Assessing Seriously Emotionally Disturbed Youth in Residential Treatment

By

Jodi Morstein Groot

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APPROVED:

[redacted]

Judith Kendall, RN, PhD, Professor, Academic Advisor, Co-Chair

[redacted]

Gail M. Houck, RN, PhD, Professor, Co-Chair

[redacted]

Sheila Kodadek, RN, PhD, Professor, Committee Member

[redacted]

Beverly Hoeffer, RN, DNSc, FAAN, Associate Dean of Academic Affairs, School of Nursing

ABSTRACT

Title: Assessing Severely Emotionally Disturbed Youth in Residential Treatment

Author: Jodi Morstein Groot

Approved: [redacted]

The purpose of this study was to use an age-normed behavioral assessment tool (CBCL) and a developmentally based, age normed, social competence measure (Rel-Q) to identify deficits and delays of SED youth at admission to residential treatment and examine both behavior problems and social competence at discharge. Demographic data were gathered and evaluated in relationship to the measures of behavior and social competence. One hundred and thirteen youth (55% male) completed the measures at admission and made up the intake group. Sixty-three of those youth (60% male) completed the discharge measures and were considered the longitudinal group. The average age of the intake group was 14.7 years and 93% of the youth had experienced previous out-of–home placement. At admission 71% of the intake group met at least borderline or clinical levels on the CBCL. The social competence measures at admission were grouped by age to compare them to established norms. Youth less than 12.5 years were not significantly below 4th grade norms on any subscale or total social competence score. Youth 12.5 years to 15 years demonstrated significantly lower scores than the 8th grade norm on the dimension of personal meaning. For the oldest youth, those over 15 years, significant deficits were apparent on three subscales and in overall social competence. Correlation between behavioral measures and social competence dimensions are reported. A regression equation was used to explore the relationships between number of out-of-home placements, demographic variables and the behavior and social competence measures. No significant relationships between predictors and dependent variables were identified. At discharge, 54 of the 63 youth in the study had made significant behavioral and social competence gains across all three age groups. The relationship between behavior problems and social competence at discharge was explored; both for the group who made gains and the group that did not. A regression equation using length of stay and psychiatric diagnosis as predictor variables did not indicate a significant relationship between those predictors and behavior problem or social competence scores at discharge. Limitations and further research directions are discussed. Important findings included, SED youth had both behavioral problems and developmental delays in the area of social competence at admission to residential treatment. The majority of behavioral problems resolved, however, social competence deficits among the older SED youth continued to exist at discharge. Gender differences between behavioral problems and their relationship to social competence were evident. Services provided and integrated in a residential setting are believed to have positively impacted both behavior problems and aided in growth in the area of social competence.

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Psalm 138:1-3

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Chapter 1

Introduction

On a daily basis, 1 of 10 or as many as 6 million youth in the United States are experiencing serious emotional disturbances (SED) that disrupt their functioning in homes, schools, and communities (Child Welfare League of America, 2000). Since the mid-1970's, child welfare efforts and mental health resources have been directed toward treatment that is community-based and focused on permanency placement and family preservation (Curry, 1991; Whittaker, 2000; Whittaker & Pfieffer, 1994). However, the National Resource Center for Permanency Planning (2000) reported that in 1985, 147,000 non-relative foster homes were available for 276,000 children in need of care, and by 1994 only 125,000 non-relative foster homes were available for 450,000 youth. Approximately 60% of the children in out-of-home foster care have moderate to severe mental health problems. A substantial number of these youth have problems so serious that their safety needs can not be met in their communities and they are placed in residential treatment (Burns, Hoagwood, & Mzarek, 1998, Halfon, English, Allen & Dewoody, 1994; Terpstra, 1998; Whittaker, 2000).

Residential treatment is defined as a 24-hour facility, which is not licensed as a hospital, that offers programming for children with diagnosable mental health disorders (Tuma, 1989). Compared to the general population, children in residential treatment have often lived in poverty, have academic problems, struggle behaviorally and have deficits in social competence. Many of them have had out-of-home placements prior to

residential treatment and their difficulties were often first identified at early ages (Curry, 1991).

In recent years, there has been little research in residential treatment settings. Studies conducted in the 1970's and 1980's generally focused on descriptions of the youth served or on the residential settings themselves. Outcomes most often were measured in terms of community re-adjustment and recidivism (Curry, 1991; Maluccio & Marlow, 1972; Pfieffer & Strezelicki, 1990).

Contemporary studies with SED youth have emphasized the complexity and difficulty presented by attempting to measure treatment outcomes. Most studies incorporate several tools in an effort to provide a comprehensive picture (Brenda, 1996). Behavioral checklists typically are employed in this research; the Child Behavioral Checklist (CBCL) is the most widely used and well-validated tool of this sort (Furlong & Wood, 1999). Behavioral measures can describe the actions of an SED youth, but do not reveal the psychological, developmental, emotional, or social factors that underlie those actions.

A theoretical framework of developmental psychopathology compels the researcher to consider outcomes of treatment for SED youth from a developmental perspective. A key indicator of psychological, social, and emotional health is an individual's effectiveness in social interactions or social competence. SED youth have significant deficits in social competence (Achenbach & Edelbrock, 1981; Hartup, 1983; Rutter & Garmezy, 1983). Although historically social competence has been measured by skills checklists, behavioral assessments, and peer reports (Merrell & Gimple, 1998; Rose-Krasnor, 1997), the perspective of developmental psychopathology points to the salience of assessing

deficits in the earlier competencies. Accordingly, Shultz and Selman (1998) have articulated a theoretical framework related to the development of social cognitive competence, the Group for the Study of Interpersonal Development (GSID) Relationship Model. This framework makes it possible to examine the development of social competence and consider the impact of this development upon outcome behaviors. They have designed the GSID Relationship Questionnaire (Rel-Q) to assess social competence from a developmental perspective.

There is little research related to the SED population served in residential treatment, and little, if any, has addressed social competence outcomes. This study used an age-normed behavioral assessment tool and a developmentally based, age-normed, social competence measure to identify deficits and delays at intake into residential treatment, and examined both behavior problems and social competence at discharge. Demographic data were gathered and evaluated in relationship to the behavior tool and measures of social competence. The specific aims of this study were

1. to explore relationships among behavior problem and social competence scores for SED youth;
2. to compare behavior problem and social competence scores of SED youth upon admission to and at discharge from residential treatment;
3. to examine how selected demographic variables and the socio-cultural variable of number of out-of-home placements explain variation in behavior problem and social competence measures at admission; and

4. to examine how demographic variables, the socio-cultural variable and the selected treatment variables of length of stay in residential treatment and psychiatric diagnosis, explain variation in behavior problem and social competence measures within 10 days of discharge from residential treatment.

Findings from this initial work will provide a foundation for a program of research focused on SED youth in residential treatment. Assessing social competence from a developmental perspective has implications for treatment, and, in turn, can influence the model of care adopted. It is hoped that this work will be an empirical contribution to the knowledge base regarding the assessment of and treatment outcomes for SED youth in residential treatment settings.

Chapter 2

Review of Literature

This chapter will discuss the prevalence of SED youth in the United States, review federal initiatives which have impacted their care, and focus on theoretical underpinnings and contemporary bias associated with residential treatment. A review of outcome studies in residential treatment will provide incentive for further research and for the incorporation of a developmental focus when assessing SED youth gains or losses.

Literature will support that SED youth have deficits in the realm of social competence. Developmental psychopathology promotes the evaluation of social competence from a developmental perspective. Social competence will be explored by reviewing studies that have addressed biological factors (nature), environmental influences (nurture), the impact of these components upon social-cognitive development, and the resulting social behaviors. The chapter will conclude with a review of the GSID Relationship Model (Selman & Demorest, 1984) which will serve as a conceptual framework for this dissertation.

SED Youth

Compiling accurate data related to the prevalence of child and adolescent psychiatric disorders in the United States has been challenging for researchers. In a review of fifty-two studies conducted in the past forty years, problems with sampling, case ascertation, case definition, data analysis, and presentation were identified (Roberts, Attkinsson & Rosenblatt, 1998). Estimated median rates of occurrence of psychiatric diagnoses were 12% for latency age children and 15% for adolescents. Serious childhood behavior

disorders have been identified within all cultures and ethnic groups, and across all socioeconomic levels (Miller, London & Prinz, 1991). The World Health Organization has predicted that, by the year 2020, mental illness will exceed all other causes of illness in the child and adolescent population (Report of the Surgeon General's Conference on Children's Mental Health, 2000).

It is clear SED youth exist in the United States. It is less clear who cares for them or how this care is provided. Whittaker and Pfeiffer (1994) concluded that the current service delivery system for SED youth is "fragmented and segregated, marked by concerns over territory, poor communication, misunderstandings regarding differing perspectives, values, and regulations and an aversion to change" (p. 593). Child welfare, juvenile justice, public education, and mental health services have each influenced the development of interventions for SED youth. Political ideology, social agendas, and economic forces all have contributed to the current state of mental health care for children and adolescents.

For at least the last 20 years, efforts and federal resources in child welfare and mental health have focused on neurological investigation, pharmacological intervention, preserving families, developing appropriate systems of care, and promoting permanency placement. Juvenile justice research also has moved toward examining community placement and family intervention. Ideologically, keeping SED youth in their homes and communities is highly desirable. However, in spite of emerging biological understanding, pharmacological interventions, and the development of community-based and family-centered models of care, the most seriously disturbed youth continue to be placed in

residential treatment (Burns, Hoagwood, & Mzarek, 1998). Reviewing the historical care and evolution of treatment for SED youth in the United States will provide a foundation for understanding current political thought and research implications for this population.

SED Youth, Federal Initiatives, and The Evolution of Residential Treatment

The first hundred years: 1850-1950. In the mid-1800's, Dorthea Dix advocated with the Massachusetts legislature for humane treatment for the mentally ill. She reported that emotionally disturbed children and adolescents were living in adult settings in which naked patients were locked and chained in cages, cellars, stalls, and pens (Rosen, Clark, & Kivitz, 1976). In the late 1800's, Linda Richards, a nurse reformer, stated, "It stands to reason that the mentally sick should be at least as well cared for as the physically sick" (Doona, 1984, p. 51). Largely in response to the work of social reformers like Dix and Richards, change began. Early medical treatment for mental illness focused almost exclusively on adults (Aries, 1962). Little emphasis was placed on the mental health care of children, who historically were treated as miniature adults.

If emotionally disturbed children received care, it is likely that they were treated in the same manner as abused or neglected youth. Early child welfare practice focused on removing a child from a situation of abuse, neglect, or poverty. At that time, the primary intervention was to relocate the child. Orphan trains carried children to families in frontier communities and new homes in the west. Private parochial systems and secular social services provided care in children's homes and orphanages. By the mid-1920's, child welfare advocates had begun to encourage family foster care over group placements for orphaned or abandoned children (Whittaker, 2000).

The earliest specific efforts related to the care of mentally ill children can be traced to the works of Sigmund Freud. In 1909, he published his paper on the treatment of "Little Hans," opening the door for psychoanalytic work with youth. Melanie Klein and Anna Freud continued to develop interventions based on psychoanalysis with children (Stuart, 1998).

Also in 1909, William Healy established the first child guidance clinic in the United States in Chicago to serve the juvenile court. Slowly, other clinics were established in metropolitan areas. They gathered an initial data set on children's mental health needs and provided limited treatment services in some settings (Fagan, 1974).

Medical interventions such as insulin shock therapy, psychosurgery, and electroconvulsive therapy were developed in the 1930's. These were primarily were used with adult patients in hospital and asylum settings (Stuart, 1998). Psychiatric services for emotionally disturbed children were rare, and, in most of the country, non-existent.

Meyers (1985) reported that the history of federal efforts to improve care for mentally ill children has been, "a story of failure marked by a series of initiatives that have neither survived beyond a few years nor accomplished much of lasting significance" (p. 182). As early as the 1930 White House Conference on Children, there were calls for a comprehensive program for emotionally handicapped children (Joint Commission on Mental Health and Children, 1969). Unfortunately, little federal attention was directed toward these youth.

Reviewing the care of SED youth through the first half of the 1900's indicates that what developed as care evolved as a response to shifts in child welfare policy and

psychoanalytic thought. Whittaker reported that, by the mid twentieth century, "less than 10% of the children in group settings fit the description of true orphans" (p. 64). Mentally ill or delinquent children, for whom family foster care was deemed insufficient or inappropriate, were the population that continued to be served in group care settings. The foundations of contemporary residential treatment in the United States can be traced to work promoted in the 1950's and 1960's.

Foundations of residential treatment: 1950'-1960's. By the early 1950's, specific treatment settings had evolved to serve emotionally disturbed youth. Most program designs were based on one of three philosophies: psychodynamic, behavioral, and guided group interactions. The conceptual models and interventions generated during these years underlie contemporary practice in residential treatment.

Bruno Bettleheim, a pioneer in the care of emotionally disturbed children, was highly influenced by a psychodynamic approach. At the University of Chicago Orthonogenic School, Bettleheim focused on the concept of ego development, with psychopathology being defined in terms of fixated or regressed ego functioning (1950). The Orthonogenic School served very disturbed youth and young adults and provided them with a "total therapeutic milieu" (1974, p. 5). Bettleheim reported that the severity of each patient's illness required considerable time, easily five years or more, in the milieu setting. Client outcomes were not studied empirically, although Bettleheim reported that eighty-five percent of the clients treated in the Orthonogenic program were "restored to full participation in life" (1974, p. 6).

Fritz Redl, at Pioneer House in Detroit, focused on how children learn to control their behaviors. Psycho-dynamic interventions were implemented to facilitate a child's ability to learn self control (Brentro & Ness, 1983). Psychodynamic thought was based upon Freudian assumptions that behavior was connected to inner states and that distorted interpersonal relationships resulted in long term personality difficulties. Treatment for children in these types of settings focused on adults being sensitized to the needs of children and providing opportunity for nurturing secure relationships (Juul, 1980).

While Bettleheim and Redl were working in in-patient settings with disturbed children, Maxwell Jones introduced the concept of the "therapeutic community" with adult psychiatric patients. His ideas emphasized that a patient's social environment could provide therapeutic experiences (Stuart, 1998). His propositions were congruent with interventions promoted by Bettleheim.

In the 1960's, the focus of care and treatment of SED youth significantly shifted with the introduction of behavioral approaches. With support from the National Institute of Mental Health (NIMH), Edward Phillips developed the Achievement Place or Teaching Family model. This model emphasized behavioral modification and social learning theory (Brendtro & Ness, 1983). Personality was considered the sum of behaviors and, in this school of thought, it was assumed that all behaviors were learned. Intervention was based on trying to modify difficult behaviors by appropriate reinforcement (Juul, 1980).

During the same years, psycho-educational models, like the Re-Ed school concept designed by Nicholas Hobbs (1979), were popular with educators dealing with emotionally disturbed youth. Psycho-educational models have been described as eclectic,

drawing ideas from other theoretical frameworks and choosing techniques that are considered appropriate (Juul, 1980). The Re-Ed school model had strong connections with behavioral approaches. In 1979, Hobbs reviewed the 20-year history of the Re-Ed program and concluded that behavioral modification, though powerful, was not a sufficient theoretical base for helping disturbed children and adolescents. He identified problems including; insufficient attention to the evocative power of identification with an admired adult, the presence of rigorous demands of stated and implicit situations, and need for focus upon the fulfillment that comes from demonstrating competency.

Guided group interaction strategies were implemented in correctional group care settings. Researchers assumed that negative behaviors were elicited and reinforced by a negative peer culture. They believed that by creating opportunities for youth to help one another, they could take responsibility for changing themselves, which in turn could impact negative behaviors. These ideas were later applied to other youth in non-correctional placements (Brendtro & Ness, 1983). However, recent longitudinal studies with delinquents have indicated that peer group interventions with this population may increase adolescent problem behaviors and negative life outcomes. Dishion, McCord, and Poulin (1999) proposed that, under certain circumstance during early adolescence, peer aggregation could inadvertently reinforce problem behavior. Joshi and Rosenberg (1997) found that children who demonstrated oppositional, defiant, or conduct disorders did the most poorly in residential treatment settings, perhaps for the reasons later proposed by Dishion et al.

In the years to follow, few programs were designed or implemented using a single theoretical framework. The specific professional or group that developed care brought its own standards and ideas to the residential treatment setting. When commenting on contemporary residential treatment, Brendtro and Ness (1983) asserted there were many models for intervention as programs, and concluded that most practice models have been psycho-educational because of the tendency to draw from several different educational and treatment frameworks. By the early 1960's, public policy and funding began to shift from providing mental health care in in-patient settings toward community-based out patient care.

Community mental health movement and diagnostic related groups: 1960's –1980's. In 1965, specific amendments to the Social Security Act mandated the creation of research to study "resources, methods, and practices for diagnosing and preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illnesses" (Joint Commission on Mental Health in Children, 1969, p. 2). The Commission recommended funding to provide incentives to communities to create a range of coordinated services that would provide interrelated and continuous care for children with emotional difficulties. Although the Commission was costly and provided both depth and detail regarding the problems, little political interest or funding came from their recommendations. During the Nixon administration, focus was placed on fewer rather than more social service programs (Meyers, 1985). The cyclical nature of initiatives has reflected the increased interest of liberals in social programming only to be followed by decreased emphasis when conservative powers were in office.

In the 1960's, some federal funding was directed toward Community Mental Health Centers. However, early legislative directives had no inclusion criteria for children until 1971, when the regulations were amended to require children's services. A provision to the Community Mental Health Center Act provided increased funding for local programming for children.

In response to the promotion of community-based care, a number of significant changes occurred for SED youth. The idea that those receiving special education and mental health services should be de-institutionalized and remain in community or family settings became a popular focus for both child welfare professionals and politicians. Whitaker and Treischman (1972) identified a significant growth of day programs, following the community health movement. However, residential treatment services continued to be necessary for some youth, including those who were "more disturbed" and "more psychotic" (p. 5). They noted that residential treatment had been de-emphasized by child welfare advocates and policy makers' and, in some respects, ignored altogether as a legitimate form or level of care. Mayer (1975), a leading advocate for quality care in residential services, coined the term "pariah care," referring to group care programs for troubled youth. He attempted to draw attention to the stigmatization and marginalization experienced both by SED youth and by the group settings in which they were being served. In 1974, Congress did not renew the funding for Community Mental Health Centers' local programming for children. This ended the first national initiative for children's mental health services.

The late 1970's and early 1980's saw a proliferation of private psychiatric hospitals that provided care to children and adolescents. This growth was due largely to the lack of cost controls on mental health services. In 1982, Congress enacted legislation to create Diagnostic Related Groups (DRG's) as a means for controlling Medicare costs for physical health care. Mental health services were not included and able to continue to bill at a fee for service rate. As time went on, corporations began to contract with mental health providers in order to control the costs and, by the late 1980's this was being achieved largely by limiting inpatient care and lengths of stay (Mordak, 1998).

Under the Carter administration, attention was once again directed toward addressing the needs of children with severe psychiatric and behavioral problems. A federal law was passed in 1981 to provide state and local communities with limited funds to deliver and coordinate care for emotionally disturbed youth. The law was repealed by the Reagan administration before it took effect (Meyers, 1985). A major division of the American Psychological Association (APA) commissioned a report in the late 1980's on the state of the art in residential treatment. Whittaker (2000) described the findings as "thoughtful, well balanced, and substantive"(p. 65). Unfortunately, the APA chose not to publish the report, presumably because it could have been viewed as an endorsement for residential care.

Unclaimed children:1980's - 1990's. During the fall of 1979 through the summer of 1982, a national survey was conducted in all 50 states and the District of Columbia to determine the organizational structures, fiscal policies, and services provided for emotionally troubled children. The Children's Defense Fund published the revealing

outcome report, *Unclaimed Children*, which brought the plight of American children with emotional difficulties once again to the attention of policy makers and the public (Knitzer, 1982). Of the three million emotionally disturbed children in the United States, two million were not receiving adequate services. Very few states offered anything other than inpatient hospital care, described as restrictive and costly. The report indicated that 40% of the children in hospital placements were not provided services at an appropriate level of care. There were few, if any, community options available to this vulnerable population and their families.

In 1984, largely in response to *Unclaimed Children,* Congress designated $1.5 million for a new service demonstration program aimed at improving the provision of mental health care for children. The Child and Adolescent Service System Program (CASSP) was administered by the NIMH and provided funds to states to improve service systems at both state and local levels. According to Katz-Levy (1991), CASSP was created to address a number of related problems. The system of care for SED youth was fragmented. At least four different service systems, child welfare, special education, mental health and juvenile justice, were providing services with no logical coordination. CASSP provided competitive challenge grants to states to improve children's mental health in very specific ways. The grants were targeted at improving leadership within the state systems, requiring state departments of mental health to collaborate with other state agencies, developing service delivery at community levels, strengthening family advocacy, and recognizing culture and ethnic diversity (Knitzer, 1993).

Traditional intervention strategies were challenged and reconsidered. Stroul and Freidman (1986) argued for a community-based system of care with a range of non-residential as well as residential services. They called for increased family support systems and linkages between agencies that would ease transitions for children. Cross system collaboration was to be promoted as well as individuation of treatment design. This paradigm shift resulted in providers rethinking level of service and intensity. According to Knitzer (1993) the appropriate level of intensity could be created within natural environments by "wrapping services around" the child and family in the home, classroom, or community. This shift in paradigm de-emphasized the use of institutional settings (hospitals and residential) in favor of developing community-based levels of care for SED youth (Salzer & Bickman, 1997).

