6-12-1998

Using impact group therapy with middle school students with behavioral disorders

Jennifer Marafioti

Using Impact Group Therapy with Middle School Students with Behavioral Disorders

Master's Project

Submitted to the Faculty

Of the School Psychology Program

College of Liberal Arts
ROCHESTER INSTITUTE OF TECHNOLOGY

By

Jennifer S. Marafioti

In Partial Fulfillment of the Requirements for the Degree of Master of Science

Rochester, New York **June 12, 1998**

Approved: G. T. Gurly
(committee chair)

Jennifer Lukemski
(committee member)

RIT
School Psychology Program
Permission to Reproduce Thesis

PERMISSION GRANTED
Title of thesis _____
Using Impact Group Therapy with Middle School Students with Behavioral Disorders

I _____ hereby **grant permission** to the Wallace Memorial Library of the Rochester Institute of Technology to reproduce my thesis in whole or in part. Any reproduction will not be for commercial use or profit.

Date: 4-1-98 **Signature of Author:** _____

PERMISSION FROM AUTHOR REQUIRED
Title of thesis _____
_____
_____

I _____ **prefer to be contacted** each time a request for reproduction is made. I can be reached at the following address:

_____
_____
_____

PHONE: _____

Date: _____ **Signature of Author:** _____

PERMISSION DENIED
TITLE OF THESIS _____
_____
_____

I _____ hereby **deny** permission to theWallace Memorial Library of the Rochester Institute of Technology to reproduce my thesis in whole or in part.

Date: _____ **Signature of Author:** _____

Abstract

Middle school students with behavioral disorders offer the greatest challenge to standard group counseling curriculas. Their age places them at the threshold of adolescence which is a notably difficult stage of development. Their disorder places them at risk of peer rejection and school failure. The rationale for developing a group counseling toolbox is to make it easier for counselors to utilize a multi-sensory approach with this unique population of students. This curricula will consist of group counseling activities appropriate for middle school students with behavioral disorders as well as the props needed to facilitate success.

Using Impact Group Therapy with Middle School Students with Behavioral Disorders

Introduction

Project Objective

Utilizing the theoretical principles of Impact Therapy, I created a toolbox of multi-sensory group counseling activities. These activities are designed to motivate middle school students with behavioral disorders to learn about themselves and others, and to encourage them to take an active part in their learning process.

Importance of Project

The purpose of this project was to examine the therapeutic needs of middle school students with behavioral disorders within a group setting. This population of students have both homogeneous and heterogeneous characteristics which require a unique approach to group therapy (MacLennan & Dies, 1992). Developmentally, middle school students are entering a difficult period of life (MacLennan & Dies, 1992). Early adolescence is characterized by profound physical, psychological, and social changes (Bootzin, Bower, Crocker & Hall, 1991). These changes directly influence emotion and behavior (Petersen, 1985). Although the profile of a student with a behavior disorder widely varies, these students often face peer rejection due to aggressive and antisocial behavior, as

well as school failure, due to attention problems and learning disabilities (Fairchild, 1997).

Social skill development programs are often used to intervene in the lives of these students (Goldstein, 1988). Group counseling is an important component of these programs (Goldstein, 1988). In my work with middle school students with behavioral disorders, I have found them to offer the greatest challenge to standard group counseling curriculas. The hyperactive, impulsive, aggressive, and passive-aggressive tendencies of many of these students can lead topics off course, significantly limiting student gains. Although role playing and self-instructional techniques are often used in adolescent groups, these techniques are not always effective for use with the adolescent with a behavioral disorder (Jacobs, 1994). A high impact, multi-sensory approach to group counseling is intended to engage students, while maximizing learning.

Order of Presentation of Literature Review

a. Reviewing the developmental issues of middle school students during the phase of early adolescence.
b. Examining the characteristics of children with behavioral disorders.
c. Efficacy of group therapy for middle school students with behavioral disorders.

d. Exploring group counseling materials currently available for use with middle school students with behavioral disorders.

e. Understanding the theoretical principles of Impact Therapy, and their application within the group setting.

