THE STATUS OF SERVICES TO STUDENTS WITH CONDUCT DISORDER BY THEIR ELEMENTARY SCHOOL COUNSELORS

by

Jeffrey Louis Cochran

Dissertation submitted to the Faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

COUNSELOR EDUCATION

APPROVED:

Claire Cole Vaught, Chair

Diane Yardley

David Hutchins

Bonnie Billingsley

Libby Hoffman

March 1996

Blacksburg, Virginia

Key words: Counseling, Conduct. Disorders. Elementary. School
The Status of Services to Students with Conduct Disorder by Their Elementary School Counselors

by

Jeffrey Louis Cochran

(ABSTRACT)

Conduct Disorder (CD) is one of the most frequently occurring childhood behavior disorders. A state wide survey of elementary school counselors was conducted concerning the services provided to these students. Elementary school counselors were asked to identify peers to be interviewed (six) who are more effective than usual in providing these services.

The study found: 1) Students with CD comprise about 2% of the populations of respondent schools. 2) On average, respondents devote 19% of their work time to students with CD. Almost all feel somewhat or highly frustrated in providing services to students with CD; rate themselves as only somewhat or not very effective in providing these services, and less effective with students with CD than with other populations. 3) Respondents identified the number one need as further training for themselves specific to providing services to students with CD, and rated their graduate training for this work negatively. 4) Seventeen percent of respondent schools receive no services for students with CD from outside agencies, and most rated the services negatively.

The six interviewees contributed: 1) Creative and unique services for students with CD are often required for success, such as a whole class treatment for a class containing two students with-CD like behaviors and a teacher mentoring program for students with CD. 2) While there was no consensus among interviewees for a most effective service activity, they tended to name indirect services such as developing and coordinating behavior modification plans and teacher mentoring programs as the most important part of treatment programs. Individual counseling was rarely named as the most important aspect
of treatment programs, but was described as important for providing an understanding of the student that allows for effective customizing of the behavior modification plan, and developing a therapeutic relationship that allows credibility for counselor guidance in times of crisis or opportunity for these students.

Recommendations to improve the status of services to students with CD by their elementary school counselors were made for counselor educators, administrators of school counselors, non-school agencies, and elementary school counselors. Further research recommendations are also made.
ACKNOWLEDGMENTS

First and foremost, I wish to thank my wife, Nancy H. Cochran, for her patience, support, and love during this project and during all the moments that lead to this time of accomplishment. Other family members and friends were also important in seeing me through. My thanks go to them as well.

My committee chair and advisor, Dr. Claire Cole Vaught, has earned my special thanks for the hard work and expertise she lent to this project. She has shown her caring and given her time to extents beyond the requirements of her position.

I wish to express my appreciation for the assistance of my committee members. They and others helped make earning my Ph.D. a valuable endeavor.

I'm not sure if it's possible to thank an institution, so instead I'll state that I'm proud to have earned my Ph.D. from Virginia Tech. Many persons and policies at Virginia Tech have served me well.

I wish to thank the counselors who allowed me to interview them and those who answered my survey. Due to the nature of counseling, we counselors are often unaccustomed to having strangers look closely at our work. I would have understood if counselors were reluctant to allow me survey and interview about their work. So I am all the more impressed with and appreciative of those who courageously honored my request to take a close look at the services they provide. Additionally, I've rarely known a school counselor who didn't have more work that they desired to accomplish than there was time in the day. So again I thank my interviewees and survey respondents for their time.

Finally, I wish to thank the children I have counseled, who taught me more than any text or research.
This work is dedicated to my sweet wife, Nancy H. Cochran, who shares a wealth of strength, talent, and understandings with me; and to my mother and father, Joyce and Louis Cochran.

I love each of them dearly.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>iv</td>
</tr>
<tr>
<td>List of Figures</td>
<td>viii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER 1--INTRODUCTION.</td>
<td>1</td>
</tr>
<tr>
<td>Importance of the Topic</td>
<td>1</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>9</td>
</tr>
<tr>
<td>Assumptions</td>
<td>10</td>
</tr>
<tr>
<td>Purpose</td>
<td>10</td>
</tr>
<tr>
<td>Research Questions</td>
<td>11</td>
</tr>
<tr>
<td>Limitations</td>
<td>13</td>
</tr>
<tr>
<td>Methodology</td>
<td>13</td>
</tr>
<tr>
<td>Definitions</td>
<td>14</td>
</tr>
<tr>
<td>CHAPTER 2--REVIEW OF LITERATURE</td>
<td>16</td>
</tr>
<tr>
<td>Conduct Disorder Defined</td>
<td>16</td>
</tr>
<tr>
<td>How Conduct Disorder is Developed and Maintained</td>
<td>20</td>
</tr>
<tr>
<td>Studies Concerning Counseling and Related Non-counseling Services to Students with Conduct Disorder or Similar Behavioral Descriptors in School Settings</td>
<td>25</td>
</tr>
<tr>
<td>Probable Areas of Effective Counseling and Related Non-counseling Services to Students with Conduct Disorder by Elementary School Counselors</td>
<td>26</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Survey Items Generating Numeric Data</td>
<td>41</td>
</tr>
<tr>
<td>2.</td>
<td>Survey Items Requiring a Forced-Choice Response</td>
<td>42</td>
</tr>
<tr>
<td>3.</td>
<td>Survey Items Generating Verbal Data</td>
<td>43</td>
</tr>
<tr>
<td>4.</td>
<td>Survey Items in which “Other” is Listed as an Option</td>
<td>44</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Responses to Survey Section I: Counselor Self Ratings</td>
</tr>
<tr>
<td>4.2</td>
<td>Responses to Survey Section II: Counselor Opinions Related to Services for Students with CD</td>
</tr>
<tr>
<td>4.3</td>
<td>Responses to Survey Item Seven: Needs of Counselors and Schools to Provide More Effective Services to Students with CD</td>
</tr>
<tr>
<td>4.4</td>
<td>Responses to Survey Items 10 Through 12: Respondent School Assignment and Education</td>
</tr>
<tr>
<td>4.5</td>
<td>Responses to Survey Item 13.a): Counselor Teaching Experience</td>
</tr>
<tr>
<td>4.6</td>
<td>Response Data for Survey Item 13.b): Respondent Counseling Experience at Other School Levels</td>
</tr>
<tr>
<td>4.7</td>
<td>Response Data to Survey Item 13.c): Respondent Outside School Agency Counseling Experience</td>
</tr>
<tr>
<td>4.8</td>
<td>Response Data for Survey Item 14: Counselor Ratings of the Specific Preparation Received for Providing Services to Students with CD</td>
</tr>
<tr>
<td>4.9</td>
<td>Respondent Data From Survey Section IV: Prevalence and Characteristics of Students with CD at Respondent Schools</td>
</tr>
<tr>
<td>4.10</td>
<td>Response Data for Survey Item 19 (Part 1): Counselor Ratings of the Extent to Which They Provide School Counselor Service Activities for Students with CD</td>
</tr>
<tr>
<td>4.11</td>
<td>Response Data for Survey Item 19 (Part 2): Counselor Rankings of First, Second, and Third Most Important Service Activities for Students with CD</td>
</tr>
<tr>
<td>4.12</td>
<td>Response Data for Survey Item 20: Top Three Terms Describing Respondents’ Direct Counseling of Students with CD</td>
</tr>
</tbody>
</table>
4.13 Response Data for Survey Items 21 and 22: Respondent Time Serving

Students with CD ................................................................. 77

4.14 Response Data for Survey Item 23.b): Types of Agencies Providing Services to Students with CD at Respondent Schools that Receive Services for Students with CD from Outside School Agencies ........................................... 79

4.15 Response Data for Survey Item 23.c): Types of Services Provided to Students with CD at Respondent Schools that Receive Services from Outside Agencies for Students with CD .................................................. 81

4.16 Response Data for Survey Item 23.d): Ratings of Services Provided by Outside School Agencies by Respondents who Report that their School(s) Receive Services from Outside School Agencies to Students with CD ............... 82

4.17 Response Data for Survey Items 24.a) and 24.b): Special Education Placements of Students with CD .................................................. 84

4.18 Response Data for Survey Item 25: Existence of Alternative Education Programs that Include Students with CD ........................................... 86

4.19 Response Data for Survey Item 29: Additional Comments Offered by Respondents ........................................................................... 89

5.1 Comparison of Rural to Urban Settings of Schools Where 'All Respondents' Verses 'Respondents with Extensive Time Commitments to Students with CD' Serve ............................................................. 116
CHAPTER 1

INTRODUCTION

Importance of the Topic

Students with behavior disorders account for the major problems encountered in schools today (Horne, Glaser, Sayger, & Wright, 1992). This study investigated services elementary school counselors provide to these students, services by elementary school counselor that are needed but not provided, elementary school counselor needs for providing more effective services, services outside school agencies provide to these students, elementary school counselor opinions on providing counseling and related non-counseling services to these students, counselor and work setting characteristics of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to these students, and services that elementary school counselors who are identified as more effective than usual in providing services to these students.

Many students with behavior disorders can be correctly diagnosed as having the mental disorder, Conduct Disorder (CD). The Diagnostic Statistical Manual of the American Psychiatric Association, Fourth Edition (DSM-IV) describes children with CD as having, “a persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (p.85). The DSM-IV authors go on to state that “These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, non-aggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules” (American Psychiatric Association [APA], 1994, p. 85). School personnel face a frustrating task in
educating children with CD and their classmates, partly because, as McMahon and Wells (1989) explain, “Much of the theoretical and empirical research has indicated that noncompliance (i.e., excessive disobedience to adults) is the key-stone behavior in the development of . . . conduct-disordered behavior” (p. 78). This frustration apples not only to the education of students with CD, but the education of their classmates as well. It is the classmates’ rights to such things as a feeling of safety, property, and education with minimal disruptions that are often violated.

School counselors are affected by this frustration as well. School counselors have a mission to provide counseling and related non-counseling services to all students’ special needs, thereby freeing more teacher time and energy to teach. School counselors listen to and assist the fellow student victims of the misbehaviors of students with CD. Because school counselors are reasonably expected to be their schools’ most knowledgeable staff members on the development of abnormal behavior, normal and abnormal social and emotional development, and the development of mental health in general, other school professionals appropriately expect assistance from school counselors with students with CD. Because the literature is unclear on what counseling and related non-counseling services would be helpful to students with CD, this assistance from school counselors is hindered.

Along with the above mentioned frustrations, and in spite of the difficulties providing education for students with CD, many of these students are ineligible for special education services. Grosenick (1981) reports that the National Needs Analysis in Behavior Disorders, University of Missouri-Columbia, indicates that many of the students with behavior disorders are unserved or served inadequately. The current definition of the special education category “serious emotional disturbance” in Public Law 94-142 specifically excludes children who are “socially maladjusted but not emotionally disturbed” (Arlen & Gable, 1992; Executive Committee of the Council for Children with Behavior
Disorders, 1987; Walker & Fabre, 1987; Weinberg & Weinberg, 1990). While many students with CD may not be in special education programs, many are, either for other disability conditions or because they are considered to be both socially maladjusted and emotionally disturbed. Because of the ineligibility of many students with CD, the resulting lack of special resources adds to the frustrations of school personnel in educating students with CD and their classmates. Because children and youth with CD are estimated to comprise from 4-10% of the population of children and youth in America (Kazdin, 1987; Offord, Adler, & Boyle, 1986; Rutter, Tizzard, & Whitmore, 1970) and because the prevalence of CD appears to have increased over the last decades (APA, 1994), most schools are faced with the challenge of educating children with CD and their classmates.

Students with Conduct Disorder pose serious challenges to the public schools’ mission to educate all children. Normally effective discipline by teachers and school administrators to student noncompliant behaviors tends to set up systems that are rewarding to the misbehaviors of students with CD (Arlen & Gable, 1992). Therefore, without the development of effective treatments for CD, students with CD will likely continue to hinder their education and that of their classmates.

Without effective treatment, children with CD face a grim future. Many can be predicted to encounter such problems as substance abuse, academic failure, suicidal behavior, a higher probability of premature death, and involvement in both violent and nonviolent crime (Horne et al, 1992). These authors assert that while many interventions are available, the best treatments will occur in the school setting because some of the people best equipped to address the problems are school personnel. Grosenick (1981) stated that public schools are the major providers of services for severely behavior disordered children. He adds that, “They appear to serve two to four times the number of labeled severely behavior disordered students than are served in mental health centers, facilities for neglected or delinquent [children and youth], and private facilities combined” (p. 24-5).
Horne et al, (1992) assert that school counselors seem to be the appropriate school personnel to provide interventions such as specialized parent training, individual and group counseling, inter- and intra-personal skill training to address many of the developmental problems that result in prevention of later, more invasive difficulties. When and if services from outside school agencies are also being provided to children with behavior disorders, communication and collaboration between agencies are often lacking (Grosenick, 1981). School counselors are in a position to act as a conduit of information and assist the coordination of outside school agencies for the student with CD (Horne et al, 1992). Placement in special education programs does not replace the need for school counselor services to these students.

The most effective age for intervention is the elementary school years. Horne et al, (1992) state that it appears imperative to intervene with those who have repeatedly been identified as showing conduct problems before they finish the fourth grade when such behaviors appear to become firmly entrenched through association with deviant peers. Also, the early onset type of CD, occurring before age 10, predicts a worse prognosis and increased risk in adult life for Antisocial Personality Disorder and Substance-Related Disorders (APA, 1994).

An additionally important way of understanding children with CD, their prognoses, and the challenges they pose to the public schools’ mission is through the role of developmental tasks and CD. No research is available specifically linking CD and theories of human development. The following are connections between human development theories and CD that seem clear to this author.

Havighurst:

Havighurst (1972) writes that in each stage of human development there are special tasks for a child to master. Both the child’s needs and societal demands drive the need to
succeed in these tasks. Havighurst writes that successful achievement of developmental
tasks leads to happiness and success with later tasks, while failed achievement leads to
unhappiness in the individual, disapproval by society, and difficulty with later tasks. The
features and nature of CD in elementary school students leave elementary school students
with CD unlikely to succeed in many of the developmental tasks that Havighurst describes
for the elementary school years. The developmental tasks that Havighurst describes for the
elementary school years are as follows (Havighurst, 1972, pp. 19-25):

1. Learning physical skills necessary for ordinary games.
2. Building wholesome attitudes toward oneself as a growing organism.
3. Learning to get along with age-mates.
4. Learning an appropriate masculine or feminine social role.
5. Developing fundamental skills in reading, writing, and calculating.
6. Developing concepts necessary for everyday living.
7. Developing conscience, morality, and a scale of values.
8. Achieving personal independence.
9. Developing attitudes toward social groups and institutions.

Elementary school students with CD are unlikely to succeed at a number of these
tasks. Perhaps due to the negative parent-child interactions common in the lives of children
with CD (which will be discussed in detail in Chapter 2), elementary school students with
CD often do not develop wholesome attitudes toward themselves (task number two) and
maintain low self-esteem. Perhaps due to the aggressive responses by students with CD to
behaviors by peers that they have misperceived as threatening, elementary school students
with CD usually do not learn to get along with age-mates (task number three). Elementary
school students with CD often do not develop fundamental skills in reading and writing
(task number five). Because parent-child interactions and other elements in the lives of
elementary school students with CD often teach acceptance of aggression, these students
often do not develop conscience, morality, and a scale of values accepted by the schools and the larger society (task number seven). Perhaps due to being frequently shunned by social groups and institutions because of the behaviors of CD, elementary school students with CD often do not develop useful attitudes toward social groups and institutions (task number nine).

Erikson:

Similar to Havighurst’s developmental tasks, Erikson (1964) defines developmental stages as psychosocial crises. In each crisis, the person resolves or fails to resolve the core conflict of that stage’s crisis. Successful resolution of each crisis is necessary for healthy development. Failure to resolve a crisis results in the person’s readdressing that crisis during later stages until achieving successful resolution. For example, the first psychosocial crisis, as defined by Erikson (1964), normally takes place between birth and 18 months. This first stage encompasses the core conflict of Basic Trust Verses Basic Mistrust. Failure to resolve this stage’s crisis leaves a child fearful, anxious, and suspicious. Probably due to the negative parent-child interactions associated with CD, students with CD have often failed to resolve this conflict. One of the school effects for students with CD of having failed to resolve this psychosocial crisis is the misperceiving of peer actions as aggressive and thus responding aggressively, which is associated with CD. Another often seems to be an inability to trust teachers and other school adults and to accept their help with academic, social and other school problems. This effect may partially explain the academic achievement deficits, especially in writing and communication skills, associated with CD.

Probably also due to the negative parent-child interactions, particularly the inconsistent discipline frequently associated with CD, students with CD often fail the second psychosocial crisis, as defined by Erikson (1964). This second psychosocial crisis
normally takes place between 18 months and three years. This second stage encompasses the core conflict of Autonomy Verses Shame and Doubt. Students who have failed to resolve this crisis exhibit loss of self-esteem, which is commonly associated with students with CD.

Erikson (1964) describes normal elementary school age children who have resolved the psychosocial crises of preschool ages as enormously curious and wishing to learn and know. Because of failures in the psychosocial crises of preschool ages, elementary students with conduct disorder do not possess these qualities. Lacking curiosity and a wish to learn partially explains the academic achievement deficits, especially in writing and communication, associated with CD. For normal elementary school-aged children who have resolved the crisis of the preschool years, a sense of accomplishment and life-long attitudes toward learning and work usually develop during the elementary school years. If children meet failure in school, a pervading sense of inferiority results, which causes these persons to give up on themselves. Failure in school, developing a sense of inferiority, and giving up on themselves is the typical course for students with CD.

Sullivan:

Sullivan (1953) theorized that personality develops through interactions with significant others. Because many of the interactions with others by children with CD are known to be negative, Sullivan’s developmental theories can also be used to illuminate the abnormal development of children with CD. Sullivan’s developmental theory defines the interpersonal experiences of life periods. The first life period, from birth to 18 months, is dominated by the interpersonal experience of dependency on parental figures. Again this points to the developmental difficulties of the inconsistent parental relationships and generally negative parent-child interactions associated with CD. The second life period in
Sullivan’s theory, from 18 months to four or five years, includes the core experience of developing mind-pictures of self and others. The familial interactions of children with CD are often filled with acceptance and expectation of aggression. Thus, children with CD often develop aggressive mind-pictures of themselves. Additionally, the development of mind-pictures of others as aggressive partially explains the misperceptions of the intent of others’ behaviors and subsequent inappropriately aggressive responses associated with CD.

Sullivan (1953) writes that personality changes as new interpersonal relationships develop. For example, in the Juvenile Period of Sullivan’s theory, ages five or six to 11 years, teachers’ interactions as the child’s first impartial authority figures become important to students’ development, and foundations for good orientations to living emerge. Unfortunately, students with CD often drive their teacher-student relationships to the negative, paralleling the parent-child interactions that they are accustomed to. Thus, they do not develop a foundation for good orientation to living. Lack of this foundation for good orientation to living may partially explain the significantly high rates of suicide associated with CD.

Many elementary school counselors intervene with students with CD out of caring for the students and their education, and due to a lack of other resources for treatment. However, many school counselors feel at a loss for what to do to provide effective treatment to children with CD. This study provides much needed information and understanding to school counselors by discerning the status of counseling and related non-counseling services available to elementary school age students with CD, and determining some of the best practices by elementary school counselors in providing services to students with CD.
Need for the Study

There is a great deal of research in effective treatments for children with CD at outside school agencies (McMahon & Wells, 1989). However, the services of the agencies are not always available to schools due to geographic location and funding limitations. Additionally, when assistance to schools from outside school agencies is available, it is not always the most appropriate or efficient approach to providing for the educational needs of students with CD. Consider these advantages to services from school counselors as opposed to those provided by outside school agencies' personnel. First, school counselors are able to collect information about troubled students from observing the student at play and work, observing important teacher-student relationships, and frequently listening to the thoughts and feelings of school adults concerning students with CD at the school. This wealth of information and understanding would very likely be less available to outside school agencies. Second, school counselors are close by to provide support and direction to students with CD and the school adults who care for them in crisis moments. Third, school counselors have already established a relationship with teachers, parents, and peers of students with CD.

Yet, there is very little research available to guide the work of school counselors in providing services to students with CD. This lack of research may be due to the traditional belief that services by school counselors are primarily for students whose behavior is within the normal range, which the behavior of students with CD is not. Unfortunately, the number of students with CD appears to be rising in recent decades (APA, 1994). Because American public schools are charged with the mission of educating all students, whether outside school agency services are available and appropriate or not, the roles of school counselors are adapting to meet the needs of their students. Thus, there is a need for research into services provided by school counselors in the school setting for students with CD. Research is needed to point out what these ideal services by school counselors
for students with CD are, and how these services can be made practical. Before answering that question, one must first know what the status of services is at this time. This study provides answers to these questions.

Assumptions

1. School counselors can describe what services they provide for students at their school who can be described as having CD.
2. This information can be surveyed.
3. School counselors can identify students with CD from a brief description of CD included in the survey.

Purpose

The general purpose of this study is to determine what the status of services by elementary school counselors for elementary school students with Conduct Disorder is and what additional services can be recommended. To achieve this purpose, the researcher has:

1. Reviewed and synthesized literature relevant to the subject.
2. Determined what services are typically offered to elementary school students with CD by elementary school counselors.
3. Determined how the services provided to elementary school students with CD by elementary school counselors, who were identified as more effective than usual in providing services to this population, differ from the services typically provided.
4. Determined what changes should be made so that the actions of those elementary school counselors identified as more effective than usual in providing services to this population can become the norm for all elementary school counselors providing services to this population.
Research Questions

Seven general questions are addressed in this research study. Through surveys and interviews of elementary school counselors, answers to the following questions have been sought.

1. What services do elementary school counselors provide for students with CD?
   a. What types of counseling do school counselors provide for students with CD?
   b. What types of related non-counseling services do school counselors provide for students with CD?
   c. What is the school counselors' typical time commitment of counseling and related non-counseling services for students with CD?

2. What counseling services and related non-counseling services do elementary school counselors believe are not being provided for students with CD that should be provided?
   a. What has caused these services not to be provided?
   b. What is needed to begin providing these services?

3. What counseling and related non-counseling services are typically provided from outside school agencies to students with CD in the public schools?

4. What are elementary school counselor opinions on providing counseling and related non-counseling services for students with CD?
   a. Would elementary school counselors prefer to provide more or less counseling and non-counseling, but related services for students with CD at their school?
   b. Do elementary school counselors believe they need more training to be able and successful in providing services to students with CD?
c. Do elementary school counselors believe counseling and related non-counseling services are best provided by themselves or others?

5. What are characteristics of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD?
   a. Do they have teaching backgrounds or not?
   b. If so, what are their teaching backgrounds?
   c. What are their ranges of years of service?
   d. What terms from counseling theories do they use to describe their direct counseling of students with CD?
   e. Are there important commonalities or differences in their training?

6. What are characteristics of the settings of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD?
   a. How many students do these counselors serve?
   b. How many of their students with CD are included in Special Education programs?
   c. Does the school have an alternative education program that includes students with CD?