Terpstra (1998) reported that, in child welfare settings, the number of children in residential placements remained fairly consistent from 1965-1981. By contrast, the number of settings providing care nearly doubled. This reflected a steady decline in large service units and a move toward settings that lodged fewer children per unit.

Movement of children to community based settings gained momentum in the early 1990's with the advancement of ideas and practices supporting family preservation and permanency placement, and in the wake of ongoing battles to control costs. In August 1993, federal legislation was passed allocating one billion dollars over a five-year period to states that would develop early intervention, prevention, and family support services (Wells, 1994). The crucial role a family plays in the development of a child was

emphasized, along with the importance of returning children to their families of origin or finding permanent placement with other families (Maluccio, Fein, & Davis, 1994).

A CASSP sponsored project attempted to define the concept of a "system of care" and its philosophical underpinnings. A system of care was defined as "a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with SED and their families" (Stroul & Friedman, 1996, p. 16). Both non-residential and residential services were included in the continuum. Prevention, early identification and intervention, assessment, outpatient treatment, home based services, day treatment, and emergency care were all considered non-residential placement. Residential placement included therapeutic foster care, therapeutic group care, therapeutic camp services, independent living services, residential treatment, crisis residential placements, and inpatient hospitalization (Stroul & Freidman, 1996).

In attempting to create a system of care, a variety of new services evolved. Although some data exists related to the design and impact of a continuum of care, little information exists in the literature regarding current or best practices in residential treatment or it's place in the system of care (Bickman, 1996; Bickman, Summerfelt, & Noser, 1997; Whittaker & Pfieffer, 1994; Whittaker, 2000). Bickman (1995) and colleagues conducted the extensive, highly funded Fort Bragg Evaluation Project (FBEP) that explored outcomes for SED youth served in a comprehensive system of care. According to Salzer and Bickman (1997), "systems reform efforts aimed at improving children's mental health services appear to produce important gains in how services are

delivered, but do not appear to significantly impact clinical outcomes" (p. 2). The rush to implement system level changes may have consumed funding and effort that could have been targeted toward developing more effective intervention.

The development of managed care systems for directing mental health services significantly impacted the care of SED youth and the professionals who served them. After decades of growth in expenditures for mental health services in both the public and private sector, confusion as to what constituted methodologically sound practices, and less than helpful findings regarding effectiveness of interventions, led government and private stakeholders to embrace managed care strategies. Fundamentally, managed care has been concerned with access, cost and quality. Proponents of managed care have advocated that active management of cases by pre-authorizations, utilization reviews, provider networks, and performance contracting enhances the quality of care while containing costs (Mordock, 1998).

However, the impact of managed care on the achievement of the desired goals is unclear. Stroul, Pires, Armstrong and Meyers (1998) concluded that under managed care, it has actually been more difficult to obtain needed services for SED youth, as well as the uninsured.The nationwide Health Care Reform Tracking Project (HCRTP) reported a number of problems that have arisen in the current environment. The project noted that ongoing efforts to develop systems of care for SED youth are not being linked to managed care initiatives and that there is a lack of coordination with other agencies serving these children (Stroul et al., 1998).

A legislative alert in August 1995 informed providers that the full House Appropriations Sub-Committee had slashed labor, education, and health and human services funds. The House Committee terminated 176 programs, and the three agency budgets were cut by $9.3 billion (Crosby & Kroeger, 1995). This essentially ended several programs, including CASSP. The committee did maintain the Children's Mental Health Service Funding (CMHS) at $60 million.

Built on CASSP principles, the CMHS provided grants to states, communities, territories, and Indian tribes for improving and expanding systems of care to meet the needs of SED youth and their families. Initially, the program was funded at $5 million annually and grew to $73 million by 1996. Grantees were required to include diagnostic and evaluation services, outpatient treatment, 24-hour emergency care, intensive home-based services, day-treatment, and respite care (Annual Report to Congress, 1997). Neither CASSP nor CMHS had any designated funds for investigating practice, innovation, or outcomes in residential treatment.

Clearly, American policy makers had become aware of the existence of the SED population during these years. Resources and efforts directed toward the population gained momentum only to be slowed by new administrations and political forces. Unfortunately, significant initiatives to promote community-based interventions seemed to discount the place of residential treatment in a continuum of care.

Contemporary trends and bias related to residential care: 1990's and beyond. Research, funding, and federal initiatives for meeting the needs of SED youth have targeted the development of systems of care and promoted community-based

interventions. Although researchers have continued to acknowledge that a percentage of the SED population are not being treated in the community, a strong conceptual bias has developed against residential treatment (Whittaker, 2000; Halfron, English, Allen, & DeWoody, 1994). In a report for the Surgeon General on mental health, residential treatment centers were judged to be serving more seriously disturbed youth (Burns, Hoagwood, & Mzarek, 1998). Concerns cited regarding residential care included a lack of a research base to substantiate effectiveness, incompatibility of this type of service with a community-based treatment approach, and costliness. Burns and colleagues (1998) questioned the usefulness of residential treatment, although they speculated that "an intensive long-term program with high staff to child ratio may be of benefit to some children, especially when sufficient supportive services are not available in their communities" (p. 16). Whittaker and Pfieffer (1994) suggested that attempts to seriously examine group childcare settings might have been resisted for fear of promoting residential services over family preservation and community alternatives. They described research for residential treatment as "sorely lacking" (p. 593). Pecora, Whittaker, and Maluccio (1992) reported that the reasons for this absence of research may be related to the lack of hard indicators of successful long term outcomes, inadequately developed models of treatment, and high costs.

A negative bias toward residential treatment was evident in the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (2000). The report called for exploration of interventions across the continuum of care, although it had little focus on in-patient settings. Burns (2000) questioned whether programs that

do not have an evidence base should be funded. It is contradictory to call for empirical data and then choose not to fund research related to a specific level of care that exists on the continuum. Well-intentioned and important programs like CASSP and CMHS promoted community-based care but ignored residential treatment settings that served the children with the most severe mental health problems.

In the Action Agenda, Burns (2000) is cited promoting that community based models have "contrasted sharply with traditional forms of institutional care, which can have deleterious consequences" (p. 35). Unfortunately, the limitations of outcome research for SED youth in residential treatment have done little to either support or dispute this claim.

Outcome Research in Residential Treatment

For at least the last 25 years, serious efforts to develop new models of care or study existing residential treatment programs have neither been funded nor promoted (Whittaker, 2000). The existing research on residential care is fragmented and varies in scope and quality. Most studies are deficient in one or more areas: absence of control conditions or comparisons, poorly defined service units, small samples, poorly selected outcome criteria, and limited relevance and utility for practice (Whittaker & Pfieffer, 1994).

It is unclear exactly which or how many children are being served in residential care. Burns and colleagues estimated that 8% of the SED children in treatment in the United States received mental health services in residential settings (Burns, Hoagwood, & Maltsby, 1998). They noted that the cost of care for these youth consumes nearly 25% of the national funding available for children's mental health services. After an extensive

review of residential treatment literature, Edwards (1994) reported that the exact number of children in residential treatment settings nationwide is not known. In an attempt to assess current data related to the diagnostic classifications of the children served, he concluded that the use of out of date language and diverse classification systems did not lead to clear information regarding the population.

Thus, little is known about what characterizes children in residential treatment. In a study that compared children served in residential treatment with those served in school settings, researchers found that youth in residential treatment were more likely to come from blended families. Children in residential treatment also had more often been previously placed in residential settings and had higher rates of conduct, anxiety, and attention deficit disorders. The two groups did not differ in intelligence, age of onset, or rate of depression or schizophrenia (Silver, et al. 1992). Blackman, Eustace, and Chowdhury (1991) suggested that residential treatment may be the "best option" for a small but significant number of SED youth. These teens generally presented with serious psychopathology, had few community supports, and often were potentially harmful to themselves or others if they remained in the community.

Youth referred to residential treatment have multiple needs and require a comprehensive spectrum of mental health, education, and child welfare related services. A National Survey of Residential Group Care was conducted from September 1981 through June 1982. Researchers examined nine types of residential placements and compared their findings to research conducted in 1966, in a Census of Children's Residential Institutions in the United States, Puerto Rico, and the Virgin Islands. They

reported that most settings were designed to serve smaller numbers of youth in 1981 than they were serving in 1966. During the fifteen years covered by the survey, the population of dependent or neglected children in residential care had dramatically decreased. Yet, mental health and psychiatric populations had increased, as had the numbers of children served in the juvenile justice placements. In the 1966 study, the collective staff in all types of settings, when asked about the presence of emotional disturbance in the population being served, believed 75% of the youth in residential care were experiencing emotional problems. In the 1981 study, across all settings, staff reported they believed at least 86% of the children they served were emotionally disturbed (Young, Dore & Pappenfort, 1989).

Pfieffer and Strzelicki (1990) reviewed all outcome studies in child and adolescent residential treatment and inpatient psychiatric hospitalization reported in the literature from 1975 to 1990. They concluded that residential treatment was often beneficial, particularly if there was a specialized treatment program and aftercare provided. They also indicated that youth with a "less pathological clinical picture" (p. 847) seemed to have more positive outcomes. Brendtro and Ness (1983) concluded that the fact that intervention is organized around a distinct conceptual framework may be more important than the specific program model.

The quality of support in the post discharge environment was found to be related to positive community adjustment (Pecora, Whittaker, & Malluccio, 1992). Family involvement and contact during residential placement also appeared to affect post placement success. Although having a specific treatment program seemed to be useful,

the type of program and severity of the presenting problem of the youth were not strongly associated with post placement adjustment.

Curry (1991) reviewed 5 major residential treatment studies published in the 1970's and 1980's. From that review, Curry concluded that research on residential treatment for children and adolescents has been limited by reliance on single sample designs. Yet, Whittaker's (2000) review suggested that this has still not been resolved. At the same time, the studies yielded useful information for conceptualization and post discharge planning. Pecora and colleagues (1992) found the degree of support and continuity of significant relationships seemed to predict better outcomes while age, IQ, sex, and length of stay did not predict discharge adjustment. Youth adaptability and adjustment within a program did not forecast discharge success, although the severity and type of dysfunction seemed to correlate with limited positive outcomes. Curry implied that the studies reviewed indicated that residential treatment should be considered "one step within a process or continuum of care" (p. 352). Blackman, Eustace, and Chowdhury (1991) reported positive outcomes and measures of long term effectiveness in their work with SED youth in a residential treatment program both at discharge and at one to three year follow up. In contrast, after reviewing outcome studies in residential treatment, Melton and colleagues (1998) generalized that there was little evidence that residential treatment was effective when compared to well-conceptualized non residential alternatives.

Future Directions

Six issues that should be explored in order to improve the quality of care in residential treatment for emotionally disturbed children were identified in the research literature.

These include: 1) appropriate identification of SED youth, 2) professional preparation and staff training, 3) intervention models and strategies, 4) coordination of resources, 5) improved research design, and 6) communication.

It is unclear which subgroups of children are best-served in residential settings. Other areas to explore include innovative program model development, client information systems, family involvement and how the coordination of residential and community resources could be enhanced. Research that examines successful community transition and the maintenance of treatment gains also would be useful (Pfieffer & Strzelecki, 1990). Staff training and improving professional preparation to bridge the gaps that often exist between education and necessary clinical skills for working effectively with difficult children also merits attention.

Clearly, there is a need for a detailed report of the current state of the art in group childcare programming (Whittaker & Pfeiffer, 1994). Curry (1991) suggested that future studies should use more powerful research designs and more sophisticated statistical analysis that would allow scientists to examine interactions among causative factors. Outcome criteria, treatment success, and child adjustments require improved definition and measurement. The dissemination and adoption of relevant findings in residential care research needs to be facilitated (Pfieffer & Strzelecki, 1990). According to Whittaker (2000) "the greatest tragedy would be to extend into the next century the polarizing debate which has engulfed group childcare through much of the last hundred years…Group care, in any of its forms is no panacea. Yet, it deserves a thoughtful,

critical review to determine its proper place and function in the over all continuum of care and services" (p. 72).

Implications for Nursing Research

Nurses work with SED youth in hospitals, residential treatment, and outpatient facilities. Settings which employ nurses tend to serve the "most disturbed," those who need medication, are difficult to keep safe, and often lack support systems. Many of these children have "failed" in family and community settings and arrive in residential care as a "last resort." Contemporary policy has advocated for a continuum of care to provide intervention for these youth although bias has been generated toward the services delivered at the restrictive end of the continuum. It is vital to remember that some children will be in out-of-home placements that are not family settings. There are not enough foster families and many youth have problems that are too severe to be managed and treated in community-based settings. Little or no up-to-date information is available which assesses these youth, identifies their difficulties or investigates their progress, or lack of progress, in treatment. This study will describe these youth and assesses their deficits and gains and will serve as a foundational study for a nurse researcher committed to caring for this population.

Measuring SED Youth Treatment Outcomes

Measuring treatment outcomes for SED youth has been described as complex and difficult (Breda, 1996). Often several tools are used in an attempt to gain a comprehensive assessment. Behavioral checklists have been the foundational tools for this type of

research although they are limited as they do not address underlying psychological, developmental, emotional or social factors.

A key indicator of psychological, social, and emotional health is an individual's effectiveness in social interactions or social competence. According to Guralnik and Neville (1997), the construct of social competence captures how individuals define and solve the most fundamental problems in human relationships. Social competence has been viewed as an organizing phenomenon with transactional, context dependant, and goal specific characteristics. As a dynamic higher order construct, it includes skills and abilities in cognitive, communicative, affective, and motor domains that are coordinated toward achieving inter and intra-personal goals. Rutter and Garmezy (1983) described social competence as that set of cognitive, emotional, and behavioral abilities that initiate and sustain interactions with others, build friendships, and achieve related interpersonal goals.

SED youth have significant deficits in social competence (Achenbach & Edelbrock, 1981; Curry, 1991; Hartup, 1983; Rutter & Garmezy, 1983). Historically, social competence has been measured by behavioral assessments, skills checklists, and peer reports (Merrell & Gimple, 1998; Rose-Krasnor, 1997). Developmental psychopathology emphasizes the salience of assessing deficits in the earlier competencies. It is crucial that researchers assess developmental deficits as well as gains when evaluating SED youth. The construct of social competence can be evaluated from a developmental standpoint. To provide additional foundation for this study, key research related to social competence

is reviewed and a theoretical framework that defines social competence from a developmental perspective is presented.

Considering Social Competence

Many investigators agree that social competence can be defined as effectiveness in social interactions; however, operationalizing and measuring the construct has proven challenging (Shultz & Selman, 2001; Rose-Krasnor, 1997; Waters & Sroufe, 1983). Empirical efforts have generated theoretical constructs and explored processes that have contributed to the understanding of the development of social competence.

Ladd (1999) completed a comprehensive review of social competence literature. He summarized that researchers in the 1960's focused on exploring pro-social behaviors and social skills. Following these early studies, investigators sought factors that contributed to the development of positive social behaviors. Skills acquisition and information processing were investigated by some, while others focused on early socialization contexts. In recent years, genetic and temperament components of social competence have been considered.

Social scientists have reviewed this diverse work and proposed that in addition to biology (nature), environment (nurture), information processing and social behavior, the construct of social competence also has a developmental quality (Shultz & Selman, 2001; Gurlanik & Neville, 1997; Masten & Coatsworth, 1998; Rose-Krasnor, 1997; Selman & Demorest, 1984; Waters & Sroufe, 1983). An overview of key research related to social competence is presented using the broad categories of biology, environment, information

processing, and social behavior. A theoretical framework, which incorporates these constructs within a developmental perspective, is discussed.

Biology - Nature

Genetics, attachment and pro-social behaviors. It is likely that genetic factors impact a child's social competence. Ones' ability to form attachments, process information and develop skills may have certain biologic underpinnings. The inability to form normal social attachments has been correlated with many types of psychopathology although there has been little research devoted to discovering the neural basis of social bond formation (Thomas, 1997). In studies with rat pups, oxytocin facilitated learning when it was associated with social cues or maternal care but did not stimulate learning with non-social stimuli (Nelson & Panskeep, 1996). Evidence suggests that oxytocin and vasopressin neural pathways are mediators in attachment behaviors though there is only preliminary understanding of how these hormones act within the brain to impact complex social behavior (Thomas, 1997). In mammals, normal brain development and behaviors are critically impacted by social experiences. However, little is known about social attachment in contrast to general environmental enrichment, as related to the impact on the developing brain (vanPragg, Kemperman, & Gage, 2000).

Eisenberg and Fabes (1998) reported that twin studies have been a means for exploring genetic contributions to individual differences in pro-social behaviors. Researchers hypothesized that if identical twins' scores on pro-social scales were more highly correlated than the scores of fraternal twins, the difference in scores could be

attributed to genetics. These investigators assumed that environmental factors were relatively equal for each type of twins.

Research using adult twins' self report data found that nearly 50% of the variance in twins' altruism could be accounted for by genetic factors. The remaining variance was attributed to environmental factors (Matthews, Batson, Horn, & Roseman, 1981; Rushton, Fulker, Neal, Nias, & Eyenck, 1986). When twin children's reactions to simulations of distress in others were examined, a significant genetic component was identified related to pro-social acts and empathic concern. Unresponsiveness and active indifference also showed genetic tendencies (Zahn-Waxler, Robinson, & Emde, 1992).

Genetic factors that impact social behaviors have also been examined. From animal studies, Panksepp (1986) hypothesized that brain opiods influenced the extent to which social contact was reinforcing. According to Panksepp (1986), helping behaviors in mammals arose from the "nurturant dictates of brain systems that mediate social bonding and maternal care" (p. 44). Brain chemistry and neurotransmission are believed to impact not only the behaviors that enhance social relationships but also the degree to which social relationships are rewarding to the individual.

Genetics, temperament and attachment. A person's behavioral style or temperament may significantly impact the development of social competence. Houck (1999) concluded that temperament is a central influence on social competence. Temperament has been described as the "how" of behavior in contrast to the "what," which reflects a child's developmental level, or the "why," that implies underlying motivation (Thomas & Chess,

1977). This characteristic style and behavioral response could be viewed across situations, especially those involving stress or change (McClowry, 1995).

Genetically based temperament characteristics are believed to be present at birth and researchers have suggested that within the first few months of life, temperament is established (Thomas, Chess, & Birch, 1968; Thomas & Chess, 1977). In their classic work, Thomas, Chess and Birch (1968) identified nine dimensions of temperament that could be assessed during infancy: activity, biologic rythmicity, initial approach withdrawal, adaptability, intensity of reaction, prevailing mood, persistence and attention span, distractibility, and sensory threshold. An infant's responsiveness to internal and external stimuli and its reciprocal influence have been observed in early interactions between infants and caregivers. These interactions in turn contribute to relationship development or attachment and subsequently support development and shape social behaviors (Carey, 1978). According to Melvin and McClowry (1995), temperament influences the interactions that occur in reciprocal relationships between the child and the environment. These interactions impact behavior and development.

Although characteristics of temperament may be recognizable in infancy, some investigators have suggested that peri-natal influences may buffer or override true temperament presentation. Furthermore, temperament may be more readily assessed in the course of early childhood (Carey, 1992). McClowry and colleagues (1994) suggested that temperament in school-aged children consisted of four dimensions: negative reactivity, task persistence, approach/withdrawal, and activity. These characteristics of a

child's temperament were thought to play a key role in social development (Kagan, 1987).

Houck (1999) found that temperament difficulty in toddlers was negatively related to social competence. High negative reactivity, high activity level, low approach, and low task persistence have also been associated with poor adjustment in school-aged children. In contrast, children with positive self-perception demonstrated lower activity levels, higher approach characteristics, and higher task persistence (Carey, 1992).

Not all children with extreme temperaments develop social or behavioral problems. It was clear that "goodness of fit" or caregivers' ability to use optimal and adequate approaches with a child significantly impact a child's behavioral and developmental responses (McClowry, 1995). Maziade and colleagues (1990) found that early school-aged children with extreme temperaments who lived in dysfunctional families were more likely to develop clinical disorders than peers with similar temperaments who lived in functional family systems.

Studies have indicated that some temperament characteristics may have contributed to the evolution of behavioral problems in early and middle childhood and at times these problems continued into adolescence (Mehregany, 1991; McClowry, 1995; Blackson, Tarter, & Mezzich, 1996; Brier, 1995). However, temperament did not seem to produce new behavioral difficulties in adolescence that were not identified in earlier years. According to Carey (1992), adolescents and older children demonstrated an ability to intentionally modify their reaction patterns in response to social pressures.

Carey (1992) implied that although temperament is a behavioral style, it is not the only factor impacting social behavior, emotional performance, and adjustment of a child. For instance, a "hot temper" may be a matter of temperament, which may or may not become a behavioral or clinical problem. Parental response and various child characteristics can impact how temperament is played out. If social competence were solely based in temperament, it would be reasonable to assume that all children with extreme temperaments would struggle with social competence. This has not been supported in the research. It is likely that the genetic predisposition for certain temperament characteristics in combination with the "goodness of fit" impacts social development.

Explorations of the biological underpinnings of attachment, prosocial behavior, and temperament have implications for the development of social competence. Many of the studies are preliminary and hypotheses are being advanced regarding neurological pathways and brain development. However, specific biochemical or pharmacological interventions related to attachment, altruistic behaviors, and temperament are not yet established. Consensus among the researchers is that social environment impacts brain development. It is not within the scope of this study to assess brain development although it is assumed that disruptions in attachment and parenting have impacted SED youth both biologically and socially.

