he is.

Further comment on this part is appropriate since the general public frequently sees institutions as rigid and inflexible. It should be pointed out that it is just this structure or inflexibility which can be of major therapeutic value. The child who arrives at an institution has frequently experienced early child rearing practices which are either extremely unpredictable or vulnerable to manipulation. The structure of an institution can provide a sense of security never before known to the youth. It can also be useful in consequences for certain behaviors. Because of these facts, it is extremely important to have a staff which fully accepts the structures of the institution as therapeutic. Great damage can be done to a child by having him see someone working in the Center "beating the system." Because of the importance of these facts, great stress is placed upon the maintenance of the rules.

(5) The organized daily life of the child is in a community of individuals who are in many ways quite similar. That is, many of the youth in the ICF have similar problems, and therefore, can relate these problems and
the solutions to one another. The group referred to as "peer group" has a large power to control the behavior of each individual child (Kadushin, 1974).

(6) The institution plans its organization to be maximally therapeutic to the child and this is certainly something which does not occur in the home. As far as acting out behavior, the institution provides certain controls and structures in its orderliness which puts limitations on these acting out behaviors. The institution also provides a great advantage for the child in removing him from the normal environment which contains many temptations.

(7) By being sent to the ICF, the youth is thoroughly diagnosed and possible problems, both medical and psychological, are brought to the proper people's attention. Of course there are other certain obvious advantages to the institution in providing structured activities that would not be obtained in the home and the community. At this point, it should be carefully noted that the institution can provide only a certain degree of therapeutic care. The rehabilitation must ultimately take place in the community. The follow-up care and reintegration into the family is a very important part of the therapeutic process and in this, the ICF maintains very close relationship with the social service workers in the community.

Deciding on an Overall Treatment Approach

As can be seen from the preceding discussion of the philosophies, goals, objectives, and treatment approaches of the ICF, a good deal of thought had to be given to the question concerning which of the many treatment
approaches should be used at the ICF. This problem is magnified when considera-
tion is given to present questions that are being raised as to the overall
effectiveness of institutions per se and the general effectiveness/ineffective-
ness of the traditional therapeutic approaches in remediating emotional
disturbances in adolescents.

Conflicting evidence exists in the literature regarding the overall
effectiveness of institutions in general, including ICFs. Stuart (1970) reported
that commitment to institutional care was not without considerable risk. Even
though as many as half of the patients treated in institutions are successful in
achieving lasting discharge from the institution, a sizable number fail to be
discharged, undergo additional behavior difficulty or suffer from the increased
risk of physical illness (Norris, 1959; Ullmann, 1967).

Institutions have been criticized from other points of view. The
most important criticism is that the environment to which the patient is
expected to adjust in treatment is so alien from the environment outside the
institution that success within the institution bears little relationship to effec-
tive adjustment in the community (Rapaport & Roscow, 1960).

Effectiveness of traditional psychotherapeutic approaches. Contrary
to many theories regarding the effectiveness of traditional therapeutic ap-
proaches, such as individual and group therapy, little evidence has been found
to indicate with any degree of accuracy to what extent these therapy modalities
are indeed effective (Stuart, 1970). According to some authors (Adamek,
1968; Raymond, 1968), post-institutional adjustment was more closely related
to the length of stay for each patient, the amount of positive social contact in the community, the age of each patient when they entered the institution, and the extent to which the patient identified with the staff as opposed to any specific "therapeutic intervention." In contrast to these findings, however, research done using behavioral therapy techniques within institutions has yielded impressive results in modifying the behavior of patients. The most impressive of the behavioral approaches within institutions have been those which use self-control or self-monitoring as a therapeutic tool (Bolstad & Johnson, 1972; Hackney, 1973; Kanfer, 1970).

Given this information about the treatment of the institutionalized, it then became the responsibility of the professional staff of the ICF to decide on an overall treatment approach. Because of the newness of the self-monitoring concept to many of the staff of the ICF, there existed a general reluctance to give up the more traditional forms of therapeutic intervention such as individual psychotherapy and group psychotherapy. This feeling of reluctance, coupled with the strong supportive evidence of self-monitoring as an effective therapeutic tool, created a need within the staff to dispel this confusion through empirical research. This research study--Self-Monitoring versus Traditional Therapeutic Approaches--evolved from this need.

Self-monitoring and training in the theory of self-defeating behavior as a therapy tool. One of the most critical responsibilities facing institutions seems to be that of helping patients become responsible for their own behavior. Several authors have recently suggested the overall effectiveness of behavioral
therapy approaches for remediating emotional disturbances in adolescents (Balser, 1973; Phillips & Weiner, 1966; Stuart, 1970). Of the many behavioral approaches being employed, methods which help the patient acquire independence and self-control seem to have the most far-reaching and long-lasting effects in helping patients in the acquisition of personal responsibility. Psychological therapies which help the client to be his own therapist through self-regulatory procedures, especially those which employ self-control techniques, lay vital groundwork prerequisite to the acquisition of responsibility for participation in the social community (Nye, 1973). Accordingly, McMains (1968) reported that life situations continually demand that persons evaluate their own performance and determine standards of behavior while self-administering praise and tangible rewards.

A recent study by Broden, Hall, and Mitts (1971) dealing with adolescents in a real life setting, demonstrated that systematic self-monitoring could dramatically alter negative behavior.

While self-monitoring has been found to be a reliable source for altering negative behaviors, when self-monitoring and training in the recognition of inappropriate behaviors are combined, these two tools become highly effective in bringing about behavioral change. McMains and Liebert (1968) showed that teaching an individual to become aware of his own self-defeating behaviors and how these behaviors affect his overall adjustment was essential in any self-control program. A method for teaching patients how to become aware of their own self-defeating behaviors has recently been developed by
Cudney (1975). Cudney indicates that self-defeating behavior patterns are learned at a time when responding just as one's self resulted in anxiety. The self-defeating behavior (SDB) pattern was conceived to assist the person to cope with his existence in a less anxious way. Oft-times the SDB patterns are created through misinformation the person takes from his culture and attempts to try to make fit himself (e.g., "My parents are divorced, and I am different from other children," or "I don't do well in school; therefore, I am inadequate"). Self-defeating behaviors may also be a result of maintaining behaviors which were fitting at one time but because of changes in the individual or his environment are no longer appropriate. Once a self-defeating pattern of behavior is conceived, the individual must take over the responsibility for maintaining it. The intent of maintaining the behavior is to avoid the fear of facing the anxiety and hurt of just responding as his own best self. The result of the behavior is always responding to new life situations in a less creative way than the potential the individual possesses.

Defeating patterns are systems in and of themselves and must be fed and nurtured in order to survive. The individual himself must work to keep self-defeating patterns alive because they are anti-life with no positive external reinforcement to assist in maintaining them. To maintain self-defeating behavior the individual must choose to use the behavior; he must create a fear of being without the behavior; he must use techniques to avoid responding as his own best self; he must disown the behavior; and, he must avoid the realization of the prices he pays for using the behavior.
In conducting a group on "Eliminating Self-Defeating Behavior," the size of the group is limited to a maximum of 10 people, but it can be conducted with fewer than 10 or on a one-to-one basis. Each individual is required to identify a self-defeating behavior he wishes to work on. A tentative list including such behaviors as poor self-image, fear of failure, fear of rejection, lack of self-confidence and negativism is provided to assist them. The individual is required to be selfish during the workshop and work only on his own problem. He is discouraged from commenting on solutions and interpretations of other's problems but may use their information as it applies to his problem.

The formal group consists of seven sessions. The first session is partly spent on ways the individual attempts to avoid changing, with the emphasis on how the individual does the behavior not why. (Why suggests someone else is making you do the behavior.) The second session is spent on identifying the ways the individual disowns the behavior, and a handout is given explaining what disowning is and ways others have disowned their behavior. The third session is spent emphasizing the prices the individual pays for the behavior. The fourth session is spent on the choices the individual makes to use self-defeating behavior to avoid testing his own adequacy. The fifth session is spent on identifying the techniques the individual uses to carry out the choices he makes not to respond as his own best self. The sixth session is spent on identifying the mythical fear the individual uses to avoid
letting go of his self-defeating behavior. The seventh session is spent using some techniques to assist the individual in facing the mythical fear.

During each session an appropriate handout is given the individual explaining the lesson and responses prior workshop participants have given. During each session the individual is requested to share with the others the ways the lesson applies to him.

From the above evidence it becomes apparent that further research in the area of self-control therapy, plus training in self-defeating behavior recognition as opposed to the traditional therapeutic approach is needed. This, then, is the focus of the present research study: to compare the overall effectiveness of two treatment modalities within an ICF.

The Problem

The purpose of this study is to determine the comparative effectiveness of two treatment modalities in changing behaviors of residents of an ICF. Since each person who enters the ICF will receive individual, group, recreational, and vocational therapy, the focus of this research problem, then, is to test the use of intensive individual and group therapy against a modality which employs self-monitoring and behavioral assessment training. According to research data previously cited in this chapter, the effectiveness of traditional intensive individual and group therapy may be suspect. The problem of this study, therefore, is to place residents into two groups or treatment modalities such that behavioral change can be assessed for those persons who engage in
individual, group, and recreational/vocational therapy against the possible behavioral change for those persons who receive instruction on how to detect self-defeating behaviors and use self-monitoring of the same. It is in this light that this study is undertaken—to assess the relative effectiveness of two treatment modalities in remediating negative behaviors in groups of subjects.
CHAPTER II

Review of Literature

The focus of this Review of Literature will be: (1) to describe the general effectiveness of institutions, (2) to describe research which explains the overall effectiveness of traditional psychotherapies (individual and group therapy techniques) in the remediation of institutionalized adolescents, and (3) to describe the effectiveness of self-monitoring techniques in remediating emotional disturbances of institutionalized adolescents.

After careful review of the mental health care facilities available to the youth of Idaho, it was determined that a serious need for an ICF existed. Similarly, Meislin (1969) determined that a strong need for ICF's existed throughout the United States. He felt that both Veterans Administration Hospitals and State Hospitals should help in creating ICF's on a regional basis. These facilities would be for those individuals whose underlying illness is in remission, but who cannot live independently. The ICF should provide various therapeutic, social, and vocational services including work-for-pay opportunities (Meislin, 1969). With respect to the need for institutions, conservative estimates suggest that 15% of our population are social deviates, that is, mentally retarded, mentally ill, alcoholics, drug addicts, and the like; however, according to Gozali and Simons (1971), facilities equipped to treat these
difficulties are too few and those available are generally not responsible to
the needs of the participants.

Effectiveness of Institutions in Remediating Emotional Disturbances

Conflicting evidence exists regarding the overall effectiveness of
institutions in general, including ICF's, in their ability to improve the emo­
tional functioning of their residents. Stuart (1970) reported that commitment
to institutional care was not without considerable risk. Even though as many
as half of the patients treated in institutions are successful in achieving lasting
discharge, a sizeable number fail to be discharged, undergo additional behav­
ioral difficulty or suffer from increased risk of physical illness (Norris,
1951; Ullmann, 1967).

Institutions have been criticized from other points of view. The most
significant of these criticisms is that the environment to which the patient is
expected to adjust in treatment is so alien from the environment outside the
institution that success within the institution bears little relationship to effec­
tive adjustment in the community (Rapaport & Roscow, 1960). A second
criticism is that the milieu concept of institutionalization usually allows the
patient to receive many positive rewards which are not contingent on adaptive
behaviors. Also, the patient does not usually bear any responsibility for his
maladaptive behaviors (Stuart, 1970). Stuart also reported that of the many
different approaches of diagnosing and treating behavioral disturbances, the
techniques of behavioral assessment and modification are the ones most likely to be successful.

Adamek (1968) studied the characteristics of institutional adjustment and positive change for a group of institutionalized subjects. His findings suggested that the degree to which a patient is changed by correctional institutions is usually related to the extent to which the patient identifies with various staff members and with the program of the institution rather than specific therapeutic intervention of one kind or another. This study also revealed that patient change is directly related to the extent to which the patient feels responsible for changing himself.

In contrast to the findings previously cited, which report the relative ineptitude of institutional settings, Raymond (1968) reported that approximately 75% of persons leaving institutions make satisfactory adjustment. As suggested by Raymond, a patient's personal improvement was related to the length of stay in the institution. He further noted that persons entering the institution prior to the age of 15 1/2 had a greater ratio of successful post-institution adjustment than did persons of an older age.

Wierig (1972) showed that post-discharge from an institution was directly related to the amount of social contact or social isolation patients had with significant people outside of the institution. A person who had no social contact with significant persons on the "outs" (family members, nurturing interpersonal relationships) was much less likely to adjust to the community than were those with close social ties.
Effectiveness of Traditional Psychotherapy in Remediating Emotional Disturbances

It would be beyond the breadth and scope of this Review of Literature to attempt to cite studies which deal with specific therapy philosophies and/or treatment applications; rather, this section of the Review of Literature will attempt to describe the general applicability and effectiveness of psychotherapy as a whole treatment approach. For a more comprehensive discussion of traditional psychotherapies and their use in clinical practice see Martin (1974).

Traditional psychotherapy is the label used to identify the "practice" and "approach" of a large body of professionals within the helping professions in which the primary effort is to understand, through talking and listening, the problems of others. It is felt that in this traditional approach, an understanding of what causes a person to think and feel the way he does will lead to a therapeutic change in the behavior of the person. It is this "insight" rather than any particular manipulation of activities or events which leads to positive change.

Traditionally, insight gaining is done either through individual or group settings and requires a talker and a listener. There exists a multiplicity of theoretical and philosophical approaches to gleaning this insight from patients; however, the more popular of these approaches include Psychoanalysis, Client-Centered Psychotherapy, Reality Therapy, Rational-Emotive Psychotherapy, and Systematic Desensitization Psychotherapy.
Over the past few years, lay and professional people alike have questioned the effectiveness of traditional psychotherapeutic approaches in reducing emotional disturbances.

In several early publications, Eysneck (1952, 1954, 1955a, 1955b, 1961, 1964) reported that approximately two-thirds of a group of neurotics would recover or improve to a great extent within 2 years of the onset of illness, whether they were treated by means of psychotherapy or not. He further argued that there existed no concrete evidence that psychotherapy was more effective than no treatment at all. These statements have raised questions, many of which have not been satisfactorily answered to date.

A second challenge to the field of psychotherapy was Bergin's observation (1963, 1966) that psychotherapy may be causing persons to become better or worse adjusted than comparable persons who do not receive treatment. Bergin noted that there was no concrete evidence to suggest that patients would get better as a result of psychotherapy; rather, the evidence suggested that as many of the patients treated would get worse as would get better. It appeared as though some therapists were effective in creating change while others were not, and the technique employed in the therapy seemed to be of little importance. If these findings are correct, it would appear that psychotherapy on the average is ineffective.

In writings presented by Smith (1975) dealing with institutionalized, emotionally disturbed individuals, the overall ineffectiveness of bringing about adequate emotional adjustment through the use of traditional
psychotherapy was noted. Smith suggested that the relevant issue of helping a person become adjusted comes through helping the individual learn to cope with life's problems through the practice of socially appropriate behaviors.

Contrastingly, Martin (1972) defended the use of certain traditional approaches which attempt to gain insight into the patient's problems but argues that these insights should be used to help the patient begin to manage his behavior through behavioral-management techniques. This approach is typically referred to as a learning-based, client-centered therapy.

Several attempts have been made by researchers to empirically prove the effectiveness of certain psychotherapy approaches in institutional settings; for the most part, these efforts have led to nebulous and inconclusive results (Bierman, 1969; Harper, 1959; Truax & Carkhuff, 1967).

With the recent advent of behavior therapy, the argument regarding insight versus management has flourished. The traditionalists argue that the behaviorists are too "simplistic" in their approach to therapy, and the behavioral therapists argue that traditional insight therapy has not yielded positive observable changes in behavior.

Contraindicative of traditional psychotherapy, a large body of research exists regarding the relative effectiveness of behavior management therapies (Lange, 1965; Lange & Lazovik, 1963; Wolpe, 1958).

Behavior modification has established a fairly impressive research record in the treatment of fears and anxieties within patients. Hospital and institutional programs have also demonstrated positive research results with
the use of behavior therapies. What seems to be lacking most in behavior therapy research is well-designed research on the treatment of real-life problems (Paul, 1969).

An area which is growing in popularity among therapists and researchers alike is the use of self-management techniques for persons who are desirous of changing their own behaviors.

**Self-Monitoring as a Tool for Changing Behavior**

Several research studies have evaluated self-monitoring (SM) as a component of other behavioral-change procedures. Ferster (1962) used SM in conjunction with other self-control techniques in his work with obese persons. This initial study combined stimulus control, aversive consequences, shaping techniques, and SM of daily intake of food to incure weight loss.

Similarly, Fox (1962) developed stimulus-control procedures to promote efficient study behaviors in a group of college students. SM was used to determine the extent to which students were able to continue or cease studying over certain periods of time.

In a study conducted by Goldiamond (1965a), an effective extension of self-control procedures was used to control a variety of behaviors. Subjects were trained to become aware of conditions that controlled the way they responded in several situations. It was felt that this awareness would effect desired behavior change for each subject. Goldiamond also used stimulus control and extinction procedures to alter the behavior of his subjects. In a
variety of cases, successes were noted in an increase in studying, a reduction in eating behavior, and the elimination of sulking, depression, and marital conflict. It was determined in this study that, while the research had been successful in altering several behaviors, the role of SM as being solely responsible for this change could not be determined.

Other early studies which employed the use of SM reported success in bringing about significant behavior change. The use of SM in these studies was used primarily as a technique to assess the effects of other experimental interventions. Homme (1965) noted that behavior being a function of its consequences, it does not matter who manipulates these consequences, even if it is the individual himself.

In a study by Rutner and Bugle (1969) dealing with schizophrenic psychiatric inpatients, SM was found to be an effective tool in reducing the number of hallucinations for patients employing this technique. For a number of days, the patients recorded the frequency of their hallucinations. After the first 3 days of SM, the behavioral observations collected by the patient were posted on the ward bulletin board. The staff praised each patient who reported having no hallucinations. After this intervention, the frequency of reported hallucinations had dramatically dropped (from 181 to 10). This significant drop had occurred after only 3 days of SM alone. After 16 days of SM, the reported number of hallucinations had dropped to zero. It could not be determined that this reduction in hallucinations reported was the result of posting the frequency of hallucinations per patient on the ward display board
or whether the introduction of SM was the cause of behavior change. It was further undetermined whether or not the persons making the self-report were, in fact, reflecting actual instances of hallucinations or whether they were contaminating the report to gain the approval of the staff. This particular problem is of considerable magnitude whenever self-report data are used for responses that are not observable for an observer. It may well be the case that social reinforcements for a recording of low rates of hallucinations may have actually brought about a lowered recording of hallucinations rather than an actual reduction of them. The results of this study are significantly intriguing to suggest that SM might produce beneficial results for institutionalized individuals.