7. What services do elementary school counselors who are identified as more effective than usual in providing services for students with CD provide?
   a. How do these school counselors understand the development and maintenance of the condition and behaviors of CD?
   b. Is this understanding important to their work?
   c. How do these school counselors define success?
d. What services do these school counselors consider most useful in producing successful outcomes with Conduct Disordered students?

e. How do these school counselors select treatments and services to provide?

g. What do these school counselors believe would be helpful for other school counselors to provide more effective services to students with CD?

**Limitations**

1. Because the study involved only elementary school counselors from Virginia, results must be cautiously generalized to areas outside Virginia and to other student age levels.

2. The study considered only elementary school students who can be identified as having CD; results may not be generalizable to other population of children.

3. Generalizations from interview data are not possible because the number of interviewees is too small to be representative and because the selection of interviewees was based on counselor self and peer perceptions.

**Methodology**

The following is a brief overview of the study’s methodology:

1. A random sample of 209 elementary school counselors in Virginia was surveyed concerning services for students at their schools that can be described as Conduct Disordered. Survey results were analyzed using descriptive statistics.

2. Survey items were used to identify a list of six to ten elementary school counselors who are more effective than usual in providing services for students who can be described as having Conduct Disorder. These counselors were interviewed about their work with these students.
Definitions

The following terms are used throughout the study.

**Affective** -- pertaining to or resulting from emotions or feelings rather than from thought or action *(The American Heritage Dictionary, 1985)*.

**Conduct Disorder** -- “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” *(APA, 1994, p. 85)*. Characteristic behaviors are: harming or threatening to cause physical harm to other people or animals, causing property loss or damage, deceitfulness or theft, and serious violations of rules. The disturbance causes clinically significant impairment of social or academic function. The diagnosis applies only to persons who are younger than age 18 years *(APA, 1994)*.

**Counseling** -- “a personal relationship and interaction in which students confidentially explore their feelings, ideas, and behaviors with a professionally trained counselor” *(Myrick, 1987, p. 7)*. Counseling may take place on an individual or small group basis.

**Elementary school** -- any school identified as an elementary school by the state of Virginia.

**Elementary school counselor** -- a school counselor whose primary assignment is the grades within the elementary school.

**Family** -- a group of persons united by lineage or marriage *(The American Heritage Dictionary, 1985)*.

**More effective than usual** -- compared to other elementary school counselors in their same school system, these counselors are perceived by their administrators and themselves as providing services that produce more desired outcomes for students with CD
in the school setting, such as having more time on task, more satisfactory teacher student relationships, less disciplinary actions taken on their behalf, and earning higher grades.

**Outside school agency** -- any agency administered separately from the public schools that may at times provide services to public school students, such as regional mental health agencies, counseling private practice agencies, residential treatment centers, court services, etc.

**Related non-counseling services** -- services provided by counselors to students that are logically and closely related to counseling, but do not fit the definition of counseling, including consultation with parents and teachers, specialized classroom presentations, coordination of counseling or closely related services from outside school agencies, and advocacy for students in important decision making committees in school or with related outside school agencies.
CHAPTER 2

REVIEW OF LITERATURE

This review of literature is a sample of the existing literature related to the provision of services to students with CD by elementary school counselors. Emphasis is given to literature published within the last 10 years. The various points of view presented in this review of literature are included in approximate proportion to the percentages they occur in existing literature. Literature was identified using not only the term Conduct Disorder, but also similar terms such as severe emotional disturbance, behavioral disorders, social maladjustment, and aggressive or anti-social behaviors. The topics addressed in this review of literature are: definitions of CD, explanations of how CD is developed and maintained, studies concerning counseling and related non-counseling services to students with CD or similar behavioral descriptors in school settings, and probable areas of effective counseling and related non-counseling services to students with CD by elementary school counselors.

Conduct Disorder Defined

Diagnostic criteria:

To begin to understand what the status of elementary school counseling and related non-counseling services to students with CD is and what best practices are, one must first understand what CD is. The diagnostic features given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), provide an effective way to understand what CD is. According to the authors of the DSM-IV, Conduct Disorder has as
its essential feature “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (APA, 1994, p. 85). This behavior pattern is divided into four main groupings: aggressive conduct that harms or threatens to harm people or animals, non-aggressive conduct causing property loss or damage, deceitfulness or theft, and serious violations of rules. Characteristic behaviors must have persisted for at least one year and must have also occurred within the last six months. The behaviors of CD cause significant impairment of social and academic functioning. The behaviors of CD are usually present in more than one setting, such as at home, at school, and in the community (APA, 1994). Thus, Conduct Disorder is unlikely to be exclusively a problem for schools.

The DSM-IV authors continue the diagnostic criteria for CD with more specific descriptions of characteristic behaviors. Aggressive conduct may include bullying, threatening, intimidating others, initiating physical fights, using weapons that can cause physical harm (e.g., a bat, brick, broken bottle, knife, or gun), being physically cruel to people or animals, stealing while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery), and forcing someone into sexual activity. Within these criteria, causing property loss or damage is deliberate and may include setting fires with the intention of causing serious damage, smashing car windows, or vandalizing a school. Deceitfulness or theft may include breaking into someone else’s house, building or car; lying or breaking promises to obtain goods or favors or to avoid debts or obligations; and stealing items of nontrivial value (e.g., shoplifting, forgery). There may be serious violations of parental or school rules. These rule violations often include staying out late at night without parental permission, being frequently truant from school before age 13, and running away from home more than once, or only once if for a lengthy period of time. Running away from home is not typically a Conduct Disordered behavior when it is a direct result of physical or sexual abuse (APA, 1994).
Associated features:

Providing more than the bare bones diagnostic criteria, the DSM-IV authors describe the following associated descriptive features of Conduct Disorder (APA, 1994). Children and adolescents with CD often have little empathy or concern for the feelings, wishes, or well-being of others. Aggressive children and adolescents with CD often perceive the intentions of others as more hostile and threatening than is the case. These children and adolescents then respond with aggression that they believe is reasonable and justified, but which societal norms do not define as reasonable and justified. Children and adolescents with CD often lack the normally expected feelings of guilt and remorse for hurtful, aggressive actions. It is common for children and adolescents with CD to readily inform on their companions and try to blame others for their own misbehaviors. Although children and adolescents with CD may project an image of toughness, their self-esteem is usually low. Children and adolescents with CD are prone to low frustration tolerance, irritability, temper outbursts, and recklessness (APA, 1994). Children and adolescents with CD often have a variety of skill deficits. These skill deficits may include distorted attributional processes (Dodge, 1985), poor problem solving skills (Lochman & Lampron, 1986; Richard & Dodge, 1982), lower levels of moral reasoning (Jurkovic, 1980), and difficulties in cognitive and affective perspective taking (Chandler, 1973).

Unfortunately, another associated feature of CD is a grim prognosis if not effectively treated. Early onsets of sexual behavior, drinking, smoking, use of illegal substances, and reckless, risk-taking acts are associated with CD. Conduct Disordered behaviors often lead to school suspension or expulsion, difficulties in work adjustment, legal problems, sexually transmitted diseases, unplanned pregnancies, and physical injuries (APA, 1994; Horne et al., 1992). Suicidal ideations, attempts, and completed suicides are
are significantly more common for persons with CD. Academic achievement, especially in reading and other verbal skills, is often below the expected level based on age and intelligence. This discrepancy often justifies the additional diagnosis of a Learning or Communication disorder. Attention-Deficit/Hyperactivity Disorder is common in children with CD. However, it is noted that although children with Attention-Deficit/Hyperactivity Disorder often exhibit impulsive behavior that may be disruptive, this behavior does not by itself violate age-appropriate societal norms and therefore does not constitute CD. When criteria for both Attention-Deficit/Hyperactivity Disorder and CD are met, a dual diagnosis is made. The following other mental disorders are often associated with CD: Learning Disorders, Anxiety Disorders, Mood Disorders, and Substance-Related Disorders. While research does not yet clearly indicate causes of CD, the following factors may predispose individuals to CD: parental rejection and neglect, difficult infant temperament, inconsistent child-rearing practices with harsh discipline, physical or sexual abuse, lack of supervision, early institutional living, frequent changes of caregivers, large family size, association with delinquent peer groups, and certain kinds of familial pathology (APA, 1994).

Prevalence and course:

The DSM-IV authors offer the following information on the prevalence and course of CD. The number of children and adolescents with CD has increased in recent decades. CD is more common in urban than rural settings. Rates of occurrence vary widely. Rates for males range from six to 16 percent. Rates for females range from two to nine percent. CD in general, and especially the Childhood-Onset Type, is more common in males (APA, 1994). Quay (1986) states that while there is some variability across studies, boys in the general population are two to three times as likely as girls to develop CD and three times as likely to present at clinics. CD is one of the most commonly diagnosed conditions in inpatient and outpatient mental health facilities for children (APA, 1994; Quay, 1986; Wells
& Forehand, 1985). Onset may occur as early as ages five to six years. However, onset occurs more commonly in late childhood or early adolescence. Early onset predicts a worse prognosis and increased risk in adult life for Antisocial Personality Disorder and Substance-Related Disorders (APA, 1994).

**Childhood-Onset Type of CD:**

Because this study focuses on counseling and related non-counseling services to elementary school students with CD, it is important to note that the Childhood-Onset Type of CD indicates that at least one of the diagnostic criterion had begun before age 10 (APA, 1994). Besides that distinction, there is little else with which to differentiate Childhood-Onset Type from Adolescent-Onset Type of CD, except, of course, the difference in violated age-appropriate societal norms.

**How Conduct Disorder is Developed and Maintained**

**Development of CD through parent-child interactions:**

The search for causes of CD primarily points to the system of parent-child interactions in the families of children with CD. McMahon and Wells (1989) explain that parents of children with CD both experience elevated levels of problem behaviors from their children and also emit higher levels of commands to and criticisms of their child, as well as poor monitoring and disciplinary practices. Furthermore, parents of children with CD experience more personal, interpersonal, and extrafamilial distress, which most investigators have suggested leads to the child behavior problems. Fendrich, Warner, and Weissman (1990) found that both parental depression and the family risk factors of poor marital adjustment, parent-child discord, low family cohesion, affectionless control, and parental divorce are significant predictors of Conduct Disorder. Further, these family risk
factors were consistently more important as risk factors for CD than they were for other disorders. Christ, Lahey, Frick, Russo, McBurnett, Loeber, Stouthamer-Loeber, and Green (1990) found that because of common associations with socio-economic status and parental antisocial personality, teenage motherhood is a significant risk factor to the development of CD in the offspring.

There is debate in the literature on CD concerning whether the parents or the children with CD drive the parent-child interactions associated with CD. Lytton (1990a) reviewed research including Conduct Disordered children’s reactions to unrelated mothers in laboratory studies, the reaction to punishment of children with CD, the autonomic reactivity of children with CD, biochemical factors associated with CD, drug treatments of children with CD, and longitudinal studies of CD. From this review, Lytton concludes that the child has the primary influence over the parent-child system of interactions associated with CD. Lytton (1990b) adds that while child effects are nearer the genetic biological drives, parent effects are more environmentally driven. From this, Lytton again concludes that the children with CD are the greater contributors to the system of parent-child interactions associated with CD. Countering these arguments, Wahler (1990) argues that the research literature does not yet permit conclusions on the directionality of parent-child effects in CD. Also in rebuttal to Lytton, Dodge (1990) argues that causation of the parent-child interaction is not as important as further study of how the mechanisms of the interaction between parents and children with CD work.

Regardless of causation of the parent-child interactions associated with CD, the prevailing theoretical formulation concerning the development and maintenance of conduct disordered behaviors emphasizes the importance of family socialization processes (Patterson, 1982, 1986). Patterson emphasizes the coercive or controlling nature of conduct disordered types of behavior and has developed a coercion model to account for their development and maintenance. In the coercion model, negative reinforcement plays a
particularly important role. Coercive behavior on the part of one family member (child or parent) is reinforced when it results in the removal of an aversive event being applied to another family member. As this shaping continues over long periods, significant increases in the rate and intensity of the coercive behaviors occur as family members are reinforced by engaging in aggressive behaviors. Additionally, the child observes his or her parents engaging in coercive responses, and this provides the opportunity for modeling of aggression (Patterson, 1982).

Patterson and colleagues have further expanded the model to incorporate some of the most significant family influence factors described above and by recasting the model along developmental lines (Patterson, 1986). The model suggests a developmental progression from a kind of ‘basic training’ in coercive process through parent-child interactions to the impact of the child’s coercive and noncompliant behavior on self-concept, peer relationships, and academic skills. The model also links variables such as parental psychopathology and stressors with disruptions in parenting skills at different stages in these processes. Preliminary investigations have provided evidence for the model as it applies to children with CD at home (Patterson & Bank, 1986; Patterson & Dishion, 1985) and at school (Walker, Shinn, O’Neill, & Ramsey, 1987). The model is currently being tested and revised in an ongoing longitudinal project (Patterson, 1986).

**Biologically based factors in the development of CD:**

Although Patterson’s familial socialization model has been especially useful in conceptualizing the development and maintenance of CD, it is important to note that biologically based factors may also contribute. There is evidence from twin and adoption studies to suggest that there may be a genetic predisposition to the development of CD (and/or criminal behavior) (Cloninger, Reich, & Guze, 1978; Jary & Stewart, 1985). Cadoret, Cain, & Crowe (1983) found that the likelihood of adolescents engaging in
conduct-disordered behavior increased when both genetic and environmental influences were present.

Although the definitions of temperament appear to be in a state of flux among developmentalists (Goldsmith, Buss, Plomin, Rothbart, Thomas, Chess, Hinde, & McCall, 1987), there is some evidence that child temperament is at least a contributing factor in the development of CD. Temperament is usually viewed as involving relatively stable innate personality characteristics (Plomin, 1981). Temperamentally difficult children, who from very early in life are intense, irregular, negative, and non-adaptable (Thomas, Chess, & Birch, 1968), are thought to be predisposed to the development of subsequent behavior problems, due to the increased likelihood of maladaptive parent-child interactions. Webster-Stratton and Eyberg (1982) have demonstrated moderate correlations between some dimensions of child temperament and parent reports of child conduct disordered behavior and mother-child interactions. Olweus (1980) found that temperament contributed substantially to the prediction of aggressive behavior in adolescent boys. However, temperament variables contributed less to the explanatory variance than did family variables such as maternal negativism and permissiveness of aggression.

**Maintenance of CD behaviors through peer relationships:**

While they are not likely as significant a factor as family interactions or innate temperament, there is evidence that peer relationships are at least a factor in the maintenance of CD. There is evidence to support the view that maladaptive peer relationships provide a social milieu in which CD behaviors can be modeled, practiced, and perhaps reinforced and strengthened by deviant, antisocial peers (Dishion, 1990). Additionally, the peer groups of children and adolescents with CD-like behaviors are smaller than those of normal adolescents and more likely composed of a homogeneous group of peers (Barone, Leone, & Trickett, 1988). Further, data suggests that children and adolescents with CD like
behaviors gain greater peer acceptance when their behavior is reflective of group norms (Kauffman, 1989). Developmental theorists such as Sullivan (1953) and Havighurst (1972) have suggested that developing a positive social network are developmental tasks that all children strive to accomplish (Sullivan, 1953; Havighurst, 1972). Thus, it stands to reason that children and adolescents with CD would increase the severity of CD behaviors through peer interactions over time.

**Maintenance of CD at school:**

Similar to peer interactions, interactions with school adults are unlikely to play a role in the development of CD, but probably do play a role in the maintenance of conduct disordered behaviors. Next to the family, the school probably provides the most significant socializing influence (Arllen & Gable, 1992). Kazdin (1991) posited that a number of school-related factors increase the risk of CD behaviors. These factors are focused on the interactions between teachers and students with CD. The factors of teacher-student interactions that seem to increase the risk of CD behaviors include a lack of teacher praise, lack of recognition of school successes, low amounts of teacher time devoted to instructing the student with CD, a lack of emphasis on individual student responsibility, low availability of teacher time to deal with children’s problems, and inconsistent teacher expectancies. In addition, there is a tendency among teachers to reinforce maladaptive behavior by attending to those behaviors, model inappropriate responses by responding aggressively to aggressive behaviors, and ignore appropriate alternative behaviors (Nelson, 1981).
Studies Concerning Counseling and Related Non-counseling Services to Students with CD or Similar Behavioral Descriptors in School Settings

There is a great deal of literature on CD and similar behavioral descriptors. There is much literature on treatments of CD by outside school agencies. However, there is very little literature on treatments or services by school counselors for students with CD. A discussion of studies closely related to this subject follows.

Loers and Prentice (1988) examined the clinical treatment of children suffering at least temporary emotional disturbance and conduct disorders following their parents’ divorce. They note that treatment for these children usually includes individual or family therapies outside school, with occasional individual counseling by a school counselor. Their study examined clinical treatment of children in the school setting. They provided treatment groups for second graders from divorced families focusing on collaborative problem-solving. Children in the treatment groups significantly reduced occurrences of peer altercations versus the control group.

Similarly, Forman (1980) provided two treatments in the school setting for third to fifth graders selected for their aggressive behavior. The two treatments included a cognitive restructuring group that met one half hour, twice weekly, for six weeks and a response costs program in which students could earn up to one half hour of play time with graduate students, twice weekly, for six weeks. Students in both treatment groups significantly decreased aggressive behaviors, based on teacher ratings, teacher records, and independent observations, compared to students in control groups. Students in the response cost treatment tended to decrease aggressive behavior more than students in the cognitive restructuring treatment. However, this difference was not significant.

Rosenbaum (1990) provided a program of counseling strategies in the school setting for elementary school students identified as severe disciplinary problems. The
counseling strategies included 12 counseling sessions in which alternative behaviors, techniques for self management and control of behaviors, and coping mechanisms were taught. After treatment, behavior referrals declined, suspensions reduced, treated students exhibited more socially acceptable behaviors, and teachers expressed greater confidence in their ability to handle minor disruptions effectively.

Kalish-Weiss (1989) describes a project in which various forms of creative arts therapies were provided to students identified as seriously emotionally disturbed in an inner city elementary school. Many of the students in the program and a majority of their parents did not speak English. Creative arts therapies were chosen because they were thought to be less culture bound than traditional psychotherapies. Kalish-Weiss includes anecdotal, case study evidence of treatment efficacy in the report.

Probable Areas of Effective Counseling and Related Non-counseling Services to Students with CD by Elementary School Counselors

Because there is a great deal written of treatment approaches for children with CD at outside school agencies, but little written for school settings, I review treatment approaches that show promise of effectiveness and adaptability to the school counselor’s role and to school settings. These treatment approaches are: 1) parent education, tailored to the needs of parents of children with CD; 2) specialized school personnel training and school setting modifications; 3) training programs for the skill deficits common to children with CD; and 4) individual and group play therapy.

Parent education tailored to the needs of parents of children with CD:

Myrick (1987) writes that parent consultation has long been considered a function of school counselors and greatly enhances the effectiveness of their direct student
counseling. Parent education tailored to the needs of parents of children with CD is a commonly used and much researched treatment approach by non-school mental health counseling professional. McMahon and Wells (1989) give an overview of common themes to models of parent education for parents of students with CD. They explain that the underlying assumption of these models is that "some sort of parenting skill deficit has been at least partly responsible for the development and/or maintenance of the conduct-disordered behaviors" (p.85). In these models the parent educator instructs the parents in behavioral techniques, such as carefully choosing which behaviors to attend to, time out, etc. The parent then uses the new skill to decrease the child's CD behaviors and to shape more appropriate pro-social responses. Parent educators often use such teaching methods as didactic instruction, modeling, behavioral rehearsal, shaping, and structured homework exercises. Parent education models tailored to the needs of parents of children with CD are an attempt to acknowledge and incorporate into treatment the variety of child and parent variables that have been associated with the development and maintenance of CD.

One parent education model for treatment of CD that seems most comprehensive and potentially applicable to elementary school is delineated in the treatment manual by Patterson, Reid, Jones, and Conger (1975), recently summarized by Reid (1987). In this model, parents are first given a copy of either Living with Children: New Methods for Parents and Teachers (Patterson, 1976) or Families: Application of Social Learning to Family Life (Patterson, 1975). These texts provide the conceptual framework for the specific skills parents will learn. Parents are then helped to pinpoint specific behaviors to change and pre-treatment measures are taken. Parents are then assisted in developing a positive reinforcement system customized to their situation. Point systems, five minute time outs, negative consequences, problem-solving, and negotiation are among the included skills. Patterson and Chamberlain (1988) have estimated that 30% of parent
education time is spent addressing such problems as marital difficulties, parental personal adjustment problems, and family crises.

Behavioral observation data of this model have indicated significant reductions in targeted behaviors (Patterson, 1974; Patterson & Reid, 1973). Improvements in mothers’ perceptions of children’s adjustment have also been reported, and there is evidence for generalization of behavioral improvements across settings, across time (up to one year post treatment), and to siblings (Arnold, Levine, & Patterson, 1975; Horne & Van Dyke, 1983; Patterson, 1974; Patterson & Fleischman, 1979). Attempts to replicate Patterson’s procedures and successes have met with promising, but mixed, results. Successful replication studies have also condensed the treatment time down to 13-16 hours per family (Eyberg & Johnson, 1974; Ferber, Keeley, & Shemberg, 1974; Fleischman, 1981; Fleischman & Szykula, 1981).

A parent training model tailored to the needs of parents of children with CD, similar to the Patterson model, is the videotape modeling/group discussion (VMGD) program developed by Webster-Stratton (1981). In it, parents learn many of the same skills as in the Patterson model. The differences are that it uses video taped vignettes and group discussion to teach the skills. The program can be successfully administered in about the same number of sessions as the Patterson model which features individual, as opposed to group, sessions.

There have been three major treatment outcome studies of the VMGD program. In the first, treated mothers’ and their children’s behaviors were compared to those on a waiting list. Outcome measures indicated significant positive changes in mothers’ and children’s behaviors, and in mothers’ perceptions of children’s adjustment. Additionally, mothers reported high levels of satisfaction with the program. Most treatment gains were maintained at a one-year follow-up (Webster-Stratton, 1981, 1982).
In a second study, the VMGD treatment was compared to a randomly assigned waiting list control group, and to parents in an individual parent education program. Both the VMGD treatment program and the individual treatment program demonstrated similar successes compared to the waiting list control group. Thus, there is indication that the VMGD program is more cost effective than individual parent education. (Webster-Stratton, 1984).

A third study analyzed the components of the VMGD program to see which accounted for what treatment success. Having the parents only view the video tapes seemed to work, but not as well as when combined with group discussion (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988).

Specialized school personnel training and school setting modifications:

School counselors have a unique opportunity to consult with and assist teachers and other school personnel involved in the education of students with CD. As with parent consultation, Myrick (1987) writes that teacher consultation is an integral part of the role of the school counselor. The school counselor’s role as consultant often includes case management, as well as staff development and training. The following are examples of school personnel training and school setting modifications that may be required in order to educate students with CD, which school counselors may provide.

