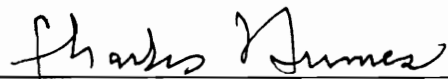


EFFECTS OF A CRISIS TRAINING PROGRAM ON
REPORTED JOB STRESS AND SELF EFFICACY OF YOUTH CARE
WORKERS MANAGING SERIOUSLY EMOTIONALLY
DISTURBED ADOLESCENTS IN PLACEMENT

by

John Joseph Lamanna

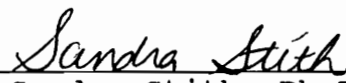
A Dissertation Submitted to Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of
DOCTOR OF EDUCATION
in
Counselor Education


Charles Humes, Ed.D., Chair


Jimmie Fortune, Ph.D.


Ron McKeen, Ph.D.


Johnnie Miles, Ed.D.


Sandra Stith, Ph.D.

April, 1993
Blacksburg, Virginia

EFFECTS OF A CRISIS TRAINING PROGRAM ON
REPORTED JOB STRESS AND SELF EFFICACY OF YOUTH CARE
WORKERS MANAGING SERIOUSLY EMOTIONALLY
DISTURBED ADOLESCENTS IN PLACEMENT

by

John Joseph Lamanna

Committee Chairperson: Charles Humes

(ABSTRACT)

Seriously emotionally disturbed adolescents in residential placement tend to act out aggressively. Such behavior often creates an atmosphere of intimidation and fear which contributes to the high stress, sense of incompetence, and frequent turn over of youth care staff. Formal training for these practitioners is limited in scope and availability. The training program, Therapeutic Crisis Intervention (TCI) (Budlong, 1983) which was the focus of this study, was designed to train youth care workers to deal with aggressive youth. It was anticipated that the program would increase youth care workers perceived sense of competence and reduce their perceived level of job stress.

The Occupational Stress Inventory (OSI) and the Correctional Institution Environment Scale (CIES) were used to measure reported perceptions of competence. The Maslach Burnout Inventory (MBI) was used to measure reported perceptions of job stress.

Fifty one subjects, from four residential centers, were

randomly assigned to a training group, a training group with follow-up, or a control group. A four way ANOVA was used to analyze main effects and single interactive effects of the classification variables (i.e., age, educational attainment and experience) with training.

In general, the analysis provided the following conclusions: (1) Neither reported self efficacy nor reported job stress were significantly impacted by TCI Training; (2) Although younger participants receiving training without follow-up reported a greater sense of depersonalization (i.e., higher perceived stress) and a lower sense of competence in using supportive skills than their older counterparts, younger participants who received follow-up in addition to the training, reported a lower sense of depersonalization (i.e., lower perceived stress) and a higher sense of competence in using support skills than their older counterparts; (3) Older participants reported lower levels of depersonalization after receiving training. Implications for these findings are discussed.

ACKNOWLEDGEMENTS

I wish to express my appreciation and gratitude to the following individuals who made it possible for me to complete this research study.

Dr. John Markwood, Executive Director of Leary Educational Foundation, who provided me the needed nudge to stay with the project and who provided me the flexibility from work to complete the study.

Dr. Richard Hall and Dr. Jerome Boyar, fellow counselors at Timber Ridge School who provided encouragement and assistance throughout the project.

The staff and students of Timber Ridge School who were the inspiration from which came the identified purpose for this study.

Mr. Ken Newbraugh, who provided the training in TCI at each of the participating schools. His competence and companionship throughout the training phase of the study was greatly appreciated.

The administrative and residential staff of Grafton School, Little Keswick School, Elk Hill Farm and Barry Robinson Center who provided me the opportunity to apply the training and investigate the effects. I was inspired by the commitment to the care and treatment of seriously disturbed adolescents evidenced by each of these schools.

For the time spent by my dissertation committee: Dr. McKeen, Dr. Miles, Dr. Humes, in reviewing the draft material; and for the advice, clarification and teaching provided by Dr. Fortune; and the special time, direction and support given by Dr. Stith - I offer my sincerest gratitude.

For the special time and talent in the development of tables and making Word Perfect work perfectly, many thanks to Scott Buckley.

And to the typist who put up not only with numerous corrections, changes and revisions, but with my awful handwriting as well, Christy Tommarello, many thanks for all you did.

And finally to my wife - my best friend. Annie, without your love, confidence, assurance and persistence, I would have completed nothing. You are truly the wind beneath my wings.

DEDICATION

This study is dedicated to my parents, Charles and Carmella Lamanna, who inspired me at an early age to always strive for my best, to always complete a job you start and to value education;

and to my wife, Annie, and my children, Nicholas and Rachel. My wife and children had to make many sacrifices for me to further my education. Their love, patience and encouragement have made the completion of this project possible.

TABLE OF CONTENTS

	<u>Page</u>
ACKNOWLEDGEMENT	iv
DEDICATION	vi
TABLE OF CONTENTS	vii
INDEX OF TABLES	x
CHAPTER I - DEVELOPMENT OF THE PROBLEM	1
Conceptual Framework	3
Assumptions	6
Statement of the Problem	7
Purpose of the Study	8
Research Questions	9
Delimitations of the Study	10
Limitations of the Study	10
Definitions	12
Organization of the Study	15
CHAPTER II - REVIEW OF THE LITERATURE	17
Characteristics of S.E.D. Adolescents in Placement	17
Training Needs of Youth Care Workers	22
Factors Which May Contribute to Burn-out and their Relevance to Training	23
Inadequate Pre-service Training	27
Infrastructure of T.C.I. Training	29
The Understanding Response	30
Non-verbal Communication	31
Verbal Communication	39
Awareness in Crisis Prevention and Intervention	42
Physical Setting	42
Youth Care Worker's Awareness of Self	45
Strategies for Physical Intervention	48
The Life Space Interview	55
Self Efficacy and Job Stress	61
Summary	66

CHAPTER III - RESEARCH DESIGN AND METHODOLOGY . . .	67
Design of the Study	67
Description of the Design	69
Population and Sample	70
Instrumentation	73
Purpose 1	73
Occupational Stress Inventory . . .	73
Correctional Institution	
Environment Scale	75
Purpose 2	77
Maslach Burnout Inventory	77
Post Training Questionnaires	80
Data Analysis	81
Summary	83
CHAPTER IV - THE ANALYSIS AND FINDINGS	84
Introduction	84
Research Questions, Hypotheses	
and Findings	84
Post Training Questionnaire	
and Findings	100
Summary	112
CHAPTER V - CONCLUSIONS, IMPLICATIONS, AND	
RECOMMENDATIONS	118
Introduction	118
Summary of the Study	118
Conclusions and Implications	123
Recommendations for Further Study	128
REFERENCES	132

APPENDICES	152
A.	Therapeutic Crisis Intervention Training Program Post Training Questionnaire. . .	153
B.	Therapeutic Crisis Intervention Training Program Follow-up Questionnaire to Physical Restraint Incident	158
C.	Therapeutic Crisis Intervention Training Program Outline - Two Day Training. . .	160
D.	Therapeutic Crisis Intervention Training Program Follow-up Session Outline	162
E.	Therapeutic Crisis Intervention Training Program Demographic Information Form	164
F.	Mean Scores on Reported Self-Efficacy.	166
G.	Mean Scores on Reported Job Stress. . .	169
VITA	171

INDEX OF TABLES

<u>Table</u>	<u>Page</u>
1. Participants Randomly Assigned to Training Groups; and Distinguished by Classification Variables	73
2. Analysis of Variance for Scores on the Correctional Institution Environment Scale, Support Subscale (s) - forty five day measurement	88
3. Analysis of Variance for scores on the Maslach Burnout Inventory, Depersonalization subscale (DP) - initial measurement	92
4. Analysis of Variance for Scores on the Maslach's Burnout Inventory, Depersonalization subscale (DP) - forty five day measurement	94
5. Maslach Burnout Inventory, Depersonalization subscale (DP). Mean Scores of older participants (> 25 years) for initial and forty five day measurements	95
6. Analysis of Variance for scores on the Maslach Burnout Inventory, Personal Accomplishment subscale (PA)' - initial assessment	97
7. Analysis of Variance for scores on the Maslach Burnout Inventory, Personal Accomplishment subscale (PA) - forty five day measurement	99
8. Question Number One: Active listening skills to include non-verbal and verbal skills	102
9. Question Number Two: Physical Intervention Strategies	104
10. Question Number Three: Life Space Interviewing Strategies	105

11. Question 14(a): If this training was offered again, would you sign up and attend? 106

12. Question 14(b): If this training were offered, would you recommend it to others? . . . 108

13. Mean responses for items Part I and Part II Questions one through thirteen on post training questionnaire 109

CHAPTER I - DEVELOPMENT OF THE PROBLEM

The inpatient population of adolescents is one of the most demanding for mental health professionals. These young people challenge the best and most talented care givers (Crespi, 1990). To care enough about such children, when they are at their worst and most destructive, is the challenge in treating seriously disturbed adolescents and the hallmark of the youth care profession.

Residential treatment centers (RTC) for emotionally disturbed youth are an important component of the mental health service delivery system in the United States. The 440 RTCs operating in 1988 represented 9% of all mental health organizations in the United States in that year. RTCs focus care primarily on children and youth with 94% of residential treatment patients in RTCs under the age of 18 (Mental Health Statistical Note, 1991).

The need for effective treatment of this client group is obvious. However, little focused attention is given to the pre-service and in-service training needs for the practitioners working with this population. Intervention effective with aggressive adolescents is a topic rarely discussed in university training programs (Crespi, 1990). Although singularly the most difficult aspect of the work, few direct service staff are prepared to deal with aggressive

acting out behavior. Professionals dealing with this population are often caught unaware.

The residential treatment center, the most common treatment setting for youth with severe behavioral problems, is usually staffed with personnel with a wide range of educational and experiential backgrounds. The educational background of staff generally ranges from a high school diploma to a post-graduate degree. In-service training often centers on job orientation and post-facto situational needs. Kalogjera, Bedi, Walson and Meyer (1989) observed practitioners dealing with an aggressive adolescent inpatient population and concluded that the majority of personnel learn how to deal with violent patients by experience rather than by pre-service or in-service training. The implication is that very little specific formalized training is offered to this dedicated group of professionals. The current study is designed to determine if a training program can be effective in assisting these professionals.

The training program, Therapeutic Crisis Intervention which is the focus of the study was developed by Budlong and colleagues at the Family Life Development Center of the Department of Human Development and Family Studies, New York State College of Human Ecology, Cornell University, in 1983. Its intent is to effectively train youth care workers to deal

with youth in crisis. Specifically the program has two major objectives.

1. Provide the staff with the necessary skills to help the child through a crisis in a way that restores the status quo, balance, and order.
2. Provide staff with the necessary skills to teach the child more constructive ways to deal with stress or painful feelings.

It was speculated that, while the training program would favorably impact the management of seriously emotionally disturbed adolescents in placement, it would directly influence the sense of competence in youth care staff and reduce their perceived level of job stress. It was the analysis of these factors which was the focus of this study.

Conceptual Framework

The conceptual framework of this study is derived from the theories of crisis management, (Budlong, 1983) self-efficacy (Bandura, 1972, 1982) and job stress (Bressil, Hoover-Dempsey, Bassler, 1988; Moslach, 1978). It explicitly includes the following concepts: the understanding response, awareness in crisis prevention and intervention, strategies for physical intervention, and the life space interview. All of which will be addressed in the review of the literature. Inherent in the effective application of these concepts is an

understanding of behavioral change theory and the characteristics of emotionally disturbed adolescents.

In a discussion of job stress and self efficacy, it is first necessary to define each concept. For the purpose of this study the concept "job stress" will imply that which leads to what is commonly called "burn out". "Personal efficacy" is defined as a belief in one's ability to succeed in a particular area of performance.

Bressil, Hoover-Dempsey, and Bassler (1988) defined burn out as "behaviorally manifest emotional and physical exhaustion deriving from stressful situational events not adequately met by effective coping strategies" (p.106). They suggest that teachers with a high sense of efficacy were less likely to report burn out and perceived less stress in their job. It is the relationship between perceived efficacy in managing aggressive, out of control behavior and perceived job stress which was examined in this research.

Bandura's theory (1977) of self-efficacy indicates that: personal efficacy is concerned with the conviction that one can successfully execute the behavior required to produce the outcome. Outcome and efficacy expectations are differentiated because individuals can believe that certain behaviors will produce certain outcomes but if they do not believe that they can perform the necessary

activities, they will not initiate the relevant behaviors, or if they do, they will not persist.

Bandura (1982) reported that the higher the level of individual self-efficacy, the higher the performance accomplishments and the lower the emotional arousal. He concluded that perceptions of self-efficacy affect emotional reactions as well as behavior. This was reported as especially true of anxiety or stress reaction to unfamiliar or potentially aversive events.

A study conducted by Safran, Safran and Bareikowski (1990) focused on teacher manageability as the self-efficacy construct most closely related to classroom management. Classroom manageability was defined as the degree to which teachers believe they can personally manage a behavior. Teachers who "believe" that they are more competent managers can positively influence student behavior and will likely be more effective managers. The study concluded with a call for training, with particular focus on in-service consultation to enhance teachers' confidence. These authors suggest that in-service training should be used to promote self-efficacy which in turn will promote effective management of student behavior.

Gibson and Dembo (1984), in addressing the concept of teacher efficacy, concluded that there is evidence that

teachers' beliefs in their abilities to instruct students may account for individual differences in effectiveness.

Finally, Berman and McLaughlin (1977), in their evaluation of 100 Title III projects under the 1965 Elementary and Secondary Education Act, reported that the factor most significantly related to effectiveness of change-agent projects was teachers' sense of efficacy, e.g., a belief that teachers can help even the most difficult or unmotivated student (cited in Gibson, 1984). These authors recommended further research to investigate the relationship between teacher efficacy and decision making in regard to classroom management.

It is crisis management theory, along with the theories underlying self-efficacy and job stress, which formulate the framework for this study.

Assumptions

In this study the following assumptions are identified:

1. Practitioners dealing with seriously emotionally disturbed youth in placement face aggressive acting-out behavior.
2. Practitioners dealing with aggressively acting out youth in placement need specific skills to effectively manage such behavior.

3. Techniques used in Therapeutic Crisis Intervention Training are validated and supported in the literature and are therefore assumed to be part of a valid program for teaching effective management of aggressive acting-out behavior.
4. Personal efficacy assumes the effective management of crisis situations and contributes to a sense of lower job stress.

Statement of the Problem

There is a tendency for seriously emotionally disturbed adolescents in placement to act out aggressively when stressed. This behavior demonstrates a lack of emotional control and adaptive responses on the part of the adolescent. Such aggressive responses create an atmosphere of intimidation and fear often experienced by the worker. Miller, Walker, and Friedman (1989), point out that the treatment of seriously disturbed adolescents requires control of violent behavior for successful therapy. The regular exposure to such episodes, or the threat of having to deal with violent, aggressive behavior, is a major contributor to the high stress and frequent turnover of youth care workers.

Formal training for practitioners dealing with seriously emotionally disturbed adolescents in placement is limited in scope and availability. Consequently, most practitioners -

youth care workers - begin their work relying on life experiences and trial and error approaches to crisis management. Most training, if it occurs, is in-service based and therefore must be clearly relevant and cost effective in terms of the consumption of staff time. The selection of training programs becomes a significant task for any residential treatment center working with seriously disturbed adolescents and must be a process supported by practical application of training models.

The problem addressed in this study was the effect of a crisis training program for youth care workers on their perceived competence in managing seriously emotionally disturbed adolescents in placement. It was anticipated that the training would result in the following:

1. an increased perceived sense of self efficacy in dealing with aggressive, acting out behavior.
2. a perceived sense that job stress was reduced.

Purpose of the Study

The general purpose of the study was to verify the following two relationships with participation in the Therapeutic Crisis Intervention Training Program:

- (a) perceived competence by trainees in their ability to manage seriously disturbed adolescents in placement, and

(b) perceived reduction in job stress of trainees.

To accomplish this purpose, three auxiliary purposes were addressed:

1. The extant literature in the following areas was synthesized:
 - characteristics of seriously emotionally disturbed adolescents,
 - training needs of youth care workers,
 - Therapeutic Crisis Management techniques.
2. The level of stress associated with youth care work was profiled.
3. Personal efficacy and its relationship to job stress was defined.

Research Questions

Two major questions were addressed in order to fulfill the purpose of this study:

1. Is there a relationship between a specific therapeutic crisis intervention training program (TCI) and a trainee's perceived sense of competence in managing seriously emotionally disturbed adolescents in placement?
2. Is there a relationship between a specific therapeutic crisis intervention training program (TCI) and a trainee's perceived sense of job stress?

Ancillary questions, addressed through the review of the literature, provided background for the major questions:

1. What are the characteristics of seriously emotionally disturbed adolescents in placement?
2. What are the training needs of the youth care worker?
3. What comprises the infrastructure of Therapeutic Crisis Intervention Training?
4. What are the theoretical underpinnings defining self efficacy and job stress?

Delimitation of the Study

In order to ensure that the study was manageable, the following delimitations were noted.

1. The study focused on the effects of a specific training program in crisis intervention.
2. The study focused on the training of practitioners who work with seriously emotionally disturbed adolescents within residential treatment centers accredited by the Virginia Association of Independent Special Education Facilities (VAISEF).
3. The study focused on the perceptions of trainees in regard to their sense of job stress and confidence in dealing with aggressive, acting out behavior.

Limitations of the Study

The study was limited as noted by the following threats to internal and external validity.

1. Internal validity of the study may have been affected by the maturation of the trainees. A variety of life experiences may have influenced the results.
2. Internal validity may have been an issue due to differential selection of subjects. Some trainees selected may have already developed effective skills in the management of aggressive behavior prior to the training. This may have effected their perception of personal efficacy and other attitudes central to the study.
3. Differential experimental mortality may also have threatened the internal validity of the study. It is indeed possible that the natural attrition of residential counselors may have resulted in the loss of trainees during the investigation.
4. Multiple treatment interference may have threatened the external validity of the study due to the varied educational and experiential background of the trainees.
5. Multiple treatment interference may have impacted the results of the study due to the trainees exposure to a variety of previous or concurrent in-service training experiences.

6. The study was delimited by a specific selection of residential treatment centers for seriously emotionally disturbed adolescents. The study was therefore affected by the interaction effects of selection bias and the training group. This threat to external validity limited its generalizability.

Definition of Terms

The following definitions refer to terms as they were used in this study.

1. Adolescence: Age span usually considered from 12 - 19 years of age and characterized by significant changes in physical, emotional, and social maturity.
2. Aggressive Behavior: An attack; hostile action directed against a person or thing (Chaplin, 1968).
3. Burnout: Behaviorally manifest emotional and physical exhaustion deriving from stressful situational events not adequately dealt with by effective coping strategies (Hoover-Dempsey, et al, 1988).
4. Conduct Disorder: A term used to describe students who exhibit antisocial behavior, referring to overt, aggressive, disruptive behavior or covert antisocial acts (Nelson, et al, 1991).
5. Crisis: A sudden change in equilibrium or balance of the individual or in the order of the social system. Crisis

is when a person has run out of or has never learned effective ways of dealing with internal or interpersonal problems or difficulties (Budlong, 1983, Introduction).

6. Delinquency: Legal term applied by the criminal justice system to indicate that a youth has been adjudicated by the courts and found guilty of criminal behavior or a status offense (Nelson, et al, 1991).
7. Delinquent Behavior: A term used to describe any illegal act performed by a person under the age majority, regardless of whether the perpetrator is apprehended (Nelson, et al, 1991).
8. Personal Efficacy: The conviction that one can successfully execute the behavior required to produce the outcome (Bandura, 1977).
9. Physical Restraint: The use of staff to hold a child safely and therapeutically in order to contain acute physical behavior (Budlong, 1983).
10. Residential Counselor: Person employed in a residential treatment center to care for the physical, emotional, and social needs of the residents. The term Youth Care Worker refers to the same function and is used interchangeably.
11. Residential Treatment Center: Facility which provides 24 hour per day, year round care for residents.

