

A REPORT OF A COUNSELLING AND ASSESSMENT
INTERNSHIP AT THE WATERFORD HOSPITAL WITH
A REPORT ON AN INVESTIGATION OF THE ABILITY
OF THE JESNESS INVENTORY TO DISCRIMINATE
BETWEEN OFFENDING AND NON-OFFENDING JUVENILES
WITHIN THE SCHOOL SYSTEM

CENTRE FOR NEWFOUNDLAND STUDIES

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JEROME LLOYD BLACKMORE





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TO DISCRIMINATE BETWEEN OFFENDING AND NON-OFFENDING
JUVENILES WITHIN THE SCHOOL SYSTEM.

by

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A Report submitted in partial fulfillment
of the requirements for the degree of
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ABSTRACT

The internship was carried out primarily at the Waterford Hospital in St. John's, Newfoundland from May 15, 1989 to August 11, 1989. Other settings included the Pre-Vocational Training and Assessment Centre and the Children's Rehabilitation Centre, both also located in St. John's.

During this internship opportunities were provided for the intern to: a) further develop and enhance both personal and professional skills in individual counselling, group counselling and consultation; b) gain experience in the administration, scoring, interpretation, and application of a wide range of instruments used in the assessment of intellectual and cognitive abilities and behavior and personality functioning; c) develop greater awareness of the issues involved in the assessment, management and delivery of services to mentally retarded clients; and d) gain experience with the rehabilitation services provided to children with physical and developmental disabilities.

The research component of the internship was conducted to determine if the Jesness Inventory could

be used to discriminate between adjudicated juvenile offenders in a residential custodial facility and non-offending juvenile students receiving remedial academic instruction in rural Newfoundland. The results show significant differences between the groups on the Social Maladjustment, Autism and Asocial Index scales at the .05 level of confidence using two-tailed t-tests.

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I would like to thank Dr. Glenn Sheppard, Head of the Department of Educational Psychology at the time of the internship program for his assistance in establishing the structure of the internship program and for his invaluable support and guidance and for his kindness and concern.

Thanks is also extended to Dr. Bruce Gilbert who supervised the beginning stages of the internship program and who offered much valuable assistance with the initial aspects of the research component.

The intern is extremely grateful for the vast amounts of patience, encouragement and unstinting support shown by staff psychologists Bill Kane, Nena Sandoval, Louise Kang, Tom Honan and Susan Jackman-Crann at the Waterford Hospital. Particular thanks is extended by the intern to Malcom Simpsom and Eileen Donahoe on whom fell much of the day-to-day supervision of assessment and counselling cases and who were always more than willing to share of themselves and their expertise.

To Dr. Justin O'Mahony, Director of Psychology at

the Waterford Hospital at the time of the internship, the intern extends the warmest thanks for his support, assistance and encouragement. His unfailing kindness, civility, humility and humour will always be a source of continuing inspiration; and if, at some point in the future, I may serve half as ably in the same capacity for some untried student, I will, with great thanks, recall his efforts on my behalf for guidance and enlightenment. Dr. O'Mahony's ability to concisely summarize all pertinent points of a difficult case and to swiftly, eloquently and with apparent ease state them clearly and simply will long serve in memory as a capacity to which I will refer others with some degree of admiration.

To Dr. Hassan Khalili, Assistant Director of Psychology at the Waterford Hospital at the time of the internship, the intern owes a debt of gratitude the extent of which cannot be fully stated. For his friendship, humour, wisdom, patience, kindness, understanding, concern, support and respect I will always be grateful. His inspiration will serve always to provide a model of professional and personal excellence to which the intern will with gratitude and

humility continually aspire.

I would also like extend a note of thanks to Lorna Piercy at the Children's Rehabilitation Centre and Satinder Manocha at the Janeway Children's Hospital for their kind efforts in assisting the intern in activities related to the internship objectives in their respective settings.

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I also wish to extend a special note of acknowledgment to my wife, Julia, whose unwaivering support and assistance enabled me to start and complete this program.

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CHAPTER 1

Introduction

This internship was based upon the rationale that a period of structured and supervised practice is a critical element in the training of a school psychologist or counsellor. Through such practice, in a variety of practical situations, the intern may apply and refine the knowledge and skills gained through formal study.

Before assuming the responsibilities of employment within the educational system, the intern wanted to have a greater awareness of the manner in which mental health services are structured and delivered within the broadest possible context. The difficulties experienced by children and adolescents in school are often greatly influenced by the immediate circumstances of the adult world in which they must live. The role of the school counsellor or psychologist frequently requires extensive coordination with many other professionals involved in the delivery of services to the child and his/her family. More experience with the provision of mental health services to adults and late adolescents within the community context was deemed, by the intern, to be an important aspect of training which

would enhance his ability to appreciate the impact of dysfunctional adults within the larger community upon children and adolescents in the school setting.

OBJECTIVES OF THE INTERNSHIP PROGRAM

The intern identified six general objectives to be met during the internship. This section of the report contains a list of these general objectives and the activities designed to meet them.

General Objective 1.

To gain greater knowledge and experience in the area of individual counselling.

Activities

- A. To observe, each for a minimum of two sessions, the field supervisor and a staff psychologist at the Waterford Hospital in counselling sessions with individual patients.
- B. To discuss and review each observed counselling session with the psychologist involved.
- C. To attend weekly staff allocation meetings to observe and participate in the process of assigning newly admitted patients to staff psychologists.

- D. To provide ongoing counselling services to a minimum of four patients on a continuing basis during the internship period.
- E. To meet with the supervising psychologist each week to review and discuss the counselling provided by the intern to each patient.

General Objective 2.

To gain increased experience, knowledge and skills with a wide variety of instruments used in the assessment of psychological processes.

Activities

- A. To become familiar with the assessment instruments located in the Test Materials room of the Psychology Department at the Waterford Hospital.
- B. To review with the assigning psychologist, before the administration of any assessment instrument with which the intern is unfamiliar, all test materials and procedures and to become familiar with appropriate standards of administration of each new test instrument.
- C. To accept for assessment, from staff psychologists, a weekly assignment of two clients requiring the use of

assessment instruments which the intern had not used previous to the internship period.

D. To conduct the psychological assessments referred to in Activity C.

E. To review, with the supervising psychologist, the results obtained from the administration of each instrument and discuss how these results would be interpreted and incorporated into the written report; to assist with subsequent treatment decisions.

General Objective 3

To participate in and gain supervised experience with interactional group therapy.

Activities

A. To co-lead an interactional therapy group for twelve weeks.

B. To participate in a thirty minute review and evaluation meeting with the supervising co-leader immediately after each group session.

General Objective 4

To increase the intern's understanding and knowledge of the issues relating to the delivery of

services to individuals who are mildly or moderately mentally retarded.

Activities

A. To visit all treatment units for the mentally retarded at the Waterford Hospital and to discuss, with staff members, issues and concerns relating to the delivery of service to this population.

B. To discuss, with personnel from the Division of Developmental and Rehabilitative Services of the Department of Social Services, the nature of the services provided to individuals with a physical and/or developmental disability.

C. To attend two case management meetings sponsored by the Avalon Community Accommodations Board to observe the discussion of issues related to the delivery of services to a group of developmentally disabled adolescents and adults residing in community-based residential housing units. The term "developmentally disabled" is used at the Avalon Community Accommodations Board to refer to clientele whom the Waterford Hospital designate as mentally retarded.

General Objective 5

To become more familiar with the rehabilitation services provided to children with physical disabilities.

Activities

- A. To review the services provided at the Children's Rehabilitation Center.
- B. To attend a Developmental Conference at the Children's Rehabilitation Centre and observe the Outpatient Clinic Team discuss issues involved in the planning and delivery of services to physically disabled children.
- C. To observe staff psychologists administer a minimum of two assessment instruments to patients at the Children's Rehabilitation Centre.

General Objective 6

To conduct a research study into the ability of the Jesness Inventory to discriminate between adjudicated juvenile offenders and non-offending juveniles in the school system.

Activities

- A. To collect data on the attitudes, values and beliefs of academically underachieving teenagers attending school by administering the Jesness Inventory to (1) adjudicated juveniles in secure residential custody in St. John's and to (2) a group of juveniles attending summer school remedial sessions sponsored by the Avalon North Integrated School Board in Green's Harbour, Newfoundland.
- B. To collect data concerning demographic information on juvenile participants in the research projects by administering a questionnaire.
- C. To review the literature on the Jesness Inventory, the assessment of juvenile offenders, and the relationship of attitudes and beliefs held by juveniles to academic underachievement and adjudicated offence status.
- D. To analyze the data collected from research subjects.
- E. To report and discuss the results of the research project.

STRUCTURE AND ADMINISTRATION OF THE INTERNSHIP

Introduction

The difficulties experienced by children in the school setting are often greatly influenced by outside factors. Services provided by psychologists and counsellors to the child in the school setting, to be most effective, must often be a part of a coordinated program within a much broader context. This delivery of service can involve the activities of many professionals, both within and outside the mental health field, and can involve many individual practitioners, agencies and institutions within the community. Accordingly, further experience with the provision of broadly-based mental health services within the context of the community was regarded by the intern to be not only relevant to, but a significant feature of, his preparation to undertake the duties and responsibilities of a school counsellor or psychologist.

THE INTERNSHIP SETTING

The Waterford Hospital, The Children's Rehabilitation Centre and the Dr. Charles A. Janeway Child Health Centre comprised the physical setting of the internship.

The Waterford Hospital is the major psychiatric treatment and referral centre for Newfoundland and Labrador. At the time of the internship, the Waterford Hospital contained 437 in-patient beds and provided services in acute psychiatry, long term care, mental retardation, as well as forensic, medical and psychogeriatric services. The hospital also has an active ambulatory program with 600 registered outpatients and a community care program which was established on the concept of re-integrating discharged patients into the community in a supervised (boarding care) program.

The clinical staff includes psychiatrists, general practitioners and consultants in internal medicine, neurology, respiratory, radiology, and anesthesiology. Other services include psychologists, social workers, occupational therapists, and graduate psychiatric nurses. The hospital's para-medical and support

services include laboratory, radiology, pharmacy, electroencephalography and a variety of rehabilitation and recreation facilities including work therapy, art therapy and physical education. The Adult Education Department provides specialized adult education programs as part of the Community College system in the Province and serves those who are capable of furthering their educational standing. This Department offers regular High School courses as well as Adult Basic Education academic upgrading programs leading to High School Grade-Equivalency certification up to Level III (Grade 12). All courses are transferrable to any community college in the province. Life skills training programs are also provided for mild and moderately mentally retarded persons.

The staff of the Psychology Department consists of the Director, three Senior Psychologists, five staff psychologists and a psychological assistant. Each of the three Senior Psychologists has clinical responsibilities within one or more of the following seven major areas or Services of the hospital: Mental Retardation; Acute Care; Ambulatory Care; Long-Stay Psychiatric; Psychogeriatrics; Forensic; and Medical.

Each staff member of the Department serves as a liason psychologist with one or more of the seven Services at the hospital. Lists of the major areas of Clinical Service and of the Units of each to which liason psychologists were assigned are given in Appendix F.

The Department of Psychology provides a wide range of therapeutic services to the adult and adolescent patient population. The spectrum of therapies available are based on cognitive-behavioral, psychodynamic and ecological principles. Among the services provided are psychotherapy, hypnotherapy, treatment of sexual inadequacy and dysfunctions, counselling (e.g., crisis, personal or adjustment, marital), cognitive-behavioral therapy for anxiety and depressive disorders and social and life skills training.

A full range of psychological assessment techniques and services are also provided, including the psychological interview, behavioral analysis, and evaluation of cognitive and intellectual abilities, personality functioning, and neuropsychological status. Forensic and diagnostic assessments are also provided. (J. O'Mahony, personal communication, 1988).

The Children's Rehabilitation Centre is a fully accredited, 52 bed, active treatment centre which provides a wide range of services for children up to age twenty residing in Newfoundland and Labrador. At the time of the internship period there were approximately 2000 active cases registered at the Centre.

The medical staff consists of a Psychiatrist, Orthopaedist, Neurologist and a Urologist. On the consulting staff are one or more of the following; Neuro-Surgeon, General Surgeon, Otolaryngologist, Plastic Surgeon, Ophthalmologist, Rheumatologist, Pediatrician, Psychiatrist and Dentist.

The professional staff at the Centre also includes physiotherapists, occupational therapists, social workers, rehabilitation nurses, teachers, recreation therapists, speech therapists, an orthotist and psychologists.

SUPERVISION

Supervision of the internship at the University was provided by Dr. Bruce Gilbert, with whom the intern met frequently, prior to and during the internship to discuss and evaluate objectives and activities.

Overall supervision of the internship in the field was provided by Dr. Hassan Khalili, Senior Psychologist, and subsequent Director of Psychology, at the Waterford Hospital. In addition to daily meetings on an unscheduled basis, a one hour period of supervision was scheduled twice weekly with Dr. Khalili.

Additional supervision was provided on a case-by-case basis by various members of the Department of Psychology. Dr. Justin O'Mahony, then Director of Psychology, supervised cases requiring the assessment of personality. Bill Kane, staff psychologist, provided supervision in the area of service delivery and programming for mentally retarded patients. Eileen Donahoe, staff psychologist, supervised counselling and therapy cases. Nena Sandoval, staff psychologist, supervised cognitive assessment tasks and Malcom Simpson, staff psychologist, supervised cases involving

the assessment of personality and behavior.

Supervision of the interactional group therapy portion of the internship was provided by Pat Edny, Public Health Nurse at the Waterford Hospital.

At the Children's Rehabilitation Centre supervision was provided by Lorna Piercey, Director of Psychology.

At the Dr. Charles A. Janeway Children's Hospital supervision was provided by Satinder Manocha, then the Director of the Psychology Department.