McMahon and Wells (1989) describe changes in teachers’ social behavior, token reinforcement systems, and home-based reinforcement techniques that have been evidenced as effective in reducing classroom disruptions. They suggest that these approaches may also be effective in improving the behavior of students with CD. Teachers and other school personnel involved in the education of students with CD may need training and consultation in the use of these approaches. School counselors may be able to provide this training and consultation.
The comprehensive systems for school-based behavior management, developed by the Center at Oregon for Research in the Behavioral Education of the Handicapped (CORBEH) for children in mainstreamed kindergarten through fourth grade classrooms include the approaches described by McMahon and Wells (1989) (Walker, Hops, & Greenwood, 1984). Two of the four CORBEH programs, Contingencies for Learning Academic and Social Skills (CLASS) (Walker & Hops, 1979) and Reprogramming Environmental Contingencies for Effective Social Skills (RECESS) (Walker, Hops, & Greenwood, 1981), are focused on many of the behaviors that define CD. Both employ a teacher consultant (e.g., school counselor or school psychologist) to begin implementing the program, with control ultimately transferred to the classroom teacher or playground supervisor. Both programs have been extensively evaluated, with positive results (Hops, Walker, Fleischman, Nagoshi, Omura, Skindrud, & Taylor, 1978; Walker, Fonseca Retana, & Gerstein, 1988; Walker & Hops, 1979; Walker, Hops, & Greenwood, 1981; Walker et al., 1984).

Training programs for skill deficits that are common to children with CD:

While training programs for skill deficits may not utilize counseling techniques, this service is encompassed by the direct student services portion of the job of elementary school counselors. The premise underlying a skills training approach is that children with CD lack one or more important social or intrapersonal skills. This skill deficit is believed to be fundamental to the child’s functioning. If remedied, the new skill is expected to lead to improvements in several domains for the student with CD (McMahon & Wells, 1989).

A number of cognitive-behavioral skills training approaches have demonstrated some success in improving behaviors that define CD in elementary school students (Camp, Blom, Hebert, & van Doornick, 1977; Glick & Goldstein, 1987; Kazdin, Esveldt-Dawson, French, & Unis, 1987a, 1987b; Lochman, Lampron, Gemmer, & Harris, 1987). One
particularly well-articulated and evaluated cognitive-behavioral skills training program for elementary school age children focuses on anger control in children with CD. Like other cognitive-behavioral approaches, the “Anger Control Program” views the student with CD’s aggressive behavior as caused, not by events, but by the child’s cognitive processing (or lack thereof) and physiological arousal surrounding those events. It is focused primarily on changes in those cognitive and physiological events that are evoked by frustrations, conflicts, problem situations, or perceived threats in students’ environments. The program authors have provided detailed descriptions of the Anger Coping Program model (Lochman, Lampron, Gemmer, & Harris, 1987; Lochman, Nelson, & Sims, 1981). The program takes place in the school setting. It consists of group discussion, structured experimental modeling and behavioral rehearsals. It utilizes many hand-on materials, such as games, instant cameras, puppets, pictures of social problems from the Developing Understanding of Self and Others kit (Dinkmeyer, 1973), role playing and videotaped feedback. Lochman and colleagues have conducted a series of studies aimed at evaluating the effects of this program (Lochman, 1985; Lochman, Burch, Curry, & Lampron, 1984; Lochman & Curry, 1986; Lochman et al., 1981). A controlled study (Lochman et al., 1984) demonstrated that the cognitive-behavioral program was more effective than either goal setting alone, or no treatment in reducing disruptive, aggressive off-task behavior in the classroom. Additionally, the goal-setting strategy (in which children set daily behavioral goals that are monitored and rewarded by their teachers) combined with the cognitive intervention resulted in greater behavioral improvements than did the cognitive intervention alone.

Individual and group play therapy:

Also encompassed in the direct student counseling portion of elementary school counselors services can be individual and group play therapy. Cochran (1996) writes of
the practicality and appropriateness of elementary school counselors utilizing play therapy. In their book, *Children with Conduct Disorders*, Kernberg and Chazan (1991) provide a model that elementary school counselors may use to provide individual and group play therapy to students with CD. Kernberg and Chazan (1991) and their collaborators focus more on clear and specific explanations of how to treat children with CD, using play, and why their model makes logical, theoretical sense than on presenting research evidence of treatment efficacy. They include many useful examples of therapist techniques and actions in describing their model. They offer the following rationale in advocating a play therapy approach for treating children with CD: “We stress that these children [children with CD] express themselves through action, rather than words; they prefer not to use language to communicate, to share experiences, or to express feelings.” (p. 2). Additionally: “For the troubled, beleaguered child, play also provides a safe haven in which reality can be suspended temporarily and new possibilities explored without fear of retaliation.” (p. 23-4).

Writing in Kernberg and Chazan (1991), Kernberg, Chazan, Kruger, Frankel, Scholl and Saunders (1991) title their model of a play therapy approach for children with CD Supportive-Expressive Play Psychotherapy (SEPP). They explain its components this way. The word ‘support’ indicates a specific kind of counseling relationship that builds positive self-esteem. The word ‘expressive’ is included because techniques, including play, are used that encourage children’s’ self-expression. The following quote is helpful for understanding the supportive-expressive aspect of their model:

[S]upport is essential as the therapist communicates to the child an attunement to, and understanding of, his or her feelings. As the feelings are shared in this open and nonthreatening way, an arena of safety emerges within which the child is free to explore, in play and in words, feelings, wishes, and behaviors he or she had heretofore hidden not only from others
but from his or her own self-awareness as well. Thus, the expressive aspects of SEPP become clearer as the child becomes increasingly open to deeper understandings of his or her wishes, motives and thoughts (p. 27).

The authors further explain, “We include play in our nomenclature for this therapy because we consider it to be an essential, developmentally appropriate component of supportive-expressive psychotherapy with children.” (p. 23).

Kernberg, Chazan, Kruger, Frankel, Scholl and Saunders (1991) offer this understanding of children with CD and how SEPP can work for them:

Conduct disordered children play aggressively and destructively with the therapist in an attempt to express without words why they are the way they are and to see if the therapist will respond to them as others have done in the past. In fact, they do not know how to play in any other way. Their aggressive behavior is often an unconscious effort to ward off the awareness of feelings being disregarded and devalued (p. 29).

Supportive-expressive aspects of the model facilitate children’s learning a new way to play. That new way to play becomes practice for a new way of being in life outside the counseling sessions.

Hence, the ensuing benefit is described this way:

It is the child’s alliance with the therapist and his increasing identification with [the therapist] that enables him to represent himself to himself in all his aspects. The unloved and unlovable child discovers he can also be loved and lovable and, moreover, that these two aspects of himself are integrated parts of a whole and subject to his own initiative. Thus, the child comes to experience himself as capable of reflection and making choices (p. 33).

Kernberg and Chazan write that therapists treating children with CD need to have frequent contact with the children’s teachers. They note that for various reasons, this is
difficult and often does not happen. This is an area of decided treatment advantage for elementary school counselors, who usually have close relationships with many of the teachers at their school.

Kernberg and Chazan (1991) also include a model, similar to SEPP, for group counseling of children with CD. The rationale for group play therapy for children with CD is that once the children have made progress in individual play therapy, they need to try out their new skills, beliefs, and insights with other children. There tends to be a strong sense of isolation in children with CD. Truly, they have often isolated themselves with antisocial behavior. Often, when the self-awareness of children with CD has increased to the point of beginning to change their behavior, they seem suddenly to realize how alone they have become. The small group experience that includes elements of play therapy is an opportunity for their counselor and selected school mates to guide them in forming what are probably their first friendships.
CHAPTER 3

METHODOLOGY FOR DATA GATHERING AND DATA ANALYSIS

This study employed both quantitative and qualitative research methods to discover the status of services to children with Conduct Disorder (CD) by elementary school counselors and what some current effective practices are. Quantitative methods were used to survey elementary school counselors in Virginia. Qualitative methods were used in interviews of elementary school counselors identified as effective in providing services to students with CD.

Study procedures are detailed throughout this chapter. Procedures and issues in research methods related to the survey are explained first. Then, procedures and issues in research methods related to the interviews are explained. All survey and interview procedures are approved by Virginia Tech's Institutional Review Board for Research Involving Human Subjects.

Survey Procedures and Issues in Research Methods

The purpose of the survey is to provide a snapshot of services by elementary school counselors to students with CD. The survey is designed to answer all or part of the following research questions: 1. What services do elementary school counselors provide for students with CD? 2. What counseling services and related non-counseling services do elementary school counselors believe are not being provided for students with CD that should be provided? 3. What counseling and related non-counseling services are typically provided from outside school agencies to students with CD? 4. What are elementary school counselor opinions on providing counseling and related non-counseling services for students with CD? 5. What are characteristics of elementary school counselors who have
extensive time commitments in providing counseling and related non-counseling services to students with CD? and 6. What are characteristics of the settings of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD?

Survey population and sample:

The surveyed population is elementary school counselors in Virginia. Because a list of elementary school counselors in Virginia was not readily available, a sample of elementary schools was drawn and surveys mailed to elementary school counselors, care of their schools. There are 1,165 elementary schools in Virginia, (Virginia Department of Education, 1994-95). Of these, 209 were sampled. The sample size was chosen by balancing the limits of the study’s budget and the desire for a low sample error in survey results. Of the 209 schools surveyed, 117 responded. Thus, the return rate is 56%. Suskie (1992) writes that most professional researchers like a 70% or better return rate and consider 50% minimally adequate. The formula and discussion by Suskie (1992) indicate that the 117 respondents yield a sampling error of 9.245% or less.

The sample method is clustered random sampling. Each public school system in Virginia forms a cluster. School systems were randomly selected using a table of random numbers. Once a system was randomly selected, each elementary school in the system was included in the sample. Selection was made of systems, not schools, because permission to conduct research in each school system was required.

Permission to survey was obtained through a mailing requesting permission. The mailing included a letter explaining the study, a prestamped, self-addressed post card on which superintendents could grant permission (see Appendix C), and a copy of the survey and cover letter for school counselors (see Appendix A). Up to two follow-up phone calls
were made when necessary. Additionally, a few school divisions requested in-house forms completed or more information. These requests were honored when possible.

The randomness of the selection procedure was compromised only slightly. Three school systems declined participation. One system declined due to “the sensitive nature of this survey.” Two systems declined participation and gave no explanation. Additionally, two other school systems delayed granting permission beyond the time that surveying needed to be completed. Two systems did not respond to the mailing or to phone calls. Each of these non-participating systems was replaced by other randomly selected school systems. Thirty-four systems granted permission, while seven declined or did not respond.

Therefore, with cautions understood that the sampling process was not perfectly random and that the return rate was low but minimally adequate, survey results are generalizable to the services by all elementary school counselors to elementary school students with CD in Virginia. The validity of inferences to other age groups is unknown.

Threats to survey validity:

In addition to the validity of generalizations to the survey population and similar populations, Suskie (1992) explains that the most important characteristic of an internally valid survey is that it measures what you want it to. Suskie (1992) further explains that validity means each respondent should interpret each question in the same way. Therefore, efforts were made to ensure that the survey was complete and explicit, yet concise and easily readable. Suskie (1992) recommends five steps to ensure survey validity. First, items were examined, checking to see that they have an intuitive relationship to the study’s topic and goals. Items in this survey were examined by the author, and his doctoral advisors. Second, the survey was pilot-tested to make sure it was clear and easily understood. This survey was informally pre-piloted by an elementary school teacher, one
elementary school counselor, two middle school counselors, and one high school counselor. The survey was more formally piloted in September 1995 by seven elementary school counselors with whom this author had contact as university supervisor of practicum students and by eight elementary school counseling practicum students at Virginia Tech.

Third, items were kept free from bias and ambiguities. To accomplish this, the author made checks for biases and ambiguities based on suggestions by Suskie (1992), and questioned doctoral advisors and pilot respondents related to potential bias and ambiguities. Fourth, Suskie recommends that survey results be compared with findings from similar studies. Studies similar to this overall study were not available. Fifth, Suskie (1992) makes recommendations for including questions to identify lying respondents, when surveying a topic for which respondents might not answer truthfully. This recommendation was not followed because there is little reason for respondents to lie, since the results are anonymous, and no single respondent is being evaluated. Additionally, lie indicator questions would make the survey longer than necessary and thus might reduce the return rate.

A description of elementary students with CD is included in the directions to the survey. Potential lack of clarity in this description could have been a threat to validity. It was important that each survey respondent refer to the same population of students when answering survey items. Care was taken to ensure that this population description is long enough to be clear, but not so long that it will not be read. The population description includes both behavioral descriptors and a brief case example. Pre-piloting and piloting the survey also helped clarify the survey's definition of students with CD.

Actions were also taken to guard against threats to external validity. A low return rate could have been a threat to external validity. For example, if the return rate was very low, counselors with a distinguishing characteristic may have been left out of the sample. The sample would then have been no longer be random. Thus, the survey would have no
longer represented the views of the population of elementary school counselors in Virginia, but only some sub-groups of that population. Therefore, the following steps were taken to ensure a high return rate. The survey was mailed with a stamped, self addressed return envelope for respondents’ convenience. The survey was checked by the author’s doctoral advisors and pilot respondents for readability, professional appearance, and concise length. Pilot respondents were carefully queried to ensure that the survey was in a format that elementary school counselors would be likely to answer and return. Additionally, the pilot groups and many respondents expressed great interest and strong opinions on the subject. This also helped yield an adequate return rate. The proposed survey, cover letter, instructions, and specific questions that persons piloting the survey were asked to address are in Appendix A. The return rate was enhanced by follow-up phone calls to counselors not returning the survey by the due date. In these phone calls, counselors were reminded of the importance of their response and asked if they needed a second copy or other assistance in responding. One hundred and thirty reminder phone calls were made. In these calls, 15 counselors requested second mailings and three counselors requested not to be included in the study due to a lack of time.

Threats to survey reliability:

The reliability of survey results was also considered. Each single survey response may not be reliable over time due to the nature of the subject. Respondent answers may change over time based on respondent experiences such as changes in student populations, training of counselors, changes in administrator and school community preferences in counseling services, or other unknown variables. Due to the potential dynamics of the topic, care was taken to report that response data represent elementary school counselors’ answers at the time of survey.
Internal consistency reliability was also considered. One way to establish this type
of reliability, according to Suskie (1992), is to repeat similar questions throughout the
survey and check for the correlation between these items. Because it would lengthen the
survey and thus probably reduce the response rate, this approach was not applied. Another
way to establish reliability, according to Suskie (1992), is to make questions as objective
and behavioral as possible. This way to reliability was vigorously pursued in drafting and
editing the survey, pre-piloting, piloting, and discussions with advisors.

Survey analysis:
Because the survey was primarily designed to describe the status of services to
students with CD by elementary school counselors, primary analysis was accomplished
using descriptive statistics. Survey items elicited three types of descriptive information: (a)
numerical; (b) forced-choice responses; and (c) written information that elaborates on
forced-choice items. Numerical data was analyzed by calculating arithmetic means, modes,
medians, and high and low ranges. Figure 1 provides a list of questionnaire items that
generated numeric data. Data analysis for the forced-choice items consisted of calculating
response frequencies. Survey items requiring a forced choice response are found in Figure
2. Written information was analyzed by coding responses into categories and then
calculating response frequencies. Items requiring written comments are listed in Figure 3.
Written responses were also generated from forced-choice items where “Other” is an
option. Items where “Other” responses are applicable are listed in Figure 4.
#11: years of service by the counselor

#15: number of students with CD at each counselor’s school

#16: gender of students with CD

#17: grade of students with CD

#18: total number of students at the counselor’s school(s)

#21. a: counselor direct service hours to students with CD

#21. b: counselor indirect service hours to student with CD

#22: counselor total work hours

#24. a: number of students with CD in special education programs

#24. b: number of students placed under each area of disability

#25. d: number of counselors employed in alternative education programs including students with CD

#26: number of full time counseling positions at the school

#27: number of part time counseling positions at the school

Figure 1. SURVEY ITEMS GENERATING NUMERIC DATA
#1: counselor level of frustration in providing services to students with CD
#2: counselor self rating of effectiveness of services to students with CD
#3: comparative self rating of effectiveness of services to students with CD as opposed to
students from more normal populations
#4: comparative self rating of effectiveness of services to students with CD as opposed to
students with other special needs
#5: comparative self rating of effectiveness of services to students with CD as opposed to
the services to students with CD by other elementary school counselors
#6. a to k: opinions related to services for students with CD
#9: willingness to be interviewed
#10. a: whether or not the elementary school counselor is assigned to more than one
school
#10. b: the number of schools served by the counselor
#13. a to e: professional background prior to elementary school counseling
#19: categories of counselor service activities and rank of importance
#20: direct service counseling approaches
#23. a: availability of outside school agency services
#23. b: types of outside school agencies providing services
#23. c: types of services by outside school agencies
#23. d: counselor level of satisfaction in services by outside school agencies
#25. a: existence of alternative education programs that include students with CD
#25. b: location of these alternative education programs
#25. c: whether or not these alternative education programs hire additional counselors
#28: rural, urban, or suburban nature of the school

Figure 2. SURVEY ITEMS REQUIRING A FORCED-CHOICE RESPONSE
#7: needs of the school for more effective services to students with CD

#8: names of elementary school counselors considered more effective than usual in providing services to students with CD

#12. a: level of highest degree

#12. b: subject area of highest degree

#29: additional comments regarding services to students with CD
#13. a to c: professional background to elementary school counseling

#19: categories of counselor service activities

#20: individual counseling approaches

#23. b: types of outside school agencies providing services

#23. c: types of services by outside school agencies
Interview Procedures and Issues in Research Methods

Purpose of the interviews:

The purpose of the interviews was to provide a fuller, more lifelike picture of services to students with CD by elementary school counselors, as well as to answer research questions which survey research would not. The interviews were designed to answer all or part of the following research questions (as numbered in Chapter 1.): #7. What services do elementary school counselors who are identified as more effective than usual in providing services for students with CD provide? This question was answered by the population of all elementary school counselors through the survey. However, it may be more useful to practitioners struggling to provide counseling and related non-counseling services for students with CD to hear the experiences of a small group of elementary school counselors who were identified as effective in providing these services. #2. What counseling services and related non-counseling services do elementary school counselors believe are not being provided for children with CD that should be provided? This research question was also addressed in the survey, but the interview format allowed for much more in-depth answers. The interview format allowed such follow-up questions as “Why?” and “How?” The interview format provided fuller answers by counselors identified as more effective than usual in providing counseling and related non-counseling services to students with CD.

Selection of interviewees:

Six elementary school counselors, identified as more effective than usual in providing services to students with CD, were selected for interview. The interviewees were identified by responses to survey items. Survey item number eight asks respondents to identify three elementary school counselors in Virginia with whose work they are
somewhat familiar, including themselves, whom they consider more effective than usual in providing counseling and related non-counseling services to students with CD. This item generated a list of 38 counselors who were said to be more effective than usual in providing services to students with CD. Most of the interviewees had also returned surveys. The following survey items were then used to narrow this list down to seven: item nine (willingness to be interviewed), items two through five (self ratings of effectiveness in providing services to students with CD), items 15 through 18 (percentage of students with CD at their school), item 19 (frequency of service activities to students with CD), and items 21 and 22 (percentage of time spent providing services to students with CD). Two interviewees had not returned surveys. Those two were selected for interview based on the fact that four different survey respondents had recommended each of them as more effective than usual in providing services for students with CD. The highest number of times a counselor was recommended by survey respondents was four. Additionally, these counselors did not work in unusually large school systems where it might be expected that more effective counselors would be recommended more often. The six interviewees were from a variety of regions of Virginia and answered survey items in a variety of ways. Two other interviews were scheduled, but canceled twice due to lengthy school cancellations after snow storms. After having missed 18 to 20 school days in January and early February, the counselors were unable to commit the time to reschedule.

Format of the interviews:

Five of the interviews were conducted in person. Two were conducted by phone. All were conducted by the researcher. Interview lengths varied from one and a half to two hours. Consistent with qualitative research methodology, the questioning was open-ended and semi-structured. McCracken (1988) describes this format as having specific questions or sub-topics to be covered, but covering the topics by beginning with a grand tour opening
question and eliciting more information with the use of floating prompts. An example of a grand tour opener is “Tell me about the counseling and related non-counseling services you provide to students with CD at your school.” Floating prompts refer to such actions as asking interviewees to elaborate when they have mentioned one of the sub-topics targeted to be addressed in the interview, or asking the interviewees to explain the meaning of a term they have used. This format achieved a balance that controlled the content and flow of information in interviews, yet allowed the interviewees to respond in their own words. See Appendix B for the interview protocol.

Validity, reliability, and standards of quality in qualitative research:

According to McCracken (1988), several standards of quality contribute to validity and reliability in qualitative research interviewing. One of these standards is the obtrusive versus unobtrusive balance of the semi-structured format. In general, researchers gain most valid data with least obtrusive techniques. In many cases interviews may be less obtrusive than surveys, because interviews allow respondents to answer in their own words. Interviews are often more obtrusive than simply observing qualities of behavior. In this research project, observation would have actually been more obtrusive due to the potential for negatively affecting the counselors’ work and the difficulty of maintaining the confidentiality of students with CD in the study. Therefore, interviews are the least obtrusive data-gathering technique for this topic and the semi-structured format is least obtrusive among interview formats, allowing the interviewee to say in their own words what they decide is important while being prompted to speak on pre-selected aspects of the subject.

According to McCracken (1988), it is important to the validity of the interviews for researchers to manufacture some distance between themselves and the data. Particularly in behavioral sciences, researchers sometimes care emotionally or intellectually about the topic
they have chosen to study. Being too close to the subject in this way can be a threat to validity. Thus, it becomes important to manufacture distance. This is like the expression: “Can’t see the forest for the trees.” In other words, being too close to the subject sets up the potential that if too close, researchers see what they expect or want to see. One way of manufacturing distance is through reviewing literature, which amounts to taking a careful look at the subject through others’ perspectives, and from a distance. Additionally, in this case the researcher has not worked extensively with this population for two years, which is another effective way to manufacture distance. The researcher had no personal connection to any of the interviewees or school systems.

Another threat to validity can be the investigator - respondent relationship (McCracken, 1988). For example, interviewees make assumptions about what the interviewer wants to hear based on such things as institutional affiliation, project description, mode of dress, patterns of speech, and mannerisms. Therefore, as McCracken (1988) suggests, as much neutrality as possible in controllable aspects such as project description was maintained.

There is a debate within the subject of qualitative interview methods over whether to make the interviewee a collaborator in the search for useful data or not (McCracken 1988). One side of the debate would say that it is better for the interviewee to know the research goals so she or he can help fill them. The other side of the debate would point out that interviewees want to be helpful, and like being interviewed. Based on these tendencies, the interviewee may distort the data in efforts to please. However, in this study only professionals were interviewed, so in opening statements and the project description, interviewees were made aware of the research goals. In this case, this action enhanced rather than detracted from validity, and served to more clearly pinpoint the data sought.