Literature Review

a. Middle School Students and the Substages of Adolescence

The period of adolescence has been widely researched. Once thought of as a time of "storm and stress," adolescence is now believed to be no more stressful than adulthood (Offer, Ostrov, & Howard, 1984). Adolescence is comprised of several substages, ie. early, middle, and late, with each substage having its own set of principal conflicts (Steinberg, 1985). Erik Erikson (1980) maintains that the formation of an identity is the primary developmental task of adolescence. In this process of finding one's own sense of individuality, adolescents must come to terms with the physical changes going on in their bodies, their emerging sexual feelings, and how these feelings will affect their social relationships (Bootzin, et al, 1991). Profound physiological changes occurring within the adolescent clearly affect emotional equilibrium (Petersen, 1985). Mood swings may accompany the process of sexual maturation, and body changes that occur during this time can negatively

impact an adolescent's sense of identity and self-worth (Petersen, 1985).

Middle school students (grades six through eight) are entering the developmental phase of early adolescence, spanning ages eleven through fourteen (Steinberg, 1985). Developmentally, early adolescents are in a state of transition. MacLennan and Dies (1992) maintain that despite their need for independence, early adolescents still experience strong dependency needs. While separation from the family is a necessary developmental task, they still long for protection. These needs for belongingness and protection are often filled by the adolescent peer group (MacLennan & Dies, 1992). Steinberg and Silverberg (1986) contend that early adolescents in the United States have a tendency to substitute peer group norms for parental authority. Pressure to conform is at its height in the ninth grade, while anti-social behavior e.g., smoking, cheating, stealing, and trespassing accelerates (Krosnick & Judd, 1982). Integration into a peer group is a critical process during adolescence, and one that often results in additional pressure from conflicting peer and parental values (MacLennan, 1992).

Steinberg (1985) defines middle adolescence as ranging from ages fifteen to eighteen. Concerns may include the establishment of heterosexual relationships, self-identity,

and peer pressure (Berkovitz, 1972). Some of the concerns typically experienced during middle adolescence may also be relevant during early adolescence (Berkovitz, 1972).

The problems experienced in late adolescence, ages nineteen through twenty-one, are significantly different than those encountered in early adolescence (Steinberg, 1985). These may include concerns over academic completion, vocational problems, premature parenthood, or even legal difficulties (Berkovitz, 1972). During this phase of development, verbal abilities are generally well-developed and impulse control is less problematic (Berkovitz, 1972). Although conformity to peers decreases during the high school years, parental influence does not necessarily increase (Krosnick & Judd, 1982). These late adolescents are beginning to control their own lives and make their own choices (Krosnick & Judd, 1982). Although the conflicts and characteristics of each substage of adolescence are not mutually exclusive, the outcome of mixing these three age periods in the same counseling group may not be desirable (Berkovitz, 1972).

Although a thorough discussion of the child with behavioral disorders follows, it is important to note that many of these children may have been retained in their early years of schooling for academic and/or social delays (Krosnick & Judd, 1982). Based upon my calculation, it is

likely that a more realistic age span of the early adolescent with behavioral disorders would be from eleven to fifteen.

b. Children with Behavioral Disorders (BD)

Determining who children with behavioral disorders are is not an easy task. The Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994) cites Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) as disruptive behavioral disorders. Diagnostic criteria for both disorders can be found in Appendixes A and B. Most children qualifying for diagnoses of CD also qualify for diagnoses of ODD (Achenbach, 1993). Additionally, Attention Deficit/Hyperactivity Disorder (ADHD) is closely associated with ODD (Achenbach, 1993). The oppositional behavior of a child with ADHD may be a result of the child's inability to sustain attention or suppress impulses (Achenbach, 1993). These ADHD "symptoms" often take the form of overt behaviors, which are viewed as disruptive within the classroom environment (DuPaul, Eckert, & McGoey, 1997). Some of these behaviors include calling out without permission, interrupting classroom activities, getting out of an assigned seat without permission, and not completing assigned tasks (Barkley, 1990). These disruptive behaviors place adolescents with ADHD at high risk for "academic underachievement, school drop-out, peer rejection,

and the development of antisocial behavior patterns" (Barkley, Fischer, Edelbrock, & Smallish, 1990, p. 546). Diagnostic criteria for ADHD is listed in Appendix C.