Chapter I has presented the rationale, objectives and activities of the internship, the structure of the internship, and a description of the settings. Chapter II will describe how the objectives and activities were addressed, along with the results.

CHAPTER II

ACTIVITIES, RESULTS AND DISCUSSION OF THE INTERNSHIP

Introduction

The purpose of this chapter is to describe the intern's participation in activities relating to his internship objectives and to discuss how those experiences helped fulfil the stated objectives.

General Objective 1.

To gain greater knowledge and experience in the area of individual counselling.

Activity A.

To observe, each for a minimum of two sessions, the field supervisor and a staff psychologist at the Waterford Hospital in counselling sessions with individual patients.

The intern observed the field supervisor, Dr. Hassan Khalili, in three counselling sessions with a 20 year old male outpatient who lived at home with his "extremely religious" parents. This client exhibited many inappropriate social behaviors. It was discovered that he had been exposing his genitalia to younger

children at the school. He was quite ashamed of this behavior and experienced considerable anxiety concerning his inability to control it.

Counselling for this patient was insight-oriented and explored his relationship with his parents, especially his mother to whom he expressed considerable ambivalence. An issue which seemed important to this client was the effect his upbringing was having upon his behavior, especially with regard to his family's strict religious beliefs.

Relaxation techniques and social skills training using role play and rehearsal were used to help him control some of the more disturbing aspects of his behavior and ongoing counselling was arranged.

The intern felt that with this client the process of developing insight into his problems was to be extremely difficult and lengthy. This individual's speech was marked by frequent, inappropriate ramblings interspersed with blushing giggles, and other manifestations of shame and anxiety. It seemed to the intern that this client's cognitive awareness of the meaning of the counsellor's words did not evidence any depth of mental processing. Although this client

expressed a desire to change and a willingness to participate, it proved, in later conversation with his mother, to have been she, who had initiated and insisted upon maintaining the counselling process after her son had been discovered sexually exposing himself at school. It appeared to the intern that the process of gaining insight had just begun for this immature adolescent.

Malcom Simpsom, staff psychologist, was observed in two counselling sessions with a 19-year-old male outpatient who had been referred from the Department of Social Services. He was attending an academic upgrading program and living in a privately operated facility which offered room and board. He complained of generalized feelings of anxiety and inadequacy, problems with drug abuse and difficulty interacting socially with others at his boarding accommodations. Also of concern to him was his inability to budget his money and purchase basic necessities because of his drug problem.

Counselling for this individual was quite directive and focused on assisting him to develop a budget and generating strategies to assist him in maintaining it.

Methods of avoiding situations in which he would be exposed to alcohol and drugs was explored and a list of alternative activities were developed which would not affect the status of his budget and greatly lessen his chance of being placed in a situation in which drugs or alcohol were being used. A daily schedule was developed to assist in those aims as well as to provide structured periods for study and assignments. Assertiveness training was arranged to provide him with the ability to express strongly to others his wish to avoid drugs. Further supportive sessions were arranged on a less frequent basis after his immediate presenting problems were under some degree of control.

Observations of the counselling sessions with this client afforded the intern a realistic perspective of the strategies and skills involved in the counselling process. The intern had, to some degree, in spite of formal training, conceptualized the process as one in which the primary focus was on the achievement of insight and assumed that cognitive awareness, once achieved, inevitably led to changes in feeling and behaviour. It became evident to the intern that proceeding with such a conceptualization of the

counselling process in this case would have quickly proven to be less than useful. The initial cooperation of this individual would quickly have given way to frustration with the lack of assistance with his immediate problems, and lead to his rapid withdrawal from counselling involvement.

The intern quickly realized that counselling must occur with the needs of the client as the primary focus and that the helping process involves addressing problems and designing intervention strategies that are understood from the client's own terms of reference. The intern also became aware of the fact that, on many occasions, client problems require extremely clear definition, outcome goals need specific delineation and treatment and monitoring strategies must be highly structured.

ACTIVITY B.

To discuss and review each observed counselling session with the psychologist involved.

Immediately after each session the intern met with the psychologist and details of interest and concern which had arisen during counselling were raised and

discussed. Matters of interest raised by the intern often concerned such issues as; the overall structure and direction of the counselling; how a particular approach was decided upon or a specific counselling technique chosen; and what factors influenced determination of the most appropriate methods of intervention.

Such concerns were often the topic of post-session discussions and it became apparent to the intern that a thorough review of the relevant data contained in the file and consultation with other professionals involved with the client provided valuable insights into how the sessions and the course of counselling might best proceed.

Relevant experience with similar cases also seemed quite important in helping the psychologist arrive at the type of questioning that might best elicit meaningful information. Sensitivity to the reactions of the client also emerged as an extremely important skill of the counsellor. Subtle, non-verbal responses, of which the clients themselves were often unaware, did in some instances provide valuable information or insights that might not otherwise have been elicited.

Sometimes the non-verbal presentation of a client contradicted the content of the verbal communication. A 37-year-old male patient, who had, two weeks previously, attempted suicide, recounted, with apparently great hesitancy, the circumstances which had resulted in his admission. He expressed great remorse and a strong desire to obtain counselling assistance for the difficulties he was experiencing and to help him make a new life. His speech was very deliberate and serious in tone. In a halting, hesitant manner he seemed to struggle to maintain control, as he responded to the questions of the interviewer. His unemployment benefits had been exhausted and his wife, who was living in another province, had filed for divorce and custody of the children. He also faced charges for drug trafficking and impaired driving. After giving a response, or before answering a question, he would make brief, but direct eye contact, alternating rapidly between the intern and the psychologist; he would pause, look away, stare out the window or at his cigarette and then slowly and deliberately respond. His eye movements were occasionally directed quickly and briefly toward activities which could be viewed

through the window and then, just as quickly, returned to gazing at his hands, or at the floor. His emotional presentation remained very serious but his eyes were lively and did not convey an emotional state that was congruent with that communicated by his speech or countenance. The impression of the intern was of one who was processing the effect his words were having in an attempt to better convey the most appropriate impression. The supervising staff psychologist pointed out these observations to the intern and suggested that we should consider the likelihood that the information provided by this individual might possibly be incomplete or misleading. Furthermore, he indicated that this patient's objectives for counselling would, most likely, focus on the best resolution of his immediate and short term legal, marital and financial difficulties rather than on any long term, significant change in attitudes or behaviour. Information, received later, indicated that the patient was wanted by authorities in another province for questioning in connection with charges of sexually abusing one of his children. Despite direct questioning, knowledge of this circumstance was denied by this individual.

Subsequent assessment with the Minnesota Multiphasic Personality Inventory tended to confirm the initial impressions of the psychologist regarding this client. Responses to items on that instrument indicated an exaggerated tendency to reply to items in a manner calculated to convey an appropriate or expected impression and that the overall prognosis for counselling was not good.

The intern also learned from these sessions how an intake interview is conducted and what types of information are required to fully establish the client's history. Procedures involved in the assessment of the mental status of a client were also observed on a number of occasions and were found by the intern to be an excellent framework for the structuring of initial observations and impressions regarding a client's appearance and behavior, speech and communication, cognitive and emotional functioning, thought content, and sensori-motor functioning.

ACTIVITY C.

To attend weekly staff allocation meetings to observe and participate in the process of assigning newly admitted patients to staff psychologists.

All newly admitted patients to the Waterford Hospital are screened by the staff psychologists, each of whom has been designated to an area of service or particular functional unit. The object of the screening process was to determine whether the Psychology Department would become involved at that time. A note was written immediately into the patient chart outlining the decision of the liaison psychologist. Following the identification of a patient in need of and amenable to psychological services, the liaison psychologist brought the patient's name and a summary of the needs requiring psychological services to the weekly Allocation meeting. The goal of the allocation process was to present the best match between the needs of the patient and the skills of the psychologist. Allocation meetings were attended by all staff members and were chaired by the Department Head, who made the decisions regarding the allocations. Those decisions were based

primarily on the nature and complexity of the presenting problem and the skills required to address that problem.

The intern attended all Allocation meetings held during the internship period, observed and participated in discussions and accepted cases from all staff psychologists for assessment and counselling.

The allocation process was one which the intern found to be useful in providing an overview of aspects considered to be important to the initial conceptualization of a presenting case and the factors relating to the manner in which the need for psychological services is addressed.

At the allocation meeting new patients were discussed and staff members shared with each other the problems they were experiencing with patients. Staff members with recognized proficiency and training in a particular area were often asked to share their experiences with each other or to serve in a consulting role on individual cases. Sometimes staff members accepted jointly a specific case in which the client could benefit from their combined experience.

The weekly allocation meeting was a significant

learning experience for the intern. A wide range of cases were considered during the course of the internship and information pertinent to subsequent decisions regarding these clients were presented and discussed. The intern was made aware of the kinds of information and observations that were most useful in deciding whether or not psychological involvement was warranted. The interplay of ideas and perspectives involved in the conceptualization of client needs, the determination of the most appropriate interventions and the allocation of the most suitable staff member to provide that treatment furnished the intern with a good sense of the processes involved in making and implementing decisions in a professional environment.

ACTIVITY D.

To provide ongoing counselling services to a minimum of four clients during the internship period.

The intern accepted from the allocation process a total of ten clients for ongoing counselling during the internship. Five of these clients were seen on three occasions each and for three others, four to six counselling sessions each were provided. Counselling

sessions were held with two other clients on a twice weekly basis for a total of eight sessions each.

Four male clients had problems with alcohol abuse and two other male clients were co-addicted to marijuana, cocaine and alcohol. Another male had extreme difficulty managing stress and controlling anger. Two female clients, one of whom experienced extreme social anxiety, were addicted to prescription medications. Another female who had been physically and sexually abused as a child experienced feelings of extremely low self esteem, periods of self injurious and aggressive behaviour as well as alcohol and drug abuse.

The cases assigned for individual counselling exhibited a large variety of distressing problems. These included extreme alcohol and drug abuse, depression, suicidal ideation, self-injurious behavior, and extreme anger and aggression. Associated with these problems were issues arising from, lack of social skills and difficulty initiating and maintaining relationships, dysfunctional family interactions, academic and training difficulties, and unemployment and poverty. Several counselling clients had

previously attempted suicide. Convictions for physical assault, break and enter, shoplifting, public drunkenness, impaired driving and possession and trafficking in drugs were also common features in the presenting history of many of these individuals. The counselling therapies selected and the services provided to these patients varied widely. For several clients the provision of direct assistance in the clarification of problems and the selection of appropriate goals were central to the counselling process and with those clients the identification of target behaviors, the exploration of controlling antecedents and consequences and the development and selection of self management and monitoring strategies were major components of the counselling process. Counselling with other clients involved a much more person-centered approach, relying heavily on the achievement of insight and self-understanding as a major counselling objective.

Many of the techniques used reflected a cognitive-behavioral approach and included cognitive modelling and thought stopping, cognitive restructuring and reframing, and relaxation training.

One patient with whom the intern made contact on three occasions was a slight, thin, middle-aged male, suffering from alcoholism. An unmarried labourer, he was unable to function independently or keep a job. He was frequently injured in habitual physical altercations at the bars he frequented. He was unable to control his money and was dependent upon his elderly parents with whom he lived. His problems were exacerbated to a great extent from boredom and the lack of socialization or recreational activities, other than those provided at the local bar. His social relationships revolved entirely around the activity of his drinking companions who exerted considerable influence upon him for their own benefit. He was referred to the interactional therapy group for persons with addictions problems, and was referred to the Adult Education Department for academic upgrading classes.

Another client, a 27-year-old male outpatient, was seen on three occasions by the intern in the Outpatient Department after he had been referred from the interactional therapy group. This man had been addicted to prescription and non-prescription drugs and alcohol for approximately 10 years. His family

background was quite dysfunctional and he had been physically abused by his father from a very early age. In the interactional therapy group, he had expressed intense rage and anger towards a number of people whom he considered to be deliberately frustrating him. He stated that he had a gun and was not afraid to use it. The intern immediately arranged with the staff psychologist to see this client on an ongoing basis and provide cognitive-behavioral techniques for coping with stress and controlling anger. This client was basically uncooperative but did for a period of time discuss the extent of his anger and the situations which precipitated and maintained it. He showed interest in controlling his anger and coping more constructively with the stressors in his life but did not show up for the fourth session and was reported to have left the province.

Two other inpatients were counselled on several occasions for alcoholism and substance abuse problems. One was a 32-year-old unmarried female, who was addicted to benzodiazepene medication prescribed for insomnia and tension. She lived with her blind mother and schizophrenic sister and complained of depression,

inability to concentrate, and social anxiety. She was low functioning intellectually and seemed unlikely to be a good candidate for insight-oriented therapies. She expressed a great degree of sexual frustration and reported continual preoccupation with sexual fantasies. Social services was contacted to investigate the possibility the possibility of providing respite care for this patient. Social skills training and stress management techniques including relaxation exercises were recommended. Another male client, seen on three occasions, was a 40-year-old mechanic who was unable to control his cocaine addiction and was bankrupting his business as a result. He had previously worked extremely hard for long hours to make his business a success and his only relaxation was a drink with his employees after work; sometimes small amounts of cocaine were used as well. Three years prior to admission his youngest child had been killed in an accident for which he held his wife responsible. His drinking increased and he spent large amounts of money on alcohol and drugs and became involved with another woman. He was admitted after experiencing hallucinations while using cocaine. Insight-oriented

therapy was begun and a referral was made to the interactional therapy group for persons with addictions problems.

Another client, seen on eight occasions, was a 35-year-old, divorced mother of three young children, who was unable to control her drinking and, because of it, was about to lose custody of her children and was also in jeopardy of losing her job. She was passive, easily frustrated and unable to function independently.