Other reports have produced variable effects with SM. In a recent study by Thomas, Abrams, and Johnson (1971), SM was used to reduce multiple tics (vocal tic, vocal sound, or neck tic) in a young male adult. Since only one of the tics could be monitored by an independent observer, each of the tic behaviors was treated independently. The subject was trained to count the number of vocal tics that he exhibited and to report them every 15 minutes to an observer who followed him. The observer gave social praise for a low rate of negative behavior. It was found that this type of procedure had rapid effects in reducing vocal tics for the patient. Although the authors of this study concluded that SM alone reduced tics, it could not be conclusively determined that the reduction in tic behavior was not a result of social reinforcement and praise.
In contrast to the above mentioned study, Jackson (1972) reported that SM alone did not lead to behavioral change. Jackson treated a subject who reported periods of chronic depression, and he had her rate her depression and impose self-reward for engaging in desirable activities. The subject was programmed to delimit the number of non-rewarding tasks that she engaged in and to reward herself for tasks that she accomplished during each day. The number of times she praised herself (used self-reward) was closely monitored. While a significant reduction in the amount of depression being experienced by the subject occurred, it could not be determined what the effect of SM was in this change.

In a similar study, Mahoney (1971) reported that SM did not result in behavioral change for a subject (adult male) who monitored his obsessions. The client self-monitored his obsessive thoughts, and later his positive self-thoughts, with no significant results.

Bayer (1972) reported similar results for a patient who had the destructive behavior of hair pulling. SM alone was not effective in reducing the amount of hair pulling, but when social reinforcers were applied with SM, a significant reduction in hair pulling occurred.

Aside from single subject case research, several other investigations have led to inconclusive results on the effects of SM alone, without the influence of other contingent and confounding influences. Rehm and Marston (1968) included SM as part of their treatment approach in reducing social anxiety in a group of males. Subjects were trained to monitor either self-reinforcement,
nonspecific therapy, or no therapy. Those males who applied self-reinforcement monitored the amount of social interactions with females and gave themselves points for positive and appropriate behaviors. These social interactions were praised by the therapist, who made an effort to encourage each patient to continue his positive interactions. The other two groups were provided contact with the therapist without SM or reinforcement. It was concluded that the interaction of the therapist, self-reinforcement, along with SM was effective in producing greater changes on several measures than the other two treatment conditions. These effects were maintained for up to 7 to 9 months of follow-up. It might therefore be concluded that SM is a crucial tool in the effective treatment since all of the groups received some type of therapist contact. It should be noted also, that self-monitoring was combined with other treatment features and cannot be conclusively shown as the causal agent of therapeutic change.

In other studies, SM was used independently of other design procedures which might account for behavioral change. Broden, Hall, and Mitts (1971) studied the effects of SM in a study using two eighth-grade students in a "real-life" setting and demonstrated that systematic self-monitoring could dramatically alter behavior. This study carefully examined what happened when a person was asked to observe certain actions over a relatively long period of time. This study was significant for several reasons: (1) it used an intensive (N = 1) research design with reversal procedure, that is, a procedure in which the influence of a factor is investigated by presenting and then
withdrawing the factor; (2) it illustrated the indirect relationship of self-observation reliability to observed behavior change; (3) it suggested the power of systematic self-observation to alter the person's environment and thereby to support the changed behavior; and (4) it clearly demonstrated the short-lived effects of self-observation on behavioral changes without making changes in the environment. These authors noted that additional studies employing this type of design are needed if the processes of self-observation and self-monitoring are to be more fully understood.

Stollak (1967) compared various experimental conditions for weight loss with obese women over an 8-week period. One group kept daily records of their eating behavior and received no feedback from the experimenter for small food intake; another treatment group monitored their eating behavior and then received experimenter praise and feedback for small amounts of food intake; in another group shock was applied for contingent inappropriate eating behavior. Results of this study showed that the SM-only group did not show a significant reduction in eating behavior or weight loss, whereas the group of women who were told to employ SM and were given periodic feedback as to their performance showed a significant reduction in eating behavior. During the follow-up interval the SM-plus-therapist-contact group returned to their previous level of eating behavior.

In another study dealing with weight-control (Hall, 1972), the weights of TOPS (Take Off Pounds Sensibly) members were obtained for 3 months prior to participation in the study. Two groups of women were employed,
with one group monitoring only their weight on a daily basis, and the other group of women monitored both their weight and their food intake. Previous records obtained prior to the study showed a negative weight change of -.01 pound per week over 3 months. With the introduction of SM of weight from one group an actual increase of +.04 pounds per week was noted, and with the introduction of SM both weight and food intake the change in weight was also in the positive area (+.19). It was noted that over a 4-week period negligible, but consistent, increases in weight were obtained through the use of SM techniques.

Still another study using multiple techniques along with SM was conducted by Mahoney, Moura, and Wade (1973). This research design compared the effectiveness of self-reward, self-punishment, self-reward, and self-punishment combined, self-monitoring, and no-SM in reducing weight. Money deposited by the subjects was used as a negative contingency for inappropriate behavioral change, for self-reward, and for self-punishment. All of the subjects monitored their daily weight, fat thoughts, thin thoughts, and their submission to, or avoidance of overeating. The results of this study tended to support the notion, consistent with other studies previously cited, that when SM is employed with self-reward, and/or self-punishment, that significant changes can be noted. The significant factor of this study reveals that SM and no-SM alone had little effect in changing eating behavior or in producing weight loss for the subjects.
Santogrossi, O'Leary, Romanszyk, and Kaufman (1973) found that SM in and of itself was not effective in reducing disruptive classroom behavior, but when self-monitoring and self-reward (token reinforcement) are coupled, this combination of techniques is effective in significantly altering disruptive behavior. Likewise, Milar (1973) reported that SM alone was not sufficient to alter negative behaviors exhibited by subjects, but when SM was coupled with a token reward system, this combination significantly reduced the manifestation of inappropriate behaviors.

Several studies have tested the effectiveness of self-monitoring and self-reward in changing behavior. In a study conducted by Allen (1971) using 36 residents of a treatment facility in short-term therapy, strong support was found for cognitive structuring and self-reward contingencies in improving the self-concepts of the participants. Contrastingly, Berglund (1971) using 90 male delinquents, predicted that negative self-reward coupled with SM would be more effective in modifying behavior than would positive self-reward plus SM. Findings of this study suggested that both negative self-reward and positive self-reward when coupled with SM were effective in altering behavior and that these two methods were more effective than no reward at all.

In contrast to the above mentioned studies which failed to show SM alone, independent of additional therapeutic interventions as effective in altering behavior, Stuart (1971) reported that SM alone was effective in weight control. The combination of a variety of behavior interventions (Stuart, 1967; Stuart & Davis, 1972) was compared with SM procedures for weight control.
Prior to treatment, subjects self-monitored their eating habits for a period of 5 weeks. During the acquisition of base line data, subjects who were self-monitoring showed significant weight loss.

Similarly, Mahoney (1974) found that three groups of subjects who self-monitored their eating habits and weight were successful in significantly altering their weight and eating habits over a 2-week base line period. Self-reward strategies were utilized for two of these groups. It was noted that the one group who employed SM alone during the treatment period showed an attenuation of weight loss. This would suggest SM's effectiveness over long periods of time.

Self-monitoring of cigarette smoking has constituted the major therapy efforts for altering this behavior. Self-monitoring is usually employed in both the treatment and control groups when smoking behavior is being studied because it seems to be the only effective means of obtaining reliable data regarding smoking behavior. However, for the most part contingent factors usually enter into most control group studies which negate inferring cause and effect relationship to self-monitoring alone (Bernstein, 1969; Keutzer, 1968; Nolan, 1968; Wagner & Bragg, 1970).

One of the most dramatic demonstrations of the effectiveness of SM was revealed in a study conducted by McFall (1970) during class sessions of a college course. Students were asked to monitor the number of times that they smoked in class or had the desire to smoke but did not. The non-smoking were instructed to monitor the frequency of smoking that was done in class
over three experimental phases (baseline, SM, and return to baseline).
Those who self-monitored their rates of actual smoking increased in their
smoking behavior, whereas individuals who monitored their urges to smoke
showed a decrease in smoking behavior. Both groups showed a decrease in
the amount of time spent in smoking cigarettes. The effectiveness of SM was
found to be durable for the group that monitored smoking, and when SM was
discontinued, the frequency of smoking behavior remained greater than
during baseline periods. This study was criticized in terms of "demand
characteristics" implicit in the study situation (Orne, 1970).

Another study which showed significant results with the use of SM
was reported by McFall and Hammen (1971). Within this study, four different
self-monitoring procedures were used. The first group of subjects received
no specific instructions on how to monitor their behavior, but were told just to
count the frequency. The second group was instructed to record negative
points on a wrist counter, whenever they engaged in smoking. A third group
monitored positive points for the frequency of times that they were tempted,
but resisted smoking. A fourth group employed both positive and negative
points to their smoking behaviors, i.e., every time they were tempted to
smoke and lit the cigarette, they told themselves that they did not want to
smoke, and recorded the incident. Even though the study provided a great
usage of the SM techniques, the results were ambiguous. The author con-
cluded that the impossibility of separating the effects of participation in a
study, and the effects of SM alone, led to the conclusion that behavior change was not solely a result of SM alone.

McNamara (1972) used three groups of subjects to compare different SM approaches to reduce nail biting. One group of subjects monitored incompatible responses to nail biting such as finger tapping or pulling one's hand away from one's mouth. A second group did not monitor their nail biting behavior; a third group engaged in incompatible responses but did not monitor these; a fourth group recorded nail biting but did not monitor the responses; and a final group did not self-monitor any behavior. Using the length of subjects' nails as a criteria for effectiveness of treatment approaches, it was determined that all of the groups showed a significant improvement, over time, with no differences among groups.

In a contrasting study conducted by Herbert and Baer (1972), two mothers were instructed to count the number of attention-getting episodes exhibited by their children. Observers were also permitted to gather data in the home to determine the reliability of monitored observations gathered by each mother. The results of the study demonstrated strong support of the effectiveness of self-monitoring. It was noted that for each of the participating mothers, a consistent increase in the amount of maternal attention was a product of SM. It was further reported that, when SM was discontinued temporarily, the amount of maternal attention stabilized at about the same levels achieved in the previous SM phase. When one of the mothers monitored
the negative behavior of her child every 3 days for 21 days, high levels of
target behavior were maintained.

Recently, Fixsen, Phillips, and Wolf (1972) studied the effects of
SM versus peer-monitoring on room-cleaning behavior of pre-delinquent
youths. After a baseline period, the boys monitored their own behavior rela-
tive to room-cleaning, with negligible effects. During the second phase of
the study, peer-monitoring was instituted wherein the subjects' peers were
told to keep a record of room-cleaning behaviors exhibited by the participants.
Although the amount of room-cleaning behavior was reported to have dramati-
cally increased, the actual amount of change in room-cleaning behavior was
insignificant. It was concluded that SM did effect behavior in that the reported
number of room-cleaning incidents increased; in reality, however, the effects
of SM were nebulous for this study.

Mahoney, Moore, Wade, and Moura (1973) compared four groups with
different applications of self-monitoring techniques. One group was told to
continuously self-monitor a programmed-learning task in which continuous
feedback was given. A second group self-monitored and received feedback
on an intermittent schedule. A third group received feedback alone, excluding
self-monitoring. And a fourth group received no feedback nor did they monitor
their behavior. It was concluded that SM subjects spent more time on the task
and had greater accuracy in math but not verbal problems than did subjects
who received feedback alone. It was also noted that SM was superior to
intermittent SM in the time spent on task.
Gottman and McFall (1972) noted that when students in class monitored their individual classroom participation, talking in class increased. However, when subjects monitored non-participation, talking generally decreased.

**Reliability of Self-Monitoring as an Assessment Device**

If SM were going to be used as an assessment device at the ICF, it would be critically important that a high degree of reliability exist between the actual frequency of occurrence and the recorded number of occurrences for behaviors being assessed. Since SM serves the purpose of being a prospective agent for changing behaviors, it is much less important to have a high degree of consistency and accuracy of report; in fact, accuracy may be irrelevant to change.

Several authors have studied the reliability of self-respect measures against actual observation of the same behaviors with mostly negative results. Fixsen (1972) reported that the accuracy of self-reports as opposed to observations was less than 50% and that peer and self-reports were nearly as ineffectual. Similarly, Broden (1971) found great discrepancies between the frequency of behavior recorded by classroom students and actual observers stationed in the classroom. Many of the students were negligent in keeping self-report, would fill the report in inaccurately, or would forget to record their behaviors altogether. However, when contingent rewards were established for accurate monitoring of behaviors, the agreement between the self-report scores and the scores of independent observers dramatically
increased. While this study suggests that SM as an assessment device is unreliable, the fact that young children were the subjects may account for some of the inaccuracy.

In contrast to studies which reported the apparent inaccuracy of self-report techniques, others have shown a relatively high degree of agreement between self-monitoring and independently monitored records. Azrin and Powell (1969) reported 98% agreement between self-report and observations of employees who kept daily records of pill consumption in a hospital ward. Moore and Mahoney (1973) reported similarly high percentages of agreement between self-monitoring and observer monitoring of correct responses on a programmed learning task. In contrast, however, others have reported proportionately low percentages of agreement between self-reported records and independently observed records (Herbert & Baer, 1972).

As an assessment device, the overall reliability of self-monitoring is still somewhat suspect. One of the greatest obstacles to accurately determining to what extent SM may or may not be reliable seems to be the fact that few studies are able to use self-monitoring alone without some type of contingent variable as part of the therapy intervention. Certainly an observer must interpret self-report data cautiously and should be wary of change which is in the direction of socially-desirable direction.
Reliability of Self-Monitoring as a Behavior Change Technique

As has been previously mentioned, SM does not have to be done with a high degree of accuracy to effect behavior change. This is partly due to the reactive effects of self-inspection. As can be noted from previous studies cited in this review (Broden, 1971; Herbert & Baer, 1972) behavior changes can be effected through the use of self-monitoring, even though the accuracy of the report is grossly inaccurate.

In making inquiry as to why self-monitoring works as effectively as it does as an agent for behavior change, several factors have been noted by Mahoney (1974). These factors include reactive assessment, instruction, and suggestion for change.

It is significant that self-monitoring works in bringing about behavior change, but much of this change is a result of subject's reaction to the assessment (that is, the subject's personal awareness that particular responses being emitted are being monitored). This awareness seems to account for much of the change in a subject's behavior and provides understanding as to why it may not be critical for the subject to record every episode of behaviors being scrutinized. On the other hand, reactivity may not be the only factor in creating change when SM techniques are employed. The effects of instruction, suggestion, or experimenter contact may also be contributing factors to behavioral change.

Several studies which have employed SM techniques to alter behavior have reported the apparent effects of instruction, suggestion, or contact by
experimenters (Herbert & Baer, 1972; Orne, 1969; Thomas, 1971). When a person is told, instructed, or given the suggestion to begin to look at and record certain behaviors, the person tends to use this particular situation as the catalyst for change and may therefore begin to alter his behavior in the direction of the instruction, suggestion, or perceived expectation. It was suggested by Orne (1969) that SM be evaluated against simple instructions from experimenters to change. It was his contention that the act of instructing or suggesting that a person change, may have dramatic enough effects to account for the effectiveness of self-monitoring itself. It is with the understanding that self-monitoring coupled with instruction or training in recognizing inappropriate behaviors became the primary focus of this study.

One of the key elements to the research study undertaken was the training of subjects to recognize their own inappropriate behaviors and to monitor them correctly. Cudney's (1975) method for teaching a person to recognize his own self-defeating behaviors has been adopted as the method for training the residents of the ICF to become aware of these inappropriate behaviors. (For a complete description of the concept and training techniques associated with self-defeating behavior, see Chapter I).

The author was unable to locate any research which has used Cudney's concept pertaining to self-defeating behavior as a tool for training clients to become aware of their own behaviors. From a personal point of view, the author has been exposed to this concept and has seen it to be
effective as a cognitive tool in helping institutionalized adolescents recognize behaviors which tend to be self-destructive (self-defeating).

In summary, it can be shown that self-monitoring, when coupled with training and therapist contact, is a highly effective tool for bringing about behavior change. On the other hand, the effectiveness of the institution and/or the traditional therapy approach (psychotherapy in individual and group settings) is suspect. It becomes apparent that an important research question could be answered by comparing SM plus training plus therapist contact against psychotherapy. This study was undertaken for this comparative purpose.
CHAPTER III

Methodology

The purpose of this study was to determine the comparative effectiveness of two treatment modalities in bringing about behavioral change in residents of an Intermediate Care Facility. The study was done to bring clarity to the treatment approach at the St. Anthony, Idaho, ICF. As previously mentioned, a primary goal of the St. Anthony ICF is to increase responsible behavior in its residents. Since each person who enters the ICF receives individual, group, recreational and vocational therapy, the focus of the present research was to determine, if possible, whether or not this intensive individual and group therapy approach was as effective as a "self-modification" therapy, i.e., intensive individual and group therapy coupled with self-monitoring and behavioral assessment training. As has been stated, the effectiveness of traditional, intensive individual and group therapy may be suspect. Therapy techniques which employ self-monitoring plus training have been shown to be effective in changing behavior. It was expected that subjects who participated in the self-monitoring plus training group would show a significantly greater reduction in negative behavior.

To test the above mentioned expectation, data from two treatment groups was obtained. Treatment group one (E1 group) received only intensive individual, group, recreational and vocational therapy, while subjects of
group two (E₂ group) received intensive individual, group, recreational and vocational therapy, coupled with self-monitoring plus behavioral assessment training. Both treatments were administered over a 6-week treatment period. The specific details surrounding the procedure of treatment are presented in the section of procedures.

Objective

The specific objective of the present study was to compare the effectiveness of intensive individual, group, recreational and vocational therapy, against self-monitoring plus behavioral assessment training coupled with intensive individual, group, recreational and vocational therapy.

Hypothesis

The E₁ group (intensive individual, group, recreational/vocational therapy) will show significantly less change in the manifestations of negative behaviors than will the E₂ group (intensive individual, group, recreational/vocational therapy plus self-monitoring with training in the recognition of negative behaviors).

The specific sub-hypotheses are:

(1) The E₁ and E₂ group participants will not differ significantly from one another with regards to the frequency of misbehavior observed during the base line observation period.
(2) No significant reduction in misbehavior will be found to exist for the $E_1$ group when the frequency of misbehavior for base line and date line observations are compared.

(3) The $E_2$ group participants will show a significant reduction in the frequency of misbehaviors when base line and data line observations are compared than will the $E_1$ group participants.