In many states, children with behavioral disorders are excluded from eligibility for special education or related services in the public schools. This occurs because children found to be socially maladjusted, as opposed to seriously emotionally disturbed (SED), are deemed ineligible for special education services under the Public Law 94-142 definition of SED (Forness, Kavale & Lopez, 1994). Appendix D outlines the educational definition of SED. Although children with behavioral disorders may have some of the characteristics generally found in those with emotional disorders (ED), there are significant differences. Sutton (1996) maintains that

> the child with BD has a longstanding history of dysfunctionality, as opposed to the child with ED, who used to function more appropriately. Similarly, the child with BD has little experience with nurturance, has few friends, and is ignorant or indifferent to social contexts. In contrast, the child with ED is responsive to nurturance and social contexts, and has friends. The child with BD denies feelings, and has little emotional interference; whereas the ED child will address feelings, and is handicapped by emotional

> interference. Children with BD are not disturbed by their own behavior, see no need to change, and are often resistant to help and intervention. Children with ED are disturbed by their own behavior, want to change, and respond to help and intervention. The child with BD may think 'differently,' while the thinking of the child with ED may quite possibly be distorted (pg. 16).

Advocates of the social maladjustment exclusion have contended that children with conduct disorders willfully disregard societal norms and therefore, do not qualify for educational services (Slenkovich, 1992). They assert that these students have likely come from chaotic homes, with higher levels of divorce, physical and sexual abuse, alcohol and chemical dependency, rejection, and inconsistent patterns of discipline (Fairchild, 1997). Aggression has been modeled to these students, and they, in turn, use aggression to communicate the frustration and distress that builds from prolonged exposure to these environmental variables (Fairchild, 1997).

Supporters of the social maladjustment exclusion do not believe that these students qualify for special education services based on an emotional disability (Slenkovich, 1992). Research has validated, however, the existence of complex conduct disorders in which another psychiatric

disorder is comorbid, or co-occurs with overt conduct disorders (Forness, Kavale, King & Kasari, 1994). Newcomer, Barenbaum, and Pearson (1995) found that the highest percentage of depression and anxiety scores in problematic levels were in the group of conduct disordered students. Their research also found that behaviors associated with depression and anxiety frequently co-occur with some types of externalizing disorders. Therefore, it is possible that overt behaviors such as anger and aggression mask less obvious depression and anxiety indicators (Newcomer, et al., 1995). Improved identification and classification of these students has lead to children with ED, and an ED-BD combined type, being placed together in self-contained classrooms.

Gender differences also exist within the population of students with behavioral disorders. Males outnumber females 2:1, and females generally self-rate as significantly more depressed than males (Newcomer, et al., 1995). Furthermore, juvenile delinquents are typically male (U.S. Bureau of Justice Statistics, 1983). "These adolescent law-breakers tend to be aggressive, impulsive risk takers who seek excitement" (Bootzin, et al., 1991, p. 481). Their self-assured appearance demonstrates a keen ability to mask anxiety, and the risk-taking behaviors they engage in may provide diversion from internal distress (Newcomer, et al., 1995). Research pertaining to delinquent youth concludes

that although their problem behaviors are similar, the etiology of the behavior varies greatly. In some situations, the delinquency may primarily be a function of grossly disturbed family functioning or a clearly defined psychiatric disturbance (Vostanis & Nicholls, 1995). These youth typically have a history of academic failure, and may gain a sense of success from being skilled at delinquent behaviors (Fairchild, 1997). Whether identified as behaviorally or emotionally disabled, Fairchild (1997) has found that when these violent and disruptive children are placed in special education, they are usually in programs for children with learning disabilities rather than in programs for children with behavioral disorders.

Overall, middle school students with behavioral disorders are a unique group. These students may be angry and aggressive, and/or depressed and anxious (Newcomer, et al., 1995). They may be impulsive and easily distractible (Barkley, et al, 1990), while readily conforming to peer pressure (MacLennan & Dies, 1992). Their motivation for self-exploration may be very low, and they may lack both insight and sophistication in expressing their thoughts and feelings (Newcomer, et al., 1995). This heterogeneous group presents a considerable challenge to standard group counseling materials, which will be examined after the efficacy of group therapy is discussed.

c. Efficacy of Group Therapy

Group treatment of children began in the 1930's, and was aimed at reducing the number of atypical symptoms a child was exhibiting, as well as improving interpersonal relations through controlled group experiences (Erickson, 1992). Although group therapy is not recommended to be the sole therapy for serious disorders, it appears to be beneficial for persons with social functioning deficits (Erickson, 1992). Corey and Corey (1992) maintain that group counseling is highly suitable for adolescents, as

> it provides a place in which they can identify and experience their conflicting feelings, discover that they're not unique in their struggles, openly question their values and modify those they find wanting, learn to communicate with peers and adults, learn from the modeling provided by the leader, and learn how to accept what others offer and to give of themselves in return (Corey & Corey, p. 316.)