Alcohol was used as an escape from the stress engendered by the daily responsibilities involved in working and caring for three small children and a home. Insight-oriented counselling was provided to assist her to see the self-defeating functions that alcohol was serving in her life and the attitudes and beliefs that served to maintain her addiction. Stress management techniques and relaxation training were provided and a referral was made to the Outpatient interactional therapy group for persons with addictions. One other alcoholic female patient was also seen for eight sessions and similar treatment strategies were used; a referral was also made to the interactional therapy group.

These counselling sessions permitted the intern not only to apply skills and techniques gained through formal study but also required that he further develop and elaborate on them. This process proved to be a demanding but extremely rewarding experience which promoted both the professional and personal growth of the intern. The support and cooperation of the field supervisor, Dr. Hassan Khalili, and Eileen Donahoe, the supervising staff psychologist for counselling and therapy cases, made these experiences both challenging and rewarding. The intern learned, in the process of providing these services, to be more comfortable and confident in his role as counsellor and to be more assured in his application of skills acquired in formal study. He also learned to seek advice and to recognize when that advice was necessary. The intern gained a fuller realization that not only skills but insight, experience and sincerity are essential aspects of the therapeutic process.

ACTIVITY E.

To meet with the supervising psychologist each week to review and discuss the counselling provided by the

intern to each patient.

In addition to those periods formally assigned in the schedule, consultation and supervision was provided generously on a daily basis by both Ms. Donahoe and Dr. Khalili. In addition, supervision was also provided by the liaison psychologist who had allocated patients for counselling. All staff psychologists contributed substantial amounts of time to give support, encouragement and advice during the entire internship period.

Much of the initial supervision concerned the fundamental skills and strategies involved in the counselling interview. Concerns related to empathy, genuineness, positive regard and the building of trust and rapport were discussed. Later topics dealt with were self-disclosure and the importance of being sensitive to nonverbal behaviors, such as facial expressions, placement of arms, legs and feet, eye movements, rate, volume and pitch of speech, and client's reaction to touch. Effective listening and summarizing skills were also reviewed during the course of the internship period.

Supervision sessions occurring during the latter

part of the program were directed toward factors involved in problem assessment, goal setting, and the selection and implementation of intervention strategies. Other discussions involved role playing, covert modelling, cognitive modelling, thought stopping and relaxation training.

The advice and support provided by supervisors was a vital component of the internship program and was found to be critical to the intern's overall development. This aspect of the internship period proved to be both demanding and gratifying. To be accepted and encouraged in a demanding professional environment was a source of continuing inspiration.

General Objective 2.

To gain increased experience, knowledge and skill with a wide variety of instruments used in the assessment of psychological processes.

ACTIVITY A.

To become familiar with the assessment instruments in the Test Materials room of the Psychology Department at the Waterford Hospital.

The Test Materials room is located in the

Outpatient Department of the Waterford Hospital and contains all test materials used by staff psychologists. The intern organized these materials and familiarized himself with each instrument, its intended uses, applicable age range, and associated materials such as manuals, record sheets and profile forms. A list of all test items reviewed is included in Appendix C.

ACTIVITY B.

To review with the assigning psychologist, prior to administration, all test materials and procedures and to become familiar with appropriate standards of administration of each new test instrument.

When a staff psychologist assigned a client for assessment, it was the responsibility of that psychologist to discuss with the intern which instruments were required to be administered and why the information provided would be necessary or useful for that patient. The referring psychologist reviewed with the intern all pertinent materials, techniques and procedures required for proper administration of a test instrument.

After the completion of each administration the

intern met with the assigning psychologist and completed the scoring and profiling process. Interpretation of the results then followed and points relating to the most appropriate interpretation were considered.

This procedure proved to be quite efficient for both the intern and the assigning psychologists and permitted wide experience to be gained in the administration of many assessment instruments.

ACTIVITY C.

To accept from staff psychologists a weekly assignment of two clients requiring the use of assessment instruments which the intern had not used prior to the internship period.

Assessment assignments were given either at weekly allocation meetings, or, more casually, as the need or opportunity arose. Twenty-eight assessment cases were completed, using instruments with which the intern had no previous experience. In total, ten assessment instruments were assigned for administration, scoring and interpretation. Some of these instruments were administered only once, while others were used more frequently. Table 2.1 lists ten different assessment

instruments studied by the intern and the number of times each was administered.

The intern found this method of gaining assessment experience to be both practical and logical. It permitted the broadest possible experience in the most relevant context. While requiring close supervision, this method entailed the minimum expenditure of extra time on the part of staff psychologists.

TABLE 1

ASSESSMENT INSTRUMENTS ADMINISTERED

<u>ASSESSMENT INSTRUMENT</u>	<u>NUMBER OF TIMES USED</u>
Minnesota Multiphasic Personality Inventory	11
Millon Clinical Multiaxial Inventory	5
AAMD Adaptive Behavior Scale	3
Raven's Standard Progressive Matrices	3
The Jesness Inventory	1
The California Psychological Inventory	1
High School Personality Questionnaire	1
Beck Depression Inventory	1
Sixteen Personality Factors Questionnaire	1
Wechsler Memory Scales	1

ACTIVITY D.

To review, with the supervising psychologist, the results obtained from the administration of each instrument and to discuss how these results would be interpreted and incorporated into the written report.

This activity occurred on an on-going basis and typically involved at least one scheduled meeting with the assigning psychologist, but often involved more frequent, informal discussions and engaged much of the intern's otherwise unscheduled time. Discussions were often lively, especially when more than one psychologist was involved and experiences with previous assessments were compared to a particular assessment case in the past.

The intern quickly became aware that the interpretation of results can lead to varying conclusions, depending upon the background and perspectives of those involved in the process. In this regard, the intern felt that psychological assessment requires not only procedural and statistical knowledge but skills gained through relevant experience with previous cases.

A total of nine reports were written by the intern,

incorporating results from the administration of assessment instruments. Each report was included in the patient's files and was reviewed in each stage of development by the supervising psychologist. Assessment results and scoring procedures were examined by the supervising psychologist for each initial administration and scoring of an instrument. Interpretations of test results were reviewed in every case and the application of assessment findings to each particular client was discussed. Intellectual assessment was often required for determining appropriate educational goals and the design of suitable programming. Occasionally, questions concerning the level of cognitive sophistication of a patient required clarification to determine the appropriateness of a particular intervention approach. Behavioral assessments were used primarily to assist in programming for life skills and social skills training with developmentally delayed individuals. Personality assessment constituted much of the assessment undertaken by the intern and was found to be extremely interesting and often very useful. The results obtained from the assessment of personality functioning

permitted basic personality traits to be distinguished from dysfunctional processes and psychiatric disorders. Results of assessment sometimes permitted insights into basic personality processes which have contributed to the development of the patient's problems or which may have assisted the client in dealing with them. The assessment was often used to confirm, clarify and further delineate the impressions and hypotheses formed by the intern in the initial interview stages. Assessment results provided the intern with a conceptual framework from which to develop an integrated picture of patient functioning and which assisted him in the preparation of the most suitable goals and intervention strategies.

General Objective 3

To participate in and gain supervised experience with interactional group therapy.

Activity A.

To co-lead a therapy group for twelve weeks.

During the first week of the internship, the intern met for one hour with Pat Edny, the group leader, to discuss the rationale and philosophy of the

interactional group therapy program at the Waterford Hospital. The goals of the program and intake/referral procedures were described and summarized. Essential background information on group members was discussed with the intern and current issues being dealt with by group members was reviewed.

The intern was made aware by Ms. Edny that his participation in the group was contingent upon the explicit consent of group members and that strict requirements relating to the confidentiality of information obtained in the group were to be observed.

After the consent of the group was obtained, the intern was accepted as co-leader for the remaining twelve weeks of the internship.

The interactional group therapy program, which commenced in January of 1982, is primarily an outpatient treatment service which offers assistance to individuals who are addicted to alcohol, prescription medications and/or street drugs.

The addictions group program is coordinated by a social worker and is staffed by social workers and nurses. A psychiatrist is available as a consultant to the group leader and as a resource in the assessment and

treatment of individuals in crisis.

Individuals in this group are referred from a variety of sources and each is interviewed and screened by the group leader and/or coordinator for suitability for admission into the program.

New members are accepted into either the Day Group or the Night Group, both of which meet for two hours once a week. The Day Group stresses exploration of drinking and other addictive behaviours, with the goal of helping members achieve and maintain a consistent pattern of freedom from alcohol or drug use. Once such a pattern has been demonstrated (typically for a period of six months) the client may, after consultation with the group co-leaders, be transferred to the Night group. This Group focuses on helping members to realistically confront and to more effectively cope with their problems and to address areas in their lives requiring positive change.

Members entered and left the Day Group according to situational circumstances or as they were recommended for transfer to the Night Group. The Day Group met from 11 A.M. to 1 P.M. on Tuesday of each week in Conference Room B of the Outpatient Department of the

Waterford Hospital. The group consisted of twelve members and two co-leaders for a maximum possible total of fourteen.

It was the usual practice that only one new member be introduced into the group at any given time. New members are first introduced to all the other members and invited to speak briefly about themselves, the circumstances that led to their presence in the group and their expectations relating to their participation in it. The function of the group was briefly explained and concerns or themes that have recently arisen were reviewed. Confidentiality concerns were explicitly addressed, with the new member and group stipulations relating to it were expressed and explained. Group members are obliged to preserve the confidentiality of information shared within the group and information obtained because of membership in the group was not to be shared with non-members except in those situations where serious consideration of the circumstances warranted the breaking of confidentiality. Members were encouraged to limit outside discussion of group issues among themselves only to those situations in which they felt it to be absolutely necessary, and in

even those situations to address only issues or concerns that related directly to themselves.

Members were not permitted to participate in group sessions while under the influence of alcohol or non-prescription drugs, and those who did so were required to withdraw from that session immediately. A demonstrated lack of commitment to the objectives and regulations of the group was a matter of serious concern to the other members. The offending individual was immediately confronted in this matter and was forcefully reminded of the commitment expressed to the co-leaders in the initial screening process and to the group in general during the introductory meetings. If improvement in attitudes and behavior was not exhibited, that member was asked to leave the group.

At the beginning of a group session the leader or co-leader welcomed everybody back to the group and took note of those who were missing and either gave or sought reasons for their absence. Members then briefly described their activities during the past week and how successful they had been in dealing with their addiction problems. Individuals were invited to share their thoughts, feelings and experiences and spoke as

the opportunity, or need, arose. During silences the group leader encouraged quieter members or those who had not had the opportunity to speak previously. She also identified and expanded upon themes that had recently emerged.

The overall focus of the group was to explore and learn from the past, but to live for today, to identify commonalities and themes both in their struggles to remain drug free and in the factors that had allowed the destructive pattern of substance abuse to develop.

The group leader also identified positive aspects in the situations of individual members and attempted to build self esteem in those who expressed discouragement and anxiety. The intern became aware that some members were extremely valuable to the functioning of the group as a whole. Because of their ability to talk honestly and openly about themselves, they provided models for the others and encouraged them to participate in the same manner. Although members were generally supportive of each other, interactions were typically lively and members frequently confronted others for inconsistencies, over-intellectualizations, omissions, manipulations, excuses, evasions and so on.

New members who were verbally aggressive, non-supportive or excessively negative were, for the first few sessions, tolerated by the others but were expected in time to adapt to the supportive interactional style already in place and were soon challenged to be more constructive and helpful. These challenges sometimes became a problem for the co-leaders in terms of redirecting, refocussing or in some way moderating the negative effects this seemed to have on the tone of the interaction among group members. Particularly evident was the inhibiting effect of this negative interaction upon the ability of some members to freely express themselves.

The process of closing usually began ten minutes before the end of the session, with the co-leaders summarizing topics that had emerged and mentioning the issues needing to be brought forward at the next meeting.

This process of co-leading an interactional therapy group was one in which much attitudinal change occurred for the intern as a result of experience with the intensive nature of interaction within the group. The intern found this aspect of internship training to be

very demanding, not only in terms of the knowledge and skills required, but also because of the necessity of paying very close attention to processes occurring within the group and responding assertively as co-leader in a meaningful and timely fashion. The intern felt that at the end of this process he had achieved more awareness of and appreciation for the therapeutic possibilities inherent in the group process. It is a measure of some pride for the intern that after a difficult beginning he felt that he had become competent in some of the essential skills and practices necessary for this role.

Group processes can be extremely powerful; members of a group do care about each other and can function as agents of therapeutic change. Sharing of experiences, feelings and ideas permits each member of the group to derive benefit from the strength of others. There was a power and immediacy to many of the exchanges in the group which brought home to the intern that such raw emotional power could have great therapeutic effect. When the members of the group are encouraged to express themselves in an honest, open, and trusting environment, they can more readily acknowledge and

confront dysfunctional circumstances in their lives.

ACTIVITY B.

To participate in a thirty minute review and evaluation session with the supervising co-leader immediately after each group session.

After each session the intern met with the supervising co-leader to discuss issues raised in the group and the concerns of individual members. Progress achieved by group members was noted and items requiring action were listed and scheduled.

The intern was given the opportunity to raise questions concerning events which occurred during the therapy session. Many questions concerned specific points relating to particular statements of group members or specific courses of action suggested by the supervising co-leader. Other matters of interest to the intern were more general and concerned problems dealing with such items as interpretation of non-verbal cues, interrupting, terminating or managing speakers, and listening carefully to what had been said. The supervising co-leader also gave advice and support to the intern relating to issues such as: being assertive

in the co-leadership role; pacing his overall contribution to group discussions; giving timely feedback and reinterpreting and clarifying member's statements.