Environment - Nurture

S*ocialization context: Family and attachment.* The environmental context of family relationships has been widely examined by investigators exploring children's social

competence. Bowlby (1969, 1980, & 1982) described how an infant's relationship with a primary caregiver underlies later social-emotional development. Early attachment relationships serve as models upon which ideas of self and attachment figure are constructed. These first experiences influence how a child relates to others, approaches the environment, and negotiates social and emotional developmental milestones. According to Bowlby (1980), the person who had formed a secure attachment has developed a representational model of an available, responsive, and helpful caregiver and a complimentary model of self as potentially loveable and valuable.

Houck and Spegman (1999) described the dynamic system that exists between parent, child, and the social context in the development of social competence. From birth onward, infants have been responsive to social interactions like facial expressions, voices, and mother's displays of emotion. These reciprocal interactions between adult and child serve as foundational experiences for infants to mimic, respond to, and initiate socialization. These infant experiences in early attachment relationships serve as foundations for internal working models of relationships. It is hypothesized that these models often guide subsequent interpersonal behaviors and social experiences. Puttalaz and Helfin (1990) proposed that attachment relationships established the social orientation that was generalized to others and provided a secure "home base" that facilitated a more confident and less anxious exploration of the social world.

The security of the attachment relationship has primarily been attributed to parental responsivity (Ainsworth, Blehar,Waters, & Wall, 1978). Developmental theorists have described the competent mother-infant dyad in which an infant was able to secure what

he or she needed through influencing the behavior and responsiveness of the mother (Masten & Coatsworth, 1998). Mothers of securely attached infants have been found to be more sensitive to the cues of their babies, more consistent and appropriate in their responses, and more positive in their emotional expressions during these interactions than mothers of insecurely attached infants (Ainsworth et al., 1978; Isabella, 1993). This correlation is so robust that Attili (1989) suggested parental sensitivity and responsiveness to infant communication could be considered a measure of an infant's social success. Clearly, infant competence is imbedded in the care giving system. The quality of these infant-adult relationships depend on both the skills of the child and the skills of the caregiver (Rose-Krasnor, 1997)

Guralnik and Neville (1997) reviewed how interactional styles between parents and their offspring have been linked to social competence in the child. The most consistent findings have indicated that the presence of parental control and warmth were strongly related to high levels of child social competence. Parents with skills to display both positive and negative affect, especially when these responses correlated with encouraging compliant behavior and discouraging non-compliant behavior, had children who were noted to be highly socially competent (Gottman, 1986; LaFreiniere & Dumas, 1992).

Studies related to pro-social child behaviors have explored a wide variety of contextual factors for their contribution to social competence. Socioeconomic status, family structure, parental presence verses absence, single parenting, family size, and ordinal position of children have been examined. The literature in these areas is not conclusive although the findings suggest that when family situations are chaotic,

unpredictable, and unclear, children have more significant difficulties (Guralnik & Neville, 1997).

Parental disciplinary practices have been investigated in relationship to pro-social behaviors. The majority of the literature indicates that an inductive style of discipline, one in which the parent explained the problem and the consequence, was most positively correlated with children who demonstrated positive social behavior (Hoffman, 1983; Ionnotti, Cummings, Pierrehumbert, Milano, & Zahn-Waxler, 1992; Miller, Eisenberg, Fabes, Shell, & Gular, 1989). When parents used power/assertive techniques such as physical punishment and deprivation, it appeared that social competence was either unrelated or negatively impacted. Punitive, authoritarian styles and physical abuse have been associated with children who have low levels of empathy and diminished pro-social behavior (Dekovic & Janssens, 1992). It is believed that these early familial experiences could impact later peer relationships.

Peers. Working models of relationships that guide subsequent social behaviors with peers and others have been founded upon the attachment relationships formed during early childhood. Rutter and Garmezy (1983) found a strong relationship between the quality of attachment in infancy and later social competence. The quality of attachment has also been correlated with more positive and less negative affect in children (La Freniere & Sroufe, 1985), increased responsiveness toward other children (Kestenbaum, Faber, & Sroufe, 1989), and displays of more positive self esteem (Sroufe, 1983). Studies with teachers have indicated that securely attached children have fewer behavioral problems and were seen as more socially competent and emotionally healthy than a peer

group identified with insecure early childhood attachment (Cohn, 1990; Erickson, Sroufe, & Egeland, 1985). It is clear that securely attached children demonstrate both affective and behavioral characteristics that contribute to positive manifestations of social competence, which in turn contributes to successful peer relationships.

Early attachment relationships have been identified as precursors to later social-emotional development. Thus, it is important to consider the impact of parents/primary caregivers in the early life of a child and disruptions in care giving relationships when looking at disturbances in social competence. While care giving relationships provide the foundation for social competence, an individual's growing ability to assess the environment, determine a course of action, and evaluate the responses of self and others also impacts positive social interaction.

Information Processing

Social information processing and social problem solving have been considered to be core abilities that underlie social competence (Gurlanik & Neville, 1997). Social problem solving research has served as foundational for information processing models (Dodge, 1986; Goldfried & d'Zurilla, 1969; Rubin & Krasnor, 1986). Several process models have been proposed. According to these models, social behavior results from a multi-step social-cognitive process. In general, this process involves the selection of a social goal, awareness of the environment, creating and selecting strategies, evaluating actions, and deciding on future actions (Rose-Krasnor, 1997). Dodge (1986) asserted that social competence was based on the ability of the child to negotiate each of these steps while integrating them into a successful sequence.

Ford (1982) developed a comprehensive systems approach, which described social competence in terms of youth and the environmental barriers that interact to produce effective behaviors. He hypothesized that three systems worked together to form social competence. The directive system consists of intentions, desires, and goals. The control system is believed to organize and monitor progress toward the goals. Finally, the regulatory system works to re-integrate outcome information.

While process models have provided ideas about how decisions are made, they have done little to explain how the behaviors and cognitive skills are acquired, how they change over time, or how they are impacted by the socialization context. Researchers have proposed that social information processing is learned within the parent-child relationship and is then generalized to others (Dodge, 1986; Pettit, Dodge, & Brown, 1988).

Parenting or primary socialization relationships impact brain development, mediate temperament, facilitate attachment, and are believed to be the contexts in which social information processing skills are acquired. When considering SED youth with deficits in social competence, exploring their ability to process social information could provide added insight into the deficiencies or difficulties in their understanding. For this study, the complexity of interactions must be considered and changes in primary caregivers and youth placements will be tracked.

Social Behaviors

Investigations exploring positive peer relationships often focused on specific child behaviors or social skills. By defining social competence in terms of pro-social behaviors

or skills, researchers were able to measure the variables by means of behavioral checklists (Gresham & Elliot, 1990; Matson, 1984; Merrell & Gimple, 1998). In an effort to identify behavioral aspects of social competence that correlated with relational constructs like peer acceptance, Ladd (1999) concluded that, whereas antisocial and disruptive behaviors were likely to cause poor peer relationships, pro-social behaviors led to positive outcomes. It was hypothesized that children with problematic relationships lacked social skills (Bielmann, Pfingsten, & Losel, 1994; Ladd, 1999; Mize & Ladd, 1990). Ladd (1999) described that out of the "skills hypothesis" grew studies that sought to determine why some children manifested skills while others did not. Research exploring skills acquisition, information processing, and socialization contexts evolved.

Decades earlier, in 1973, the U.S. Office of Child Development supported research that ultimately identified 29 diverse aspects of social competence ranging from specific motor skills to abstract concepts, like consolidation of identity (Anderson & Messick, 1974). Although the list was generated by a panel of experts and was theoretically based, it has been difficult to empirically validate the large number of diverse skills (Dodge, 1986; Waters & Sroufe, 1983). Specific behaviors and positive status in peer groups have not been found to have a strong correlation (Parker & Asher, 1993). Although defining competence as a set of skills may make measurement easier, it is questionable whether a skills list truly reflects social competence. As Waters and Sroufe (1983) asserted a decade ago, social skills are likely to be highly specific to given ages and situations, and are not likely to be relevant to understanding ongoing individual adaptation. Therefore, in this study, the measurement of social behavior will be included. An underlying assumption is

that social behavior in and of itself does not constitute social competence. It is anticipated that prosocial behaviors may reflect more positive levels of social competence.

Developmental Implications

Historically, research in child development and in child psychiatric disorders have been separate endeavors. However, developmental psychopathology has drawn these efforts together (Rutter & Garmezy, 1983). Rutter (1987) proposed that development stands as a link between biological endowment and environmental influences. Disruption in early childhood, such as illness, family dysfunction, major loss and trauma, has been found to be associated with adult psychopathologies. Negative effects of maltreatment on long term mental health have been documented (Cicchetti & Toth, 1995). Thus, the severity of psychiatric disorder can be considered in terms of the extent of interference that occurred in the normal course of development (Rutter, 1975). It is important to recognize that developmental level is not necessarily synonymous with chronological age (Rutter, 1989). If a child does not successfully negotiate an earlier developmental stage, he or she will be less able to negotiate later stages, and will be less competent in later life (Arend, Gore, & Sroufe, 1979). Therefore, children must be assessed in terms of their patterns of adaptation with respect to the salient developmental issues of a given age of disruption (Kazdin, et al, 1997).

Cox and Rutter (1985) asserted that, just as there are milestones in physical and motor development, likewise there are indices of social and psychological growth. An assessment must include individual domains of cognitive, linguistic, representational, social-cognitive, social-emotional, and interpersonal functioning (Cicchetti & Toth,

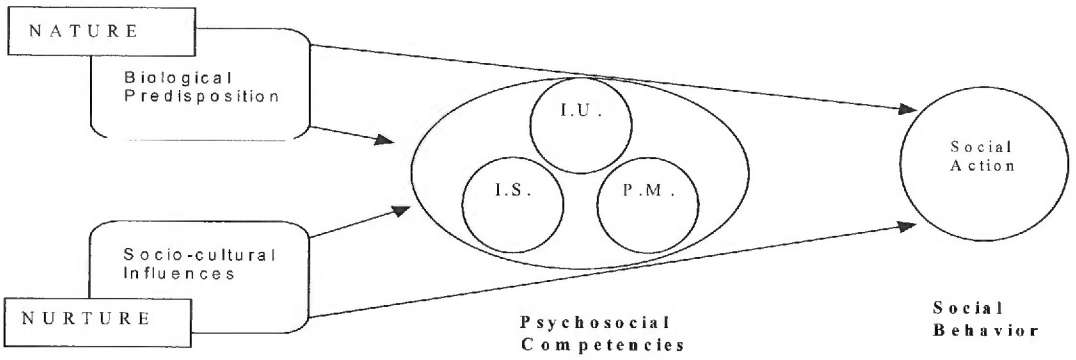
1995). Further, within-subject variability is likely; that is, a child may be advanced cognitively, but may lag behind socially or emotionally.

Contemporary researchers and theorists, from this perspective, hold that the foundation of competency in adulthood originates in childhood. In broad terms, competence is a result of complex interactions between a child and the environment into which he or she was born or adopted. As the child develops, changes occur and the social contexts vary. Children's developmental levels impact their reception of parental information (Masten, Coatsworth, Neeman, Gest, Tellegen, & Garmezy, 1995). A child's environment and, hence, attainment of competency is influenced by his care givers, peers, and social environment. Social competence therefore may be influenced particularly by the social environment, and has been described as a salient developmental issue beginning in infancy (Rose-Krasnor, 1997). In healthy development, specific behavior patterns emerge to meet the adaptive demands associated with each new life stage (Guralnik & Neville, 1997; Matsen & Coatsworth, 1998; Rose-Krasnor, 1997; Rutter & Garmezy, 1983; Waters & Sroufe, 1983). Realizing the importance social competence plays in positive human relationships, this study proposes to not only examine social competence in SED youth but also to view social competence from a developmental perspective.

Group for the Study of Interpersonal Development (GSID) Relationship Model

Selman and Demorest (1984) have articulated a conceptual framework depicting the development of social competence. They proposed a model for considering social competence from an orthogenic perspective. Orthogenesis implies movement from a

relatively global state and lack of differentiation to a position of differentiation and hierarchic integration (Werner, 1948). An orthogenic perspective allows for regression, which differs from an ontologic focus that views development in a chronological, sequential fashion. The GSID has advanced this work and proposed the GSID Relationship Model (Shultz & Selman, 1998). The model indicates that nature (biology) and nurture (environment) proceed and influence the development of social competence. In turn, social behavior is viewed as the outcome of these factors mediated by the developing coordination of social perspective (Figure 1).



I.U. = Interpersonal Understanding P.M. = Personal Meaning I.S. = Interpersonal Skills
Adapted Levitt, Selman, and Richmond (1991)

Figure 1

The GSID Relationship Model serves as a useful conceptual framework for exploring the development of social competence. This conceptual framework proposes that "social competence ultimately rests upon the capacity for forming close relationships with other people, and that capacity in turn is grounded in psychosocial competence or internal psychological development" (Shultz & Selman, 1998, p. 2). The model assumes that development of social competence is based on the growing ability of a person to

differentiate and organize the social perspective of self and others on a cognitive as well as an emotional level.

Three distinct developing psychosocial components impact social perspective coordination and thus competence: interpersonal understanding, personal meaning, and interpersonal skills. These constructs are viewed as dynamic and transactional, related to one another, and organized around the core cognitive operation, coordination of social perspective (Figure 2).

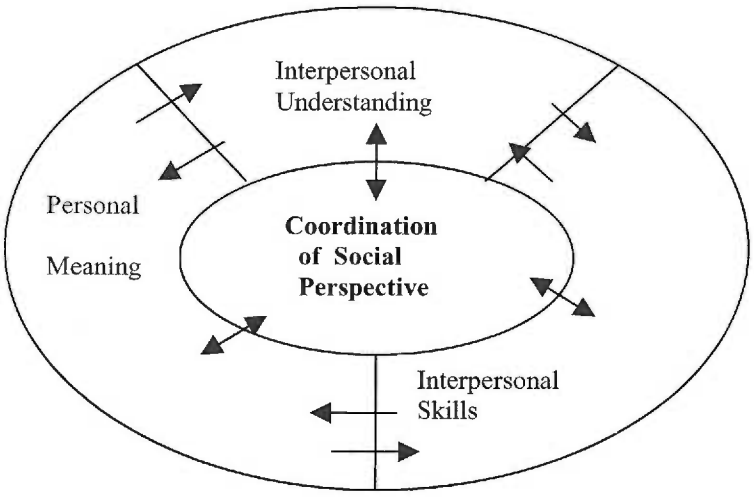


Figure 2

Interpersonal understanding is defined as the individual's ability to comprehend core psychological and social qualities of persons and relationships. This construct includes the understanding related to forming and maintaining relationships. At its most early stage, interpersonal understanding is based entirely on self-identification. Through growth and development, individuals increase their abilities to consider others' points of view and to comprehend the impact of external factors (society and culture) on social relationships.

Personal meaning or relationship valuing refers to a person's ability to connect their behavior in relationship to their own life history. It is considered the affective component of the model. With increased development, individuals are able to integrate the impact of past experience on present relationships. This construct takes into account the values, attitudes, and beliefs about specific relationships.

Interpersonal relationship skills are the repertoire of actions that people develop in the context of relationships. These skills serve to promote autonomy, which is operationalized as interpersonal negotiation strategies as well as intimacy which is viewed as shared experience. Shultz and Selman (1998) proposed that these components develop on parallel paths reflecting a continuum from immature or undifferentiated, to mature or differentiated and integrated.

Children's developing capacity to reflect on their own and others' perspectives related to social interactions is the core social developmental process (Figure 3). A key assumption of the model is that individuals do not consistently reason or act at the same developmental level in different interpersonal contexts. Even within a single interaction or context the developmental level of one's communication strategies may cover a wide range, and performance levels are often not consistent with the highest level of thought possible (Shultz & Selman, 1998).

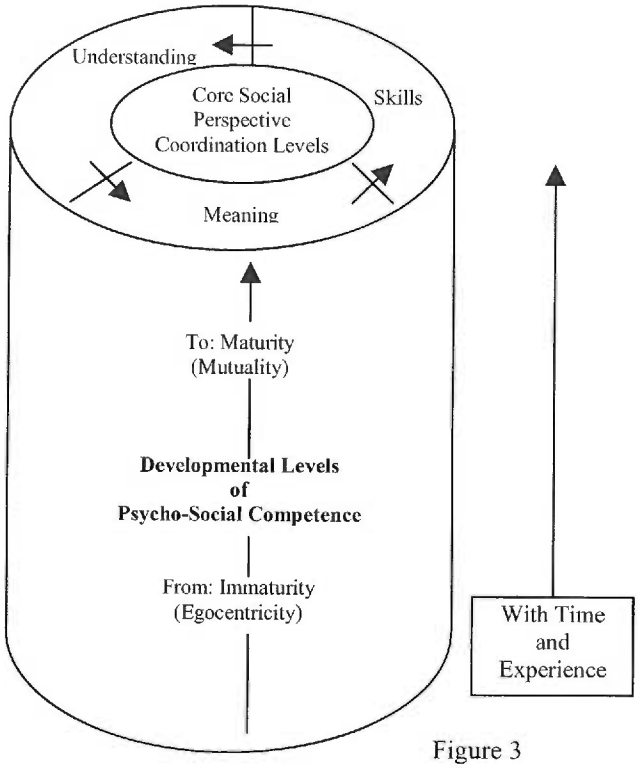


Figure 3

This conceptual model makes it possible to examine the development of social competence and consider the impact of this development on outcome behaviors. Based upon this framework, Schultz and Selman (1998) designed the GSID Relationship Questionnaire (Rel-Q) to assess deficits and gains in social competence.

Summary

Residential treatment for SED youth is often the intervention of "last resort". Children are placed in residential settings when they have not been able to remain safe in less restrictive environments. Although their deficits can be demonstrated on behavioral measures, interventions that solely target behaviors or social skills have not been proven to produce the development of healthy social competence (Ladd, 1999; Parker & Asher, 1993; Waters & Sroufe, 1983). Developmental psychopathology compels one to consider

developmental trajectories when assessing youth. It is clear that many children in residential treatment have significant deficits in their social emotional development. Selman and Demorest (1984) proposed that social competence is a developmental construct that begins with biology (nature) and environment (nurture) and is impacted by information processing which in turn produces social behavior. Exploring SED youth deficits and gains in the development of social competence using the Rel-Q could provide increased understanding of the population being served in residential treatment. It is hoped that research attention directed toward SED youth in a residential treatment setting and the exploration of behaviors and social competence in this population will positively impact treatment strategies and, in turn, influence child and adolescent outcomes.

Chapter 3

Method

Design

A one-group pretest-posttest design using previously collected data was used to explore the relationship between behavior problem and social competence scores of SED youth upon admission to and within 10 days prior to discharge from residential treatment. Specific demographic and socio-cultural variables were examined for their contribution to the variation in both behavioral problem and social competence scores at admission. These variables and selected treatment variables were examined for their contribution to the variation of the behavioral problem and social competence scores gathered within 10 days of discharge from residential treatment.

Hypotheses

1. SED youth at admission to residential treatment will have behavioral problems (CBCL) and deficits in the development of social competence (Rel-Q).

2. Upon admission to and within 10 days of discharge from residential treatment, higher behavioral problem scores (CBCL) will correlate with lower scores on social competence measures (Rel-Q).

3. Between admission and discharge, SED youth in residential treatment will exhibit fewer behavior problems (CBCL) and demonstrate positive change on social competence measures (Rel-Q).

4. Controlling for demographic variables of age, gender, and race, it is expected that SED youth who have the socio-cultural variable of many changes of placement prior to

residential treatment will have higher behavior problem scores (CBCL) and lower social competence scores (Rel-Q) at admission to residential treatment.

Sample

The target population for this study was children between the ages of 11 and 18 years who were identified as SED and admitted to a psychiatric residential treatment center in central Montana. Data were collected, via chart review, on all youth admitted from June, 2001 through February, 2003 to the residential treatment center (RTC), who met inclusion criteria. Inclusion criteria were: youth, age 11-18, who were admitted into the RTC, had an IQ over 80, a reading level at least at 4th grade, and a length of stay at the facility of 4 months or more. Exclusion criteria were: under age 11, an IQ less than 80, a reading level below 4th grade, and/or a length of stay at the residential treatment center less than 4 months.

In this study, 125 youth met inclusion criteria; 113 completed the intake tools. Three of those originally enrolled had insufficient reading skills, 2 refused testing, and 7 failed to complete the Rel-Q correctly. Of the 113, 62 were male (55%). The population was largely Caucasian (68%; n = 77), with 12% Native American (n = 13), 11% multi-racial (n = 12), 4% Hispanic (n = 5), 3% African Americans (n = 4), and 2% Asian (n = 2). The children ranged in age from 10.4 to 17.8 years; the average age at admission was 14.65 years (*SD* = 1.71).

Data collection was completed by June 2003. Within the study period, 76 youth were discharged from the residential treatment center. Thirteen of those discharged were not assessed due to short lengths of stay or unplanned exits. Thirty-seven youth had not been

discharged and remained in the treatment program. The age range, number of out-of-home placements, and scores on the Rel-Q and CBCL of the early discharge group and those who remained in treatment were not significantly different than those youth who completed the discharge assessments.

Sixty-three youth completed both the intake and discharge assessments. In this group 38 (60%) were male. The majority of those completing the intake and discharge assessments were Caucasian (71%, n =45), with 8% Hispanic (n= 5), 8% multi-racial (n = 5), 5% African American (n = 3), 5% Native American (n =3), and 3% Asian (n=2). They ranged in age from 11.5 - 17.8 years of age at admission with their average age being 15.08 years (*sd* = 1.5). The length of stay ranged from 2.0 to 18.6 months with a mean length of stay of 9.6 months (*sd* = 4.4).