Generally, students who have difficulty with authority and peer relationships can benefit from the group structure (MacLennan & Dies, 1992). The presence of both adults and peers offer the chance for interpersonal skill deficits to manifest; this may lead to eventual resolution (MacLennan & Dies, 1992). Adolescents are much more apt to self-correct if criticized by a peer as opposed to an adult. Furthermore,

there is a natural tendency for adolescents to form groups; they derive a sense of "safety in numbers" (MacLennan & Dies, 1992). Receiving support and experimenting with different roles are two reasons why group treatment is so effective with adolescents (MacLennan & Dies, 1992). In this way, adolescents can be instrumental in each other's growth by assisting one another in the struggle for self-expression (Corey & Corey, 1992).

d. Group Counseling Materials Currently Available for the Middle School Student with a Behavioral Disorder

The availability of group counseling materials that specifically target middle school students with behavioral disorders is limited. Many counselors must resort to modifying general curricula designed for the typical adolescent. Morganett (1990) wrote Skills for Living: Group Counseling Activities for Young Adolescents. This useful manual provides detailed descriptions of ways to organize group agendas around themes such as dealing with divorce, making and keeping friends, learning communication skills, acquiring skills for managing anger, surviving and succeeding in school, and coping with grief and loss. Although a number of these resources exist, few have taken a multi-sensory approach in order to engage highly resistant adolescents. In his book Creative Counseling Techniques: An Illustrated Guide, Jacobs (1992) discusses creative

techniques to use in group sessions, and offers examples of ways props can be utilized in focusing the group. Although his examples are relevant and can be adapted to fit into various group themes, there are not enough examples, and an overall group plan does not accompany each prop. The group counseling toolbox I am proposing would offer both the plan and the props needed to run a successful group counseling session for middle school students with behavioral disorders.

Arnold Goldstein developed a series of programs targeting youth with deficiencies in prosocial competencies. In his book Skillstreaming the Adolescent, Goldstein (1980) utilizes modeling and role play to teach interpersonal skills. This technique supports the position that inadequate problem-solving skills lead to socially unacceptable behaviors (Goldstein, 1980). Many other social skills programs were patterned after Goldstein's work. Several of these include the ASSIST program which is designed to build affective and social skills (Huggins, n.d.) the TASK program which consists of social competency modules (Krieg, 1992), and the ACCESS program which is an adolescent curriculum for communication and effective social skills (Walker, Todis, et al., n.d.). Although these programs may develop some useful coping tools, they do not sufficiently meet the needs of middle school students with

behavioral disorders. Ormont (1992) states that,

> Role playing can merely be a superficial remedy to underlying problems. Instead of developing insight into behavioral patterns, role play primarily teaches new behavior. This will not broaden awareness of the emotional avoidance one is engaging in through his or her self-defeating style (pg. 46).

Role play also encourages spontaneity, and usually intensifies feelings (Corey & Corey, 1992). This can involuntarily lead to impulsive, and often aggressive, behaviors (Corey & Corey, 1992). These behaviors can easily get out of control, making group management difficult (Goldstein, 1988). Furthermore, peer models are often used in Skillstreaming to demonstrate appropriate behavior and decision-making skills. Due to the self-contained nature of many special education programs which include students with behavior disorders, these peer models are not always available. Consequently, role play may merely reinforce the inappropriate behavioral patterns of these students (Goldstein, 1988).

The Prepare Curriculum (1988) was developed by Goldstein as an extension to his earlier Skillstreaming work. It is designed for adolescents and younger children who are deficient in prosocial competencies. This ten course-length program includes training in problem-solving,

interpersonal skills, situational perception, anger control, moral reasoning, stress management, empathy, relationship building, cooperation, and understanding groups. Prepare focuses on moderately to severely aggressive and withdrawn youth, whose disturbing behaviors may be exhibited during group (Goldstein, 1988).