Supervision was found to be an extremely worthwhile component of the intern's experience with the interactional therapy group. In these sessions the apparent natural ease with which the supervising co-leader managed the group proved instead to be the result of much effortful attention and the sensitive application of experience and skill. It became rapidly evident to the intern that it was extremely difficult to be aware of and respond appropriately in the group setting to the number of variables requiring attention.

General Objective 4

To increase the intern's understanding and knowledge of the issues relating to the management, training and delivery of service to individuals who are mildly or moderately mentally retarded.

Activity A.

To visit all treatment units for the mentally

retarded at the Waterford Hospital and to discuss with staff members current issues relevant to the delivery of service to this population.

Six residential treatment units at the Waterford Hospital are involved with the provision of services to approximately 150 mentally retarded adults. The units are organized so that homogenous groups of residents are placed together in order to facilitate the development of appropriate programs which would benefit all residents of the unit. A full range of diagnostic, treatment, rehabilitational and residential services are provided, and there is also an active outreach and consultative service.

The intern visited the units on twelve separate occasions accompanied by the liaison psychologist, and informal discussions were held with nursing and medical staff pertaining to the type of problems encountered, typical daily activities, the type of service provided and other items of interest.

Two units, West 1A and 2B, provide services for patients with the greatest disabilities. Most residents on these units are severely handicapped, require very close supervision and care and are

restricted to their wards. Many of these patients have been institutionalized for extremely extended periods of time. A number of factors were suggested by the supervising psychologists as having contributed to this situation: debilitating illnesses; old age; the extreme nature of the disability and the total care required by some of the patients. All of these factors have served to exacerbate the lack of alternative, appropriate residential placements.

Problems expressed to the intern by personnel of these units typically concerned such issues as: toileting and soiling; bedwetting; disrobing; exposure of the genitals; inappropriate sexual self-stimulation and other self-stimulating activities such as persistent rubbing and scratching; self-injurious and aggressive behaviors; and, general concerns relating to the difficulties encountered with feeding, dressing and maintaining bodily cleanliness. Also of concern was the necessity on occasion of using techniques involving physical restraint and methods of non-violent control.

The units which provided services to the highest functioning mentally retarded patients were West 2A and 1B. Efforts were being made to develop support systems

to allow these individuals to be reintegrated into the community, and programs were being developed by the Hospital in cooperation with a number of other agencies to generate this capacity. It was explained to the intern that much of the effort of staff was centered around providing services, with the goal of promoting the development of as much independent functioning ability as possible. Programming was established with the aim of permitting the fullest development of the individual's capacity for growth with the least limiting interventions. The provision of the necessary community support systems was considered by all staff to be vital to the process of integrating the patient as fully as possible into all aspects of community living.

Discussions with staff from these units concerned issues such as: life skills and social skills training as well as academic and vocational skill assessment. This aspect of service was provided by personnel from the Department of Adult Basic Education at the Hospital; occupational and recreational therapy and the provision of supervision and guidance on community experience trips. Access to physical education

opportunities and recreational and socialization activities were also other issues of concern as well as behavior modification programming and the provision of medical, dental and other support services.

ACTIVITY B.

To discuss with personnel from the Division of Developmental and Rehabilitative Services of the Department of Social Services the nature of the services provided to individuals with a physical and/or developmental disability.

The intern was provided with a general overview of issues related to the deinstitutionalization of individuals with developmental disabilities by the field supervisor, Dr. Hassan Khalili. The intern also met on two afternoons met with Ruby Sharpe, Behavior Management Specialist with the Department of Social Services and Kevin O'Brien, Director of the Pre-Vocational Training and Assessment Centre to discuss the programs and services provided by the Department of Social Services to developmentally delayed individuals. Also present was Roland Terry, staff member at the Centre.

The Department of Social Services provides many

services and support programs for individuals with a physical and/or developmental disability. The Division of Developmental and Rehabilitative Services has the responsibility in this Department for the delivery of service to these individuals. In April of 1989 this Division had been created from an amalgamation of two former divisions within the Department of Social Services.

Programs offered by the Division of Developmental and Rehabilitative Services can be categorized as either developmental or rehabilitative. Developmental programs and services are designed to meet the needs of individuals with developmental delays, regardless of age, whereas rehabilitative services are provided for the adult population. Some services and programs are delivered directly while others are delivered by non-profit incorporated Boards of Directors such as the Avalon Community Accommodations Board. Annual private agency and group home agreements are arranged for those groups providing services on behalf of the Department of Social Services.

The Direct Home Services Program is a home-based early intervention program for pre-school aged children

emphasizing skill teaching and parent training. This program is delivered through 18 Child Management Specialists located throughout the province, each with a caseload of approximately 200 families.

The Community Behavioral Services Program provides assistance to families and community members who are experiencing difficulty in the management of severe behavior problems of developmentally delayed individuals. The primary goal of this service is the maintenance of individuals in community-based programs. There are sixteen Behavior Management Specialists throughout the province. The provision of Alternate Family Homes is part of the Residential Services Program and is designed to provide care and supervision to a maximum of two adults in a family atmosphere when these individuals can no longer be supported by their natural families. There are approximately 100 Alternate Family Homes in the province.

The Residential Services Program also provides Co-operative Apartments and Group Homes. A Co-operative Apartment is a private residence operated by an incorporated community board designed to provide appropriate accommodations for adults. These

accommodations are usually rented apartments and are shared by two or three persons who are supported by a live-in supervisor and relief staff. The aim of this residential arrangement is to provide an environment in which the emphasis is on independent living. There are approximately twenty co-operative apartments operating in the province.

A Group Home is a private residence operated by an incorporated community board and staffed by a Co-ordinator and Counsellors. A maximum of four individuals live in a typical home-like environment. The orientation of a Group Home is to assist in the transition of residents to less restrictive living alternatives. The emphasis in the home is on the provision of a co-ordinated developmental program designed for each individual. There are approximately ten Group Homes in operation in Newfoundland and Labrador. Respite services are also provided to families of individuals with developmental delays. This service provides short term temporary care to a family member with developmental delays so that the particular individual, as well as other members of the family, can participate in activities outside the home.

Respite is provided on an individual basis and is dependent upon an eligibility assessment of the needs of the family. Longer periods of respite care are also available if the need is assessed to be sufficient. Grants are also awarded to other community agencies, such as the Canadian Association for Community Living, that provide and monitor respite care on a fee-for-service basis.

Social work personnel providing developmental or rehabilitative services make use of a General Service Plan process as a means of ensuring the effective co-ordination of services on behalf of persons who have a disability. The General Service Plan (G.S.P.) is used to assist in difficult cases where individuals living at home or in a Residential Alternative are deemed to be at risk. The G.S.P.'s identify and describe long term goals in several key domains and attempt to consolidate and co-ordinate efforts in each area.

At the Pre-Vocational Assessment and Training Centre a wide variety of services is provided for approximately 60 people. The focus of the programming at the Centre is on functional living skills, applied academics, community access and pre-vocational and

vocational skills training. Students can also receive on-the-job training at various sites in and around the St. John's area. On-going assessment of individual strengths and needs determine daily activities, as well as long range goals.

Funding for Supported Employment Programs is also provided. Employment options are identified or created in the local community and made available to persons with a developmental delay. The ultimate goal of this program is paid competitive employment. Supported employment programs are available at approximately ten communities in the province.

Also provided is a program known as a Work Oriented Rehabilitation Centre (W.O.R.C). This is a work related training process in which the individual's progress is continually assessed as the introduction to the specific needs of the working environment is made. The development of work skills is promoted through placement in a community work program in which the amount of contact needed by a supervisor is gradually reduced. There are two centres operating in the province, which provide service to approximately 150 individuals.

The intern found this aspect of the internship program activities to be very interesting and pertinent in many respects to his future employment within the educational system. The Direct Home Services and the Community Behavioral Services Programs provide assistance which can be of great benefit to the child in the school setting and can also provide help to the school in the provision of appropriate behavioural programming. Respite services and G.S.P.'s are also matters of great interest to all school personnel involved in the delivery of educational programs and services to students with developmental delays.

ACTIVITY C.

To attend two case management meetings sponsored by the Avalon Community Accommodations Board to observe the discussion of issues relating to the delivery of services to a group of developmentally disabled adolescents and adults residing in community-based residential housing units.

Two case management meetings were attended by the intern. One was held at the Pre-Vocational Assessment and Training Centre and was attended by Ruby Sharpe, a

Behavior Management Specialist with the Community Behavioral Services Program, and the Co-ordinator and two counsellors from a group home in the St. John's area. Also attending at this meeting was Ms. Embleton, a representative from the Avalon Community Accommodations Board, and two staff members from another division of the Department of Social Services.

Case management meetings are held every two weeks to discuss behavioural incidents and specific areas of concern relating to the residents. The needs of a number of individuals from two group homes were discussed. One of these was a 26-year-old male who had been transferred from Exon House, an institution for the mentally retarded, operated by the provincial government, which has since closed. He was sometimes aggressive and self-abusive and often refused to get out of bed or attempt assigned activities. It was decided that a medical referral was to be made for the sleep-related problems which it was thought could possibly be related to the levels of medication prescribed for seizure activity. Aggressive behavior was to be dealt with firmly, using non-violent restraint methods; and consequences for this behavior,

involving the loss of television and other privileges, was to be instituted. On community access experiences he was to be accompanied by a particular staff member with whom he interacted well.

Another case discussed was that of a 20-year-old developmentally delayed female who had lived in foster or group homes from early childhood. She had recently been exhibiting periods of extremely agitated and sometimes violent behaviour during which she had severely bitten and scratched others. She was also occasionally self-abusive. It was decided to physically restrain her only when absolutely necessary, as she was usually quite friendly and of a non-violent temperament. Her brother, to whom she had been very close had recently died and she was unable to contact her step-sister. She was to be handled by staff as sensitively as possible in the immediate future while arrangements were being made to contact her step-sister.

The second case management meeting attended by the intern was held at an office of the Avalon Community Accommodations Board. This meeting concerned two other group homes operated by the Board in the St. John's

area. This meeting addressed the needs of five residents of these group homes. Two of the residents were in Work Oriented Rehabilitation Centre programs; two others were in supported employment programs, and the remaining resident was in a sheltered employment program at the Vera Perlin Centre.

A variety of problems affecting these individuals were addressed, ranging from cleanliness and hygiene concerns to issues relating to theft from other residents, noncompliance with counsellor and coordinator instructions, and behavioural outbursts directed at the work centre supervisor.

The intern was impressed with the difficulties inherent in the provision of suitable care for those with developmental delays. It also occurred to him that many of the problems being expressed by the staff were of the same type as those often encountered by teachers and other educational personnel in the school setting.

Younger children with developmental delays are required to be in full-time attendance at school. The integration of these children in the regular school setting often involves the services of Behavior

Management Specialists, student assistants, specially trained teachers, as well as school counsellors and psychologists. The behavioral concerns addressed are similar to those listed above for older developmentally delayed persons. Intervention for behavioral concerns at the school involves the same type of management principles and programs and is directed via a similar process in which the concerns and expertise of a broad range of specialists are considered. Principals, teachers, resource room personnel, student assistants, and parents as well as counsellors and psychologists, are involved in a school team process which addresses the problems of, among others, the developmentally delayed. In this regard the intern found this process to be one which provided a valuable and unifying procedural perspective for the delivery of service and the direction and coordination of efforts in the school.

General Objective 5

To become more familiar with the rehabilitation services provided to children with physical disabilities.

ACTIVITY A.

To review the services provided at the Children's Rehabilitation Center.

During his initial two days in this setting, a total of seven hours was spent by the intern being accompanied by staff psychologists, visiting various departments at the Centre and discussing with personnel the services provided by their department.

The medical staff at the Centre consisted of a Psychiatrist, Orthopaedist, Neurologist and a Urologist. A broad range of medical expertise was also available from the consulting staff which was composed of representatives from one or more of the following speciality areas: Neuro-Surgery; General Surgery; Plastic Surgery; Otolaryngology; Ophthalmology; Rheumatology; Pediatrics; Psychiatry; and Dentistry.

Services for children at the Centre were provided through treatment teams whose participating members were drawn from the departments of Nursing; Psychology;

Speech Therapy; Physiotherapy; Orthotics; Recreation; Social Work; Occupational Therapy; and Education.

All children admitted to the Centre were required to attend daily classes on a regular basis. A three room school with four fully qualified teachers was provided by the Department of Education. The school provided a full range of educational programming from Nursery School, Kindergarten and Grade One on through to secondary school levels. Special education programs and developmental programs for the multi-handicapped were also provided. Student assistant volunteers were available and tutoring services were provided on an individual basis, if necessary.

The health needs of the children at the Centre, in such areas as immunizations, bowel and bladder function, dental care and nutrition, were assessed by nurse therapists on admission, in clinic visits at the Centre, or during travelling clinics. Nurse therapists were also responsible for teaching children and other family members methods of maintaining proper health care at home.

Occupational therapy services were provided on both an in-patient and an out-patient basis to assist

children in the development of the skills necessary for their fullest possible level of independent performance in all facets of daily living. Emphasis was placed on functional activities of daily living such as feeding, dressing, hygiene, fine-motor and perceptual skills, and school-related learning ability .

Personnel from the Occupational Therapy Department also fitted patients with wheelchairs and other mobility enhancing devices. One wheelchair was provided for each child as required by the Newfoundland and Labrador Society for the Care of Crippled Children and Adults. Equipment was provided to any child, when necessary, and was returned to the Centre when it was no longer required or had been outgrown. Necessary maintenance for this equipment, such as cleaning and lubrication, was provided by the families of the children to whom the equipment had been loaned.

Occupational Therapy also conducted an adaptive seating program to accommodate children who were unable to sit by ordinary means. Special chairs and inserts were constructed by department personnel, and it was often necessary that the child be admitted for the process of assessing, measuring, constructing and

evaluating the equipment.