(4) When the frequency of misbehavior for the data line observation period are compared for both groups, the $E_2$ group participants will show a significantly greater reduction in the frequency of misbehavior than will the $E_1$ group participants.

Subjects

Of the possible 24 participants available for this study, 20 (two groups of 10 subjects) were used. Subjects were selected randomly from the total population of residents by means of a table of random numbers and were assigned to either treatment group on a random basis.

The residents of the St. Anthony ICF represent a sample of a unique and distinct population of persons in the State of Idaho. For example, each subject was a court-referred juvenile offender with a history of deviant activity including both status and criminal offenses. Without exception, each resident came from a conflicted family background wherein they were party to a variety of unstable family situations including single parents, alcoholic parents, incest, child abuse and substance abuse. To further elaborate on the
homogeneity of subjects which comprised the two treatment groups, a dis­
sion of descriptive background information follows.

**Age of subjects.** Participants of both treatment groups were randomly
assigned to either group and had no prior knowledge of any aspects of the
research plan. As can be seen from Table 1, the two groups did not differ in
terms of age.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of Subjects</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>E1 Group</td>
</tr>
<tr>
<td>E2 Group</td>
</tr>
</tbody>
</table>

$\text{t} = 0.121, \text{df} = 18, \alpha = \text{N.S. (non-significant)}$.

In each of the tables of this chapter where a t score is reported, a t
of 1.732 or greater is needed for significance.

**Race of subjects.** The two groups did not differ with regard to
racial composition. Both groups had equal numbers of whites versus minori-
ties (whites = nine per group, minorities = one per group).
Family Backgrounds

To better understand the environment from which each participant came prior to entering the ICF, a comparative description dealing with (1) income of parents (see Table 2), (2) solvency of family structure (see Table 3), (3) history of substance abuse (see Table 4), (4) history of divorce (see Table 5), and (5) number of siblings (see Table 6), will be presented in this section.

(1) Income of parents. Table 2 shows the income of parents for each group of participants in the study.

Table 2
Income of Parents

<table>
<thead>
<tr>
<th>N</th>
<th>Salary Range</th>
<th>No. of Low Income Group</th>
<th>No. of High Income Group</th>
<th>Salary</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ Group</td>
<td>10</td>
<td>2,500-10,000 per annum</td>
<td>6</td>
<td>0</td>
<td>$6,710</td>
</tr>
<tr>
<td>E₂ Group</td>
<td>10</td>
<td>2,500-21,000 per annum</td>
<td>5</td>
<td>2</td>
<td>$8,490.40</td>
</tr>
</tbody>
</table>

\( t = 0.832, \text{ df } = 18, \alpha = \text{N.S.} \)
It can be seen from Table 2 that both groups are similar with regard to the income level (financial status) of their parents or guardians. Although the salary range of the families of each group appeared to be significantly different, the mean salaries for the groups did not significantly differ. It can also be noted from Table 2 that a large percentage of ICF residents come from low-income environments.

(2) Psychological solvency of family structure. For purposes of this portion of the study, a family environment was considered to be solvent if both parents were in the home, were actively caring for their children both financially and affectionately, and wanted the children to return home to them upon release. A family was considered insolvent if one or more of the parents was missing from the family, if one or more of the parents did not want their child to return home to him, or if there was extreme conflict between the child and one or more of the family members. (It was assumed that this extreme conflict would preclude satisfactory adjustment to the home environment for the ICF resident.)

Table 3 shows a chi square representation of the number of solvent versus insolvent family backgrounds for each group.

In each of the tables where chi square scores are reported, a chi square score equal to or greater than 3.841 was needed for significance.

Chi square analysis showed that the two groups did not differ from each other relative to the numbers of insolvent versus solvent families per group. Table 3 does show that a greater percentage of study participants
Table 3

Psychological Solvency of Family

<table>
<thead>
<tr>
<th></th>
<th>Solvent</th>
<th>Insolvent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ Group</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>16</td>
<td>20</td>
</tr>
</tbody>
</table>

Chi square = 0.00, df = 1, $\alpha = N.S.$

came from conflicted and insolvent family backgrounds than did those who came from solvent family backgrounds. It can be concluded from the above findings that there is a greater likelihood that subjects of the two treatment groups came from insolvent family backgrounds.

(3) History of substance abuse. This section will compare the extent to which alcohol, drugs, and other habituating substances were abused within the family setting. It should be noted that for this information to be placed in the file of an ICF resident, the abuse of various substances would had to have been extensive and usually condoned or participated in by parents in the family.

Table 4 is representative of the extent to which substances were abused by the families of the treatment group participants.

Table 4 shows that a significantly greater percentage of participants from both study groups came from families which had a history of substance abuse than those who came from families which had no history of substance
Table 4

Family Substance Abuse

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ Group</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>7</td>
<td>20</td>
</tr>
</tbody>
</table>

Chi square = 0.2197, df = 1, $\alpha$ = N.S.

abuse. However, no significant difference exists between the two groups regarding the history of substance abuse in their respective families. The extent of the abuse was found to be generally severe and typically included alcoholism and extensive drug abuse. In other words, the probability of substance abuse being reported without a fairly severe problem existing within each family would be small. It is impossible and inappropriate to draw a cause and effect relationship between substance abuse within families and delinquent activities; it is, however, probable that a relationship exists.

(4) History of divorce in the immediate family. It is very common that ICF residents come from a background where divorce has taken place. It has been found that most of the families of ICF residents have been subjected to marital dissolution at one time or another. This is not to say that only one divorce occurred or that the single parent did not remarry, but rather that marital discord and the conflicts associated with divorce have been experienced.
by a majority of residents within each treatment group. Table 5 deals with the frequency of divorce for each of the two groups of subjects.

Table 5

<table>
<thead>
<tr>
<th>History of Divorce</th>
<th>No History of Divorce</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ Group</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>E₂ Group</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>5</td>
</tr>
</tbody>
</table>

Chi square = 0.2666, df = 1, \( \alpha = \text{N.S.} \)

As can be seen from Table 5, a strikingly large percentage of families of both treatment groups have experienced divorce or marital dissolution. No significant difference was found to exist between the two treatment groups respect to the number of families who had experienced divorce. Again, it would be inaccurate to conclude that because of divorce within families that this alone caused the ICF resident to become delinquent; it would appear, however, that a combination of family conflicts, including divorce, may have been a determining factor in creating a pattern of delinquency among subjects of each group.

(5) Number of siblings. While the number of siblings a person has would not be considered as a contributing factor to criminal activity, it is indicative of other important factors. For example, if the typical ICF resident
comes from an environment which is both financially unable to satisfy the material needs as well as spend the necessary time to satisfy the emotional needs of a large number of individuals, then this combination of frustrated needs may lead to acting-out behavior of various types. Table 6 indicates the number of siblings of each group of study subjects.

Table 6

Number of Siblings and Institutionalized Siblings

<table>
<thead>
<tr>
<th>Group</th>
<th>Range of Siblings/Gp</th>
<th>( X )</th>
<th>No. of Institutionalized Siblings/Gp</th>
<th>% of Institutionalized Siblings/Gp</th>
<th>( t ) value for number of siblings</th>
<th>( t ) value for Institutionalized Siblings</th>
</tr>
</thead>
<tbody>
<tr>
<td>( E_1 ) Group</td>
<td>0-7</td>
<td>3.8</td>
<td>4</td>
<td>11%</td>
<td></td>
<td>0.1014</td>
</tr>
<tr>
<td>( E_2 ) Group</td>
<td>0-6</td>
<td>3.7</td>
<td>2</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\( t = 0.493, \ df = 18, \ \alpha = \text{N.S.} \)

As indicated in Table 6, there was no significant difference found between the two study groups with regard to the number of siblings per group or the number of siblings per group who had been institutionalized (0.05 level).

Although the mean number of siblings per group was not significantly high, the mean number of children per family did exceed the mean number of children for families in general living in the United States. It can also be noted that a
likelihood exists that the residents of the St. Anthony ICF will typically be the only members of their families who will receive institutionalization.

In summary, the two groups can be considered homogeneous with respect to family backgrounds. More specifically,

(1) There was no significant difference in average income of families of the ICF residents in the two groups.

(2) A significantly greater number of subjects of both groups came from homes which have one or more parents missing from the home, parents which have stopped caring adequately for their children, extreme conflict between the parent and child, or a home which is not considered a resource upon release from the ICF. However, no significant difference existed between the two groups of subjects with regard to the psychological solvency or insolvency of the family environment.

(3) No significant difference existed between the two treatment groups with regard to substance abuse within the home. However, a greater percentage of subjects within both treatment groups came from an environment where there was extensive involvement in the use of harmful and habituating substances (alcohol or drugs), as opposed to study participants which came from homes which did have a history of substance abuse.

(4) No significant difference existed between the two treatment groups with regard to the amount of divorce experienced in their families. It was noted that a significantly greater percentage of subjects of both groups came
from home environments which had experienced divorce as opposed to study participants who had come from homes which were free from divorce.

(5) No significant difference existed between the two treatment groups with regard to the average number of siblings per family or the average number of siblings who were institutionalized.

Essentially, the two groups of subjects were not shown to be different with respect to their family backgrounds.

Delinquent Activities of Subjects

To better understand each group of subjects' past criminal activities and delinquent involvements, this discussion will focus on (1) the type of offense (criminal versus status) typically engaged in by study subjects, (2) the extent to which subjects were institutionalized prior to entering the ICF, (3) the extent of drug involvement prior to entering the ICF, and (4) the type of psychological diagnosis typically given to study subjects.

(1) Type of offense. As stated in the beginning of this chapter, ICF residents are court-referred juvenile offenders who are either involved in criminal or status offenses. A criminal offense is one in which a person violates the laws of the land, usually harming another person or another's property and would include such offenses as theft, rape, assault, and possession of and trafficking in drugs. A status offense is not considered criminal, per se, but involves offenses which are typically thought of as societal inconveniences and nuisances. These offenses would include such activities as
truancy, running away, incorrigibility, and being out of the control of the parents. Table 7 gives a descriptive breakdown of the number of subjects in both groups who have committed either criminal or status offenses.

### Table 7

**Type of Offense: Status Versus Criminal**

<table>
<thead>
<tr>
<th></th>
<th>Status</th>
<th>Criminal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ Group</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>7</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Chi square = 0.0021, df = 1, $\alpha = \text{N.S.}$

Two findings are suggested by Table 7. First, it can be seen that no significant difference (0.05 level) existed between the two groups with regard to the types of offenses typically made by study subjects. In other words, as many subjects from $E_1$ group were involved in either status or criminal offenses as in the $E_2$ group. Second, it is shown that a greater number of subjects in both groups were status, rather than criminal, offenders.

When the information regarding the instability of the family situations of ICF residents is considered, it becomes clear why status offenses are more typical to each group. One would expect a person to consider running from a conflicted and unstable home environment, which typically caused him to be subject to a poverty-stricken, alcoholic tempered living environment.
We would expect this unstable home situation to carry over into the school setting, causing a multitude of scholastic problems which might lead to truancy. This combination of truancy and running away might lead a parent to turn a son or daughter over to the local authorities because of his/her apparent incorrigibility. In most cases, it would appear that the status offender is attempting to survive an arena of pathos.

(2) Prior institutionalization. It is important to the discussion of homogeneity between groups of subjects, to consider the extent to which subjects of either group have been institutionalized. This factor (prior institutionalization) is important in that it represents the history of prior institutionalization and the extent to which adaptive institutional behavior may be a part of the day-to-day functioning of subjects within either treatment group. Table 8 shows the extent to which subjects within each treatment group have been institutionalized.

<table>
<thead>
<tr>
<th>Table 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Institutionalization</strong></td>
</tr>
<tr>
<td>No. of Subjects who have been institutionalized before entering the ICF</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>E₁ Group</td>
</tr>
<tr>
<td>E₂ Group</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Chi square = 0.0694, df = 1, α = N.S.
It can be seen from Table 8 that the two treatment groups did not differ significantly from each other with respect to the number of subjects who had previously been institutionalized (within some other institutional setting) prior to entering the ICF. On the other hand, it is apparent that both groups of subjects have had a rather extensive history of previous institutionalization. It would appear that the delinquent activities which caused the subjects to be placed in the ICF have had a chronic development pattern. If adaptive behavior to institutional settings is typical of the study subjects, it is typical in equal proportions to each group, verifying again the consistency and homogeneity between subjects in both treatment groups.

(3) **Drug involvement.** One of the most typical activities engaged in by the residents of the ICF is drug usage. Table 9 depicts drug involvement for subjects in both study groups.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ Group</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>E₂ Group</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Chi square = 0.0595, df = 1, α = N.S.
Table 9 shows that a majority of the subjects within both treatment groups were involved in illicit drug usage. Only a very small percentage of subjects in both groups had not used drugs on a regular basis prior to admittance to the ICF. Drug usage may be symptomatic of a need within users to withdraw from their conflictive environment. This assumption would be consistent with the information presented regarding the conflictive family backgrounds of each treatment group and the possible need to escape such conflict by using drugs.

(4) Diagnosis: Typical versus non-typical. As mentioned within the body of Chapter I, each resident admitted to the ICF has an extensive diagnostic evaluation which accompanies him. By the very nature of the ICF staffing pattern, most of the persons admitted to the unit have similar types of problems. Most of the residents typically receive a diagnostic label of "Behavioral Disorders of Adolescence" (Diagnostic Statistical Manual, Category No. 308), or "Drug Dependence" (DSMII, No. 304). The world "typical" is used to describe those persons of either group who would receive either or both of the above mentioned diagnostic labels. These typical ICF diagnostic categories would not include individuals who might be diagnosed as psychotic, sexual deviates, psycho-physiologically impaired, chronic non-psychotic personality disorders, or organically or neurologically impaired. A person who receives a non-typical label could be considered as having an impairment, described above, that would fall outside the category of behavioral disorders or drug dependence.
Table 10 shows a breakdown of those individuals in both treatment groups who were diagnosed as either typical or non-typical in their mental anomaly.

Table 10

<table>
<thead>
<tr>
<th></th>
<th>Typical</th>
<th>Non-Typical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ Group</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

Chi square = 0.000, df = 1, $\alpha$ = N.S.

It can be seen from Table 10 that no significant difference was found to exist between the two groups of subjects with respect to the type of their mental disorder. In both groups, the majority of subjects were diagnosed as having behavioral disorders or drug dependency problems. Only one person in each group of subjects was diagnosed as having problems which are not typically associated with ICF residents. In both cases, the individuals were diagnosed as having more chronic psychotic disorders than typical behavioral disorders.

Additionally, it should be noted that all of the participants of the present study had been residents of the ICF for about the same amount of time. This suggests that all of the participants had been subjected to similar types of experiences since entering the ICF.
In summary, it can be concluded that the subjects of both treatment groups had similar family backgrounds and personal characteristics, making both groups virtually homogeneous in nature.

**Procedure**

The design of this research study was three-fold. First, base line data was collected to determine the frequency of misbehavior being exhibited by both the $E_1$ group and the $E_2$ group subjects. Second, a 6-week treatment phase was implemented wherein the $E_1$ group subjects received only intensive individual, group, recreational and educational therapy, and the $E_2$ group subjects received intensive individual, group, recreational and educational therapy plus self-monitoring coupled with training in the recognition of negative or self-defeating behaviors. Third, after the 6 weeks of treatment was completed, data line data was gathered.

**Gathering base line data.** The following discussion is designed to help the reader understand (1) what information made up the base line data, (2) how the data was collected, (3) who collected that data and how they were trained, and (4) the schedule under which the data was collected.

(1) The overall objective of the research study was to determine whether or not either of two treatment modalities was effective in reducing negative behaviors. It had been found that most of the negative behaviors which are typically exhibited by the residents of the ICF fall into three general categories, i.e., passive-withdrawal, overt-hostility, and manipulation. In order
to observe the extent to which subjects of the two treatment groups exhibited behaviors within these three categories, three specific manifestations of misbehavior for each category was spelled out. In other words, the three general categories of misbehavior were identified, and then three specific examples or ways in which people manifest behaviors appropriate to each category were identified. The three specific categories and the manifestation or examples of misbehavior within each category are as follows:

(I) Passive-withdrawal:

I-A. Obvious attempts to avoid any type of interpersonal interaction. Examples: hiding from others; removing one's self into remote areas of the cottage; sleeping to avoid contact with others; prolonged daydreaming or fantasizing.

I-B. Refusal to relate to others when it would be appropriate to do so. Examples: use of shyness; refusal to talk in groups or individual settings and use of daydreaming or listlessness to avoid responsible communication with another person.

I-C. Obvious attempts to create hostility in another individual through passive-aggressiveness. Example: when being talked to refuses to answer or gives nonsense responses.

(II) Overt-hostility:

II-A. Any attempt to release frustration or to control another individual's behavior by outbursts of physical aggression.
Example: fighting or threatening to do physical damage.

II-B. Use of verbal aggression to release frustration or to control another's behavior. Example: rapid, abusive, and usually vulgar usage of language; name calling; hostile ridicule.

II-C. Obvious, but subtle, attempts to release frustration or control others through self-destruction or non-verbal communication of hostility. Example: head-banging; wrist-slashing; or rumination (wrist-wrangling, stereotypical movements, extreme narcissisms, and self-induced anxiety).

(III) Manipulation of others:

III-A. Obvious attempts to draw attention to one's self through immature or deviant behavior. Example: "Macho" speech; use of language to make others feel guilty; anxious; or ignorant; going along with the crowd to gain status; buying friendships.

III-B. Obvious attempts to manipulate staff. Example: playing staff against staff; asking for special privileges or extra attention; using "sweet talk" to get one's way.

III-C. Manipulation of others including parents or friends. Example: communications which suggest the need for
special or preferential treatment such as early releases, special visits or telephone calls; or sending contraband.

It is within the framework of these three general categories that each subject was observed. The accumulated frequency of misbehaviors observed for each treatment group made up the base line data for both groups.

(2) With regard to how the data was collected for both base line and data line, five specific factors should be understood. First, the observation of misbehaviors manifested by subjects within both treatment groups was done by trained observers (a discussion of how the observers were trained will follow). Second, the data was obtained from four pairs of observers (eight individual observers) all observing in the cottage and among the study subjects. Third, each pair of observers had no prior knowledge as to which group the subjects which they were observing belonged. Fourth, the subjects were observed on a fixed schedule between the hours of 2:00 p.m. and 8:00 p.m. Fifth, the observations were collected over a 7-day period.

It should also be noted that each pair of observers was randomly assigned to observe 10 study participants each day of the 7 days. They observed the same 10 participants each of the 7 days (a complete explanation of how the observations were scheduled will follow).