Goldstein (1988) stresses the importance of having a competent group trainer with effective classroom management skills. He recommends the use of behavior modification techniques to minimize the amount of time a student engages in distracting, aggressive, and off-task behaviors. Goldstein discusses three means of contingently managing behavior through the removal of positive reinforcers. "Ignoring the behavior or removing the reinforcer of attention (e.g., extinction), physically removing the person from important sources of reinforcement (e.g., time out), and removing the reinforcers from the person (e.g., response cost) are three means of contingently managing student disruptiveness" (p. 544). Students with behavioral disorders can escalate to high levels of disruption very quickly (Barkley, et al., 1990).Removing the positive reinforcer (student participation in group through the method of time out) is often used in social skill development programs (Goldstein, 1988). In my experience working with this population, I have found that when a student is removed from

the group, that individual's learning, as well as group cohesiveness is negatively affected. The student may angrily return to the group minutes later, significantly less invested. This is not to discourage the use of behavioral management techniques in group, but rather, to advocate the use of a group therapy approach which will motivate the adolescent with a behavioral disorder to maintain appropriate behavior while in group. Goldstein (1988) concedes that "enhancing youth motivation to participate in Prepare and achieve mastery of its contents is a difficult goal to accomplish" (pg. 587). By their very nature, adolescents with behavioral disorders are oppositional and resistant to change. Furthermore, the Prepare Curriculum does not offer activities that are likely to maintain the interest of adolescents with behavioral disorders. But an even greater challenge to Prepare's effectiveness is the student's motivation to apply the prosocial lessons to daily life (Goldstein, 1988). Without sufficient motivation to do so, antisocial behavioral patterns will remain unchanged (Goldstein, 1988).

Eggert, Nicholas and Owen (1995) developed a curriculum entitled Reconnecting Youth: A peer group approach to building the life skills. This program targets high-risk youth in their middle and high school years. It is designed to "develop greater personal control, adaptive coping

behaviors, supportive communication skills, and improved interpersonal relationships" (Eggert, pg. 4). Eggert et al. teach a problem-solving approach to controlling stress in their personal-control skills training module. Self-assessment encourages students to raise their stress awareness. Decision making, coping and supporting strategies are utilized as students practice skills (e.g., visualization, relaxation, and self-talk) (Eggert, et al, 1995). These strategies and skills will help students find solutions to stress-related problems.

Although Reconnecting Youth has proven to be effective with some adolescents, my experience with this population of students has led me to the conclusion that it does not sufficiently meet the needs of middle school students with behavioral disorders. Kendall, Reber, et al.'s (1990) research indicates that "the effectiveness of self-instructional, or self-control, training is influenced by the youngster's age, sex, socioeconomic status, cognitive level, attributional style, and apparent motivation" (p. 285). Therefore, the efficacy of self-talk or verbal mediation training is dependent upon many variables. Middle school students with behavioral disorders do not have the cards stacked in their favor (Bootzin, et al., 1991). Their age places them within a difficult substage of development, socially, emotionally, and cognitively

(Bootzin, et al., 1991) Because the age of cognitive maturation varies greatly, it is difficult to determine if the early adolescent has reached the stage of formal operations (Bootzin, et al., 1991). This capacity for abstract thought may determine how meaningful these sessions are to the student (Bootzin, et al., 1991). Group material that is too abstract or analytic may not only puzzle the adolescent, but also reinforce their belief that they are not normal (MacLennan & Dies, 1992).

To summarize, group counseling materials currently available do not sufficiently meet the needs of middle school students with behavioral disorders. Although helpful in providing themes, standard social skills curriculas do not take a multi-sensory approach (Morganett, 1990). Conversely, Jacobs (1990) offers creative techniques for group counseling, but does not connect them with any overall theme. Skills-based programs (Goldstein, 1980) may develop some useful coping tools, but do not explore the needs of these students to any real depth (Ormont, 1992). Lastly, the effectiveness of self-instructional programs are dependent upon motivation, and are often written at a cognitive level too high for many middle school students with behavioral disorders (Kendall, et al., 1990).

Other variables which may interfere with program effectiveness include the fact that the majority of them

tend to be boys (DSM-IV, 1994), and boys are less likely to show short-term gains from self-instructional training (Kendall, et al., 1990). Middle school students with behavioral disorders are often classified as learning disabled (Fairchild, 1997), have an external attributional style (Newcomer, et al., 1995), and are not highly motivated to participate in group (Goldstein, 1988).