Orthotic services were provided to both in-patients and out-patients at the Centre. In-patients were seen during regular clinics and out-patients were seen during orthotic clinics held on three Fridays of each month or as needed.

Staff members from the Orthotics Department devised, adapted and built equipment to assist with or compensate for limitations in the functioning of organs or limbs.

Staff members of this department also designed, fabricated and fitted various types of orthoses, as prescribed by the physician, such as: shoe modifications, lifts, upper limb bracing, hand and arm splints, lower limb bracing, foot inserts, short leg and long leg braces and splints, spinal bracing, body jackets, and cervical collars. Also provided were corsets, and other orthotic appliances, including standing braces, parapodium and various types of walkers.

The activities of the Physiotherapy Department were related to the physical development of the child. All patients referred to the Centre were assessed by

physiotherapists to establish their physical and developmental status. Results of this assessment were presented to all other Team members during clinics or developmental conferences. This information was used by the physiotherapist to design the most appropriate treatment plan. If required, the physiotherapist also taught family members how to carry out these programs at home. Travelling clinics and home and school visits were also held when necessary.

The Psychology Department at the Children's Rehabilitation Centre consisted of two Psychologists and a Director. Children were referred from other departments and the referral was discussed at the weekly Mental Health Conference. Psychological assessment often concerned issues associated with learning and other school-related problems. Behavior problems at home, school or with other people were also addressed.

Therapeutic services provided by psychology focused on developing and promoting the integration of the cognitive, perceptual and motor skills required for school-related tasks. Behavior management programs, social skills training, and counselling services were

also provided. Suggestions were provided by psychologists for the child's teacher or parents to assist with educational programming or behavior management. Follow-up was provided during regular clinic visits, and parents and teachers were always encouraged to phone the psychologist with any questions or problems.

The Recreation Department provided counselling to assess children's leisure needs, and individual recreation programs were planned in conjunction with the children and their parents. Recreational opportunities available in the child's home community were also assessed and the child's participation in these activities was encouraged. A variety of activities were provided for children at the Centre and in the community. Swimming and crafts programs were available in the Centre and facilities and programs in the community, such as bowling and theatre, were availed of. Trained recreational counsellors and volunteer assistants were available to provide opportunities for the children to participate to the maximum possible extent of their capabilities on an individual basis, as well as in groups.

Social Workers, trained and experienced in rehabilitation counselling, were also available for counselling and guidance with any children or members of their family who were experiencing personal difficulties or problems. In addition to personal and family counselling, educational and vocational counselling were also provided.

Therapeutic services were also provided for the assessment, diagnosis, treatment and management of disorders of communication. Such disorders included articulation problems, receptive and expressive language difficulties, and troubles with vocal quality and speech fluency. Associated with disorders of speech and language were difficulties reflected in reading and writing problems at school, which often required the assessment services of the Speech Therapists at the Department.

ACTIVITY B.

To attend a Developmental Conference at the Children's Rehabilitation Centre and observe the Outpatient Clinic Team discuss issues involved in the planning and delivery of services to physically disabled children.

The clinical process at the Centre involved the services of many professionals who comprised the treatment team. On the first day of the clinic a child was seen by the Clinical Director and personnel from the Departments of Nursing, Occupational Therapy, Physiotherapy, and Social Work. On the second day of the clinic the patient was examined by an Orthopaedist and a Neurologist, with additional specialists and personnel from other departments consulted as required.

Following assessment by the team, a conference between all those taking part in the clinic was held to discuss the information obtained and to decide how to best meet the child's needs. Parents were invited, after the conference, to participate with members of the team and further discuss the conference results.

Conference decisions were of a number of general types; no specific treatment might be recommended and the parents would be asked to return at a later date for further clinical assessment. A home program of exercises or other therapy might be given, the details of which would be explained and demonstrated by the therapist, usually after the conference. Written instructions might also be provided and outpatient

treatment recommended. If the travelling distance were not unreasonable, appointments would be scheduled so that supervision could be provided by the therapist(s) during treatment, or the child would be admitted at the earliest possible date for further assessment or intensive therapy.

The intern attended one developmental conference with the staff psychologist and observed the process in which team members considered information derived from clinical examinations and decided upon appropriate treatment programs.

Two patients were referred from clinics held during the preceding two days. Present for the conference were representatives from Nursing, Occupational Therapy, Physiotherapy, Pediatrics, Social Work, Medicine and Psychology. The first patient was a two-year-ten-month-old female with a history of seizure activity, tantrum behavior, feeding problems and unusual play activity. The history of the mother's pregnancy was presented by medical personnel and several physiotherapists discussed delays in gross motor development. Personnel from Pediatrics reviewed cognitive development, and a caseworker from the

Social Work Department reviewed the parenting capabilities of the mother and father and the support mechanisms available in the extended family to assist with the care of this child at home. The provision of respite care was recommended; vision and hearing were to be referred for assessment; and a full review of medications was to be undertaken to stabilize seizure activity. A referral was made to Psychology for cognitive and behavioral assessment and Physiotherapy was asked to provide a general program to address difficulties with gross motor development and to provide follow-up on a monthly basis. A referral was also made to Speech Therapy for assessment of language development and the provision of appropriate programming.

Another patient seen was a three-year-two-month-old female with hydrocephalus, multiple anomalies, and seizures. Cardiac difficulties included patent ductus arteriosus, and a cardiac murmur. Also present was slight facial dysmorphism, cleft palate and cortical blindness. Respite care was recommended by Social Work personnel and the involvement of the Direct Home Services Program was discussed and agreed upon. A

dental examination was also required. Occupational Therapy was asked to provide a seat for car travel and another that could be used for lying down and sleeping. A referral was to be made to the cleft palate team in Pediatrics and Physiotherapy was asked to provide a program of exercises to increase the child's capacity for spinal flexion and extension. Psychology was asked to provide suggestions to deal with biting and other self-stimulating behaviors.

The intern was thoroughly impressed with the amount that was accomplished in a short period of time at this conference. Cases were presented succinctly and efficiently. The information supplied and the questions asked appeared, to the intern, to be always purposeful and admirably efficient in its economy of words. Discussions were focused and disciplined; family members were treated with consideration and respect, and were always fully informed of the meaning of technical or medical terminology and were asked frequently for their opinions.

Special services in the school system are also delivered through a team approach. The intern gained an awareness of the potential of the team model for the

coordinated and efficient delivery of service. It has been the subsequent experience of the intern that problems arising with program planning for special needs students in the school system often have been the consequence of lack of attention to the team process, rather than any fault with the team model of service delivery itself. Experience with the team system in the context of the Children's Rehabilitation Centre has provided the intern with a good appreciation of the necessity of perfecting the practice of this process in order to derive the maximum benefit.

ACTIVITY C.

To observe staff psychologists administer a minimum of two assessment instruments to patients at the Children's Rehabilitation Centre.

The intern observed the administration of the McCarthy Scales of Children's Abilities to a 5-year-10-month-old female with a history of seizure activity.

The McCarthy Scales of Children's Abilities is an individually administered test of the cognitive abilities of children ranging in age from 2 years 6 months to 8 years 6 months. This test usually requires 45 to 60 minutes to administer, depending on the age of

the child.

This child presented with a number of problems, including delays in the development of motor coordination and language skills, behavior problems, including low frustration levels, tantrum behavior and excessive dependency, and academic and cognitive difficulties. Psychological assessment was required, not only to provide assistance with educational programming needs at the school for her approaching entrance into Grade 1, but also to provide suggestions related to addressing the behavioural concerns of both the home and the school.

The test administration observed by the intern was one part of the assessment process with this child and required approximately 2 hours for completion. The administration was viewed by the intern from behind a one-way viewing mirror. At the insistence of the child the mother was present in the room during the administration of the test. Cooperation was initially obtained from the child after the mother had promised her a treat when the test was done. Test items were responded to in a slow and laborious manner with many distractions, pauses, digressions, and protestations on

the part of the child and with many expressions of concern and repetitions of the promised treat being declared by the parent. Gentle refocusing was continually required and the child tended to give up quickly and easily at the slightest obstacle or frustration or task that demanded any but the most perfunctory of effort. The psychologist took great care to introduce herself to the child and briefly explained to her what they would be doing; she showed the child the games and the puzzles and spoke to her of the fun they would have doing them. She expressed sincere interest in the toys the child had brought to the test room and introduced the test materials in a casual and natural manner. The psychologist often encouraged and praised the child in a soft, reassuring tone of voice and offered supportive comments during difficult items. Instructions were given slowly and repeated as necessary. The child's attention required quiet redirection to the test situation on numerous occasions but the rapport, initially established, was maintained throughout, so that all subtests were completed without major behavioural outbursts or a refusal to continue. Numerous rest periods were

suggested by the psychologist when the child appeared to be excessively frustrated or anxious. Trips for a glass of water or to use the washroom separated the test session into a number of more manageable and less stressful intervals. The child was often allowed to play with the test materials until the opportunity arose to guide her on to the next item. Great tact and patience were exhibited by the psychologist throughout the test session in order to elicit maximum cooperation from the child and to maintain the momentum of the test situation. The psychologist also took the opportunity, on a number of occasions, to leave the mother and child alone in the test room so that she could view them from the observation room.

The intern also observed the administration of the Kaufman Assessment Battery for Children to a 10-year-old female outpatient who had been referred to Psychology for an intellectual and cognitive assessment to assist the school in the development of appropriate educational programming.

The child was accompanied into the test situation by her mother, who remained for only a brief period. Some speech articulation problems were evident, but

file information indicated that vision and hearing had been assessed and were within normal limits. The child was friendly and talkative and seemed eager to begin; the test administration proceeded smoothly after initial rapport had been established. Frequent breaks were necessary, however, when she complained of fatigue. Responses given by her to some test items were required to be repeated because of the difficulty encountered in easily understanding her speech. Her attention often required refocusing, and maintaining concentration appeared to be difficult for her. She appeared not to become frustrated, but rather gave up easily and needed encouragement to continue. When difficulty was encountered with test items she sometimes attempted to distract the examiner with conversation, and at these times she required reassurance, encouragement or rest. Test administration was fully completed in approximately 90 minutes, but the child appeared too fatigued to continue with other assessment and was provided with a snack and allowed to play until her mother returned.

The observations of these test administrations permitted the intern direct experience with some of the

types of problems encountered in the assessment of physically handicapped children. The intern felt that this experience provided him with valuable insights which were directly applicable to the school setting. He learned that every effort must be made to establish and maintain rapport with children to maximize their cooperation and elicit their best efforts and that the assessment of physically handicapped children often requires great patience, understanding and flexibility. The status of the child's sensory functioning must also be established before assessment begins so that appropriate items or tests can be selected or appropriate modifications to the test procedure may be prepared for. Departures from standard procedures may be required when testing handicapped children, and consequently estimates of the child's range of abilities may be less precise than is usually the case; results should be reported with this consideration in mind. Assessment may require much longer than is usual and it might often be necessary to schedule a number of assessment periods to avoid fatigue and promote maximum performance.

In this activity the intern gained increased

awareness of these and other important considerations involved in the assessment of children in general and with particular reference to the assessment of those who are physically handicapped. The intern felt that this knowledge was extremely relevant to his future employment in the school setting.

CHAPTER III

THE RESEARCH COMPONENT: AN INVESTIGATION INTO THE ABILITY OF THE JESNESS INVENTORY TO DISCRIMINATE BETWEEN ADJUDICATED JUVENILE OFFENDERS AND NON-OFFENDING JUVENILES IN NEWFOUNDLAND

INTRODUCTION

School psychologists and counsellors often encounter difficulty in accurately assessing students who exhibit a pattern of academic underachievement and asocial, disruptive, aggressive and non-compliant behavior. Walker and Fabre (cited in Morgan and Jenson, 1988) suggest that the processes involved in accurately assessing these students is not well understood and that there is very little professional agreement about the specific assessment procedures to be used.

Many assessment instruments designed to provide information pertinent to the evaluation of behavior disordered children are currently available. Most of

these instruments have not been specifically designed for this purpose; even a number of years ago, as Shark and Handal (1977) indicated:

available measures appear to be inadequate because they were developed for other uses and thus, lack appropriate content either because they are psychometrically inadequate, or because they depend on subjective scoring criteria, or because their scope is too narrow. (p. 692)

Deciding which of the instruments would be most useful requires extensive knowledge of their psychometric properties, and much skill and judgement is also needed to determine the appropriate emphasis to place upon each source of information. The process of interpreting results, applying them to the individual involved and formulating suitable counselling and behavioural intervention strategies from information collected from measures not specifically designed for this purpose is likely to be a less than satisfactory undertaking.

In the assessment of disordered behavior, it is reasonable to assume that the skills and experience brought to the task will vary considerably from one

situation to another and that this variability would serve to greatly reduce the overall reliability of the decision-making process relating to these behaviour disordered individuals. It would be extremely worthwhile, therefore, for school counsellors and psychologists to have an integrated system for the assessment of disruptive, non-compliant behavior in children. The ability to identify, on the basis of responses to test items, a pattern of behavior which is associated with a significantly higher probability of repeated and/or more serious offenses would constitute an exceptionally useful capability of such a test. The capacity to provide developmental information related to the underlying patterns of attitudes, values, feelings and beliefs associated with seriously disordered behavior would also be exceptionally beneficial.

The Jesness Inventory is one of the few assessment instruments designed specifically for the psychological evaluation of asocial behavior of teenagers (Kunce & Hemphill, 1983) and the discrimination of delinquent youths from others (Forest, 1977). The Inventory consists of 10 scales designed to measure various

personality characteristics and an Asocial Index used in the prediction of delinquency (Jesness, 1983). The Interpersonal Maturity classification typology (I-levels) which can be derived from item responses on the Jesness Inventory provides a complete description of behavioral subtypes and outlines appropriate intervention approaches for each.