Reliability and validity of interview data were increased by asking interviewees to review interviewer summaries of their interview. The interviewer frequently summarized
or repeated back aspects of the interview to check for understanding. At the end of each interview, the interviewer summarized the most important points and the qualities of the counselor's work. The counselor was then asked to check their agreement with the characterization. Particular attention was paid to getting a correct understanding of treatment aspects in successful case examples. These summary checks served reliability by, in effect, asking the interviewee, "Now that you hear back what you said, is it what you meant to say? Would these statements stand the test of time?" These summary checks served validity by, in effect, asking the interviewee, "This is what I heard you say. Have I understood you correctly?"

In-person interviews were recorded. Phone interviews were not. Whether recorded or not, the interviewer rewrote notes and wrote any further impressions immediately after each interview. This process varied in length from one and one-half to two hours. The reason for this immediate review was to ensure as much accuracy and completeness to interview data as possible.

**Interview data analysis:**

Interview data are comprised of written notes made during the interview, notes on both content and interviewer thoughts and impressions written immediately after the interview, and recordings of the interviews that were done in person. Interview findings consist of 1) themes that run through interview data, 2) comparisons and contrasts of between data of interviewees, 3) agreement or contradiction of interview data with survey data or review of literature data, and 4) case examples from interviewees successful provision of services to students with CD.
The Data Analysis and Discussion Chapter details the findings. First, results from the survey portion of the project are presented. Next interview findings are presented. To protect the anonymity of survey and interview respondents, their school systems, and their students, all results are reported in composite form.

Survey Results

Respondents were elementary public school counselors in Virginia. Of the 209 surveys mailed to elementary schools in Virginia, 117 schools returned a survey, for a response rate of 56%. While 117 schools are represented in the survey, some counselors serve more than one school and were instructed to fill out one combined survey for both schools. Therefore, no single survey item has 117 separate responses. One hundred and two surveys were returned, representing the 117 schools. Survey results are reported and discussed by survey sections.

Survey Section I: Counselor Self-Ratings Related to Services to Students With CD

Survey items in this section do not directly answer but, rather shed light on answers to research question one, which asks: What services do elementary school counselors provide for students with CD? Counselors were instructed to skip this survey section if they had never had any students with CD at their school(s). Eighty-eight counselors responded to this section; 15 did not. However, the 15 not responding do not represent a
proportion of schools that have never had any students with CD. There are a variety of reasons for non-responses, including unreadable responses, accidentally skipping a page, misreading directions, or other reasons.

Item one questioned respondents' level of frustration in providing services to students with CD. Almost all respondents (91%) reported frustration in providing these services.

Item two questioned respondents' self-rating of the effectiveness of the services they provide to students with CD. Most respondents (68.2%) rated themselves as somewhat effective. However, a large minority (21.6%) rated themselves not very effective, while only a small number (5.7%) rated themselves as highly effective.

Item three prompted respondents to rate comparatively the services they provide for students from more normal populations to those for students with CD. A large majority of respondents rated the services they provide to students from more normal populations as more effective than for students with CD (87.4%), while relatively small percentages of respondents rated the services they provide to students from more normal populations as effective as for students with CD (9.2%) or less effective than for students with CD (3.4%).

Item four prompted respondents to rate comparatively the services they provide for students that are in special education programs but are not Conduct Disordered, to those for students with CD. The majority of respondents rated the services they provide to students in special education programs as more effective than for students with CD (62.5%), while smaller percentages rated the services they provide to students in special education programs as effective as for students with CD (35.2%) or less effective than for students with CD (2.3%).

Item five asked counselors to compare their services to students with CD to those provided by other counselors. This item is used for selection of interviewees only.
In summary, respondents tend to be frustrated in providing services to students with CD, consider themselves less than highly effective in providing these services, and consider themselves more effective providing services to students from more normal populations and to students in special education programs (who are not Conduct Disordered) than to students with CD. Exact percentages of survey responses for Section I are found in Table 4.1.

Survey Section II: Counselor Opinions Related to Services to Students with CD

Survey items in this section contribute to answering research question four, which asked: What are elementary school counselor opinions on providing counseling and related non-counseling services for students with CD? All counselors were asked to complete this section. Ninety-eight counselors responded to this section. Items 6.a) through 6.k) asked counselors to indicate their response to statements related to providing services to students with CD as: strongly agree, agree, disagree, or strongly disagree. For this narration, responses are collapsed into two categories: agree and disagree.
Table 4.1 - Responses to Survey Section I

Counselor Self Ratings

<table>
<thead>
<tr>
<th>Items</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of frustration:</td>
<td></td>
</tr>
<tr>
<td>- 9.1% not frustrated</td>
<td>70.5% somewhat frustrated</td>
</tr>
<tr>
<td>Effectiveness of services to students with CD:</td>
<td></td>
</tr>
<tr>
<td>- 5.7% highly effective</td>
<td>68.2% somewhat effective</td>
</tr>
<tr>
<td>Comparison of services to more normal populations:</td>
<td></td>
</tr>
<tr>
<td>- 87.4% more effective than for students with CD</td>
<td>9.2% as effective as for students with CD</td>
</tr>
<tr>
<td>Comparison of services to students in special education programs, but not Conduct Disordered, to students with CD:</td>
<td></td>
</tr>
<tr>
<td>- 62.5% more effective than for students with CD</td>
<td>35.2% as effective as for students with CD</td>
</tr>
</tbody>
</table>
Respondent opinions are as follows. The majority of respondents (65.6%) agreed with the statement: “Public schools lack the resources to provide an education to students with CD.” The majority of respondents (81.2%) agreed with the statement: “Public schools should be required to educate children with CD.” Respondent opinions ran stronger on this statement than to all but one other in the survey, with 26% strongly agreeing. The majority of respondents (59%) agreed with the statement: “Students with CD are unreasonable hindrances to the education of their schoolmates.” The majority of respondents (60.5%) disagreed with the statement: “School counselors are qualified to provide direct counseling services to students with CD.” The majority of respondents (66.6%) disagreed with the statement: “School counselors are qualified to provide parent and school consultation services for students with CD.” The majority of respondents (79.6%) agreed with the statement: “Other demands of the job of school counselors make it impossible for us to adequately provide services for student with CD.” The majority of respondents (89.5%) agreed with the statement: “Students with CD at my school need more counseling and related non-counseling services than the school is able to provide.” Respondent opinions ran stronger on this statement than any other in the survey, with 41% strongly agreeing. The majority of respondents (84.5%) disagreed with the statement: “The counseling services that I provide meet the needs of students with CD at my school.” Partly due to the fact that no respondent strongly agreed with this statement, the direction of responses to this statement is the second highest in the survey. The majority of respondents (55.3%) disagreed with the statement: “Students with CD at my school need more counseling and related non-counseling services than outside school agencies in my area provide.” This is the smallest majority for or against any statement in the survey. The majority of respondents (74.3%) agreed with the statement: “I would prefer to provide more direct counseling services to students with CD at my school, if it were possible.” Lastly, the majority of respondents (73.2%) disagreed with the statement: “Ideally, the
school counselor, not counselors or psychologists from outside school agencies, should be the provider of counseling services for students with CD.”

The following opinion contrasts are important to note. 1) The typical respondent would agree that school counselors are qualified to provide parent and school consultation services to students with CD. Yet they also agree that they are not qualified to provide direct counseling to students with CD, that the services they provide do not meet the needs of students with CD at their school, and that ideally counselors or psychologists from outside school agencies should be the primary providers of services for students with CD. Summarizing these opinions, school counselors are qualified to provide consultation, but not direct counseling services, or at least not as well as a counselor or psychologist from an outside school agency. 2) The typical respondent would agree that public schools lack the resources to provide an education to students with CD. Yet public schools should be required to educate children with CD. 3) The typical respondent would agree that school counselors are qualified to provide parent and school consultation services for students with CD, and would prefer to provide more direct counseling services to students with CD, if it were possible. Yet other demands of the job of school counselors make it impossible for them to adequately provide services for students with CD. 4) The typical respondent would agree that school counselors are not qualified to provide direct counseling services to students with CD. Yet they would prefer to provide more direct counseling services to students with CD, if possible. Exact percentages of survey responses for Section II are found in Table 4.2.
<table>
<thead>
<tr>
<th>STATEMENTS:</th>
<th>tend to strongly agree</th>
<th>tend to agree</th>
<th>tend to disagree</th>
<th>tend to strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Public schools lack the resources to provide an education to students with CD.</td>
<td>12.5%</td>
<td>53.1%</td>
<td>28.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>b) Public schools should be required to educate children with CD.</td>
<td>26%</td>
<td>55.2%</td>
<td>17.7%</td>
<td>1%</td>
</tr>
<tr>
<td>c) Students with CD are unreasonable hindrances to the education of their schoolmates.</td>
<td>15.8%</td>
<td>43.2%</td>
<td>37.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>d) School counselors are qualified to provide direct counseling services to students with CD.</td>
<td>4.2%</td>
<td>35.4%</td>
<td>56.3%</td>
<td>4.2%</td>
</tr>
<tr>
<td>e) School counselors are qualified to provide parent and school consultation services for students with CD.</td>
<td>8.3%</td>
<td>58.3%</td>
<td>32.3%</td>
<td>1%</td>
</tr>
<tr>
<td>f) Other demands of the job of school counselors make it impossible for us to adequately provide services for students with CD.</td>
<td>24.5%</td>
<td>55.1%</td>
<td>17.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>g) Students with CD at my school need more counseling and related non-counseling services than the school is able to provide.</td>
<td>41.1%</td>
<td>48.4%</td>
<td>9.5%</td>
<td>1.1%</td>
</tr>
<tr>
<td>h) The counseling services that I provide meet the needs of students with CD at my school.</td>
<td>0%</td>
<td>15.5%</td>
<td>74.2%</td>
<td>10.3%</td>
</tr>
<tr>
<td>i) Students with CD at my school need more counseling and related non-counseling services than outside school agencies in my area provide.</td>
<td>11.7%</td>
<td>33%</td>
<td>47.9%</td>
<td>7.4%</td>
</tr>
<tr>
<td>j) I would prefer to provide more direct counseling services to students with CD at my school, if it were possible.</td>
<td>12.4%</td>
<td>61.9%</td>
<td>24.7%</td>
<td>1%</td>
</tr>
<tr>
<td>k) Ideally, the school counselor, not counselors or psychologists from outside school agencies, should be the provider of counseling services for students with CD.</td>
<td>5.2%</td>
<td>21.6%</td>
<td>48.5%</td>
<td>24.7%</td>
</tr>
</tbody>
</table>
Survey item seven asks counselors to name the top three things needed by their school to provide more effective services to students with CD. Open-ended responses were sorted into nine categories. Ninety-six counselors responded to this item, totaling 262 responses. In this narration, response categories are in order from most to least frequently stated. Sixty counselors (68.4%) said that additional training for themselves [counselors] concerning services to students with CD was needed. Forty-seven counselors (52%) said that more counselor time needed to be available to serve students with CD. Thirty-eight counselors (44.7%) said that more counseling and related services from outside agencies were needed. Thirty-seven counselors (42.8%) said that changes in overall school discipline and related policies were needed. Thirty-one counselors (35.4%) said that additional cooperation and involvement from parents of students with CD were needed. Twenty-seven counselors (30.9%) said that additional training for teachers regarding the educating of students with CD was needed. Eleven counselors (12.9%) said that increased willingness and time for overall school staff to be involved in providing services to students with CD were needed. Nine counselors (10.6%) said that special classes to include students with CD were needed. Lastly, two counselors (2.4%) said that additional training for school administrators related to providing educational services to students with CD was needed. A listing of response categories, numbers of respondents and percentages in each category is found in Table 4.3. Survey items eight and nine were used for interviewee identification purposes only.
Table 4.3 - Responses to Survey Item Seven

Needs of Counselors and Schools to Provide More Effective Services to Students with CD

<table>
<thead>
<tr>
<th>Response Categories (in order of most to least frequent):</th>
<th># of counselors responding in this category:</th>
<th>% of counselors responding in this category:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional training for counselors, concerning provision of services to students with CD</td>
<td>60</td>
<td>68.4%</td>
</tr>
<tr>
<td>Additional counselor time available to serve students with CD</td>
<td>47</td>
<td>52%</td>
</tr>
<tr>
<td>Additional counseling and related services for students with CD from outside agencies</td>
<td>38</td>
<td>44.7%</td>
</tr>
<tr>
<td>Changes in overall school discipline and related policies</td>
<td>37</td>
<td>42.8%</td>
</tr>
<tr>
<td>Additional cooperation and involvement from parents of students with CD</td>
<td>31</td>
<td>35.4%</td>
</tr>
<tr>
<td>Additional training for teachers regarding the educating of students with CD</td>
<td>27</td>
<td>30.9%</td>
</tr>
<tr>
<td>Increased willingness and time for overall school staff to be involved in providing services to students with CD</td>
<td>11</td>
<td>12.9%</td>
</tr>
<tr>
<td>Special classes to include students with CD</td>
<td>9</td>
<td>10.6%</td>
</tr>
<tr>
<td>Additional training for school administrators related to providing educational services to students with CD</td>
<td>2</td>
<td>2.4%</td>
</tr>
</tbody>
</table>
Survey Section III: School Counselor Characteristics

Survey items in this section contribute to answering research question five, which asks: What are characteristics of elementary school counselors, who have extensive time commitments in providing counseling and related non-counseling services to students with CD? All counselors were asked to complete this section; one hundred counselors did so.

Number of schools served: Seventy-seven of the one hundred respondents serve one school. Twenty-three respondents serve two schools.

Number of years as an elementary counselor: The range of years was 1 to 20, with 41.7% serving six or seven years. The mean years of service was 5.664.

Counselors' highest degree: The vast majority of respondents (92.8%) have a master's degree, while 4.1% have a bachelor's degree, and 3.1% have a doctoral degree. Subject area of highest degree was: 1) Counseling or counselor education (81.4%), 2) Education other than counseling or special education (13.4%), 3) Special education (1%), and 4) Other than above (4.1%). Response data for survey items 10 though 12 are found in Table 4.4.

Teaching experience: Most respondents (82.5%) answered that they did have teaching experience prior to counseling. Of those with teaching experience, 25.6% have high school teaching experience, 33.3% have middle school teaching experience, 70.5% have elementary school teaching experience, 7.7% have preschool, college or adult education teaching experience, 7.7% have special education teaching experience, and 98.7% have regular education teaching experience. Response data for survey item 13.a) are found in Table 4.5.
Table 4.4 - Responses to Survey Items 10 Through 12

Respondent School Assignment and Education

| Item 10: # of schools respondents' are assigned to | One school only: 77%
| | Two schools: 23%
| Item 11: respondents' years of service as an elementary school counselor | Most common numbers years of service: 6 yrs., 7 yrs.
| | Mean years of service: 5.664 yrs.
| Item 12. a): respondents' level of highest college degree | Bachelors: 4.1%
| | Masters: 92.8%
| | Doctoral: 3.1%
| Item 12. b): subject area of respondents' highest college degree | Counseling: 81.4%
| | Education (not counseling or special education): 13.4%
| | Special Education: 1%
| | Other than above: 4.1%
Table 4.5 - Responses to Survey Item 13.a)

Counselor Teaching Experience

<table>
<thead>
<tr>
<th># of respondents with teaching experience prior to elementary school counseling</th>
<th>% of respondents with teaching experience in each area:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Those with prior teaching experience: 82.5%</td>
</tr>
<tr>
<td></td>
<td>Those without prior teaching experience: 17.5%</td>
</tr>
</tbody>
</table>

Of those respondents with prior teaching experience, that experience falls in the following areas:

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage with experience in each area</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Level</td>
<td>26.5%</td>
</tr>
<tr>
<td>Middle School Level</td>
<td>33.3%</td>
</tr>
<tr>
<td>Elementary School Level</td>
<td>70.5%</td>
</tr>
<tr>
<td>Other Levels (Pre-school, college, adult)</td>
<td>7.7%</td>
</tr>
<tr>
<td>Special Education</td>
<td>7.7%</td>
</tr>
<tr>
<td>Regular Education</td>
<td>98.7%</td>
</tr>
</tbody>
</table>
School counseling experience other than elementary: Seventeen and a half percent of the respondents had counseling experience at other school levels prior to elementary school counseling. Of those with this counseling experience at other school levels, 38.9% have high school counseling experience, 76.5% have middle school counseling experience, and 11.8% (only two respondents) have college counseling experience. Response data for this survey item are also found in Table 4.6.

Counseling experience other than school: Fourteen respondents (14.7%) had counseling experience prior to elementary school counseling. They reported this counseling experience at: community/regional mental health agencies (6), a counselor or psychologist private practice (1), residential treatment centers (2), juvenile court services (3), substance abuse services (1), and other settings (3) (Department of Social Services, Child Protective Services, and the federal government). Response data for this survey item are also found in Table 4.7.

Other professional background: Only 8.4% responded that elementary school counseling is their first professional job. The following is the list of other professional jobs that the counselors had held: director of admissions, assistant principal, director of family life education, human resources manager at a state agency, piano teacher, parent, banker, coach of competitive springboard diving at a college, social worker, school psychologist.

Rating of the effectiveness of the specific preparation respondents received for providing counseling and related non-counseling services to students with CD: Most respondents (67%) rated their specific graduate school preparation as inadequate or non-existent. Additionally, 33% had had no graduate training related to providing counseling to students with CD.
Table 4.6 Response Data for Survey Item 13.b)

Respondent Counseling Experience at Other School Levels

| Percentage of respondents with counseling experience at other school levels prior to elementary school counseling | 17.5% do have counseling experience at other school levels  
| 82.5% do not have counseling experience at other school levels |
| Prior counseling at high school level | 38.9% |
| Prior counseling at middle school level | 76.5% |
| Prior counseling at college level | 11.8% |
Table 4.7 - Response Data to Survey Item 13. c)

Respondent Outside School Agency Counseling Experience

<table>
<thead>
<tr>
<th></th>
<th># of respondents with counseling experience in other settings prior to elementary school counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 14 respondents (14.7%) do have counseling experience at other settings</td>
</tr>
<tr>
<td></td>
<td>• 81 respondents (85.3%) do not have counseling experience at other settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior experience in community/regional mental health setting</th>
<th>6 respondents reported having this experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior experience in counselor or psychologist private practice setting</td>
<td>1 respondent reported having this experience</td>
</tr>
<tr>
<td>Prior experience in residential treatment center setting</td>
<td>2 respondents reported having this experience</td>
</tr>
<tr>
<td>Prior experience in foster care agency setting</td>
<td>no respondent reported having this experience</td>
</tr>
<tr>
<td>Prior experience in juvenile court services setting</td>
<td>3 respondents reported having this experience</td>
</tr>
<tr>
<td>Prior experience in substance abuse services setting</td>
<td>1 respondent reported having this experience</td>
</tr>
<tr>
<td>Prior experience in other settings (Department of Social Services, Child Protective Services, Federal Government)</td>
<td>3 respondents reported having this experience</td>
</tr>
</tbody>
</table>
Workshops specific to providing services to students with CD: Respondents rated their specific professional workshop preparation in the following ways: 41.1% of respondents do not have any such workshops available to them. Apparently these workshops would be of interest if available, since no respondents indicated that such workshops were not of interest to them. Fifty-nine percent of the respondents indicated that such workshops were available to them and rated them positively. Response data for graduate school and workshop trainings for counseling students with CD can also be found in Table 4.8.

Survey Section IV: Prevalence and Characteristics of Students with CD

While survey items in this section do not answer any one research question, they shed light on each of them. All counselors were asked to complete this section. Ninety-nine counselors responded with usable answers.

Survey item 15 asked counselors for the number of students at their school fitting the description given in the survey instructions for students with CD. Because 23% of the respondents have combined data for the two schools they serve, the number of students with CD at their school(s) is meaningless data when considered alone. However, the proportion of students with CD at respondent schools was determined by dividing the total number of students at each respondent’s school(s) into the number of students with CD at their school(s), then obtaining descriptive statistics on the resulting percentages.

This process yielded the following data. The average percentage of students with CD at respondent schools is 1.98% of the total student body. The percentage of students with CD at respondent schools ranges from zero to 9.524% of the school population at these schools. Only 12 counselors (12.1%) reported having no students with CD at their school(s).
Table 4.8 - Response Data for Survey Item 14

Counselor Ratings of the Specific Preparation Received for Providing Services to Students with CD

<table>
<thead>
<tr>
<th>Training Source:</th>
<th>Excellent</th>
<th>Adequate</th>
<th>Existent, but inadequate:</th>
<th>Non-existent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate School</td>
<td>13.4%</td>
<td>19.6%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>Professional Workshops</td>
<td>17.8%</td>
<td>41.1%</td>
<td>None available: 41.1%</td>
<td>Not of interest: no counselors responded in this way</td>
</tr>
</tbody>
</table>
Item 16 asked counselors the number of male and female students with CD at their school(s). Of the students with CD at respondent schools, there are many more boys than girls. The average percentage of males is 82.632%. The median percentage is 83.334%. It is important to note that a large percentage of respondents (36.9%) reported that 100% of the students with CD at their school(s) are male.

Item 17 asked counselors the number of students at their school(s) with CD in early elementary grades (Kindergarten - Third Grade) and in older elementary grades (Fourth grade and above). Students with CD at respondents' schools are close to evenly distributed across the elementary school grades. Of the students with CD at respondent schools, the average percentage in early elementary grades is 52.298%, and the median is 50%.

Respondent data from survey section IV can also be found in Table 4.9.

Survey Section V: Counselor Services to Students with CD

Survey items in this section contribute to answering research question one, which asks: What services do elementary school counselors provide for students with CD? Counselors were asked to skip this section if they had no students with CD at their school(s). Eighty counselors responded to this section.
Table 4.9 - Respondent Data From Survey Section IV

Prevalence and Characteristics of Students with CD at Respondent Schools

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average percentage of students with CD within overall student population:</td>
<td>1.98%</td>
</tr>
<tr>
<td>Average percentage of students with CD who are male:</td>
<td>82.63%</td>
</tr>
<tr>
<td>Average percentage of students with CD who are in early elementary grades:</td>
<td>52.298%</td>
</tr>
</tbody>
</table>
Item 19 asked counselors to rate the extent to which they provide each of a list of school counselor service activities for students with CD. The response choices were: not at all, seldom, often, and very frequent. For this narration, responses are collapsed to extensive and nonextensive amounts. Almost all counselors (85.1%) reported providing extensive amounts of individual counseling to students with CD. Most counselors (63.8%) reported providing nonextensive amounts of group counseling that includes students with CD. Most counselors (57.7%) reported providing nonextensive amounts of counseling of peers of the students with CD. Most counselors (62%) reported providing extensive amounts of consultation with parents of students with CD. Almost all counselors (85.7%) reported providing nonextensive amounts of parent training or parent counseling groups that include parents of students with CD. Almost all counselors (93.8%) reported providing extensive amounts of consultation with teachers of students with CD. Almost all counselors (88.6%) reported providing extensive consultation with administrators regarding students with CD. Most counselors (56.4%) reported providing extensive coordination of outside school agency services for students with CD. Almost all counselors (88.5%) reported providing nonextensive amounts of special classroom presentations related to the difficulties of students with CD. Most counselors (66.3%) reported providing minimal advocacy for students with CD on important decision making committees. Only two respondents marked other in item 19. One of these respondents wrote in “working with outside resources” and rated the activity as often being provided. The other wrote in “home visits very important” and rated the activity as very frequent. In summary, the three service activities that respondents provide most extensively for students with CD are teacher consultation, individual counseling, and administrator consultation. The two provided least extensively are specialized classroom presentations related to the difficulties of students with CD and parent training/parent counseling groups. Counselor
ratings of extents of provision of service activities for students with CD can also be found in table 4.10.