Three broad categories of primary diagnoses were assigned to the youth at discharge. Seventy-one percent of the youth had primary diagnoses of mood or anxiety disorders (n = 45) that included bipolar disorders, depressive disorder, dysthymic disorder, major depression, obsessive-compulsive disorder, generalized anxiety disorder, and posttraumatic stress disorder. Disruptive behavior disorder including attention deficit disorder, oppositional defiant disorder, conduct disorder, impulse control disorder and intermittent explosive disorder diagnoses were primary diagnoses for 19% (n = 12) of the sample. Reactive attachment disorder and pervasive developmental disorders were discharge diagnoses for 5% of the population (n = 3). Less than 5% of the youth had other diagnoses, e.g., schizoaffective disorder and cannabis abuse.

Measures/Instrumentation

Child Behavior Checklist 4-12 (CBCL). The CBCL (Achenbach, 1991) is a multi-axial empirically based measure of children's competencies and behavior problems as reported by their parent or surrogate parent (Appendix A). Youth self report (YSR), parent/caregiver (CBCL), and teacher report (TRF) forms of the instrument are available. The CBCL can be self-administered or administered by an interviewer and consists of a 118-item checklist of behavior problems. Additional space is also provided for the interviewee to include other physical problems not accounted for medically, and any other problem or issue. Responses are circled on a 3-step scale (2 = "very true", 1 = "somewhat true", and 0 = "not true") and refer to the child's behavior currently or within the past 6 months. The CBCL was designed to discriminate between children referred for mental health services and those not referred.

The CBCL, TSR, and YSR consist of eight subscales and two major syndromes: internalizing and externalizing. Subscales for withdrawn, somatic complaints, and anxious/depressed behaviors are summed for the internalizing score. Delinquent behavior and aggressive behavior constitute the externalizing score. Other subscales include social problems, thought problems, and attention problems. An additional subscale can also be scored for sexual problems.

Subscale scores are computed by summing item scores. Scores are converted to T scores in order to compare child scores with those obtained in a normative sample of children. Normative sample scores have been calculated for age groups 4 - 12 years and 12 - 18 years for both males and females. T scores range form 50 - 100 for each broad

dimension and subscale, and borderline clinical range falls between 67 and 70. T scores above 70 indicate clinical problems. For raw total problem scores, borderline clinical range falls between 60 and 63. The syndrome scales were derived from principal components analysis of correlations among items and thus composition of scales is based upon internal consistency among certain subsets of items.

Measures of internal consistency have been calculated for each subscale and syndrome as well as total problem scores. Previously reported Chronbach's alphas for syndrome subscales ranged from .68 - .96 for males (12 - 18 years) and .70 - .96 for females (12-18 years). In this study, alpha coefficients were .65 -.93 for males (12 - 18 years) and were .70 - .93 for females (12 - 18 years). The consistency estimates for the internalizing subscale for males were .86 and for females were .92. The externalizing subscales for males were .94 and for females were .95. The total problem score alpha for males was .95 while females alpha was .97.

Test retest reliability on the CBCL was calculated with mothers' ratings of a non-referred sample (n = 80) over an average of 7 days. All test re-test r's were significant at $p < .01$. The Pearson correlation for all competence scales was .87 and for the problem scales was .89 (Achenbach, 1991). Therefore, the scales are thought to be stable over the short term.

Construct validity for the CBCL was established with the Quay - Peterson Revised Behavioral Checklist (r = 82) and the Connors Parent Questionnaire (r = .81) (Achenbach, Connors, Quay, Berhulst, & Howel, 1989; Achenbach & Edelbrock, 1978; Weissman, Orvashel, & Padian, 1980). Criterion related validity was discussed in terms

of the relationships between scores on the CBCL and the classifications in the Diagnostic and Statistical Manual (DSM). Since the DSM has undergone multiple revisions it has been difficult to establish precise calibrations. Studies have shown significant relationships between CBCL syndrome scores and relevant DSM diagnoses (Edelbrock & Costello, 1988). Because there are no other empirically validated diagnostic systems, the authors examined the degree to which each scale differentiated between referred and demographically matched non-referred youth.

In this study, correlations were calculated between the CBCL total problem scale and the major dimensions, internalizing syndrome (r = .76) and the externalizing syndrome (r = .87).

Group for the Study of Interpersonal Development Relationship Questionnaire (GSID Rel-Q). The GSID Rel-Q (Schultz & Selman, 1998) assesses children's developmental level of interpersonal competence and self reported action. The measure has two conceptually similar though empirically different versions: a K-3rd grade picture-based version, and a 4th - 12th grade written version. The version for 4th through 12th grade was used in this study (Appendix B). It is a multiple-choice instrument that requires third to fourth grade reading skills.

Each item represents a social situation or problem to which there are four multiple choice responses. Each response represents a particular developmental perspective in the domain represented by the item. The domains or scales are: 1) interpersonal understanding of relationships, 2) hypothetical interpersonal negotiations and social perspective coordination, and 3) real life interpersonal negotiation and personal meaning

of relationships. Participants are asked to respond to the 24 items by using a 4-point Likert-type scale on which the youth is asked to rate responses as poor, OK, good, or excellent, and to select the best of the four given responses. An example of an interpersonal understanding of relationship item is question "4" from the GSID Rel-Q.

4. The best reason to explain why kids your age fight is

	Poor	OK	Good	Excellent
a) they get mad at people who talk behind their back	___	___	___	___
b) they were hit by another kid	___	___	___	___
c) they can't see any other way to deal with some people	___	___	___	___
d) they like fighting to show who's boss	___	___	___	___

Write the letter (a,b,c,d) of the choice that you think is best in this box: [_]

The item rating is not a forced choice; rather, each item can be scored independently by the youth. The scoring guide presents the level scores to be assigned for each response on the Likert scale. A total item rating is calculated for each question by summing the 4 level scores and dividing by 4. "Best response" scores are computed by averaging "best response" item ratings for each question in a given domain. Selman and Schultz (2001), note that the best response and item rating scores have an assigned developmental metric and can be averaged into one overall relationship maturity score and one score for each subcale. The raw scores on items and "best responses" are coded egocentric (0), one-way (1), reciprocal (2), and mutual (3). The questionnaire is pre-coded with developmental levels. Raw scores were obtained at admission and discharge and were converted to T scores for comparison with norms.

Internal consistency for the 4+Rel-Q was adequate, with an alpha of .85 for the overall relationship maturity score (Schultz & Selman, 1998). In this study, alpha was .77 for the overall score. Subscale coefficients in Schultz and Selmans' work ranged from .32 to .63, indicating that the overall score had more internal consistency that the relationship subscales. In this study subscale coefficients ranged from .39 to .53. In earlier studies, intercorrelation between subscales ranged from .32 to .60 (Schultz & Selman, 1998 & 2001). The current study yielded intercorrelations ranging from .23 to .74.

Validation studies used data from three school-based program evaluation studies on children from kindergarten through eighth grade and one summer program for high school seniors. On the 4+Rel-Q, there were significant differences between fourth, eighth, and twelfth graders on all relationship scales. As expected, there was a .30 developmental level difference between fourth and eighth graders and the same difference on the overall relationship maturity scale between eighth and twelfth graders. Children in upper elementary and high school, on average, gained a quarter to a third of a developmental level every four years. In fourth grade, the mean was 1.8, which falls between unilateral and reciprocal levels of perspective coordination. By twelfth grade, the mean was 2.4, which falls between reciprocal and mutual levels of perspective coordination. Females have demonstrated higher scores on traditional social skills assessments; relationship maturity, as measured by the 4+ Rel-Q, shows gender differences similar to those reported on the Social Skills Scale of the Social Skills Rating System (Schultz & Selman, 2001). Females in this study did score slightly higher on the Rel-Q (m = 2.09, *sd* = .17) than males (m = 2.05, *sd* = .17). However, the difference was

not significant. Unlike Schultz and Selman's (2001) work, youth in this study did not demonstrate significant differences between scores on Rel-Q in 4^{th} (m = 1.98), 8^{th} (m = 2.04) and 12^{th} (m = 2.09) grades.

Threats to validity include subjects completing the questionnaire without carefully considering their responses. For this reason, the Rel-Q is not a reliable assessment for an individual subject although, across large samples, the measure successfully differentiates subjects in theoretically predictable ways (Schultz & Selman, 1998).

Procedures

Data for the proposed study were collected through chart review only. An intake coordinator for the RTC requested consent for diagnostic testing from all youth and their parents at the time of admission to the facility. Among these tests were the measures (CBCL & Rel-Q) that were analyzed in this study. Demographic, socio-cultural and treatment variable data were obtained from the medical record.

As part of the admission consent, all youth and their parents were informed that data could be collected for research purposes (Appendix C, see statement #18). This statement is as follows: "Aggregate data may be collected for research purposes and possible publication may emerge from that research. No identifying information on any individual will be collected and all records accessed for the purpose of research will be anonymous".

All youth admitted between June 2001 and February 2003 were considered as possible participants in the study. Confidentiality information and the rights of the youth were provided in writing in the admission packet (Appendix D). Within twenty-four hours of

admission to the treatment center, the assessment team coordinator scheduled psychological testing for each youth. The study instruments were used in every intake assessment of youth at the residential treatment center and were administered by the psychologist and school psychologist following the protocols indicated by each tool. Responses to the two specific instruments in this study, CBCL and Rel-Q, were part of the initial comprehensive evaluation. These were administered at both admission and within 10 days of discharge. The youth, parent/caregiver, and teacher forms of the CBCL were completed at intake and were repeated within 10 days prior to discharge. The Rel-Q is completed by the child during the assessment phase and is repeated within 10 days prior to discharge. The CBCL is completed by the primary staff member assigned to the youth in the residential unit both at intake and within 10 days of discharge. In addition, demographic information and number of out of home placements were recorded from the medical record at admission and treatment variables were recorded from the medical record at discharge.

Human Subjects

Access to the previously collected demographic variables and scores from the CBCL and Rel-Q were gained through the following process. On admission to the treatment center, the medical charts of those residents who met inclusion criteria were assigned a code number by a designated medical records person. After admission and discharge testing had been respectively completed, the designated person in the medical records department, copied the CBCLs, Rel-Qs, and completed the demographic data form removing all identifying information from the documents. These copies were placed in a

file; each file was labeled using only the assigned code number. The investigator was given these files only after the identifying information was removed. The files were kept in the investigator's locked office. A master list of patient numbers and file codes was kept in a locked file cabinet in the medical records person's office until the completion of the study. Only the medical records' person knew the identities of the participants in the study. The identities of the participants were anonymous to the investigator. Expedited review by the Internal Review Board at Oregon Health and Sciences University was obtained in December 2000.

Chapter 4

Results

All data were stored and analyzed using SPSS. Descriptive statistics were generated for all variables and the data were carefully screened for outliers. The descriptive results of the measure of behavior problems (CBCL) and the measure of social competence (Rel-Q) are reported for admission and discharge. Subsequently, the results of analyses are reported according to the aims.

One hundred thirteen youth completed the intake measures. Sixty-three of those youth completed the discharge evaluations at exit and are referred to in this study as the longitudinal group. The non-longitudinal group was composed of those that were discharged but did not complete the discharge evaluations plus those that remained in the residential treatment program. The primary aims of this study were explored using data gathered from the intake and the longitudinal groups. The non-longitudinal group was also assessed to determine if it differed from the longitudinal group in demographic characteristics or test scores.

The average age at admission in the intake group was 14.7 years, the longitudinal group was 15.1 years, and the non-longitudinal group was 14.2 years, respectively (see Table 1). In the intake group, 7 % (n= 8) of the youth had no out of home placements prior to admission. Twenty-nine percent (n = 35) had 6 or more non-home placements and, on average, the intake group had 4.3 out of home placements prior to admission to the residential treatment center. In the longitudinal group, 10 % (n = 6) had no out of home placements and 20 % (n = 13) had more than 6 out of home placements prior to

admission. The average number of out of home placements prior to admission for the longitudinal group was 3.5.

Table 1

Characteristics of the Sample

Group		Range	Mean	Std. Deviation
Intake	Age (yrs)	10.4 – 17.8	14.70	1.68
(N = 113)	Placement (#)	0 - 15	4.31	3.48
Longitudinal	Age (yrs)	11.5 – 17.8	15.08	1.52
(n = 63)	Placement (#)	0 -11	3.49	2.78
Non-longitudinal	Age (yrs)	10.4 – 17.3	14.22	1.77
(n = 50)	Placement (#)	0 - 15	5.34	3.99

Note. Age = Age at admit. Placement = Number of out of home placements prior to admission.

Behavior Problems

Admission CBCL scores were examined in relationship to the established norms for age and gender using t-tests to assess for mean differences (see Table 2). Scores were coded in terms of whether they reached a level of clinical significance (T scores > 70), borderline clinical range (T-scores 67-70), or did not meet clinical levels (T scores < 67). For females (n = 50), the average externalizing subscale T-score was 67.08 (*sd* = 12.22), which fell within the borderline clinical range. For the males (n = 63), the average T-scores on both the externalizing subscale (*m* = 67.33, *sd* = 12.93) and the total behavioral problem score (*m* = 68.29, *sd* = 10.98) were within the borderline clinical range.

Table 2

Females and Males CBCL T-Scores at Admission

Group	Scales	Range	Mean	Std. Deviation
Females (n = 50)	Internal	41 – 89	63.59	10.86
	External	39 – 95	67.08	12.22
	Total	34 - 92	66.65	12.30
Males (n = 63)	Internal	22 – 83	65.41	10.42
	External	33 – 93	67.33	12.93
	Total	41 - 97	68.29	10.98

Note. Internal = Internalizing subscale. External = Externalizing subscale. Total = total behavioral problem score at intake.

In the intake group, 39 % (n = 44) did not reach the clinical level on the admission total CBCL. On the total CBCL score at intake, 20% (n = 23) of the youth scored within the borderline clinical range and 41% (n = 46) youth scored in the clinical range. On the externalizing subscale of the admission CBCL, 39 % (n = 44) of the youth that did not meet a clinically significant level, while 22 % (n = 25) were within the borderline range and 39% (n = 44) had scores above the level of clinical significance. Fifty-five percent of the youth (n = 62) were below the level of clinical significance on the internalizing subscale. Twelve percent of the youth (n = 13) fell within the borderline range and 33% (n = 38) had scores beyond the level of clinical significance.

Further examination revealed that within the group of 44 that did not meet clinical levels on the total score, 9 youth did have borderline or clinical levels on the externalizing subscale and an additional 3 had borderline or clinical levels on the internalizing subscale. Therefore, in the intake group, 29 % (n = 32) did not meet

borderline or clinical levels on the CBCL total or subscale scores whereas 71% (n = 81) of the youth at admission met at least borderline clinical level on one of the scales.

In the longitudinal group, the distribution of the admission total behavioral problem score were similar to the intake group: 32 % (n = 21) did not meet the clinical level, 19% (n = 12) were within the borderline range and 48 % (n = 30) scored at the clinical level or above. Within the group of 21 that did not meet clinical levels, 2 had scores that were borderline or above on the internalizing dimension and 2 had scores that were borderline or above on the externalizing dimension. Thus, in the longitudinal group, 27 % (n =17) did not meet borderline or clinical levels on the intake CBCL total or subscale scores whereas 73 % (n = 46) met at least borderline clinical levels on one of the measures.

The behavioral scores (CBCL) for the intake group (N = 113) were calculated for the CBCL internalizing dimension; the group yielded an average 18.41 (sd= 10.07). For the externalizing dimension, the group yielded and average score of 25.95 (sd =14.96). For the total problems, the group yielded and average score of 64.59 (SD = 33.42). See Table 3. Raw total problem scores above 63 are considered clinically significant; raw scores between 60 and 63 are in the borderline clinical range (Achenbach, 1991). The CBCL total scores for females (n = 50, m = 64.06, sd = 34.95) did not significantly differ from those of males (n = 63, m = 65.03, sd = 32.38), t (111) = - 80, p = .93.

Table 3

CBCL Raw Scores at Admission

Group	Scale	Range	Mean	Std. Deviation
Intake (*N* =113)	Internal	2 - 50	18.41	10.07
	External	0 - 70	25.95	14.96
	Total	3 - 161	64.59	33.42
Longitudinal (*n* = 63)	Internal	2 - 50	18.67	10.08
	External	0 - 70	27.02	15.68
	Total	3 - 139	65.57	32.74
Non-longitudinal (*n* = 50)	Internal	4 - 47	18.08	10.15
	External	1 - 60	24.60	14.05
	Total	6 - 161	63.36	34.55

Note. Internal = Internalizing subscale; External = Externalizing subscale; Total = total behavioral problem score at intake.

Using independent-sample t-tests, the scores of the longitudinal group (n = 63) did not significantly differ from the scores of the non longitudinal group (n = 50) group on the internalizing dimension, $t(111) = -.31$, $p = .76$, externalizing dimension, $t(111) = -.85$, $p = .40$, or CBCL total score, $t(111) = -.35$, $p = .73$.

Social Competence

The mean scores for the admission Rel-Q total and its subscales are reported in Table 4. The average Rel-Q total score for the non-longitudinal group was 2.05 (sd= 0.26), which did not differ significantly from the mean score of 2.12 (sd = .18) at admission for the longitudinal group, $t(111) = -1.61$, $p = .11$. These scores represent approximately an 8th grade level of social competence.

Table 4

Rel-Q at Admission (raw scores)

Group	Scales	Range	Mean	Std. Deviation
Intake (*N* = 113)	IU	1.24 – 2.56	2.07	.26
	HIN	1.09 - 2.91	2.19	.37
	SPC	1.22 - 2.75	2.19	.35
	PM	1.13 - 2.69	1.88	.31
	RL	1.25 - 2.88	2.26	.34
	Rel-Q	1.42 - 2.53	2.09	.22
Longitudinal (*n* = 63)	IU	1.54 - 2.56	2.11	.20
	HIN	1.31 - 2.81	2.22	.33
	SPC	1.34 - 2.75	2.25	.29
	PM	1.13 - 2.69	1.86	.33
	RL	1.25 - 2.88	2.28	.36
	Rel-Q	1.65 - 2.49	2.12	.18
Non-longitudinal (*n* = 50)	IU	1.24 - 2.54	2.03	.32
	HIN	1.09 – 2.91	2.15	.42
	SPC	1.22 – 2.69	2.11	.40
	PM	1.31 – 2.48	1.90	.29
	RL	1.44 – 2.88	2.24	.32
	Rel-Q	1.42 – 2.53	2.05	.26

Note. IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake.

Best response scores and norms. To assess for differences in relationship to a normative population, the best response scores for each group were compared to the normative best response scores (4th, 8th, & 12th grade) using one-sample, two-tailed t-tests with an alpha of .05. Scultz and Selman (2001) suggested that the best response developmental level derivation was more easily observed than the developmental level derivation for the item rating or overall relationship maturity total scores. The intake samples were grouped by age using 3 categories: < 12.5 years, 12.5 to 15 years, and > 15 years. The youngest subjects in both the intake (n = 10, m = 1.9, sd = .42) and

longitudinal groups (n = 3, m = 2.14, sd = .21), scored slightly higher than the normative group (m = 1.8, sd = .36) although these differences were not significant, $t(9) = .77$, p = .46, $t(2) = 2.78$, $p = .11$. For the 12 – 15 year olds, neither the intake group (n = 48, m = 2.07, sd = .35), nor the longitudinal group (n = 23, m = 2.13, sd = .30) were significantly different from reported 8th grade norms (m = 2.1, sd = .38), $t(47) = -.50$, $p = .61$, and $t(22)$ = .43, $p = .67$. However, for those over 15 years of age, the intake (n = 55, m = 2.19, sd = .30) and longitudinal (n = 37, m = 2.18, sd = .22) groups both scored significantly lower than the 12th grade norm (m = 2.4, sd = .40) reported by Schultz and Selman (2001), $t(54)$ = -.15, $p < .00$ and, $t(36) = -6.19$, $p < .00$, respectively.

For the intake group, the best response scores on the total Rel-Q and its subscales were compared to the reported norms (see Table 5). Four of the five subscale scores for the youngest group (<12 years) did not differ from the norms reported for the 4th grade. On the real life subscale, the sample group (m = 2.08, sd = .42) actually scored significantly higher than the normative group (m = 1.72, sd = .71), $t(7) = 2.42$, p =.05. The only subscale score in the youngest group that was less than the norm but not significantly so, was the personal meaning subscale (m = 1.67, sd = .50). The youth in the 12.5- to 15-year-old group scored at or above the norm on all the subscales except personal meaning, m = 1.89 (sd = .50) which was significantly lower than the norm, m = 2.10 (sd =.57), $t(48) = -2.95$, $p = .00$. The oldest group (>15 years) scored significantly lower than the norms on 3 of the 5 subscales: interpersonal understanding; $t(55) = -2.95$, $p = .00$; hypothetical interpersonal relations; $t(55) = -3.39$, $p = .00$; and personal meaning

, $t(54) = -7.32$, $p = .000$. Those over 15 years of age also scored significantly lower than the norm on the total Rel-Q, $t(55) = ,-4.37$ $p = .000$.

Table 5

Rel-Q and Subscales: Best response Scores by Age at Admission

	<12.5 years (n = 8)		12.5 – 15 years (n = 47)		>15 years (n = 56)	
Rel-Q Scales	m	sd	m	sd	m	sd
IU	1.98	.73	1.96	.42	2.25**	.38
HIN	1.72	.49	2.21	.63	2.18**	.54
SOC	1.72	.93	2.20	.57	2.13	.43
PM	1.67	.50	1.89**	.50	1.94**	.50
RL	2.08*	.42	2.28	.56	2.48	.47
Total	1.83	.42	2.07	.35	2.20**	.30

Note. IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Total = total social competence at admit. * p <.05, ** p < .00. differ from 4th, 8th , & 12th grade norms.