Identification of a pattern of behaviour which is likely to advance to adjudicated offender status would have important implications in the educational setting. The ability of a test instrument to discriminate between individuals whose academic achievement and pattern of disordered behavior indicates a greater likelihood of committing adjudicable offenses from those who exhibit similar difficulties but who are less likely to commit such offenses would obviously be quite practical in determining the allocation of resources and effort. If the discrimination can be made sufficiently early, there may be a greater possibility of effecting behavior change before chronic patterns of delinquency become established. To provide prevention programs across the board to all children, however, might prove enormously costly, making it imperative to

intervene only with those having the highest probability of future delinquency.

If the ability of the Jesness Inventory to discriminate between adjudicated juvenile offenders and non-offenders can be established, this Inventory could serve to lessen some of the difficulties faced by psychologists and counsellors in the assessment of disordered behaviour among juveniles and the development of effective strategies of intervention. If such a discrimination can be achieved, intervention efforts may not only be specifically targeted and established early, but also the associated classification of Interpersonal Maturity Levels which may be derived from Inventory responses would be valuable in selecting approaches to the behavior of the individual being assessed.

This study will investigate the ability of the Jesness Inventory to discriminate adjudicated juvenile offenders being treated at a residential, custodial facility in St. John's from non-offending summer school students in Conception Bay, Newfoundland.

REVIEW OF RELATED LITERATURE

It has long been known to professionals that a major attribute associated with behavior disordered children is difficulty with school learning and achievement (Morse, Cutler & Fink, 1964). It seems clear that many aspects of ability and behaviour, such as academic aptitude, attitude towards school and authority and frequency of disciplinary infractions, are associated with both groups. Early surveys indicated that as many as 90% of delinquents were reading deficient and failures in school (Kvaraceus, 1944). In a study by Margolin, Roman and Haruri (1955), 84% of the children examined at a juvenile detention centre were found to be retarded in reading by two or more years. A study by Tarnopol (1970) found that 60% of delinquent populations were reading retarded by two or more years. Zinkus, Gottlieb and Zinkus (1979) found that 73% of the delinquents in their study were two or more grades below their expected achievement levels in reading and 87% were below expected achievement levels in spelling and mathematics. They state that "The majority of delinquent subjects, despite adequate intelligence,

were functioning at levels considerably below expected achievement levels" (p. 182). Generally, behavior disordered students exhibit levels of academic achievement below that which would be predicted based on levels of ability (Kauffman, 1985).

Morgan and Jenson (1988) further stress the link between academic underachievement and disruptive behavior: "there appears to be a reciprocal relationship between learning problems and behavior problems; a child's behavior problems reduce the chances for academic success and the lack of academic success further exacerbates the behavior problem" (p. 17).

Psychological assessment of students exhibiting disordered behavior is considered by Lidz (1981) as the process of gathering information for a number of purposes: to guide and direct the classification of student behaviour; to assist in the development of instructional programming; to evaluate student progress; and, to formulate predictions about future adjustment. Information may be obtained from many sources, such as cumulative student records, files held by outside agencies, interviews with parents or

teachers, during counselling sessions, and in periods of classroom observation. Morgan and Jenson (1988) state that information can be collected using rigorously structured approaches such as academic achievement testing, formal behavioral observations, and structured interviews or in less structured approaches, such as anecdotal reports, social histories, and projective testing. They further suggest that multiple sources of assessment information permit the best control of individual assessment error and allow the most accurate results to be obtained. It seems safe to assume that the greater the number and diversity of the measures used to obtain information, the greater the probability of obtaining the fullest understanding of the factors which allow the disruptive behavior to manifest itself and to maintain its frequency of occurrence. The most broadly based information would also promote the selection of the most appropriate approaches to counselling and placement and the development of the most effective strategies of behavioral and academic intervention.

Acquiring information from multiple sources, however, often involves significant and, sometimes,

prohibitive expenditures of time and effort. Many difficulties and complications often occur in the process; files may be unavailable or incomplete; information may be inconsistent or contradictory or extremely subjective in nature; the student may be unavailable for observation; or difficulties may be encountered in arranging interviews with parents and others. In such circumstances, information gained using test instruments associated with the traditional, formal model of behavioral assessment may be used to effectively provide the information not readily obtained from a diversity of other sources.

However, traditional assessment procedures, are viewed by some as less than directly useful. Morgan and Jenson (1988), for example, feel that, " the overall purpose of the traditional assessment approach has been to diagnose, classify, and predict future outcomes. Less emphasis is placed on making everyday decisions for interventions" (p. 52). In contrast, Hersen and Bellack (1981) suggest that it might be advantageous to search, in behavioral assessment, for nomothetic or general principles which could be utilized in an idiographic or individualized manner.

They further suggest that there are common patterns of response covariation which are useful in suggesting behaviors in addition to the presenting problem which should be examined in an individual client. Their view suggests that the traditional methods of obtaining information associated with the underlying psychological processes involved in the actions of individuals who exhibit a pattern of asocial behavior can provide a useful function. Information which lends itself to the appropriate diagnosis and classification of behavior may supply a framework from which the behavior in question may be more clearly understood. The integration of information from other sources with that obtained from traditional assessment measures, such as the Jesness Inventory, would encourage a clearer representation of the psychological processes underlying behavior to emerge, and this would be an advantage in the process of developing appropriate counselling strategies and selecting effective approaches to intervention.

School underachievement may be closely associated with a greater likelihood of committing juvenile offenses, but most underachievers do not commit

offenses which would lead to adjudication. The ability to discriminate between those persons whose academic underachievement is associated with a pattern of adjudicable juvenile offending and those whose academic underachievement is not likely to lead to such a pattern is one of great importance. If this discriminative ability can be demonstrated for the Jesness Inventory, treatment based on the I-level (Interpersonal Level) classifications derived from item responses on the Inventory, may prove extremely useful in schools and residential treatment facilities for juvenile offenders.

The Jesness Inventory was the product of a large scale, sustained research project conducted by the California Youth Authority (Jesness, 1972). The test contains 155 true-false items, scored on three empirically derived scales and seven scales derived from an item cluster analysis. Additionally, an Asocial Index can be computed from weighted scores on the ten scales.

Three of the ten subscales of the Jesness Inventory were constructed empirically: Social Maladjustment, Value Orientation, and Immaturity. An

item pool for each subscale was derived rationally and was then administered to criterion groups whose members were divided into subgroups according to appropriate dimensions. Those items that best differentiated the subgroups were retained.

The remaining seven subscales were derived by means of cluster analysis: Autism, Alienation, Manifest Aggression, Withdrawal, Social Anxiety, Repression, and Denial. The responses of a group of delinquent males (N = 970) formed the basis of the cluster analysis, which created scales that maximized item intercorrelations within clusters and independence between clusters. The final score provided by the Jesness Inventory is the Asocial Index, which is a predictive equation for delinquency derived from a multiple discriminant analysis of nine of the subscales that were administered to 1888 delinquent and non-delinquent subjects (Jesness, 1972). A description of the personality characteristics associated with each of these subscales is given in Appendix D.

The theory of the Interpersonal Maturity Level (I-level) of psychological development and its application to the problems of juvenile delinquency was

first proposed by Sullivan, Grant and Grant in 1957; further refinements by Warren and others in 1966 included recommended treatment strategies for delinquent subtypes (Jesness, 1974). A further improvement, The Sequential I-Level classification system, was published by Jesness in 1974 and finally developed, by him, to its present form in 1985 (Jesness, 1985).

The theory of Interpersonal Maturity Level postulates a basic core structure of personality which is comprised of a relatively consistent set of expectations in regard to the external world. Each of the seven successive levels of integration (I-levels) is defined by a crucial interpersonal problem that must be resolved before further maturity can occur. Threats to the individual which are too extreme or intense lead to fixation and resistance to change.

Although published research on the Jesness Inventory is relatively sparse, research findings tend to support its effectiveness in discriminating adjudicated delinquents from non-delinquents and successfully predicting a tendency to recidivism.

Davies, in 1967, (cited in Martin, 1981), in

Britain, found significant differences between the scores obtained by a sample of British delinquents and American non-delinquent norms on six Jesness Inventory subscales. The Social Maladjustment scale has been used in a number of settings to successfully differentiate delinquents from non-delinquents, including Cowden, Peterson and Pacht, (1969) and Decker, 1979 (cited in Kunce & Hemphill, 1983). Saunders and Davies (1976), in a study with British subjects, reported that the Social Maladjustment, Value Orientation, Autism, Alienation and Manifest Aggression subscales of the Inventory were "able to differentiate between different levels of delinquency" and that the Social Maladjustment, Value Orientation, Alienation, Manifest Aggression and Denial subscales were predictive of continued delinquency (p. 35). Martin (1981) in a Canadian study, found that the Asocial Index of the Jesness Inventory "was significant across and between all groups with a progressive increase in T scores directly related to delinquent involvement" (p.10) and found six other scales which demonstrated significant differences between controls and various delinquent subjects.

Other studies have not supported the discriminative validity of the Jesness Inventory. Shark and Handal (1977) concluded that the Jesness Inventory does not distinguish between delinquent and non-delinquent youth and that the reliability of the measure is less than satisfactory. Jesness (1977), however, in reply, points out a number of deficiencies which tend to negate the findings of Shark and Handal. In particular, Jesness feels that an inadequate definition of delinquency may have lead to contamination of the sample and misleading results.

The validity figures previously mentioned for the Jesness Inventory in Canada, the United States, Britain and elsewhere require further study to confirm their ability to be generalized to the Newfoundland setting. There has been subsequent studies cited in the literature which dealt with use of the Jesness Inventory; however, these studies were not directly related to the research questions addressed in this study.

METHOD

Subjects

Two groups of subjects were used in this investigation. The first group initially included thirteen male, adjudicated juvenile offenders ranging in age from fourteen to eighteen years. All of these subjects were involved in a custodial residential rehabilitation treatment program at the St. John's Youth Centre.

The second group was composed of twenty-six students (thirteen male and thirteen female) from a major school system on the Avalon Peninsula. This group consisted of students attending summer school classes to receive assistance in subjects in which they had not been successful during the regular school year. From information provided by this group on a pre-test demographic questionnaire, three were identified as having been previously convicted of juvenile offenses and were included with the group of adjudicated offenders. None of the remaining subjects attending summer school session had been charged with or convicted of juvenile offenses.

Of the thirteen juvenile offenders in the first group, two were discounted because of difficulties interpreting item responses and scoring the Inventory. The inclusion of the three from the second group brought the total number of subjects in this group to fourteen, (thirteen male and one female).

From the remaining twenty three students in the second group, fourteen (ten male and four female) were chosen to match as closely as possible the composition of the first group in terms of age, school achievement, measures of overall non-verbal reasoning ability, and family occupational status.

The following tables summarize and compare the data obtained from the two groups of subjects from the demographic data sheets and from the Raven's Standard Progressive Matrices.

Table 2

Age Comparison of Study Subjects

Age	Adjudicated offenders	Non-offenders
14	1	1
15	4	4
16	4	3
17	3	6
18	2	0

Table 3

Number of non-academic promotions per subject group

Number of non- academic promotions	Adjudicated Offenders	Non-offenders
1	4	4
2	2	1

Table 4

Number of School Grades Repeated per Subject Group

Number of Grades repeated	Adjudicated Offenders	Non-offenders
0	3	5
1	6	7
2	2	0
>2	1	1

Table 5

The Number of Offenses Against People and Property in the Adjudicated Offender Group

Number of convictions	Nature of Offenses		
	people	people & property	property
>4	0	5	2
4	0	1	0
3	0	0	0
2	0	1	1
1	1	0	3

Table 6

Percentile Ratings Achieved by each Subject Group on
the Raven's Standard Progressive Matrices

Percentile interval	Adjudicated Offenders	Non-offenders
0 - 10	3	6
11 - 20	3	2
21 - 30	1	0
31 - 40	1	1
41 - 50	2	1
51 - 60	1	2
61 - 70	0	1
71 - 80	1	1
81 - 90	1	0
91 - 100	1	0

Table 7

Comparison of Mother's Occupations in each Subject Group

Mother's Occupation	Adjudicated Offenders	Non-offenders
Nurse	2	0
Electrician	1	0
Mill Control Operator	1	0
Assistant Manager	1	0
Bookkeeper	0	1
Shop Clerk	0	1
Housewife	6	6
Nursing Assistant	0	1
Fishplant Worker	1	1
Child Care	0	2
Student	1	0

Table 8

Comparison of Father's Occupations in each Subject Group

Father's Occupation	Adjudicated Offenders	Non-offenders
Sea Captain	0	1
Coast Guard	0	1
Pharmacist	0	1
Manager	1	0
Foreman	1	1
Millwright	1	1
Mechanic	1	2
Bricklayer	1	0
Welder	2	0
Technician	1	0
Equipment Operator	0	1
Clerk	1	0
Carpenter	1	2
Nursing Assistant	0	1
Salesman	0	1
Construction Labour	0	1
Fisherman	2	1
Security Guard	1	1

Instrumentation

The Jesness Inventory (1972) was used to obtain scores on scales assessing eleven personality characteristics. Appendix D contains a brief definition of each scale. Three or more of these scales have been found useful in discriminating a pattern of delinquent, offending juvenile behavior from a less serious pattern with lower likelihood of recidivism and also from non-delinquent behavior. Split-half reliability coefficients ranging from .56 to .83 are reported in the Jesness Inventory Manual from a South Australian sample (n=467).

The Raven's Standard Progressive Matrices (RSPM), first published in 1938, was used to obtain estimates of non-verbal reasoning ability. Scores achieved on this instrument are based on "the ability to form comparisons, to reason by analogy, and to organize spatial perceptions into systematically related wholes." (Sattler, 1988). Figures reported by Raven, Court & Raven (1983) reports a coefficient of .86 to be the best estimate of split-half reliability for this instrument. Sattler (1988) further reports test-retest

reliabilities to be adequate, ranging from .71 to .93 .