12. Seriously Emotionally Disturbed: The definition is found within Public Law 94-142 as an educationally handicapping condition manifested in a child's inability to cope with normal stresses associated with age. Specifically, it is a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
- (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors; (b) an inability to build a or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a general pervasive mood of unhappiness or depression; or, (e) a tendency to develop physical symptoms or fears associated with personal or school problems (Nelson, et al, 1991).
13. Socially Maladjusted: The term is based on the belief that certain youth are socialized in a deviate cultural group; that is, their behaviors and attitudes are shaped by a social context that encourages them to act in ways that violate the standards and mores of the mainstream culture (Nelson, et al, 1991).
14. Therapeutic Intervention: Defined in Therapeutic Crisis Intervention Training as that which enhances the self

concept of the individual by providing adaptive coping strategies for dealing with crisis situations (Budlong, 1983, Intro.).

15. VAISEF: Virginia Association of Special Education Facilities. An association which serves as an accrediting body for its members, private special education schools. The authority to grant such accreditation comes from the Virginia Commission on Private Education.

Organization of the Study

Chapter Two contains a review of the literature. The literature review was directed in the following manner:

1. Characteristics of emotionally disturbed adolescents in placement were established.
2. The need for specific training of youth care workers dealing with this special population was established.
3. The importance of specific skills presented in the training model were supported:
 - a. The Understanding Response
 - non-verbal communication
 - verbal communication/active listening
 - b. awareness in crisis prevention and intervention
 - physical setting
 - self awareness of the youth care worker

- c. physical intervention strategies
 - d. The Life Space Interview
4. The significance of self-efficacy as it related to job performance and job stress was established.

The methods used in this study are discussed in Chapter Three. The analysis of data and results are reported in Chapter Four. The general efficacy of the training program is discussed through the results of this research.

Chapter Five interprets the findings of the study. Subjective analysis, conclusions and implications are discussed.

CHAPTER II - REVIEW OF THE LITERATURE

The purpose of this chapter is to review the literature relevant to this study. The general approach used is to (a) describe the characteristics of emotionally disturbed adolescents in placement; (b) establish the need for specific training of youth care workers; (c) describe the infrastructure of Therapeutic Crisis Intervention training supporting each skill area through pertinent literature; and, (d) support the significance of self-efficacy in relation to job performance and job related stress.

Characteristics of S.E.D. Adolescents in Placement

"Children and young teenagers who are antisocial, and especially those who are aggressive and violent, cause considerable dismay among professionals as well as the public" (Faretra, 1981, p. 439). Many of the youth who end up in residential settings were placed there as a consequence of their inability to appropriately manage their anger which resulted in aggressive behavior.

"The appropriate control of anger is a particular salient issue in residential treatment centers" (LeCroy, 1988, p.30). The source of such anger is varied. The seriously disturbed

adolescent in placement will have most likely experienced the physical pain and terror of physical abuse, the nightmare of incest and the dull ache of rejection and deprived love. "The residents need to express their aggression and despair in order to begin to come to terms with it is an essential part of the therapeutic process" (Rose, 1988, p. 5). Consequently, they may often turn on their helper, the youth care worker, in the expression of these emotions. As Rose (1988) states, "Their internal world is in chaos, and much of their energy is invested in trying to obliterate traumatic memories and in containing their general state of anxiety" (p. 6). Yet it is through the relationship with the youth care worker by which a sense of trust and personal safety develops and the adolescent can begin to lower his/her defenses. It is when they begin to lower these defenses that their inner terror and misery may overwhelm them and we see the demonstration of oppositional, aggressive behavior.

The experiences the adolescent has had within the family can impact his or her emotional condition. A study conducted by Forehad, Long and Hedrick (1987) substantiated the hypothesis that a family with a seriously emotionally disturbed child is often characterized by conflict and chaos. It is within such an environment that the adolescent learns inappropriate ways to interact which may generalize to peers and adult authority. Also, in such a family setting, the

typical inadequate monitoring and discipline by the parent provides the adolescent with the opportunities to engage in antisocial behavior (Forbad, Long and Hedrick, 1987). Such an environment leads the adolescent to the door of a residential treatment center where the youth care worker faces the "oppositional" adolescent.

It appears from the literature that poor family functioning is a significant risk factor for the presence of child and adolescent emotional and behavioral disorders (Rae-Grant, Thomas, Offord and Boyle, 1989). Kalogjera (1989) hypothesized that the parents of aggressive adolescents failed to provide secure boundaries with which their children could experiment safely with new behaviors and learn to master their environment in socially acceptable ways. "As a result, when they reach adolescence, these children use disruptive behavior to provoke parental figures to provide clearly defined boundaries and a healthy environment" (Kalogjera, 1989, p. 285). Gardner (1989) supports a link between incompetent parental discipline and children's conduct patterns. He concludes that mixed, inconsistent consequences were aversive to the child. "Evidence suggested that during sequences of parent-child conflict, parent responses became more consistent and hence the interaction became less aversive to the child" (Gardner, 1989, p. 224). Engaging in conflict would thus be negatively reinforcing for the child, leading to escape from

unpredictable interactions. The adolescent has most likely habituated this response to ensure predictability in his environment. This pattern of behavior presents a challenge to the youth care worker, calling for patience and objectivity.

The severity of the problems presented by the seriously disturbed adolescent is further stated by Rose (1988):

The youngster may be compelled to remain sullen, depressed, self destructive, aggressive, paranoid, defensive until he can relax with his peers. He may agonize about his hostility for it seems to confirm his "badness" but it needs to be worked through before new growth can be made (p. 10).

It is the youth care worker who must confront this "badness" and help the adolescent work through this quagmire of emotions. The difficulty is often intense because the adolescent's adult-oriented delinquent negativity is likely to have become generalized and habitual rather than specific and reactive (Rose, 1988). Consequently, the adolescent requires seemingly endless patience from the youth care worker and repeated confrontations addressing maladaptive behaviors.

Verbal and physical aggressive behavior are typical responses of the frustrated, angry adolescent. Elder, Edelstein and Marick (1979) state that such aggressive behaviors are the most frequent problems for which this

population is referred to outpatient clinics. The seriously disturbed adolescent magnifies this tendency to an alarming degree. Eason (1969) describes the typical presenting symptoms of the adolescent in placement to include: depression, oppositional/defiance, withdrawal, disturbed thought, extreme anxiety, rageful outbursts, and poor social skills.

A common developmental event in adolescents is emerging sexual drives which produce inner turmoil and are frequently channeled through aggressive behavior. "Acting aggressively may allow adolescents to recruit adults' cooperation in clarifying their conflicts about sexuality and channeling them properly" (Kalogjera, 1989).

Perhaps Agee (1979) termed this adolescent population in placement most appropriately as "aversive treatment evaders". The term "aversive" refers to the effect these youth have on the people with whom they interact. "Treatment evaders" refers to their ability to sabotage or resist attempts at intervention.

The youngsters entering placement have grown worse in the intensity of their presenting problems. As stated by Grellong (1987), "they are described as more severely impaired than even a decade ago" (p. 61). That is, the diagnoses reflect more severe psychopathology, more violence, more destructive and assaultive behaviors occurring more frequently at home,

at school, and in the community (Berlin, Critchley and Rossmore, 1984; Grellong, 1987).

These characteristics are common symptoms of the seriously disturbed adolescent in placement. They typify the daily challenges presented to the youth care worker.

Training Needs of the Youth Care Worker

The previous section described the seriously disturbed adolescent in placement as an extremely difficult population to serve. To care enough about these troubled youth to want to help is an essential pre-requisite, without such a commitment the task is unsurmountable. However, to promote change and expect success relying solely on commitment is like trying to play the violin with only a desire to make music. As one must learn to read music and develop the skill necessary to stroke the bow to produce desired harmonic sounds, one must learn to understand the adolescent condition and acquire the necessary skills to evoke change in their beliefs, attitudes, and behaviors.

A review of the literature substantiating the need for specific training of youth care workers will concentrate on two areas: 1. factors which may contribute to burnout and their relevance to staff training; 2. specific reference to the lack of formal and adequate pre-service training in youth care.

Factors Which May Contribute to Burnout
and Their Relevance to Training

Often within education circles one hears from the "regular" classroom teacher - if only Johnny wasn't in my class how much easier my job would be, he's just not interested and will not behave. Well, where do the Johnnys go? Who deals with these difficult to manage, aggressive kids? The job often falls to the youth care worker. The youth care worker, commonly called the residential counselor, has chosen to spend their time with "the Johnnys to beat all Johnnys". However, due to the make up and demands of this special population the tenure of the residential counselor is short lived.

The existence of the phenomenon known as "burnout" has been extensively reviewed in the literature (Eldridge, Blostein and Richardson, 1985; Edelwick and Brodsky, 1980; Wakin, 1985; Kenley and Mossholder, 1987) and has become common place when discussing personnel management issues and concerns in any type of work. However, as Edelwick and Brodsky (1980) have stated, "burnout does not occur with anything like the same regularity or carry with it the same social cost in business as it does in human services, where it takes on a special character and intensity" (p. 15). The impact of the youth care worker forced to leave his/her work due to job stress related reasons has a significant adverse

effect on the treatment of the youth in their care. The success of a residential treatment center is contingent on two important factors: 1. the development of a comprehensive treatment program that addresses the remedial and developmental needs of the youth, or as Redl (1966) states, an effective "Therapeutic Milieu", and a competent staff to implement the program. Although this may appear to be an oversimplified assumption one can not argue with the clear necessity to maintain a competent staff. If burnout becomes a major cause of turnover, then attention must be given to avoiding circumstances which lead to it.

Maslach (1978) extended the concept of burnout to members of the helping profession. She defined burnout as "emotional exhaustion resulting from stress of interpersonal contact" (Maslach, 1978, p. 56). Her findings indicated that a person who is unable to cope with continued emotional stress loses concern and feelings for the individuals he/she is trying to help. Gradually, the helper increased the distance between self and others, becoming less involved emotionally and less concerned about the client's social, physical, and emotional needs (Maslach, 1976).

Lockman and Dramet (1987) in their investigation of the occurrences of burnout found that it is more prevalent among professions which require continuous and high emotional involvement with other people. Such involvement is part-and-

parcel of youth care work. The youth care worker is totally enmeshed in the daily lives of the young people he/she works with. Certainly this work environment is fertile ground for burnout.

Freudenberger (1977) directly investigated the occupational stress of child care workers. He has stated that "workers are required to be emotionally available to the deprived youngster, to expend great energy over long periods of time, to view themselves as motivated human beings, and to do all this for negligible salary" (Freudenberger, 1977, p. 91). The enormous task of caring for deprived or difficult children can cause youth care workers to become disenchanted, disillusioned, angry, and burned out while working with these children in need. Lack of perceived success with job can contribute to low self esteem and eventual burnout (Freudenberger, 1977; Mattingly, 1977).

Perhaps Kuduskin (1974) has stated the plight of the youth care worker most succinctly, "the flow of emotional supplies goes one way, from the worker to the client, and may lead to the emotional depletion of the worker" (Kuduskin, 1974, p. 715). This state of the youth care worker is comparable to Freudenberger (1977) definition of burnout. He defines burnout "as becoming exhausted from excessive demands on energy, strength and resources" (Freudenberger, 1977, p. 90).

Another source of burnout is role ambiguity (Kenley and Mossholder, 1987). Role ambiguity as a characteristic in youth care work is presented in Berlin, Critchley and Rossman (1984) statement of purpose for residential treatment.

The aim is to aid the child to understand interpersonal expectations and limits - within the context of a supportive, firm, and caring relationship. Both aspects of the treatment program must be equally emphasized. Staff often find it difficult to achieve this balance. They may begin to "wing it", based upon personal biases (p. 119).

Another source of burnout is reported as disillusionment and has been theorized and researched by Edelwick and Brodsky (1980). In their book titled Stages of Disillusionment in the Helping Profession, they state, "professionals are destined to experience some degree of disillusionment and it is the disillusionment when unchecked which caused burnout (p. 27). These stages are outlined below:

Enthusiasm - which describes the youth care worker with unrealistic expectations motivated by idealism.

Stagnation - idealism is shattered and the job which was once thrilling has become boring.

Frustration - the worker calls into question his/her effectiveness in doing the job and the value of the job itself.

Apathy - a defense mechanism against frustration. This stage usually occurs when a person is chronically frustrated over the job, yet needs the job to survive (pp. 27-29).

The specific training program, T.C.I., can have a direct impact on the frustration stage of this cycle. The repeated interactions with an aggressive, hostile adolescent without a sense of effectiveness or impacting change will cause frustration and lead to apathy. The skills presented during the training can result in a sense of accomplishment and effectiveness in dealing with aggressive behavior.

Inadequate Pre-service Training

The specific training needs of the youth care worker can be first realized by a review of criterion for employment. The State of Virginia's regulatory body for monitoring residential treatment centers requires a minimum age of 18 and a minimum education of a G.E.D for youth care workers (CORE Standards, 1986, p. 66; Standard 3.54). This is typical of national standards and speaks to the relevant regard our society places on the effective treatment of our troubled youth. This minimum standard allows for significant flexibility on the part of each residential facility.

Consequently, it is not uncommon to find a range of backgrounds for youth care workers from G.E.D to master level education. The youth care profession seems to allow, indeed attracts, people from a variety of educational backgrounds. It is not uncommon to have a youth care worker with a degree in chemistry, history, or a masters degree in philosophy working along side a person degreed in a more pertinent discipline such as sociology, counseling, or psychology. Such a variety of backgrounds requires the attention of each facility to ensure adequate training of its practitioners (Freudenberger, 1977).

An investigation of the literature, in regards to training, points to the special education teacher. Most of the research has investigated the training needs of this group and little has examined the needs of youth care workers. However, youth care workers demonstrate comparable training needs.

The need for behavior management training in dealing with the emotionally/behaviorally disordered in the classroom is well documented (Joyce and Wienke, 1989; Morsink, Ferdig, Algozzine and Algozzine, 1987). Yet training for these professionals appears to be inadequate. In a study conducted by Beare (1991) teacher training was found to be less than comprehensive and many teachers of S.E.D. students reported

using techniques not included in their present training programs.

A study investigating the sources of stress among student teachers conducted by Hourcade and Parette (1988) implied that "the movement from classroom studies to classroom teacher was stressful and significantly impacted student teachers" (p. 347). The significance of this study dramatizes the impact a lack of pre-service training has on the residential counselor. Since youth care work serves as an entry position to the human services field, more attention needs to be given to the training needs of the first year worker.

Infrastructure of T.C.I. Training

The main focus of the training is to approach a crisis as an opportunity to teach a child more constructive and adaptive ways to deal with uncomfortable feelings such as frustration, anger or depression. The underlying philosophy behind the training program is that residential counselors are important influences in lives of the youth in placement.

The techniques presented during the training are designed to provide the youth care worker with the skills, knowledge and confidence to deal with youth in crisis and to be in control of the situation in order to bring about a maximum amount of lasting change. Residential treatment is a complicated application of a wide range of personal attributes

and learned skills. As Fineberg, Sowards and Kettlewell (1980) state, "It requires more than simply caring and coexisting with patients in the treatment environment to produce positive change for emotional disturbed adolescents" (p. 915). Specifically focused training of youth care workers is essential if they are expected to be effective as agents of change.

Four specific skills are presented during TCI training. They are listed here followed by evidence supporting their importance:

1. The Understanding Response. This involves specific techniques in non-verbal and verbal communication.
2. Awareness in crisis prevention and intervention.
3. Strategies in physical intervention in dealing with the aggressive, out of control adolescent.
4. The Life Space Interview.

The Understanding Response

William Blake poetically refers to dealing with anger in the following poem:

I was angry with my friend:
I told my Wrath, my Wrath did end.
I was angry with my foe:
I hid my Wrath, my Wrath did grow.

Bottling up anger without expression may lead to overly explosive anger episodes (LeCroy, 1988). The inability of the

emotionally disturbed adolescent to identify and express his/her anger in an adaptive manner is a major concern in residential treatment. A key developmental task for these youngsters is to learn when they are exhibiting aggressive behavior and how to control such behavior. Treatment strategies aimed at anger reduction management are needed to improve the therapeutic milieu in residential treatment centers (LeCroy, 1988). Unfortunately, aggressive behaviors frequently occur with adolescents in placement, requiring inordinate numbers of staff members, quantities of staff time and attention, physical violence and concomitant injuries (Edler, Edestein and Narvick, 1979). An important treatment goal in work with seriously emotionally disturbed adolescents is therefore the appropriate expression of emotions. This leads to a discussion of specific strategies and skills which foster effective communication, The Understanding Response.

In the youth care worker's intent to encourage the youth to "talk out" rather than "act out" his/her feelings, the understanding response is an effective strategy. This response requires the effective use of non-verbal and verbal communication skills.

Non-verbal Communication

One important factor in The Understanding Response is non-verbal communication. In our communication with other people, our verbal communication is either reinforced or

contradicted by aspects of our non-verbal communication. This becomes even more crucial when dealing with the upset, out of control adolescent. When upset the adolescent may not be "hearing" our words at all and is responding solely to non-verbal cues. The significant strength of non-verbal communication is described by Charles Galloway (1977):

When we communicate an entire array of wordless expressions conveys attitudes and feelings. These are clearly portrayed by the face, hands, and body. Words miss their mark when compared to the furrowing of a brow, to the smile of a greeting, or to the wink of a confidante. The power of the nonverbal is unmistakable. (p. 129).

Non-verbal communication has been defined in similar ways. Siegman and Feldstein (1978) define it as "all nonverbal behaviors that are involved in the transmission of experiences or information from one person to another" (p. 5). Robert Koch (1971a) defines it simply as "any message we send or receive outside of words" (p. 231). And Hadl, Rosenthal, Archer, DiMatteo and Rogers (1977) define it as the "sending and receiving of nonverbal cues indicating feeling or attitude" (p. 162).

Specific to the skills acquired from the Therapeutic Crisis Intervention Training are: structural aspects of non-

verbal communication, body language, personal space, facial expression, eye contact and voice tone.

Structural Aspects This aspect of non-verbal communication refers to the structure or the way in which an interaction is set up. In addressing the factor of attention relevant to structure aspects of communication, Friedman (1986) states "The background or setting can serve to focus attention as desired or it can provide competing, distracting stimuli" (p. 11). The aspect of structure is usually the message received upon entering the physical environment of an interpersonal activity. A clear example of this aspect of non-verbal communication is the typical court room. Upon entering one can easily note that the person dressed in a black robe, sitting center stage, behind a large assuming desk is IN charge and that the interaction will take on a very formal, authoritative structure. Structure, or a setting, can establish a business/authoritative tone or can be manipulated to set a warm, informal, inviting tone. It is important that the intent of the communication is reinforced by the environmental structure.

Body Language "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore" (Freud, 1905, p. 77 - 78). This statement by Freud emphasizes the importance that body

actions play in conveying of information to people. Ray Birdwhistell in his investigation of body expression wrote:

There is a language of body expression and motion which is order and structured as the language we speak. Like the language we speak it is made up in pieces of structure which can be assembled to form orderly sequences of message material which others trained in the same code can translate and respond to in kind (Schusler, 1971, p. 286).

Body action communicates a person's emotional state, attitude and moment-to-moment reaction to his/her environment and the people in the environment (Schneider, 1979). People will have a tendency to try to conceal their facial expressions; however, they will not try as hard to manage what their bodies are saying (Ekman and Friesen, 1974). It is important then when communicating to remain attentive to the message your body action is delivering. Is it consistent with the words you are using? Even more significant, is it consistent with the message you want to deliver? Particularly, when dealing with a crisis our body stance becomes crucial. How the youth care worker holds his/her hands, sits or stands and positions his/her body relevant to the youth in crisis can communicate different messages. The intent is to portray a sense of confidence, caring and support

for youth rather than the message of fear, intimidation or threats.

Personal Space We all have areas of public and private space. The intrusion of another from our public to private space can have particular significance to a person in crisis. Robert Somner (1969) defines personal space as "an area with an invisible boundary surrounding the person's body into which intruders may not come...Personal space is not necessarily spherical in shape, nor does it extend equally in all directions" (p. 26). Eduard T. Hall describes personal space slightly differently. His description is a series of concentric circles with the person at the center (Hall, 1961). The circles have within them four distinct distances or zones for human interaction: the intimate distance (0" - 18"), the personal distance (1-1/2' - 4'), the social distance (4' - 12'), and the public distance (beyond 12') (Hall, 1969).