There were no significant differences between scores for females ($m = 2.12$, $sd = .23$) and males ($m = 2.07$, $sd = .21$) on the total Rel-Q1, $t(111) = 1.24$, $p = .22$. There was a significant difference on the interpersonal understanding subscale between females, ($m = 2.14$, $sd = .28$) and males ($m = 2.02$, $sd = .28$), $t(111) = 2.38$, $p = .02$, with females scoring higher.

Relationship between Behavioral Problem and Social Competence

Intake findings. The first aim of the study was to explore the relationships between behavior problem and social competence scores for SED youth placed in residential treatment. Correlation analysis, using Pearson's r, was carried out between the subscale

and total scores on the CBCL and the Rel-Q obtained on admission. For the intake group ($N = 113$), there was a significant inverse relationship between the CBCL total score and the Rel-Q total score, $r = -.27$, $p < .01$, (see Table 6). Children with more behavior problems had less social competence. The CBCL internalizing and externalizing subscale scores and the Rel-Q total score were also negatively correlated at a significant level, $r = -.23$, $p < .05$ and $r = -.20$, $p < .05$, respectively. The total CBCL score was inversely correlated with one of the Rel-Q subscales, personal meaning, $r = -.35$, $p < .01$. The externalizing subscale of the CBCL also had significant inverse correlation with the personal meaning subscale of the Rel-Q, $r = -.36$, $p < .01$. Essentially, those with more behavioral problems had immature interpersonal understanding and less well developed ideas related to personal meaning.

Table 6

Correlation Matrix between CBCL and Rel-Q at Admission (N = 113)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	-.15	-.17	-.15	-.19*	-.13	-.23*
EXT	-.09	-.12	.06	-.36**	-.05	-.20*
Total	-.17	-.14	-.06	-.35**	-.12	-.27**

Note. INT = Internalizing subscale; EXT = Externalizing subscale; CBCL = total behavior problem score at intake; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake; **p = 0.01level (2-tailed). * p = 0.05 level (2-tailed).

Relationship between non-clinical CBCL scores and social competence deficits.

Within the longitudinal group, 17 youth did not meet borderline or clinical levels on the

intake CBCL total score or the subscales. Five youth were under 15 years of age (m =13.8, sd = 1.03) and 12 were 15 and over (m = 16.58, sd = .74). The best response total Rel-Q scores for those with non-clinical CBCL scores were examined. For the younger group the average total Rel-Q score of 2.09, was not significantly different than the normed score of 2.1 (8th grade), $t(4)$= -.06, p =.95. For the older group (> 15 years), the average best response Rel-Q score was 2.22, (sd = .30), which was significantly less than the 12th grade norm of 2.4, t (11)= -2.29, p < .05. While this group did not score high enough on the total CBCL to meet clinical levels, their average Rel-Q scores were immature compared to the normed group.

Gender patterns at admission. The correlations between the Rel-Q and CBCL total and subscale scores were also examined separately, by gender. For females (n = 50), in the intake group, the total on the CBCL was significantly related to the Rel-Q total score, r = -.36, p = <.01, the interpersonal understanding subscale, r = -.32, p < .05, and the personal meaning subscale, r = -.28, p < .05 scores (see Table 7). There were also significant inverse relationships between the internalizing subscale score of CBCL and the interpersonal understanding, r = -.37, p < .01, hypothetical interpersonal relationship, r = -.30, p < .05, and the social perspective coordination subscales, r = -.28, p = < .05 of the Rel – Q. .

Table 7

Correlations Between Admission CBCL and Rel-Q Scores for Females (n = 50)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	-.37**	-.30*	-.28*	-.17	-.26	-.37**
EXT	-.13	-.12	-.14	-.26	-.08	-.22
Total	-.32**	-.24	-.24	-.28*	-.21	-.36**

Note. INT = Internalizing subscale; EXT = Externalizing subscale; CBCL = total behavior problem score at intake; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake.
** p = 0.01level (2-tailed). * p = 0.05 level (2-tailed).

For males (n = 63), there were no significant correlations between the CBCL total problem score, and the Rel-Q total score (r = -.18, p = .19) or between the internalizing (r = -.08, p = .52) or externalizing (r = -.18, p = .20) subscales with the Rel-Q total score. The total CBCL score for males did significantly and negatively correlate with the Rel-Q personal meaning subscale score (r = -.42, p = .01).The externalizing subscale of the CBLC also demonstrated a significant negative correlation with the Rel-Q personal meaning subscale score, r = -.45, p = .01, (see Table 8).

Table 8

Correlation Between Admission CBCL and Rel-Q Scores for Males (n = 63)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	.09	-.06	.06	-.21	-.01	-.08
EXT	-.02	-.12	.19	-.45**	-.03	-.18
Total	-.03	-.05	.06	-.42**	-.05	-.18

Note. INT = Internalizing subscale; EXT = Externalizing subscale; CBCL = total behavior problem score at intake; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake.
** p = 0.01level (2-tailed). * p = 0.05 level (2-tailed).

Longitudinal findings. The longitudinal group (n = 63) completed the discharge CBCL and Rel-Q. The only significant correlation among the CBCL and Rel-Q total and subscale scores was between the CBCL total problem score and the Rel-Q interpersonal understanding subscale, r = -.34, p < .01, (see Table 9). The externalizing subscale of the CBCL at discharge also correlated with the Rel-Q total at discharge, r = -.26, p <.05, the interpersonal understanding subscale, r = -.28, p <.05, and the real life subscale, r = -.28, p <.05.

Table 9

Correlation Between CBCL and Re-Q Scores at Discharge (n =63)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	-.09	.06	-.00	.08	-.11	-.00
EXT	-.26*	-.15	-.14	-.10	-.28*	-.26*
Total	-.34**	-.07	-.08	-.02	-.23	-.20

Note. INT = Internalizing subscale; EXT = Externalizing subscale; CBCL = total behavior problem score at discharge; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at discharge.
** p = 0.01level (2-tailed). * p = 0.05 level (2-tailed).

Relationship between clinical CBCL scores and social competence at discharge. In the longitudinal group at discharge, 21% (n = 13) of the youth scored high enough to meet clinical criteria on the CBCL, and 5% (n = 3) were within the borderline range. These results contrast with those on admission when 41% scored in the borderline range and 20% scored in the clinical range. Five youth in the group of 16 who had CBCL discharge scores in the clinical or borderline range did not have clinical or borderline CBCL scores at intake. Three met clinical criteria at intake and their scores increased over the length of stay. One youth had a CBCL score that did not change. Seven of the youth that had clinical scores at admission, had lower scores at discharge that remained within the borderline or clinically significant range. The average CBCL raw score at intake for these 16 youth was 74 (sd = 30) which was not significantly different than their average discharge score of 79 (sd = 16), $t(15) = -.54$, $p = .60$.

Seven of the 16 youth were under 15 years of age and 9 were older than 15 years of age. Rel-Q best response scores for the younger group changed from admission, m = 2.13, (sd = .16) to discharge, m =2.06 (sd = .27), though the change was not significant, $t(6) = .61$, $p = .56$. The average score at discharge of 2.06 (sd = .27) was also not significantly different from the normative score for 8th grade of 2.1, $t(6) = -.44$, p = .68. A positive gain was noted in the Rel-Q best response scores for the older group from admission, $m = 2.15$ (sd = .29) to discharge, $m = 2.25$ (sd = .31), however, the change was not significant $t(8) = -1.11$, $p = .30$. The average best response score for the older group at discharge was not significantly lower than the normed score of 2.4 reported for 12th grade, $t(8) = -1.49$, $p = .17$.

Gender patterns at discharge. Table 10 shows that, for the females at discharge (n = 25), the CBCL total score was significantly related to the "real life" subscale on the Rel-Q, $r = -.42$, $p < .05$. There were no other significant correlations for females.

Table 10

Correlation Between CBCL and Rel-Q Scores for Females at Discharge (n = 25)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	-.06	.05	-.08	.12	-.20	-.05
EXT	-.22	.04	-.06	.09	-.30	-.13
Total	-.36	-.07	-.12	.15	-.42*	-.24

Note. INT = Internalizing subscale; EXT = Externalizing subscale; CBCL = total behavior problem score at discharge; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at discharge.
** p = 0.01level (2-tailed). *p = 0.05 level (2-tailed).

For males (n = 38) at discharge the CBCL total score correlated with the interpersonal understanding subscale, $r = -.33, p < .05$ (see Table 11). The CBCL externalizing subscale score was related to both the discharge Rel-Q total score, $r = -.39, p < .05$, and interpersonal understanding subscale score, $r = -.41, p < .05$. In these correlations, higher behavior problem scores were related to lower social competence scores.

Table 11

Correlation Between CBCL and Rel-Q for Males at Discharge (n = 38)

	REL-Q					
CBCL	IU	HIN	SPC	PM	RL	Total
INT	-.18	.11	.05	.03	.05	.03
EXT	-.41*	-.28	-.21	-.28	-.23	-.39*
Total	-.33*	-.10	-.06	-.10	-.10	-.18

Note. INT = Internalizing subscale; EXT = Externalizing subscale; Total = total behavior problem score at dischare; IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Total = Rel-Q at discharge.
** p = 0.01level (2-tailed). * p = 0.05 level (2-tailed).

Two tailed t-tests were conducted to assess for gender differences on the CBCL total and subscale scores and, the Rel-Q total, subscale scores. The only significant difference among scores at discharge between females, $m = 2.28$ ($sd = .24$) and males, $m = 2.12$ ($sd = .23$) was on the interpersonal understanding subscale of the Rel-Q, $t(61) = 2.65, p = .01$. Females averaged a higher score on interpersonal understanding than did males.

Differences between Admission and Discharge Scores

CBCL. The second aim of this study was to compare behavior problem and social competence scores of SED youth from admission to discharge from residential treatment.

Paired one tailed t-tests were used for the analysis of mean differences between admission and discharge scores on the CBCL and are reported in Table 12. The total problem score mean on the CBCL at discharge was significantly lower than the intake CBCL total problem score mean, $t(62) = 4.34$, $p = .00$. The scores on the internalizing dimension at discharge ($m = 14.06$, $sd = 10.45$) were on average, significantly lower than on admission ($m = 18.79$, $sd = 10.05$), $t(62) = 2.75$, $p = .00$. The scores on the externalizing dimension at discharge also were, on average ($m = 17.29$, $sd = 11.44$) significantly lower than those at intake ($m = 26.73$, $sd = 15.67$), $t\ (62) = 4.96$, $p = .00$. In general, youth behaviors, assessed by the CBCL, became less problematic over the course of stay in residential treatment.

Table 12

Differences between Admission and Discharge Raw CBCL Total and Subscale Scores (Longitudinal Group, n = 63)

	Admission		Discharge				
Scales	M	SD	M	SD	t	df	p
Internal	18.79	10.05	14.06	10.45	2.75	62	.00
External	26.73	15.67	17.29	11.44	4.96	62	.00
Total	65.30	32.78	45.67	29.37	4.34	62	.00

Note. Internal = Internalizing subscale; External = Externalizing Subscale; Total = total behavior problem score.

Rel-Q. In Table 13, significant changes are seen on the Rel-Q total and subscale scores between intake and discharge using one-tailed paired t-tests. The only subscale on which

scores did not change between admission and discharge was social perspective coordination.

Table 13

Differences between Admission and Discharge Rel-Q Total and Subscale Scores, (n =63).

	Admission		Discharge				
Rel-Q Scales	M	SD	M	SD	t	df	p
IU	2.11	.20	2.19	.25	-2.61	62	.03
HIN	2.22	.33	2.30	.31	-1.87	62	.03
SPC	2.26	.29	2.27	.24	-.28	62	.39
PM	1.86	.33	2.10	.34	-5.05	62	.00
RL	2.28	.37	2.44	.34	-2.85	61	.00
Total	2.12	2.18	2.24	.20	-4.75	62	.00

Note. IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Total = total social competence score.

The social competence scores of the longitudinal group were further investigated by separating the subjects into age groups. Given there was only one youth under 12.0 years, two groups were examined: those 12.0 to 15 years of age (n = 24) and those over 15 years (n = 38). The group under 15 years of age, demonstrated significant change, from admission to discharge on the Rel-Q total score , $t(23) = -1.89$, $p = .04$, and on the personal meaning subscale, $t(23) = -2.20$, $p = .02$. Those over 15 years of age also had a significant change from intake to discharge on the Rel-Q total score, $t(37) = -4.76$, $p = .00$, and on 4 of the 5 subscales: interpersonal understanding, $t(37) = -2.44$, $p = .01$,

hypothetical interpersonal relationships, $t(37) = -1.71$, $p = .05$, personal meaning, $t(37) = -4.44$, $p = .00$, and real life, $t(37) = -2.64$, $p = .01$. The exception was the social perspective coordination subscale that did not change significantly. In all other cases, social competence improved between intake and discharge.

Best response Rel-Q total and subscale score changes by age. Using paired sample two tailed t-tests, admission and discharge best response scores were compared (see Table 14). Significant positive changes were noted in the younger group ($m = 14.72$ years, $sd = .94$) at discharge, on the personal meaning subscale, $t(23) = -2.10$, $p = .05$, and on the Rel-Q total, $t(23) = -2.04$, $p = .05$. In the older group ($m = 16.90$, $sd = .73$), significant positive changes occurred on the personal meaning, $t(37) = -3.95$, $p = .00$, real life, $t(37) = -2.18$, $p = .04$, and total scores, $t(37) = -3.90$, $p = .00$.

Table 14

Mean Rel-Q Total and Subscales Best response Scores by Age

	Admission 12.0 – 14.9 years n = 24		Discharge 13.2-16.3 years n =24	
Rel-Q Scales	mean	sd	mean	sd
IU	2.07	.07	2.16	.31
HIN	2.27	.04	2.36	.33
SOC	2.26	.49	2.26	.49
PM	1.89	.42	2.16*	.57
RL	2.25	.61	2.42	.64
Total	2.12	.30	2.28*	.32
	15.1 - 17.8 years n = 38		15.7 – 18.1years n=38	
	mean	sd	mean	sd
IU	2.23	.31	2.32	.37
HIN	2.17	.52	2.27	.50
SOC	2.34	.41	2.32	.28
PM	1.83	.50	2.22**	.49
RL	2.47	.49	2.65*	.37
Rel-Q	2.18	.22	2.33**	.24

Note. IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake. *p <.05, ** p < .00.

Longitudinal best response scores on Rel-Q by age at intake and discharge compared to norms. Best response scores for the longitudinal group were examined compared to age norms for each scale and subscale (see Table 15). In the younger group, at admission,

all of the scores were equal to or greater than the norms with one exception. The personal meaning subscale was significantly less than the normed 8th grade score, $t(23) = -2.42$, p = .02. On the hypothetical interpersonal relationship subscale, the younger group scored significantly higher than the 8th grade nor, $t(23) = 2.18$, $p = .04$. The older group had significant deficits on 3 of the 5 subscales; interpersonal understanding, $t(38) = -3.37$, p = .00, hypothetical interpersonal relationships, $t(38) = -3.07$, $p = .00$, and personal meaning, $t(38) = -7.37$, $p = .00$. The older group also had significantly lower scores on the Rel-Q total scale, $t(38) = -5.28$, $p = .00$.

Ten youth from the younger group at intake were re-grouped with the older group at discharge as they had aged past 15 years during their stay. Those (n = 14) that were 15 years or younger at discharge scored at or above the normed score on each of the subscales and total Rel-Q. They scored significantly higher than the 8th grade norms on the hypothetical interpersonal relationship, $t(13) = 2.85$, $p = .04$, and social perspective subscales $t(13) = 3.21$, $p = .01$. The majority of youth at discharge were over 15 years of age ($n = 49$). For this group, scores on two of the subscales remained significantly below the normed group: hypothetical interpersonal relationships and personal meaning, $t(48) = -2.05$, $p < .05$, and $t(48) = -3.29$, $p < .00$, respectively.

Table 15

Rel-Q Total and Subscales Best response Scores Compared to Norms at Admission and Discharge.

Admission		12.0 – 15.0 years (n = 24)		> 15 years (n = 38)	
	Rel-Q Scales	mean	sd	mean	sd
	IU	2.07	.07	2.23**	.31
	HIN	2.27*	.04	2.17**	.52
	SOC	2.26	.49	2.34	.41
	PM	1.89*	.42	1.83**	.50
	RL	2.25	.61	2.47	.49
	Total	2.12	.30	2.18**	.22
Discharge		12.0 – 15 years (n =14)		>15 years (n=49)	
		mean	sd	mean	sd
	IU	1.98	.29	2.33	.34
	HIN	2.37*	.45	2.30*	.45
	SOC	2.46**	.34	2.32	.31
	PM	2.22	.57	2.19**	.50
	RL	2.43	.59	2.61	.48
	Total	2.26	32	2.33	.25

Note. IU = Interpersonal Understanding; HIN = Hypothetical Interpersonal Negotiations; SPC = Social Perspective Coordination; PM = Personal Meaning; RL = Real Life; Rel-Q = Rel-Q at intake.

$p < .05$, ** $p < .00$. difference from 4^{th}, 8^{th} , & 12^{th} grade norms.

Demographic and Socio-cultural Predictors of Behavior Problems and Social Competence at Admission

The third aim was to examine how selected demographic variables of, age, gender, and race (Caucasian vs. Non-Caucasian) and a selected socio-cultural variable number of out-of-home placements explained variation in behavior problem and social competence scores at admission to residential treatment ($N = 113$). As seen in Table 16, the only significant correlations between predictors and dependent variables were between age and the CBCL total problem score, $r = .23$, $p = .05$ and between age and the Rel-Q total score, $r = .32$, $p = .01$. With increasing age, there were fewer behavior problems and greater social competence.

Table 16

Correlation Matrix between Demographic Variables and CBCL and Rel-Q Total Scores (N=113)

	1	2	3	4	5	6
Age						
Gender	-.16					
Caucasian vs. Non-Caucasian	.18	-.02				
Out of Home Placements	-.14	-.10	-.16			
CBCL	-.23*	-.02	.14	-.02		
Rel-Q	.32**	-.18	.10	.13	-.25**	

Note. *p < .05 (2 tailed); ** p < .01 (2-tailed).

Hierarchical multiple regression was proposed to explore the extent to which selected variables impacted CBCL and Rel-Q total scores. In the first step, age at admission, gender, and race (Caucasian vs. non-Caucasian) were entered as predictors for the total intake CBCL total score. The second step added the variable of out of home placements as a predictor. There was no significant change in the R squared from step one to step two; thus out of home placements did not explain any additional variance in CBCL total scores beyond that predicted in step one, $F = 1.22$, $p = .27$ (see Table 17).

Table 17

Summary of Hierarchical Regression Analysis for Variables Predicting Total CBCL Score at Admission (N = 113).

Predictors	B	SEB	Beta
Step 1			
Gender	3.04	6.21	.00
Age	-5.38	1.87	-.27**
Caucasian vs. Non-Caucasian	13.8	6.67	.19*
Step 2			
Gender	1.56	6.30	.00
Age	-5.39	1.90	-.27**
Caucasian vs. Non-Caucasian	13.8	6.76	.19*
Out of Home Placements	-1.51	.91	-.00

a. Dependent variable: CBCL at intake

b. *Note.* R2 = .09 for Step 1; Change R2 = .00 for Step 2; Significance of F change = .99; *p < .05; **p <.00

In a similar manner, age, gender, and race were examined as predictors for intake Rel-Q total scores. The addition of number of out of home placements added little to the $F = 2.7$, $p = .99$, and thus did not explain any additional variance (see Table 18).

Table 18

Summary of Hierarchical Regression Analysis for Variables Predicting Total Rel-Q Score at Admission (N = 113).

Predictors	B	SEB	Beta
Step 1			
Gender	-3.16	.04	-.07
Age	3.88	.01	.30*
Caucasian vs. Non-Caucasian	1.67	.04	.04
Step 2			
Gender	-3.81	.04	-.09
Age	3.69	.01	.28*
Caucasian vs. Non-Caucasian	9.98	.05	.02
Out of Home Placements	-6.12	.01	-.10

a. Dependent variable: Rel-Q at intake

b.Note. R2 = .10 for Step 1; Change R2 = .01 for Step 2; Significance of F change = .27; *p < .05.

The average number of out of home placements for the intake group was 4.3 (sd = 3.49). Given the sizeable range (0-11), 2 groups were formed: those with 2 or fewer out of home placements verses those with 3 or more out of home placements. Using this dichotomous variable as a grouping variable, there were no significant differences

between the groups on the CBCL total score, (m = 64.16, sd = 35.48, and m = 74.66, sd = 29.09), $t(61) = -1.30$, $p = .20$.These groups also did not differ on Rel-Q total scores, (m = 2.12, sd = .17 and m = 2.12, sd = .19), $t(61) = .11$, $p = .9$, at admission.

Demographic and Treatment Predictors of Behavioral Problems and Social Competence at Discharge

The fourth and final aim was to examine how selected demographic variables, of age at discharge, gender, and race, and selected treatment variables, of length of stay in residential treatment and psychiatric diagnosis, explained variation in behavior problems and social competence scores within 10 days of discharge from residential treatment. Initially, correlations between the demographic and treatment variables and discharge scores were examined (see Table 19). There were no significant correlation between the predictors and dependent variables.