A demographic data sheet was completed by each subject to provide information regarding parental occupation, school achievement, and legal offenses (adjudicated or non-adjudicated). See Appendix A

Procedure

Data collection from the group of juvenile offenders occurred at the St. John's Youth Centre on September 1, 1989. This process involved the completion of a demographic data sheet and group administration of the Jesness Inventory and the Raven's Standard Progressive Matrices. Administration of both of these instruments was completed according to instructions contained in the manual, and assistance was provided, as necessary, to students who had difficulty with reading items contained in the Inventory.

Information obtained from the demographic data sheets and the Raven's Standard Progressive Matrices was used to assess the similarity of the groups on the variables of age, sex, and general level of non-verbal intellectual ability. Information provided in the

demographic data sheet allowed a number of summer session students with juvenile adjudication records to be identified, and their data included with that provided by the group in the residential treatment centre.

Data collection from the second group (non-juvenile offenders) occurred July 18 and 19, 1989 and also involved completion of the demographic data sheet and group administration of the Jesness Inventory and Raven's Standard Progressive Matrices.

The Raven's Standard Progressive Matrices responses were scored according to the procedures outlined in the 1983 edition of the Manual for the Raven's Progressive Matrices and Vocabulary Scales, and the norms used were those from the Research Supplement No. 3 (Raven & Summers, 1986) to the same manual.

The Jesness Inventory was hand-scored according to the procedures outlined in the revised edition of the Jesness Inventory Manual (Jesness, 1983). Standard scores were calculated for each subject for each of the eleven scales, and the mean scores of each of the two groups on each of the eleven scales of the Jesness Inventory were compared at the .05 significance level,

using two-tailed t -tests.

Limitations of the Study

The results of the study were limited by the following factors:

1. Certain external factors restricted the number of subjects available for inclusion in this study. The number of youths at the residential custodial facility available for participation in the study was limited, and appropriate signed consent from many of the parents/guardians of the summer session students was unable to be obtained. The small number of subjects in each group inhibits wide generalizability of results.

2. Information relating to specific school discipline problems was unavailable during the period of summer vacation in which data was collected. Such records were not held in a central location, but in many different and widely separated schools in a number of school systems. Results of this study, therefore, cannot be generalized to include the effects that non-adjudicable disciplinary offenses at school might have had upon the results. If information relating to this criterion were available, much power could be lent to

the results obtained from this study. Information related to this factor could be either controlled for in the selection of subjects or permit inferences to be made relating to its effects upon the mean scores of each of the groups on any of the 11 subscales of the Jesness Inventory.

3. The great majority of subjects in this study are from rural schools and communities; attempts to have included subjects from more urban areas were unsuccessful. Results of the study therefore may not be generalizable to students drawn from a more urban area. On the Values Orientation scale, for example, such differences may be more distinct for urban students. The values tapped by this scale were based on a description by Miller in 1958 of elements that he believed were typical of lower class culture (cited in Jesness, 1983,). Whether or not this typification is applicable to rural Newfoundland and whether mean scores of non-delinquent rural youth in Newfoundland, or other provinces, resemble those of delinquent youth in urban settings, is a matter for further study. This matter should be considered in the generalization of findings from this study related to the Values

Orientation scale and to other scales with which it may be highly correlated.

4. The preponderance of males in the sample, although typical for both groups under study, may limit generalizability to the female offender and non-offender groups.

Analysis of Results

Table 9 presents the mean scores achieved by both groups of study subjects on the 11 scales of the Jesness Inventory and the resulting t -ratio comparisons. These results indicate significant differences between groups on the Social Maladjustment (3.63), Autism (3.68) and Asocial Index (4.14) scales, with the adjudicated offender group receiving much higher mean scores. These results support those provided by Jesness (1983) in the Inventory Manual for these scales.

In addition to significant differences on these scales, the Jesness Inventory Manual further states that the mean t -scores on the Values Orientation, Alienation, Manifest Aggression and Withdrawal scales are significantly different for delinquent and non-

delinquent groups (Jesness, 1983, chap. 3). No significant difference between groups on these scales was found in this study, but the mean t -scores of the offender group was higher on the Values Orientation and Alienation scales.

Only on the Social Anxiety (44.57), Repression (54.21) and Denial (42.3) scales did the non-offender group receive higher mean t -scores. This result is generally consistent with the information provided in the Manual; non-delinquents tend to score higher on the Denial scale; there is no consistent pattern of difference between delinquents and non-delinquents in scores on the Social Anxiety scale; and there is a general tendency for delinquents to make more use of repression as a defense mechanism than non-delinquents.

The results of this study relating to the ability of the Social Maladjustment scale to discriminate between delinquents and non-delinquents or levels of delinquency support the findings of Mott, 1969 (cited in Graham, 1981), Vallance and Forest (1971), Saunders and Davies (1976, cited in Forrest, 1977) in the British Isles, Stott and Olczak (1978) in the United States, and Martin & Fisher (1983) in Canada.

Table 9

Comparison of Mean Standard Scores of Subject Groups on
the Jesness Inventory Scales

Jesness Scale	Mean Standard Score		t	p
	Non-offenders	Adjudicated offenders		
Social Maladjustment	57.7	73.5	-3.63	0.0013*
Values Orientation	56.36	60.29	-1.46	0.16
Immaturity	57.79	61.6	-0.97	0.34
Autism	56.50	68.36	-3.68	0.0012*
Alienation	59.4	65.57	-1.64	0.11
Manifest Aggression	58.1	60.4	-0.57	0.57
Withdrawal	50.9	52.36	-0.46	0.65
Social Anxiety	44.57	44.4	0.06	0.95
Repression	54.21	51.07	0.95	0.35
Denial	42.3	41.29	0.28	0.78
Asocial Index	55.21	71.2	-4.14	0.0004**

*p<.01

**p<.001.

Some investigators have found that the Asocial Index was not useful for the purpose of discriminating delinquents from non-delinquents (Saunders & Davies, 1976; Shark & Handal, 1977). The results of many other previous investigations, however, have found it to be useful for this purpose: (Davies, 1967; Cowden, Pacht & Peterson, 1969; Martin, 1981; Graham, 1981; Kuncce & Hemphill, 1983). The results of this study strongly support the reported ability of the Asocial Index to discriminate between subjects manifesting delinquent behavior from those who do not. Results relating to the discriminative power of the Autism scale as reported in some studies are less strong (Saunders & Davies, 1976; Stott & Olczak, 1978) but in others (Martin, 1981; Kuncce & Hemphill, 1983) results are reasonably supportive of the discriminative ability of the Autism scale. The results of this study are strongly supportive of the reported ability of the Autism scale to discriminate delinquent from non-delinquent behavior.

Findings of previous investigations relating to the discriminative ability of the Values Orientation, Alienation, Immaturity, Regression and Manifest

Aggression scales were not supported by the results of this study.

The strongly significant differences between the two study groups on the Social Maladjustment, Autism and Asocial Index scales suggest that these scales of the Jesness Inventory could be used to discriminate between groups of adjudicated offenders and non-offenders. Jesness (1977) states that, "the ability of the Jesness Inventory to predict future delinquency has not as yet been tested; its potential can only be estimated by its ability to discriminate among groups identified after the fact" (p 697). This study supports the ability of three of the scales of the Jesness Inventory to discriminate between non-offending students receiving summer session academic remedial instruction and a group of similar students receiving educational services in a residential custodial facility subsequent to adjudication for a variety of juvenile offenses.

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Appendix A

Demographic Information Sheet

INFORMATION SHEET

DATE: _____

- 1.) NAME: _____ MALE/FEMALE: _____
AGE: _____ DATE OF BIRTH: _____
PLACE OF BIRTH: _____
- 2.) ARE YOU PRESENTLY A STUDENT?: _____
IF YES, NAME OF PRESENT SCHOOL: _____
PRESENT GRADE LEVEL: _____
IF NO, HIGHEST GRADE LEVEL PASSED: _____
- 3.) ARE YOU, OR HAVE YOU BEEN, A SPECIAL EDUCATION
STUDENT? _____
- 4.) HAVE YOU EVER REPEATED A GRADE: _____
IF YES, LIST GRADES REPEATED: _____
- 5.) HAVE YOU EVER BEEN "PROMOTED WITHOUT CERTIFICATE"?
YES _____ NO _____
IF YES, HOW MANY TIMES: _____
- 6.) FATHER'S OCCUPATION: _____
MOTHER'S OCCUPATION: _____
- 7.) TOTAL NUMBER OF BROTHERS AND SISTERS IN FAMILY: _____
- 8.) HAVE YOU EVER BEEN ARRESTED FOR OFFENSES UNDER THE
YOUNG OFFENDERS ACT?
YES _____ NO _____
IF YES, HOW MANY TIMES? _____

9.) HAVE YOU EVER BEEN CONVICTED FOR OFFENSES UNDER
THE YOUNG OFFENDERS ACT? YES _____ NO _____

IF YES, HOW MANY TIMES? _____

10.) IF YOU HAVE BEEN CONVICTED, WAS/WERE YOUR
CONVICTION(S) FOR

a.) OFFENSES AGAINST PEOPLE _____

b.) OFFENSES AGAINST PROPERTY _____

Appendix B

Consent Form

PARENT/GUARDIAN CONSENT FORM

This form requests consent for your son/daughter/legal ward to participate in a research project conducted by Jerry Blackmore, a graduate student, with the Department of Educational Psychology at Memorial University. This research project is being conducted under the supervision of Dr. Bruce Gilbert as part of Mr. Blackmore's requirements for a Master's Degree in Educational Psychology.

The purpose of this research is to investigate the ability of a personality test called the Jesness Inventory to discriminate juvenile offenders from non-offenders on the basis of their responses to the items contained in the test. Information gained from this project will, hopefully, provide useful information for school counsellors for the early identification of a delinquent pattern of behaviour and an appropriate approach to treatment.

The participation required of each subject will be approximately of 45 minutes duration and involves completing a self-administered, pencil and paper questionnaire consisting of 155 true or false questions concerning general attitudes towards school, police, friends, family, etc.

There will also be an information sheet requiring essential details such as; age, sex, number of brothers and sisters, parent's occupations, towns/cities in which they have lived, present or last grade achieved in school and number of convictions, if any, under the Young Offenders Act. It will also be necessary for a test of non-verbal reasoning ability to be administered. This part of the research should require a further 30 minutes involvement on the part of the student.

All information will be maintained in strictest confidence and used only for the purposes of the research project. Individual responses to particular questions will not be examined and all information will be identified using coded answer sheets.

Any further inquiries regarding this project are welcomed and will be responded to as quickly as possible.

I _____ give my consent for
_____ to participate in the above
research project.

Signature: _____ Date: _____

Thank you
Jerry Blackmore
Memorial University
Tel. 738-2331

Appendix C

List of Testing Materials Reviewed by the Intern
at the Waterford Hospital

List of Testing Materials Reviewed by the Intern
at the Waterford Hospital

Section 1: Personality Tests (projective)

House-Tree-Person Drawings (HTP)

Thematic Apperception Test (TAT)

Section 2: Personality Tests (objective) and Inventories

Beck Depression Inventory (BDI)

High School Personality Questionnaire
(HSPQ)

Millon Clinical Multiaxial Inventory (MCMI)

Minnesota Multiphasic Personality Inventory
(MMPI)

Mooney Problem Checklist

SCL-90-R

Sixteen Personality Factors Questionnaire
(16PF)

Section 3: Adaptive Behavior Scales

AAMD Adaptive Behavior Scale

Vineland Adaptive Behavior Scale

Section 4: Intellectual Ability and Achievement Tests

Peabody Picture Vocabulary Tests

Raven's Progressive Matrices (Three Forms)

Wechsler Adult Intelligence Scale-Revised
(WAIS-R)

Wechsler Intelligence Scale for Children -
Revised (WISC-R)

Wide Range Achievement Test (WRAT)

Appendix D

Brief Description of Each of the Scales of The Jesness
Inventory

Brief Description of Each of the Scales of The Jesness Inventory

I. Social Maladjustment

This term is meant to define a group of attitudes and opinions held by youngsters who are socially inadequate or disturbed, those who have shown an inability or unwillingness to meet the demands of their environment in a socially approved manner. High scores on this scale are directly correlated with the seriousness of delinquency: incarcerated delinquents score higher than minor offenders who score higher than non-delinquents.

Characteristics:

1. negative self-concept
2. feels misunderstood
3. unhappy
4. distrusts authority
5. externalizes blame onto others
6. has an unrealistically positive evaluation of parents
7. has problems controlling hostile impulses
8. sensitive to criticism
9. there may be a masculine identification problem

II. Value Orientation

This scale refers to a tendency to hold opinions and attitudes characteristic of persons in the lower socioeconomic class. Delinquents of all ages generally score higher than non-delinquents.

Characteristics:

1. wants to appear "tough", be considered by others to be a "man"
2. is a thrill seeker
3. gang-oriented
4. perceives internal tension and anxiety in external concrete symptoms, e.g., "my hands shake a lot"

High scorers on the Values Orientation scale will also show:

- a. show greater ego strength (perhaps a high Denial score)
- b. freely admit to family conflict
- c. be more self-confident and may not attempt to avoid conflict with others, including physical fights

III. Immaturity

Scores on this scale show a tendency to perceive self and others in a manner characteristic of those younger than the subject. Delinquents consistently score higher at each age level. This scale is not necessarily correlated with physical immaturity but rather reflects attitudinal immaturity.