"Studies point to the fact that the more antisocial or fearful an individual is, the greater his sense of personal space becomes and when violated by another, the individual will defend this intrusion (Nunno, 1983, p. III-3). McBride, King and James (1965) and Middenent, Knowles and Matter (1976) support the notion that a person will become physically aroused when personal space is invaded. Perhaps most significant to the problem of dealing with adolescents in crisis is the findings of Evans and Howard (1973). They

suggest that the reasons for the reactions to the invasion of personal space are due to the fact that personal space intrusion is stressful, and it is the space that is "a mediating cognitive construct which allows the human organism to operate at acceptable stress levels and aids in the control of intraspecies aggression" (p. 340). It is apparent that the sensitivity to the personal space of an emotionally disturbed adolescent in crisis is essential to avoid acting out behaviors.

Facial expressions, eye contact and voice These three components of non-verbal communication greatly influence the affect behind verbal messages. We communicate 55% of our messages by the face, 38% by the voice, and 7% by the spoken word (Mehrabian and Farris, 1967; Mehrabian and Weiner, 1967; Mehrabian, 1968). Body cues indicate the intensity of specific emotion with the face providing the most information (Friedman, 1986). It is this level of communication which can support or contradict our words and which delivers the emotional feelings behind the statement. According to Ekman and Freisen (1983), investigations have supported that the face can convey the emotions of happiness, sadness, surprise, fear, anger and disgust.

Of the components of facial expression, the eyes are capable of having the greatest impact (Koch, 1971a). The strongest message the eyes can send is when staring at another

individual. When a person is stared at, he/she can become aroused (Kleinke and Pohler, 1971; J. Nicholas and Chapness, 1971). According to Ellsworth (1975) this arousal gets the perceiver to notice and interpret the stare in order to respond and reduce the sense of arousal. It is important to note that prolonged eye contact is a physical and emotional stimulation. Establishing initial eye contact will convey a sense of interest. However, if maintained, eye contact will make an upset youth apprehensive and defiant - less likely to "talk out his problems" and more like to "act them out" (Ellsworth and Langer, 1976).

Although the face predominates in expressing emotions, feelings are also expressed by way of the voice. Koch (1971a) has written that "the voice seems to be verbal, but interwoven around and among the words and tone, intonation, volume, pitch, hesitation, quivering, silence, etc. Emotion comes through such as anger, fear, or enthusiasm" (Koch, 1971a, p. 236). Often when a youngster becomes more agitated, noise level in a situation rises. The youth care worker will often raise his/her voice to ensure that the youth is hearing the message. When this occurs the message often received is anger and disregard. This in turn will often result in an aggressive response from the youth. The ability of the youth care worker to speak in a calm, controlled nonthreatening tone is critical to the goal of de-escalating a crisis.

If the non-verbal communications are contrary to what is being said, verbally, the messages will conflict. Then the non-verbal messages will be believed over the verbal messages (Koch, 1971b; Mehrabian, 1972). It is therefore imperative that the youth care worker be fully aware of the messages communicated non-verbally.

Berlin, Critchly and Rossman (1989) suggest that "nonverbal staff interventions are often helpful: a knowing look or glance, warmth and attention expressed through proximity or simple touch. These interventions aid the client to feel less alone, and to be aware that the adults understand the child's tension and anxiety" (p. 125).

The importance of non-verbal communication is not only significant in the communication delivery of the residential counselor, it also becomes an important behavior to observe in the youth in crisis. "We can listen with our eyes and ears to much more than words ever provide" (Friedman, 1986). Attending to the non-verbal messages presented by the youth can lead to an understanding of the underlying feelings and needs causing the pain and stress. Staff members must develop the ability to observe and attend to antecedent signs of tension, irritability, restlessness and loud voice, angry complaining which often precede impulsive, aggressive behavior (Berlin, Critchly and Rossman, 1989).

The skills outlined as non-verbal communication are critical as a part of crisis prevention and intervention as well as the foundation for establishing The Understanding Response.

Verbal Communication

A significant aspect of The Understanding Response is the use of verbal communication skills. Generally one can look at a hierarchy of responses which project understanding and elicit a response. Referred to as active listening skills, the training process emphasizes the following:

Minimal encouragements - invitation to speak with minimal words: "uh-huh", "go on", "I see".

Door openers - invitations to the child to continue speaking: "I'd like to hear more", "tell me about that".

Question - Closed questions have specific short answer responses. Closed questions ask the child for minimal responses and are appropriate for gathering factual information. The danger in using them is that they may make the child defensive, or angry, or resistant to further probing. Open questions encourage the child to explain further, provide more information, expand on the expression of feelings.

Reflecting Response - Reflecting the content and feeling of a message received encourages youth in crisis to talk out his/her feelings. The emotionally disturbed youth

often has a limited understanding of his/her emotions. The reflecting response helps them identify what they are feeling. Reflecting content identifies and confirms the content of the message. Reflecting feelings validates the youth's emotions while encouraging him/her to talk through his/her difficulty - to talk out rather than act out.

Active listening can help to diffuse the upset child and prevent him/her from having to ACT out because his/her words are being understood. The emotionally disturbed adolescent often ACTS OUT because they lack the ability to TALK OUT the underlying issues or causes of their upset or they don't think anyone will hear them. Active listening demonstrates our concern, empathy, desire to help and respect the youth. It is through these strategies, and the underpinning concept that "talking out" will prevent "acting out", that T.C.I. training can be most effective in preparing the youth care worker.

The verbal expression of anger can in fact decrease the tendency for acting out these feelings and the subsequent need for youth care workers to respond with intrusive interventions. As noted by Kalogjera (1989), "verbal intervention can often render seclusion and restraint unnecessary" (p. 282). Nezlík and Brehm (1975) found that older adolescents experienced a decrease in their hostility when an option for expressing aggression was made available

to them. They noted that "a decrease in hostility occurred before overt aggression could actually be performed" (Nezleck and Brehm, 1975, p. 32). The emotionally disturbed adolescent has probably spent many years learning to reduce his/her level of stress through acting out behavior. It is the destructive expression of stress induced anger which has resulted in their out of home placement. Freshback (1964) has noted the reinforcing qualities of a successful aggressive act. If the act has been instigated by a frustrating experience, then removal of the ability to destroy or control a frustrating object can reinforce the aggressive act. He goes on to support the proposition that aggression can be replaced by socially acceptable responses. Often, when the emotionally disturbed adolescent is stressed, his/her feelings take over making the initial situation worse by acting out in impulsive, defensive, or destructive ways. Long (1990) states "it is helpful for students to see the connection between their behavior and their feelings, to own and accept their feelings, and to learn to say 'yes' to their feelings, but to say 'no' to the improper expression of their feelings" (p. 123). The importance of "talking out" ones feelings is further supported by research conducted by Gold-Englander, Jackson, Crane, Schwarzkopf and Lyle (1989). They reported that students realized that "giving voice to their deepest feelings, their deepest wishes, was a way to be in charge of themselves" (p.

497). This study supports the notion that talking about feelings is not only helpful, but can prevent anti-social behavior.

Awareness in crisis prevention and intervention

During crisis prevention and intervention an awareness of the physical environment and of our own emotions are essential. The T.C.I. training program provides material for lecture, role play, and discussion intended to develop a sensitivity to these two areas of awareness.

Physical Setting

The environment which surrounds the adolescent in placement can have a profound influence on his/her behavior. The immediate setting, where the youth lives, can contribute to or discourage acting out. The appearance of a dormitory or cottage communicates a message about what is expected and what is and isn't tolerated. A dirty, messy unkempt environment can give the message that "anything goes". While a clean, tidy, well organized environment sends a message promoting control and clear behavioral standards. Rose (1988) supports this concept when he stresses that all experiences must provide a clear positive message to the adolescents in placement. He states "The physical attributes of the buildings, the carpets, curtains, furniture, must say 'we are obviously something special - you deserve them'" (Rose, 1988, p. 11).

While attending to the physical setting in a residential treatment center one can not help but realize the irony in the environmental conditions. Such settings attempt to provide a therapeutic environment for troubled, distressed youth by forcing them to sleep, eat, recreate and be schooled with other troubled, distressed youth. As Le Croy (1988) states "In many cases these settings may serve only to exacerbate the problem. The concentration of troubled youth together in a communal living environment sets the stage for frequent shouting, and verbal and physical aggressive behavior" (p. 30).

The forced interaction with many others does tend to result in aggressive acting out behavior by the seriously disturbed adolescent in placement, often necessitating a form of physical intervention to de-escalate the behavior (Phillips, and Nasr, 1983, and Kologjera, 1989).

Meskimins (1990) has referenced a number of experts in the field of residential treatment for adolescents who stress the importance of the physical environment to the overall treatment process (Redl, 1959; Nosphpitz, 1962). Specifically Meskimins (1990) states "The physical surroundings in which the treatment is supposed to occur can have tremendous impact upon both the nature and course of the treatment" (p. 878). It can be difficult to feel comfortable or secure in a chaotic, depressing, dirty or deteriorating physical

environment. Meskimins (1990) states that "one variable that is universally considered antithetical to a psychotherapeutic treatment process is environmental chaos" (p. 879). By attending to the orderliness of the physical environment one potential source of the residents' stress is eliminated.

Within the aspects of environmental awareness is lighting, noise, and activity planning. These three environmental aspects can have a significant impact on the mood and subsequent behavior of the resident. For example, bright, harsh ceiling lighting has a greater stimulating effect than soft table lamps. Also, noise level in the dormitory or cottage can contribute to the overall tranquility or excitement of the group. Finally, activities can serve to stimulate crisis situations and acting out of residents or they can prevent frustration building and increase self control. The key is to provide an appropriate flow of activities through the day while ensuring the residents' readiness and competency to actively participate. As stated by Redl (1966) "The sequence of events and the conditions under which people experience repetitive maneuvers in their life space can have strong impacts on whether or not they can keep themselves under control or whether or not their impulse control behavior breaks down" (p. 84).

Youth care workers awareness of self

"Aggressive behavior is probably the most common presenting problem among youngsters classified as behaviorally disordered" (Etchedt, 1991, p. 107). It is the behaviorally disordered adolescent which most frequently populates the residential treatment center. Perhaps one of strongest feelings provoked when dealing with aggressive acting out behavior is anger: For the youth care worker to wrestle with both the child's behavior and the feelings it arouses in him/her is not an easy task. As Lewis (1981) states:

"Anger is part and parcel of child care work. Show me a child care worker who claims to never have been angry at his/her kids and I will show you an uninvolved practitioner. If you deny the existence of your own anger, you may be heading for problems" (Nunno, 1983, p. III-3).

As Trischman (1969) confirms "The child gets some pleasure from the adult's tormented struggle to maintain logic and consistency - vindictive aggression toward the child is very tempting" (p. 185). Many adults can become uncomfortable with this feeling of anger toward a youth, which can escalate the situation more.

Carauli (1984), who has studied the management of aggressive and violent behavior, identifies two levels of reaction on the part of the staff to aggressive, violent

behavior: the physical/practical level and the inner/emotional level. He suggests that the focus of training programs have been on the physical/practical level and that more important inner/emotional level has been neglected. The exercises and strategies presented in T.C.I. training address both of these levels.

Miskimins, (1990) in discussing a theoretical model of residential treatment, supports the influence of such emotions on staff working with aggressive adolescents. He phrases his interpretation in more psychoanalytical terms. "The psychodynamic aspects of treatment require an ability to work in the face of very emotional and difficult transference-projections and to recognize and deal with issues of countertransference. Both aspects of intervention require considerable psychic energy, enthusiasm and optimism, all couched within a realistic framework" (p. 881).

Freudenberger (1977) raises the concept of countertransference as a critical aspect of burnout. "It is important for child care professionals to recognize that in working in the front line of child care, one's basic emotions, needs, and unresolved problems come in to play" (p. 92).

A study conducted by Hunter (1989) of front line milieu workers supports this concept of countertransference. Of the approximately 150 staff surveyed, almost all were concerned about the feelings they experience following situations

involving physical restraint. "Anger, sympathy, and sadness were identified as the three feelings most commonly experienced" (Hunter, 1989, p. 150). Hunter (1989) concludes from his study that the reactions staff have to the youth in their charge are on multiple levels. "Historical facts that come to the staff's attention, the youth's physical appearance, the context of an interaction - all have an impact on the staff's expectations of themselves and the youth involved and ultimately affect the ways in which they respond" (Hunter, 1989, p. 151). A lack of insight on the part of the youth care worker into the effects these young people have on them and the negative feelings that can be evoked can lead to unnecessary and harmful reactions.

The demands on staff are stated in a somewhat more emotional way by Rose (1968). He references the constant demands from the emotionally disturbed youngster as requiring endless patience and often repeated confrontation. "Such needs and the frequently sadistic hostility of the youngsters would drive a saint to retaliate (Rose, 1998, p. 11). But of course to retaliate would be unthinkable. Yet without adequate alternatives to deal with such feelings the level of stress and anger of the youth care worker will increase and their personal sense of competency will be questioned.

The T.C.I. training program recognizes these feelings as "part and parcel" of youth care work and provides a setting

within which they can be discussed and effective strategies to deal with them presented. As stated by Berlin, Critchly and Rossman (1984), through specific training the youth care worker can become more attuned to his/her own feelings of anxiety elicited by the aggression projected by the adolescent. "When the child is at the point of losing behavioral control, or has just entered into that phase, staff need to appreciate that aggressively disturbed children require adults who are themselves calm, directive, and in control" (Berlin, Critchly and Rossman, 1984, p. 125). The techniques taught during T.C.I. training promote a sensitivity to the youth care worker's own emotions when confronted with an adolescent in crisis. They promote a calmness and directiveness essential in managing the out of control, aggressive adolescent.

Strategies for Physical Intervention

The seriously disturbed adolescent in placement presents a challenge to the youth care worker. These adolescents are often aggressive, hostile, and lacking in impulse control. The youth care worker is the adult most responsible for setting limits, creating a sense of discipline and managing their general behavior.

When the adolescent is unable to control him/herself, caring adults must take over control with the intent of teaching the skills necessary for self control. The training

program T.C.I. presents practical, therapeutic techniques to manage the agitated, out of control adolescent and to help him or her begin to function at a higher level.

The objective of physical intervention is twofold:

1. Short term goal: to help the child regain self control.
2. Long term goal: to teach the child better ways of responding to and coping with the environment and uncomfortable, painful feelings (Nunno, 1983, p. IV-2).

For the purposes of this study physical restraint is defined as: "the use of staff to hold a child safely and therapeutically in order to contain acute physical behavior" (Nunno, 1983, IV-3). Acute physical behavior includes only that behavior which clearly indicates the intent to inflict physical injury upon oneself or others, or to destroy property (Nunno, 1983; Drisko, 1981).

The concept of maltreatment includes the responsibility on the part of the adult to protect the child from harm and to provide adequate supervision (CORE Standard Manual, 1986, p. 168; Article 40). Not using physical restraint when needed to protect the child from harm can be viewed as an act of neglect. Physical restraint, then, can be morally and professionally justified because it keeps a violent, out of control child from doing harm (Drisko, 1981).

The literature supports the concept and use of physical restraint as outlined in the training program. Specifically supported is the following rationale:

Where other techniques are unsuccessful in controlling the aggressive child, an adult's brief, professional restraint can allow a deep and profound trust to develop. The overwhelmed child begins to learn that adults can help limit the out of control behavior as well as the guilt feelings that follow an aggressive outburst. The child also learns that adults can control dangerous behavior without losing control themselves and resorting to punishment or retaliation for the child's actions (Drisko, 1981, p. 318).

The necessity for physical intervention in dealing with the aggressive adolescent is well supported in the literature (Haborg, 1988; Crespi, 1990, Soloff, Gutheil, Weiler, 1985, Garrison, 1984; Miller, Walker and Friedman, 1989, Kologjera, 1989; Drisko, 1976, Drisko, 1981, and Hunter, 1989). A study conducted by Miller, Walker and Friedman (1989) of the use of therapeutic holding to control violent behavior of seriously disturbed adolescents not only indicates its common use but its effectiveness compared to other intrusive techniques. According to the study "it enabled patients to regain behavioral control after a mean of 21.2 minutes, a much

shorter period of containment than the four to sixteen hours reported in studies of seclusion (p. 52).

The predominance physical restraint has in the treatment of the seriously emotionally disturbed youth is pointed out in a previously mentioned study conducted by Hunter (1989). He states that it "remains obvious that dealing with out of control behavior in youth is a fact of life for front line staff" (Hunter, 1989, p. 150). Hunter supports the findings of his study with reference to previous work done by Helmer (1978). Helmer (1978) suggested that where workers need help and support centers around two issues: recognizing and understanding their own feelings which have been triggered by an acting out youth, and knowing alternative ways to help an acting out youth regain control.

To physically hold a child or adolescent, to force him or her to regain personal control, may appear untherapeutic and distasteful. However, the failure to protect a child or adolescent whose actions endanger himself or others is reprehensible. "The use of physical restraining is neither unprofessional nor antitherapeutic. Efforts to assure safety, no matter how demanding, must not be confused with punishment or professional incompetence" (Drisko, 1981, p. 321). Physical restraint therefore must be used when required to enhance safety and in so doing the youth care worker demonstrates a concern for the youth while encouraging the

development of inner controls. Drisko (1981) states, "there is no question that child staff are inevitably required to use brief physical restraint in emergency circumstances during their work with violent, out of control children" (p. 321). In their historical work, Redl and Wineman (1952) refer to physical intervention and restraint as "antiseptic manipulation". They state, "...holding him in an extreme temper outburst, is a clear cut job of antiseptic manipulation. There is not even an inkling of punitiveness involved" (Redl and Wineman, 1952, p. 210 - 211).

This message of caring while exerting external control on the emotionally disturbed adolescent's behavior is supported by Agee (1979). In her discussion of treating violent, incorrigible adolescents, she stressed the need for concerned controls. She states that concerned controls imply an ego-saving message such as "you are too valuable to continue doing stupid things" (Agee, p. 37). Such a message can come through in the therapeutic physical restraint process.

The need for the youth care worker to provide external control over the out of control, violent adolescent is well established. However, to be most effective, the adult must ensure that the intervention will allow the adolescent to feel safe and supported while restricting his/her movements. In order to provide this the youth care worker must acquire the

necessary skills. As opposed to mechanical restraints or seclusion/isolation, the holding method in therapeutic physical restraint maintains contact with caring, supportive adults. It can take place within the context of an ongoing relationship between the adult and the adolescent in crisis and it remains responsive to the need of the adolescent who is being released as soon as self control is regained. As stated by Miller, Walker and Friedman (1989) "Staff time and staff manpower required to perform therapeutic holding appear reasonable...although consistent staff training and supervision are necessary for therapeutic holding to be successful" (p. 524). The message behind the restraint should be "I care enough about you not to let you do damage to yourself or others".

The skills taught during the training allow for such a message to be sent and the techniques acquired limit the physical danger to the adult and adolescent. The training program involves a series of structured lectures and role plays as well as a video tape demonstrating the proper techniques. A brief description of the technique for therapeutic physical restraint follows.

The worker (single person restraint) or worker(s) (two person restraint) immobilizes the violent, acting out youth by placing him/her in a face down position. This reduces stimulation to the youth and assists in his/her calming down.

Specific steps outlined in the training involve (1) obtaining a hold, (2) the take down and turning the adolescent to a face down position, (3) maintaining the hold and (4) the letting go process. The basic principles of the physical techniques presented are "maximum amount of caring with minimum amount of force, with the goal of de-escalating by reducing stimulation" (Nunno, 1983, p. IV-5).

Once the decision to physically intervene is made then it must be done swiftly using the techniques outlined. By each youth care worker knowing the techniques and applying them in a step by step fashion control and safety can be achieved in a quick and therapeutic manner. Self confidence in the youth care workers own ability to handle a difficult situation will convey a nonverbal message of confidence and establish the expectation that order and safety will prevail (Drisko, 1981).