A group counseling method which meets the needs of this special population of students must be explored. Finding the most appropriate method, however, may be as challenging as the students themselves. Diverse learning styles naturally exist within any group of students (Jacobs, 1994). A multi-sensory approach to group counseling would utilize all learning pathways in the brain (visual/auditory, kinesthetic-tactile) simultaneously in order to enhance memory and learning (Jacobs, 1994). This approach is recommended for use with middle school students with behavioral disorders, because it would offer these students a better chance of getting their individual learning needs met within the group setting (Jacobs, 1994).

e. Theoretical Principles of Impact Group Therapy

Jacobs and Smith (1997) define Impact Therapy as an "active, creative, multi-sensory therapeutic approach that emphasizes the use of props, chairs, movement, writing and drawing to access the different learning styles of the

client" (p.13). Jacobs (1994) states that the goal of Impact Therapy groups is to create a positive experience for each student, and make counseling clear, concrete, and thought-provoking. The therapist's objective is to get to the core of the problem; only then will the process for change be set in motion (Jacobs, 1994). To do this, the therapist must be an active leader, as opposed to taking the more inactive role of facilitator (Jacobs, 1994). At times, the therapist must limit students from sharing unnecessary details or lengthy stories, which will lead groups off track and lose the attention of some members (Jacobs, 1994). Adolescents may feel a greater sense of security with a strong leader, and may even be more willing to take more emotional risks, providing that the leader makes the group "interesting, engaging, supportive, helpful, informative, and insightful" (Jacobs, 1994, p. 151).

Jacobs (1994) discusses five key concepts that the impact therapist must consider: theory, timing, teaching, training and thinking. An effective counselor will use *theory* to lead students to a greater understanding of themselves and others (Jacobs, 1994). Impact Therapy integrates concepts from Rational Emotive Therapy (RET), Transactional Analysis (TA), Gestalt, Reality Therapy, and others. It serves as a solid bridge between theories and techniques (Jacobs, 1994). Proper *timing* (Jacobs, 1994) is

crucial in group counseling sessions with middle school students with behavioral disorders. A keen sense of observation will enable the counselor to read the emotional temperature of the group. If the group is more active, a quicker pace may be necessary to engage and maintain the attention of each individual. If the group is less active, a slower pace will create less anxiety, while creating a more trusting and sensitive environment.

Teaching is an integral part of Impact Therapy (Jacobs, 1994). If properly timed, well thought out, and delivered in an interesting way, students can gain needed information. Teaching students about such topics as birth control, diet, hygiene, parenting, or how to cope with anger, stress, and peer pressure can be useful counseling activities. Impact Group Therapy involves *training*, or coaching (Jacobs, 1994). Students learn new skills through practice and receiving feedback. This is where skills training and role play can be used as tools within an approach, rather than as the primary group counseling approach in and of itself. Examples of this may include assertiveness training, job interviewing, and how to talk to parents. Lastly, the impact therapist is not only listening, but *thinking* about strategy, theory, and creative possibilities (Jacobs, 1994). By focusing on a student's thoughts, as well as feelings, the therapist may induce that student to think differently

about his or her situation (Jacobs, 1994).

Impact group therapists must be "creative and courageous" (Jacobs, 1994, p.7). They must be open to trying many different techniques in order to have a meaningful session, and be "willing to direct the session to difficult issues, such as divorce, loss, abuse, or anger" (Jacobs, 1994, p.7). Therapists may have to confront students or use language that will get the students' attention. Jacobs (1994) believes that in order to move students through unfinished business, therapy may at times be painful. By addressing challenging topics, and discussing them in greater depth, the messages the therapist imparts will have greater impact. Jacobs (1994) utilizes a depth chart in monitoring the flow and impact of a group therapy session. See Appendix E (Jacobs, 1992).

In Sutton's (1996) workbook, he addresses the needs of the Conduct Disordered Child, or "The Kid Who Doesn't Care (pg. 1)." In working with this population of students, Sutton suggests using many of the same strategies that Jacobs advocates. Sutton (1996) suggests that the leader create a curiosity appeal, encourage activity, and stress the value of preparation over "luck" in order to increase the effectiveness of any program. The way in which adolescents express themselves and deal with tension is different than that of adults; they function on a more

motoric level (Sutton, 1996). Consequently, motoric expression-- with verbal discharge of tension being the most preferred outlet- must be understood and accommodated within the group structure through flexible seating arrangements that permit some movement (Sutton, 1996). Corey and Corey (1992) write that taking an active approach in group therapy is essential. It is necessary in order to avoid chronic resistance, engage less active members, and keep the momentum of group going. Group silence can overwhelm adolescents, thereby impeding communication (Corey, 1992).