Also in item 19, counselors were asked to rank the first, second, and third most important of the school counselor service activities for students with CD. Percentages of respondents ranking the activities as most important are as follows: 54.3% (38 respondents) ranked individual counseling as most important, 15.7% (11 respondents) ranked parent consultation as most important, 8.6% (6 respondents) teacher consultation, 8.6% (6 respondents) coordination of services from outside school agencies, 7.1% (5 respondents) group counseling including the student(s) with CD, 1.4% (1 respondent) counseling with peers of the student(s) with CD, 1.4% (1 respondent) parent training or parent counseling groups, 1.4% (1 respondent) administrator consultation, 1.4% (1 respondent) special classroom presentations related to the difficulties of the student(s) with CD. No counselors ranked advocacy for students with CD on important decision making committees as most important. Percentages of respondents ranking the activities as second to most important are as follows: 27.1% (19 respondents) ranked parent consultation as second most important, 25.7% (18 respondents) teacher consultation, 11.4% (8 respondents) individual counseling, 11.4% (8 respondents) advocacy for students with CD on important decision making committees, 8.6% (6 respondents) parent training or parent counseling groups, 4.3% (3 respondents) counseling with peers of the student(s) with CD, 4.3% (3 respondents) coordination of services from outside agencies, 2.9% (2 respondents) group counseling including the student(s) with CD, 2.9% administrator consultation, and 1.4% special classroom presentations related to the difficulties of the student(s) with CD. Percentages of respondents ranking the activities as third to most important are as follows: 30% (21 respondents) ranked teacher consultation as third most important, 14.3% (10 respondents) parent consultation, 12.9% (9 respondents) individual counseling, 10% (7 respondents) coordination of services from outside school agencies,
Table 4.10 - Response Data for Survey Item 19 (Part 1)

Counselor Ratings of the Extent to Which They Provide School Counselor Service Activities for Students with CD

<table>
<thead>
<tr>
<th>School Counselor Service Activities (in order from most to least extensive):</th>
<th>Response Means on Four Point Scale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Consultation</td>
<td>3.386</td>
</tr>
<tr>
<td>Individual Counseling of the student(s) with CD</td>
<td>3.225</td>
</tr>
<tr>
<td>Administrator Consultation</td>
<td>3.215</td>
</tr>
<tr>
<td>Parent Consultation</td>
<td>2.772</td>
</tr>
<tr>
<td>Coordination of services from outside school agencies</td>
<td>2.564</td>
</tr>
<tr>
<td>Counseling with peers of the student(s) with CD</td>
<td>2.333</td>
</tr>
<tr>
<td>Group Counseling, including the student(s) with CD</td>
<td>2.238</td>
</tr>
<tr>
<td>Advocacy for students with CD on important decision making committees</td>
<td>2.091</td>
</tr>
<tr>
<td>Parent Training or Parent Counseling Groups</td>
<td>1.623</td>
</tr>
<tr>
<td>Specialized Classroom Presentations, related to the difficulties of the student(s) with CD</td>
<td>1.577</td>
</tr>
</tbody>
</table>
8.6% (6 respondents) administrator consultation, 7.1% (5 respondents) counseling with peers of the student(s) with CD, 4.3% (3 respondents) group counseling including the student(s) with CD, 4.3% (3 respondents) parent training or parent counseling groups, 4.3% (3 respondents) special classroom presentations related to the difficulties of the student(s) with CD, and 4.3% (3 respondents) advocacy for students with CD on important decision making committees. Survey response data for the rank of importance portion of item 19 can also be found in Table 4.11.

Survey item 20 asked counselors who devote some of their time to direct counseling of students with CD to number the top three from a list of terms that may describe their counseling. Seventy-four counselors responded to this item. By far the largest group of respondents (27%, 20 respondents) selected behavior skills training as the term most descriptive of their direct counseling of students with CD. Groups of respondents selecting other terms as most descriptive of this direct counseling are smaller and closer to each other in size. The sizes of the groups selecting these other terms are as follows: 17.6% (13 respondents) behavior modification, 12.2% (9 respondents) advising on right and wrong behaviors, 9.5% (7 respondents) advising on consequences of behaviors, 9.5% (seven respondents) play therapy oriented counseling, 9.5% (7 respondents) Rogerian child-centered counseling, 5.4% (4 respondents) cognitive skills training, 5.4% (4 respondents) Reality Therapy, and 4.1% (3 respondents) cognitive counseling.
Table 4.11 - Response Data for Survey Item 19 (Part 2)

Counselor Rankings of First, Second, and Third Most Important Service Activities for Students with CD

<table>
<thead>
<tr>
<th>School Counselor Service Activities:</th>
<th>Rank by % of respondents ranking as most important</th>
<th>% of respondents ranking as most important</th>
<th>Rank by % of respondents ranking as 2nd most important</th>
<th>% of respondents ranking as 3rd most important</th>
<th>Rank by % of respondents ranking as 3rd most important</th>
<th>% of respondents ranking as 3rd most important</th>
</tr>
</thead>
<tbody>
<tr>
<td>individual counseling</td>
<td>1st</td>
<td>54.3%</td>
<td>3rd</td>
<td>11.4%</td>
<td>3rd</td>
<td>12.9%</td>
</tr>
<tr>
<td>group counseling</td>
<td>5th</td>
<td>7.1%</td>
<td>8th</td>
<td>2.9%</td>
<td>7th</td>
<td>4.3%</td>
</tr>
<tr>
<td>counseling peers</td>
<td>6th</td>
<td>1.4%</td>
<td>6th</td>
<td>4.3%</td>
<td>6th</td>
<td>7.1%</td>
</tr>
<tr>
<td>parent consultation</td>
<td>2nd</td>
<td>15.7%</td>
<td>1st</td>
<td>27.1%</td>
<td>2nd</td>
<td>14.3%</td>
</tr>
<tr>
<td>parent training</td>
<td>6th</td>
<td>1.4%</td>
<td>5th</td>
<td>8.6%</td>
<td>7th</td>
<td>4.3%</td>
</tr>
<tr>
<td>teacher consultation</td>
<td>3rd</td>
<td>8.6%</td>
<td>2nd</td>
<td>25.7%</td>
<td>1st</td>
<td>30%</td>
</tr>
<tr>
<td>administrator consultation</td>
<td>6th</td>
<td>1.4%</td>
<td>6th</td>
<td>2.9%</td>
<td>5th</td>
<td>8.6%</td>
</tr>
<tr>
<td>coordination of outside services</td>
<td>3rd</td>
<td>8.6%</td>
<td>6th</td>
<td>4.3%</td>
<td>4th</td>
<td>10%</td>
</tr>
<tr>
<td>specialized classroom presentations</td>
<td>6th</td>
<td>1.4%</td>
<td>10th</td>
<td>1.4%</td>
<td>7th</td>
<td>4.3%</td>
</tr>
<tr>
<td>advocacy</td>
<td>not selected</td>
<td>not selected</td>
<td>3rd</td>
<td>11.4%</td>
<td>7th</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
The largest group of respondents (27%, 20 respondents) selected advising on consequences of behavior as the term second most descriptive of their direct counseling of students with CD. Groups of respondents selecting other terms as second most descriptive of their direct counseling of students with CD are as follows: 21.6% (16 respondents) behavioral skills training, 13.5% (10 respondents) cognitive skills training, 10.8% (8 respondents) behavior modification, 8.1% (6 respondents) advising on right and wrong behaviors, 5.4% (4 respondents) Reality Therapy, 4.1% (3 respondents) play therapy oriented counseling, 4.1% (3 respondents) Rogerian child-centered counseling, 4.1% (3 respondents) cognitive counseling, and 1.4% (1 respondent) other (Solution Focused Behavior Therapy was specified).

Two terms were selected equally more often than the others by respondents as describing their direct counseling of students with CD. Advising on consequences of behaviors and behavior modification were selected by 24.7% (18 respondents). Groups of respondents selecting other terms as third most descriptive of their direct counseling of students with CD are as follows: 15.1% (11 respondents) advising on right and wrong behaviors, 12.3% (9 respondents) behavioral skills training, 6.8% (5 respondents) play therapy oriented counseling, 4.1% (3 respondents) cognitive skills training, 4.1% (3 respondents) Rogerian child-centered counseling, 4.1% (3 respondents) cognitive counseling, and 4.1% (3 respondents) Reality Therapy. Response data for survey item 20 can also be found in Table 4.12.

Survey items 21 and 22 are used to determine the percentage of work time respondents spend providing services to students with CD. Item 21 asked counselors for the amount of hours per week they spend providing direct counseling to students with CD and the amount of hours per week they spend providing indirect services to students with CD. Item 22 asked for the total number of hours that counselors work per week, so that a percentage of work time devoted to serving students with CD could be obtained.
Table 4.12 - Response Data for Survey Item 20

Top Three Terms Describing Respondents’ Direct Counseling of Students

<table>
<thead>
<tr>
<th>Terms that may describe direct counseling</th>
<th>Rank by % of respondents ranking as most descriptive</th>
<th>% of respondents ranking as most descriptive</th>
<th>Rank by % of respondents ranking as 2nd most descriptive</th>
<th>% of respondents ranking as 3rd most descriptive</th>
<th>Rank by % of respondents ranking as 3rd most descriptive</th>
<th>% of respondents ranking as 3rd most descriptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral skills training</td>
<td>1st</td>
<td>27%</td>
<td>2nd</td>
<td>21.6%</td>
<td>4th</td>
<td>12.3%</td>
</tr>
<tr>
<td>Cognitive skills training</td>
<td>7th</td>
<td>5.4%</td>
<td>3rd</td>
<td>13.5%</td>
<td>6th</td>
<td>4.1%</td>
</tr>
<tr>
<td>Advising on right and wrong behaviors</td>
<td>3rd</td>
<td>12.2%</td>
<td>5th</td>
<td>8.1%</td>
<td>3rd</td>
<td>15.1%</td>
</tr>
<tr>
<td>Advising on consequences of behaviors</td>
<td>4th</td>
<td>9.5%</td>
<td>1st</td>
<td>27%</td>
<td>1st</td>
<td>24.7%</td>
</tr>
<tr>
<td>Play therapy oriented counseling</td>
<td>4th</td>
<td>9.5%</td>
<td>7th</td>
<td>4.1%</td>
<td>5th</td>
<td>6.8%</td>
</tr>
<tr>
<td>Rogerian child-centered counseling</td>
<td>4th</td>
<td>9.5%</td>
<td>7th</td>
<td>4.1%</td>
<td>6th</td>
<td>4.1%</td>
</tr>
<tr>
<td>Cognitive counseling</td>
<td>9th</td>
<td>4.1%</td>
<td>7th</td>
<td>4.1%</td>
<td>6th</td>
<td>4.1%</td>
</tr>
<tr>
<td>Behavior modification</td>
<td>2nd</td>
<td>17.6%</td>
<td>4th</td>
<td>10.8%</td>
<td>1st</td>
<td>24.7%</td>
</tr>
<tr>
<td>Reality Therapy</td>
<td>7th</td>
<td>5.4%</td>
<td>6th</td>
<td>5.4%</td>
<td>6th</td>
<td>4.1%</td>
</tr>
<tr>
<td>Other (Solution Focused Therapy)</td>
<td>not selected</td>
<td>not selected</td>
<td>10th</td>
<td>1.4%</td>
<td>not selected</td>
<td>not selected</td>
</tr>
</tbody>
</table>
The average number of hours per week that respondents spend providing direct counseling to students with CD is 3.413. The maximum number of hours per week spent providing direct counseling to students with CD is 15. The median is 2.25 hours. Seven respondents reported spending no hours providing direct counseling to students with CD. It is important to remember that counselors were asked to skip this section if they have no students with CD. Therefore, all responses should represent counselors who have students with CD in their case loads.

The average number of hours per week that respondents spend providing indirect services to students with CD is 3.539. The maximum number of hours per week spent providing indirect counseling to students with CD is 20. The median is 2 hours. Eight respondents reported spending no hours providing indirect services to students with CD.

The average total number of hours per week that respondents spend providing services to students with CD is 6.951. The maximum total number of hours per week spent providing services to students with CD is 27.5. The median is 5.5. About half that time is direct counseling. Five respondents reported spending no hours providing services to students with CD.

The average percentage of respondent time spent providing counseling and closely related non-counseling services to students with CD is 18.51%. The maximum percentage of respondent time spent providing counseling and closely related non-counseling services to students with CD is 71.428%. The median is 14.643%. Five respondents reported spending no percentage of their time providing counseling and closely related non-counseling services to their students with CD. Response data for survey items 21 and 22 can also be found in Table 4.13.
### Table 4.13 - Response Data for Survey Items 21 and 22

**Respondent Time Serving Students with CD**

<table>
<thead>
<tr>
<th>Respondent time serving students with CD</th>
<th>Average amount per week</th>
<th>Median amount per week</th>
<th>Maximum amount per week</th>
<th>Minimum amount per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct counseling hours</td>
<td>3.412 hours</td>
<td>2.25 hours</td>
<td>15 hours</td>
<td>0 hours (seven respondents reported 0)</td>
</tr>
<tr>
<td>Indirect service hours</td>
<td>3.539 hours</td>
<td>2 hours</td>
<td>20 hours</td>
<td>0 hours (eight respondents reported 0)</td>
</tr>
<tr>
<td>Total service hours</td>
<td>6.951 hours</td>
<td>5.5 hours</td>
<td>27.5 hours</td>
<td>0 hours (five respondents reported 0)</td>
</tr>
<tr>
<td>Percentage of work hours spent providing counseling and closely related non-counseling services</td>
<td>18.51%</td>
<td>14.643%</td>
<td>71.428%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Survey Section VI: Characteristics of the Work Setting

Survey questions in this section contribute to answering research question five, which asks: What are characteristics in the settings of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD? All counselors were asked to complete this section. One hundred counselors contributed usable responses to this section.

Survey item 23.a) asked counselors if any outside agencies provide counseling or closely related non-counseling services to students with CD at their school. These outside services are provided at 83.2% of respondents’ schools.

Item 23.b) asked counselors which types of agencies provide these services to students with CD at their school(s). The percentages for agency types providing services to students with CD at respondent schools are as follows: 88.6% (70 respondents) community/regional mental health center, 73.4% (58 respondents) counselors or psychologists in private practice, 34.2% (27 respondents) residential treatment centers, 17.7% (14 respondents) foster care agencies, 26.6% (21 respondents) juvenile court services, 7.6% (6 respondents) other. In the other category, departments of social services were specified three times. Assessment centers, child psychologists, and YMCA were each specified once. Respondent data for survey item 23.b) can also be found in Table 4.14.
Table 4.14 - Response Data for Survey Item 23.b)

Types of Agencies Providing Services to Students with CD at Respondent Schools that Receive Services for Students with CD from Outside School Agencies

<table>
<thead>
<tr>
<th>Agency types</th>
<th>Percentages of respondents reporting that their school(s) receive counseling or closely related non-counseling services for students with CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Regional mental health centers</td>
<td>88.6% (70 respondents)</td>
</tr>
<tr>
<td>Counselors or Psychologists in private practice</td>
<td>73.4% (58 respondents)</td>
</tr>
<tr>
<td>Residential treatment centers</td>
<td>34.2% (27 respondents)</td>
</tr>
<tr>
<td>Foster care agencies</td>
<td>17.7% (14 respondents)</td>
</tr>
<tr>
<td>Juvenile court services</td>
<td>26.6% (21 respondents)</td>
</tr>
<tr>
<td>Other - Specified agencies are: Departments of Social Services (specified 3 times), Assessment Centers, Child Psychiatrists, and YMCA (each specified once).</td>
<td>7.6% (6 respondents)</td>
</tr>
</tbody>
</table>
Item 23.c) asked counselors which counseling and closely related non-counseling services are provided to students with CD at their school(s) by the outside school agencies. The percentages of types of services being provided to students with CD at respondent schools that receive services by outside agencies are as follows: 96.2% direct child counseling, 16.7% education of school personnel, 41% consultation with teachers, 43.6% consultation with school administrators, 87.2% family counseling, 29.5% attending school decision making committees, 24.4% child advocacy, 33.3% coordination of services from other agencies, and 2.6% other. Two respondents answered other. One of these two respondents specified after school day care and one specified recreation. Respondent data from survey item 23.c) can also be found in Table 4.15.

Survey item 23.d) asked counselors to rate the adequacy of counseling or closely related non-counseling services provided by outside agencies for students with CD at their school. The scale of rating selections is: 1) adequately fill the needs of our students with CD for counseling and related services, 2) fill almost all the needs of our students with CD for counseling and related services, 3) fill only some of the needs of our students with CD for counseling and related services, 4) fill very few of the needs of our students with CD for counseling and related services. The mean rating given by respondents with services provided to students with CD at their school(s) by outside school agencies is 2.826. The median and mode rating is three. Thus, respondent ratings tend toward negative evaluation (in this case negative evaluations were coded with higher numbers) of services provided by outside school agencies for students with CD. Respondent data from item 23.d) can also be found in Table 4.16.
Table 4.15 - Response Data for Survey Item 23.c)

Types of Services Provided to Students with CD at Respondent Schools that Receive Services from Outside Agencies for Students with CD

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Percentages of respondents reporting that their school(s) receive outside services for students with CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling and related non-counseling services</td>
<td>96.2% (75 respondents)</td>
</tr>
<tr>
<td>Direct child counseling</td>
<td>96.2% (75 respondents)</td>
</tr>
<tr>
<td>Education of school personnel</td>
<td>16.7% (13 respondents)</td>
</tr>
<tr>
<td>Consultation with teachers</td>
<td>41% (32 respondents)</td>
</tr>
<tr>
<td>Consultation with school administrators</td>
<td>43.6% (34 respondents)</td>
</tr>
<tr>
<td>Family counseling</td>
<td>87.2% (68 respondents)</td>
</tr>
<tr>
<td>Attending school decision-making committees</td>
<td>29.5% (23 respondents)</td>
</tr>
<tr>
<td>Child advocacy</td>
<td>24.4% (19 respondents)</td>
</tr>
<tr>
<td>Coordination of services from other agencies</td>
<td>33.3% (26 respondents)</td>
</tr>
<tr>
<td>Other (after school day care and recreation were specified)</td>
<td>2.6% (2 respondents)</td>
</tr>
</tbody>
</table>
Table 4.16 - Response Data for Survey Item 23.d)
Ratings of Services Provided by Outside School Agencies by Respondents Who Report that Their School(s) Receive Services from Outside School Agencies to Students with CD

<table>
<thead>
<tr>
<th>Ratings:</th>
<th>Percentages of respondents selecting each rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequately fill the needs of our students with CD for counseling and related services</td>
<td>11.6% (8 respondents)</td>
</tr>
<tr>
<td>Fill almost all the needs of our students with CD for counseling and related services</td>
<td>8.7% (6 respondents)</td>
</tr>
<tr>
<td>Fill only some of the needs of our students with CD for counseling and related services</td>
<td>65.2% (45 respondents)</td>
</tr>
<tr>
<td>Fill very few of the needs of our students with CD for counseling and related services</td>
<td>14.5% (10 respondents)</td>
</tr>
</tbody>
</table>
Survey item 24.a) asked counselors for the number of students with CD at their school(s) that are in Special Education programs. Each respondent's answer to this item was divided by the total number of students with CD at their school(s) to derive the percentage of students with CD at respondent schools that are in Special Education programs. The mean percentage of students with CD in Special Education programs at respondent schools is 38.272%. The median is 40%. Sixteen respondents reported that none of their students with CD are in Special Education programs.

Item 24.b) asked counselors for the percentages of students with CD who are in Special Education programs, with primary placement in each area of disability. The average percentages of primary placements of students with CD who are in Special Education programs at respondent schools are as follows: 43.746% Learning Disabled, 41.682% Severely Emotionally Disturbed, 5.258% Developmentally Delayed, 7.22% Other Health Impaired, 4.978 Mentally Retarded. Thus, most students with CD who are in Special Education programs have primary placements of Learning Disabled or Severely Emotionally Disturbed. Response data from survey item 24.a) and 24.b) can also be found in Table 4.17.
Table 4.17 - Response Data for Survey Items 24.a) and 24.b)

Special Education Placements of Students with CD

<table>
<thead>
<tr>
<th>Percentage of students with CD in Special Education programs</th>
<th>38.272%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areas of Disabilities</td>
<td>Average percentages of primary placements of students with CD who are in Special Education programs at respondent schools</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>43.746%</td>
</tr>
<tr>
<td>Serious Emotional Disturbance</td>
<td>41.682%</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>5.258%</td>
</tr>
<tr>
<td>Other Health Impairment</td>
<td>7.22%</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>4.978%</td>
</tr>
</tbody>
</table>
Survey item 25.a) asked the counselors if their school systems have elementary, alternative education programs that include students with CD. Twenty-three percent (23 respondents) of the respondents reported that their school systems do have such programs. Item 25.b) asked the counselors whose school systems have such a program if the program is housed at their school. Thirteen percent (3 respondents) of these respondents affirmed that it was. Item 25.c) asked counselors whose school systems have such a program if counselors are employed specifically for this program. To this question, 27.8% (5 respondents) of these respondents affirmed that counselors were employed for this program. Of the five respondents with these alternative education programs that employ additional counselors, one reported the program having a half-time counselor, two reported the program having one counselor, and one reported the program having three counselors. Response data for item 25 can also be found in Table 4.18.

Survey items 26 and 27 asked counselors how many full and part time counselors are employed by their school(s). Answers to these items were combined to determine the total number of counselors employed by their schools. The mean number of counselors employed by respondent schools is .918. The median is one.

Survey item 28 asked counselors to describe their school(s) as rural, suburban, or urban. To this question, 57% of the respondents described their school(s) as rural, 25% as suburban, and 18% as urban.
Table 4.18 - Response Data for Survey Item 25

Existence of Alternative Education Programs that Include Students with CD

<table>
<thead>
<tr>
<th>Percentage of respondents reporting that their school system has an alternative education program that includes elementary school students with CD</th>
<th>23% (23 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of respondents, whose system has such a program, reporting that this program is housed at their school</td>
<td>13% (3 respondents)</td>
</tr>
<tr>
<td>Percentage of respondents, whose system has such a program, reporting that counselors are employed specifically for this program</td>
<td>27.8% (5 respondents)</td>
</tr>
</tbody>
</table>
| Number of counselors employed by above programs | • 1 respondents reported .5 counselor employed  
• 3 respondents reported 1 counselor employed  
• 1 respondent reported 3 counselors employed |
Survey Section VII: Additional Comments by Respondents

All counselors were asked to complete this section. Only 33 counselors responded to this section. This final section included only one question. Survey item 29 asked counselors to make any additional comments they feel would be helpful to create understanding of their work or that of other elementary school counselors in providing counseling and related non-counseling services to students with CD. Counselor responses were coded into six categories. The categories, numbers of counselors responding in each, and some example statements in each category follow. Answers given in this section were, at least in part, already covered by other survey questions, but the 33 respondents restated the answers.