Once the youth is under physical control the "letting go process" can begin. This process is gradual with constant assessment of the youth's ability to follow directions. The letting go process is a gradual test of how in control the youth is becoming. During the process the residential counselor telegraphs what he/she is about to do and what is expected from the youth. Through a step by step process physical control and contact is reduced and finally let go. As stated by Berlin, Critchly and Rossman (1984) "When the

child's anger begins to subside, it is important for the staff to offer nonverbal and symbolic gestures of support ... conveying implicitly that the adult is not angry or punitive and does not wish to get 'even'" (p. 125). This letting go process sets the emotional stage for the second objective in Physical Intervention; that is, to teach the child better ways of responding to and coping with uncomfortable, painful, destructive feelings.

Life Space Interview

The Life Space Interview is used to help the adolescent to better cope with painful, destructive feelings. The Life Space Interview (L.S.I.) was developed by Fritz Redl and is considered an effective series of techniques in dealing with seriously disturbed adolescents (Fagen, 1981; Graham, 1981; Lloyd, 1985; Wood, 1990; Gardner, 1990; Long, 1990). It was adapted for physical restraint and intervention by the T.C.I. training program (Nunno, 1982). There are three specific goals listed for L.S.I. in the training. They are:

1. to return to the level of emotionality at which the child can function appropriately,
2. to use the loss of control and the subsequent restraint episode to clarify the underlying causes and issues that caused the restraint to be necessary in the first place, and
3. to develop a strategy for change with the child.

Prior to detailing the steps of the L.S.I as adapted in T.C.I. training, credit must be given to Fritz Redl. In his book When We deal with Children (1966) he states, "When the adult finds it necessary to surround a youngster's experience at a given time with some form of verbal communication that has the purpose of regulating the impact of his experience on child, we have before us the life space interview" (p. 39). It is conducted by a person (youth care worker) who is perceived by the child as a part of his "natural habitat or life space".

Gardner (1990) indicates the following advantages as purported by Redl and Wineman (1959) in their text Controls from Within: Techniques for the treatment of the aggressive child.

1. enables students to express feelings in a nonjudgemental environment,
2. helps students learn to problem solve,
3. provides a technique that is readily available for use in most crisis situations,
4. helps students identify those feelings that "cause" the acting out,
5. teaches students that they can make changes in their behavior, and

6. enables the professional that is in proximity to the problem to aid the client in a close temporal relationship to the problem (Gardner, 1990, p. 111).

There are seven steps to the L.S.I. interview adapted for Therapeutic Crisis Intervention. Each will be presented with relevant support from the literature.

Step 1: Isolate The first step in the L.S.I. is to isolate the adolescent from the problem situation or from the location where the restraint took place. This is where the message in restraint - "I care enough about you not to allow you to hurt yourself or others" begins to be demonstrably delivered. Symbolic gesturing of support such as providing a glass of water or assisting the youth in washing up is a way of conveying implicitly that the adult's not angry or punitive and does not wish to get even.

Step 2: Explore The second step in the L.S.I. involves exploring the youth's point of view of what happened. As Redl (1966) calls "drain off of frustration acidity", this action allows the youth to express hostility over the physical restraint itself and precipitating events. This, when reinforced, will begin to set a pattern for the youth to "talk out" rather than "act out" his painful feelings.

Step 3: Share The third step involves the youth care worker sharing his/her view of what happened. In sharing views the worker reinforces the fact that the intervention was

done out of caring and concern and also dispels any feelings the youth might have regarding the physical involvement having been based on anger, rejection, retaliation or punishment (Berlin, Critchley, and Rossman, 1984). "Physical holding will always increase the child's feelings of anger and rage, because being immobilized tends to reinforce feelings of helplessness and reactive anger. It is crucial, therefore, after the holding for the adult to make some effort to talk with the child and to clarify with the child why physical holding was required" (Berlin, Critchley, and Rossman, 1984, p. 125).

Providing this perspective has other psychological benefits beyond the obvious relationship building. Research has indicated that the expression of aggression can be affected by an adolescent's understanding of others' cognitive and affective processes during social interaction (Urbain and Kendall, 1980). Further, Platt, Spiro^{ck}, Altman, Altman and Peizer (1974) concluded that intervention programs that have systematically focused upon increasing perspective-taking have successfully reduced aggression and delinquency for some adolescents. Research therefore seems to support this step in the L.S.I. as a productive maneuver in responding to aggressive behavior. Redl (1966) refers to this process as "Reality Rub-In" as he states, "the trouble with some of our

youngsters is that they are socially nearsighted - we must present reality and its implications" (p. 44).

Step 4: Connect This step involves connecting what just happened to other situations or choices the youth makes each time he/she feels a certain way or is in a particular situation. It is important throughout this process that the youth realize that the recent loss of control is not an isolated incident, but part of a pattern of responses that is dangerous and destructive and has most likely resulted in his/her current placement. As Redl (1966) states with his concept of "symptom estrangement" - "we use many of life's situations to try to pile up evidence that their pathologies really don't pay or that children pay too heavily for what meager secondary gains they draw from the pathologies or that the glee they are after can be much more regularly and reliably drawn from others focus of problem-solving or pursuit of life and happiness" (p. 45).

Step 5: Alternatives The fifth step of the L.S.I. involves developing alternative behaviors. Research has indicated that if persons do not have a vested or participatory interest in their treatment, then treatment most likely will not occur (Davis and Salvatore, 1976; Adleman and Taylor, 1984; Adleman, Kaiser-Boyd and Taylor, 1984). This step of the L.S.I. recognizes this factor and is designed as an opportunity for the youth to develop, with adult guidance,

a set of responses more adaptive and less destructive than previously chosen.

Step 6: Plan This step involves getting the youth to agree to a plan on how he/she will respond and behave the next time he/she is feeling this way. As Redl (1966) coins it, this is time for "new tact salesmanship". Through the clarification of the youth's life experiences by the adult, old "tools" may be disregarded and new "tools" tried.

Step 7: Enter Lastly return the youth to the program, entering the group or activity will help normalize the restraint episode. The final message delivered by assisting the youth back into the group can be profound. This final step which culminates the process tells the youth that the adult cared for him/her prior to the restraint episode, during the episode and will continue to care. Redl (1966) calls this "support for the management of panic, fury and guilt" and stresses to the youth that adults in his/her life are just as interested in "protecting him from his own exaggerated wishes as from the bad intents of other people" (Redl, 1966, p. 49).

The Life Space Interview is an essential tool in helping the youth learn and benefit from an otherwise dangerous, destructive experience.

Self-efficacy and Job Stress

It has previously been noted that the role of the youth care worker, or residential counselor, carries with it factors common to high levels of job stress (Mattingly, 1977, Freudenberger, 1977, Reed, 1977, Berlin, Critchly, and Rossman, 1984). One specific factor is extended hours the residential counselor is required to work. They may work 10 - 12 hour shifts for several extended days. A study conducted by Maslach and Pines (1977) indicated that hours of work staff members spend in direct contact with children affected both their attitude toward the children and the approaches they employed. They concluded that "longer working hours were associated with more stress and negative attitudes on the part of the staff" (Maslack and Pines, 1977, p. 107).

As has been stated earlier several surveys (Seeman, 1984, Crichon and Koff, 1980) regarding stress factors among teachers have reported that the management of disruptive children was a major factor of stress in their job. Again, it can be noted that the residential counselor's primary function is to manage a group of seriously behaviorally disturbed youth.

Berlin, Critchly and Rossman (1984) have thoroughly investigated aspects of residential treatment for seriously emotionally disturbed adolescents and have concluded that "one of the most serious problems encountered in milieu treatment

is the continuous stress which can lead to burnout (p. 129). They explain that burnout results from repeated stress which is not relieved. Working with very difficult, often unresponsive adolescents can produce an ongoing pervasive feeling of helplessness and hopelessness which becomes intolerable (Mattingly, 1977; Freudenberger, 1977; Reed, 1977; Maslack and Pines, 1977; Berlin, Critchly and Rossman, 1984). An interesting factor of residential treatment is that when the adolescent "gets better", when he/she progresses and becomes a joy to be with, it is time for him/her to leave and be replaced by an oppositional, resistant, often aggressive individual. As Freudenberger (1977) remarked regarding "burn out" of youth care workers, "They are often not aware that as they day - in - day -out physically 'feed' the needy young person, they day - in - day - out deplete themselves" (p. 92). Freudenberger (1977) responds to this emotional draining inherent in the work by calling for specific, relevant training. "Training is often an intellectual process through which emotional feeding may take place. Training of staff is absolutely essential to the diminishing and prevention of burn out" (Freudenberger, 1977, p. 95).

Another aspect of youth care work which contributes to job stress is the unfinished product. The residential counselor, as with any other worker, needs to view himself/herself as successful. However, as Mattingly (1977)

phrases it, "one's very best work will frequently nurture a seed that grows and bears fruit in the future and beyond one's personal awareness" (p. 128). The residential counselor often has the sense that he/she has stopped in the middle, left with concern, fear and hopes for the youth discharged from their care. The residential counselor is frequently denied the rewards of a job well done. The burn out syndrome is a response to stress that is inherent and severe in the work with seriously disturbed adolescents in placement. Ultimately, burn out affects the youth's treatment. As reported by Blase (1986), productivity of helping professionals drops significantly with increased stress. Burned out residential counselors think only of their personal survival. At best the burned out youth care worker neither prevents progress nor furthers it. At worst a cynical, negative staff person could seriously impair the treatment of the residents in their care (Weiskopf, 1980).

How then does the concept of self-efficacy relate to the occurrence of job stress? One area that impacts job stress, and is correlated with a sense of self-efficacy, is job satisfaction. Job satisfaction was investigated by Atwood and Woolf (1985). Their findings implied that skill requirements are a significant factor in job satisfaction. This factor, as it relates to youth care workers, raises support for the development of a body of knowledge pertinent to the functional

responsibilities of the residential counselor. The lack of defined, specific skills associated with youth care may indeed contribute to low job satisfaction. A further reference to job satisfaction and its relationship to the acquisition of job skills is noted by Gruneberg (1979) in his book Understanding Job Satisfaction where he states, "one individual is unlikely to feel that he has achieved something worthwhile unless the application of some skills is involved" (p. 117).

A discussion on self-efficacy must include the work of Albert Bandura. His concept of self-efficacy can be linked to a reduction of job stress. The following definition will clarify this linkage. "An efficacy expectation is the connection that one can successfully execute the behavior required to produce desired outcome" (Bandura, 1977b, p. 193). For the purpose of this study, self-efficacy is further defined as a residential counselor's belief that he or she has the capacity to affect the performance of an emotionally disturbed adolescent in his/her care. This definition is extrapolated from the research conducted by Ashton and Webb (1986). Specific to this study is the management of a youth's behavior while in crisis.

Self-efficacy includes the belief that certain behaviors will lead to a desired outcome and the belief that one possesses the competence to execute the behavior required to

bring about the outcome. These beliefs influence the kinds of behavior initiated, the amount of effort expended and the degree of persistence maintained in stressful situations. Kauffman and Wong (1991) investigated the impact of teacher efficacy and defined it as "referring to a teacher's perception of her or his ability to affect students performance positively" (p. 231). With reference to the residential counselor, it is his or her perception of his or her ability to affect a resident's performance positively.

Ashton and Webb (1986) concluded that many teachers who work with low ability students tend to develop a low sense of efficacy. As stated earlier, the residential counselor often experiences little observable, sustainable progress of the resident's in their care. One can see, unfortunately, how a low sense of self-efficacy can develop. This is unfortunate because high energy and sustained effort is required and yet contraindicated with a low sense of self-efficacy.

In a recent study, Greenwood, Olejnik and Parkway (1990) examined the relationship between teacher efficacy beliefs and teacher feelings of stress, loss of control, gender, race, ethnic origin, education, age, grade level and teacher experience. Results showed that efficacy was related to lower stress and internal levels of control.

Osipow (1991) and Lazarus, DeLongis, Folman and Gurer (1985) found that the most salient construct in predicting job stress

was the worker's perception of stress, not some objective reality. These studies support the assumption that reported self-efficacy influences perceived stress.

Summary

A review of the literature has examined the typical characteristics of the emotionally disturbed adolescent in placement. Depression, oppositional/defiance, withdrawn, extreme anxiety, rageful outbursts and poor social skills are common characteristics. The literature also indicates how such characteristics make the job of the residential counselor both challenging and stressful. The need for specific training is supported.

The skills and techniques presented in T.C.I. training are reviewed and supported by relevant literature and research. Emphasis is placed on preventive, as well as, crisis intervention techniques stressing the opportunity for change and growth.

Finally, a theoretical connection between reported self-efficacy and perceived job stress is supported. It is an assumption of this study that T.C.I. training will provide the personal conviction by the residential counselor that he/she can successfully intervene to safely control out of control residents and use the crisis as an opportunity for learning and change.

CHAPTER III - RESEARCH DESIGN AND METHODOLOGY

Presented in this chapter is a description of the design of the study, population and sample, instrumentation, data collection procedure, and data analysis technique.

Design of the Study

The study is a full factorial experimental design requiring a four way analysis of variance (Huck, Cormier, Bounds, 1974). In order to accomplish this, four residential treatment centers were selected from which were drawn a representative sample of youth care workers. The four residential facilities are licensed by the Commonwealth of Virginia and accredited by the Virginia Association of Independent Special Education Facilities to serve seriously emotionally disturbed adolescents.

Training was facilitated by the same person at each of the four schools allowing for a consistent presentation of the material. The facilitator was trained by the project director and was observed in a training role at Timber Ridge School, a residential treatment center, prior to initiating the research project. In addition each training session was observed by the researcher to ensure consistency in terms of sequence and context of the material.

The purpose of the study was to determine if there is a relationship between participation in the Therapeutic Crisis Intervention Training Program and a trainee's perceived sense of:

1. competence in dealing with aggressive acting out behavior,
2. reduction in job stress.

Defining the purpose in this manner allows for clear delineation of the following dependent variables or treatment affects:

1. Youth care workers' reported personal competence or efficacy measured by subscales of the Occupational Stress Inventory and subscales of the Correctional Institution Environment Scale.
2. Youth care workers' reported sense of job stress measured by subscales of the Maslach Burnout Inventory.

Finally, in order to further define the treatment effects, specific classification variables were used to control subject characteristics.

1. Youth care workers may have less than one year of experience; or one year and more experience.
2. Youth care workers may have a high school diploma; or may have a college degree.

3. Youth care workers may be under the age of 25; or may be 25 years of age or older.

Description of the design

Three distinct groups are defined for the purpose of conducting the research. Group 1 is comprised of residential counselors, randomly selected, who participated in the training. Group 2 is comprised of residential counselors, randomly selected, who participated in the training along with a follow-up three-hour session. The follow-up program occurred between 21 and 45 days after the initial training. It involved a review of the skills presented during the training and a discussion regarding their practical application and effectiveness. Group 3 is comprised of residential counselors, randomly selected, as a control group. This group did not receive any training during the research project. However, at the conclusion of the project the researcher will provide Therapeutic Crisis Intervention training to the control group members.

Each group member was administered three standardized measurements to report the treatment effects. The measurements were administered in a three interval time series: first, at the conclusion of the training; second, at approximately 21 days following the training; and finally, at approximately 30 - 45 days following the training.

In addition, the two experimental groups received a post-training questionnaire approximately 45 days following the training. The post-training questionnaire (Appendix A) was intended to address the participant's subjective opinion regarding the skills and techniques presented during the training.

Finally, a questionnaire to be completed whenever the residential counselor was involved in a physical intervention with a resident was given to each facility for use by all participants (see Appendix B).

Population and Sample

A survey jointly conducted by the Virginia Association of Independent Special Education Facilities (VAISEF) and the Virginia Association of Children's Homes (VACH) indicated that in September 1991, 32 residential schools affiliated with these Associations had a capacity for serving 1,637 residents. At the time of the survey they were operating at a 78% capacity, or 1,274 clients (VAISEF, 1991). These numbers are reflective of a national trend in residential care. For example, on a national level, private juvenile detention centers admitted 553,000 juveniles in 1988. This was an increase of 129% from a 1978 survey (National Juvenile Custody trends, 1978-1979; 1992). This study focuses on the

population of youth care workers who work with this growing population.

The sample of youth care workers for this study was drawn from residential treatment centers accredited by VAISEF, serving a total of 717 emotionally disturbed youth with a total capacity of 817 residents. Four schools were selected for the study. They are:

Little Keswick Founded in 1963, it is licensed by the Virginia Board of Education and accredited by VAISEF to serve a capacity of 29 boys who are learning disabled, emotionally disturbed and between the ages of seven and 17. It is a residential program located in Keswick, Virginia near Charlottesville. Twelve residential staff were selected to participate. From these 12 staff two training groups were randomly selected and assigned (n = 4 from each group); along with a randomly selected control group (n = 4).

Elk Hill Farm Located in Goochland, Virginia, Elk Hill Farm was founded in 1970. It is licensed and accredited to serve emotionally disturbed and learning disabled youth between ages of 13 and 18 years. It has a capacity of 30 residents. Eleven residential staff were selected to participate in the research. From these 11 staff, two training groups were randomly selected and assigned (n = 4; n = 3); along with a randomly selected control group (n = 4).

Grafton School Grafton School was established in 1958 and is located in Berryville, Virginia. It is licensed and accredited to serve a capacity of 169 residents with a variety of handicapping conditions to include emotionally disturbed and learning disabled youth ranging in age from three to 18. For the purpose of this research residential staff were selected who work directly with an adolescent population. Sixteen residential staff were selected to participate in the research. From these 16 staff two training groups were randomly selected and assigned (n = 6; n = 5); along with a randomly selected control group (n = 5).

Barry Robinson Center This center, established in 1986, is located in Norfolk, Virginia. It is licensed as a residential school and accredited by VAISEF to serve emotionally disturbed and learning disabled youth. The school has a capacity of 72 residents. Twelve residential staff were selected to participate in the research. From the 12 staff two training groups were randomly selected and assigned (n = 3; n = 4); along with a randomly selected control group (n = 5).

The selection provided the study with a total sample size of 51 participants. Thirty-three participants were randomly assigned to the training groups and 18 to the control group. Of the participants in the training groups, 17 received the training and 16 received training with a follow-up session.

Specific demographic information of the participants relevant to the classification variables is found on Table 1.

Instrumentation

Three standardized measures were selected to determine the treatment results. They are noted here with reference to their purpose and supported by reported validity and reliability information.

Purpose 1. Relationship between participation in T.C.I. training and reported perception of self-efficacy.

Two instruments were selected to measure self-efficacy: The Occupation Stress Inventory (OSI) and Correctional Institution Environment Scale (CIES).

OSI was selected to measure the perception of self-efficacy. It measures three dimensions of occupational adjustment: Occupational Stress, Psychological Strain, and Coping Resources. The Occupational Stress domain is measured by a set of six scales which are collectively called the Occupational Roles Questionnaire (ORQ). This study uses the ORQ to determine competence or self-efficacy reported by residential counselors. Specifically the ORQ subscales of Role Overload (RO) which measure the extent to which job demands exceed resources, and Role Insufficiency (RI) which measures the extent to which the individual's training, education, skills and experience are appropriate to job

Table 1

Participants Randomly Assigned to Training
Groups; and Distinguished by Classification Variables

Training groups: Exp. Grp. 1 - Training w/o follow-up

Exp. Grp. 2 - Training with follow-up

Control Grp. - No training

Classification Variables: Experience

Educational Attainment

Age

	Exp. Grp 1 N = 17	Exp. Grp 2 N = 16	Control Grp N = 18	Total N = 51
< 1 YR. EXP	1	3	3	7
> 1 YR. EXP	16	13	15	44
HIGH SCHOOL DIPLOMA	5	4	4	13
≥ COLLEGE DEGREE	12	12	14	38
< 25 YRS. OF AGE	1	3	5	9
≥ 25 YRS. OF AGE	16	13	13	42

requirements will be used for this purpose. High scores in the RO scale indicate a work load unsupported by needed resources, not feeling well trained or competent for the job. High scores in the RI subscale indicate a poor fit between job skills and job performance, that is, a sense of low self efficacy.