(3) The behavioral observations which made up both base line and data line data were collected by four pairs of trained observers. Each observer was a volunteer student who was majoring either in psychology or sociology and was attending Ricks College. The observers had no prior
knowledge of the purpose of the study and were not informed as to the assign-
ment of subjects to either of the two treatment groups. The eight observers
trained to do the behavioral observations were randomly paired and randomly
assigned to observe 10 subjects. Each observer was given a schedule to
follow, was trained over an 8-hour period on how and what to observe, and
was given a monitoring instrument which was used to make his frequency
check during each period of observation (a description follows of the monitor-
ing instrument used).

Training of the Observers

Each observer received 8 hours of training in the recognition of
misbehavior and the monitoring of the same prior to the actual base line data
gathering period. The training was done in the following manner.

(1) **First hour.** Pictures of the study subjects were introduced to
the observers. This was done to minimize the number of times the observers
had to ask the cottage staff who a particular individual was before they observed
him.

(2) **Second hour.** The resident psychologist gave an in-depth explana-
tion of each of the three specific categories of misbehaviors and role-played
situations so that each misbehavior was dramatically demonstrated.

(3) **Third hour.** The observers practiced rating different types of
negative behaviors which were being role-played. This was done to acquaint
each observer with the use of the monitoring instrument and to let each pair
of observers compare notes to check the accuracy of their own observations against the observations of another observer.

(4) **Fourth hour.** During this hour, the observers went to the cafeteria of the adjoining Youth Services Center to observe the residents of another treatment facility. These other residents typically manifest similar behaviors to residents of the ICF. They were asked to observe in pairs and were then evaluated on the amount of agreement between teams regarding the type and frequency of misbehaviors being displayed.

(5) **Fifth through eighth hour.** Accompanied by a psychologist, each team of observers was escorted into the ICF cottages where they began to observe all of the residents on a trial basis. Coaching was given to each pair during this phase of the training to insure that each pair of observers was observing this same behavior with the same degree of accuracy. This was done until a reliability coefficient of .90 or higher was obtained between observers on the observations being recorded.

It should be noted that because of the extensive training that was done for this research project, a very high level of reliability was noted between each pair of observers (reliability between pairs of observers was .82-.98) during the actual base line and data line observation periods. Reliability was computed on each of the four pairs of observers using all nine categories for each study participant.
Effects of the Observers on the Subjects' Behavior

Consideration had to be given to the effects of the observers on the behavior of the study group subjects. Experience gained from working with adolescents in the ICF suggests that the introduction of a "stranger" does little, if anything, in the way of altering behavior. It was found that very little time was needed for the residents of the ICF to become accustomed to the new persons in the cottage and to begin to act normally. According to Borg (1973), the effect of observers on the behavior of study subjects in most situations is short-lived.

It should be remembered that the focus of this study was not to test the effect of observers on behaviors exhibited by the residents of the ICF, but to test the effectiveness of one treatment modality against another.

Since the observers were present during both data gathering periods (base line and data line) and observed the same residents during the same period of the day (see the section describing the schedule of observations and recording of behaviors), the effect of observers on the behavior of the study participants was discounted.

Reliability of Observations

As was mentioned in the section on training of observers, a high rate of reliability or inter-rater agreement was obtained between each pair of observers. It was essential to the design of this study that a high degree of reliability existed between observers so that accurate interpretation of the
data could be made. Stuart (1970) and Mahoney (1974) found that inter-rater reliability is typically high during base line and data line data gathering periods and suggested the superiority of multiple raters over single observers. For these reasons, pairs of observers were used during all of the data gathering periods, and it was found that a high rate of inter-rater reliability could be obtained through this method.

Schedule of Data Collection

Each study participant was observed four times each day for 7 days. Each observation period during the day was 15 minutes in duration, making the total observation time 1 hour per subject per day, or a total of 7 total hours of observation during the base line and data line observation periods. The observers were on the cottage a total of 6 hours each day from 2:00 p.m. until 8:00 p.m. Each pair of observers was given four 15-minute breaks where they could do anything that they wanted or needed to do.

A rotating schedule of observation was devised so that each study participant was observed at the same time periods, during the same activity or situation, for each of the 7 days, for both base line and data line observation periods. For example, John Doe (study participant No. 1 of the E1 group) was observed at 2:00 p.m. and 5:00 p.m. by team one during "canteen time" and "group" time respectively, on Monday, the first day of observation. This participant was not only observed during these time slots and within these situations on Monday, day one of the base line period, but also on Monday,
day one of the data line period. This type of scheduling procedure was followed for several reasons.

(1) It was necessary to create an environment which was as close to being a laboratory as possible to reduce the threats to internal and external consistency. If subjects were found to have significantly reduced their negative display of behavior during the exact situation and time period when the negative behaviors were observed prior to treatment implementation, then an interpretation about the effectiveness of treatment alone could be made with greater confidence.

(2) It was necessary to insure that no one study subject was observed during one activity more than another and that all of the subjects had an equal opportunity (probability) to be observed during a certain activity as had any other study participant.

(3) It was necessary to negate the possibility of one study participant being observed during a certain time of the day more frequently than the other available times of the day. Because of scheduling, each subject was observed on a rotating basis, and all study subjects were observed with equal frequency during each of the available time slots.

It should be noted that a specific behavioral assessment device was devised for this study and was filled out by each observer for each subject during each day of observations. The instrument contained a list of the categories including specific examples of misbehaviors to be observed. Whenever an observer saw a subject manifesting any of the nine misbehaviors specified
for this study, he made a check on the behavioral assessment device and recorded the situation (recreation, group, free time, canteen, etc.) in which the behavior occurred (a more complete description of the assessment device used during the data collection periods can be seen in a following section on instrumentation).

Treatment

After base line data had been gathered, the treatment phase of the study was initiated. Essentially, two treatment approaches were begun at that time and continued for 6 treatment weeks.

The $E_1$ group received 6 weeks of intensive individual and group psychotherapy, along with recreational and vocational therapy. Each study participant of the $E_1$ group was seen once each day for 1 hour in individual counseling with either a psychologist, drug counselor, or member of the cottage staff. Each study subject of the $E_1$ group was involved in group therapy at least once per day. Some form of recreational and vocational activity was engaged in by each $E_1$ group participant. The philosophical approach used during either individual or group psychotherapy was left to the discretion of the respective counselor conducting each session. While no formal approach to therapy was employed with the members of the $E_1$ group, all of the staff were informed that no form of self-monitoring was to be employed with any of the $E_1$ group participants during the treatment phase of the research. Further, no specific feedback as to the progress of any
particular study participant of the E1 group was given during the treatment phase.

It should be pointed out at this point that the participants of the E1 group received intensive individual, group, and recreational/vocational therapy on a daily basis throughout the treatment period. With the exception of the training in the recognition of self-defeating behaviors and the actual self-monitoring exercises, the E1 group received as much therapy as did the subjects of the E2 group.

The second group of subjects (E2 group) began a 1-week training session in which they were taught to recognize their own self-defeating behaviors and began to monitor the number of times that they exhibited misbehaviors from category one (passive-withdrawal) each day for the entire 6-week period. Each of the E2 participants monitored only behaviors from the passive-withdrawal category because it was the category of highest frequency of misbehavior for both the E1 and E2 groups during the base line observation period. Each participant, then, was asked to monitor the number of times he used passive-withdrawal each day in a self-defeating or negative way. They recorded the frequency of misbehaviors for each day on a modified form of Cudney (1975) self-defeating behavior assessment form (see Instrument section). During the training of self-defeating behavior recognition, the E2 group monitored on a daily basis the number of times that they withdrew inappropriately, and this monitoring continued throughout the entire treatment phase of the research. At the end of each day, between the hours of 8:00 p.m. and
9:00 p.m., each $E_2$ group participant met with a member of the staff who went over his/her personal self-monitoring assessment sheet for that day. This was done to insure that each participant of the $E_2$ group filled out his self-monitoring device completely and accurately. At that time, the member of the staff gave the study participant feedback as to how he (the staff member) thought the subject's performance had been during the day. This was done to insure that the participants were being realistic in their assessments and were accurately recording the frequency of misbehavior.

During the training period in which the subjects were taught to recognize their own self-defeating behaviors, the $E_2$ group subjects were also receiving intensive individual, group, and recreational/vocational therapy on a daily basis. In addition to whatever the theoretical approach employed in therapy by the various counselors of $E_2$ group participants, they were encouraged to use the information being written on the self-monitoring assessment sheets by the study participants as much as possible in the therapy process.

**Data Line Observation Period**

At the end of the 6-week treatment period, data line observations were acquired using the same observers, and the same method as was employed for obtaining the base line data. Since the same observers were used during the data line observations period as were used during the gathering of base line data, training of observers was not deemed necessary the second time.
Instruments

A modified form of the behavioral check list which was developed by Cudney (1975) was employed by the participants of the $E_2$ group who used this device as a tool for monitoring their negative behaviors on a day-to-day basis (the self-monitoring behavior check list can be seen in the Appendix).

The device which was used by the observers during the gathering of base line and data line data was a checklist which allowed the observers to see what behaviors they were to monitor during each observation period and gave them an example of the type of behavioral manifestation to be noticed. This device also allowed the observers to record the situation under which the negative behavior was exhibited and to make appropriate comments as needed. For a complete description of the observers checklist see the Appendix.

Analysis

This study was designed to determine which of two treatment modalities might be considered to be most effective in reducing negative behaviors for institutionalized adolescents. Data available for analysis came from three specific groups of statistics.

(1) Each of the two groups of subjects were compared in terms of biographical information. This information was descriptive in nature and was presented as a means of showing homogeneity between subjects of both groups. Descriptive data was analyzed by means of chi square analysis and
in some cases which were not ameanable to chi square analysis, a t test was used. Such descriptive items as family background, months of institutionalization, substance abuse involvement, and other descriptive data were analyzed. This data was presented in this chapter.

(2) In order to determine whether or not either group showed a significant change in behavior "before" treatment as opposed to "after" treatment, a t test for dependent samples was used.

(3) The third analysis of data was designed to determine whether or not the two groups differed significantly from each other in the amount of change evidenced as a result of application of either of the two treatments. Essentially, this analysis showed whether or not one treatment modality could be considered more effective than another. The method used to determine whether or not mean change score for each group could be considered to be significantly different from each other $\left(\bar{x}_1 - \bar{x}_2 \neq 0\right)$, a t test for independent samples was used.
CHAPTER IV

Results

Analysis of Data

The results are presented in tabular form and will compare the $E_1$ group and $E_2$ group against themselves and against each other with respect to the frequency of manifestation of negative behaviors for both base line and data line periods.

The general hypothesis of the present study states:

The $E_1$ group (intensive individual, group, recreational/vocational therapy) will show significantly less change in the manifestations of negative behaviors than will the $E_2$ group (intensive individual, group, recreational/vocational therapy plus self-monitoring with training in the recognition of negative behaviors).

The specific sub-hypotheses related to the general hypothesis are:

1. The $E_1$ and $E_2$ group participants will not differ significantly from one another with regards to the frequency of misbehavior observed during the base line observation period.

2. No significant reduction in misbehavior will be found to exist for the $E_1$ group when the frequency of misbehavior for base line and data line observations are compared.
(3) The $E_2$ group participants will show a significantly greater reduction in the frequency of misbehaviors when base line and data line observations are compared than will the $E_1$ group participants.

(4) When the frequency of misbehavior for the data line observation period are compared for both groups, the $E_2$ group participants will show a significantly greater reduction in the frequency of misbehavior than will the $E_1$ group participants.

In order to test the above hypotheses, trained pairs of observers monitored participants of the study over two 7-day periods (base line = 7 days, data line = 7 days). Pairs of observers were used in order to compute the degree of reliability of observations being made. All pair of observations made by the four pairs of observers for all nine categories of misbehavior were assessed by means of the Pearson-Product-Moment test for reliability. The results of this computation revealed the reliability between observers to range from .82 to .98 for both base line and data line periods. The overall average reliability for all pairs of observers was .91.

As stated in Chapter III, both groups of subjects were monitored on the number of times they manifested any of nine specific negative behaviors in three general categories of behaviors as follows: (I) Passive-withdrawal: Obvious attempts to avoid any type of interpersonal interaction refusal to others when it would be appropriate to do so, or obvious attempts to create hostility in another individual through passive-aggressiveness; (II) Overt-hostility: any attempt to release frustration or to control another individual's
behavior by outbursts of physical aggression, use of verbal aggression to release frustration or to control another's behavior, or obvious, but subtle, attempts to release frustration or control others through self-destruction or non-verbal communication of hostility; (III) Manipulation of others: Obvious attempts to draw attention to one's self through immature or deviant behavior, obvious attempts to manipulate staff, or manipulation of others including parents or friends.

In order to determine whether or not either group of participants differed from each other in the frequency of behaviors manifested for either base line or data line, a t test for dependent and independent samples was used. The results of this analysis are as follows:

**Base Line Comparisons: E₁ Group Versus E₂ Group**

Sub-hypothesis (1) stated that no significant difference would be found to exist between the E₁ and E₂ group participants on the frequency of misbehaviors manifested during the base line period of observation. Table 11 gives a comparison between the two treatment groups with regards to the overall manifestation of negative behaviors in all three categories of misbehavior combined.

Table 11 shows that no significant difference existed between the two groups (E₁ and E₂) with regard to the total frequency of behavior for all three general categories combined. Both groups of participants were found to be virtually identical in the amount of misbehavior being exhibited on all of the
Table 11

Base Line Comparisons of the $E_1$ Group Versus $E_2$ Group for
the Three Categories of Misbehavior Combined

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tail probability</th>
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</table>

nine sub-categories of misbehavior. This finding lends credence to the notion that both groups were homogeneous in nature and tend to exhibit the same types of behaviors with equal frequency. An analysis of the three general categories and the nine specific sub-categories support the above findings.

Table 12 represents a comparison between the $E_1$ group participants and the $E_2$ group participants with respect to the base line data obtained for the three general categories of misbehavior (I. Passive-withdrawal; II. Overt-hostility; and, III. Manipulation).

As can be seen from Table 12, neither group differed significantly from each other with respect to the frequency of misbehaviors being manifested in the three general categories being observed. Table 13 further shows a comparison between the $E_1$ group and the $E_2$ group with respect to the nine specific sub-categories of misbehavior observed during the base line period.
Table 12
Comparisons of Base Line Data for the $E_1$ Group Versus the $E_2$ Group on the Three General Categories of Misbehavior

<table>
<thead>
<tr>
<th>Category I: Passive-Withdrawal</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>$t$ value</th>
<th>df</th>
<th>Probability</th>
</tr>
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<th>SD</th>
<th>$t$ value</th>
<th>df</th>
<th>Probability</th>
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<td>13.066</td>
<td>4.005</td>
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<td>0.058</td>
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<td>$E_2$</td>
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<td>17.383</td>
<td>5.382</td>
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<table>
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<th>Category III: Manipulation</th>
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<th>SD</th>
<th>$t$ value</th>
<th>df</th>
<th>Probability</th>
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<td>20.450</td>
<td>7.778</td>
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Table 13

Comparison of Base Line Data for the $E_1$ Group Versus the $E_2$ Group

on the Nine Specific Sub-Categories of Misbehavior

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
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</thead>
<tbody>
<tr>
<td>I-A (General withdrawal)</td>
<td></td>
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<td>$E_1$</td>
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<td>22.100</td>
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<tr>
<td>I-B (Withdrawal in groups)</td>
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<td>I-C (Passive-Aggressive Withdrawal)</td>
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<td>II-A (Fighting)</td>
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<td>$E_1$</td>
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<td>13.23</td>
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Sub-Category II-C (Self-Destructiveness)

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Sub-Category III-A (Manipulation of Peers)

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Sub-Category III-B (Manipulation of Staff)

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</tbody>
</table>

Sub-Category III-C (Manipulation of Others)

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<table>
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</tbody>
</table>

*Significant at the 0.05 level of confidence.*
The nine specific sub-categories are identified on pages 68-69. The base line data obtained for each sub-category is presented in the order which it appears on the preceding page.

Of the nine specific sub-categories represented in Table 13, all but one (sub-category II-A) did not differ significantly from each other. Sub-category II-A (overt-hostility: fighting) was found to show significant differences between the two groups, with the $E_1$ group showing a higher frequency of this behavior than the $E_2$ group. However, closer consideration of this difference revealed that one or two participants in each group manifested this behavior, indicating that this particular category did not satisfactorily represent the majority of participants for both groups. It was therefore concluded that while this sub-category was statistically significant, it was not representative of the entire sample for both groups. For this reason, the difference noted in this sub-category was discounted.

**Base Line Versus Data Line: $E_1$ Group**

Sub hypothesis (2) stated: No significant reduction in misbehavior will be found to exist for the $E_1$ group when the frequency of misbehavior for base line and data line observations are compared.

When comparisons were made between the frequency of misbehaviors for base line and data line for the $E_1$ group (intensive individual, group, recreational/vocational therapy), results varied. Table 14 shows the total (all
Table 14

Base Line Versus Data Line for all Categories Combined:

<table>
<thead>
<tr>
<th>E₁ Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Line</td>
<td>10</td>
<td>83.600</td>
<td>3.594</td>
<td>4.28</td>
<td>9</td>
<td>0.002**</td>
</tr>
<tr>
<td>Data Line</td>
<td>10</td>
<td>65.050</td>
<td>13.435</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Significant at the 0.01 level of confidence.

nine categories combined) amount of significant change from base line to data line for the E₁ group.

As can be seen from Table 14, the E₁ group subjects showed a significant reduction in the frequency of negative behaviors. This finding would suggest that the traditional approaches (individual, group, recreational and vocational therapy) being used in institutional settings may, for the most part, be effective in significantly reducing behaviors over a short period of time.

A closer examination of the data reveals the areas wherein the traditional psychotherapy approach wrought the greatest changes. Table 15 shows the differences between base line and data line misbehavior frequencies for the E₁ group in the three general categories of misbehavior being studied.
Table 15

Base Line Versus Data Line for the Three General Categories:

<table>
<thead>
<tr>
<th>E₁ Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category I (Passive-Withdrawal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>47.15</td>
<td>5.297</td>
<td></td>
<td>9</td>
<td>0.000**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>28.216</td>
<td>7.677</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category II (Overt-Hostility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>13.066</td>
<td>4.005</td>
<td></td>
<td>9</td>
<td>0.415</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>11.550</td>
<td>5.118</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category III (Manipulation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>23.380</td>
<td>5.965</td>
<td></td>
<td>9</td>
<td>0.512</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>25.283</td>
<td>13.043</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Significant at the 0.01 level of confidence.
Table 15 shows that of the three categories of misbehavior being studied, only one (Category I: Passive-withdrawal) showed a significant reduction in frequency of occurrence from base line to data line periods for the $E_1$ group. The possible reasons for this dramatic reduction in the frequency of misbehavior for Category I will be given in Chapter V. Nevertheless, the $E_1$ group did make significant reductions in the total number of times that they were engaged in passive and withdrawing behavior. Since this general category was the only category of the three to make a significant change between base line and data line periods, these behaviors alone may account for the overall significant reduction in behavior as is noted in Table 14 of this chapter.