Table 19

Correlation between Demographic and Treatment Variables and Discharge CBCL and Rel-Q Total Scores (N=63)

	1	2	3	4	5	6	7
Gender							
Age at Discharge	.20						
Caucasian vs. Non-Caucasian	.16	-.19					
Diagnosis	.26*	.13	.04				
Length of Stay	.06	.06	.15	.07			
Total CBCL	.09	-.14	-.07	.11	-.04		
Total Rel-Q	-.07	.10	-.15	.22	.14	-.21	

Note. Diagnosis = primary DSM IV diagnosis at discharge; Total CBCL = total behavior problem score at discharge; Total Rel-Q = Rel-Q at discharge; * $p < .05$ level (2-tailed).

Using hierarchical multiple regression, discharge behavior problem scores (CBCL) were regressed on the demographic predictors (age at discharge, race, and gender) and on the treatment predictors (length of stay, and DSM IV discharge diagnoses; attention/disruptive behavior disorder, mood/anxiety disorder, and reactive attachment disorder plus other) which were dummy coded (see Table 20).

Table 20

Summary of Hierarchical Regression Analysis for Variables Predicting Total CBCL Score at Discharge (n = 63).

Variable	B	SEB	Beta
Step 1			
Gender	5.67	8.14	.09
Age at DC	-2.30	2.84	-.11
Caucasian vs. Non-Caucasian	1.72	9.14	.025
Step 2			
Gender	8.20	8.45	.14
Age at DC	-2.60	2.89	-.12
Caucasian vs. Non-Caucasian	2.30	9.84	.03
DSM IV Dx	-.13	.94	-.02
Length of Stay	7.27	6.10	.16

a. Dependent variable: CBCL at discharge.
b.*Note.* R2 = .03 for Step 1; Change R2 = .03 for Step 2; Significance of F change = .49.

The regression equation for age at discharge, gender, and race, predicting discharge CBCL total scores was not significant. The addition of diagnosis and length of stay, did not add to the prediction, F change = .71, p = .49. Age at discharge, gender, and race accounted for less than 3% of the variance and the additional predictors of diagnosis and length of stay added less than 5% to the variance in total scores on the CBCL at discharge.

Using hierarchical multiple regression, discharge social competence scores (Rel-Q) were separately regressed on the demographic predictors (age at discharge, race, and gender) and on the treatment predictors (length of stay, and DSM IV discharge diagnoses (attention/disruptive behavior disorder, mood/anxiety disorder, and reactive attachment disorder plus other) which were dummy coded (see Table 21). The discharge Rel-Q total score, age at discharge, race, and gender were not significant predictors nor were diagnosis, and length of stay, $F = 1.9, p = .16$.

Table 21

Summary of Hierarchical Regression Analysis for Variables Predicting Total Rel-Q Score at Discharge (n = 63).

Variable	B	SEB	Beta
Step 1			
Gender	-3.22	.05	-.08
Age at Discharge	3.98	.02	.03
Caucasian vs. Non-Caucasian	1.53	.06	.03
Step 2			
Gender	-1.04	.05	-.03
Age at Discharge	-1.35	.02	-.01
Caucasian vs. Non-Caucasian	4.70	.06	.11
Length of Stay	6.13	.01	.14
DSM IV Dx	6.32	.04	.22

a. Dependent variable: Rel-Q at discharge.
b. *Note.* R2 = .01 for Step 1; Change R2 = .06. for Step 2; Significance of F change = .16.

All of the predictors together accounted for less than 9% of the variance in discharge Rel-Q total scores. None of the variables that had been hypothesized to impact discharge social competence scores were actually significant

Chapter 5

Discussion, Summary, and Implications

The purpose of this study was to use an age-normed behavioral assessment tool and a developmentally based, age-normed, social competence measure to identify deficits and delays among SED youth at intake into residential treatment, and examine both behavior problems and social competence at discharge. Demographic data were gathered and evaluated in relationship to the measures of behavior and social competence. Four aims were considered and four hypotheses were proposed. In this chapter, the results of this study will be discussed in terms of the aims, corresponding hypotheses and in relation to the literature review. Limitations of the investigation, recommendations for future research, and conclusions will be presented.

Characteristics of the Intake and Longitudinal Samples

Nationally, 8% of SED youth are being served in residential care (Burns, Hoagwood, & Maltsby, 1998). This sample was a segment of that population. One hundred and thirteen youth, 63 males and 50 females completed the assessment tools at admission to the residential treatment facility. The group was largely Caucasian and each subject was admitted to the setting with initial psychiatric diagnoses. The majority of the group (71%) had primary diagnoses of mood and/or anxiety disorders, 19% were diagnosed with disruptive behavior disorders, 5% with reactive attachment disorder, and 5% with other primary diagnoses.

The majority of the youth had been placed out-of-home prior to admission, which was consistent with reports that most youth in residential settings had histories of prior out-of-

home placements (Silver, et al, 1992). Earlier out-of-home settings reported at admission included: foster care, shelter care, group homes, juvenile justice placements, drug and alcohol rehabilitation, and psychiatric in-patient hospitals. The catalysts for placing a youth in residential treatment were often behaviors that could result in harm to self or others and could not be managed in less restrictive settings. Alternatively, placement often occurred after acute stabilization in a psychiatric hospital following significant and/or dangerous acting out.

The longitudinal group was comprised of youth from the intake group that completed the discharge assessments. The characteristics of the longitudinal group closely resembled those of the intake group with the majority of the youth being Caucasian, and having 50% more males than females completing the study. The distribution of primary psychiatric diagnoses was similar to the larger intake sample. The longitudinal group averaged three to four out-of-home placements prior to admission while the larger intake group averaged four to five.

Behavioral Problems, Social Competence and their Relationship

Relationships among behavioral problems and social competence at admission. It was hypothesized that youth in this study would have delays and developmental deficits in social competence in addition to having behavioral problems. It was important to consider not only their behavior but also their maturity or lack of maturity within social relationships. Early interactions between people serve as templates for understanding and interpreting future social situations and in turn these interpretations impact behaviors.

The first aim was to explore relationships among behavior problem (CBCL) and social competence (Rel-Q) scores for SED youth. It was hypothesized that upon admission to and within 10 days of discharge from residential treatment higher behavioral problem scores would correlate with lower scores on social competence measures. For the intake sample, higher behavioral problem scores did correlate with lower social competence scores. The internalizing and externalizing subscales both had an inverse relationship with overall social competence on admission. Other studies have not explored the relationship between behavior problems as measured by the CBCL and social competence (Rel-Q). However, researchers have identified significant inverse relationships between the shy/anxious and the acting out subscales of the Hightower Teacher-Child Rating scale with overall relationship maturity or social competence (Shultz & Selman, 2001).

In previous studies using the Rel-Q, females scored higher than males across all age groups on each dimension. In this study, females' scores did not differ significantly from males. Although overall behavior problems were similar between males and females, the correlation between behavior measures and social competence measures did differ by gender.

An important finding of this study was the observation that externalizing and internalizing behaviors mean something different for social competence across genders. For males with high externalizing behaviors, social competence deficits were most apparent in the personal meaning dimension. Essentially, they had difficulty reconciling

or integrating past experience in relationship with important others into their present actions. Females with high externalizing behaviors did not demonstrate the same pattern.

Females with high internalizing behavior problems, had social competence deficits that were evident in their level of interpersonal understanding or their awareness of how relationships work. They also lacked skills used in situations of social conflict (hypothetical interpersonal relations) and their capacity to coordinate their own and other viewpoints toward shared social experience (social perspective coordination) was below the norm. Males with internalizing behaviors did not demonstrate any relationship between internalizing behaviors and any of the social competence dimensions. These differences have important implications for assessment and intervention.

Recognizing that shy, anxious, withdrawn females may benefit from education related to social relationships, social skills training, and social problem solving is important. Likewise, helping aggressive or acting out males examine past relationships and the impact they might have on their present relationships could be helpful. While some acting out youth truly have anti-social thinking patterns, it is possible that others struggle from developmental delays, especially in respect to interpersonal relationships. Recognizing deficits and strategizing interventions could potentially be quite helpful to these youth.

Relationships among behavioral problems and social competence at discharge. At discharge the correlation pattern within the sample differed from correlation pattern at admission. Unlike the average behavioral problem scores at admission, the average behavioral problem scores and internalizing and externalizing syndrome scores at discharge were well below clinical range for the majority of the youth in the study. In

fact, higher behavior problems at discharge generally fell within a normal range for child behaviors. Regardless, relationships still existed in the discharged group, whereby higher behavior problems were related to deficits in interpersonal understanding while increased externalizing behaviors correlated with lower interpersonal understanding, real life negotiation skills, and total social competence. More important, the relationships between behaviors and social competence at discharge should be considered by examining the data from the youth that continued to have clinically significant behavioral problems.

Over the course of treatment the majority of the youth in this study demonstrated significant behavioral gains, and at discharge did not score within the clinical range on the CBCL. Of the 16 youth that continued to reach at least borderline levels on the behavioral problem or syndrome scores (internalizing, externalizing) at discharge, 11 were males and 5 were females. Higher externalizing syndrome scores were related to lower hypothetical interpersonal and real life negotiations subscale scores. Males' aggressive or delinquent behaviors (externalizing) correlated with a lack of hypothetical interpersonal negotiation skills. Females' behavioral scores did not correlate with any of the social competence dimensions at discharge. Essentially, those who still had clinical range behavioral problems lacked interpersonal skills for problem solving within relationships and life experiences that reflected successful application of skills. This is different than those who had high behavior problems on admission; in this group it was skills rather than understanding or processing that remained problematic. Additional discussion related to this subgroup will be included in the review of the second aim.

Differences in Behavior Problems and Social Competence from Admission to Discharge

The second aim of this study was to compare behavior problem and social competence scores of SED youth upon admission to and at discharge from residential treatment. It was hypothesized that SED youth at admission to residential treatment would have serious behavioral problems and deficits in the development of social competence. This hypothesis was supported by the data.

Behavior problems for intake and longitudinal groups at admit. The average raw CBCL score for the intake group at admission fell within the clinical range and nearly three-fourths of the subjects met at least the borderline clinical range on the total behavior problem score, and/or one of its subscales (internalizing or externalizing). Achenbach (1991) reported that borderline or clinical CBCL scores differentiate between youth referred to mental health settings and those not referred. The primary childcare worker completed the admission CBCL within 10 days of admission to the residential treatment setting. Unfortunately, the person completing the assessment did not have prior observation of the youth to draw upon. The tool requests that responses be based upon the past 6 months of behavior. Thus, the initial CBCL may have under represented the extent of behavioral problems. This phenomenon may have been reflected by the percentage of youth that did not meet clinical levels on the admission CBCL.

One-fourth of the youth at intake did not meet clinical levels of behavioral problems. Several explanations are possible. First, it may be that the initial evaluations did not accurately reflect behaviors that had occurred and which prompted placement. Child care staff completing the assessment were asked to rate each child based upon their observations in the milieu after admission. They did not have retrospective knowledge of

youth behaviors. Second, since many youth were admitted following a psychiatric hospitalization, it is possible that, medically, certain acting out behaviors could have been decreased related to increased psychotropic medication. Finally, a new environment with new rules may have impacted their initial presentation as they made efforts to be on their "best behavior". Pre-certification and authorization for care is necessary for admission to residential treatment; thus, every youth on admission had serious emotional disturbance identified by outside others, although nearly one-fourth of the intake group did not reflect this on the CBCL.

Internalizing and externalizing problems. Beyond the average raw scores, several interesting findings were observed among subscale results. In the intake sample, nearly half of the youth scored at the borderline clinical level or above on the internalizing subscale. The syndrome scales of withdrawal, somatic complaints, and anxious/depressed were summed to determine the internalizing score. Clinical scores on the internalizing subscale often correlate with clinical scores on the externalizing subscale (Achenbach, 1991). Females in this study reflected this trend. Males did not. The syndrome scales of delinquent and aggressive behaviors are summed to determine the externalizing score. In this study, 61% of the intake group met at least the borderline level on the externalizing score. Overall, female scores on the internalizing or externalizing subscales of the CBCL did not differ significantly from male scores. Both genders in this study had similar distribution and intensity of internalizing and externalizing problems.

Social competence at admission. The finding that most subjects exhibited significant deficits in social competence is not surprising given that they are SED youth in a

residential setting. To fully appreciate the meaning of such deficits, however, it is necessary to understand the implications of the various subscale scores. Schultz and Selman (2001) described the scoring pattern for the Rel-Q in terms of developmental levels based upon their theory of interpersonal relationships. Scoring gave credit to the extent the subject recognized the maturity or immaturity of a given item. There are four levels. The first is impulsive thinking, the most primitive level, in which typical responses are unpredictable and random. The next step in the developmental trajectory was described as one-way or egocentric thinking where strategies of force are used to get what one desires. Reciprocal thinking strategies are gained and demonstrated when one uses psychological influences to change others' minds and compliance to benefit the self. The last level discussed in this theoretical framework is mutual or mature thinking where strategies use both self and shared reflection to collaboratively change both own and others'views in pursuit of mutual goals (Selman & Deomorest, 1984).

The average Rel-Q score for both the intake and longitudinal groups was not significantly different from the reported 8th grade norm, indicating basic reciprocal thinking patterns. However, the mean age of 14.65 years in the intake group was almost 2 years older than the average youth at the beginning of 8th grade and the average age in the longitudinal group was older yet, at nearly 15 years. The youngest group (<12.5 years) and the mid-age group (12.5 –15 years) were not significantly different than the normed groups (4th & 8th grade) on overall social competence scores.

However, the oldest group (>15 years) scored lower on the total social competence measure than the reported 12th grade norm which should indicate movement from

reciprocal to more mutual thinking patterns. Youth over 15 had clear deficits in total social competence and responded in a manner typical of 12 to 13 year olds, seeing relationships based upon reciprocal bargaining with little indication of mutual concern. Immaturity predisposes this group to a variety of risks. These delays have critical implications for social relationships and intervention planning.

Friendships are social relationships, which develop throughout childhood and adolescence. Peer groups are primarily homogenous and cliquish in late childhood. As youth move into early adolescence their relationship circles grow and begin to include new friends with more diverse interests and backgrounds. These early adolescent groups are mixed in gender and more flexible in their boundaries, mingling and mixing. Later in adolescence the large group situations begin to dissolve as youth move toward more serious "coupling" relationships and less group activity.

For the oldest youth in this study, the average level of social competence was closer to that of an eighth grader than a twelfth grader. Drifting away from peer group norms predisposes a youth to multiple risks. Interactions with developmentally appropriate peers are essential to learning new skills and negotiating new understanding. Rejection or exclusion by same age yet more mature peers, susceptibility to negative or anti-social peer leadership, and limited access to a developmentally equal peer group increases a youth's potential for difficulties. Likewise, being grouped by chronological age often places more immature youth at a serious disadvantage when authority figures, teachers, and organizational structures have expectations that the youth are not developmentally able to meet. Thus, their relationships with supportive adults are also at risk.

Basing relationships on reciprocal bargaining indicates that youth are also likely to be in an early stage of moral development (Kohlberg, 1976, 1986). For an adolescent to function at this level predisposes him or her to increased potential for interpersonal conflict because they are likely to make decisions based on what they want or what a friend is doing, rather than on following a set of standards or rules. Relationships with same aged peers who are further along in their moral development could be difficult as older more mature peers may choose to be intolerant of, or not interact with, the immature youth. Interactions with adults who have expectations that a youth's moral reasoning would be congruent with the expected norms of his or her chronological age would also likewise be compromised. When adolescents choose to not follow rules or seem to disregard expectations that other same-aged peers understand and respect, they are often labeled troubled, not caring, or even delinquent.

Reviewing the findings in the study related to the dimensions of the social competence measures may provide assessment information that would allow clinicians to plan specific interventions for this population. Youth admitted to residential treatment scored differently on social competence measures than the normed groups. Rel-Q subscale scores were similar for the intake and longitudinal groups at admission, and several patterns were identified.

Social perspective coordination. The core social cognitive operation of the GSID model is social perspective coordination. An individual's capacity to coordinate his own and other individuals' points of view toward shared social experience emerges within the relationship between interpersonal understanding, interpersonal skills, and personal

meaning (Schultz & Selman, 2001). This construct is reflected in the social perspective subscale.

All groups scored within the normed range on the social perspective subscale at admission. Though this ability was at the normed level across each age group, when deficits were present in interpersonal understanding, interpersonal skills, or personal meaning competencies, the youth would be likely to function in a manner congruent with the immature competency. Shultz and Selman (1998) concluded that, when the competencies are not in developmental synchrony, the gaps often result in lower levels of interpersonal action.

Interpersonal skills:hypothetical interpersonal negotiations. Relationship skills are competencies that are directly used in interaction to address intimacy and autonomy needs within the social context. Autonomy is operationalized in the construct of interpersonal negotiations. Interpersonal negotiation strategies are the skills an individual uses in situations of social conflict to deal with self and others. These skills depend on both the knowledge base and the core operation of social perspective coordination (Schultz & Selman, 2001).

In this study, the youngest group responded to hypothetical interpersonal negotiation questions in a similar manner, as did the normed group. While the mid-aged group actually scored higher than the 8th grade norm on this subscale, the oldest group was well below the expected 12th grade norm.

The majority of the youth in this study had experienced a variety of out patient services, therapy, and likely social skills training prior to placement in residential

treatment. Basic skills understanding with clear boundaries would be relatively simple for latency age youth to articulate. Sophisticated skills that are acquired with increased abstract thinking were less apparent in this population. It is possible that deficits in the area of personal meaning could hinder the development of mature interpersonal skills.

Interpersonal skills: real life negotiations. The real life subscale also measured social skills. Relatedness or intimacy interactions in the interpersonal model were operationalized by shared experience as measured by youth reports of real life negotiations. Scores at admission were equal to or greater than reported the norms in each age group. Youth were asked to report their response to others by remembering specific interpersonal interactions.

One possible explanation for this would be that, like the hypothetical interpersonal negotiations score, youth with basic social skills training or experience may have answered the questions in a predictable manner, anticipating the "appropriate" response based upon generic social norms. Yet, when reaching adolescence, basic understanding of social etiquette without increased ability to apply the skills in more abstract situations could result in increased difficulties in interpersonal relationships. Just knowing the "rules" does not necessarily facilitate smooth interaction with others. While "rules" often make sense to a latency age youth, adolescents with abstract thinking skills are more apt to negotiate, challenge, and change rules if a situation arises where set rules do not adequately address a problem. Thus, if an adolescent's social understanding is limited to latency age ways of thinking, conflict could easily arise with more mature peers.

Interpersonal understanding. Interpersonal understanding is the social cognitive competency that includes a child's developing understanding of what goes into forming a close relationship, how trust, and jealousy impact friendships. Interpersonal understanding is necessary but not solely sufficient for establishing healthy relationships; a repertoire of actions or skills is also essential. Interpersonal understanding is a prerequisite for engaging in relationships and impacts how a relationship evolves (Schultz & Selman, 2001).

In this study, interpersonal understanding dimensions were similar to the interpersonal skills dimensions. The youngest youth scored slightly above the expected 4th grade norm. The mid-age group was nearly identical to the 8th grade norm. The oldest group, as with other dimensions, scored significantly below the 12th grade norm.

For some reason, the social understanding of the older adolescents in this study was "stuck" between late childhood and early adolescence. Once again, the developmentally intertwined ideas about thinking and its movement from concrete to abstract, rigid to flexible, and egocentric to mutual seem to have been delayed.

From a moral reasoning perspective, interpersonal norms should begin to be apparent in early adolescence (Kohlberg, 1986). In this stage, a person values trust, caring and loyalty to others as the basis of moral judgements. Children often adapt the moral values of their parents. For youth in this study, chaotic interpersonal relationships and separation from or disintegration of family structures were common. It would be very difficult to move through this stage of moral reasoning without people who serve as standards. Unfortunately, many of the youth in this study lacked those types of relationships. This

presents another issue of increased risk for this population, as SED youth have potential to be easily drawn into gang affiliation and anti-social activities. They may look for people to trust and value, and then pattern their moral decisions after that group. Many of the youth in this study were delayed in the development of interpersonal understanding. The older youth had the most prominent deficits.

These deficits would predispose a youth to having limited approaches to social problem solving, rigid or rule laden response patterns, and lack flexibility for adapting. Thus they would be likely to experience more conflict and be off course socially from same age peers. Essentially, they are traveling in social environments in which they are not developmentally equipped to navigate.

Personal meaning. The concept of personal meaning encompasses the values, attitudes and beliefs one has about a particular relationship and is similar to the psychoanalytic constructs of object relations or working models of attachment (Bowlby, 1982, Bretherton, 1985). Ainsworth (1979) proposed that the quality of a child's early attachment to caregivers impacts his or her ongoing reactions to other people. In essence, personal meaning is the notion that a persons' past experience in significant relationships impacts current interactions, and that the patterns and tendencies of behavior in relationships are based upon the internalization of aspects of the primary relationships with significant others. Social competence is believed to emerge from the experience one has in close relationships (Hartup, 1989; Shultz & Selman, 2001).

Personal meaning has been described as the affective component of the GSID interpersonal relationship model. In this sample, personal meaning was the only subscale

on which all age groups scored lower than the norms. While the score of the youngest group was not significantly lower, it was the only subscale that was not at or above norms. Essentially, youth in this sample had less ability to process their social understanding of relationships than did normative groups. Further, their developmental deficits in this area became greater with increasing age.