Reliability. An internal consistency analysis was completed using a sample of 549 working adults to determine the reliability of each scale. An Alpha Coefficient for total questionnaire scores indicated the ORQ scale as .89 (Osipow and Spokane, 1992, p. 9).

Validity. Each of the questionnaires were repeatedly subjected to a confirmatory factor analysis using a varimax rotation procedure. The factor structure provides confirmatory evidence for the scales of the ORQ (Osipow and Spokane, 1992). A large number of correlational and multivariate studies have employed the OSI as an experimental measure and provide evidence of the relationship between stress, strain, and coping. These studies provide moderate to strong support of the concurrent validity of the OSI (Osipow and Spokane, 1992, p. 10).

Correctional Institution Environment Scale (CIES) The measurement was selected to report the perception of self-efficacy. The selection of this scale is predicated on the assumption that the reported perceptions of a residential

counselor's work environment can be interpreted as reported perceptions of personal competence or self-efficacy. The CIES is composed of nine subscales that measure the social climate of juvenile and adult correctional program. The nine subscales assess three underlying domains or sets of dimensions: Relationship Dimension, Personal Growth or Goal Orientation Dimension, and System Maintenance Dimension. The short form was administered to the participants and the following three subscales were compared to determine reported perceptions.

Support (S) - the extent to which staff are supportive of residents;

Expressiveness (E) - how much the program encourages the open expression of feelings of residents;

Personal Problem Orientation (PPO) - the extent to which residents are encouraged to understand their personal problems and feelings.

In all three subscales higher scores indicate a reported higher sense of competence in the skills presented during Therapeutic Crisis Intervention Training.

Reliability. To measure the stability of the overall CIES profile, one residential environment unit was retested after one week, two units were retested after one month, and another unit was retested after two years. Intra-class correlation between the two sets of CIES subscale standard

scores .94, .95, and .96 for the one week and two one month intervals and .91 for the two year intervals were reported (Moos, 1987).

To determine whether the CIES reflects program change when it occurs, 13 units in which new treatment programs were introduced were tested both before and after the change. The average interclass correlation over these 13 units was .37 indicating the CIES is sensitive to change in the milieu (Moos, 1987).

Validity. The users guide reports adequate face validity and construct validity. The scales are based on specific constructs which are supported by relevant social and environmental theory and which directed item selection. Item selected was further supported by independent raters. Criterion validity of the scales is reported as acceptable. The dimension are related to external criteria supported in both concurrent and predictive studies (Moos, 1987, p. 35).

Purpose 2. Relationship between participation in T.C.I. training and reported perception of job stress.

One measurement was selected in response to this research purpose: The Maslach Burnout Inventory (MBI).

Maslach Burnout Inventory (MBI) The MBI is designed to assess the three aspects of the burnout syndrome: emotional exhaustion, depersonalization, and lack of

personal accomplishment. The Emotional Exhaustion (EE) subscale assesses feelings of being emotionally overextended and exhausted by one's work. High scores indicate a high degree of burnout. The Depersonalization (DP) subscale measures an unfeeling and impersonal response toward residents. High scores indicate a high degree of burnout. The Personal Accomplishment (PA) subscale assesses feelings of competence and successful achievements in one's work with people. Low scores on this subscale indicate a high degree of burnout.

Reliability. Internal consistency was estimated by Cronbach's Coefficient Alpha (n=1,316). The reliability coefficient for the subscales were reported as follows: .90 for Emotional Exhaustion; .75 for Depersonalization; and .71 for Personal Accomplishment (Maslach and Jackson, 1986). Data on test-retest reliability is reported as: .82 for Emotional Exhaustion; .60 for Depersonalization; and .80 for Personal Accomplishment. The test-retest interval was two weeks (Maslach and Jackson, 1986).

Data on test-retest reliability with a one year interval was reported as: .60 for Emotional Exhaustion; .54 for Depersonalization; and .57 for Personal Accomplishment (Maslach and Jackson, 1986).

Validity. A group of 40 mental health workers were each asked to provide an anonymous behavioral evaluation of a designated

coworker who had completed the MBI. The critical question in terms of validating the Emotional Exhaustion and Depersonalization subscale, were ratings of how "emotionally drained" the person was, and how he or she reacted to clients. People who were rated by the coworker as being emotionally drained by the job scored higher on Emotional Exhaustion and Depersonalization. People who were rated as appearing physically fatigued also scored higher on Emotional Exhaustion and Depersonalization (Maslach and Jackson, 1986).

A comparison of subjects' scores with the MBI and the Job Diagnostic Scale (JDS) measure of "general job satisfaction" (n=91, social service and mental health workers) supported discriminant validity of the burnout construct. Job satisfaction had a moderate negative correlation with both Emotional Exhaustion ($r=-.23$, $p < .05$) and Depersonalization ($r=-.22$, $p < .02$), as well as a slightly positive correlation with Personal Accomplishment ($r=.17$, $p < .06$) (Maslach and Jackson, 1986).

Another comparison of the MBI and JDS scale dealt with certain job dimension. Ninety one social service and mental health workers completed both measures. One measure of JDS assess the dimension, "feedback from the job itself". High scores on this dimension were correlated with low scores on Emotional Exhaustion and Depersonalization and high scores on

Personal Accomplishments. Another dimension measured by JDS, "dealing with others", was weakly correlated with Emotional Exhaustion. A third dimension, "task significance", assesses the degree to which the job has a substantial impact on the lives of others. High scores on this dimension were correlated positively with Personal Accomplishments (Maslach and Jackson, 1986).

Post Training Questionnaire

In order to gather further data regarding the perceptions of participants in the Therapeutic Crisis Intervention Training, two questionnaires were developed. One questionnaire titled Therapeutic Crisis Intervention Training Program - Child Care Worker Questionnaire (Appendix A) was adapted from the Classroom Management Training Program Questionnaire developed by Dr. Fredric Jones and used by Dr. Barton Kramer in his dissertation titled Improving classroom management skills in secondary school classroom through the use of limit setting, an incentive system, and structured teaching (Kramer, 1986). Revisions were made for the purpose of this research. The adjusted questionnaire was reviewed by four persons considered experts in the field of residential youth care.

A second questionnaire and final measure was developed intended to report perceptions of trainees following their physical involvement with an out of control, disruptive youth.

Each participating facility was given the questionnaire and instructed to complete it along with the standard reporting required for such incidents. This form was reviewed by the six experts previously noted. Minor changes were made after the review and prior to distributing the questionnaire. This questionnaire is included in Appendix B.

Data Analysis

A four way analysis of variance (ANOVA) (with .05 level of significance) was used to analyze the effect of the four main independent variables (TCI Training, age, educational attainment and experience) on reported personal competence and reported sense of job stress. In addition, the ANOVA is used to analyze the single interactive effect between each independent variable (age, educational attainment and experience) and the treatment categories (training, training with follow-up, control group) on reported personal competence and reported sense of job stress (Huck, Cormier and Bounds 1974).

The following null hypotheses are developed to direct the analyses:

Two substantive null hypotheses are developed to direct the analysis of the main effect of treatment on reported competence and job stress.

H₀₋₁: There is no difference in reported sense of competence between youth care workers trained, those trained with a follow-up training session, and a control group without TCI training.

H₀₋₂: There is no difference in reported job stress in youth care workers trained, those trained with a follow-up training session, and a control group without TCI training.

A total of six sub-hypotheses are developed to analyze the interactive effect of each of the three factors of age, educational attainment and experience on the treatment categories.

H₁₋₁: There is no interaction effect between the factors of age and treatment on reported personal competence.

H₁₋₂: There is no interaction effect between the factors of educational attainment and treatment on reported personal competence.

H₁₋₃: There is no interaction effect between the factors of work experience and treatment on reported personal competence.

H₂₋₁: There is no interaction effect between the factors of age and treatment on reported job stress.

H₂₋₂: There is no interaction effect between the factors of educational attainment and treatment on reported job stress.

H₂₋₃: There is no interaction effect between the factors of work experience and treatment on reported job stress.

In addition, the post training questionnaire (Appendix A) will be analyzed using a Chi Square analysis of the nominal data collected, and a mean score comparison providing a descriptive analysis of the interval data collected.

Summary

The design of the study, the population and sample have been discussed. In addition, specific instruments selected relevant to the defined research purposes have been specified and supported. Finally, a description of procedures for analyzing the data were outlined in this chapter.

CHAPTER IV - ANALYSIS AND FINDINGS

Introduction

In this chapter, the results of the data analysis are presented. This chapter is divided into three sections. The first two sections deal with data relevant to the effects of training on reported competence and job stress. Each of these two sections is composed of three principal subsections addressing the interaction of the factors of age, educational attainment and experience with the training categories on reported competence and job stress.

Finally, the third section deals with an analysis of data gathered from the post training questionnaire.

Research Questions, Hypotheses and Findings

Research Question: Is there a relationship between Therapeutic Crisis Intervention Training (TCI) and a trainee's perceived sense of competence in managing seriously emotionally disturbed adolescents in placement?

The following statistical hypothesis was developed to answer this research question.

H_{0-1} : There is no difference in reported sense of competence between youth care workers trained, those

trained with a follow-up training session and with a control group with no TCI training.

The scores from two subtests of the Occupational Stress Inventory; Role Overload (RO) and Role Insufficiency (RI) and three subtests of the Correctional Institution Environment Scale; Support (S), Expressiveness (E), and Personal Problem Orientation (PPO) were analyzed using a four factor analysis of variance (ANOVA). The factors in the analysis were: training, age, educational attainment and experience. This statistical treatment permitted examination of differences with training, training with follow-up, and no training. Measurements taken at the time of training and 45 days after training were used. (It is noted here that the 21 day measurements were discounted throughout the analysis due to an inadequate number of returns from a particular school). There were no statistically significant differences noted in any of the analyses at the .05 level of significance. Consequently the main effect null hypotheses cannot be rejected. Specifically, there is no significant difference between the reported sense of competence in youth care workers trained, those trained with a follow-up session and a control group with no training. (Refer to Appendix F for reported Mean scores for each group).

Sub-Hypotheses. These same measures - RO and RI of the Occupational Stress Inventory and S, E, and PPO of the

Correctional Institution Environment Scale were used to investigate three sub-hypotheses. These can be stated as follows:

H₁₋₁: There is no interaction effect between the factors of age and treatment on reported personal competence.

H₁₋₂: There is no interaction effect between the factors of educational attainment and treatment on reported personal competence.

H₁₋₃: There is no interaction effect between the factors of work experience and treatment on reported personal competence.

Findings H₁₋₁. The five subscale scores were analyzed using a four factor analysis of variance (ANOVA). This statistical treatment permitted examination of the interactive effect between training in TCI and the age of the participants. Measurements taken at the time of training and at 45 days after training were used. The analysis indicated that the training group and the training group with follow-up, measured at 45 days after training had significantly different mean scores relevant to age on the Correctional Institution Environment Scale, S-subscale. Specifically, those in the training group without follow-up who were 25 years and older had significantly higher scores (M = 4) on the

support subscale than did those in the training group without follow-up who were younger ($M = 2$). In contrast, the mean scores for those younger than 25 who were in the training group with follow-up were significantly higher ($m=4$) on the support subscale than were the scores of those older than 25 who had follow-up ($m = 3$). This suggests that residential counselors who are older than 25 trained in TCI without receiving follow-up perceive themselves as more competent in the use of support skills than do their younger counterparts. In contrast, residential counselors younger than 25 years who are trained in TCI, with a follow-up session, perceive themselves as more competent in the use of support skills than their older counterparts perceive themselves. A further assumption may be made that the follow-up session enhances the learning of supportive skills for the under 25 year trainee group.

The ANOVA (Table 2) bears this supposition out. It can be stated at the .05 level of confidence that there is an interaction effect between age and training, as reported on the 45 day support subscale of the C.I.E.S.

($F, df=2,31 = 7.42, p < .002$).

This specific subscale of the Correctional Environment Scale reported the only significant result. There were no other significant results, at the .05 level of confidence,

Table 2

Analysis of Variance for Scores on the Correctional
 Institution Environment Scale
 Support Subscale (S)
 45 day Measurement
 (N = 46)

<u>Source of Variance</u>	<u>df</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>P > F</u>
Treatment (A)	2	1.64	.82	1.91	.165
Experience (B)	1	.20	.20	.47	.499
A x B	2	.32	.16	.38	.688
Education (C)	1	.68	.68	1.59	.217
A x C	2	.65	.33	.76	.477
Age (D)	1	1.15	1.16	2.69	.111
A x D	2	6.37	3.19	7.42	.002*
Error	31	13.31	.43		
Total	45	24.96			

noted for the remaining four subtests. Specifically, there were no other significant interactive effects between the factors of age and treatment on reported personal competence.

Findings H₁₋₂: The five subtest scores used to measure reported competence were analyzed using a four factor analysis of variance (ANOVA). This statistical treatment permitted examination of the interactive effect between training in TCI and the educational attainment of the participant. There were no statistically significant differences noted, at the .05 level of confidence, for any of the analyses. The null hypothesis can therefore not be rejected. Specifically, there were no interactive effects between educational attainment and treatment on reported personal competence.

Findings H₁₋₃: The five subtest scores used to measure reported competence were analyzed using a four factor analysis of variance (ANOVA). This statistical treatment permitted examination of the interactive effective between training in TCI and work experience of the participants. There were no statistically significant differences noted, at the .05 level of confidence, for any of the analyses. The null hypothesis can, therefore, not be rejected. Specifically, there were no significant interactive effects between work experience and treatment on reported personal competence.

Research Question: Is there a relationship between Therapeutic Crisis Intervention Training and a trainee's perceived sense of job stress?

The following statistical hypothesis was developed to answer this research question:

H_{0-2} : There is no difference in reported job stress in youth care workers trained, those trained with a follow-up training session, and a control group with no TCI training.

The scores for the Maslach Burnout Inventory subscales; Emotional Exhaustion (EE), Depersonalization (DP) and Personal Accomplishment (PA) were analyzed using a four factor analysis of variance (ANOVA). The four factors were: training method, age, educational attainment and experience. This statistical treatment permitted examination of differences due to training, training with follow-up, and no training. Measurements taken at the time of training and 45 days after training were used. There were no statistically significant differences noted in any of the analyses. Consequently, the main effect hypothesis can not be rejected at the .05 level of confidence. (Refer to Appendix G for reported mean scores).

Sub-Hypotheses. These same subtests, EE, DP and PA of the Maslach Burnout Inventory, were analyzed to investigate three sub-hypotheses. These can be stated as follows:

H₂₋₁: There is no interaction effect between the factors of age and treatment on reported job stress.

H₂₋₂: There is no interaction effect between the factors of education attainment and treatment reported job stress.

H₂₋₃: There is no interaction effect between the factors of work experience and treatment on reported job stress.

Findings H₂₋₁. The three subscale scores were analyzed using a four factor analysis of variance (ANOVA). This statistical treatment permitted examination of differences due to the interactive effect of training with age of the participant. The analysis indicates significant results with regard to the DP subscale. Initial measurements indicated that the older participants had a greater depersonalization mean score (m=8.5) than their younger counterparts (m=5). This indicates that the older participants perceived themselves as having a greater sense of job stress. In this analysis it can be reasonably stated at the .05 confidence level that there exists an interaction effect between age and treatment on reported stress ($F_{df=2,35} = 3.53, p < .04$, Table 3).

Forty five days after training the younger group who received training without follow-up reported a higher

Table 3

Analyses of Variance for Scores on the Maslach's Burnout Inventory

Depersonalization Subscale (DP)

Initial Measurement

(N = 50)

<u>Source of Variance</u>	<u>df</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>P > F</u>
Treatment (A)	2	10.01	5.00	.29	.75
Experience (B)	1	27.91	27.91	1.62	.21
A x B	2	35.16	17.58	1.02	.37
Education (C)	1	18.56	18.56	1.08	.30
A x C	2	.90	.44	.03	.97
Age (D)	1	19.23	19.23	1.12	.30
A x D	2	121.46	60.73	3.53	.04 *
Error	35	601.84	17.20		
Total	49	1104.32			

depersonalization mean score ($M = 11$) than their older counterparts ($M = 5$). In contrast, the training group which received follow-up reported different results. In this group, the younger participants reported a lower depersonalization mean score ($M = 7$) than their older counterparts. The inference can be made that training with follow-up impacts the younger participants' sense of job stress in a positive way, when compared to their older counterparts. The ANOVA bears this inference out. At the .05 level of confidence, there exists a significant interactive effect between age and training on reported job stress. ($F_{df=2,33} = 3.36, p = < .05$, Table 4).

Although no significant differences were reported for those participants who were under 25 on their level of depersonalization between the initial and 45 day measurements, the older participants did report significantly less depersonalization at the 45 day measurement than they reported initially. In comparing treatment with treatment follow-up groups, the older participants who received treatment without follow-up decreased their mean scores from $m=5.94$ to $m=4.94$. The older participants who received follow-up also decreased their DP mean score from $m=10.75$ to $m=8.62$. This can be noted by review of Table 5.

Table 4

Analyses of Variance for Scores on the Maslach's Burnout Inventory
 Depersonalization Subscale (DP)
 Forty-five Day Measurement
 (N = 48)

<u>Source of Variance</u>	<u>df</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>P > F</u>
Treatment (A)	2	66.40	33.20	2.22	.12
Experience (B)	1	10.52	10.52	.70	.41
A x B	2	89.96	44.98	3.01	.06
Education (C)	1	54.15	54.15	3.63	.07
A x C	2	12.30	6.15	.41	.66
Age (D)	1	2.03	2.03	.14	.71
A x D	2	100.39	50.19	3.36	.05 *
Error	33	492.39	14.92		
Total	47	1019.92			

Table 5

Maslach's Burnout Inventory

Depersonalization Subscale

Mean Scores of Older Participants (>26 yrs.)

Initial and Forty-Five Day Measurements

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>
Treatment group			
Initial measurement	16	5.94	4.48
45 Day measurement	16	4.94	4.52
Treatment with follow-up			
Initial Measurement	12	10.75	4.47
45 Day measurement	13	8.62	4.51
Control Group			
Initial measurement	13	8.23	4.46
45 Day measurement	12	9.08	4.50

A review of the analysis conducted on the PA subscale indicates that age has both a main effect and an interactive effect with treatment. This was indicated in analyzing the initial and the 45 day measurement.

The older group of participants (> 25 years) in general initially scored higher on the PA subscale (m=41) than their younger counterparts (m=38). This can be interpreted as the older, more mature residential counselor reporting a higher sense of personal accomplishment than their younger counterparts. This is supported at the .05 level of confidence ($F_{df=1,35} = 8.46, p = < .01$, Table 6). In addition, the analysis of the initial measurement indicates an interactive effect between age and treatment as reported by the PA subscale. Age had a significant impact on the training groups reported PA scores. The younger participants reported a mean score of 36 and the older participants reported a mean score of 41. The ANOVA (Table 6) bears this supposition out. It can be stated at the .05 level of confidence that there exists an interaction between age and treatment ($F_{df=2,35} = 3.30, p = < .05$).

A review of the second 45 day measurement of the PA subscale score reveals similar results. The older group of participants (> 25 years) in general scored higher on the PA scale (m=40) than their younger (< 25 years) counterparts

Table 6

Analysis of Variance for Scores on the Maslach's Burnout Inventory

Personal Accomplishment Subscale (PA)

Initial Assessment

(N = 36)

<u>Source of Variance</u>	<u>df</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>P > F</u>
Treatment (A)	2	103.69	51.84	2.34	.11
Experience (B)	1	19.04	19.03	.86	.36
A x B	2	137.46	68.73	3.10	.06
Education (C)	1	94.68	94.68	4.27	.05 *
A x C	2	24.58	12.29	.55	.58
Age (D)	1	187.42	187.42	8.46	.01 *
A x D	2	146.42	73.21	3.30	.05 *
Error	35	775.55	22.16		
Total	49	1540.00			

($n=35$). This can be interpreted as the older, more mature residential counselor reporting a higher sense of personal accomplishment than their younger counterparts in the study. This inference is supported at the .05 level of confidence and can be reviewed on Table 7 ($F_{df=1,33} = 7.28, p = < .01$).