Table 16 shows the change scores for each of the nine sub-categories of misbehaviors for the $E_1$ group before and after treatment.

Table 16 shows that when the frequency of misbehavior during base line period is compared to the frequency of misbehavior during data line period for the $E_1$ group, only three sub-categories of misbehavior were found to significantly differ (0.01 level) for those two observational periods. The three sub-categories which significantly differed after treatment were: I-A, general withdrawing behavior; I-B, withdrawal in groups; and, I-C, passive-aggressive withdrawal. In all three cases, the $E_1$ group participants showed a significant reduction in the manifestation of the above three mis-behaviors after treatment was applied.
Table 16

Base Line Versus Data Line for the Nine Specific Sub-Categories:

E1 Group

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-A (General Withdrawal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>21.316</td>
<td>2.633</td>
<td>4.99</td>
<td>9</td>
<td>0.001**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>14.166</td>
<td>4.905</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-B (Withdrawal in Groups)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>17.65</td>
<td>3.152</td>
<td>3.72</td>
<td>9</td>
<td>0.005**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>11.98</td>
<td>2.765</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-C (Passive-Aggressive Withdrawal)</td>
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<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>8.183</td>
<td>1.725</td>
<td>5.95</td>
<td>9</td>
<td>0.000**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>2.066</td>
<td>2.163</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II-A (Fighting)</td>
<td></td>
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</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>1.966</td>
<td>1.323</td>
<td>0.75</td>
<td>9</td>
<td>0.470</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>1.683</td>
<td>1.255</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II-B (Verbal Aggression)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>4.566</td>
<td>1.656</td>
<td>1.310</td>
<td>9</td>
<td>0.221</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>3.300</td>
<td>2.485</td>
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</tr>
</tbody>
</table>
Table 16
Continued

<table>
<thead>
<tr>
<th>Sub-Category II-C (Self-Destructiveness)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base line</td>
<td>10</td>
<td>6.533</td>
<td>3.620</td>
<td>0.04</td>
<td>9</td>
<td>0.971</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>6.566</td>
<td>3.741</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Category III-A (Manipulation of Peers)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base line</td>
<td>10</td>
<td>11.450</td>
<td>4.419</td>
<td>1.62</td>
<td>9</td>
<td>0.140</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>14.750</td>
<td>7.718</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Category III-B (Manipulation of Staff)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base line</td>
<td>10</td>
<td>9.933</td>
<td>2.718</td>
<td>0.46</td>
<td>9</td>
<td>0.654</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>9.316</td>
<td>5.966</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Category III-C (Manipulation of Others)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base line</td>
<td>10</td>
<td>2.000</td>
<td>1.349</td>
<td>1.470</td>
<td>9</td>
<td>0.176</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>1.216</td>
<td>1.618</td>
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</table>

**Significant at the 0.01 level of confidence.
Base Line Versus Data Line: $E_2$ Group

Sub-hypothesis (3) stated that after treatment the $E_2$ group will show a significantly greater reduction in the frequency of misbehaviors when base line observations are compared to data line observations.

In keeping with format, the following three tables will represent changes between base line and data line for the $E_2$ group as follows: (1) the change in frequency of misbehavior--base line versus data line--for all three categories combined (Table 17), (2) the change in frequency of misbehavior--base line versus data line--for the three general categories of misbehavior (Table 18), and, (3) the change in frequency of misbehavior--base line versus data line--for the nine specific sub-categories of misbehavior being observed for this study.

Table 17

<table>
<thead>
<tr>
<th>Base Line Versus Data Line for all Categories Combined: $E_2$ Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Base line</td>
</tr>
<tr>
<td>Data line</td>
</tr>
</tbody>
</table>

**Significant at the 0.01 level.

Table 17 shows that the $E_2$ group participants significantly reduced (0.01 level of confidence) the frequency of misbehavior in all of the categories
combined when base line observations are compared against data line observations. A further breakdown of the misbehavior into the three categories shows exactly which misbehaviors were most amenable to the application of self-monitoring plus training in the recognition of self-defeating behaviors.

Table 18 represents the change in misbehavior for the three general categories of misbehavior being treated.

Table 18

Base Line Versus Data Line for the Three General Categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category I: Passive-Withdrawal</td>
<td>Base line</td>
<td>10</td>
<td>46.100</td>
<td>4.453</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data line</td>
<td>10</td>
<td>6.05</td>
<td>4.762</td>
<td>29.73</td>
<td>9</td>
<td>0.000**</td>
</tr>
<tr>
<td>Category II: Overt-Hostility</td>
<td>Base line</td>
<td>10</td>
<td>17.383</td>
<td>5.382</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data line</td>
<td>10</td>
<td>6.183</td>
<td>6.190</td>
<td>3.88</td>
<td>9</td>
<td>0.004**</td>
</tr>
<tr>
<td>Category III: Manipulation</td>
<td>Base line</td>
<td>10</td>
<td>20.450</td>
<td>7.778</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data line</td>
<td>10</td>
<td>6.333</td>
<td>11.187</td>
<td>7.43</td>
<td>9</td>
<td>0.000**</td>
</tr>
</tbody>
</table>

**Significant at the 0.01 level of confidence.
Base line versus data line comparisons (Table 18) reveal that in all three categories of misbehavior, the $E_2$ group significantly reduced the frequency of misbehavior. Whereas, the $E_1$ group was noted to have reduced the frequency of misbehavior in only one of the three categories (Category I: Passive-withdrawal), the $E_2$ group participants showed dramatically significant reductions of misbehavior in all three categories. It should be remembered that only one category of misbehavior (Category I: Passive-withdrawal) was being self-monitored by the $E_2$ group participant, yet the significant reduction in all categories of misbehavior suggests a generalizing effect from one specific area of misbehavior to other inappropriate behaviors.

Table 19 gives a representation of the nine sub-categories and how the frequency of misbehavior during the base line period compares to the frequency of behavior during the data line period for the $E_2$ group participants.

Table 19 shows that when the frequency of misbehavior for the base line and data line periods are compared, the $E_2$ group made significant reductions in all but one of the nine sub-categories being monitored. The sub-category which did not show a significant reduction in frequency from base line to data line was sub-category II-A (Overt-Hostility, fighting). However, since this behavior was only engaged in by two participants of the $E_2$ group, this specific sub-category was not found to be sufficiently representative of the entire group and discounted as significant on these grounds. Close examination of Table 19 reveals the apparent magnitude of reduction in the frequency of the manifestation of the nine specific sub-categories of
Table 19

Base Line Versus Data Line for the Nine Specific Sub-Categories:

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>Base line</th>
<th>Data line</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-A (General Withdrawal)</td>
<td>10</td>
<td>10</td>
<td></td>
<td>22.100</td>
<td>2.237</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.37</td>
<td></td>
<td>9</td>
<td></td>
<td>0.000**</td>
</tr>
<tr>
<td>I-B (Withdrawal in Groups)</td>
<td>10</td>
<td>10</td>
<td></td>
<td>15.000</td>
<td>2.458</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.75</td>
<td></td>
<td>9</td>
<td></td>
<td>0.000**</td>
</tr>
<tr>
<td>I-C (Passive-Aggressive Withdrawal)</td>
<td>10</td>
<td>10</td>
<td></td>
<td>9.00</td>
<td>3.841</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.35</td>
<td></td>
<td>9</td>
<td></td>
<td>0.000**</td>
</tr>
<tr>
<td>II-A (Fighting)</td>
<td>10</td>
<td>10</td>
<td></td>
<td>0.776</td>
<td>0.725</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.47</td>
<td></td>
<td>9</td>
<td></td>
<td>0.175</td>
</tr>
<tr>
<td>II-B (Verbal Aggression)</td>
<td>10</td>
<td>10</td>
<td></td>
<td>6.283</td>
<td>3.882</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.51</td>
<td></td>
<td>9</td>
<td></td>
<td>0.033*</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 19
Continued

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>II-C (Self-Destructiveness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>10.333</td>
<td>5.748</td>
<td>2.34</td>
<td>9</td>
<td>0.044*</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>3.316</td>
<td>5.101</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III-A (Manipulation of Peers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>11.233</td>
<td>6.859</td>
<td>2.75</td>
<td>9</td>
<td>0.022*</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>4.433</td>
<td>5.738</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III-B (Manipulation of Staff)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>7.333</td>
<td>4.359</td>
<td>4.51</td>
<td>9</td>
<td>0.001**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>1.283</td>
<td>1.553</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III-C (Manipulation of Others)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>10</td>
<td>1.883</td>
<td>1.152</td>
<td>3.444</td>
<td>9</td>
<td>0.007**</td>
</tr>
<tr>
<td>Data line</td>
<td>10</td>
<td>0.616</td>
<td>1.116</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant at the 0.05 level of confidence.
**Significant at the 0.01 level of confidence.
misbehavior. Out of the nine sub-categories being monitored, eight showed a significant reduction in the frequency of misbehaviors being manifested, five of these were significant at the 0.01 level.

Since both the $E_1$ and $E_2$ group participants were found to have significantly reduced the frequency of manifesting negative behavior after treatment was applied (see Tables 14 and 17), it now becomes necessary to determine which group of subjects was able to make a greater reduction in manifestation of negative behaviors. This is determined by comparing the data line observations for both groups.

**Data Line Comparisons: $E_1$ Group Versus $E_2$ Group**

Sub-hypothesis (3) states: When data line observations for both groups are compared, the $E_2$ group participants will show a significantly greater overall reduction in the manifestations of misbehaviors than will the $E_1$ group participants.

The following section will compare the $E_1$ group against the $E_2$ group with regards to the frequency of misbehavior for the two groups after treatment was applied to both groups. Table 20 compares the two treatment groups with respect to the total frequency of misbehavior for all nine sub-categories within the three general categories of misbehaviors combined.

Table 20 shows that a significant difference (0.01 level of confidence) was found to exist between the $E_1$ group and the $E_2$ group participants with regard to the total frequency of misbehavior observed during the data line
Table 20

Data Line Comparisons of the $E_1$ Group Versus the $E_2$ Group for the Three Categories of Misbehavior Combined

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>65.05</td>
<td>13.435</td>
<td>-7.37</td>
<td>17.84</td>
<td>0.000**</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>18.566</td>
<td>14.757</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Significant at the 0.01 level of confidence.

Overall, the $E_2$ group had significantly lower occurrence of misbehavior than did the $E_1$ group. Again, even though both treatment groups had significant overall reductions in misbehavior (base line versus data line), the $E_2$ group had a significantly greater reduction of misbehavior overall than did the $E_1$ group. Owing to treatment alone, it would appear that intensive individual, group, recreational, and vocational therapy coupled with self-monitoring plus training in the recognition of negative behaviors, has more effect on the overall reducing of negative behaviors than does a treatment modality which employs only intensive individual, group, recreational, and vocational therapies.

Table 21 shows how both treatment groups compare to each other with regards to the three general categories of misbehavior.

As can be seen from Table 21, the $E_2$ group had significantly greater reductions of negative behaviors after treatment than did the $E_1$ group, for
Table 21
Comparisons of Data Line Data for the $E_1$ Group Versus the $E_2$ Group on the Three General Categories of Misbehavior

| Category I: Passive-Withdrawal | $E_1$ Group | 10 | 28.216 | 7.677 | 7.76 | 15.03 | 0.000** |
|                              | $E_2$ Group | 10 | 6.05   | 4.762 |

| Category II: Overt-Hostility  | $E_1$ Group | 10 | 11.550 | 5.118 | 2.11 | 17.39 | 0.050*  |
|                              | $E_2$ Group | 10 | 6.185  | 6.191 |

| Category III: Manipulation   | $E_1$ Group | 10 | 25.283 | 13.043 | 3.95 | 14.62 | 0.001** |
|                            | $E_2$ Group | 10 | 6.333  | 7.725 |

all of the three general categories of misbehaviors being observed. While only Category I (Passive-Withdrawal) was monitored by the $E_2$ group participants, all of the categories of misbehavior showed significant reduction when base line information was compared with data line information. The possible explanations for these results are given in Chapter V.
As an indication of how the two treatment groups compared to each other on the nine specific sub-categories of misbehavior during data line observation period, Table 22 is presented.

Table 22 shows that out of the nine specific sub-categories of misbehavior being studied, the $E_2$ group had a significantly lower frequency of misbehavior manifestation on six of the nine sub-scales being observed. Those sub-scales which were being monitored by the $E_2$ group (sub-scales I-A, I-B, and I-C) showed significantly greater reduction in the manifestation during the data line data collection period than did their $E_1$ group counterparts.
### Table 22

Comparison of Data Line Data for the $E_1$ Group Versus the $E_2$ Group

on the Nine Specific Sub-Categories of Misbehavior

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-A (General Withdrawal)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>14.166</td>
<td>4.905</td>
<td>4.41</td>
<td>17.37</td>
<td>0.000**</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>5.300</td>
<td>4.047</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-B (Withdrawal in Groups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>11.983</td>
<td>2.765</td>
<td>12.56</td>
<td>10.49</td>
<td>0.000**</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>0.550</td>
<td>0.790</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-C (Passive-Aggressive Withdrawal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>2.066</td>
<td>2.163</td>
<td>2.71</td>
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<td>0.024*</td>
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<td>0.200</td>
<td>0.219</td>
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<td></td>
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<tr>
<td>II-A (Fighting)</td>
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<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>1.683</td>
<td>1.255</td>
<td>3.26</td>
<td>11.41</td>
<td>0.007**</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>0.300</td>
<td>0.463</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>II-B (Verbal Aggression)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>3.300</td>
<td>2.485</td>
<td>0.66</td>
<td>18</td>
<td>0.519</td>
</tr>
<tr>
<td>$E_2$ Group</td>
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<td>2.566</td>
<td>2.505</td>
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</table>
### Table 22

Continued

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<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>df</th>
<th>Two-tailed probability</th>
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</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>6.566</td>
<td>3.741</td>
<td>1.62</td>
<td>16.51</td>
<td>0.123</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>3.316</td>
<td>5.101</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Category III-A (Manipulation of Peers)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>14.750</td>
<td>7.710</td>
<td>3.39</td>
<td>16.62</td>
<td>0.003*</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>4.433</td>
<td>5.738</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Category III-B (Manipulation of Staff)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>9.316</td>
<td>5.963</td>
<td>4.12</td>
<td>10.22</td>
<td>0.002**</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>1.283</td>
<td>1.553</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Category III-C (Manipulation of Others)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$E_1$ Group</td>
<td>10</td>
<td>1.216</td>
<td>1.618</td>
<td>0.97</td>
<td>15.99</td>
<td>0.349</td>
</tr>
<tr>
<td>$E_2$ Group</td>
<td>10</td>
<td>0.616</td>
<td>1.116</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Significant at the 0.05 level of confidence.

**Significant at the 0.01 level of confidence.
CHAPTER V

Discussion

It was the purpose of this study to compare the effectiveness of two treatment modalities in reducing the frequency of misbehavior being exhibited by residents of an Intermediate Care Facility in St. Anthony, Idaho. Two treatment groups were used for this study, both of which received intensive individual, group, recreational and vocational therapy with the second group (E₂) receiving training in the recognition of misbehavior and the monitoring of the same. It was expected that the treatment which utilized both traditional psychotherapy plus self-monitoring and training would yield the most significant and positive results.

Analysis of the data yielded results which were in the predicted direction. In order to understand the significance of the results obtained from the analysis of the data, a discussion will follow which (1) considers each treatment group with respect to the frequency and kind of behavior exhibited both before and after treatment, (2) discusses the similarities and contradictions in findings between the two treatment groups being studied, and, (3) gives possible explanations for the results which were obtained.

Findings Regarding Total of all Categories

When the two treatment groups (E₁ and E₂) are compared as to the total frequency of misbehavior (frequency of misbehavior in all nine
sub-categories of misbehavior combined) which was exhibited and recorded during the base line observation period, the following results emerge.

(1) No significant difference was found to exist between the two treatment groups with regards to the total frequency of misbehavior exhibited (see Table 11) during the base line observation period. This finding was in the expected direction and substantiated sub-hypothesis one. This finding further lends credence to the homogeneity between subjects that was suggested in Chapter III. The factors of homogeneity and random assignment to groups would seem to be the most likely explanation for non-significance between the two treatment groups for the overall frequency of misbehavior manifestation during the base line period.

(2) When the total frequency of misbehaviors for all the categories combined were compared--base line versus data line--both treatment groups showed a significant reduction in total frequency of misbehavior (see Tables 14 and 17). This finding suggests that both treatment modalities were effective in reducing the overall frequency of misbehavior exhibited by both groups. However, the intensity and extent of behavioral change for each group tends to be the critical issue in this study, and a comparison between groups during the data line period will determine which group had the greater overall change.

(3) When the $E_1$ and $E_2$ groups are compared for total frequency of misbehavior during the data line observation period, the $E_2$ group participants showed a significantly (0.01 level) greater reduction in the overall frequency of misbehavior than did the $E_1$ group participants substantiating sub-hypothesis
four. This finding suggests that a treatment modality which combines intensive individual, group, recreational and vocational therapy with self-monitoring and training, will have greater impact on reduction of the frequency of negative behaviors (this is true at least of the nine negative behaviors which were studied in the present research), than will a modality which employs only intensive individual, group, recreational and vocational therapy. It can be further noted that this finding substantiates the general hypothesis of the present study which stated that the $E_2$ group would show a significantly greater reduction in negative behaviors than would the $E_1$ group.

**Findings Regarding Three General Categories**

When the $E_1$ group participants are compared to the $E_2$ group participants on the three general categories of misbehavior during the base line observation period, the following is evident.

1. No difference was found to exist between the two groups. This result further substantiates hypothesis one in the expected direction.

2. When base line data is compared to data line data for the $E_1$ group, significance is only noted for one general category of misbehavior (Category I: Passive-Withdrawal). Whereas, when the same comparisons are made for the $E_2$ group, significant differences are noted in all three categories. This finding suggests that although the $E_2$ group self-monitored only behaviors associated with Category I during the 6-week treatment period, that this activity alone had a generalizing effect to other areas of the participant's
behavior (a more comprehensive explanation of the reason for the noted results will be given at the end of this discussion section).

(3) When both treatment groups were compared against each other with regard to the frequency of misbehavior in the three general categories for the data line period of observation, the $E_2$ group was found to show significantly (0.01 level) greater reduction in misbehavior for that observation period than did the $E_1$ group participants. This finding suggests the strength of the phenomenon observed when self-monitoring techniques are applied to the traditional psychotherapy approaches and varifies sub-hypothesis four in the expected direction.

**Findings Regarding the Nine Specific Sub-Categories**

When the $E_1$ and $E_2$ group participants are compared on the nine specific sub-categories of misbehavior, the following becomes evident.