Discussion/Recommendations

Middle school students with behavioral disorders are heterogeneous in nature: their cognitive, affective, and behavioral characteristics widely vary. For this reason, a "one size fits all" approach to group counseling is not appropriate. Effective group therapists must be willing to try different strategies and techniques in order to engage their students. A multi-sensory approach to group counseling may serve to motivate middle school students with behavioral disorders to learn about themselves and others, and take an active part in their learning process. Group therapy should never be boring. Once student interest is lost, so too, will be the impact of the message. For this reason, many group counseling programs currently on the market do not meet the needs of middle school students with

behavioral disorders. Many of the prosocial competency programs are either too basic or too high level in terms of cognitive functioning. The rationale for developing a group counseling toolbox is to make it easier for counselors to utilize a multi-sensory approach. Jacobs (1994) emphasizes the importance of planning; it almost insures that the group will be productive and beneficial. Planning time for school counselors, however, is often limited. They may be responsible for many different groups within the same week. Therefore, a prepared multi-sensory toolbox of counseling activities would enable them to provide more effective counseling services to a group of highly challenging adolescents. With creativity, courage, and the appropriate materials, impact group therapists can make a difference in the lives of middle school students with behavioral disorders.

References

Achenbach, T.M. (1993). Taxonomy and comorbidity of conduct problems: Evidence from empirically based approaches. Development and Psychopathology, 5, 51-64.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Barkley, R.A. (1990). Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment. New York: Guilford.

Barkley, R.A., Fischer, M., Edelbrock, C.S., & Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria: I. An 8-year prospective study. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 546-557.

Bootzin, R.R., Bower, G.H., Crocker, J., and Hall, E. (1991). Psychology Today: An Introduction. New York: McGraw-Hill.

Corey, M.S., & Corey, G. (1992). Groups: Process and Practice, 4/e. Pacific Grove, CA: Brooks/Cole Publishing Co.

DuPaul, G.J., Eckert, T.L. & McGoey, K.E. (1997). School-based interventions for students with attention-deficit/hyperactivity disorder: A meta-analysis. School Psychology Review, 26, 5-27.

Eggert, Nicholas and Owen (1995). Reconnecting Youth: A peer group approach to building the life skills. Bloomington, IN: National Educational Service.

Erickson, M. (1992). Behavior Disorders of Children and Adolescents: Assessment, Etiology, and Intervention 2/e. Englewood Cliffs, NJ: Prentice Hall.

Erikson, E. H. (1980) Identity and the life cycle. New York: Norton.

Fairchild, T. (Ed.). (1997). Crisis Intervention Strategies for School-Based Helpers 2/e. Springield, IL: C.C. Thomas Publisher, Ltd.

Forness, S.R., Kavale, K.A., King, B.H., & Kasari, C. (1994). Simple versus complex conduct disorders: Identification and phenomenology. Behavioral Disorders, 19 (4), 306-312.

Forness, S.R., Kavale, K.A., & Lopez, M. (1993). Conduct disorders in school: Special education eligibility and co-morbidity. Journal of Emotional and Behavior Disorders, 1 (2), 101-108.

Goldstein, A.P. (1988). The Prepare Curriculum: Teaching Prosocial Competencies. Champaign, IL: Research Press.

Goldstein, A.P., Sprafkin, R.P., & Gershaw, N.J. (1976). Skillstreaming the adolescent. Champaign, IL: Pergamon.

Huggins, P. (n.d.). The ASSIST Program: Affective/Social Skills: Instruction Strategies and Techniques. Longmont, CO: Sopris West.

Kendall, P.C., Reber, M., McLeer, S., Epps, J. et al ((1990). Cognitive-behavioral treatment of conduct-disordered children. Cognitive Therapy and Research, 14, 279-297.

Jacobs, E. (1992). Creative Counseling Techniques: An illustrated guide. Odessa, FL: Psychological Assessment Resources, Inc.