In addition, the analysis of the 45 day measurement indicates an interactive effect between age and treatment as reported by the PA subscale. As in the initial measurement, age had an impact when interacting with training on PA scores. Younger participants reported a mean score of 31 and older participants reported a mean score of 40. The ANOVA (Table 7) bears this supposition out. It can be stated at the .05 level of confidence that there exists an interaction between age and treatment ($F_{df=2,33} = 4.54, p = < .02$).

In summary there is evidence of an interactive effect of age with training as reported on the Personal Achievement initial and 45 day measurement and with the Depersonalization initial and 45 day measurements.

Findings H_{2-2} . The three subscales were analyzed using four factor analysis of variance (ANOVA). This statistical treatment permitted examination of differences due to the interactive effect of training with education attainment of the participants. There was no evidence of an interactive effect to report at the .05 level of confidence.

Table 7

Analysis of Variance for Scores on the Maslach's Burnout Inventory
 Personal Accomplishment Subscale (PA)
 Forty-five Day Measurement
 (N = 34)

<u>Source of Variance</u>	<u>df</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>P > F</u>
Treatment (A)	2	95.24	47.62	1.43	.25
Experience (B)	1	73.49	73.49	2.21	.15
A x B	2	37.83	18.92	.57	.57
Education (C)	1	30.27	30.27	.91	.35
A x C	2	42.91	21.46	.64	.53
Age (D)	1	242.21	242.21	7.28	.01 *
A x D	2	302.09	151.04	4.54	.02 *
Error	33	1098.40	33.28		
Total	47	1905.67			

Specifically, there were no interactive effects between the factors of education attainment and treatment on reported job stress. However, there is evidence of a main effect in regard to education attainment. Interestingly, the initial analysis indicated that those participants with a high school education reported, overall, a higher sense of personal accomplishment on the PA subscale ($m=42$) than their more educated (college degree or higher) counterparts ($m=40$). The ANOVA supports this supposition at a .05 level of confidence ($F_{df=1,35} = 4.27$, $p = < .05$, Table 6).

Findings H_{2-3} . The three subscale scores were analyzed using a four factor analysis of variance (ANOVA). This statistical treatment permitted examination of differences due to the interaction effect of training with experience of the participants. There was no evidence of an interactive effect to report at the .05 level of confidence. This hypothesis cannot be rejected. Specifically, there were no significant interactive effects between the factors of work experience and treatment on reported job stress.

Post Training Questionnaire and Findings

A post training questionnaire (Appendix A) was administered to both the training group and the training group with follow-up session. Participants were given the

questionnaire 45 days following the initial training in TCI. Each question was analyzed with results reported here.

Questions one through three of the post-training questionnaire and question 14 were analyzed using a Chi-Square analysis. This statistical treatment permitted examination of the nominal scale data collected.

Question No.1 Active listening skills to include non-verbal and verbal skills.

There exists a significant relationship between the treatment method provided (follow-up training vs no follow-up) and the respondents' answers regarding the use of active listening skills ($X^2_{df=1} = 4.89, p = < .03$). That is, participants who received follow-up training were less likely to use active listening skills.

The following descriptive trends are supported by this statistically significant relationship. All 16 respondents that received training without follow-up reported that they have been using these skills. Only eleven out of the 15 respondents that received training with follow-up stated that they have been regularly using these skills. From the training group with follow-up, four out of 15 respondents stated that they have been partially using these skills (Table 8).

Table 8

Question #1: Active listening skills to include
non-verbal and verbal skills

(N = 31)

<u>Question #1</u>	<u>Training</u>		<u>Total</u>
	<u>Training</u>	<u>with Follow-up</u>	
I have been using these skills	16	11	27
I have been partially using these skills	0	4	4
I have not been using these skills	0	0	0
<u>Total</u>	16	15	31

Question No.2 Physical Intervention Strategies.

A Chi-Square analysis revealed no statistical significance, at the .05 level of confidence, between the treatment method provided (follow-up training vs no follow-up) and the respondents' answers to question number 2 regarding the use of physical intervention strategies. The majority of the participants tended to use these techniques (Table 9).

Question No.3 Life Space Interviewing Strategies.

A Chi-Square analysis revealed no statistical significance, at the .05 level of confidence, between the treatment provided and the respondents' answers to question number 3 regarding the use of the Life Space Interviewing Technique. The majority of the participants in both training groups reported use of the techniques (84%) with 70% of these participants reporting the use of these skills on a regular basis (Table 10).

Question No 14 If this training was offered again, I would:

- a) sign up and attend (yes/no);
- b. recommend it to others (yes/no).

A Chi-square analysis revealed no statistically significant results, at the .05 confidence level, between the treatment methods provided and the respondents answer to question 14(a) regarding a tendency to attend the training again. A majority of the respondents (68%) reported that they

Table 9

Question #2: Physical Intervention Strategies

(N = 31)

Question #2	Training		Total
	Training	with Follow-up	
I have been using these skills	8	4	12
I have been partially using these skills	5	2	7
I have not been using these skills	3	9	12
Total	16	15	31

Table 10

Question #3: Life Space Interviewing Techniques

(N = 31)

Question #3	Training		Total
	Training	with Follow-up	
I have been using these skills	10	8	18
I have been partially using these skills	3	5	8
I have not been using these skills	3	2	5
Total	16	15	31

would attend the training again if offered. Out of this 68%, 57% were members of the training group without follow-up (Table 11).

A Chi-Square analysis revealed no statistical significance, at the .05 level of confidence, between the treatment method provided (follow-up training vs no follow-up) and the respondents' answers to question 14(b) regarding the tendency to recommend TCI training to others. A vast majority of the 27 respondents (89%) indicated that they would recommend the training to others. Both the training group and the training group with follow-up reported that they would recommend the training to others (Table 12).

Questions Part II and Part III, numbers 1 - 13, of the questionnaire were analyzed through a review of the mean score responses for each question. Mean scores were computed in order to permit an examination of the interval scale data. The mean responses for items one through thirteen are provided in Table 13. A descriptive analysis of each item will be presented here with the training group referred to as Group A and the training group with follow-up referred to as Group B.

Items in Part II of the questionnaire were intended to report the respondents' perceptions of how the skills presented in TCI training have helped to produce a change in student or resident behavior.

Table 11

Question #14(a): If this training were offered again would you sign up and attend?

(N = 31)

<u>Question #14(a)</u>	<u>Training</u>		<u>Total</u>
	<u>Training</u>	<u>with Follow-up</u>	
No, I would not attend training	4	6	10
Yes, I would attend training	12	9	21
<u>Total</u>	<u>16</u>	<u>15</u>	<u>31</u>

Table 12

Question #14(a): If this training were offered again would you recommend it to others?

(N = 27)

<u>Question #14(b)</u>	<u>Training</u>		<u>Total</u>
	<u>Training</u>	<u>with Follow-up</u>	
No, I would not recommend training to others	2	1	3
Yes, I would recommend training to others	11	13	24
<u>Total</u>	<u>13</u>	<u>14</u>	<u>27</u>

Table 13

Mean Responses for Items Part I & Part II
1 through 13 on Post Training Questionnaire

Question	Training without follow-up		Training with follow-up	
	N	M	N	M
1. Talking out their anger	16	4.63	15	4.53
2. Aggressive behavior toward staff	16	3.63	15	3.73
3. Aggressive behavior toward peer	15	3.73	15	3.53
4. Destructive behavior toward property	16	3.56	15	3.47
5. Aggressive behavior necessitating a time-out intervention	16	3.90	15	3.67
6. Behavior necessitating physical restraint	15	3.27	15	3.47
7. Discussing alternatives to destructive acting out behavior	15	4.60	15	4.40
8. Active use of alternatives to destructive acting out behaviors	14	4.64	15	4.27
9. Active listening skills	16	3.94	15	3.27
10. Physical intervention strategies	14	3.64	11	2.36
11. Life space interviewing	15	3.40	13	3.08
12. Overall, I found the training to be...	16	3.60	15	3.67
13. In regard to my comfort level in dealing with a crisis confrontation with a student, this training was...	16	3.25	15	3.53

Question No. 1. The resident's ability to talk out his or her anger is reported as marginally increased in both training programs (m=4.63, Group A; m=4.53, Group B).

Question No. 2. The resident's aggressive behavior toward staff was reported as slightly decreasing from both training groups (m=3.63, Group A; m=3.73, Group B).

Question No. 3. The resident's aggressive behavior toward peers was reported as slightly decreasing from both training groups (m=3.73, Group A; m=3.53, Group B).

Question No. 4. The resident's destructive behavior toward property was reported as slightly decreasing from both training groups (m=3.56, Group; m=3.47, Group B).

Question No. 5. The resident's aggressive behavior necessitating a time out intervention was reported by both training groups as marginally decreasing (m=3.9, Group A; m=3.67, Group B).

Question No. 6. The resident's behavior necessitating physical restraint was reported from both training groups as a modest decrease (m=3.27, Group A; m=3.47, Group B).

Question No. 7. The resident's activity in discussing alternatives to destructive acting out behavior was reported as increasing moderately by both training groups (m=4.6, Group A; m=4.4, Group B).

Question No. 8. The resident's active use of alternatives to destructive acting out behavior was reported

as increasing moderately by both training groups (m=4.64, Group A; m=4.27, Group B).

Items in Part III of the questionnaire are intended to report the participants' perceptions of the helpfulness of the acquired skills in managing the behaviors of adolescents in placement.

Question No. 9. Active listening skills were reported as being moderately helpful in both training groups (m=3.94, Group A; m=3.27, Group B).

Question No. 10. Physical intervention strategies were reported as moderately helpful in the training groups without follow-up (m=3.64, Group A) and helped a little in the training group with follow-up (m=2.36, Group B).

Question No. 11. Life Space Interviewing was reported as moderately helpful in both training groups (m=3.4, Group A; m=3.08, Group B).

Question No. 12. The helpfulness of the overall training was reported as moderately helpful for both training groups (m=3.6, Group A; m=3.67, Group B).

Question No. 13. The helpfulness of the training in regard to a perceived comfort level when dealing with a crisis was reported as moderately helpful for both training groups (m=3.25, Group A; m=3.53, Group B).

Follow up questionnaire attached to incident report. The return rate on the follow-up questionnaire to be attached to

a facility's incident report form (Appendix B) is considered insufficient. Only two schools returned information. Out of those two schools only three participants responded. With only three respondents little descriptive information can be gathered and summarized.

Summary

In general, the findings can be summarized as follows:

1. There was no statistically significant relationship between Therapeutic Crisis Intervention Training and the participants reported sense of job competence nor reported job stress, regardless of the method of treatment.
2. The interactive effect of the classification variables with training categories on reported personal competence and job stress are as follows:
 - a. Older residential counselors of the training group without follow-up perceived themselves as being more supportive than their younger counterparts. This implies that the older residential counselors without follow-up perceived themselves as having a higher sense of job competence than their younger counterparts.

- b. Younger residential counselors, who are trained in TCI with follow-up session, perceive themselves as more supportive than their older counterparts. This implies that the younger residential counselors who received follow-up perceived themselves as having a higher sense of job competence than their older counterparts.
- c. The follow-up session enhances the perceived sense of competence for the younger participants as reported in higher support subscale scores.
- d. Older residential counselors reported a higher sense of depersonalization than their younger counterparts when initially measured. This implies a higher sense of job stress.
- e. At the 45 day measurement, the younger training group without follow-up reported a higher sense of depersonalization than their older counterparts. This implies a higher sense of job stress.
- f. At the 45 day measurement, the younger training group which received follow-up, reported a lower sense of depersonalization than their older counterparts. The inference can be made

that training with follow-up impacts the younger participants' sense of job stress in a positive direction, when compared to their older counterparts.

- g. The older participants indicated a drop in a reported sense of depersonalization from the initial to the second measurement. This implies a decrease in one aspect of reported job stress for the older participants training group over time.
- h. An analysis of the Personal Achievement subscale reveals that older participants have a higher reported sense of accomplishment than their younger counterparts. This was consistent over time with initial and 45 day measurements. This implies a lower sense of job stress.
- i. The initial measurement indicated that the less educated group of participants reported a higher sense of personal accomplishment than their more educated counterparts. This implies a lower sense of job stress.
- j. There were no statistically significant results to report in regard to the relationship between

work experience and reported sense of personal competence nor with reported job stress.

Post training questionnaire and findings:

1. Twenty-seven out of 31 respondents (87%) report using active listening skills regularly while four respondents use these skills occasionally.
2. A statistically significant relationship can be reported between the training group without follow-up and the training group with follow-up. The training group without follow-up reported comparatively more regular use of active listening skills.
3. Twelve out of 31 respondents (39%) report using physical intervention strategies regularly, seven (22%) report occasional use, and 12 (39%) report no use of these skills. Out of the 12 who have not used these skills, four (30%) commented that the opportunity or necessity to physically intervene had not occurred during the assessment period. Therefore, for these respondents, the physical intervention strategies have not been required.
4. Eighteen out of 31 respondents (58%) report regular use of the Life Space Interviewing Techniques, eight (26%) report occasional use and five (16%) report no use.

5. Twenty-one out of 31 respondents (68%) report that they would take the TCI training again if offered; 10 (32%) would not. Twenty-four of 27 respondents (89%) would recommend the training to others; three (11%) would not.

In general, the respondents in both the training groups and the training group with follow-up reported similar perceptions regarding the impact of the skills presented in TCI on their work as residential counselors.

1. The resident's ability to "talk out" their anger, discuss and use alternatives to acting out behavior was reported as a slight increase.
2. The resident's aggressive behavior toward staff, peers and property was reported as a moderate decrease.
3. The resident's aggressive behavior necessitating a time out or physical restraint intervention was reported as a modest decrease.
4. The skills presented: active listening, physical intervention, Life Space Interviewing, were reported as moderately helpful in managing the behavior of emotionally disturbed adolescents in placement.
5. Overall there appears to be little difference in the mean scores of the training group and the training group with follow-up session for any of the items.

The implications that these findings have on pre-service and in-service training of residential counselors working with seriously emotionally disturbed adolescents in placement, and for further study, are discussed in the next chapter.

CHAPTER V - CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Introduction

This final chapter will discuss the implications of the findings of this study with relevance to the training of residential counselors working with seriously emotionally disturbed adolescents in placement. First, however, a summary of the study itself and of the conclusions which were reached will be presented.

Summary of the Study

The purpose of the study was to investigate the effects of Therapeutic Crisis Intervention Training on the reported personal sense of competence and reported sense of job stress of residential counselors working with seriously emotionally disturbed adolescents in placement. The training program stresses an interactive process between the residential counselor and the adolescent. The underlying philosophy behind the training is that residential counselors are important influences in the lives of youth in placement. The training presents the following core areas, which have been documented, through a review of the literature in Chapter 2, as being effective skills and strategies: active listening, therapeutic physical intervention and the Life Space Interview.

In order to answer the research questions, a full factorial analysis experimental design was used. Four residential treatment centers were selected from which were drawn a representative sample of youth care workers. The RTC's had a total capacity enrollment of 717 residents and are accredited by VAISEF and licensed by the Virginia Departments of Education, Correction, Social Services and Mental Health/Substance Abuse to serve seriously emotionally disturbed adolescents. Three distinct groups were defined with a total of 51 participants. One group (n=17) was comprised of residential counselors, randomly assigned, who participated in TCI training. A second group (n=16) was comprised of residential counselors, randomly assigned, who participated in the training along with participation in a follow-up three hour session. The third group (n=18) was comprised of residential counselors, randomly assigned, as a control group receiving no training during the research project.

In order to further investigate certain influences on the treatment categories (training, training with follow-up, control group), specific classification variables were identified (age, educational attainment, and work experience of the participants). The treatment groups differed on these classification variables as follows (Table 1, Chapter 3):

Training groups without follow-up (n=17)

1. Sixteen participants were 25 years and older; one participant was younger than 25 years.
2. Twelve participants had a college degree or greater; five participants had a high school diploma.
3. Sixteen participants had one year of experience or more; one participant had less than one year experience.

Training groups with follow-up (n=16)

1. Thirteen participants were 25 years of age and older; three participants were younger than 25 years.
2. Twelve participants had a college degree or greater; four participants had a high school diploma.
3. Thirteen participants had one year of experience or more; three participants had less than one year experience.

Control group, no training (n=18)

1. Thirteen participants were 25 years of age or older; five participants were younger than 25 years.
2. Fourteen participants had a college degree or greater; four participants had a high school diploma.

3. Fifteen participants had one year of experience or more; three participants had less than one year of experience.

Each participant was administered three standardized instruments to measure treatment effects. The Occupational Stress Inventory (subscales: RO and RI) and the Correctional Institution Environment Scale (subscales: S, E and PPO) were administered to measure the participants' reported perception of competence or self-efficacy. The Burnout Inventory was administered to report participants' perceptions of job stress. The measurements were administered at three intervals: first, at the conclusion of the training; second, at approximately 21 days following training; and finally, at approximately 45 days following training. The 21 day measurement was not analyzed because of the low return rate.

The data which were obtained were analyzed using a four way analysis of variance (ANOVA) to determine the effect of the training program and the relationship of the classification variables on the treatment categories. The ANOVA did not substantiate a relationship between the training and the participants' reported competence nor reported job stress. There was evidence that the younger participants reported themselves as more supportive (an area of reported level of competence) than their older counterparts. The younger participants of the training group with follow-up

reported lower sense of depersonalization (an area of job stress) than their older counterparts. Older participants reported having a higher sense of accomplishment (an area inversely effecting job stress) than their younger counterparts. Experience and educational attainment had no reported noticeable influence on either treatment category.

In addition, each training group member received a post training questionnaire intended to address the participants' subjective opinion regarding the skills and techniques presented during the training. Chi-square tests and mean comparisons were used to report inferential and descriptive findings from each item on the post training questionnaire. The data described the following characteristics of the participants in the training groups.

1. 100% of the training group participants reported using active listening skills with 89% using these skills regularly.
2. 61% of the training group participants reported using the Therapeutic Physical Intervention strategies.
3. 84% of the training group participants reported using the Life Space Interview techniques.
4. 68% of the training group respondents reported that they would take the TCI training again, and 89% would recommend the training to others.

5. In general, the skills taught during the TCI training were reported as being moderately helpful in managing the behavior of the residents and having a slightly positive impact on decreasing the aggressive behavior of the residents while increasing their abilities to "talk out" their feelings.

Conclusion and Implications

Based on the findings reported, the following conclusions and implications are presented.

Related to Personal Competence

Conclusions: The analysis of variance used to analyze the effect of the training on reported competence in working with seriously disturbed adolescents in placement resulted in statistically insignificant results. That is, the training did not seem to impact the level of competence perceived by these participants. Part of the reason for the statistically insignificant results is the relatively small sample sizes which did not allow for a large pool of data. Interestingly, the scores on all five scales had a very small range with data narrowly clustered in both the initial and 45 day measurements. Within this sample, the respondents can be viewed as having similar perceptions of personal competence.

Another potential explanation for the lack of significant results is that the criterion measures may not have been precise enough to adequately discriminate between groups. It is possible that different results may have been found if measures which were more appropriate or more discriminating had been used to assess competence.

Another explanation for the finding that the training had little impact on perceptions of personal competence, is derived from the assumption regarding the source of that perception. The perception of self-efficacy is likely to be derived from the respondents' belief that the behavior of the residents they treat has improved. This concept of self-efficacy, derived by a perceived sense of accomplishment, is supported in the literature review contained in Chapter Two. Consequently, when considering this assumption, the length of time between the training and the measurement becomes crucial. The 45 day period, most likely three to four typical working shifts for the residential counselor, may not have allowed enough time for the skills and techniques applied to impact the behavior of the residents being treated. Indeed, if one takes note of the high percentage of skill use noted from the questionnaire, and accepts the theoretical foundations for the skills presented in Chapter Two, the assumption of insufficient time in applying the skills may have face validity.

The study indicates that while older residential counselors perceived themselves as more competent in terms of supportive skills, the younger participants receiving TCI training with follow-up report a higher level of competence in support skills. The conclusion reached here is that the follow-up training for the younger residential counselors enhances the acquired skills and is essential to their increased sense of self-efficacy.