(1) For all but one of the nine specific sub-categories of misbehavior being studied, no significant differences were noted between the two groups for the base line period of observation. The one category in which a difference was evidenced was Category II-A (Overt-Hostility: Fighting). The discrepancy in findings for this particular sub-category when compared to the other non-significant sub-categories, can be explained by the fact that only one or two participants actually engaged in this behavior during the base line period of observation. This lack of consistent and frequent behavior made this particular variable more susceptible to statistical error because of the low frequency of
occurrence. It was also found that this particular sub-category of misbehavior was not representative of all of the subjects all of the time. This is not to say that each of the residents of the ICF do not engage in this behavior, it is suggesting that the occurrence of this behavior may be more rare than was originally anticipated at the onset of this study. This finding substantiates sub-hypothesis one.

(2) When the $E_1$ group participants base line frequency of behavior is compared against its data line frequency, a significant change was only noted on three of the nine specific sub-categories. These three categories were Category I-A, I-B, and I-C. When the same comparison of base line versus data line frequencies for the $E_2$ group is made, it was found that the $E_2$ group made a significant reduction in all but one sub-category of misbehavior. Again, the sub-category which did not show significant reduction in behavior was sub-category II-A (Overt-Hostility: Fighting). The same explanation given previously for this sub-category would again seem to apply here. This finding substantiates sub-hypothesis two.

(3) When data line observations are compared for the $E_1$ and $E_2$ group participants, it was noted that the $E_2$ group showed a significantly greater reduction in the frequency of misbehavior in six of the nine sub-categories. All withdrawal behavior (Category I) was significantly lower for the $E_2$ group participants than for the $E_1$ group participants during the data line period of observation. Although both groups were shown to have made a significant reduction in their overall misbehavior, the $E_2$ group can be shown to
have made significantly greater reduction in the frequency of misbehavior overall, and in more specific areas of misbehavior than can the \( E_1 \) group. For this reason, the general hypothesis of the study was excepted in the expected direction.

**Explanation of the Results**

Now that the results have been presented, some general questions arise as a result of the findings. First, why did the \( E_2 \) group participants show significantly greater reduction in the frequency of misbehavior than the \( E_1 \) group in all three categories of misbehavior and not just Category I—Passive-Withdrawal—the category of misbehavior that this group was self-monitoring? Second, why did the \( E_1 \) group participants show a significant reduction in withdrawing behavior (Category I) and not in other categories of misbehavior? And, third, why did the \( E_2 \) group show greater overall change in misbehavior than did the \( E_1 \) group?

1. Several possible explanations might be given in answer of the first question. It appears that three major factors were effective in producing the results that were noted, i.e., the \( E_2 \) group significantly reduced the frequency of misbehavior in all three categories of misbehavior and not just Category I, the category which was being monitored during the treatment period. The first of these factors seems to be the effect of generalization. Success in reducing one negative behavior within an institution may indeed lead to reducing several. This feeling of success in being able to monitor
change in one's behavior may have strong reinforcing effects, and may lead the participant to become aware of and change other aspects of his behavior which he, himself, perceives as negative.

A second possible explanation for this generalization effect may be the result of the training on the participants of the $E_2$ group. During this training period, the participants were taught to recognize a large variety of negative behaviors, and they may have equated these negative behaviors to themselves and felt a need to change.

A third explanation seems to lie in the concept of immediate feedback and self-reward. As was mentioned in the Review of Literature chapter, SM tends to not only provide a person with immediate feedback relative to his own performance, but tends to be reinforcing when the person sees himself changing. This internal and subjective reinforcement may create within the client, increased feelings of self-worth and a greater desire to improve in several aspects of his behavior.

(2) When consideration is given to the second querie regarding the significant reduction in withdrawal (Category I) behavior for the $E_1$ group without reducing the frequency of misbehavior in any of the other two categories, two explanations seem appropriate. First, the $E_1$ group's successful reduction in the frequency in Category I behaviors seems best explained by the fact of intercommunication between treatment groups. In other words, the $E_2$ group tells participants of the $E_1$ group that they are monitoring the number of times in which they use passive and withdrawing behavior. This
may then have triggered a need on the part of the $E_1$ group participants to change the amount of withdrawing that they engaged in. The $E_1$ group may have felt that the staff of the ICF was particularly displeased with withdrawal and may have come to believe that any privileges within the ICF was contingent on their active participation. Without the reinforcing and self-concept improving effects of self-monitoring, there was no generalization to other behaviors of a negative nature, as was true in the case of the $E_2$ group participants.

Second, it may be that reduction in withdrawing behavior for both groups could be accounted for by the natural process of getting acquainted with peers, staff, and the institution. This explanation seems less likely because all of the study subjects were in the institution for nearly the same length of time and had from 2 to 3 months to become acquainted prior to the study.

(3) The overall greater change in behavior of the $E_2$ group participants as compared to the $E_1$ group must be attributed to the combination of intensive individual, group, recreational/vocational therapy, coupled with self-monitoring plus the training in the recognition of misbehavior treatment approach. This combined treatment approach tended to improve feelings of self-worth (this is not statistically validated) and success, provided immediate feedback and reinforcement for changing negative behaviors and generalized to other aspects of negative behaviors, resulting in their reduction and the replacement of more productive and positive behaviors.
Significant Findings of the Study

(1) Self-monitoring plus training in the recognition of misbehavior coupled with intensive individual, group, and recreational/vocational therapy was more effective in reducing the frequency of misbehaviors of institutionalized adolescents than was a treatment approach which employed only intensive individual, group, and recreational/vocational therapy.

(2) Self-monitoring tends to provide immediate feedback to the person monitoring his behavior, provides internal reinforcement when behaviors are changed, and may lead to feelings of accomplishment and increased feelings of self-worth.

(3) Self-monitoring of one behavior and the successful reduction of the frequency of that behavior may have a generalizing effect on other behaviors and lead to their reduction.

(4) In an institutional setting, when a small group of persons are asked to monitor certain behaviors and begin to reduce the frequency of those behaviors, others who are not asked to monitor may follow suit because of the communication network which exists in institutions.

Limitations of the Study

One of the major limitations of this study is the inability to control the inter-communication between groups of subjects. For this reason, we cannot be certain that the reduction of misbehavior that was noted in the $E_1$ group (on Category I) was due, in fact, to treatment (intensive individual,
group, recreational and vocational therapy) or whether it was due to their learning that the $E_2$ group was supposedly expected to decrease the frequency of withdrawal behavior and therefore, they too were supposed to reduce the frequency of the same types of behavior. The $E_1$ group may have "picked up" the notion that the staff expected everyone to reduce the amount of withdrawal behavior that was being exhibited. At any rate, we cannot be certain as to the cause of behavioral change in the $E_1$ group since if the change were due to the application of treatment, we would expect to see changes in other categories of misbehavior.

Another limitation of the present study is the time factor. For this study, a treatment period of 6 weeks was chosen. However, during the implementation of treatment, it became apparent to several members of the staff that some immediate effects to self-monitoring had occurred. Some residents made dramatic changes within the first 2 weeks of the study. It may well have been more effective to reduce the time period of the treatment phase of this study to determine the more immediate effects that self-control principles have on reducing inappropriate behaviors.

Another obvious limitation to this study is the fact that we are dealing with a very select group of individuals. The findings of this study can only be applied to institutionalized adolescents in Idaho, and may, therefore, not apply to adolescents in general or for institutionalized adolescents of other states or in institutions which employ other forms of treatment approaches than the one referred to in this study.
Recommendations for Further Research

(1) The present study should be repeated using similar types of institutionalized adolescents and compare the same two types of treatment modalities. During the repeat study, three treatment groups might be compared. The first group would receive only individual, group, recreational and vocational therapy, the second would receive individual, group, recreational and vocational therapy coupled with self-monitoring, and the third would receive a combination of intensive individual, group, recreational and vocational therapy coupled with self-monitoring and training in the reduction of misbehaviors. This would allow the experimenter to determine singularly, the effects of traditional psychotherapies versus the effects of self-monitoring versus the effects of training in the recognition of inappropriate behaviors.

(2) Further investigation should be given to the concept of intermittent monitoring among adolescents. This suggests that intermittent schedules for self-monitoring may very well be as effective as self-monitoring on a daily basis. A similar design might be employed as was used in the present study with the exception of a third group which monitored their behavior on an intermittent schedule rather than daily.

(3) A longitudinal follow-up study should be done on the present study to determine how permanent the behavior change may be. This would provide significant insight into the long-range effects of self-monitoring and provide new insight into the direction that therapy should take when dealing with institutionalized adolescents.
CHAPTER VI

Summary

The effectiveness of self-control techniques in significantly altering certain types of behavior has been demonstrated numerous times. Likewise, the traditional psychotherapeutic approaches of individual and group psychotherapy has yielded mixed results. The purpose of the present study was to compare the relative effectiveness of two treatment modalities at the St. Anthony, Idaho, Intermediate Care Facility for emotionally disturbed adolescents. The two treatment modalities which were compared were (1) intensive individual, group, recreational, and vocational therapy, and (2) intensive individual, group, recreational, and vocational therapy coupled with self-monitoring plus training in the recognition of inappropriate behaviors.

Of the 24 residents of the Intermediate Care Facility (ICF) at St. Anthony, Idaho, 20 adolescents participated in the study. These subjects were found to be homogeneous with regard to age, family background, emotional disturbance, type of offense leading to institutionalization, and they were randomly assigned to one of either two treatment groups. Each treatment group had 10 subjects in each.

Not only were the subjects considered homogeneous with respect to their idiographic backgrounds, but they were also considered homogeneous in the types of behaviors which they typically exhibited. Because most subjects
who enter the ICF exhibit similar behaviors to every other resident, these behaviors were identified and used as a means of determining whether or not one particular treatment modality was more effective in reducing these specific misbehaviors. The behaviors which were seen to be typically manifested by this group of adolescents were categorized into three general categories of misbehavior. Under each of the three general categories, three specific behavioral manifestations representing each category were identified. These three general categories and specific sub-categories were as follows:

Category I: Passive-Withdrawal

I-A. General withdrawal. Attempts to avoid any interpersonal contact or interchange.

I-B. Withdrawal in group. Refusal to relate to others when it would be appropriate to do so.

I-C. Passive-aggressive withdrawal. Obvious attempts to create hostility in another by means of passivity.

Category II: Overt-Hostility

II-A. Physical aggression. Attempts to release frustrations or control another individual's behavior by outbursts of physical aggression.

II-B. Verbal aggression. Attempts to release frustration or control another individual's behavior by verbal abusiveness.

Category III: Manipulation

III-A. Manipulation of peers.

III-B. Manipulation of staff.

III-C. Manipulation of others such as visitors, parents, etc.

Sub-categories I-A, through and including III-C represent the specific misbehaviors which were observed and used as the criterion for change between the two groups--pre-treatment frequency of misbehavior versus post-treatment frequency of misbehavior.

The study was performed over an 8-week period. One week was used to gather base line data, 6 weeks consisted of treatment intervention, and 1 week after treatment was used to gather data line data. The data for both base line and data line periods was collected by trained pairs of observers. The reliability of observations being made ranged from .82 to .98 for both base line and data line observation periods.

During the treatment phase of the study, the $E_1$ group participants received only intensive individual, group, and recreational/vocational therapy while the $E_2$ group received daily intensive individual, group, and recreational/vocational therapy coupled with self-monitoring and training. The training phase of the study was conducted for the first 5 days of the treatment period and occurred concurrently with self-monitoring. The $E_2$ group subjects were
asked to monitor only the number of times that they were consciously withdrawing in their particular environment.

A t test for dependent and independent samples yielded significant results in the expected direction. Both the $E_1$ group and the $E_2$ group participants showed a significant reduction in the overall frequency of misbehavior when base line and data line data for each group was compared separately, however, the $E_2$ group participants had a significantly greater reduction in the overall frequency of misbehaviors for all categories than did the $E_1$ group participants.

The possible explanations for the significant difference between groups seems to be (1) the immediate feedback aspect of monitoring one's own behavior on a daily basis; any change in behavior is going to be fed back soon enough to have reinforcing elements to it; (2) changes in behaviors for the better tend to be positively reinforcing. This immediate reinforcement may lead to increased desire to try new forms of behavior and to abandon less productive behaviors, and, (3) success in changing one behavior may generalize to other behaviors and may have a multiplying effect on altering a person's behavior. These phenomenon raise further questions for further research in the use of self-monitoring techniques.

The results of this study seem to indicate that intensive individual, group, and recreational/vocational therapy coupled with self-monitoring and training in the recognition of inappropriate behavior is significantly more effective in reducing the frequency of misbehaviors in institutionalized
adolescents than is a treatment modality which employs intensive individual, group, recreational, and vocational therapy alone.
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NAME: ____________________

Behavioral Assessment

(1) What is the specific self-defeating behavior you are trying to change? Please be very specific.

(2) How often did you engage in this behavior today?
   
   0  1  2  3  4  5  6  7  8  9  10

(3) How did you engage in this behavior today?

(4) What, if anything, caused you to behave as you did?

(5) How might you have avoided this behavior?

(6) How did you feel when you behaved this way?

(7) Did you avoid displaying this behavior?
   
   How many times_______

(8) (Staff Conference) How much do your observations agree with the staff?

Are you changing?
NAME ____________________________ TIME ONE ___ FREQUENCY  

NAME ____________________________ TIME TWO ___  

OBSERVER'S NAME ____________________________  

PASSIVE WITHDRAWAL  
1. Attempts to avoid any interpersonal interchange. EXAMPLE: hiding, removing one's self to remote areas, sleeping to avoid contact, daydreaming, and prolonged fantasizing.  

2. Refusal to relate to others when appropriate to do so. EXAMPLE: use of shyness, refusal to talk in group or individual situations, and using daydreaming or listlessness to avoid communication with others.  

3. Obvious attempts to create hostility in another individual through passive-aggressivity. EXAMPLE: when being talked to, refuses to answer or given non-sense responses.  

OVERT-HOSTILITY  
1. Attempts to release frustrations or control another individual's behavior by outbursts of physical aggression. EXAMPLE: fighting or threatening to fight.  

2. Use of verbal aggression to release frustration or to control another's behavior. EXAMPLE: rapid, abusive, and usually vulgar use of language: verbal accusations, threats, name-calling, or yelling and screaming.  

3. Obvious, but subtle, attempts to release frustration or control others through self destruction: or nonverbal communication of hostility. EXAMPLE: head-banging, wrist-slashing, or rumination.
1. Obvious attempt to draw attention to one's self through immature or deviant behavior. EXAMPLE: "Macho" speech, tough-guy/girl role going along with crowd, or buying friends.

2. Obvious attempts to manipulate staff. EXAMPLE: playing staff against staff, use of "sweet talk" to get own way, deviant acts to get special privileges.

3. Manipulation of parents or legal guardian. EXAMPLE: communications which suggest the need for preferential treatment including early release, special visits, or sending contraband.
Objectives:

1. To provide each participant the opportunity to get acquainted with the trainer and each other participant of the training group.

2. To explain the overall goals of the SDB training group.

3. To explain how training group participants may try to defeat the workshop (see hand-out #1 which follows).

4. To give each participant the opportunity of identifying his own Self-defeating-behaviors (see hand-out #2 which follows).

5. To give each participant an understanding of what Self-defeating-behaviors are and how to overcome them (see hand-out #3 which follows).

Trainers Outline:

1. After a brief (5 minute) introduction session, the instructor gave the participants of the training group a simplified layout of what the major goals of the workshop were to be. Essentially these goals were:

   a. To teach each participant the concept of Self-defeating-behavior, in five sessions.

   b. To allow each participant the opportunity of identifying his own Self-defeating-behavior.

   c. To give each participant the skills necessary to eliminate their own Self-defeating-behaviors.

2. After the initial introductions and explanation of goals were given, the trainer gives each participant hand-outs 1-3.
DEFEATING THE WORKSHOP  Hand-out #1

The participants were instructed by the trainer that sometimes during training in SDB some people try to defeat it in an attempt to keep their SDB behavior. One way people defeat the training is by using the SDB that they came to the workshop to change. For example, if a participant came to change procrastination, they undoubtedly will use that behavior in the workshop to defeat it. If they came to the training to change inferiority, they probably will use that. If they depress themselves often, they could do that in the workshop. If they use blaming to keep this SDB, they can blame in the training.

During the workshop participants are given opportunities to share how they are trying to defeat it. It not only helps them if they will be open about this, but it helps others as well. Not being open about how they are defeating the workshop is a method to defeat it too. By getting their method of trying to defeat the workshop out in the open, they will have a chance to see it in a new light and receive data about it that they did not have before; and this will help them be less defeating.

Following is a partial list of way other persons have tried to defeat training: The list is shared with participants in hopes that it will help them eliminate their Self-defeating-behavior.

1. To withhold important data from the program that is needed to bring about change.
2. To put the responsibility for change entirely on others.
3. To be non-committal to the change program.
4. Not to fulfill the assignments given in the workshop.
5. When something that has to be done to change becomes very clear, not to go ahead and do it.
6. To use various means of defeating the change program as a way of feeling legitimate about getting discouraged and giving up.
7. To be inattentive to the parts of the program.
8. To avoid anxiety laden data inside oneself. To avoid risk.
9. To maintain an attitude that change is impossible.
10. To use techniques that will defeat the change process, like daydreaming, and to be inattentive to the use of the techniques.
11. To believe that something worse will happen if the SDB is given up.
12. Part way through the program to forget the SDB trying to be changed.
13. To talk about various subjects in the workshop (which may be of real interest) that are irrelevant to the change process and are used to get in the way.
14. To see the group as uncaring (which it might be) because others are working on their own behavior, and use this reality as a reason for retreating from the program.
15. To have been involved in a change program in the past, to have defeated that, and then use this as a buffer against change in this program.

16. To approach the workshop with the notion that the learnings will be applied later and nothing really done now to change.

17. To focus on Why the behavior is kept going rather than How it is kept going.

18. To see someone else actually change and to deny that the change occurred. By minimizing the potency of the workshop, one can have an excuse not to get involved.

19. To imagine that the time taken to change will inconvenience others.

20. To write down ideas that are important and not to do anything about them.

21. To be writing down ideas, smoking, doodling, etc., as a way of distracting oneself from getting information that will help one let the SDB go.

22. To get sleepy in this change program and not own up to how the sleepiness was created. Being sleepy serves the purpose of closing one off to data that can bring change.

23. To focus on another person as a way of avoiding self.

24. To go into a trance to keep the behavior, if all of one's past ways of keeping the SDB does not work.

25. To make honest progress, legitimately feel better, and then to drop out before full change occurs.

26. To keep bringing up examples that have some connection to the SDB, but to make sure they are not right on the money.

27. To avoid being responsible for a behavior by maintaining an aura of mysticism or a religious flavor around it, and then see the SDB as something beyond one's control.