Sixteen counselors responded in category 1: General Frustration with the Problem of CD and Self-Criticism. Exemplary comments from this category are: “Filling out this survey has made me think I could/should do so much more.” “There is so much we [school counselors] can’t/don’t do.” “Conduct Disorder is a very complex problem.” “It is very difficult to bring about change in students with CD.” “I felt hopelessly inadequate [in providing services to students with CD] until our in-house school psychologist took over our cases of students with CD.”

Two counselors responded in category 2: Frustration with Staff Reaction to Students with CD. An exemplary comment from this section is: “Our school creates Conduct Disorder in students that have early tendencies toward CD through inconsistent school responses and inflexible teacher attitudes.”

Three counselors responded in category 3: Unhappiness with Lack of Outside School Agency Services for Students with CD. An exemplary comment from this category is: “I feel isolated, all alone in attempting to help students with CD.”

Two counselors responded in category 4: Frustration with Parents of Students with CD. Exemplary comments from this category are: “Parents are an essential part of the
problems and any solutions for students with CD.” “Cooperation of parents of students with CD is very difficult or impossible to obtain.” “Parents of students with CD are sometimes mentally ill.” “Parents of students with CD often will not follow through when a referral is made for them or their child.”

Four counselors responded in category 5: Additional Treatment Actions Taken. Treatment actions listed in this category are: social skills training, teacher support, “cool off” time, and peer mediation.

Six counselors responded in category 6: Other. The large variety of responses in this category are summarized as follows: Two counselors noted that they have observed and expect continued increasing numbers of students with CD. Two counselors noted that because they are told they are not therapists, it was difficult to answer many survey questions. One counselor noted that meeting regularly with other counselors to discuss cases of difficult students was helpful. One counselor noted that the nurturing nature of a small school was helpful in bringing about positive changes for students with CD. Response data for survey item 29 can also be found in Table 4.19.
Table 4.19 - Response Data for Survey Item 29

Additional Comments Offered by Respondents

<table>
<thead>
<tr>
<th>Categories of Respondent Comments</th>
<th>Number of Respondents with Comments in Each Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized frustration with problems providing services to students with CD and/or self criticism</td>
<td>16</td>
</tr>
<tr>
<td>Frustration with staff reactions to students with CD</td>
<td>2</td>
</tr>
<tr>
<td>Unhappiness with lack of outside school agency services to students with CD</td>
<td>3</td>
</tr>
<tr>
<td>Frustration with parents of students with CD</td>
<td>2</td>
</tr>
<tr>
<td>Additional treatment actions taken</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>
Interview Results

Interviewees were six elementary school counselors in Virginia identified by their peers as more effective than usual in providing services to students with CD. Each interviewee responded to eight subtopics related to the counseling and closely related non-counseling services they provide to students with CD. In this section, interviewees are introduced with some background information about their work. Then, interviewee responses to each of the eight subtopics are discussed. Then, pervasive qualities of interviewees’ work in providing counseling and closely related non-counseling services to students with CD are discussed.

Introduction of Interviewees

The interviewees have a variety of amounts of experience, ranging from 1 to 11 years as elementary school counselors. Five interviewees had previous teaching experience. For one, school counseling was her first professional job. Five interviewees serve rural school systems. One of those rural school systems is about an hour from one of Virginia’s largest urban areas. One interviewee serves a suburban to urban school system, which surrounds one of the state’s largest urban areas. Three of the interviewees seem to have moderate amounts of services for students with CD from outside school agencies. Two seem to have very limited amounts of services for students with CD from outside school agencies. One interviewee seems to have relatively high amounts of these services. Four interviewees serve kindergarten through fifth-grade students. One serves kindergarten through seventh grade students. One serves pre-kindergarten through third grade students. One interviewee serves third through fifth grade students. Five interviewees serve one school. One interviewee serves two. All six interviewees serve schools with populations of about 500 to 600. The interviewee who serves two schools, serves about 200 students at her second school. Five of the interviewees’ estimates of the
percentage of students with CD in their school populations range from about 1% to 3%.

Three interviewees rated themselves as somewhat frustrated, and two as highly frustrated.

Four interviewees rated themselves as somewhat effective, and one as not very effective.

One interviewee rated herself as both highly effective and not frustrated.

**Subtopic One: Illustrative and Successful Case Examples**

At some point in each interview, each interviewee told one to three illustrative case examples in which counseling and closely related non-counseling services were successfully provided to a student with CD. A total of 10 successful cases were related. While the counselors were as accurate as possible in relating the cases, they were careful not to give any information that would identify students. Analyses of interviewee case examples follow.

**Theme One -- Coordination of Services Between Agencies and Between School Adults:**

One theme running through many of the successful case examples is coordination of services between agencies and among school adults. In one case, the student with CD was receiving individual counseling from an outside school agency counselor. This agency counselor communicated her understanding of the student to the school counselor. This understanding was that the student did not perceive the school as a safe place. Rather, he perceived that school adults were all against him. From this understanding, the school counselor and principal coordinated an aspect of the treatment plan in which heroic efforts were made to ensure that the student perceived the school as a nurturing environment, characterized by all school adults taking appropriate opportunities to hug the student, praise small positive behaviors, and ignore any misbehaviors they could. It was important to have all school adults involved in this aspect of the treatment plan, because a single negative interaction carried much more weight in the student’s mind than many positive interactions. Other examples of coordinated services included: a school counselor
coordinating with the school office staff and a parent of the student with CD to allow the student to call the parent as often as each hour in order to calm the student’s anxieties, and another school counselor coordinating with a kindergarten teacher to build a special friendship relationship with a fifth-grade student with CD.

One case example stood out because of the lack of coordination of services with persons other than the school counselor. In this case, the principal and teacher of the student with CD were reluctant to participate in coordinated treatment plans. So, the counselor proceeded with only minimal assistance from them. The school counselor built a relationship with the student through Child-Centered individual counseling and attempted to teach him social skills through small group counseling experiences. This case was not as successful as the others and was ongoing at the time of interview. However, the counselor was able to report progress. After more than 15 sessions, the student began to open up to her, expressing his fears and self-perceptions. As he trusted her acceptance of him, he began to admit the fault of his actions. At this point, the counselor expected to be able to begin cognitive-behavioral problem solving and expected positive behavior changes to follow soon.

Theme Two -- School to Home Communication:

School to home communication is also a theme that runs through many of the reported successful cases. In several instances, school adults called home with daily reports of the behavior of the student with CD. In one case, the counselor and teacher decided to make only positive reports home. That way the student was aware of the communication. Yet, because the reports were only positive, they had the effect of changing the pattern of negative parent-child interactions. Additionally, the student looked forward to his parent’s reactions to being told of his successes and worked to increase his successes.
Theme Three -- Unique Treatment Interventions:

Many of the cases involved seemingly unique treatment interventions. In one case, a last resort negative consequence was for the teacher and other students in the class to leave the tantruming student with CD alone in the class to finish the tantrum. When this took place, a school adult stayed behind to make sure the student with CD was not at risk of harming himself or valuable property. This action was only taken when the student could not be safely removed for time out. This action was only needed on a few occasions.

In another unique intervention, the counselor decided to treat a whole class that contained two students with close to CD behaviors, as a major part of the treatment plan for the students with CD. The whole class, often led by the two students with CD behaviors, spent most of their time in conflict. The teacher did not normally have difficulty controlling classroom behavior. In the treatment, the counselor took half the class onto the playground for unstructured play, while the teacher kept the other half. The initial division was made by gender. The procedure was followed three times per week, 10 minutes per each half of the class. During this time the students were allowed unstructured play, under the counselors' supervision. When conflicts naturally occurred during this time, the counselor helped the students evaluate their actions and the conflict. She led their evaluation with two basic questions: “Is what you are doing [to or with] your classmate(s) working?” and “Decide something else to do.” If conflict became aggressive before the counselor could intervene or after she had intervened, the group was sent immediately back to class. This procedure was continued for six weeks in the gender groups, then for two more weeks in mixed gender groups with a different grouping each time, and then for two more weeks with the whole class, totaling 10 weeks. The counselor explained that the class, including the students with CD behaviors, learned to play cooperatively, recognize a developing conflict and choose new behaviors, trust and expect consistent consequences
from school adults. This trust and expectation generalized to all class activities. As a result, conflicts in the class and CD behaviors were greatly reduced.

In a unique and partially unintended intervention, one counselor attributed successful changes for one student with CD to his being removed from the home of a parent in which abuse was taking place. This removal was partly due to repeated reports by school officials of evidence of child abuse. The student was also transferred to another school after changing homes. The counselor explained that much of the student’s success was due to the opportunity these changes presented to start over and build new relationships.

In another case where the student with CD gained a chance to start over and build new relationships, the student gained a new principal and a teacher known to be highly persistent and caring. The counselor was trusted and respected by the student largely because she had provided individual counseling to the student, at least intermittently from kindergarten (the year in which when the student’s CD behaviors had first been recognized) to fifth grade. So when the student gained the opportunity to establish new relationships with the new teacher and principal, the counselor was in a position to successfully advise the student on how to take advantage of the opportunity.

In another unique intervention, in the above case, a student with CD was made a conflict manager of peer conflicts. The counselor had for years trained students who were already effective at resolving conflicts in their lives to assist peers in conflict resolution. When the new principal came to her school, she gained support for providing more intensive training and supervision of the student with CD and other students with some CD behaviors to manage peer conflicts. The counselor reported that by training and employing the student with CD as a conflict manager, the student with CD gained a new sense of responsibility and self-respect. He came to believe that he could be a contributing member of his society at school. He also gained opportunity to observe others lying to him about
conflict situations. With their well-developed counseling relationship, the counselor was then able to help him see the similarities and differences between how he and others acted in conflict situations. Thus, he gained a greater awareness of his CD behaviors and their effects on others. As the school showed trust in him by making him a conflict manager, he came to trust and believe in his own positive potentials.

In a final example of a unique intervention, a school counselor and classroom teacher worked together to note the behaviors, affect, and body language of a student with CD who was prone to violent tantrums, just before tantrums occurred. The counselor developed, then she and the teacher implemented, a set of questions to help him avoid tantruming. The questions were: 1) “What are you feeling?” 2) “What do you want (e.g., time to think and calm yourself, others to stop doing something)?” 3) “How can you ask for what you want?” In individual sessions, his counselor helped him learn the skills needed to answer the above questions. The counselor and teacher’s work in this process was characterized by tones of matter of fact acceptance of the student, and nurturing firmness. The counselor explained that through this aspect of the student’s treatment, the student learned to recognize when he was beginning to feel agitated, think carefully, make new decisions avoiding rage, and use words, not violence, for what he wanted. Examples of what was meant by using words, not violence, are to simply ask a peer to stop something they are doing that he disliked or to use an I statement: “I feel angry, when you tease me.”

Theme Four -- Use of Behavior Modification Plans:

Another theme running through the 10 successful case examples is the use of behavior modification plans based on frequent applications of positive and negative consequences to positive and negative behaviors. In several of these cases, frequent meant more than once per hour, especially for the positive consequences. In many of the cases
positive consequences were emphasized over negative as much as possible, because negative consequences were what the students with CD had previously learned to expect.

**Theme Five -- Use of Individual Counseling:**

In each of the 10 successful cases, individual counseling was a component. This individual counseling was often attributed with giving the counselor-student relationship the strength to allow for counselor guidance through other aspects of treatment. In many of the cases, the interviewees credited individual counseling with helping the counselor gain understandings of the student that counselors used to develop other aspects of treatment. However, it is important to note that in almost every case, counselors attributed most of the treatment success to other aspects (such as behavior modification plans, school wide changes, or pairing the student with a teacher for a special friendship relationship), rather than individual counseling.

**Theme Six -- Counselor Emotional Investment:**

While telling the successful case examples, the counselors’ emotional investment in the cases was apparent. These emotions are related to counselor empathy for the emotions and self-perceptions of the students with CD; sympathy for the home lives of students with CD, which were sometimes described as horrible; and regret for the difficulties that the students with CD sometimes pose for the counselors, the students’ peers, teachers, and other caring school adults. While relating the treatment plans, several spoke of their frustrations. One told of expressing her anger during a Child Study Team meeting regarding the lack of support she was receiving in her efforts for a student with CD. Her expression of anger seemed to motivate others to contribute more to the student’s treatment. One counselor spoke of going to visit a former student with CD to see how he was progressing, after he had transferred to another school. Another counselor described her relationship with a student with CD with whom she had worked closely with for several years as being “like a mother to her here at school.” Yet another counselor related part of
her work in successful and other cases of students with CD as “loving them, crying with them, laughing with them, and hurting with them.”

**Theme Seven -- Lengthy Amount of Time Before Achieving Success:**

The counselors’ telling of the 10 successful cases demonstrated the large amounts of time required to achieve success with students with CD. It had often taken about one school year to achieve success with which the counselor was reasonably satisfied. Even at that point, treatments were usually continued or phased out gradually in order to maintain successes. Some counselors related that, prior to the year of intensive treatment, the counselor had built a relationship with the student with CD over many years (four to five). These years of relationship building were a key ingredient to other aspects of the treatment success during the year of intensive treatment.

**Subtopic Two: Definitions of Success in Providing Counseling Services to Students with CD**

At some point each interviewee commented on how they define success in providing counseling services to students with CD. In general, they spoke of defining success in terms much lower than for students with more normal difficulty levels. The interviewees usually expressed their definitions in behavioral terms. Some of the behavioral measures of success suggested were: staying seated for one lesson at a time, earning at least passing grades, reducing - but not eliminating - the number of times the student is sent to the office or to in-school and out-of-school suspensions, and employing rational problem-solving thought patterns. The qualities of success for students with CD were defined as the student learning to trust school adults, the student gaining a reasonably positive school attitude and reasonably high self-esteem, close to normal acceptance by peers, and the counselor hearing more teacher reports of behavioral and academic improvements than failures. Many of the counselors cautioned against expecting too much
success too soon. One stated that: “gradual improvement is what counselors should look for” and “counselors may often work all year for small improvements.” Another explained that she reminds herself not to expect an outcome prompting her to exclaim, “Wow, no more problems.” Instead, she likes to see “little bits of success,” and reminds herself that “there is no magic wand.”

Subtopic Three: Most Useful Counseling or Closely Related Non-Counseling Services

During each interview, counselors commented on which of the services they provide to students with CD that they consider most useful. There was no consensus among the interviewees as to the most useful counseling or closely related non-counseling services provided to students with CD. Two interviewees cited developing and coordinating behavior modification plans as their most useful service to these students. One of these counselors asserted that it was important for these plans to be non-punitive so that they could assist the student with CD in feeling safe at school. Also, the behavior modification plans and individual counseling work best together. This is because the counselor often learns in individual counseling what students’ needs are and what would be rewarding to them. She added that individual counseling often must be done at school, by the school counselor, because parents of students with CD often do not follow through with referrals for outside counseling for themselves or their children. Another commented that the reason behavior modification plans are most useful is because they reinforce pro-social behaviors that her students with CD have often learned in small group or individual counseling.

Another counselor stated that the most useful service she provides to students with CD is her implementation of the Save One Student Program. At the beginning of each school year, she leads the faculty in identifying at-risk students. Some of the at-risk
students can be described as having CD. From the generated list, teachers select a student who is not in their class, with whom they would like to be paired as a secret special friend. Paired teachers are to do a minimum of one kind thing per week for their special friend. The school counselor instructs teachers that kind things should be creative, innovative, and/or inventive, but not expensive. Examples include a pat on the back, a pencil, a sticker, a congratulation on a fine job, and a minute of total communication between the teacher and special friend. When the at-risk student is also a student with CD, the teacher needs to provide the kindness much more often than once per week. In these cases, the counselor often makes a special request of teachers known to really enjoy and to be adept at the program to pair with the student with CD. Teacher participation is completely voluntary. Yet, the counselor explained that almost all the teachers at the school love to be involved in the program. Many of the teachers do much more for their secret friend than is required of them by the program. The counselor trains the teachers interested in the program in the beginning of the year by educating them about what the lives and self-perceptions of at risk students are often like. Consistency throughout the year is very important to the program, so she reminds participating teachers periodically. She is careful to follow-up frequently with the teachers paired with students with CD, because establishing friendships with students with CD is often difficult. The counselor explained that the program builds strong self-esteem and changes self-perceptions through the unconditional love given by teachers in the program. Other most useful services for students with CD that were suggested by interviewees were: making students with CD conflict managers, reiterating teacher expectations to students with CD, using counselor times and space as a cool-off time for students with CD prior to cognitive problem solving, and teaching acceptance and management of anger to all students in classroom guidance lessons.
Subtopic Four: Causes of CD Behaviors

During the interviews, each interviewee commented on the subtopic of causes or the development and maintenance of CD behaviors. Several interviewees began their thoughts on causes by stating their belief that CD behaviors sometimes have biological or chemical causes, but were careful to point out that this is not true of most of their cases.

Most of the interviewees attributed much of the cause of CD behaviors to difficult home life, often including forms of child abuse. One counselor characterized the home lives of students with CD as “chaotic and unsafe.” Another characterized this cause of CD behavior this way: “Many students with CD have rarely had clear rules and consequences for their home behavior.” Another commented that not only are pro-social behaviors not taught in the homes of many students with CD, but anti-social behaviors are often modeled in homes filled with family violence, drug and alcohol abuse, and child abuse, as well as modeled on the television shows that many students with CD are allowed to watch. Expanding on child abuse in the home as a cause of CD behaviors, one interviewee explained: “Emotional abuse, such as repeatedly telling a child that they are stupid or can’t do anything right, can be damaging enough to cause CD behaviors.” Another added that owing to these problematic family situations, students with CD often lack an ability to trust adults. Illustrating the connection between home and school CD behaviors, one counselor offered the following explanation: CD behaviors are often caused by repressed anger. This repressed anger is due to the perception or fact of an abusive home life. Then, if a teacher yells at a student with CD, this reminds the student of their abusive parent relationship. Self-perceptions learned in this abusive parent relationship are then reinforced. These self-perceptions translate into words like: “I’m bad,” “Everyone knows I’m no good,” and “I’ll never be good or liked.” Thoughts like these increase the student’s already high anxiety. The next chain of thoughts translate something like: “All is lost. I have no reason not to have a tantrum, no recourse but to fight/defend at all costs.”
Then the tenuous hold the student had on the pent up rage breaks, and many CD behaviors occur. All this happens in a matter of seconds or less.

Almost all the interviewees phrased parts of their explanation of causes of CD behaviors in terms of skill deficits. They explained that students with CD do not know how to self-discipline themselves to follow school rules. All students are taught school rules and consequences. However, students with CD have to also be taught such things as the connections between rules, behaviors, and consequences, to trust that their behaviors, not their persons, are punished or rewarded, and that positive consequences will occur for them when earned.

A smaller number of interviewees attributed large portions of the causes of CD behaviors to low self-esteem and negative self-perceptions. One interviewee explained, “Students with CD use outbursts to cover other emotions, negative self-perceptions, and insecurities.” Another illustrated the point by explaining that students with CD often come to school with a self-perception that translates, “I’m unloved (at home). Therefore, I’m unlovable. So school adults can’t/don’t/won’t care for me.”

**Subtopic Five: Selection of Counseling and Related Service Approaches for Students with CD**

During the interviews, each interviewee commented on their methods and reasonings in selecting treatment approaches for students with CD. Almost all the interviewees described their methods of treatment selection as conforming to the following steps. Step one is to collect information from school adults, the student with CD, and from any outside agencies involved in providing services to the student with CD. Step two is to make a group decision with school adults, the student, and any outside agencies involved. Step three is a trial and error process of attempting different sets of treatment interventions.
until an effective set is found. One counselor pointed out that it is important to listen with empathy to the student with CD and to all adults involved in the case.

Most interviewees had little to say about their reasoning in treatment selection, beyond it being a process of trial and error. However, one counselor stated her reasoning in selecting treatments for students with CD in terms of person-centered counseling theory. She explained her understanding of CD behaviors as caused by negative self-perceptions. Thus, she provides unconditional love to students through pairing the students with caring teachers for a special friend relationship emphasizing unconditional love, and through individual and small group counseling. She concluded that it is this unconditional love that changes the students’ negative self-perceptions.

Another counselor included influences from counseling theories by Virginia Axline, Carl Rogers, and Victor Frankel in her reasoning when selecting treatments for students with CD. From Virginia Axline’s theories of non-directive play therapy, this counselor learned to allow students with CD to communicate with her through their unstructured play. From Carl Rogers’ theories of person-centered counseling she learned to keep the whole student the focus of the treatment, even when the center piece of the treatment is a behavior modification plan. From writings by Victor Frankel she learned to remember to consider the question of what is meaningful to the student. She explains that answering this question to herself benefits her overall understanding of the student and helps her in developing rewards to include in behavior modification plans for the student.

**Subtopic Six: Coping with the frustration and Other Difficulties in Providing Services to Students with CD**

While one counselor stated that she was not frustrated in providing services to students with CD, frustration and other negative emotions related to providing services to students with CD were evident during discussions with almost all the interviewees. So, the
interviewer asked each counselor how they cope with these difficulties. All the interviewees mentioned using positive self-talk to cope with their personal difficulties in providing services to students with CD. Examples of positive self-statements used by these counselors are: “I’m a good counselor.” “I did the best I could today.” “I don’t have all the answers.” “Change is so hard to come by that a little step in the right direction is great.” “The fact that this student has made some progress is a tribute to him and me, considering the difficulties and complexities of the situation.” Similar to these statements, one counselor explained that she was able to keep her hope alive by believing that her work planted seeds of successful treatment that will grow later, even in cases that have so far been unsuccessful. The counselor who stated that she was not frustrated in providing services to students with CD explained that she is able to cope because of her belief that all children are succeeding to the best of their abilities.

Some of the interviewees mentioned taking actions to get their mind off of school problems when not at school, such not taking any work home and watching television shows (e.g., “Melrose Place”) and movies to escape from thinking about student difficulties.

Some of the interviewees also mentioned that it was very helpful for them to get support from friends, family, and coworkers. One counselor mentioned discussing her reactions to cases to friends and family and seeking their support. Another mentioned that her school system had begun having elementary school counselors meet at least each month for the purpose of discussing their reactions to troubling cases. She explained that this process has been helpful to her coping.
Subtopic Seven: Overall Adequacy of the Public Schools and School Counselors in Providing Services to Students with CD

Each interviewee addressed the questions: Do you think that public schools and the school counseling profession are providing all the counseling and related services to students with CD that should be? (How so? Why? What is needed?). The gist of the answer from most of the interviewees was that public schools and elementary school counselors are not providing all the services to students with CD that should be, but are providing all that they can.

Each of the interviewees addressed: What is needed to provide more effective services to students with CD? Several interviewees mentioned that more time was needed for themselves and other school counselors to focus on cases of students with CD. Two of the interviewees specified that a smaller counselor-student ratio was needed in order to have this time available. One interviewee specified that she and other school counselors needed to be required to do less clerical work to free time to focus on cases of students with CD.