The deficits in the personal meaning dimension seemed indicative of the salient problems within the SED population admitted to residential treatment. Disruptions in primary relationships or attachments, whether based on an individual's own set of difficulties or the problems experienced and perpetuated by caregivers, were likely to have had a crucial impact on the ability of SED youth to establish developmentally appropriate ideas of personal meaning. As the youth grew older, significant delays were apparent in all three areas of psychosocial competence. The oldest group often responded to social competence questions like normed peers who were 3 to 4 years younger.

The majority of the youth admitted to the residential treatment facility had significant behavioral problems. It was also clear that social competence deficits were common among youth over 15 years of age, and underdeveloped ideas of personal meaning were evident in each age group. The hypothesis that SED youth at admission to residential treatment would have behavioral problems and deficits in the development of social competence was strongly supported.

The youth in this study came from a variety of backgrounds, family situations and communities. Some of the common denominators in their lives were the severity of their acting out, the intensity of their emotional difficulties, and their deficits in the

development of social competence. The problems of these children had not been resolved in less restrictive settings. Whether by family circumstance, individual crises, or societal norms, they had been identified as youth that were "out-of-bounds" and out of control. Placement in residential treatment was often a "last resort" or an attempt to find "level ground" in the midst of an unpredictable downhill slide.

Changes in behavior problems and social competence from admit to discharge. An additional hypothesis proposed that, at discharge, SED youth in residential treatment would exhibit fewer behavior problems and demonstrate positive change on social competence measures than from admission. At discharge, the average age was 16 years after an average length of stay of nine and a half months. Youth in this study had impressive gains both with decreased problem behaviors and with growth in the development of social competence.

The primary childcare worker completed the CBCL within 10 days of discharge from the residential setting. Significant changes were revealed for internalizing, externalizing, and total behavior problems over the course of treatment. The group averages no longer met the borderline clinical range. Essentially, youth behavior at discharge would not have been considered problematic to the degree that would typically require a mental health referral.

Yet, though the group as a whole did not average scores at clinical levels, 16 youth in the longitudinal group had problems severe enough to qualify as borderline or clinical on behavior measures at discharge. Further examination of this group revealed that 5 of the 16 did not have clinical scores on admission so had deteriorated behaviorally. Three

children met clinical levels at intake and their behavior problems at discharge were higher. Thus, for half of the group that remained at clinical levels for problem behavior at discharge, either their behavior problems worsened over the course of treatment or the CBCL did not accurately portray the degree of behavior problem at the time of admission. Of these 8 youth, 2 had lengths of stay less than 4 months, 2 had additional diagnoses of psychotic disorders, and 4 had either conduct or reactive attachment disorders on their diagnostic lists. Thus, the severity of their mental health problems or their anti-social thinking patterns may have been factors that contributed to their lack of progress.

The remaining youth that had a clinical level of behavioral problems at discharge in fact demonstrated significant decreases in the problems. This group had numerous difficulties and very high behavioral problem scores on admission and, although obvious improvement was observed, they continued to exhibit enough behavioral difficulty to remain in the clinical range. It could be argued that, with additional time in treatment, these youth might continue to make gains. Increased time in treatment could be anticipated and, at times, necessary for youth with severe behavioral problems.

Nonetheless, in this study, 54 of the 63 subjects demonstrated a decrease in behavior problems over the course of treatment. This finding in itself supports the idea that residential treatment can be a helpful intervention for SED youth.

Social competence at discharge. Shultz and Selman (2001) reported that youth in upper elementary through high school appeared to gain between 0.25 and 0.33 of a developmental level, on average, every four years. This means that moving from a mean

of 1.8 in 4th grade to a mean of 2.4 in 12th grade is a normative progression. Considering this information, it was anticipated that normal social development would progress at a rate of approximately .06 to .08 of a specific developmental level (as in the GSID) each year. Admission SED youth in residential treatment were often behind their same age peers in the development of social competence, on average, social competence scores increased .09 to .39 of a developmental level. These were larger gains than would have been accounted for by normal developmental growth over the nine to ten month length stay.

Youth under 15 years of age made especially substantial gains on personal meaning (+ .27), which was equivalent to approximately 4 years growth. They also showed nearly 2 years growth for total social competence score (+.16). At discharge, those under 15 years actually scored significantly higher than the 8th grade norm on hypothetical interpersonal negotiations and social perspective coordination. They demonstrated insight into how relationships function beyond their normed peers and had the ability to integrate the dimensions of social competence in fairly mature manners.

Youth over 15 of age made gains on most of the dimensions of social competence. Social perspective coordination, however, remained the same between admission and discharge. Further, although all other dimensions improved, the personal meaning (+.39) and hypothetical interpersonal relationship (+.10) aspects remained significantly below 12th grade norms. Essentially, significant gains were made from admission to discharge with some gains representing 4 to 5 years' growth in normal development. However, the oldest subjects had not gained to a normative level in their beliefs related to relationships

based upon their past experience and actual social skill. Thus, at discharge, they would be likely to continue to exhibit immature social competence. Nonetheless, the hypothesis that between admission and discharge, SED youth in residential treatment would exhibit fewer behavior problems and demonstrate positive change on social competence measures was strongly supported by the data.

It is very difficult to separate out which aspects of residential treatment program were significant in their contribution to the gains made by each youth. In this study, the services and interventions provided by the residential treatment facility were complex, multidisciplinary, and extensive. Many factors were likely to have impacted the growth seen in the youth. Specific elements of the program that differed from what could have been offered in the average home or community included the increased capacity for containment, multidisciplinary on-site staff, and a physical setting and community built around the special needs of SED youth.

The residential treatment facility provided increased safety and security to and for the youth. Lodge programs were staffed at 3 youth to 1 adult ratios and school classrooms were equally well supervised. Other safety related factors included: a progressive development behavioral modification system, ongoing psychotropic medication evaluation and administration, seclusion rooms, physically holding out-of-control youth, nursing and psychiatric staff availability 24 hours a day, 7 days per week, and emergency psychotropic medication. While it is politically unappealing to discuss interventions that control extreme youth behaviors, it is unacceptable to ignore the potential for youth to

harm self or others. Providing youth with a setting where they and their peers were kept safe was likely a foundation to productive intervention.

The multidisciplinary staff in this setting contributed to the care of youth throughout their stay in the residential setting. Psychiatric and psychological assessment were completed at admission and caregivers participated with primary therapists, teachers, front-line staff, nurses, recreation therapists, dietary staff, youth, families/guardians and appropriate outside agencies in all treatment team meetings and in developing the plan of care for each youth.

The physical setting of the residential treatment program in this study also was important. The 400-acre campus has exceptional facilities. These include treatment units or lodges that house 8 to 10 youth, a free standing K-12 school, a recreation center (swimming pool, bowling alley, gyms), playing fields, large out door ropes course, cafeteria, chapel, indoor riding arena, and family housing that is available at no cost for family visits. The facility is located on a rural road approximately 8 miles from the nearest town. With over 300 employees, and about 90 youth on campus, it is essentially a small community built around the needs of SED youth and their families. It is possible that the peer community, with both equally immature peers, and more mature others, who were coached to tolerate and interact with less mature residents, contributed to the youth being able to make gains in social competence. Basically, when a youth could build relationships with other peers in a well monitored and teaching setting they gained understanding and skills.

Predictors at Admission.

The third aim was to examine if the number of out-of-home placements explained variation in behavior problem and social competence measures on admission. It was hypothesized that controlling for demographic variables of age, gender, and race, SED youth that had many changes of placement prior to residential treatment would have higher behavior problem scores and lower social competence scores at admission to residential treatment.

However, in this study, there were no significant correlations between out-of-home placements and total behavioral problem scores or social competence and the regression equation revealed no significant predictors. The average youth in the longitudinal group had 3 to 4 out-of-home placements prior to admission and many had serious disruptions in primary caregiver relationships. Re-grouping the sample and comparing those who had 2 or less out-of-home placements with those who had more than 2 did not provide any additional information. The hypothesis that SED youth who had many changes of placement prior to residential treatment would have higher behavior problem scores and lower social competence scores was not supported by the data.

Initially, this finding was somewhat confusing. The majority of the youth in this study had more than 2 out-of-home placements. It was clear from the social competence scales that youth in this study had experienced difficulties or disruptions in early relationships as evidenced by the personal meaning dimension. It seemed that out of home placements would be an objective measure of this type of disruption. It is possible that "out-of- home placement" was not specific enough to capture the idea of disrupted relationships. Several

aspects of the out-of- home variable were not investigated. Examination of the types of settings youth were placed in, descriptions or characteristics of primary caregivers, and/or how long youth were separated from their families might provide additional information. A further consideration was that any separation or out-of-home placement might not only be a result of behavioral or emotional difficulties but also could have contributed to lags in social competence and increased behavioral problems. The impact of out-of –home placement may have little to do with the number of placements and more to do with the aspect of not having, or being separated from, one's primary support group or attachments.

Predictors at Discharge.

The forth and final aim was to examine how length of stay in residential treatment and psychiatric diagnosis impacted variation in behavior problem and social competence measures. There were no significant correlation among the variables and no strength in the regression. The fourth hypothesis was not upheld by the data.

Two simple explanations may account for why length of stay and psychiatric diagnoses did not seem to be related to behavioral problems and social competence at discharge. First, the majority of youth in the study had mood disorders. With consistent cognitive behavioral therapy and good pharmacological management most people with mood disorders experience remission of symptoms.

Second, youth do not get discharged from residential treatment settings until they are "ready" to step-down to less restrictive settings. In general, the behaviors that justified

placement at this level of care significantly decreased or had resolved prior to discharge planning.

Limitations

Several limitations were evident over the course of this study, including issues with the sample, the measures chosen, and data gathering methods. First, the length of stay impacted the sample size. Many youth remained in treatment when the study period had ended. Sample size was also influenced by the persistence of the assessment staff. At times, data were not collected or assessments were incomplete and several discharge assessments were not administered. Tracking information over 24 months also presented occasional problems when communication between the assessment staff and the researcher were unclear.

The CBCL was completed by the primary staff person assigned to each youth at admit. This was somewhat limiting, as some youth may have been on their "best behavior" shortly after admission and more problematic behaviors may not have been readily assessable. It is likely that some of the youth in the "non-clinical" range at admission were in a "honeymoon" phase of treatment.

The Rel-Q was reported to be appropriate for youth with 4th grade reading levels. However, assessment staff reported that several youth were confused and requested input from the psychologist to decipher some of the questions on the Rel-Q. Several youth also failed to fill out the questionnaire correctly, choosing to only mark "best response" categories even after clear directions for completing the tool were given both verbally and in writing. These youth were not included in the sample due to inadequate data.

The Rel-Q age norms of 4th, 8th, and 12th grade were different than the actual age distribution in this sample. After grouping the youth as 15 years or less and >15years, the mean ages of the groups were more congruent with 9th and 11th grade students. Unfortunately, 9th and 11th grade norms were not available.

This study did not place any emphasis on the level of sophistication and intervention in the particular setting. Implying that any setting that falls under the category of "residential treatment" would have similar outcomes would be very unrealistic. Significant behavior and social competence gains were made in this residential setting where considerable treatment focus was placed on interpersonal behavior, reconciling and understanding earlier life experiences, gaining problem solving skills, and negotiating and communicating with others. Finally, it is not known to what extent gains made in this setting were sustained by the youth after discharge.

Recommendations for Future Research

The setting in which this study took place is an ideal environment to continue research with SED youth in residential treatment. The tools used in this study continue to be used by the assessment department. More sophisticated tracking systems and data entry could be developed and organized to promote a larger sample. Youth and teacher forms of the CBCL have been collected by the residential setting and could also be included in the data set. Initial assessment by primary child care staff could take place at 14 to 21 days in an effort to give youth time to "settle in" to the treatment setting and give staff opportunity for increased observation and interaction with new youth.

CBCL information from parents or care providers prior to admission would be useful and could give a clearer picture of youth problem behaviors at admit. However, considering the complexity and inconsistencies of the systems and processes whereby youth enter residential treatment, developing a method to gather data from parents, guardians, and caregivers would be difficult and at times impossible.

The authors of the Rel-Q continue to validate their tool and establish more sophisticated norms. Continuing to use the Rel-Q would contribute to their database. Future studies could also incorporate specific treatment interventions directed toward identified social competence deficits.

Further research is necessary to determine how this group is similar and different from SED youth in community based care. A study that would incorporate both youth in residential treatment and youth in community settings would be useful to determine if behavior problems and levels of social competence differ between the two groups.

In this study the chosen predictor variables of out-of-home placement, length of stay, and psychiatric diagnoses had little impact on behavior or social competence scores. However, personal meaning scores clearly demonstrated that youth admitted to this setting had serious delays related to their understanding and integration of early life experience in significant relationships. Further exploration of factors such as family constellation, functioning, and disruptions in primary care may provide increased insight into etiologies that contribute to SED youth social competence deficits.

Change was explored from admission to discharge though little emphasis was put on the specific interventions or care youth received. Examination of specific residential

treatment programs and the services they provide is necessary to establish who should be and who is most effectively served in a particular setting. While psychiatric diagnoses were considered in this study, pharmacological intervention was not seriously investigated. In the future, it would be important to clarify and describe the intensity of the services provided.

Conclusions

In this study, youth placed in residential treatment were seriously emotionally disturbed and had significant behavior problems and developmental deficits in social competence. While three-fourths of the intake group met clinical levels of behavior problems at intake only 15% scored at clinical levels at discharge. Contrary to Burns' (2000) critique that residential treatment could be likened to "institutional care, which can have deleterious consequences" (p. 35), youth in this study demonstrated impressive gains over the course of stay.

On social competence measures at admission, younger youth (15 years or less) responded in a congruent manner with the normed peer group and also made significant gains over the course of treatment. Older youth (>15 years) on admission lagged behind in the development of social competence but also demonstrated significant growth by discharge. However, even with scores that represented 4 to 5 years' gain in a normal population, they did not reach norms on the dimension of personal meaning or total social competence. They continued to respond at an immature level compared to norms, which had potential to be problematic as they re-entered communities, schools, and families after discharge.

Several key findings of this study merit recognition and ongoing investigation. First, SED youth had not only problematic behaviors but also developmental lags in social competence and although behavioral problems were generally resolved, social competence deficits among the older SED adolescents continued to exist. Second, gender differences between behavioral problems and their relationships to social competence dimensions were evident in the population. Finally, the services provided and integrated in the residential treatment setting are believed to have had a very positive impact on outcomes for youth in this study.

Recognition of developmental deficits is crucial for planning and implementing interventions for this population. Strategies that target specific areas of deficits including social understanding, processing and skills should be further investigated defined and implemented. Developing social circumstances and settings where youth have opportunity to interact with both developmentally equal and more mature others is necessary for promoting social competence growth and development.

Acknowledging and strategizing interventions, which take into account gender differences, could be potentially very helpful to SED youth. In this study, females with internalizing behaviors and males with externalizing behaviors demonstrated correlations with social competence deficits. Recognizing that shy, depressed, anxious females may need help with their social understanding of interpersonal skills, and processing about social relationships is an important finding. Likewise, acting out or delinquent males had immature ideas related to their early child relationships and focus on understanding the

impact of these relationships might help them to move along the developmental trajectory.

Finally, the safety, interdisciplinary care, and therapeutic community provided by a residential treatment setting must be respected, considered and acknowledged. Among professional providers it is clear that no one wants to see youth out-of-home or separated from their family or community. However, it is crucial that the most vulnerable and problematic SED youth be served in settings that can best meet their needs. Residential treatment should be viewed as an important and at times necessary level intervention along the continuum of care.

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Appendix A

Child Behavior Checklist

CHILD BEHAVIOR CHECKLIST FOR AGES 4–18

Please Print

For office use only
ID #

CHILD'S FULL NAME: FIRST MIDDLE LAST

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. _____ Date _____ Yr. _____

CHILD'S BIRTHDATE Mo. _____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY:

☐ Mother (full name) _____

☐ Father (full name) _____

☐ Other—full name & relationship to child: _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do ***not*** include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

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Please Print

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. For ages 6 and older—performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Does your child receive special remedial services or attend a special class or special school? ☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start?

Have these problems ended? ☐ No ☐ Yes – when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food – ***don't*** include sweets (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight

56. Physical problems ***without known medical cause:***

0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe): _____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries

113. Please write in any problems your child has that were not listed above:

0 1 2 _____
0 1 2 _____
0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

Appendix B

Group for Interpersonal Development Relationship Questionnaire

GSID Relationship Questionnaire

Grades 4+

Version 4.0

This questionnaire is not a test and there are no right or wrong answers to any of the questions. Each student will have different opinions, thoughts, and feelings about different issues or situation. We are interested in <u>your</u> experiences and what <u>you</u> think about certain things. We hope you will find these questions interesting.

STUDENT INSTRUCTIONS:

☛ 1. For each incomplete sentence, indicate with a check mark whether you think that each sentence completion choice is **POOR, OK, GOOD, or EXCELLENT.**

☛ 2. Next write the letter (a, b, c, or d) of the choice that you think is the best in the box provided.

EXAMPLE

	Poor	OK	Good	Excellent
It is good to work hard in school because				
a. you might win an award	☐	☐	☐	☐
b. you don't have a choice about being there, so you might as well	☐	☐	☐	☐
c. you will feel good about yourself	☐	☐	☐	☐
d. it will make you parents happy	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

I AM A GIRL ☐ I AM A BOY ☐

1. Someone is a good friend because he or she:

	Poor	OK	Good	Excellent
a. does what you ask	☐	☐	☐	☐
b. lives close by	☐	☐	☐	☐
c. shares his or her friends with you	☐	☐	☐	☐
d. will keep your secrets	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

2. A good teacher:

	Poor	OK	Good	Excellent
a. does not yell	☐	☐	☐	☐
b. keeps the class quiet	☐	☐	☐	☐
c. lets the students help make some decisions	☐	☐	☐	☐
d. listens to students' ideas	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

3. When you trust someone it is because they:

	Poor	OK	Good	Excellent
a. give you presents	☐	☐	☐	☐
b. mean what they say	☐	☐	☐	☐
c. are loyal to you	☐	☐	☐	☐
d. keep your secrets	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

4. The best way to explain why kids your age get into fights is:

	Poor	OK	Good	Excellent
a. they get mad at people who talk behind their back	☐	☐	☐	☐
b. they were hit by another kid	☐	☐	☐	☐
c. they can't see any other way to deal with some people	☐	☐	☐	☐
d. they like fighting to show who's boss	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

5. The best way to explain why some kids your age *don't* get into fights is:

	Poor	OK	Good	Excellent
a. they don't like fighting	☐	☐	☐	☐
b. they know how to see each person's point of view in an argument	☐	☐	☐	☐
c. they are not good fighters	☐	☐	☐	☐
d. they have learned other ways to deal with problems	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

6. The best reason to explain why someone your age joins gangs is:

	Poor	OK	Good	Excellent
a. to show off in front of other girls or boys	☐	☐	☐	☐
b. because they want to be cool	☐	☐	☐	☐
c. they just like being in a gang	☐	☐	☐	☐
d. being in a gang gives them a feeling of belonging to a family	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

7. Jody doesn't like the idea of shoplifting or stealing things from stores. One day Jody's best friend Naomi says she is going to steal something from a store and asks Jody to go with her. Jody says she doesn't want to, and Naomi calls her a wimp. Jody could

	Poor	OK	Good	Excellent
a. tell Naomi not to steal`	☐	☐	☐	☐
b. explain to Naomi why she thinks stealing is wrong and talk her into not stealing	☐	☐	☐	☐
c. persuade Naomi that stealing is not worth the risk of getting caught	☐	☐	☐	☐
d. just walk away	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

8. Steve and Carlos are friends. One day at school, they try to decide what they want to do that night. Steve wants to invite a new kid in school to go to the movies with him and Carlos. Carlos wants to go to the movies alone with Steve. Carlos could

	Poor	OK	Good	Excellent
a. tell Steve that he can't go because he's sick	☐	☐	☐	☐
b. tell Steve he won't go	☐	☐	☐	☐
c. explain to Steve why he wants the two of them to go alone, ask Steve to explain	☐	☐	☐	☐
d. tell Steve he'll go to the movies with Steve and the new kid if he and Steve can do something together later	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

9. The principle of the school had told the student council that this year there are no funds for after-school activities such as sports and art. Because a lot of students in the school are upset about losing these activities, Leticia and the other members of the student council need to decide what to do. Leticia and the other student council members could

	Poor	OK	Good	Excellent
a. begin an awareness plan to get parents to understand how important sports and art for the students	☐	☐	☐	☐
b. offer to paint the school building in return for money for after-school programs	☐	☐	☐	☐
c. don't do their school work	☐	☐	☐	☐
d. go to the school board meeting and tell people to get the money for sports and art	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

10. Glady's who has a ten o'clock curfew, goes to a party on Saturday night. She gets home at 12:00 and her father is waiting up for her. He is very angry and grounds her for a month. Gladys feels that the punishment is too severe and thinks she is old enough to stay out past 10:00. Gladys could

	Poor	OK	Good	Excellent
a. storm out of the room	☐	☐	☐	☐
b. tell her father he can't tell her what to do	☐	☐	☐	☐
c. ask her father to work with her on an agreement which would allow her to stay out later on weekends	☐	☐	☐	☐
e. explain to her father why she feels she's old enough to stay out late	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

11. Amy is very athletic and likes sports. She particularly likes baseball and decides to try our for the neighborhood Little League team one spring, even though there are no other girls on the team. During the tryouts, some of the boys start "dissing" her, saying that baseball is for boys and that they don't want her on the team. Amy tries out anyway, but the next day when the coach announces who made the team, Amy is not chosen. Amy could