Implications: The literature review presented in Chapter Two established a link between perceived improved sense of personal competence, self-efficacy, and reduced level of job stress. The residential counselor, particularly the younger youth care worker, cannot be allowed to drift without direction or defined purpose. While this study did not find that Therapeutic Crisis Intervention significantly influenced the residential counselor's perceived level of competence, the results of the review of literature indicate that youth care workers are in need of additional training. Future research, using this program and/or other programs is needed to determine which aspects of training are most valuable in helping youth care workers feel more competent at their work.

Related to Job Stress

Conclusions: Analysis of variance used to analyze the main treatment effect of the training on reported job stress of residential counselors working with seriously emotionally

disturbed adolescents in placement produced statistically insignificant results. Comparing the three designated groups (training, training with follow-up and no training) indicated a trend did emerge on the Depersonalization subscale of the Burnout Inventory. A reported sense of depersonalization decreased in the training group and the training group with follow-up and increased in the control group from the initial measurement to the 45 day measurement. Although the scores remained in the moderate range, the trend may be indicative of a significant result over time. Future research should examine this possibility.

The residential counselors, as a total group, reported a low range of personal accomplishment and moderate range on the Emotional Exhaustion scale of the Burnout Inventory. As stated in relation to reported personal competence, post training time may have been a significant factor when analyzing the true effects of the training. A sense of personal accomplishment, in particular, may not be effected over the 45 day period of the study. Indeed, the results of the training, as interpreted by the residential counselors' sense of effecting resident behaviors, may require significantly longer than 45 days.

Implications: The field of youth care as described in the literature review of this study maintains conditions characteristic of a high stress, high burnout occupation.

Therefore, it is important that future research determine which factors in training may be most useful in reducing the stress experienced by these workers. The skills presented in TCI training focus on building and maintaining relationships with the residents in treatment. The training, with regularly scheduled follow-up sessions, may provide the residential counselor with the skills to establish and maintain productive relationships with the adolescents in their care. The results of this study suggest that an ambitious training program, such as TCI, at frequent intervals can provide adequate resistance to the tendency to become depersonalized, at least with older providers.

Post Training Questionnaire

Conclusion: The results of the post training questionnaire clearly indicated the participants' positive attitude toward the content of the training. The three core areas of active listening, therapeutic physical intervention and Life Space Interviewing strategies were all actively used by the majority of the participants through the 45 days of the study. However, in reviewing the responses on the questionnaire, it is not certain whether the skills and techniques presented were enthusiastically accepted and used because of their perceived potential and credibility, or if they were accepted merely to fill a void due to the lack of existing training programs. Further, the study did not provide a pretest

therefore the skills presented may have been acquired and used before the training was presented.

Implications: The fact that almost 90% of the participants would recommend the training program to others indicated that these participants viewed the training as beneficial. Since so little training is available to these youth care workers, it is clear that the need exists and that these workers are eager for more training. Although further research is needed to determine the long-term value of this training program with regard to efficacy and job stress of participants, the fact that the participants rated the experience as valuable should be given credibility.

Recommendations for Further Study

The following are recommendations for future study to enhance the effectiveness of the current training program and to broaden the training offered to the persons working with seriously emotionally disturbed adolescents in out-of-home placements.

1. Investigate further the stressors that are unique to the role of residential counselors working in a treatment center for seriously emotionally disturbed adolescents. The existence of the phenomenon known as "burnout" is well defined in the literature and has become commonplace when discussing personnel

management issues and concerns in any type of work. Its existence in the field of youth care is documented in Chapter Two of this study. This condition in the youth care profession may be prevented if the factors contributing to it are defined and their implications understood.

2. Investigate the impact of TCI training specific to the behaviors of the resident population.
3. Further research is needed investigating ways to alleviate personal stress through applied field research. A qualitative study investigating the environmental factors which contribute to the stress within a residential treatment center can lead to the development of effective methods, both personal and environmental, to alleviate these factors.
4. Much of the training program examined here relies on verbal interactive skills between the resident and the residential counselor. An investigation of the level of verbal ability and processing ability required by the residents to ensure effectiveness would be helpful in adapting the training program to other populations.
5. A longitudinal study over several months is suggested with a larger sample of participants to

allow for a more accurate analysis of the training effects.

6. The training program does not provide assessment tools to determine whether the participants have acquired the skills and can effectively demonstrate the techniques presented. Role plays are available but limited. The development of such an assessment procedure would benefit the training program.

It is fitting that a study involving residential treatment close with comments from Bruno Bettelheim, an architect of the current residential treatment milieu. Bettelheim speaks of the value in residential treatment for severely disturbed children and references. He suggests that the essence of residential treatment is captured with the following experience (Bettelheim, 1982, p.59):

Fighting Helen Keller's parents, Ann Sullivan insisted on taking Helen away from her parents to live alone with her in a little cottage. They had vicious fights there and Helen Keller knocked out a couple of Ann Sullivan's teeth. I think this fight, and the loss of teeth, was very important. Only by living with her in seclusion from the family could learning take place. The learning could only take place because at the propitious moment when the water spurted on Helen's little hand, Sullivan

was there to take advantage of this unique moment - to create the "miracle".

To care enough about children to help them even when they are at their worst, to be there to take advantage of unique experiences, to be there to create a "miracle" is the essence of residential youth care work.

References

- Adelman, H. and Taylor, L. (1984). Children's reluctance regarding treatment: incompetence resistant, or an appropriate response? School Psychology Review, 15, 1, 91 -99.
- Adelman, H.S. and Kaser-Boyd, N. Taylor, L. (1984). Children's participation in consent for psychotherapy and their subsequent response to treatment. Journal of Clinical Child Psychology, 13, 2, 170 - 178.
- Agee, Vicki L. (1979). Treatment of the Violent Incurable Adolescent. Lexington, MA: Lexington Books.
- Aston, P.T. and Webb, R.G. (1986). Making a difference: Teachers' sense of efficacy and student achievement. White Plains, New York: Longman. In Kauffman, James, M. and Wong, Kathleen, L.H. (1991). Effective Teachers of Students with Behavioral Disorders: Are generic teaching skills enough? Behavioral Disorders, 16, 3, 228 - 237.

- Atwood, Carol Ann and Woolf, Donald (1985). Job Satisfaction of Physical Therapists. In The Employee, Contemporary Viewpoint. M. Ensign and L. Adler. Santa Barbara: ABC-CLIO Information Services. p. 156.
- Bandura, A. (1977b). Self Efficacy: Toward a Unifying Theory of Behavioral Change. Psychological Review, 84, 191 - 215.
- Bandura, A. (1978). Reflections of Self-efficacy. Advances in Behavioral Research and Therapy, 1, 237 - 269.
- Bandura, A. (1982). Self Efficacy Mechanism on Human Agency. American Psychologist 37, 2, 122 - 147.
- Beare, Paul L. (1991). Philosophy, instructional methodology, training, and goals of teachers of the behavioral disordered. Behavioral Disorders, 16, 3, 211-218.
- Berlin, Critchly, Rossman (1989). Current Concepts in Milieu Treatment of Seriously Disturbed Children and Adolescents. Psychotherapy, 21, 1, 118 - 131.
- Bettleheim, Bruno, M.D. (1982). The Necessity and Value of Residential Treatment for Severely Disturbed Children. Family and Child Mental Health Journal, 8, 1 and 2.

- Blase, Joseph, J. (1986). A qualitative analysis of sources of teacher stress: Consequences for performance. American Educational Research Journal, 23, 1, 13 - 40.
- Bressil, Jane S., Hoover-Dempsey, Kathleen V., Bassler, Otto C. (1988). Individual Situational Contributions to Teacher Burnout. The Journal of Educational Research, 82, 2, 106 -112.
- Budlong, M. (1983). Therapeutic Crisis Intervention for the Child Care Worker. Family Life Development Center, Cornell University.
- Caplan, Gerald, Ed. Prevention of Mental Disorders of Children. N.Y.: Basic Books (1961). In Nunno, Michael A. (1983). Therapeutic Crisis Intervention for the Child Care Worker. Ithaca, N.Y: Cornell University.
- Carauli, A. (1984). Managing aggressive behavior in human service facilities: Changes and direction in the field. The Crisis Prevention Institute. (CPI) National Report, 4, 2. In Hunter, Don, S. (1989). The Use of Physical Restraint in Managing Out-of-Control Behavior in Youth: A Frontline Perspective. Child and Youth Care Quarterly, 18, 2, 141 - 154.

Cichon, D. and Koff, R. (1980). Stress and Teaching. NASSP Bulletin, 64, 434, 91 - 104. In Seeman, H. (1984). A major source of discipline problem: Miscalls. Educational Horizons, 62, 4, 128 - 131.

Core Standards Manual for Interdepartmental Licensure and Certification of Residential Facilities for Children (1986).

Crespi, Tony D. (1990 - winter). Restraint and Seclusion with institutionalized adolescents. Adolescence, 25, 100, 825 -828.

Davis, A., and Salvatore, P.D. (1976). Residential treatment of disturbed children and adequacy of their subsequent adjustment. American Journal of Orthopsychiatry, 46, 62 - 73.

Drisko, James (1976). Memo to institution staff: Physical involvement with children - a therapeutic intervention. Child Welfare, 55, 469 - 477.

Drisko, James (1981). Therapeutic Use of Physical Restraint. Child Care Quarterly, 10, 4, 318 - 328.

Eason, W.M. (1969). The Severely Disturbed Adolescent: Inpatient, residential, and hospital treatment. New York: International Universities Press.

- Edelwich, J., Brodsky, A. (1980). Burnout: Stages of disillusionment in the helping profession. New York: Human Sciences Press.
- Ekman, P., and Frieser, W. (1974). Detecting deception from the body or face. Journal of Personality and Social Psychology, 29, 288 - 298.
- Ekman, P, Friesen, U.V., (1983). Research on facial expression of emotion. In A.M. Katz and V.T. Katz (Ed.S.), Foundation of nonverbal communication: Readings, exercises and commentary. Southern Illinois University Press.
- Elder, J., Edestein, B. and Narvick, M. (1979). Adolescent Psychiatric Patients: Modifying Aggressive Behavior with Social Skill Training. Behavior Modification, 3, 161 - 178.
- Eldridge, W., Blostein, S., Richardson, V. (1985). A multi-dimensional model for assessing factors associated with burnout in human services organization. In The Employee, Contemporary Viewpoint. M. Ensign and L. Adler. Santa Barbara: ABC-CLIO Information Center. p. 203.
- Ellsworth, P.C. (1975). Direct gaze as a social stimulus. In P. Pliner, L. Krames, and T. Alloway (Ed). Nonverbal Communication. NY: Plenum Press.

- Ellsworth, P.C. and Langer, E.J. (1976). Staring and approach: An interpretation of the stare as a nonspecific activator. Journal of Personality and Social Psychology, 33, 117 - 122.
- Etcherdt, Susan (1991). Reducing Aggressive Behavior and Improving Self Control: A cognitive behavioral training program for behaviorally disordered adolescents. Behavioral Disorders, 16, 2, 107-115.
- Evans, G.W., and Howard, R.B. (1973). Personal Space. Psychological Bulletin, 80, 334 - 344.
- Fagen, Stanley A. (1981). Conducting an L.S.I.: A process model. The Pointer, 25, 2, 9 - 11.
- Faretra, G. (July, 1981). A Profile of Aggression from Adolescence to Adulthood: An 18 year follow-up of psychiatrically disturbed and violent adolescents. American Journal of Orthopsychiatry, 5, 3, 439 - 453.
- Fineberg, B.L., Sowards, S., K., and Kettlewell, P., W., (1980). Adolescent inpatient treatment: A literature review. Adolescence, 15, 60, 913 - 925.
- Finnian, M., Blanton, L. (1987). Research note: Stress, burnout, and role problems among teacher trainees and first year teachers. Occupational Behavior, 8, 2, 157-63.

- Forehard, R., Long, N., Hedrick, M. (1987). Family Characteristics of Adolescents who Display Overt and Covert Behavior Problems. Journal of Behavior Therapy and Experimental Psychiatry, 16, 4, 325 - 328.
- Freshack, S. (1964). The function of aggression and the regulation of aggressive drive. Psychological Review, 71, 257 - 272.
- Freud, S. (1953). Fragment of an analysis of a case of hysteria. The standard edition of the complete psychological works of Sigmund Freud (p. 77 - 78). London: Hogarth Press (originally published in 1905).
- Freudenberger, Herbert, J. (1977). Burn out: Occupational Hazard of the Child Care Worker. Child Care Quarterly, 6, 2, 90 - 98.
- Friedman, Paul, G. (1986). Listening Processes: Attention, Understanding, Evaluation. Washington, D.C.: National Education Association.
- Galloway, C.M. (1977). Nonverbal: Authentic or Artificial. Theory Into Practice, 16, 129 - 133.
- Gardner, Frances (1989). Inconsistent parenting: is there evidence for a link with children's conduct problems? Journal of Abnormal Child Psychology, 17, 2, 223-233.

- Gardner, Ralph (1990). Life Space Interviewing: It can be effective, but don't ... Behavioral Disorders, 15, 2, 111 -119.
- Garrison, William, T. (1984). Aggressive behavior, seclusion and physical restraint in an inpatient child population. Journal of the American Academy of Child Psychiatry, 23, 448 - 452.
- Gibson, S., and Dembo, M. (1984). Teacher Efficacy: A Construct Validation. Journal of Educational Psychology, 76, 4, 569 - 582.
- Golden-Englander, Paula, Jackson, Joan, Crame, Karen, Schwarzkopf, Albert, Lyle, Patricia (Summer, 1989). Communication skills and self-esteem in prevention of destructive behaviors. Adolescence, 24, 94, p. 481-501.
- Greenwood, G., Olejnik, S. and Parkay, F. (1990). Relationships between four teacher efficacy belief patterns and selected teacher characteristics. Journal of Research and Development in Education, 23, (2), 102 - 106.
- Grellong, B., A. (Spring, 1987). Residential Care in Context: Evolution of a Treatment Process in Response to Social Change. Residential Treatment for Children and Youth, 4, 3, 59 - 70.

- Gruneberg, M. (1979). Understanding Job Satisfaction.
McMillan Press.
- Hall, E.T. (1961). The language of space. Journal of American Institute of Architects, 35, 71 - 74.
- Hall, E.T. (1969). The Hidden Dimension. Garden City, NJ:
Anchor Books.
- Hall, J., Rosenthal, R., Archer, D., DeMattea, M.R., and Rogers, P. (1977). Nonverbal skills in the classroom. Theory into Practice, 16, 162 - 166.
- Helmer, J. (1978). Constructive and destructive anger in child care work: An exploratory study and conceptual scheme. Child Care Quarterly, 7, 4, 320 - 317. In Hunter, Don S., (1989). The Use of Physical Restraint in Managing Out-of-Control Behavior in Youth: A Frontline Perspective. Child and Youth Care Quarterly, 18, 2, 141 - 154.
- Hoover-Dempsey, Kathleen V., Bassler, Otto C. (1988). Individual Situational Contributors to Teacher Burnout. The Journal of Educational Research, 82, 2, 106 - 112.
- Hourcade, H., Parette, H. (1988). Stress sources among student teachers. The Clearing House, 61, 8, 347 - 349.

- Huck, Schuyler, Cormier, William and Bounds, William
(1974). Reading Statistics and Research. New York:
Harper & Row.
- Hunter, Don, S. (1989). The Use of Physical Restraint in
Managing Out-of-Control Behavior in Youth: A Frontline
Perspective. Child and Youth Care Quarterly, 18, 2, 141
- 154.
- Jay, D.E., & Padilla, C.L. (1987). Special Education
Dropouts. Menlo Park, CA: SRI International.
- Joyce, B.G. & Wrenke, W.D. (1989). Preservice competencies
for teachers of students with behavior disorders in a
rural setting. Teacher Education and Special Education,
12, 13-18.
- Kalogjera, I., Bedi, A., Walson, W., and Meyer, A. (1989).
Impact of Therapeutic Management on Use of Seclusion and
Restraint with Disruptive Adolescent Inpatients.
Hospital and Community Psychiatry, 40, 3, 280 - 285.
- Kauffmann, J.M., Bernice-Smith, M., Eichberg, C.G., Hart-
Hester, S., McCullough, L., and William, R. (1985).
Guidelines for describing programs for behaviorally
disordered children and youth. Student Columbia Journal
of Special Education, 9, 1, 11-17.

- Kauffman, James, M. Lloyd, John, W., MacGee, Kathleen, A. (1989). Adaptive and Maladaptive Behavior: Teacher's attitudes and their technical assistance needs. The Journal of Special Education, 23, 2, 185 - 200.
- Kauffman, James M., Wong, Kathleen, L., H., (1991). Effective Teachers of Students with Behavioral Disorders: Are Generic Teaching Skills Enough? Behavioral Disorders, 16, 3, 225 -237.
- Kemley, Alice, Mossholder, K. (1987). Role stress, physical symptomology and turnover intentions: A causal analysis of three alternative specifications. Journal of Occupational Behavior. 8, 1, 11-23
- Kleinske, C.L., and Pohlen, P.D. (1971). Affective and emotional responses as a function of other person's gaze and cooperativeness in a two person game. Journal of Personality and Social Psychology. 17, 308 - 313.
- Koch, R. (1971a). The teacher and nonverbal communication. Theory into Practice, 10, 231 - 242.
- Koch, R. (1971b). Nonverbal Observables. Theory into Practice, 10, 288 - 294.

- Kramer, Barton (1986). Improving classroom management skills in secondary school classrooms through the use of limit setting, an incentive system, and structured teaching. Dissertation: Virginia Polytechnic Institute and State University.
- Kudushin, A. (1974). Child Welfare Services, New York: Macmillan. In Weiskopf, P.E. (1980). Burnout among teachers of exceptional children. Exceptional Children, 47, 18-23.
- Lazarus, DeLongis, Folkman, and Gurer (1985). Stress and adaptional outcomes: The problem of confounded measures. American Psychologist, 40, 770 - 779. In Osipaow, Samual, H. (1991). Developing Instruments for use in Counseling. Journal of Counseling and Development, 70, 2, 322, 326.
- LeCroy, Craig, Winston (1988). Anger Management or Anger Expression: What is Most Effective? Residential Treatment for Children and Youth, 5, 3, 29 - 39.
- Lewis, David K. (1981). Working with Children: Effective Communication through Self-Awareness. Beverly Hills: Sage. In Nunno, Michael A. (1983). Therapeutic Crisis Intervention for the Child Care Worker. Ithaca, N.Y.: Cornell University.

- Lloyd, Wimberly (1985). Guidelines for Crisis Management. The Pointer, 29, 2, 22 - 26.
- Lockman, R., Dramet, E. (1987). Withdrawal and restraining factors in teacher turnover intention. Journal of Occupational Behavior, 8, 3, 220-231.
- Loeber, R. and Schmalin, K.B. (1985b) The Utility of differentiating between mixed and pure forms of antisocial child behavior. Journal of Abnormal Child Psychiatry, 13, 315 - 336.
- Long, N.J. (Feb. 1990). Comments on Ralph Gardner's article 'Life Space Interviewing: can be effective but don't ...'. Behavioral Disorders, 15, 2, p. 119 - 125.
- Maslach, C. and Jackson, S. (1986). Burnout Inventory Manual. Palo Alto, CA: Consulting Psychologists Press.
- Maslach, C. and Pine, A. The burn-out syndrome in the day care setting. Child Care Quarterly, 1977, 6, 100 - 113.
- Mattingly, Martha, A. (1977). Sources of Stress and Burn Out in Professional Child Care Work. Child Care Quarterly, 6, 127 - 137.
- McBridge, G., King, M.G., and James, J.W. (1965). Social proximity effects on galvanic skin responses in adult humans. Journal of Psychology, 55, 245 - 247.