Several interviewees explained that more school personnel of various professions were needed to provide more effective services to students with CD. These interviewees specified a need for school social workers to further assist families of students with CD. These interviewees also specified a need for smaller class sizes to free teacher time to focus attention on students with CD.

Several interviewees stated a need for more easily accessible outside services for students with CD. These interviewees specified that they would most want family counseling for families of students with CD and consultation regarding their own efforts to provide services to students with CD from these outside agencies.

Two interviewees stated that in-service training for teachers regarding educating students with CD in their classrooms is needed. According to these interviewees, a primary purpose of these in-service trainings would be to promote greater school-wide
acceptance of students with CD. One of these interviewees specified that this training
should include techniques for classroom management of students with CD and knowledge
that increases the teachers' empathy with students with CD.

Unlike survey respondents, no interviewees stated a need of further training for
themselves in providing counseling services to students with CD. In general, the
interviewees thought themselves well trained for providing counseling services to students
with CD.

Only one of the interviewees served more than one school. Speaking from that
experience, she explained that each school needs a full-time counselor in order for more
effective services to be provided to students with CD. She explained that the school
counselor needs to be at the school for moments of outburst common to students with CD.
Often, in these moments, the school counselor can remind the student of discussions from
personal counseling that help the student manage themself in the outburst. She further
explained that students with CD need someone to be at the school who understands them,
especially the baggage they bring from home. The student with CD needs to be able to get
to this person during or shortly after crisis moments.

Subtopic Eight: Advice to Counselors Beginning or Increasing Their Work
with Students with CD

Each interviewee was asked responded to the question: What advice might you
give to a beginning counselor with students with CD at their school or to counselors
wishing to improve their work with students with CD? Two of the interviewees responded
that they did not feel confident or competent enough to advise others in their work.

Acknowledging the difficulties of counselors providing services to students with
CD, one counselor addressed her response to the issue of counselor self-care. Her advice
was to: "Know that achieving success will be difficult" and "Develop a support system for yourself."

Other interviewees responded with suggestions of actions to take in treating students with CD. The advice from one was to involve students with CD in programs like training for and becoming conflict managers. The advice from another was to "Be stubborn enough not to give up on your commitment to children and belief that all students can mature to become useful contributors to their school and society." Another offered two pieces of advice. The first is: "Really listen and empathize. Don't tell them [students with CD] what they should and should not do. Through listening and empathy in individual counseling, and discussion of films and stories in small group counseling, lead them to find answers for themselves." The second is: "Love them. If you can't love them, at least be honest enough not to fake it." She explained that not faking it might mean finding outside counseling or other adults to love them.

**Pervasive Qualities of Interviewees’ Provision of Counseling and Closely Related Non-counseling Services to Students with CD**

Near the end of each interview, the interviewer stated his impressions of the pervasive or overall qualities of the interviewee’s provision of services to students with CD. Each interviewee then had an opportunity to correct the interviewer’s understanding. Partly because these qualities are generalizations, the qualities tend to apply equally to almost all of the interviewees. The provision of services to students with CD by all the interviewees is pervaded by a heavy emphasis on team work, whenever possible, and a strong faith that at least some success will be possible. Almost all the interviewees expressed tremendous love and caring for students with CD.

The following two descriptions of qualities of interviewees’ work with students with CD applied to specific interviewees, but also exemplified the qualities of all the
interviewees. The interviewer and interviewee in one interview agreed that the counselor had a quality of stubbornness. This stubbornness was primarily aimed at remaining child-focused, as opposed to school-, adult- or self-focused. Yet, this stubbornness is tempered with a respect for others working together to provide an education for students with CD. This respect is characterized by the counselor listening for understanding of the perspectives, thoughts, and emotions of other adults involved in cases of students with CD.

The interviewer and interviewee in another interview agreed that the counselor had a quality of tenacity. This tenacity was primarily focused on pursuing initial solutions, cooperation from other professionals, and seeking new solutions when initial solutions appear to be not effective in themselves or to be failing.
CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

This final chapter reviews answers to the study’s research questions, then makes recommendations based in the study’s findings. Summaries of answers to the research questions follow.

Summary of Answers to Research Questions

Research Question 1: What services do elementary school counselors provide for Conduct Disordered students?

Survey respondents spend about 19% of their work time providing services to students with CD. About half of this time is spent in direct counseling services and about half in indirect counseling services. Of the direct counseling activities, respondents reported that they often provide individual counseling and seldom provide group counseling to students with CD. Respondents ranked individual counseling of students with CD as the most important single service activity, while group counseling for students with CD was not highly ranked. The terms that respondents ranked as most descriptive of their direct counseling were behavioral skills training, advising on consequences of behaviors, and behavior modification.

Interviewees clarified the value of individual counseling of students with CD, explaining that the value of this individual counseling is a part of an overall treatment plan. Instead of problem solving or bringing about change directly through individual counseling, interviewees more often gain understandings of students with CD that help them design overall treatment programs for students with CD, and build rapport and relationships that allow them to advise students with CD effectively in important moments. This is an apparent contradiction of respondent emphasis on behavioral skills training, advising on consequences, and behavior modification, which allow for less observation of
client communication and relationship building than other types of individual counseling. Because interviewees were identified as more effective than usual, it seems that survey respondents may not be making optimal use of their time in individual counseling of students with CD.

About half of the 19% of work time that respondents spend providing services to students with CD is spent in indirect counseling activities. Respondents reported that they often provide teacher and administrator consultation for students with CD, and provide parent consultation less often, because parents of students with CD are often unwilling to accept this school counselor assistance. Respondents ranked teacher consultation as their most important indirect counseling service for students with CD and parent consultation as second most important. Apparently, administrator consultation is often done, but not considered to be highly important to the students with CD, while parent consultation is considered highly important but not often possible. Interviewees explained that indirect counseling services to students with CD (e.g., behavior modification plans, and coordination of services from other school adults and outside agencies) need to be combined with direct counseling and are often the most effective part of treatment plans for students with CD.

Research Question 2: What counseling services and related non-counseling services do elementary school counselors believe are not being provided for students with CD that should be provided?

Neither survey respondents nor interviewees offered many answers to what services are not provided that should be. However, counselors in this study frequently named two types of services from outside school agencies. Those services are family counseling and consultation with the school counselor regarding the services provided within the school. Additionally, one interviewee commented that most school systems do
not provide any, or near enough, opportunity for elementary school counselors to support each other by discussing difficult cases, such as those of students with CD.

However, respondents and interviewees did report that more, or more effective, services for students with CD were needed. This response was a general consensus among interviewees. Respondents agreed that public schools lack the resources to provide an education to students with CD, that more services were needed than their school is able to provide, and that neither the services they provide nor that outside school agencies provide completely meet the needs of students with CD at their schools. Respondents agreed that elementary school counselors are qualified to provide parent and school consultation services to students with CD, but are not qualified to provide direct counseling services to these students.

To the inquiry of what is needed to provide more effective counseling and related non-counseling services to students with CD, respondents and interviewees were ready with answers. Respondents agreed that other demands of the job of school counselors make it impossible for them adequately to provide services to students with CD. Confirming this, when counselors responded with open-ended answers to what is needed to provide more effective services to students with CD, additional counselor time available was the second most common response. Some interviewees also stated that more counselor time available to students with CD was needed. Several specified that a lower counselor-student ratio should accomplish this, while one specified that school counselors needed to be required to do less clerical work to free up time to provide services to students with CD.

Additional training for counselors concerning provision of services to students with CD was the most common response to this survey item. Interviewees did not confirm this need. However, because interviewees were identified as more effective than usual, this is not a contradiction.
Additional counseling and related services for students with CD from outside school agencies was the third most common response to this survey item. Interviewees confirmed this, specifying family counseling and consultation regarding the services school counselors provide as most desired services from these outside agencies. Family counseling and consultation were also specified by some survey respondents within this category of open-ended responses.

Interviewees also specified a need for in-service training for teachers regarding students with CD. Additionally, the one interviewee who served more than one elementary school explained that a full time counselor was needed at each school to be there when needed at crisis moments for students with CD.

Research Question 3: What counseling and related non-counseling services are typically provided from outside school agencies to students with CD in the public schools?

Most respondent schools receive at least some services from outside school agencies for students with CD. Community and regional mental health agencies are the most common providers of these services, followed by counselors or psychologists in private practice. By far the most common services provided by outside agencies to students with CD are direct child counseling and family counseling. Consultation was a need stated by survey respondents and interviewees. Consultation services are provided by outside school agencies to many schools regarding students with CD, but to far fewer schools than direct child counseling and family counseling. This consultation may be unsatisfactory to school counselors because the service is split among the school counselors, administrators, and teachers. Additionally, services from outside school agencies do not often include attending school decision-making committees and rarely include education of school personnel. Several respondents stated that the type of services they would like to have from outside school agencies for students with CD is collaboration.
and consultation on treatment decisions, as much or more than direct child counseling. Overall, respondents rated the set of services from outside school agencies as inadequately filling the needs of their students with CD.

**Research Question 4:** What are elementary school counselor opinions on providing counseling and related non-counseling services to students with CD?

Three opinion questions were specified corollary to research question four: 1) Would elementary school counselors prefer to provide more or less counseling and related non-counseling services for students with CD at their school? Most respondents responded that they would prefer to provide more, if possible. 2) Do elementary school counselors believe they need more training to be able and successful in providing services to students with CD? Considering that respondents stated this need most frequently when asked what was most needed to provide more effective services to students with CD, most indicated that more training is needed. 3) Do elementary school counselors believe counseling and related non-counseling services are best provided by themselves or others? Most respondents stated that counselors or psychologists from outside school agencies should be the provider of counseling services for students with CD. However, one interviewee pointed out that parents of students with CD often will not follow up on referrals for outside school services. Another interviewee explained that a school counselor needs to establish relationships with students with CD through individual counseling, then be there to utilize that relationship in times of crisis for the student. This would not be possible if a counselor or psychologist from an outside school agency was the provider of counseling services to the student.

Two other elementary school counselor opinions were sought, even though they were not specified in the research question. Respondent opinions to these items are 1) Students with CD are unreasonable hindrances to the education of their schoolmates. 2)
Yet, in spite of this and other difficulties, public schools should be required to educate children with CD.

**Research Question 5:** What are the characteristics of elementary school counselors, who have extensive time commitments in providing counseling and related non-counseling services to students with CD?

Extensive time commitments are defined as 20% or more of the counselor’s time spent providing services to students with CD. This cut-off point is slightly above the mean time commitment of 18.509%, includes roughly the upper quartile of respondents, and provides a reasonably sized set of cases to study. Counselor responses to survey items likely to indicate important differences between the total group of respondents and those with extensive time commitments were compared. The topics of those survey items are: existence of previous teaching experience or previous counseling experience, number of years of service, terms selected as most descriptive of respondents’ direct counseling of students with CD, subject of highest degree, level of highest degree, and ratings of satisfaction with graduate training or professional workshops for providing services to students with CD. None of the differences between the total group of respondents and those with extensive time commitments were found to be mathematically or practically significant. Therefore, the characteristics of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD cannot be determined from the data of this study.

**Research Question 6:** What are the characteristics of the settings of elementary school counselors who have extensive time commitments in providing counseling and related non-counseling services to students with CD?
Counselor responses to survey items likely to indicate important differences between the total group of respondents and those with extensive time commitments were compared. The topics of those survey items are: the number of students that respondents serve, the percentage of students with CD that respondents serve, the percentage of students with CD in special education programs at the respondents’ school(s), the rural to urban nature of respondents’ school(s), existence of outside agency services to students with CD at respondents’ school(s), ratings of the sets of services from these outside school agencies, and existence of alternative education programs for students with CD within respondents’ school districts. Again, none of the differences between the total group of respondents and those with extensive time commitments were found to be mathematically significant. However, there are some differences to be noted. Respondents with extensive time commitments to students with CD tend to serve far fewer suburban schools and more urban schools than the total group of respondents do. This may be explained by the higher percentage of students with CD in urban areas that is noted in current literature (APA, 1994). These respondents with extensive time commitments also tend to serve a higher percentage of students with CD (5.45% by respondents with extensive time commitments verses 1.976% by the total group of respondents). Thus, the larger number of students with CD at the schools of those with extensive time commitments at least partly explains the more extensive time commitment. It is important to note that in states with larger urban populations, the percentage of students with CD and the percentage of counselor time spent providing services to these students should be expected to be higher. Percentage comparisons for these groups can be found in table 5.1.

**Research Question 7:** What services to students with CD are provided by elementary school counselors identified as more effective than usual in providing services to these students?
This research question is broken into five smaller questions. The answers to each of these questions, based on responses from the study’s interviewees follow.

a) How do these school counselors understand the development and maintenance of CD behaviors? Interviewees attributed CD behaviors to difficult home lives, often including forms of child abuse, for many students with CD, as well as to social and behavioral skill deficits and to low self-esteem and negative self-perceptions.

b) Is this understanding important in treatment decisions? Some of the interviewees stated that they based their treatment decisions on their understanding of the causes of CD behaviors. Yet a more common response was that treatment decisions were made through group decisions with other professionals involved in the lives of students with CD, and through a process of trial and error.

c) How do these school counselors define success? In general, the interviewees defined success for students with CD in terms much lower than for students with more normal difficulty levels. Interviewees focused their responses on making progress with one small behavior at a time, and keeping expectations low.
Table 5.1 -- Comparison of Rural to Urban Settings of Schools Where ‘All Respondents’ Versus ‘Respondents with Extensive Time Commitments to Students with CD’ Serve

<table>
<thead>
<tr>
<th>Setting types of respondent schools:</th>
<th>Percentages from the total set of respondent schools in each setting type:</th>
<th>Percentages from set of respondents with extensive time commitments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>57%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Suburban</td>
<td>25%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Urban</td>
<td>18%</td>
<td>29.2%</td>
</tr>
</tbody>
</table>
d) What services do these school counselors consider most useful in producing successful outcomes for students with CD? There was no consensus among interviewees on this topic. Suggested most useful services were: developing and coordinating behavior modification plans, implementing a teacher as mentor program for students with CD, training and supervising students with CD as peer conflict managers, reiterating teacher expectations to students with CD, using counselor time and space as a cool off time for students with CD prior to cognitive problem solving, and teaching acceptance and management of anger to all students in classroom guidance lessons. While no interviewee named individual counseling as the most important service for students with CD, all interviewees noted that relationships built through individual counseling helped make other aspects of treatments for students with CD possible.

e) What do these school counselors believe would be helpful for other school counselors to provide more effective services to students with CD? Each interviewee stated what was needed to provide more effective services to students with CD. Their suggestions were: more counselor time available to serve students with CD, more school personnel from various professions available to serve students with CD (teachers and social workers were specified), more easily accessible services from outside school agencies for students with CD, and in-service training for teachers regarding educating the students with CD in their classrooms. The one interviewee who served more than one school explained that it is important for each elementary school to have a school counselor there full time to serve students with CD. Several interviewees also offered advice for other counselors beginning or increasing their services to students with CD. They advised others to: maintain good emotional self-care when working to provide services to students with CD, “be stubborn enough not to give up on your commitment to children and belief that all students can mature to become useful contributors to their school and society,” to “really listen and
empathize” with students with CD, and to “love them, hurt with them, laugh with them, and cry with them.”

Recommendations

Limitations of Conclusions and Recommendations of This Study:

Care should be taken in generalizing conclusions and recommendations from this study. The survey did not have a sufficiently high return rate to rule out errors in generalizing to all elementary school counselors. The study’s process of selecting counselors to interview who are more effective than usual in providing services to students with CD was primarily based on qualitative judgments by peers, as opposed to more exacting quantitative measures. Additionally, the small number of interviewees identified as more effective than usual is not meant to represent all elementary school counselors who are more effective than usual in providing services to students with CD. The study involved only elementary school counselors in Virginia and may not generalize to school counselors in middle and high schools or to elementary school counselors in other states. Additionally, results may not generalize to elementary school counselors’ work with populations of students other than students with CD.

Recommendations For Counselor Educators:

More training for elementary school counselors is needed regarding the development and maintenance of CD behaviors, selecting treatments based on these understandings, and most effective treatments for students with CD. This recommendation is supported by survey respondents naming additional training for themselves as the number one need for providing more effective services to students with CD, and agreeing that they would like to provide more services to students with CD, but not feeling qualified, and rating themselves as only somewhat effective and frustrated providing services to

118
students with CD, yet spending large percentages of their time providing services to these students. This training will be even more important in states with large urban populations, as those states should be expected to have higher percentages of students with CD and larger counselor time commitments to those students. Additionally, school counselors are often the professionals most available to provide services to students with CD because services for these students from outside agencies are often very limited and, as one interviewee pointed out, parents of students with CD will often not follow-up on referrals to outside school agencies when such services are available. It is important to note that the interviewees, who were selected as more effective than usual, did not identify deficits in their training for providing services to students with CD. This is an indication that it is possible for elementary school counselors to feel well prepared to provide services to students with CD.

Selecting treatments based on an understanding of the development and maintenance of CD behaviors should be a part of this training. This assertion is based on the fact that a number of the interviewees who were identified as more effective than usual described trial and error as their primary method of making treatment decisions for students with CD. Due to individual differences among students with CD, some trial and error decision making is inevitable. However, because large percentages of elementary school counselor time is spent providing services to students with CD, correct first treatment selections are preferable and would reduce frustrations of the counselors.

Training in most effective treatments for students with CD should focus on the skills of building counselor-student relationships through individual counseling. Survey respondents listed individual counseling as by far the most important counselor service for students with CD, but a service not utilized very frequently. Survey respondents agreed that school counselors are qualified to provide consultation for students with CD, but not direct counseling. Thus elementary school counselors know individual counseling is
highly important in treating students with CD, but do not always feel qualified or follow through with it. Interviewees stated the importance of counselor-student relationships built through individual counseling to other aspects of successful treatment for students with CD.

Even though services to students with CD occupy a large percentage of elementary school counselor time, group counseling of students with CD was rarely mentioned by survey respondents or interviewees. Thus, elementary school counselors may need to be better trained in ways to include students with CD in group counseling. This training should include the concept of students with CD learning to build a successful relationship with their counselor in individual counseling, then applying the new relationship skills, under counselor guidance, in small group counseling. Including students with CD in small group counseling should be expected to be difficult, due to the CD behaviors. To successfully include students with CD in small group counseling, elementary school counselors will also need training in managing abnormally anti-social behaviors in small group settings. While including students with CD in small group counseling can be expected to be difficult, it can also be expected to be highly effective. This is because the literature on children with CD indicates that often at the core of CD behaviors is a negative parent-child relationship, and hence distorted thoughts and behaviors surrounding the building of relationships. Learning to build a relationship with their school counselor, then with members of a small group, can help change distorted thoughts about human relationships and build useful skills for human relationships in students with CD.

As well as individual counseling, this training should focus on developing and coordinating behavior modification plans for students with CD. This assertion is based on the fact that interviewed counselors, identified as more effective than usual, often named this as the single most effective service for students with CD.
Methods of counselor self-care should also be included in training counselors to provide more effective services to students with CD. Almost all survey respondents rated themselves as frustrated in providing services to students with CD. Each interviewee expressed emotional involvement when working with students with CD, and many stressed the need for counselor self-care.

Finally, this training should focus on encouragement of counselors, as well as skills and knowledge. There seems to be a crisis in confidence among elementary school counselors in providing services to students with CD. Even without evidence that others were more qualified, many of the counselors involved in this study believed that other counselors or psychologists, especially those from outside school agencies, would do a better job than themselves in providing services to students with CD. Even counselors who had been identified as more effective than usual attributed more of their success with students with CD to actions by other professionals involved in the case or to indirect counseling interventions than to the direct counseling they provided. Additionally, this crisis in confidence should be addressed throughout counselor education programs, as well as when the focus is directed to providing services to students with CD. Some methods of addressing this crisis in confidence throughout counselor education programs are: increasing the use of classroom role plays, especially of difficult client situations (for example: building rapport with highly defensive clients); increasing amounts of earlier and more frequent real counseling experience (i.e., practica and counseling labs); and teaching graduate students in counseling to evaluate their work with a focus on their positive skills and acceptance of their skill deficits as part of a normal counselor development process.

Additional training for school counselors for providing more effective services to students with CD needs to take place both in graduate schools and in professional workshops. Graduate school training for providing services to students with CD was negatively rated by survey respondents. Professional workshops were more often rated as
adequate, but just as many stated that workshops were unavailable to them. These professional workshops are needed because many counselors, who are already employed either are, or perceive themselves to be, poorly trained and unqualified to provide effective services to students with CD.

Recommendations For Principals and Other Administrators of Counselors:

Administrators of counselors need to provide elementary school counselors with opportunities to discuss and support each other with difficult cases, such as those of students with CD. Unlike middle and high school counselors, almost all of the elementary school counselors in this study were the only counselor at their school(s). Few of these counselors had an opportunity, in any formalized way, to discuss and support each other through difficult cases. One interviewee had recently gained this opportunity and related how much help it was to her. This peer support would help relieve the frustration felt by elementary school counselors providing services to students with CD, reduce burn out caused by the emotional drain of providing services to students with CD, increase confidence of counselors providing services to students with CD, and facilitate sharing of effective ideas. The end result should be increased service to students with CD. Similar support should also be formalized for teachers of students with CD, as many counselors in the study expressed their concern for the emotional drain on teachers due to struggling to educate students with CD.

Principals and other administrators of elementary school counselors should arrange for in-service training at or near the worksites of counselors and teachers of students with CD, regarding providing services to students with CD. Counselors in this study identified this as a priority need for themselves and for teachers. Yet, this training is unavailable to large numbers of counselors.
Principals and administrators also need to work to provide additional school personnel so that more time can be devoted to educating students with CD. Counselors in this study would like to see a more favorable counselor-student ratio, and would like to have more of their time freed from clerical duties so that it can be devoted to providing counseling services to students with CD. One interviewee pointed out the importance of having a full-time counselor at each elementary school, to be present to intervene in times of crisis for students with CD. Counselors in this study would like to see teachers have smaller classes so that they can devote more of their time and energies to students with CD. Counselors in this study would like to have assistance from school social workers so they can accomplish more with the families of students with CD. The benefits to schools from taking these actions in support of counselors and others providing educational services to students with CD will likely include more administrator time freed from directly attending to students with CD, greater educational successes for students with CD, and a safer, more conducive learning environment for peers of students with CD.

Recommendations For Outside School Agencies:

There is a great opportunity for outside school agencies, such as community or regional mental health agencies, and counselors and psychologists in private practice to provide more services to students with CD. What counselors in this study most want is family counseling for the families of students with CD and consultation regarding their own work with these students. Because respondents and interviewees in this study explained that families of students with CD often do not follow through with referrals to outside school agencies, the most effective place for these agencies to offer family counseling or direct child counseling for students with CD may be at the schools. Consultation by outside agencies to schools regarding students with CD should include: being available to discuss school counselors’ handling of the cases of students with CD, attending school
decision making committees, consulting with teachers and administrators, and sometimes training of school personnel. While that is a lot to ask, it could lessen the numbers and severity of CD referrals to these agencies, as well as help these clients gain an education. That may be a worthwhile goal for agency counselors, as CD is one of the most commonly diagnosed childhood disorders in outpatient and inpatient mental health agencies (APA, 1994).