	Poor	OK	Good	Excellent
a. tell the coach "I know I played better than some of the boys who made the team and you know I deserve to be on it."	☐	☐	☐	☐
b. say to the coach what she thinks about not making the team.	☐	☐	☐	☐
c. slam her locker door and tell her friend what she thinks of the coach.	☐	☐	☐	☐
d. go to the coach to hear his reasons for not putting her on the team and explain her point of view to him.	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

12. Holly is baby-sitting for her little brother, Max, so her parents can enjoy a Saturday out. Before leaving for the evening, they tell Holly to be sure not to let Max watch any TV after 9:00. Holly sends Max to bed at 9:00 and stays up to watch a movie she's been wanting to see. At 9:30, Max comes downstairs, awakened by a bad dream, and asks to watch TV with Holly because he can't sleep. Holly should say to Max

	Poor	OK	Good	Excellent
a. "I'll let you stay up, I know your scared."	☐	☐	☐	☐
b. "You can stay up. Just be quiet so I can watch the movie"	☐	☐	☐	☐
c. "You can stay up – Mom and Dad will understand that I let you stay up because you had a bad dream."	☐	☐	☐	☐
d. "You can stay up – Mom and Dad wouldn't want you to be alone when you're afraid."	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

13. Tanya and Stanley have a date to go rollerskating. An hour before she is supposed to leave home to meet Stanley, Tanya gets a call from a friend who has an extra ticket to a football game and would like Tanya to come with her. The game starts at the same time Tanya is to meet Stanley. Tanya calls Stanley to change their plans, but gets Stanley's answering machine. Tanya should

	Poor	OK	Good	Excellent
a. leave the message "A friend called and offered me a ticket to today's football game, so I'm sorry about this. I'll call you when I get back"	☐	☐	☐	☐
b. leave the message "I know you'll be disappointed, but I have to change our plans. I was looking forward to seeing you, and I'm sorry about this. I'll call you when I get back."	☐	☐	☐	☐
c. Leave the message "I have to change our plans to go skating. I'll call you later"	☐	☐	☐	☐
d. call back after the game	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

14. Dan's grandfather doesn't speak English and needs to find a job. Dan, how does speak English, goes out with his grandfather to help him find work. Dan sees a restaurant with a Help Wanted sign in the window and goes inside to speak with the owner. Because his family needs money so badly, Dan lies to the man, telling him that his grandfather knows how to cook. Dan also lies to his grandfather, telling him the owner has hired him even though he know, he isn't a cook. Dan lies to his grandfather because he

	Poor	OK	Good	Excellent
a. is thinking only about himself and not about how his grandfather might feel	☐	☐	☐	☐
b. is thinking about earning money to feed his family, and so he didn't think about how his grandfather might feel.	☐	☐	☐	☐
c. thought that once he had time to explain the situation to his grandfather, he'd understand and forgive him.	☐	☐	☐	☐
d. thought his grandfather would be upset if he knew Dan had lied to the man hiring cooks.	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

15. My closest friends are important to me because:

	Poor	OK	Good	Excellent
a. they make me feel better about myself	☐	☐	☐	☐
b. they like me	☐	☐	☐	☐
c. they help me stay out of trouble	☐	☐	☐	☐
d. we can talk to each other about anything	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

16. My parents are important to me because:

	Poor	OK	Good	Excellent
a. they make me feel better about myself	☐	☐	☐	☐
b. they like me	☐	☐	☐	☐
c. they help me stay out of trouble	☐	☐	☐	☐
d. they provide the support that I need	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

17. When I get in fights or arguments with other people, it is because

	Poor	OK	Good	Excellent
a. they get in my way	☐	☐	☐	☐
b. they talk about me behind my back	☐	☐	☐	☐
c. if I don't fight they'll think I'm afraid	☐	☐	☐	☐
d. I keep my self-respect by not backing down	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

18. When I don't get in fights or arguments with Other people, it is because:

	Poor	OK	Good	Excellent
a. it's not part of who I am	☐	☐	☐	☐
b. not fighting is the only solution to all problems	☐	☐	☐	☐
c. nobody likes their friends to fight	☐	☐	☐	☐
d. I'm in a good mood	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

19. If someone calls my mother a name or insults me In school I would Fight Them because:

	Poor	OK	Good	Excellent
a. if I let them get away with it once they'll do it again	☐	☐	☐	☐
b. it gets me mad	☐	☐	☐	☐
c. even though I know that fighting is not always in my best interest, sometimes there's no other way to deal with disrespect	☐	☐	☐	☐
d. you don't let anybody mess with you or your family	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

20. If someone calls my mother a name or insults me in school I would NOT FIGHT THEM because:

	Poor	OK	Good	Excellent
a. I could get hurt	☐	☐	☐	☐
b. I don't want to get into trouble	☐	☐	☐	☐
c. I only fight when someone hits me	☐	☐	☐	☐
d fighting's not going to make me feel better or solve anything	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

21. My best friend and I do things separately sometimes because:

	Poor	OK	Good	Excellent
a. we ignore each other when we've had a fight	☐	☐	☐	☐
b. we can't agree about what we do	☐	☐	☐	☐
c. we like to do different things	☐	☐	☐	☐
d our friendship is secure without always being together	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

22. When my best friend and I don't agree on what I do, I might:

	Poor	OK	Good	Excellent
a. try to convince my friend	☐	☐	☐	☐
b. listen to my friend and work it out	☐	☐	☐	☐
c. get upset and go away to be by myself	☐	☐	☐	☐
d go along with my friend	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

23. When I don't agree with the adult I am closest to, I might:

	Poor	OK	Good	Excellent
a. try to convince them	☐	☐	☐	☐
b. just forget it	☐	☐	☐	☐
c. listen to them and work it out	☐	☐	☐	☐
d get so upset I run into my room	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

24. I sometimes don't agree with what my teachers tell me at school because:

	Poor	OK	Good	Excellent
a. they blame me for thing I don't do, and that makes me mad.	☐	☐	☐	☐
b. I need to stick up for what I think and believe is right	☐	☐	☐	☐
c. I don't think they understand my point of view	☐	☐	☐	☐
d I don't listen to them	☐	☐	☐	☐

Write the letter (a, b, c, or d) of the choice that you think is the best in this box: ☐

25. During the past SIX MONTHS, how many times, if any, were you in a physical fight?

a. 0 times ☐
b. 1 time ☐
c. 2 or 3 times ☐
d. 4or 5 times ☐
e. 6 or 7 times ☐
f. 8 or 9 times ☐
g. 10 or 11 times ☐
h. 12 or more times ☐

Appendix C

Admission Consent

Name:_____ ID# :_____

CONDITIONS OF ADMISSION

1 Certification of Receipt of Patient Rights. The undersigned acknowledges receiving, reading, and understands the Statement of Patient Rights outlined in the Parent Handbook. It is understood and agreed that the undersigned may discuss the same with YBGR staff should he/she have any questions concerning patient rights.

2. Teaching Institution. The undersigned acknowledge and understand that YBGR also functions as a clinical teaching institution, and that the patient may participate as a teaching subject in various clinical educational programs offered at YBGR. Any objection to this condition shall be made in writing to YBGR staff.

3. Personal Valuables. To avoid loss or damage, patients are encouraged not to keep personal items of value on the unit. Items of value should be sent home. YBGR will not be liable for the loss of or damage to any money, jewelry, glasses, dentures, documents, clothing or other items of value.

4. Searches. The undersigned understands and agrees that the patient is subject to the search of his/her person, room and belongings upon admission, after returning from a pass, prior to seclusion and restraint, following visitation, and any other time YBGR staff deems it necessary. Anything given to the patient by a visitor may be inspected by the staff at their discretion. All drugs, sharp objects, and any other item deemed to be potentially harmful will be considered to be contraband, will not be permitted in the facility, and will be confiscated. The purpose of such searches is to maintain an environment free from threat or danger by safeguarding every patient from exposure to such items which might cause harm to the patient, other patients, staff, or visitors.

5. Patient Conduct. The undersigned acknowledges receiving, reading, and understanding the rules and regulations for patient conduct, to which the patient is bound to comply as outlined in the Parent Handbook. Any violations of said rules and regulations will be reported to the undersigned as soon as practicable. Violations of said rules and regulations will be dealt with as provided in said rules.

6. Photographs. The undersigned gives consent for the use of photographs for the following purposes:

   Internal Use

   _____ Use only at facility (YBGR employees or other authorized representatives). This may include still photography, 24-hour video monitoring, one-way mirror, audio and/or videotapes of psychotherapy, school instruction, and job club

   External Use

   _____ Public Viewing (only – no hard copy released)

   _____ Publication (printed document)

The undersigned understands that this authorization may be revoked at any time, upon written notification to YBGR, except to the extent that action has been taken in reliance thereon. Any use of the above after a patient's discharge without additional consent is prohibited.

7. Grievance Procedures. The undersigned acknowledge receiving, reading, and understands the Yellowstone Boys and Girls Ranch Grievance Procedure as outlined in the Parent Handbook. It is understood and agreed that the undersigned may discuss the procedure with YBGR staff should he/she have any questions.

8. Religious Services. Nondenominational religious services are offered and available to all patients. All patients are expected to attend the Sunday morning services.

9. Consent to Routine Psychiatric Services. The undersigned hereby consents to the rendering of such routine psychiatric/medical care and treatment as the admitting physician or others of YBGR's staff consider to be necessary, and as established pursuant to the treatment plan. Examples of routine procedures that may be utilized in the patient's treatment are:

a. Physical, psychiatric and related diagnostic tests;
b. AIDS Assessment;
c. Administration of medication;
d. Individual psychotherapy;
e. Group psychotherapy;
f. Family therapy;
g. Biofeedback therapy;
h. Behavior modification therapy and other treatment modalities that foster socially appropriate behavior and healthy personality growth;
i. The therapeutic milieu and activities of the program to which the patient is admitted;
j. Relaxation techniques;
k. Therapeutic work experiences;
l. Activities/recreational therapy;
m. Immunizations as needed and deemed appropriate by medical staff; (please note to be withheld for religious/ethical reasons)
n. Other treatment techniques that remove a patient from environmental stimulations when other forms of intervention fail to assist the patient to maintain self-control.

The nature, purpose and benefits of these routine treatments, the possible alternate methods to these treatments, any risks involved, and any possible side effects or complications arising from them will be explained to the undersigned and the patient prior to their use. Non-routine care and treatment or medications will not be administered to the patient without the undersigned's and/or patient's prior informed consent.

10. Consent to Treatment Procedures. The undersigned hereby consents to the rendering of the following treatment procedures, to be used only when the patient's behavior makes him/her dangerous to himself/herself, to others, or a serious disruption to the therapeutic milieu:

a. Timeout from positive reinforcement - a short interval spent in a quiet area where the patient can calm down and regain control and his/her behavior and emotions.

b. Open-door time out - a procedure implemented when a patient cannot regain emotional control in the therapeutic environment and need the outlet of a Time-Out Room where he/she can pace, move around, and ventilate until a calm state is achieved.

11. Consent to Special Treatment Procedures. The undersigned hereby consents to the rendering of the following special treatment procedures to be used only when the patient's behavior makes him/her dangerous to himself/herself, to others, or a serious disruption to the therapeutic milieu:

a. Physical Restraint - a procedure to prevent a youth from harming himself/herself or others. Its purpose is to allow the patient an opportunity to regain control of intense emotions.

b. Mechanical Restraint - a procedure where the patient is removed from the therapeutic environment and mechanical restraints are applied in order to prevent behaviors that threaten self-injury or harm to others.

c. Seclusion - a procedure where the patient is confined to the locked time-out room. The behavior must create a serious threat of harm to others, or be a serious disruption to the environment.

d. Emergency medications - a procedure where the patient would be given a medication to help him/her to calm down when in an extremely agitated situation. The medication would be used to allow the patient to regain emotional control.

12. Consent to Emergency Medical Treatment. The undersigned hereby consents to the rendering of such emergency medical treatment as may be necessary in the event of a medical emergency. YBGR will make every reasonable effort to notify the undersigned in advance of such treatment, unless doing so creates a life-threatening situation. Should more comprehensive emergency medical treatment be necessary, the undersigned consents to the transfer of the patient to a local general hospital facility for medical treatment.

13. Consent to Activity Therapy. The undersigned hereby consents to the patient's participation in indoor and outdoor therapeutic activities, and the patient's transportation to and from these activities. These activities are part of the patients treatment program and are planned, conducted and supervised by qualified activity therapists. Physical activities may include strenuous aerobic exercise, swimming, sports and games. Outdoor education activities may include rope courses, biking, camping, hiking, backpacking, horseback riding, canoeing, orienteering or rock climbing. Patients are carefully screened prior to participation in these activities. All activities are conducted with the patients' safety in mind, and take into account each patient's capabilities.

14 Financial Agreement. The undersigned agrees that in consideration of the services to be rendered by YBGR to the patient, he/she individually obligates himself/herself to pay the account of YBGR in accordance with its regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney fees and collection expenses. The existence of a third-party payer shall not relieve the undersigned of the obligation to pay the balance of the account after payment by the third-party payer. The undersigned shall be informed in advance, where possible, of any limitations placed on the duration of services by the third-party payer.

15. Assignment of Insurance Benefits. The undersigned hereby assigns to YBGR all insurance benefits which are or shall become payable under all insurance policies which provide for payment of the patient's psychiatric/ medical expenses. The undersigned authorizes and directs all insurance companies to pay all benefits directly to YBGR. The undersigned consents and agrees that even though insurance benefits have been assigned to YBGR, the undersigned remains financially responsible for the payment of the patient's account.

16. Release of Information to Yellowstone Academy. The undersigned hereby authorizes YBGR to disclose to Yellowstone Education Center certain healthcare information necessary to develop specific special education services for the patient.

17. Release of Patient Information. Unless instructed otherwise by the undersigned or the patient and a member of the psychiatric treatment staff, the patient's records will be marked "confidential" and his or her name will not be printed or displayed where it can be seen by the public. The patient's presence in YBGR will not be acknowledged to anyone, including visitors, callers, or family members inquiring at the switchboard, information telephones, or information desks.

18. Data Collection. Aggregate data may be collected for research purposes and possible publication may emerge from that research. No identifying information on any individual will be collected and all records accessed for the purpose of research will be anonymous.

The undersigned certifies that he/she has read the foregoing, understands its contents, accepts and agrees to its terms, and has received a copy thereof. The undersigned acknowledges that all blanks requiring completion were filled in before signing this document. The undersigned further certifies that he/she was fully informed about the treatment methods referred to herein, understands the same, and had the opportunity to discuss any concerns or have any questions answered. The undersigned further acknowledges there are no physical conditions/limitations that prevent the patient's participation in the treatment activities referred to herein.

Patient's Name: *(print)*_____ ID#:_____ DOA:_____

_____
Patient Date

_____ _____
Parent / Guardian *(circle one)* Date Address

_____ _____
Parent / Guardian *(circle one)* Date Address

_____ _____
Witness Date Address

Appendix D

Confidentiality and Youth Rights

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH CARE INFORMATION

I authorize: _____

to disclose certain confidential health care information concerning:

Patient: _____ To: _____

Date of Birth: _____ _____

_____

_____

Purpose or need for disclosure: _____

Specific nature of information to be disclosed and dates: (list specific documents, reports, etc. ***(required)***)

_____

_____

- This authorization authorizes release of prior records and records pertaining to health care furnished within six (6) months after the date of this authorization.
- The undersigned understands that this authorization includes disclosure of ALCOHOL AND DRUG ABUSE records which are protected by virtue of the provisions of Federal Regulations (42 C.F.R. part 2)
- The undersigned makes this authorization upon the promise that all disclosures of any alcohol and drug abuse records made pursuant to this authorization shall be accompanied by the following notices:

  NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- In the event that an oral disclosure of information is made pursuant to this written Authorization, then said oral disclosure shall be accompanied by or followed by a copy of this Release of Information.
- The undersigned understands that this Authorization may be revoked at any time, upon written notification to the providing organization, but if I do it won't have any affect on actions taken prior to the revocation of this release.
- The undersigned hereby acknowledges that he/she has read, is familiar with, and fully understands the terms and conditions of this Authorization. The undersigned understands that he/she may get a copy of this form after signing it.

_____ _____

Print or Type Patient's Name Patient Signature Date

_____ _____

Signature of Legal Representative Date Witness Date

(If patient under 18 years)

(circle one) Parent, Legal Guardian, Agency

ANY DISCLOSURE OF HEALTH CARE INFORMATION BY THE RECIPIENT(S) IS PROHIBITED.

CHILDREN'S RIGHTS

To further clarify the rights of children in our programs, Yellowstone adheres to the following standards of children's rights. If you would like to discuss any item, please feel free to contact any team member of your unit.

1. Children have the right to impartial access to treatment, regardless of race, religion, sex, ethnicity or sources of financial support.

2. Children have a right to living space that promotes dignity, comfort, positive self concept and privacy.

3. Children have the right to individualized treatment which includes the provision of adequate and humane treatment services.

4. Children have the right to the least restrictive appropriate treatment alternative.

5. Children have a right to an individualized treatment plan and the periodic review of that plan by an inter-disciplinary team.

6. Children and their parents or adults with legal custody have the right to active participation in the treatment planning process.

7. Children have the right to the provision of professional staff adequate to supervise and implement the individualized treatment plan.

8. Children have the right to daily exercises and access to out-of-doors unless specifically restricted by a mental health professional. A written order reviewed at least every three days must be maintained in the youth's record.

9. Children have the same rights to visitation and reasonable access to telephone communications, including the right to converse with others privately, except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. This order must be developed with limitations determined with the participation of the child, his/her family and/or when appropriate, the agency of responsibility and evaluated by the person ordering the limitations at least every seven days. All such limitations must be fully explained to the child and his/her family.

10. Children have an unrestricted right to send sealed mail. Children have an unrestricted right to receive sealed mail from their attorneys, private physicians and other professional persons, the mental disabilities board of visitors, courts, and government officials. Children have the right to receive sealed mail from others except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. This order must be developed with limitations determined with the participation of the child, his/her family and/or when appropriate, the agency of responsibility, and evaluated by the person ordering the limitations at least every seven days. All such limitations must be fully explained to the child and his/her family.

11. Children and their families have a right to full information in a language he/she understands regarding:
    a. the Children's Rights;
    b. the professional staff members responsible for his/her care, their professional status and their staff relationship;
    c. the nature of care, procedures and treatment that he/she will receive;
    d. the current and future use and disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies or photographs;
    e. the risks, side effects and benefits of all medications and treatment procedures used;
    f. the alternative treatment procedures that are available;

g. the right to refuse to participate in any research project without compromising his/her access to facility services;
h. the right to refuse the specific medications or treatment procedures;
i. the responsibility of the facility, when the patient refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with the patient upon reasonable notice;
j. the source of the facility's reimbursement and any limitations placed on duration of service;
k. the reasons for any proposed change in the professional staff responsible for the patient or for any transfer of the patient either within or outside the facility;
l. the rules and regulations of the facility applicable to his/her conduct;
m. the right to initiate a complaint grievance procedure and the appropriate means of requesting a hearing or review of the complaint (request procedure information from Intake Coordinator);
n. the discharge plan;
o. the plans for meeting continuing mental and physical health requirements following discharge;
p. the services available in the facility and of related charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate.

12. Children have the right to prompt and appropriate medical treatment for physical ailments.

13. Children have the right to be free from unnecessary or excessive medication. No prescription medication, tranquilizers or amphetamines shall be administered except by orders of a physician.

14. Children have the right to worship. An All Faiths Chapel service is provided for children of Protestant and Catholic faith on a weekly basis.

15. Children have the right to the maintenance of confidentiality of communication between themselves and staff and all of the information recorded in their record by all staff. This right does not negate legal responsibility to report incidents of abuse or neglect or other criminal activity. Neither does it restrict communications between team members regarding treatment issues or the general safety of the youth.

16. Children will have the right to appropriate pay for work done in accordance with the established pay scale which is based on the nature of their job. Paid jobs are part of the work therapy program and are a part of the individual treatment plan. Children will be required to perform tasks and work in accordance with standards of good maintenance and neatness of the living unit without compensation. Children will not be required to do meaningless work as punishment nor excessive work for their age and development.

17. Children have the right to express and pursue the resolution of complaint using the Grievance Procedure outlined in Policy 606 which is available upon request from the Intake Coordinator.

18. Children will have the right to meals that meet at least the minimum recommended dietary allowances as developed by the National Academy of Sciences. Denial of nutritionally adequate diet, or any meals, shall not be used as punishment.

19. Children will not be physically or verbally abused in any way. Hitting, spanking, verbal derogatory and belittling comments are not to be used by staff. Physical restraint and seclusion may be used only to the degree necessary to prevent the child from hurting self, others or property.

20. Children have the right to appropriate educational services, utilizing the educational principle of "least restrictive alternative."

21. Children have the right to treatment planning which includes therapeutic passes or visits home based on the child's and family's needs and discharge planning. Visits home may be withheld as part of the treatment plan but are not to be used in a punitive way.

Restriction of Rights

The Montana Mental Health Code permit the attending mental health professionals to suspend, curtail, restrict, supervise, and/or monitor all visits, telephone calls and mail, when the child's mental condition is such that unrestricted access would be injurious to the child. In these instances, a "Restriction of Rights" form will be completed and given to the parents and the child describing the restrictions and explaining why. If clinically necessary, this is renewed every seven (7) days by order of the mental health professional in the weekly treatment staffing with justification provided.

I have read or have had read to me and understand the Children's Rights at outlined in this document.

Patient	Date	Address
Parents/Guardian	Date	Address, Telephone Number, County of Residence
Parents/Guardian	Date	Address, Telephone Number, County of Residence
Witness	Date	Address