Jacobs, E. & Smith, A. (1997) Multi-sensory counseling: A must for the future. Paradigm, 1 (3). 12-20.

Jacobs, E.E., Harvill, R.L., & Masson, R.L. (1994). Group Counseling: Strategies and skills, 2/ed. Pacific Grove, CA: Brooks/Cole.

Jacobs, E. (1994). Impact Therapy. Odessa, FL: Psychological Assessment Resources, Inc.

Krieg, F.J. (1992). TASK: Social competencies modules. Columbia, MO: Hawthorne Educational Services.

Krosnick, J., & Judd, C. (1982). Transitions in social influence at adolescence: Who induces cigarette smoking? Developmental Psychology, 18, 359-368.

MacLennan, B.W., & Dies, K.R. (1992). Group Counseling and Psychotherapy with Adolescents. New York, NY: Columbia University Press.

Morganett, R.S. (1990). Skills for living: Group counseling activities for young adolescents. Champaign, IL: Research Press.

Newcomer, P.L., Barenbaum, E., & Pearson, N. (1985). Depression and anxiety in children and adolescents with learning disabilities, conduct disorders, and no disabilities. Journal of Emotional and Behavioral Disorders, 3 (1), 27-39.

Offer, D., Ostrov, E. & Howard, K.I. (1984). Epidemiology of mental health and mental illness among adolescents. In J. Call (Ed.), Significant advances in child psychiatry. New York: Basic Books.

Ormont, L.R. (1992). The Group Counseling Experience: From Theory to Practice. New York, NY: St. Martin's Press.

Petersen, A.C. (1985). Pubertal development as a cause of disturbance. Genetic, Social, and General Psychology Monographs, 3.

Slenkovich, J.E. (1992). Can the language "social maladjustment" in the SED definition be ignored? School Psychology Review, 21 (1), 21-22.

Steinberg, L. (1985). Adolescence. New York: Knopf.

Steinberg, L.D. & Silverberg, S.B. (1986). The vicissitudes of autonomy in early adolescence. Child Development, 57, 841-851.

Sutton, J.D. (1996). The Conduct Disordered Child: A Seminar Workbook. Pleasanton, TX: Friendly Oaks Publications.

U.S. Bureau of Justice Statistics. (1983). Report to the nation on crime and justice. Washington, D.C.: U.S. Government Printing Office.

Vostanis,P. & Nicholls, J. (1995). The family environment scale: comparison with the construct of expressed emotion. Journal of Family Therapy, 17, 299-315.

Walker, H.M., Todis, B., Holmes, D., & Horton, G. (n.d.). The ACCESS Program: Adolescent Curriculum for Communication and Effective Social Skills. North Tonawanda, NY: MHS.

Appendix A

Diagnostic criteria for 312.8 Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of property

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (ie., "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) oftens stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Specify type based on age at onset (**Childhood-Onset or Adolescent-Onset**) and severity (**Mild, Moderate, or Severe**).

Appendix B

Diagnostic criteria for 313.81a Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
(1) often loses temper
(2) often argues with adults
(3) often actively defies or refuses to comply with adults' requests or rules
(4) often deliberately annoys people
(5) often blames others for his or her mistakes or misbehavior
(6) is often touchy or easily annoyed by others
(7) is often angry and resentful
(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Appendix C

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):
(1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention
(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity
(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder *(continued)*

(i) often interrupts or intrudes on others (e.g. butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Appendix D

Educational definition of Seriously Emotionally Disturbed (SED) under Part 200 Regulations of IDEA

There are three steps to identification of a child as SED according to IDEA:

1. SED is an emotional condition.
2. SED meets 3 limiting criteria, all of which must be met.
3. SED involves 1 of 5 characteristics.

Conceptualization:

A. The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree:

(i) an inability to build or maintain satisfactory interpersonal relationships with peer and teachers;

(ii) inappropriate types of behavior or feelings under normal circumstances;

(iii) a generally pervasive mood of unhappiness or depression; or

(iv) a tendency to develop physical symptoms or fears associated with personal or school problems.

B. The term does not include socially maladjusted students unless it is determined that they are emotionally disturbed.

Appendix E

Depth Chart from Jacobs (1992) book entitled Creative counseling techniques: An illustrated guide.

**For group counseling, PPFF (Purpose, Plan, Focus, Funnel) is used instead of RCFF.