**Recommendations For Elementary School Counselors:**

There are two primary areas indicated by this study in which elementary school counselors should increase their skills in order to be optimally effective with students with CD. Because interviews with counselors identified as more effective than usual illuminated the value of building counselor-student relationships through individual counseling, and the extreme difficulty of building trustful relationships with students with CD, school counselors should strive to enhance their skills in this area. School counselors may already have well-developed skills for teacher and parent consultation regarding students with CD (respondents rated themselves as qualified in these skills), especially in developing and coordinating behavior modification plans. Yet, because interviewees identified this work as the single most useful type of services for students with CD, elementary school counselors should work to further increase their qualifications in this area of service.

Survey respondents indicated in many ways the difficulties of providing effective services to students with CD. Interviewees identified as more effective than usual confirmed this. Counselors are generally frustrated and self-critical of themselves in providing services to students with CD. Therefore, counselors who provide services to students with CD need to take actions to care for their emotional well being. These actions should include: positive, rational self-talk; developing support networks among peers,
friends, and family members; and partaking in activities to take their minds off the students with CD when not at work.

**Recommendations for Further Research:**

More research is needed regarding elementary school counselors providing services to students with CD. Elementary school counselors already spend large percentages of their time providing services to students with CD, and many counselors in this study reported that the number of students in their case loads is increasing. Yet, counselors in this study rated themselves as only somewhat effective at providing services to students with CD, and less effective in providing services to students with CD than to students from more normal populations or to students in special education programs who are not CD. This research should strive to pinpoint most effective elementary school counselor services for students with CD, most useful counseling theory orientations for counseling these students, and predictors of counselor effectiveness with these students from counselors’ background experiences. Because many professionals from both schools and outside agencies are often involved in providing services to students with CD, research is needed into how these agencies can best interact and what the role of the school counselor should be in this interaction. Also, because of the crisis in confidence among elementary school counselors in providing services to students with CD, more research needs to be conducted into how counselors develop therapeutic confidence.

Additional research is needed regarding methods of obtaining the cooperation of parents of students with CD in consultation with the school counselors providing services to students with CD. Parent consultation is an area of service that respondents identified as highly important to treatment for students with CD, but often unavailable due to the frequent unwillingness of these parents to accept this assistance.
The recommendations for counselor self-care from this study are not new to the counseling profession. Because of the emotional involvement needed and the frustration that many elementary school counselors feel in providing services to students with CD, more research is needed. This research should focus on identifying most effective counselor self-care strategies, and a broader range of emotional self-care strategies for elementary school counselors providing services to students with CD.

Additionally, more research is needed concerning the effectiveness of teacher mentoring programs for students with CD. One interviewee strongly stressed the value of the teacher mentor program she coordinated for students with CD at one of her schools. Another emphasized the importance in the success of the case of one student with CD of the close relationship a special education teacher formed with the student. Research is needed to more clearly indicate how and why teacher mentoring is successful with students with CD and best practices for implementing teacher mentoring programs.

In Summary

Providing effective services to students with CD may always be difficult. Accomplishing the recommendations from this report certainly will be. Yet, implementation of these recommendations will not only benefit the students with CD and their schools, but society as a whole, as students with CD are at high risk of developing adult personality disorders, becoming involved in criminal behavior, and failing in the world of work, just as in school. Interventions are most effective for students with CD in their childhood years, so with these recommendations followed, elementary school personnel have an opportunity to fulfill their mission of education for all children as well as serving others of society’s needs as well.
REFERENCES


Appendix A - Survey Materials

Dear Elementary School Counselor:

As a doctoral candidate in Counseling and Student Personnel at Virginia Tech, I have chosen as my dissertation topic the status of services by elementary school counselors to students with abnormally aggressive behavior. Having been a school counselor, I am interested in what typical services to these students are, what ideal school counselor services might be, and how ideal services are accomplished. There has been a great deal written on treatments for these students at non-school settings, but very little written on services by school counselors, in the school settings. Yet, almost all children fitting the description of having abnormally aggressive behavior attend elementary school. My dissertation will help answer these questions and will also, I hope, provide a useful source of information to school counselors about what services other school counselors are providing and what some potential best practices are.

Please help by taking the time to assist in this initial phase of the study by answering the enclosed survey, whether or not you have students at your school who fit the description given. This survey is expected to take no more than 20 minutes of your valuable time. The survey contains an identification number for mailing and follow-up purposes only. A postage-paid envelope has been provided for your convenience and a prompt response will be appreciated.

If you have any questions, please feel free to call me at . My doctoral committee advisor is Claire Cole Vaught, Ed.D., a Virginia Tech faculty member in Counselor Education who has extensive experience in school counseling and in Virginia public school systems. Thank you for your participation!

Sincerely

Jeff L. Cochran
STUDY OF SERVICES BY SCHOOL COUNSELORS
TO STUDENTS WITH ABNORMALLY AGGRESSIVE BEHAVIOR

PURPOSE: This survey aims to determine the extent and nature of services school counselors in Virginia are providing for elementary school children with abnormally aggressive behavior.

RESULTS: A summary of the study’s results will be provided to all survey participants upon request.

CONFIDENTIALITY: The information you provide will be subject to the strictest confidentiality procedures. Data will be reported in composite form, representing a portrait of school counselor services, rather than the services by a particular school counselor. Your anonymous participation in this survey is voluntary.

DIRECTIONS: This survey has taken about 20 minutes for other school counselors to complete. Answer all items as fully as possible, with out stopping to look up student information in files. Your expert knowledge of your school and students is more than enough and a great help to me. Please complete the survey even if you have no students at your school who fit the definition in the survey. If you counsel at more than one school, fill out only one survey for both schools. Please return by 12-6-95. If you need any clarification, please contact me at .

TERMINOLOGY:
- outside school agencies: any agency administered separately from the public schools that may at times provide services to public school students, such as regional mental health, counseling private practices, residential treatment centers, or court services.
- Conduct Disorder (CD): Many elementary school students will not have been formally diagnosed. Please use your judgment to discern which students at your school can be described as having CD based on the following description. It is not necessary for school counselors to be familiar with the term to answer this survey or to provide effective services. However, please consider the following description of students with CD.

Characteristics of students with CD:
• incidence could be as high as 10% among some groups of children, but is probably much lower
• may not be in special education or in pull out programs
• persistent pattern of misbehavior is maintained at least a year
• significant impairment in social and academic functioning results from misbehavior
• adequate behavioral improvement does not occur due to normal disciplinary techniques

Example school behaviors of students with CD:
• Aggression to people and animals -- bullying, threatening, or intimidating others; initiating physical fights; physical cruelty to people or animals.
• Destruction of property -- fire setting or other destruction of property with the intention of causing serious damage.
• Deceitfulness or theft -- stealing, lying to obtain goods or favors or to avoid obligations.
• Serious violations of rules -- repeated blatant defiance of school rules and norms or instructions from school adults (e.g., hitting a teacher, running away from school, and truancy).

The following case example should help further clarify which students I wish you to refer to in answering this survey and help clarify the behaviors of children with CD in elementary schools:
Second Grade Shannon -- From kindergarten to second grade, Shannon has argued several times daily with other students and with teachers. Shannon rarely physically fights, but at times hurts other students in cruel ways (average incidence: once each 2 weeks). For example, in 1st grade Shannon was once found making a classmate cry by bending her smallest finger back. There was no indication that they had been arguing. Shannon has destroyed property such as repeatedly ripping down classroom decorations, and once intentionally overturning a partition size bookshelf. When sent out of class Shannon has thrown rocks through the open classroom windows. Thus, Shannon's CD behaviors include physical cruelty, property destruction, and serious rule and norm violation. These behaviors have persisted and escalated for over two years. Negative consequences such as loss of recess, field trips, or classroom privileges, or being sent to the school office for disciplinary actions have tended to prompt escalation of misbehavior. Caring teacher, administrators, and counselors have reported experiencing a sense of being driven away, as if Shannon was trying to demonstrate being beyond help.

Please note: Depending on circumstances, such as whether or not you have students fitting the characteristics of Conduct Disorder (CD), your responses may not be needed for each section. So to save time, note the direction at the beginning of each section.

Section I: Counselor Self Ratings Related to Services to Students with CD - [Skip this section if you have never had any students with CD at your school(s). Check 1 rating for each item.]

1. Rate your level of frustration at providing services to students with CD at your school.
   - not frustrated
   - somewhat frustrated
   - highly frustrated.

2. Please rate the effectiveness of the services you provide in helping to facilitate the education of students fitting the description given for students with CD.
   - Highly effective
   - Somewhat effective
   - Not very effective

3. Comparatively rate the services you provide for students from more normal populations.
   - More effective than for students with CD
   - As effective as for students with CD
   - Less effective than for students with CD

4. Comparatively rate the services you provide for students that are in special education programs, but are not Conduct Disordered.
   - More effective than for students with CD
   - As effective as for students with CD
   - Less effective than for students with CD

5. Compared to the work of other school counselors you are somewhat familiar with, rate the effectiveness of the services you provide for students fitting the description of students with CD.
   - More effective than others
   - As effective as others
   - Less effective than others
## Section II: School Counselor Opinions Related to Services to Students with Conduct Disorder (CD)

[All counselors please complete this section.]

1. Rate your agreement with the following statements:

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>strongly agree</th>
<th>agree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Public schools lack the resources to provide an education to students with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Public schools should be required to educate children with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Students with CD are unreasonable hindrances to the education of their schoolmates.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) School counselors are qualified to provide direct counseling services to students with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) School counselors are qualified to provide parent and school consultation services for students with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Other demands of the job of school counselors make it impossible for us to adequately provide services for students with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Students with CD at my school need more counseling and related non-counseling services than the school is able to provide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) The counseling services that I provide meet the needs of students with CD at my school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Students with CD at my school need more counseling and related non-counseling services than outside school agencies in my area provide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) I would prefer to provide more direct counseling services to students with CD at my school, if it were possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Ideally, the school counselor, not counselors or psychologists from outside school agencies, should be the provider of counseling services for students with CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Name the top three things needed by you or your school to provide more effective services to students with CD:

1) 

2) 

3)
8. Of the elementary school counselors in Virginia with whose work you are somewhat familiar, list up to three whom you consider more effective than usual in providing counseling and related services to students with CD. (You may list yourself.) Please note: Results of the study will not list any counselor names; I request names here so I may contact some of these counselors to request more information about the services they provide.

COUNSELOR'S NAME

1) COUNSELOR'S SCHOOL

2)

3)

9. As part of this study I will interview a small number of elementary school counselors about the difficulties, successes, and other qualities of their work with students who can be described as CD. Each interview will be conducted at a time and place convenient to the counselor. Unless a counselor who is interviewed wishes otherwise, the anonymity of each counselor will be carefully protected. Analyzed information from the interviews will then be made available to counselors to assist in their efforts to provide services to students with CD. Under these conditions, would you consider being interviewed about your work in providing services to students with CD? Yes ____ No ____.

Section III: School Counselor Characteristics - [All counselors please complete this section.]

10. a) Are you assigned as an elementary school counselor to more than one school? Yes? ____ No? ____

b) If so, how many elementary schools do you serve? 1? ____ 2? ____ 3? ____ Other? ____

11. How many years of service have you provided as an elementary school counselor? ____

12. a) What is the level of your highest college degree? Bachelors ____ , Masters ____ , Doctoral ____.

b) What is the subject area of your highest college degree? _______________________

13. What is your professional background, prior to working as an elementary school counselor (you may need to check more than one)?

a) ____ Teacher: At what level: _____ high school,  
   _____ middle school,  
   _____ other (please specify):

   In what program area: _____ special education, _____ regular education,

b) ____ School counselor: At what level: _____ high school,  
   _____ middle school,  
   _____ other (please specify):
c) ____ Counselor at outside school agency: At which type:
   ____ Community/Regional mental health
   ____ Counselor or psychologist in private practice
   ____ Residential treatment center
   ____ Foster care agency
   ____ Juvenile court services
   ____ Substance abuse services
   ____ Other, please specify:

d) ____ Elementary school counseling is my first professional job.

e) ____ Other professional job(s) led into my work as an elementary school counselor (please specify):

14. Rate the effectiveness of the specific preparation you received for providing counseling and related non-counseling services to students with CD in:
   a) Graduate School: excellent ____, adequate ____, existent, but inadequate ____ , non-existent ____.
   b) Professional Workshops: excellent ____, adequate ____, none available ____, not of interest ____.

Section IV: Prevalence and Characteristics of Students with CD - [All counselors please complete this section.

15. Estimate, as accurately as possible, the number of students at your school fitting the description given for Conduct Disorder (CD)? ____ . (If 0, skip to Section VI.)

16. Estimate, as accurately as possible, the number of students with CD are there of each gender at your school: Male? ____ Female? ____.

17. Of these students with CD, estimate:
   a) the number in early elementary grades (Kindergarten - 3rd grade) ____
   b) the number in older elementary school grades (4th grade and above) ____

18. Estimate the total number of students at your elementary school? ____
Section V: Counselor Services to Students with CD - [Skip this section if you have 0 students with CD.]

19. Rate the extent to which you provide each service for students with CD:

<table>
<thead>
<tr>
<th>School Counselor Service Activities:</th>
<th>Not at all</th>
<th>Seldom</th>
<th>Often</th>
<th>Very Frequent</th>
<th>Rank of Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Counseling of the student(s) with CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Counseling, including the student(s) with CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling with peers of the student(s) with CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Consultation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Training or Counseling Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher Consultation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator Consultation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination of services from outside school agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized Classroom Presentations, related to the difficulties of the student(s) with CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy for students with CD on important decision making committees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Activities, please specify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. If some of your time providing services for students with CD includes direct counseling, number the top three terms that describe this counseling. (Only 3 items will have numbers.)

- Behavioral skills training
- Cognitive skills training
- Advising on right and wrong behaviors
- Advising on consequences of behaviors
- Play therapy oriented counseling
- Rogerian child-centered counseling
- Cognitive counseling
- Behavior modification
- Reality therapy
- Other, please specify:
21. a) Estimate the average number of hours per week you spend providing services to students with CD. ____
b) Estimate the average number of these hours in direct service ____.
c) Estimate the average number of these hours in indirect service ____.

22. Estimate the total number of hours you work per week as a school counselor. ____

Section VI: Setting Characteristics - [All counselors please complete this section.]

23. a) Are there any outside school agencies that provide counseling or closely related non-counseling services to students with CD at your school? Yes ____ No ____.
   (If no, skip to #24.)

b) If yes, check the types of agencies that provide services to students with CD at your school:
   ___ Community/Regional mental health center
   ___ Counselors or psychologists in private practice
   ___ Residential treatment centers
   ___ Foster care agencies
   ___ Juvenile court services
   ___ Other, Please specify:

   c) If yes, check each service which those outside agencies provide:
   ___ Direct child counseling
   ___ Education of school personnel
   ___ Consultation with teachers
   ___ Consultation with school administrators
   ___ Family counseling
   ___ Attending school decision making committees
   ___ Child advocacy
   ___ Coordination of services from other agencies
   ___ Other, please specify:

   d) If students with CD at your school receive counseling and related services from outside school agencies, rate the adequacy of this set of services from the various outside school agencies. Select 1 completion of the following statement: Outside school agencies in our community __
   ___ adequately fill the needs of our students with CD for counseling and related services
   ___ fill almost all the needs of our students with CD for counseling and related services
   ___ fill only some of the needs of our students with CD for counseling and related services
   ___ fill very few of the needs of our students with CD for counseling and related services

24. a) Of the students at your elementary school who fit the description given for CD, estimate the number that are in special education programs? ____
b) If some of these students are in Special Education programs, write in your estimate of the number placed under each area of disability:

- Learning Disability ____
- Serious Emotional Disturbance ____
- Developmental Delay ____
- Other Health Impairment ____
- Mental Retardation ____
- Other (please specify):

25. a) Does your school system have an elementary, alternative education program that includes the students fitting the description given for elementary school students with CD?

Yes ____ No ____.

b) If yes, is this program housed at your school?

Yes ____ No ____.

c) If yes, are counselors employed specifically for this program?

Yes ____ No ____.

d) If yes, how many counselors? ____

26. How many full time school counselors are employed by your school? ____

27. How many part time school counselors are employed by your school? ____

28. Is your school (Select only one.):

Rural? ___, Suburban? ___, or Urban? ____.

Section VII: Additional Comments - [All counselors please complete this section.]

30. Thank you again for lending your valuable time in completing this survey. Please make any additional comments that you feel would be helpful to create understanding of your work or that of other elementary school counselors in providing counseling and related non-counseling services to students with CD.
Dear School Counselor,

Thank you for your assistance in the development of this survey. Your input and expertise is greatly appreciated. Please answer the following questions about the survey:

1. I'm concerned with my description of the population of students with Conduct Disorder (CD). I want this description to be such that the responding counselors and I are referring to the same student population when counselors answer the survey and when I read their answers. I want it to be clear that students with CD do not include all students with behavior problems (especially not those for whom usual disciplinary actions and counseling techniques will usually be effective). However, I also want it to be clear that CD is not that rare (Most school counselors probably knows more than one student with CD.). So what do you think: Is there a problem with my population description? Suggestions? Comments?

2. a) If you received this mailing, do you think you would read and answer this survey? b) Does it seem too long?, boring?, or intimidating? c) Is the topic of interest to you and/or to other school counselors you know?

3. a) Do you see problems with any particular question? (If so, which ones?) b) Are the question readable? / Do they make sense? (Note question with problems.) c) Do you find any of the questions offensive? / Do you think others would? d) Are there any questions you wouldn’t feel comfortable answering?

4. What would you suggest I leave out (I'd like to avoid undue length and redundancy)?

5. About how long did it take you to read the introductory pages and answer the survey?

6. I have asked a set of fairly narrow questions, in interests of conserving my request of your time. So if you wish, please make any additional comments you believe will be helpful to me and this survey in the space below.
Appendix B - Interview Protocol

I. Statement of Interview Purpose: “Other counselors and your survey answers have helped me identify you as more effective than usual in providing services to students with CD. So, I wish to learn what services you provide?, how?, and why? I can then make the understandings I have gained from interviewing you and others available to all elementary school counselors, in anonymous form, as it may be helpful to them in their work.”

II. Instructions: “I have a set of topics related to your work that I want you to address. However, I want you to feel free to tell me what you see that I and others should understand about your work with students with CD. I want to start with the broadest of questions, then go back for specifics later.”

III. Questions or topics to be covered:

A. The grand tour: “Tell me about the counseling and related services you provide to students with CD.”

B. Sub-topics to be covered:

1. a) What defines success in providing services to students with CD?
   b) Tell me about a success. Does one particular case illustrate your more successful services?

2. Which of the variety of counseling and related services you provide to students with CD do you see as most useful in producing successes? Why?

3. Tell me some of your thoughts on the causes of CD behavior. How does CD develop? How is it maintained/why would it continue?

4. How do you select counseling and related service approaches?

5. Do you think that public schools and/or the school counseling profession are providing all the counseling and related services to students with CD that can or should be? How so? Why? What is needed?

6. Have you had cases you consider failures? If so, tell me about that.
7. How do you cope with that failure or with other difficulties (perhaps frustration) in providing services to students with CD?

8. What advice might you give to a beginning counselor with students with CD at their school or to counselors wishing to improve their work with students with CD?

Follow-up questions to survey items of particular interest (different in each interview). Examples follow:

- In the survey you rated yourself as “more effective than others.” (Item #5 and others)
- Tell me about this.
- What are your thoughts related to the statement?
- Why is it so?
- Compared to who?

- I’m very interested in the terms you selected as describing the counseling you provide to students with CD (item #20).
- Tell me what each of those terms mean in your work.
- Why do you choose to emphasize those counseling approaches?
- How do those counseling approaches interact/work together/complement or contrast each other?

- You marked individual counseling as your most frequent and most important counseling activity with student with CD.
- Tell me about that.
- How is it so?
- Why is it so?

I begin to close each interview by thanking the counselor for their time and expertise again. Then, ask them what else I should know to understand the services you provide to students with CD?

Before ending, I ask for a few moments to review my notes and collect my thoughts. Then, attempt a final summary in which I tentatively name about three qualities predominating the counselors work and review highlights of their work (especially from successful case examples). I then invite the counselor to correct and add to this summary.
Appendix C: Materials for Permission to Survey Mailing

10-6-95

Dr. Margaret S. Meara, Superintendent
Powatan School System
2320 Skaggs Rd.
Powatan, VA 23139

Dear Dr. Margaret S. Meara:

I am writing to request your permission to survey elementary school counselors in the Powatan school system concerning their provision of counseling and related services to students with Conduct Disorder. As a doctoral candidate in Counseling and Student Personnel at Virginia Tech, I have chosen as my dissertation topic the status of services and best practices in providing counseling and related services to elementary school students with Conduct Disorder by their school counselors. The first phase of this study includes a state wide survey of elementary school counselors.

I believe that this study will add to the effectiveness of elementary school counselors. The behaviors of students with Conduct Disorder makes them unusually difficult to educate, requires a great deal of teacher and staff time, and may limit the education of schoolmates. Students with Conduct Disorder are a small, but growing percentage of the elementary school students in Virginia. Students with Conduct Disorder may or may not be included in special education programs and are probably not officially diagnosed as Conduct Disordered by the school system. There is very little written to guide school counselors in providing counseling and related services aimed at facilitating the education of students with Conduct Disorder and their schoolmates. This study will help to fill this gap of information for school counselors.

To guarantee the anonymity of all schools, school systems, and school personnel participating in the study, all data will be reported in composite form, representing a portrait of school counselor services, rather than the services by a particular school counselor. No statements will be made identifying any school, system, or personnel participating in the study. The participation of each school counselor is voluntary.

Please complete and return the enclosed postage paid post card to me by October 20, 1995 to give me your permission to survey elementary school counselors in the Powatan school system. This post card also asks for you to mark your preference on the choice of having me mail a copy of the enclosed survey and a postage paid return envelope to each elementary school in the Powatan school system or send a set of surveys and postage paid return envelopes to you for redistribution.

A summary of the study’s results will be provided to all participating superintendents and school counselors upon request.

If you have any questions, please call me at . My doctoral committee advisor is Claire Cole Vaught, Ed.D., a Virginia Tech faculty member in Counselor
Education who has extensive experience in school counseling and in Virginia public school systems. Thank you for your consideration.

Sincerely

Jeff L. Cochran
College of Education - ELPS
East Eggleston Hall
Blacksburg, VA 24060-0302
Dear Jeff L. Cochran,

Check appropriate response:

1. I grant permission for this study ____.
   a) Mail survey packets directly to elementary schools ____.
   b) Mail survey packets to superintendents office for distribution to counselors ____.

2. I am unable to approve this survey because ____________________________

   Signature: ________________________
   School System: ____________________

   Jeff L. Cochran
The vita has been removed from the scanned document