- Mehrabian, A. (1968, April). Communication Without Words. Psychology Today. p. 53 - 55.
- Mehrabian, A. (1972). Nonverbal Communication. Chicago, IL: Aldine - Ahteton.
- Mehrabian, A., and Ferris, S.R. (1967). Inference of attitudes from nonverbal communication in two channels. Journal of Consulting Psychology, 31, 248 - 252.
- Mehrabian, A., and Wiener, M. (1967). Decoding of inconsistent communication. Journal of Personality and Social Psychology, 6, 108 -114.
- Mental Health Statistical Note No. 198 (July, 1991). Residential Treatment Centers and other Organized Mental Health Care for Children and Youth: United States, 1988. U.S. Department of Health and Human Services.
- Middlemist, R.D., Knowles, E.S., and Matter, C.G. (1976). Personal space invasion in the laboratory: Suggestive evidence for arousal. Journal of Personality and Social Psychology, 33, 541 - 546.
- Miller, Dereck, M.D., Walker, Mark C., M.D., Friedman, Diane, R.N. (1989). Use of a Holding Technique to Control the Violent Behavior of Seriously Disturbed Adolescents. Hospital and Community Psychiatry, 40, 5, 520 - 524.

- Miskimins, R.W. (1990). A Theroretical Model for the Practice of Residential Treatment. Adolescence, 25, 100, 867 - 890.
- Moos, Rudolph, H. (1987). Correctional Institution Environment Scale. Palo Alto, California: Consulting Psychological Press, Inc.
- Morgan. Rex, M. (1981). Group Life Space Interviewing. The Pointer, 25, 2, 37 - 41.
- Morgan, Robert L., Striefel, Sebastian (Winter, 1987-88). Restrictiveness of Procedures to Decrease Behavior: View of School Psychologists, Administrators, Teachers, and Specialists. Journal of Special Education, 21, 4, 108 - 121.
- Moslach, C. (1976). Burnout. Human Behavior, 5, 16, 16-22.
- Moslach, C. (1978). Job Burnout: How People Cope. Public Welfare, 36, 56-58.
- Mosnik, C., Fardig, D., Algozzine, K., and Alogzzine, B. (1987). Competencies for teachers of students with high incidence handicaps. British Columbia Journal of Special Education, 11, (2), 109-122.
- Moss, Rudolph, H. (1987). Correctional Institution Environment Scale Manual. Palo Alto, CA: Consulting Psychologists Press.

Naslurd, S. (1984). Life Space Interviewing: A descriptive analysis of crisis intervention with emotionally disturbed children in a special education school; Doctoral Dissertation.

National Juvenile Custody Trends 1978 - 1989

(November, 1992). The office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Neel, R.S., Meadows, N., Levine, P., and Edgar, E.B. (1988). What happens after special education: A statewide follow-up study of secondary students who have behavioral disorders. Behavioral Disorders, 13, 209-216.

Nelson, C., Rutherford, R., Center, D., and Walker, H. (1991). Do Public Schools Have an Obligation to Service Troubled Children and Youth? Exceptional Children, 57, 5, 406 - 414.

Nelzleck, J. and Brehm, J.U. (1975). Hostility as function of the opportunity to counteraggress. Journal of Personality, 43, 421 - 433.

Nichols, K.A. and Chapmen, B.G. (1971). Eye gaze and GSR. Journal of Experimental Social Psychology, 17, 623 - 636.

- Nosphpitz, J.D. (1962). Notes on the therapy of residential treatment. Journal of the American Academy of Child Psychiatrists, 1, 284 - 296. In Miskimins, R.W. (1990) A Theoretical Model for the Practice of Residential Treatment. Adolescence, 25, 100, 869 - 890.
- Nunno, Michael A. (1983). Therapeutic Crisis Intervention for the Child Care Worker. Ithaca, N.Y: Cornell University.
- Osipow, S.H. and Spoken, A.R. (1992). Occupational Stress Inventory Manual - Research Version. Odessa, Florida: Psychological Assessment Resources, Inc.
- Osipow, Samuel, H. (1991). Developing Instruments for use in Counseling. Journal of Counseling and Development, 70, 2, 322-326.
- Osipow, Samuel, H. and Spokane, Arnold, R. (1992). Occupational Stress Inventory Manual. Odessa, Florida: Psychological Assessment Resources.
- Phillips, Paul, Nasr, Lubay (1983). Seclusion and restraint and prediction of violence. American Journal of Psychiatry, 140, 229 - 332.
- Platt, J.J., Spivack, G., Altman, N., Altman, D., and Peizer, S.B. (1974). Adolescent problem-solving thinking. Journal of Consulting and Clinical Psychology, 42, 787 - 793.

- Rae-Grant, Naomi, Thomas, Helen, B., Offord, David R., Bogle, Michael, H. (1989). Risk, protective factors, and the prevalence of behavioral and emotional disorders in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 2, 262-268.
- Redl, F. (1959). The Concept of a "Therapeutic Mileu". American Journal of Orthopsychiatry, 29, 721 - 736. In Miskimins, R.W. (1990) A Theoretical Model for the Practice of Residential Treatment. Adolescence, 25, 100, 867 - 890.
- Redl, F., and Wiseman, D. (1952). Controls from Within: Techniques for the Treatment of the Aggressive Child. New York: Free Press.
- Redl, Fritz (1966). When we deal with children. New York: The Free Press.
- Reed, Michael, J. (1977). Stress in Line in Child Care. Child Care Quarterly, 6, 2, 114 - 120.
- Rose, Melyin (1988). The Need for Enchantment: Imagination and the psychotherapeutic atmosphere - context for a total approach to adolescents. Residential Treatment for Children and Youth. 5, 3, 5 - 16.

- Safran, S.; Safran, J.; Barcikowski, R. (1990). Predictors of Teacher's Perceived Self-competence in Classroom Management. Psychology in the Schools, 27, 2, 148 - 155.
- Schneider, D.J., Hastorf, A.H., and Ellsworth, P.C. (1979). Person Perception (2nd ed.). Reading, MA: Addison-Wesley.
- Schusler, R.A. (1971). Nonverbal communication in the elementary classroom. Theory into Practice, 10, 282 - 287.
- Seeman, H. (1984). A major source of discipline problem: Miscalls. Educational Horizons, 62, 4, 128 - 131.
- Siegmán, A., and Feldstein, S. (1978). Nonverbal Behavior and Communication. Lawrence Erlbaum.
- Soloff, P., Gutteil, T., Weiler, B. (1985). Seclusion and restraint in 1985: A Review and Update. Hospital and Community Psychiatry, 36, 6, 652 - 656.
- Somner, R., (1969). Personal space: The behavioral basis of design. Englewood Cliffs, NJ: Prentice Hall.
- Treichman, A.E., Whittaker, J.K. and Brendtro, L.K. (1969). The Other 23 Hours. New York: Adline De Gryter.

U.S. Department of Education (1986). Eighth annual report to Congress on the implementation of the education for all handicapped children act. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Education (1987). Ninth annual report to Congress on the implementation of the education for all handicapped children act. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Education (1990). Twelfth annual report to Congress on the implementation of the education for all handicapped children act. Washington, D.C.: U.S. Government Printing Office.

Virginia Association of Independent Special Education Facilities, (1991). Richmond, Virginia.

Weiskopf, Patricia, E. (1980). Burn out among teachers of exceptional children. Exceptional Children, 47, 18 - 23.

Wood, Frank, H. (1990). When we Talk with Children: The Life Space Interview. Behavioral Disorders, 29, 2, 22 - 26.

APPENDICES

APPENDIX A

THERAPEUTIC CRISIS INTERVENTION TRAINING PROGRAM
POST TRAINING QUESTIONNAIRE

Therapeutic Crisis Intervention Training Program

Child Care Worker Questionnaire
(Post-Training)

Name: _____ Training Date: _____ Today's Date: _____

Residential Treatment Center: _____

Group Member Identification No. _____

The purpose of this questionnaire is to allow those youth care worker's who have been trained in the skills of the Therapeutic Crisis Intervention Training Program to express their opinions regarding the effects of these skills on themselves and the residents in their care.

Part I.

Direction: Place a check mark () next to the statement that best indicates the degree to which the listed skills have been used.

(1) Active listening skills to include non-verbal and verbal skills (check one).

_____ I have been using these skills.

_____ I have been partially using these skills.

Why? _____

_____ I have not been using these skills.

Why? _____

(2) Physical intervention strategies.

_____ I have been using these skills.

_____ I have been partially using these skills.

Why? _____

_____ I have not been using these skills.

Why? _____

(3) Life Space Interviewing Techniques.

_____ I have been using these skills.

_____ I have been partially using these skills.

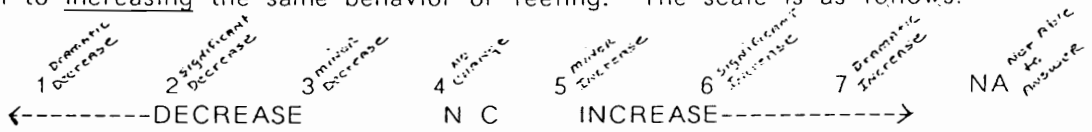
Why? _____

_____ I have not been using these skills.

Why? _____

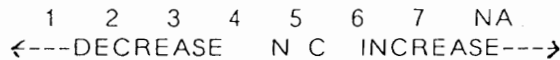
Part II.

Directions: Read the following items and rate each on a seven point rating scale by placing a circle around the number which best represents your experience with the skills obtained from the Therapeutic Crisis Intervention Training Program. The scale represents a continuum from decreasing or eliminating the behavior or feeling in question to increasing the same behavior or feeling. The scale is as follows:



Ratings should represent the discrepancy between present performance and past performance, and not the discrepancy between past performance and what you would like the performance to be.

To save space, the rating scale as defined above will be represented schematically on each page in the following form.



Please read each question carefully. "Increase" or "Decrease" may refer to either positive or negative behavior. Circle only one number for each numbered statement.

1. To what extent have the skills that you have obtained from the Therapeutic Crisis Intervention Training Program helped you to produce a change in the following student behaviors? (Remember: Circle only one number per each numbered statement).

A. Student Discipline

		DECREASE	NC	INCREASE	NA
		←-----		-----→	
		1 2 3	4	5 6 7	NA
(1)	"Talking out" their anger.	1 2 3	4	5 6 7	NA
(2)	Aggressive behavior toward staff.	1 2 3	4	5 6 7	NA
(3)	Aggressive behavior toward a peer.	1 2 3	4	5 6 7	NA
(4)	Destructive behavior toward property.	1 2 3	4	5 6 7	NA
(5)	Aggressive behavior necessitating a time-out intervention.	1 2 3	4	5 6 7	NA

(2)

	DECREASE ←-----			NC	INCREASE -----→			NA
(6) Behavior necessitating physical restraint.	1	2	3	4	5	6	7	NA
(7) Discussing alternatives to destructive acting out behavior.	1	2	3	4	5	6	7	NA
(8) Active use of alternatives to destructive acting out behaviors.	1	2	3	4	5	6	7	NA

B. Comments: _____

Part III.

Directions: To what degree have you found the acquired skills helpful in managing the behavior of adolescents in placement? (Rate 1 through 5 or Not Applicable (NA) if you have not practiced this skill and circle only one number per each numbered statement).

A. Skills	1 <i>No HELP</i>	2 <i>HELPED A LITTLE</i>	3 <i>Moderately HELPFUL</i>	4 <i>VERY HELPFUL</i>	5 <i>Extremely HELPFUL</i>	NA
(9) Active listening skills.	1	2	3	4	5	NA
(10) Physical intervention strategies.	1	2	3	4	5	NA
(11) Life Space interviewing	1	2	3	4	5	NA
(12) Overall, I found the training to be ...	1	2	3	4	5	NA
(13) In regard to my comfort level in dealing with a crisis confrontation with a student, this training was ...	1	2	3	4	5	NA
(14) If this training were offered again, I would: sign up and attend? yes _____ no _____ recomend it to others? yes _____ no _____						

This questionnaire was adapted from the Classroom Management Training Program questionnaire developed by Dr. Fredric Jones and used by Dr. Barton Kramer in a dissertation titled Improving Classroom Management Skills in Secondary School Classrooms through the use of Limit Setting, an Incentive System, and Structured Teaching (1986).

(4)

APPENDIX B

THERAPEUTIC CRISIS INTERVENTION TRAINING PROGRAM
FOLLOW-UP QUESTIONNAIRE TO PHYSICAL RESTRAINT INCIDENT

Therapeutic Crisis Intervention Training Program
Follow Up Questionnaire

To be attached to a facility incident Report Document
(Post Training)

Instructions: Read the following open ended questions. Please respond to each with reference to the attached incident report. The questionnaire is to be sealed in the attached envelope and will be reviewed by an examiner only for purposes of this research.

1. Briefly describe the incident without indicating the names of the participants.

2. My relationship with the resident prior to the incident may be described as ...

3. My relationship with the resident following the incident may be described as ...

4. As a result of my intervention, I believe the resident benefitted in the following way ...

5. While dealing with the crisis, I recall the following techniques as being effective ...

6. While dealing with the crisis, I recall the following techniques as not being effective...

7. While involved in the incident, I recall feeling ...

Name _____ Date _____

Residential Treatment Center _____

Group Member Identification No. _____

This questionnaire will be used to determine child care worker's perceptions following an incident involving aggressive, acting out behavior.

APPENDIX C

THERAPEUTIC CRISIS INTERVENTION TRAINING PROGRAM
OUTLINE - TWO DAY TRAINING

Therapeutic Crisis Intervention Training
Outline - Two Day Training

Section I - Crisis as Opportunity

- "The Nature of Crisis"
- "Working Styles in Child Care"

Section II - "Awareness"

- Awareness of Our Emotions
- Awareness of the Environment
- Awareness of the Child

Section III - "Communication"

- Non-verbal Communication
- Verbal Techniques - Active Listening

Section IV - "Therapeutic Physical Intervention"

- Rationale for Restraint
- "Time Out" through Escorting
- Techniques of Therapeutic Physical Restraint

Section V - "Self-Protection"

- Releases
- Avoiding Restraint

Section VI - "Recovery"

- "Letting Go"
- "The Life Space Interview"

APPENDIX D

THERAPEUTIC CRISIS INTERVENTION TRAINING PROGRAM
FOLLOW-UP SESSION OUTLINE

THERAPEUTIC CRISIS INTERVENTION
FOLLOW-UP TRAINING

- I. Crisis as opportunity
 - A. Review definition of crisis
 - B. Review crisis cycle

- II. Awareness
 - A. Awareness of self
 - Dealing with our own anger
 - B. Awareness of child
 - sensitivity to child's emotional response to placement
 - C. Awareness of environment
 - noise
 - light
 - cleanliness
 - activity planning

- III. Communication: avoiding a crisis (talk out rather than act out)
 - A. Non-verbal skills
 - discussion regarding effectiveness
 - B. Verbal skills - active listening
 - review practical application
 - discussion regarding effectiveness

- IV. Therapeutic Physical Intervention
 - A. Single Person Restraint
 - application, discussion regarding effectiveness
 - B. Team Restraint
 - application, discussion regarding effectiveness
 - C. Self Protection
 - application, discussion regarding effectiveness

- V. Recovery
 - A. Letting go process
 - application, discussion regarding effectiveness
 - B. Life Space Interview
 - application, discussion regarding effectiveness

APPENDIX E

THERAPEUTIC CRISIS INTERVENTION TRAINING PROGRAM
DEMOGRAPHIC INFORMATION FORM

Therapeutic Crisis Intervention Training Program

Participant Information

1. Name _____ 2. Date of Birth _____
 3. Today's Date _____ 4. Date of Training _____
 5. Education (check one)
High School Diploma _____ Associate Degree _____
Bachelor Degree _____ Graduate Degree _____
 6. Experience working with seriously emotionally disturbed children:
Less than one year _____ Less than two years _____
Less than three years _____ Less than five years _____
Over five years _____
-

To be completed by Trainer:

Group Member Identification No. _____

Name of Trainer: _____

APPENDIX F

MEAN SCORES ON REPORTED SELF-EFFICACY

OCCUPATION STRESS INVENTORY

- Role Overload Subscale
- Role Insufficiency Subscale

CORRECTIONAL INSTITUTION ENVIRONMENT SCALE

- Support Subscale
- Expressiveness Subscale
- Personal Problem Orientation Subscale

Mean Scores of Training Levels

Reported Sense of Competence

Occupational Stress Inventory

Group 1 - Training without follow-up

Group 2 - Training with follow-up

Group 3 - No training

<u>Initial Measurement</u>	<u>45 Day Measurement</u>
N = 51	N = 48

Role Overload Subscale (RO) of OSI

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	22.94	1	17	22.18
2	16	24.19	2	16	24.94
3	18	21.33	3	15	19.40

Role Insufficiency Subscale (RI) of OSI

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	22.47	1	17	22.18
2	16	27.75	2	16	27.63
3	18	25.50	3	15	24.80

Mean Scores of Training Levels

Reported Sense of Competence

Correctional Institution Environmental Scale

Group 1 - Training without follow-up

Group 2 - Training with follow-up

Group 3 - No training

<u>Initial Measurement</u>	<u>45 Day Measurement</u>
N = 50	N = 46

Support Subscale (S) of CIES

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	3.41	1	16	3.69
2	16	3.06	2	15	3.07
3	17	3.29	3	15	3.40

Expressiveness Subscale (E) of CIES

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	3.06	1	16	3.50
2	16	2.56	2	15	2.93
3	17	2.71	3	15	2.87

Personal Problem Orientation Subscale (PPO) of CIES

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	3.06	1	16	3.31
2	16	2.38	2	15	2.33
3	17	2.71	3	15	3.00

APPENDIX G

MEAN SCORES ON REPORTED JOB STRESS

MASLACH BURNOUT INVENTORY

- Emotional Exhaustion Subscale
- Depersonalization Subscale
- Personal Accomplishment Subscale

Mean Scores of Training Levels

Reported Job Stress

Maslach's Burnout Inventory

Group 1 - Training without follow-up

Group 2 - Training with follow-up

Group 3 - No training

Initial Measurement 45 Day Measurement

N = 50

N = 48

Emotional Exhaustion Subscale (EE) of MBI

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	17.06	1	17	15.18
2	15	22.07	2	16	19.75
3	18	16.61	3	15	14.33

Depersonalization Subscale (DP) of MBI

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	5.88	1	17	5.29
2	15	9.53	2	16	8.38
3	18	7.50	3	15	8.93

Personal Accomplishment Subscale (PA) of MBI

<u>Group</u>	<u>N</u>	<u>Mean</u>	<u>Group</u>	<u>N</u>	<u>Mean</u>
1	17	42.24	1	17	41.24
2	15	38.53	2	16	37.38
3	18	40.22	3	15	38.47

John Joseph Lamanna
166 Jennifer Ct.
Winchester, Virginia 22603
(703) 667-3788

EXPERIENCE

- * 1976 to present. Leary Educational Foundation.
Residential Counselor (1976-77)
Counseling Supervisor (1977-79)
Facility Director (1979-present)
- * 1974 to 1976. Bradford Children's Home.
Residential Counselor

EDUCATION

- * Degree: Post Masters Certificate in Marriage and Family Therapy, Virginia Polytechnic Institute and State University, May 1990.
Major: Marriage and Family Therapy.
- * Degree: Certification of Advanced Graduate Study, Virginia Polytechnic Institute and State University, August 1989.
Major: Counselor Education and Student Personnel Services.
- * Degree: M.S.Ed. - Counseling & Personal Guidance, St. Bonaventure University, 1974.
- * Degree: B.A. - Social Science, St. Bonaventure University, 1972. ,

CERTIFICATION/LICENSURE


1989: Licensed Professional Counselor Board #0701
1989: National Certified Counselor #21859
9/75: Certified Social Studies Teacher (7-12)
9/75: Certified Guidance Counselor (7-12)

SPECIAL TRAINING AND ACTIVITIES

1982-present: Member Virginia Association of Independent Special Education Facilities.
Executive Board Member 1988-present.

SPECIAL TRAINING AND ACTIVITIES (cont'd.)

- 1985: Trainer's Program in Therapeutic Crisis Intervention. Cornell University, N.Y.
- 1988-1989: Parents Anonymous, group facilitator.
- 1989-present: Member American Association of Counseling and Development.
- Association for Counselor Education and Supervision
- 1990-present: Associate member, American Association for Marriage and Family Therapy.
- 1992-present: Member For Kids Sake, Winchester, Virginia.
1992 - Vice President
1993-present: President elect


Signature