28. To seek closeness with change leaders as a way of avoiding change within oneself.

29. To pray to God that he will help change the SDB. Then not do anything to help oneself.

30. To work hard at understanding some concepts such as the prices paid for keeping the behavior or the techniques used, but not to get a clear understanding of another concept such as choice.

31. When someone else uses a technique to keep a SDB to commend him for it. The person hopes that doing this will help him be able to use the technique should he want to.

32. To get close to something important in oneself and then not be able to comprehend what this close thing is. Or, to get close to anxiety feelings and then make them unreal.

33. To identify specific things that need to be done to change, but not do anything by saying that all of the angles regarding the behavior have not been explored yet.

34. To keep oneself as an observer of the program rather than a full participant.

35. When one has something important to be said, to keep it to self.
36. To take on all sorts of other tasks while the workshop is on as a way of
not having to concentrate on letting the behavior go.
37. To make the workshop a frightening experience in one's mind.
38. To believe that one's SDB is so much more severe than everyone else's
and use this to back out.
39. To convince self that the SDB chosen to change is not severe enough to take
up workshop time.
40. Et cetera.

The trainer then explains the following:

Although all of you in this workshop want to let yourself-defeating behaviors go,
please understand that for most people there is a scariness connected to letting
the SDBs go. Thus, they try to hang onto their SDBs even when they are in a
change program.

The more you are open to ways you try to defeat the workshop, the greater chance
you will have of achieving a full behavior change.
The trainer asks each participant to take five minutes and mark behaviors which he uses to defeat himself as follows:

- Inferiority feelings
- Negative self-concept
- Fear of failure
- Perfectionism
- Over-dependency
- Lack of motivation
- Withdrawal
- Feelings of hatred
- Alcoholism
- Excessive worry
- Alienation of others
- Inability to finish tasks
- Depressions
- Feelings of loneliness
- Avoidance of responsibility
- Fear of hurting others
- Drug abuse
- Inability to concentrate
- Inability to be open with loved ones
- Difficulty in making friends
- Inability to organize self on job
- Unhappiness in job
- Inability to communicate with parents
- Folding up under pressure
- Temper
- Defensiveness
- Negativism
- Inability to say no
- Authority hand-ups
- Insomnia
- Inability to talk in a group
- Fear of being oneself
- Always feeling pushed by something
- Unhappiness created by oneself
- Fear of commitment
- Excessive jealousy
- Lack of confidence in oneself
- Fear of rejection
- Extreme nervousness

When the residents have identified behaviors which they use to defeat themselves, the trainer then reads through the following information, after which discussion from each participant is encouraged by the trainer to facilitate optimum understanding of lesson I.
Self-defeating behaviors: Something the person does to himself but disowns the fact that he does it

Self-defeating behaviors are conceived to decrease the anxiety experienced because the culture is not sensitive to the way people (living things) creatively grow and develop. In essence, SDB's are a human's way to cope with the world when just reacting naturally as oneself does not bring satisfactory results. People develop SDB's to cope with rejection, loneliness, fear and hostility, as well as the anxiety produced in being different or by being given wrong information by the culture.

To change a SDB it is crucial to understand that once a self-defeating behavior is established, the person must fully take over the responsibility of doing the behavior or it would not continue. SDB's can never become an integrated part of a person. They must be fed and nurtured and constantly used to keep them alive. As a person goes from one moment of his life to another, self-defeating behaviors do not automatically go with him. The person does the SDB to himself, and to that extent is his own worst enemy. People that change their behavior always come to realize that nothing else or nobody else is responsible for the behavior.

Some people will say, "I know I do the SDB but that does not help." What they may be aware of is the outer behavior (eating, withdrawing, putting someone else down, not studying) but not realize that the inner feelings and thoughts behind the behavior are something the person does to himself, too.

Self-defeating behaviors are not a condition people have, a sickness plaguing them, nor an ingrained automatic response. Self-defeating behaviors are not even something people have to get rid of. The truth of the matter is that these behaviors are ways of responding that people have to quit using. If a person would not respond in a self-defeating way, there would be no self-defeating behavior.

If you want to quit using your SDB, begin by watching yourself do it and identify to yourself how expert you are at it. If you do not identify all your ways of doing this SDB, you will not really own up to the fact that you are the doer of it. If you put the responsibility for this behavior outside of yourself, you will be helpless to change, because you will have the feeling it is being done to you rather than you are doing it to yourself.

All people that do use SDB's have ways to disown the fact they are doing it. In other words, a person does the SDB entirely but tries to put the responsibility for it any place but on his shoulders.
Blaming is the most common way to disown responsibility. One can blame others, society, the past, and things. One can even blame himself or a part of himself, and in so doing avoid the responsibility for his SDB. When people blame something else they usually do it in such a way so as to deceive even themselves. For instance, they will look at society and see something wrong and tack on to that wrongness the responsibility for what they do to themselves. Or, if they blame their parents, or spouse, or children, they will identify weaknesses in the others and use that as a way to disown what they do. An example of that could be, "Well, if my parents would not keep harping at me, I would be able to relax and study more." What they fail to realize is that their parents may harp at them, but it is what they do with their parents responses to them that causes SDB troubles.

Following are some disowning statements that former workshop participants have made, along with my comments in parentheses. They are included to help you understand this lesson and help you to identify the ways you disown.

1. He put me down and gave me an inferiority complex. (It's his fault I feel inferior.)

2. My homosexuality is imbedded in me. (If it is imbedded in me, then I'm not responsible for doing it.)

3. My SDB is an automatic reflex. (It just happens--I can't help it.)

4. That's just the way I am. (A good excuse to continue doing my SDB by making myself think it is a part of my make-up.)

5. I get relapses. (Instead of owning up to what I do to make a relapse happen.)

6. In social situations I become tense. (To say I become tense as though it just happens and to blame the situation for my tenseness.)

7. I find myself depressed. (Without owning up to what I do to get myself depressed.)

8. Something won't let me do what I want to do. (I am helpless--something else is doing it to me.)

9. I just lost my concentration. (Instead of clearly seeing what was done to spoil concentration.)

10. Then I began to worry out of thin air. (It just happened--I didn't have anything to do with it.)
11. I would like to drop the anxiety. (Instead of realizing the anxiety is created. If anxiety was not created it would not have to be dropped.)

12. It got so bad in the group I had to leave. (Blame one's up-tightness on the group.)

13. My SDB has happened a few times. (Sort of saying it just happened instead of admitting what was done to bring it about.)

14. I cannot control my feeling. (Therefore, I cannot be held responsible.)

15. Because of a headache I could not wait up for my husband. (Put it on the headache.)

16. The devil made me do it. (It was not me that caused the SDB.)

17. It's God's wish. (It wasn't me that wanted to do it.)

18. If my parents would not be like they are, everything would be okay. (It's not me; it's my parents.)

19. I always work best under pressure. (Give the responsibility to work best over to pressure rather than to keep it on oneself.)

20. I prayed that I would do the right thing. (Go outside of oneself to ask for direction rather than to decide for oneself what is right and do it.)

Life continues to offer people new moments of living. These moments can be filled with self-defeating or creative responses. If you desire the creative route, you need to begin by fully taking the responsibility for your own behavior. Begin by doing two things:

(1) Watch yourself do the SDB and become aware of how really expert you are at accomplishing the behavior.

(2) Make a list of the ways you disown and add to the list as you discover new ways.
Training in Self-defeating-behavior Concept: Day 2

Objectives:

1. To give each person an understanding of the prices which are paid by the human organism to keep and maintain Self-defeating-behaviors.

2. To give each person the opportunity of identifying the prices which he pays to maintain his own Self-defeating-behaviors.

Trainer Outline:

1. After the instructor gives the participants of the group the opportunity to respond to the experiences gained from the first day of training, he introduces the training for the day, and gives each person hand-out #4.

2. The trainer reads with the group hand-out #4, and opens the group for discussion about how each person pays prices for maintaining Self-defeating-behaviors.
The prices paid for maintaining SDB's

To appreciate fully this price concept, one would have to understand on a deep psychic level the penalty living things pay for using behaviors that interfere with their functioning. Humans are made to perform as a whole system and when people utilize self-defeating behaviors to cope with their world, they interfere with the harmonious operation of their creative human system.

Not only is a person made to function best as a whole, but so is the culture in which he lives, the world that his culture is part of, and the universe from which they all spring. Thus, when people use SDB's, they pay a very deep price within themselves; and in ways that are not easily detected, so do immediate family, friends, city, state, country, world, and the universe beyond. To clog up any part of the creative works of something is to interfere in some way with the whole system.

Using self-defeating behaviors is the same as maintaining a death system within one's self. SDB's kill energy, destroy joy, consume time, destroy spontaneity, ruin relationships, contribute to poor health, cost money to maintain, and interfere with growth.

People that keep using self-defeating behaviors report some degree of unhappiness within themselves, an awful feeling of not being in full control of their lives, and a growing tiredness that piles up as the behavior is continually used. Workshop participants that completely drop their defeating behaviors report a joy and a delight in being themselves, more meaning and peace within, an ability to love more deeply, an eagerness for a new moment of living to come along, and a sense of freedom and control that comes from being at the helm of one's own life. In essence what they are saying is this: When I used self-defeating behaviors, I paid some very deep prices; it was only after I let the behaviors go that life opened up for me and I could then truly see what the behaviors cost me.

Most people, especially those that get involved in a change program, have some understanding of the costs for maintaining self-defeating behaviors. However, people have their reasons for starting to use and continuing to use these behaviors, and to let them go they need to deepen their understanding of the prices paid as defeating behaviors are used.

When people get to the point of letting the SDB go and cannot seem to make the change, it is often because they have not fully owned up to this concept. This concept, like the others, is easy to understand, but it must be internalized until you not only understand the prices, but feel them as well.
The following scale is useful in understanding this concept and the importance of it. As long as people use their SDB, they are saying they are better off with the behavior than without it. Honestly facing the many prices will help tip the scale.

The prices for using self-defeating behaviors fall into two categories. The first category consists of the actual results that come about from using the behavior and the other category consists of those positive experiences missed as the behavior is used.

**Category I - Actual Results**

1. Inability to be fully happy with self
2. Depression
3. Impaired relationships
4. Living with fear
5. Poor health and early death
6. Unnecessary expenditure of money
7. A giving-up-kind-of-tiredness from carrying around a SDB.
8. Contributing to hurt in others and getting in the way of their growth.
9. Death of energy, time, and spontaneity.
10. Shame with self as the behavior is used.
11. Negative contributions (if only in very tiny ways) to all of the systems one is part of: family, church, school, city, country, world, universe.
12. Loss of full control over one's life.
13. An inability to fully know oneself as a person.
14. Et cetera

Category II - What is Missed

1. Increased time and energy to do important things
2. An ability to accept self as a person and being happy with just that
3. More meaning and peace within
4. A deeper ability to love
5. Eagerness for a new day to dawn and looking forward to new unknown moments of living
6. An ability to live in the now, fully, without holding back
7. A sense of freedom by being at the helm of one's own life
8. Increased production at work, home, and at play
9. Openess to growth
10. An ability to experience in a life-giving manner the full range of emotions from joy to grief
11. A positive impact on the lifes of others
12. Et cetera

To help yourself change your should identify the prices you pay for maintaining your SDB and add to your list as you become aware of new prices.
Training in Self-defeating-behavior: Day 3

Objectives:

1. To introduce each person to the concept of choice in determining whether or not they will engage in Self-defeating-behaviors.

2. To help each participant recognize the choices he is making.

3. To help each participant learn to control the choices that they make and learn to respond differently to situations which typically elicit SDB's.

4. To help each participant face the fears experienced when a non-SDB choice is made in situations where SDB choice was made before.

Trainer Outline:

1. This training session is in lecture form, wherein instructor using hand-out #5 helps the participant learn the difference between internally controlled choices and externally controlled choices.

2. The instructor reads and explains hand-out #5 and then discusses the concepts with the participants.
Internal and External Choice

A self-defeating behavior does not happen on its own. Each time a SDB is used, a choice is required to activate it, and repetitive choices are needed to keep it going. The following diagram will help you to understand this.

In the above diagram the person decided to use his SDB when he was confronted with his situation. At any moment after the SDB was activated, he could decide not to use it, but he continues choosing to respond in the SDB pattern moment after moment.

It is important to distinguish between two areas of choices. The inner choice is made when people are confronted with a situation that demands a response. The choice there is always, "Will I respond just as me without any defeating behaviors, or will I undermine myself by not responding as my best and most complete self?" This inner choice is connected to daring to be completely one's best in a moment of living. For instance: Do I dare test out my
intelligence? Do I dare see just how adequate I am as a male or female? Do I dare put my ability as a writer, painter, student, parent, or worker on the line? Do I dare test myself out as a lone person?

Once the inner choice is made, the stage is set for the outer choices which are needed to carry out the inner decision. If it is that the person will not test his intelligence, then he needs to make decisions to put tasks off, not finish assignments, and only do a partial job in situations that test his ability. If his inner decision is that he will not trust his own judgment on something, outer choices are required to manipulate other people to decide for him. If an inner choice is, "I'll not be as attractive a woman as I can be," then outer choices are needed to take on excessive weight, maintain hostility, misinterpret how other people respond, and so on.

The inner choice is recognizable from its outer manifestations. If a person continually defeats himself in areas that require him to use his intelligence, his inner choice is to avoid seeing how intelligent he is. By alienating members of the opposite sex, one can avoid testing his sexual adequacy. Using behaviors to withdraw and avoid other people keeps one from seeing how acceptable he is to others. By being dependent on the ideas of others, a person chooses not to find out how good or bad his ideas are.

Trying to change a SDB in the outer choice area is not the way to go about it. Many people will make an inner choice to respond in a SDB way, and once this is in gear try to change it at the outer choice level. Will power attempts, New Year's resolutions, telling oneself something else, all fall in this category. One must become aware that he makes a decision not to confront a situation as his integrated self, but to use a SDB, and at the moment the choice is made, realize he has power over the choice. A sense of helplessness comes from making SDB choices and not realizing one does this. A sense of control over one's own life comes from the knowledge that the person himself has power over choosing to go the SDB or creative response route. When a person clearly sees that he can choose the SDB or Non-SDB route, he stands at the moment of behavior change.

Reasons that people do not control their own choices

Apparently assuming full responsibility for personal choice is frightening to people because people have many ways of disowning their choices or even that they do chose. In our culture people are often taught (and then they take over and keep the erroneous idea alive) that it is best not to trust their own judgment. Too often people are led to believe that trusting in sources outside themselves (books, teachers, parents, God, rules) is better than trusting themselves.
Another reason people fail to recognize their inner choices is because in our culture we are taught to focus on and live in the outer area of doing, performing, and acting, rather than spending time probing the inner world of thinking and feeling. Thus, we can make lots of inner choices and because we are largely unfamiliar with our world within, not recognize that we are choosing. If one always focuses on happenings outside his mind he will not be in touch with what happens within.

The fact that choices are made in a fraction of a second can make it difficult to catch oneself doing it, too. Thus, a choice can be made so fast that a person can believe it just happened.

If a person does a SDB for a good many years, he may come to believe that the behavior is just part of him and not something he does. By maintaining this perception he would not recognize the choices he makes that activate and keep the SDB alive.

To have full power over eliminating a SDB one needs to fully control choices. The following steps can be followed to help you grasp this power:

1. Recognize that you make inner and outer choices to do your SDB.
2. Catch yourself making the SDB inner choice and be aware of its alternative.
3. Come to a new moment of living where a SDB would historically have been used. Before responding be aware of the choice options you have: (1) SDB choice (2) non-SDB choice.
4. Make a non-SDB choice in situations where a SDB choice was previously made.
5. People that have used SDB's to cope with life often become scared being without it. Therefore, after they respond with a non-SDB choice, they revert back and make a SDB choice. You must catch yourself doing this and be aware of what you have done.
6. Face the fears experienced when a non-SDB choice is made in situations where a SDB choice was made before.
Training in Self-defeating-behavior Concept: Day 4

Objectives:

1. To instruct each participant in the techniques used to keep and maintain Self-defeating-behaviors.

2. To allow participants the opportunity of role-playing; how they use various techniques in the institution to keep Self-defeating-behaviors.

Trainer Outline:

1. The participants are given hand-out #6 and each is given an opportunity to read and explain various aspects of the hand-out.

2. After the hand-out has been read, the participants, using various examples given in hand-out #6 of techniques used to keep Self-defeating-behaviors, are given the opportunity to role-play these techniques.

3. A discussion of their feelings during the role-play situation is held afterwards.
Techniques Used to Keep Self-defeating-behaviors

Self-defeating-behaviors are created at a time when people are anxious and are built on top of anxiety in such a way that convinces them that they cannot cope without the SDB. At the time the behavior was initiated it may have been that the only way known to cope was to use behaviors that later became self-defeating, but they are kept because people are afraid to face life without them.

Earlier, mention was made of the fact that SDB's are poor fittings people carry with them and cannot be integrated. That which cannot be successfully integrated within the human must be carried from one moment to the next by people themselves. The way they are carried forward moment by moment is by people making choices to use SDB's and then to use techniques to carry out these choices. Techniques are to a SDB what fuel is to a fire. Without something to burn, the fire would die out. Without techniques to keep a SDB going, it would cease to exist.

People will often say, "But I don't know the techniques that I use to keep my self-defeating-behavior." It is impossible to become an expert at doing dependency, doing inferiority, doing failure, doing alcoholism and all the other self-defeating-behaviors, without knowing how they are being done. If you find yourself at the point where you believe you do not know your techniques for keeping your SDB, and if you are serious about wanting to change, look for how you keep yourself from being fully aware of something you are expert at. What you can do is to use a technique on your techniques. The technique would be used to keep you from knowing your techniques.

Something closely connected to the above is to use a technique, and by not taking full responsibility for the doingness of it, believe it happened automatically. This denies the fact that choices to use techniques, and, hence to keep the behavior, were even made. The feeling is, "I didn't do it, it happened automatically."

Most people usually have four or five techniques that they rely on most frequently. By isolating these favorites the task is reduced to manageable proportions.

The fear of being without techniques is often frightening enough that people will create new ones if their old standbys are no longer usable. People display an ingenious amount of cunning in creating new techniques once their old ones do not work. When people are pinned down and their techniques exposed they can create new ones such as: suddenly forgetting everything, developing a lump on the side of their neck, feel like they are going to pass out or actually
do it, create a vomiting feeling so they have to leave, and to bring back a terrible incident in their life that was frightening so they could scare themselves in the present.

These fears of being without ways to keep the SDB alive feel very real, even though being without the SDB would be life-giving. Do not minimize your fears of being without your SDB, but at the same time know that if you want to change you will have to let the behavior go and face the fears.

Too often people treat techniques superficially. In some circles it seems to be a game to identify the techniques people use, and in so doing entirely miss the very real human fears behind why the techniques are used. Treating techniques superficially is in itself a technique not to have to face what one is doing.

Some techniques are blatant while others are more subtle. However, they all serve the purpose of helping people keep SDB's. A blatant technique could be one a child could use such as saying, "The devil made me do it." This same technique can be used in a more subtle way by blaming a spouse for one's own behavior. Some of the most subtle techniques are used by people that consider themselves enlightened. For instance, some people under the guise of wanting to change will involve themselves in all kinds of change programs. They might, for example, be those that hop around from one weekend to another attending groups, but using techniques of conforming to group standards as a way not to change, or to reinforce other people in their techniques as a way of them being able to use the techniques themselves. A professional was in a group where pseudo-openness was the symbol of success and he found when he displayed anger (a technique on his part so he would not have to change) he got all kinds of reinforcement for being "open" with his feelings. His anger was anything but openness, but members of the group felt they needed to have ways not to get to the real change issues, and reinforcing a technique was their way of accomplishing this.

Subtle techniques are those that can become institutionalized in such a way that the technique itself appears as a virtue. The emphasis on gum-chewing in schools is a technique the staff uses to waste time because they are afraid to put themselves to the real test to see if they can really do the job with kids. Yet, not allowing kids to chew gum is too often seen as a virtue by school people. In the church there are lots of techniques used to have people mistrust themselves and rely on a supreme being, and this dependency is seen as a virtue.

The cleverest church-connected technique uncovered so far was by a gal that made her techniques coincide with her religious values. Each time the counselor hit one or her techniques she took it as a direct insult to one of her religious values and then had what she hoped was an airtight case as to why she did not have to change.
When one can understand the great lengths people go to use techniques to keep SDB's one can begin to appreciate the fear people have of letting the behaviors go.

It is possible for you, the reader, to technique this handout in such a way that it will make no impact on you at all. You could search the paper, not find the techniques you use, and conclude you do not have any. Or, you can say I use that one and that one and that one, and keep right on using them. You could quickly read the handout and conclude you know this material in depth, and then not have to understand it more deeply. Or, if you use blanking your mind out as a technique not to face deeper issues in yourself, you might do it with the material in this paper. If you procrastinate a lot, you could read this and put off doing anything about applying the ideas to changing your particular behavior.

This paper by no means has an all-inclusive list of techniques. The examples given are numerous enough, though, and you should be able to find some techniques you use. If you do not find your techniques in this handout, by studying the examples in it, you will have leads in finding yours.

Remember! In order to maintain a SDB you must have techniques you use. If you identify the techniques and quit using them you will stand face to face with the deep feelings the techniques have let you run from. The opportunity will then be there for you to face these feelings and free yourself of your defeating behaviors.

A partial listing of techniques:

1. To respond to life in a feelingness manner and to avoid emotionally laden subjects. This serves the purpose of setting a part of oneself off and not having to face this part of self.

2. To avoid risk and to hang onto old, familiar ways of responding because it seems safer.

3. To take a test such as an interest or personality test and give the test decision power over oneself.

4. To label oneself an alcoholic and by so doing view self as having a condition and use this as a subtle means for shifting the responsibility for what is done onto that condition.

5. To do homosexuality but to consider oneself as just being a homosexual and there is no sense trying to fight a condition.
6. To institutionalize homosexual behavior by developing views that society is an ogre for not accepting this behavior as normal, by developing the gay liberation movement, and by surrounding oneself with people that reinforce the behavior.

7. To misuse drugs, but to become an expert at identifying society's faults (which are plentiful) as a means of not seeing one's own irresponsibility.

8. To hold onto a poor concept by comparing self to others and coming off second best all of the time.

9. To build a deceptive wall around oneself so no one can get near, and to refer to this defensiveness as depth and try to convince oneself and others this so called "depth" is a mark of distinction. People often elicit praise for this "depth."

10. To maintain irresponsibility by a person separating, in his thinking, a part of himself from himself and giving this part control over him. Examples of this come from people who say, "I couldn't help it," or "my mind just blanked out." Another example is drawn from a man who was in the audience at a presentation by the author. He said that as the SDB talk was given, he sincerely decided to give up smoking; but as time went on, his fingers began to want a cigarette so bad he had to light up. He did not have to blame the devil for making him do it, he could blame his fingers.

11. To keep from venturing ahead into the unknown by bringing back previous defeats.

12. To have unrealistic expectations of oneself.

13. To break up relationships as a way of not having to build close relationships but to make it appear that the other people are at fault.

14. To begin tasks and not finish them so adequacy does not have to be checked out.

15. To blank one's mind when getting close to important data.

16. To imagine what other people are thinking and feeling rather than to check out reality. To project one's own meaning onto another's intentions.
18. To know something important is going on in oneself but to keep it vague.

19. Avoiding eye contact and developing various looks that communicate to other people how shy one is so they will stay away.

20. To be argumentative as a way of not getting into deeper areas.

21. To turn caring on and off depending how close someone gets to covered data.

22. To take something that was not really a problem in the past--such as being an adopted child--and make it a problem to cover up facing something in the present--such as loneliness.

23. Lying

24. In interactions with other people only give them partial data about oneself so they cannot really know who you are.

25. To keep so busy there is little time or energy left to think about oneself or face deeper issues.

26. To use denseness or stupidity as a way of not understanding information and concepts that might lead one into anxiety.

27. To agree with people even when one does not.

28. To blame one's past for the self-defeating behavior one does to himself today.

29. To pick out something someone else does that really is a mistake, and then to add to this mistake, but to put the total responsibility onto the other person.

30. To cry as a way of not to have to face deeper issues.

31. To hold back crying as a means of not expressing feelings.

32. To minimize the good aspects of life and to overexaggerate mistakes and bad points.

33. To make a mountain our of a molehill.
34. To distort praise and minimize other people's feedback.

35. To take direction for what one ought to do in life's many situations from sources outside oneself; other people (especially experts), books, religious doctrine, magic.

36. To have a real and strong feeling but to keep it longer than is necessary.

37. To take something that is valid like tiredness or a real limitation and magnify it in such a way so as to incapacitate self.

38. When faced with a real conflict, to build added tension and involve self with the tension and avoid the real conflict.

39. To rationalize that some will not like me as a means of not checking the reality of that out.

40. To maintain the idea that it is weak and wrong to ask for help, and to believe that one ought to be able to work out his difficulties on his own even when his reality says differently.

41. To maintain guilt about water over the dam that one cannot do anything about.

42. To take a reality such as a husband's sex interest and to perceive it as something dirty, as gluttonous, as an excessive demand.

43. To know how to respond to a situation but to convince oneself otherwise.

44. To have the attitude that life is a game with all of the rules of a game. By so doing one never has to respond honestly.

45. Not to like the way another person responds as a way for not doing anything to change.

46. When someone touches a reality about you, especially if it is unpleasant, to deny that it hit home.

47. To take on a lot of little responsibilities to the point of immobilizing one by not choosing what is important and unimportant in one's life. Never saying no to others helps to accomplish this one.

48. To believe the problem is outside when, in fact, it is inside.
49. To see the problem inside when, in fact, it is outside.

50. To develop friends that will reinforce one in SDB ways.

51. To make people as objects in one's mind and then manipulate them, as needed, to stay stagnant.

52. To romanticize and build certain people up that expound ideas and stand for beliefs that reinforce avoiding patterns.

53. To see the SDB manifested in only one situation, i.e., with one's girlfriend, and not to recognize its emergence in other situations.

54. To openly admit using one or more techniques to maintain a SDB, but do it in such a way that if one admits it he does not have to change it.

55. To create an outer restrictive box, to see the box (now with people in it such as a boss or a spouse or parents) as not allowing one to move very much.

56. To avoid risking into the unknown by not speaking unless one is sure ahead of time on what he is going to say.

57. To make other people's reactions so important it overrides one's own beliefs.

58. Not to demand certain things one has a right to demand.

59. To tell oneself he has nothing in common with anyone else and, therefore, nothing to talk about.

60. To put on an air of hostility and then with a scowl on the face and a chip on the shoulder other people will stay away.

61. To cut oneself down before others do.

62. To distract oneself (when doing an important task like studying) by baking, doing dishes, thinking, listening to music, cleaning, calling people on the phone, taking the first invitation to do something else, and so on.

63. To computerize responses rather than give fresh responses to fresh situations.
64. Silence.

65. To predict what situations will be like, to get ready for the predictions, and never take life as it comes.

66. To avoid taking care of my appearance or body or room as a way of convincing myself I need to be taken care of.

67. To take people's reactions and distort them by putting another meaning onto them.

68. To go into a classroom situation with the attitude that the total responsibility for one getting anything out of the class is all on the instructor's shoulders.

69. To know what one must do in a given situation, but not to trust one's knowledge and to ask another person for advice. This can be seen most clearly by the people that write in to an advice column. They want someone else to do their thinking for them and then they do not need the responsibility for a mistake on their shoulder. It also shows up in a client's relationship with a counselor or a doctor or a lawyer. In these situations a person can legitimately ask for advice from the professional because the professional knows some things he does not, but too often the client gives some of his responsibility over to the professional when it should be kept back home.

70. To have a variety of voices designed to manipulate others and keep a SDB. The voices can be used to communicate dependency, helplessness, harshness, patheticness, and so on, and can vary from a whine to an ultra-power sound.
Training in Self-defeating-behavior Concept: Day 5

Objectives:

1. To give each participant an understanding of the mythical fears associated with giving up SDB.

2. Help each participant meet goals for changing their Self-defeating-behaviors permanently, especially the behavior of Withdrawal.

3. To summarize, the previous four days of training, and allow each participant to get closure on the experience they had during the five days.

 Trainer Outline:

1. The trainer explains that this is the last day of instruction, gives each participant hand-out #7, and instructs the participants regarding the mythical fear concept.

2. After the mythical fear concept has been explained, a discussion follows which includes asking the participants to become aware of and to monitor the amount of withdrawing behavior that they engage in on a daily basis.

3. Self-Monitoring sheets are handed out and participants are excused.
Avoidance of a Mythical Fear

Each person that uses a self-defeating-behavior has a fear of meeting his world without it. The fear began at the time the behavior was conceived; a time when the person felt that just being himself was not sufficient to cope with the world as he was experiencing it. As an example: (1) If just being one's self did not seem to please parents, conforming behaviors could be developed that pleased the parents, but did not fit the person. (2) Through no fault of his own, a child can experience deep loneliness. He might develop behaviors that may not fit him, but which help him decrease the loneliness. (3) A child may be physically or culturally different than the majority of children he grows up with. This difference can cause him discomfort and he may develop behaviors to ease this feeling. (4) Or, a child can face this large world, experiencing no particular trauma other than the universal feeling of needing a means with which to cope. He may be taught behaviors that have many self-defeating components (values, attitudes, perceptions) to them. His inward feeling is, "I needed a way to handle this world; thank goodness I now have one even if it is not the greatest."

Self-defeating behaviors, at their conception, reduced anxiety for the owner; the person did not feel so lonely, or afraid, or rejected, or helpless. Thereafter, as the person approaches new moments of living, he uses the SDB because he believes that it is the best way to live. He is afraid that without the SDB he will re-experience those feelings he had when he first started the behavior.

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Choice Moment

(SDB Route)

(Non-SDB Route - route of the mythical fear)

As a person with SDBs approaches new moments of living, he inwardly says, "One time I went down this road. I was openly me and somehow it did not work. Now I'm afraid to go back down this road even though I want to. Will the same thing happen to me as before? Will I feel the same as before? Will it be worse?"
A mythical fear increases each time a person comes to a new moment of living and rather than let the SDB go and check out the fear, he avoids it. By avoiding the mythical fear it oftentimes takes on monstrous overtones. In addition, going down the SDB route a person splits himself apart. One part of himself works against the other and out of this split springs neurotic ideas and feelings. The person becomes frightened of who he is inside because rather than realizing that these neurotic phenomenon come out of the split, he believes they come out of who he is deep inside. Nothing could be further from the truth but the person does not know it until he moves beyond his mythical fears.

Mythical fears fall into two categories: (1) A fear that if the behaviors are not used, what the person will find out about himself, and (2) A fear of what will happen to the person. Typical fears of what people will find out about themselves include such things as:

1. I'll be dumb and incompetent.
2. My feelings will take over.
3. I'll be helpless and weak.
4. I won't like who I'll find.
5. I'll be mistrustful.
6. I won't be good at anything.
7. I'll be evil or crazy.
8. I'll be all alone.
9. I'll find a nothing person.
10. I'll find a person that is vulnerable to hurt.
11. I won't know wrong from right.
12. I'll be undesirable even to myself.
13. I'll be rudderless; unable to decide what to do.
14. I'll be unhappy.
15. I'll be hideous.
16. I'll be mentally ill.
17. I'll be frigid.
18. Et cetera.

Fears of what will happen that seem impossible to cope with include:

1. Others will hurt me.
2. I'll be rejected.
3. No one will like or want me.
4. I'll be forever lost.
5. People will laugh and ridicule me.
6. I'll die a horrible death.
7. Others will take advantage of me; I'll be a vessel for their pleasure.
8. I'll go over the brink.
9. I'll be shut away in an institution.
10. I don't know what will happen, but I know it will be bad.
11. Et cetera.

Life is never worse by letting go of the SDB and facing oneself at deep levels. However, to intellectually understand this is not very helpful. People need to actually go down the mythical fear road and behaviorally find out that beyond the mythical fear is the route of creativity, of meaning, of joy, of competency, and where one finds the wheel by which he can steer his own life.

The following diagram will help the reader see this more clearly.
Choice (one can go either way)

Non-SDB route

Person at this point is afraid of what he will find out down this road.

MYTHICAL FEARS

1. What will I be like if I look inside?
2. What will happen to me if I open up and let the SDB go?

Fears to be faced

CREATIVE
OPEN
WHOLE
ENERGETIC
HAPPY
MEANINGFUL
VITA

Paul David Warner

Candidate for the Degree of

Doctor of Philosophy

PERSONAL DATA

Birthplace: Payson, Utah.
Date of Birth: January 1, 1949
Married with two children

OBJECTIVES

Clinical psychology in adolescent and adult areas, with private practice of psychotherapy.

EDUCATIONAL--PROFESSIONAL QUALIFICATIONS

B. S. --Psychology, Brigham Young University, 1973.
M. S. --Counseling Psychology, Utah State University, 1975.
Ph. D. --Clinical Psychology, Utah State University, 1976. The Psychology Department at Utah State University is accredited by the American Psychological Association--Professional-Scientific Accreditation.

FIELD OF SPECIALIZATION

Adolescent and adult clinical psychology, including psychodiagnosis and treatment.
Assertive Therapy, application and research.
Research in the area of "Self-Control Therapy" with adolescents.
Hypnotherapy.

TEACHING EXPERIENCES

Developed and instructed several workshops in Systematic Assertiveness Training.
Teaching Assistant in Organization Development, MBA Department, Utah State University. Responsible for teaching psychological principles in industry.
Conducted Operation Guidance Symposium Workshop, Utah State University. Instructed 350 participants of the Utah Education Association.
RESEARCH AND REPORT WRITING

Longitudinal follow-up research dealing with role choices of women, leading to a Master's thesis. "Self-Control" research using a population of institutionalized adolescents, Dissertation. Women in sports, researched the applicability of Title IX legislation and the desire among women to compete in sports. Under review for publication. Participated as a research interviewer and report writer for "Project Talent."


PUBLICATIONS AND ARTICLES


THESIS AND DISSERTATION

"Some Characteristics of Female College Students Who Select Academic Majors in Fields of Exact Science and Non-Exact Science: A Longitudinal Follow Up." Unpublished thesis.

"A Test of the Effectiveness of Two Treatment Modalities for Adolescent Residents of an Intermediate Care Facility." Unpublished dissertation.

GRANTS

Presently preparing a National Institute of Mental Health Grant Proposal to fund the purchase of audio-visuals for longitudinal research to be conducted at the Intermediate Care Facility in St. Anthony, Idaho.

PROFESSIONAL MEMBERSHIPS

American Psychological Association, Associate Member. Idaho Psychological Association, Member.
Presently completing an internship in Clinical Psychology at the Intermediate Care Facility, St. Anthony, Idaho. Responsible for individual and group psychotherapy, family psychotherapy, psychodiagnosis, and behavior management. Responsible for training of other staff members in Transactional Analysis, Systematic Assertiveness Training, Gestalt Therapy, Group Dynamics, and Hypnotherapy. Placed in charge of treatment team and given the responsibility as Director of Therapy for ICF residents.

Developed treatment approach for the Intermediate Care Facility at St. Anthony, Idaho. Approach included types of therapeutic interventions to be used, record keeping, and "Therapeutic Community Concept" for residents of the treatment facility.

Presently employed as a Counseling Psychologist for off-campus housing at Ricks College, Resburg, Idaho. Responsible for remediating emotional problems among residents of off-campus housing. Therapeutic intervention usually consists of individual and group psychotherapy with some behavioral management.

Member and colleague, Clinical Associates Incorporated. Presently a corporate partner with four other professional psychologists and a psychiatrist. Services provided in psychodiagnosis, individual and group psychotherapy, consultation, and workshop direction.

District psychologist, Randolph, Utah. Worked as a consultant to Randolph School District (Elementary-Secondary) in identifying and remediating emotional and learning difficulties.

State of Utah Coordinator for "Operation Guidance."

Directed and implemented a nationally funded career guidance package in three school districts. Responsible for the operation of the project and training of school coordinators.
American Institute of Research (AIR) area interviewer and researcher for "Project Talent." Completed research and write-up of findings on a 1960 study developed by AIR.

Research Assistant to Dr. E. Wayne Wright. Utah State University. Compiled research data regarding the Department of Psychology at USU for application to the American Psychological Association. Application was made to the APA for accreditation of the Psychology Department. Department was subsequently accredited by APA under the title: Professional-Scientific.

Researcher for Idaho State Department of Education. Gathered data regarding career opportunities within the State of Idaho.

Presently engaged in research at Intermediate Care Facility, St. Anthony, Idaho, dealing with use of "Self-Control Therapy" in increasing responsible actions on the part of adolescent residents.

Operation Guidance Training Seminar, Ohio State University, Columbus, Ohio. Received five days of training in the operation and implementation of Operation Guidance, career development module.

William Glasser Workshop--From Hickory Sticks to Human Relations. Brigham Young University, Provo, Utah. Received training in reality therapy coupled with logical consequences.

Conducted three days of training in the area of vocational exploration skills at a convention for the Utah Educational Association, UEA 1975 Convention.

Symposium of Clinical/Psychological Ethics. Utah State University. Legal and ethical implications of private practice.

Clinical Hypnosis Workshop. Utah State University. Received training in the induction and application of clinical hypnosis.