Characteristics:

1. improperly evaluates people's motivations, including own
2. tends to repress or suppress problems
3. anxiety manifests itself in somatic symptoms
4. high scorers seem to be working to give a good impression
5. a high score indicates the presence of naivete and rigidity
6. a low score indicates pessimism and cynicism

IV. Autism

This scale measures a tendency in thought and perception to distort reality according to one's personal needs. Delinquents tend to score higher.

Characteristics:

1. self concept is that of being: smart, good looking, tough but at the same time may hear "things", daydream, and feel there is something wrong with his mind
2. may be seclusive
3. cognitive behavior is over-regulated by drive to meet personal needs
4. may be hostile-aggressive
5. easily perturbed

V. Alienation

Scores indicate the presence of distrust and estrangement in the subject's attitudes toward those representing authority, highly evident among delinquents.

Characteristics:

1. generally experiences poor interpersonal relationships, except perhaps with highly simpatico peers
2. critical and intolerant of others
3. tends to project his hostile feelings onto others
4. denies personal problems

VI. Manifest Aggression

This scale measures an awareness of unpleasant feelings and a tendency to react quickly with emotion.

Characteristics:

1. principally the perception of unpleasant feelings, especially anger
2. is aware of and feels discomfort with the presence of negative feelings
3. is concerned about controlling self
4. high scores are correlated with assaultive aggressive behavior
5. however, high scorer may exhibit unusually conforming, over-controlled behavior

VII. Withdrawal-Depression

This scale reflects a tendency to isolate one's self from others and involves a perceived lack of satisfaction with self and others.

Characteristics:

1. depressed
2. dissatisfied with self
3. prefers isolation from others, may be a loner in criminal acts
4. views others negatively, perhaps as too aggressive

VIII. Social Anxiety

This scale measures a perceived emotional discomfort associated with interpersonal relationships. This scale does not discriminate delinquents from non-delinquents.

Characteristics:

1. emotionally uncomfortable in interpersonal relationships
2. aware of nervous tension
3. shy, sensitive
4. intrapunitive (can blame "self", experiences feelings of guilt)

IX. Repression

Repression means the exclusion from consciousness of feelings which normally the subject would be expected to feel, or failure to identify these feelings.

Characteristics:

1. will not admit (or is unaware of) negative feelings
2. has noncritical attitude toward self
3. may be impunitive (unwilling or incapable of blaming "self")
4. a low score represents the presence of pessimism and cynicism
5. a high score may indicate an attempt to "fake good", but is more likely due to the unconscious exclusion of negative thoughts rather than an attempt to be deceptive

X. Denial

This scale reflects a subject's reluctance to accept or acknowledge unpleasant aspects of reality which are frequently encountered in day-to-day living. Denial is the only scale on which non-delinquents consistently score higher than delinquents.

Characteristics:

1. is overwilling to criticize others
2. is defensive about interpersonal difficulties

3. a high scorer sees
 - a. no family problems
 - b. no personal inadequacies
 - c. no cause for personal discomfort or unhappiness
4. a low score (less than 40) denotes low ego strength and/or the lack of the common defense mechanism of denial

XI. Asocial Index

This score refers to a generalized disposition to resolve problems of social and personal adjustment in ways ordinarily regarded as showing disregard for social customs or rules. This calculated index is the Inventory score most closely related to, and most predictive of, delinquent behavior.

Appendix E
Correspondence

Waterford Hospital
St. John's, Newfoundland
Canada

Consulting Psychologists Press Inc.
577 College Avenue
Palo Alto, California
94306

Dear Sirs:

I am a graduate student with the Department of Educational Psychology at Memorial University in St. John's, Newfoundland and am presently completing a research project as part of my internship program at the Waterford Hospital. This research project involves using the Jesness Inventory to discriminate juvenile offenders from non-offenders and the possible subsequent classification of subjects using I-level typology.

I would like permission to photocopy pages 3-18 of the Jesness Inventory Manual and pages 3-12 and 40-42 of the Sequential I-Level Classification Manual for inclusion in the research report.

This report is to be submitted by the first week of September and if accepted will be printed in sufficient numbers for distribution within the Department.

Further information, if necessary, will be gratefully supplied.

Jerome Blackmore
Dept. of Educational Psychology
Memorial University of Newfoundland

Mailing Address

c/o Waterford Hospital
Department of Psychology
Waterford Bridge Road
St. John's, Canada

Tel: Waterford Hospital: 704-364-0111 ext. 337
Home: 738-2331

Waterford Hospital
St. John's, Newfoundland
June 19, 1989

Mr. Fred Bullen
Assistant Superintendent
Avalon North Integrated School Board
Spaniard's Bay, Newfoundland.

Dear Sir,

I am currently completing a Master's Degree in Educational Psychology at Memorial University. As part of my degree program I am conducting a research project involving a personality assessment instrument called the Jesness Inventory. This test is used in several countries around the world and is regarded as extremely reputable. The Jesness Inventory carries great credibility in many centers which provide services to troubled youth. For school counsellors this instrument is of interest because of its reported ability to discriminate delinquent patterns of behavior from those of non-delinquents.

I am hoping that it would be possible to enlist your cooperation in this research project. It is my intention to use summer school students as part of my research sample and I am seeking up to 25 students to serve as subjects in my control group. Student participation would involve a brief introductory talk in which they would be introduced to the task of completing the paper and pencil, self-administered, questionnaire which simply requires of the subject to fill in the boxes indicating that certain statements, in their opinion, are true or false. The questionnaire will be group administered and require approximately 1 hour to complete. Subjects will also be required to complete an information sheet eliciting other essential details such as age, sex, grade/level, town of origin, parent's occupations, etc. There will also be a group administration of the Raven's Standard Progressive Matrices, a test of non-verbal reasoning ability which will take about 20 minutes to administer. In total, less than two hours of student time will be required.

The information obtained will be maintained in strictest confidence and used only for the stated purpose of the research. I am enclosing for your further information relevant sections of my research proposal. Further inquiries will also be addressed to appropriate authorities at the School Board for their consideration.

Sincerely,
Jerry Blackmore

Waterford Hospital
St. John's, Newfoundland
June 9, 1989

Mr. Rob Shea
Brother T.I. Murphy Centre
Water Street, St. John's, Newfoundland.

Dear Sir,

I am presently completing a Master's Degree in Educational Psychology at Memorial and as part of my degree program I am conducting a research project involving a personality assessment instrument called the Jesness Inventory. The Jesness Inventory carries great credibility in many centers which provide services to troubled youth. For school counsellors this instrument is of interest because of its reported ability to discriminate delinquent patterns of behavior from those of non-delinquents.

I am hoping to enlist your cooperation in this project. I would like to involve some of your summer students as part of my research sample and I am looking for 25 or more students to participate. Students would be given a brief talk after which they will be required to complete an information sheet eliciting essential details such as age, sex, grade/level, town of origin, parent's occupations, etc. They will then be introduced to the task of completing the paper and pencil, self-administered, questionnaire. Subjects simply fill in boxes indicating that certain statements, in their opinion, are true or false. There will also be a group administration of the Raven's Standard Progressive Matrices, a test of non-verbal reasoning ability which will take about 20 minutes to administer. In total, less than two hours of student time will be required.

The information obtained will be maintained in strictest confidence and used only for the stated purpose of the research. I am enclosing for your further information relevant sections of my research proposal. Further information, if required, will be gratefully supplied.

Sincerely,

Jerry Blackmore

Appendix F

Waterford Hospital Psychology Department:
List of Liaison Psychologists and Distribution of
Clinical Responsibilities

Psychology Department**Liaison Psychologists****November, 1988****Admission Units**

N3B: Mr. M. Simpson/Dr. H. Khalili
N2B: Ms. E. Donahoe/Mr. B. Kane
N4A: Dr. R. J. O'Mahony

Forensic Unit

N4B: Ms. N. Sandoval

Mental Retardation Units

W2A, W2B: Dr. H. Khalili
W1A, W3B: Ms. N. Sandoval
W1B, W3A: Ms. L. Kang

Long-Stay Psychiatric Units

E1B/E3A: Mr. T. Honan
E2B: Mr. E. Donahoe
E1A: Mr. B. Kane

Geriatric Units

N2A/N3A/E2A: Mr. T. Honan

Ambulatory Care/Out-Patient Clinics:

Ms. S. Jackman-Cram

Day Care:

Ms. S. Jackman-Cram

Rehabilitation Departments:

Ms. N. Sandoval

PSYCHOLOGY DEPARTMENT
DISTRIBUTION OF CLINICAL RESPONSIBILITIES

November, 1988

DIRECTOR OF PSYCHOLOGY

DR. R. J. O'MAHONY: Forensic Service

SENIOR PSYCHOLOGISTS

Dr. H. Khalili: Mental Retardation
Ms. S. Jackman-Cram: Acute Care Services/
Ambulatory Care
Mr. Thomas Honan: Long-Stay Psychiatric/
Psychogeriatrics

Appendix G

Waterford Hospital Addictions Program

A Case Study

by Denise E. Lawlor, M.S.W.

July 7, 1987

Preamble

An Addictions Program has been successfully operating since January 1982 through the Ambulatory Care Department of the Waterford Hospital. It is an out-patient treatment service which offers assistance to individuals who are addicted to alcohol, prescription medications and/or street drugs. The program is coordinated by a social worker and is staffed by social workers and nurses. A psychiatrist is available as a consultant to the staff and as a resource in the assessment and treatment of individuals in crisis.

Philosophy of Addictions Program

The program is based on the premise that alcohol/drug addiction is a problem that impacts on everyday living, and is also influenced by the way a person handles everyday life. therefore, treatment must address a variety of issues about the individual's addiction and lifestyle.

Furthermore, this program recognizes that any individual can develop the ability to gain control over an addiction. However, such control can only be achieved if the person is motivated to make changes. It is accepted that a motivated person requires support

and treatment in order to gain the desired control.

It is generally known that overcoming an addiction is a difficult and lengthy process. Therefore, this program does not expect quick and lasting results. Instead it accepts that a person may be involved in treatment for an indefinite period of time. The availability of long-term treatment and support is seen as essential to reducing the effects of addiction.

Goals of Program

The program is not designed to meet the needs of all people with addictions problems. It does attempt to help members achieve the following:

- (1) Identify the dimensions of their problems with alcohol, street drugs and/or proscription medications.
- (2) Reduce the dependency and/or control their addiction.
- (3) Identify their individual coping patterns in relation to their problems.
- (4) Adopt new and healthier ways of coping with life and life problems.
- (5) Build their self-esteem and learn to communicate effectively.

Theoretical Basis

The complexity of addiction problems demands a multiplicity of approaches. In order to provide various treatment approaches as well as offer support on a long-term basis, group work has been chosen as the model of therapy.

This model allows group members to relate to one another in a therapeutic manner while drawing on the expertise of trained therapists. This approach is preferred because it combines the efforts of the addicted person's peers. This combination enhances peer learning, and provides role models to the group. It also gives people an opportunity to share their difficulties and their ideas in an environment where everyone is taking similar risks. Thus it is a relatively safe place.

A Case Study: Tom's Story

Let's look at typical case referred to the Addictions Program and follow him through the stages of group work treatment.

Tom, age 35 years, is married and the father of two children. He has a comfortable job as an electrical engineer and lots of friends. For the past ten years

his drinking has increased to the point that his wife feels he has a "problem". His boss is concerned about his job performance as in the past year he has been missing more time, as well as being caught drinking "on the job" on two occasions. Lately, he has forgotten important meetings which cost his employer the loss of two contracts. His friends tend to visit less often as it always seems that Tom is drinking "a few too many". The children shy away from him after he has had a few drinks and seldom bring their friends home. Tom is beginning to wonder: "Does he have a problem?"

On talking with his family doctor he is informed of the Addictions Program. An appointment is made for him to meet the co-ordinator of the program. On assessment by the social worker, Tom is accepted into the Addictions Program. For Tom there are still many questions unanswered. yet, he is willing to give the program a try.

Stage I: Educational Session

In starting the program, Tom attended a three hour educational session which focused on providing pertinent information on addictions. He was introduced to other members who were just beginning treatment. All had lots of questions they wanted answered. For

example: "Can I ever drink again? Am I an alcoholic? Will my children inherit my problem? Do I have a disease? What is the addicted personality?"

The answers to these questions are not necessarily simple. the role of the therapist conducting the educational session was to help Tom and the group understand that it is natural to have fears and concerns when initially entering the program. There are no simple answers or cures in treatment. Much depends on Tom himself in taking responsibility and control of his life. This means acknowledging a problem and reaching out for help. Sometimes fear and looking for simple solutions can stand in the way of seeking help.

for the first time Tom began to question his drinking and his lifestyle. He was not alone. Other members had similar feelings. He began to realize that if he wanted help there were several stages to treatment.

Stage II: Day Group
Interactional Insight Awareness Model

Tom was accepted into an open-ended day group which met once a week for two hours. this group was co-led by two therapists with space available for twelve members. All members were at the beginning stage of attempting

to gain some insight into themselves and their addiction problems. Confidentiality was respected by members and co-therapists, which helped Tom begin to open up and trust in the group. He began to talk about his battle with alcohol and his present craving for it. He acknowledged the fact that alcohol had taken control of his life. He was now struggling to stay sober. During this crisis, he began to realize that he was not alone as other members had shared similar experiences and had coped. At last there was hope!

As Tom began to trust the group he started to learn new things about himself. His insight into himself helped him face his life more honestly and set more realistic goals. During his stay in the day group he had two slips. These slips became learning experiences for him and the group. He learned that if he wanted a better life he must make the choice to stop drinking.

After attending the weekly group sessions for nine months, Tom was ready to move on. After consultation with the co-therapists he was referred to the night group.

Stage III: Night Group
Psychotherapy Model

After achieving six months of sobriety Tom was ready to

participate in the night group. this group met once a week for two hours with a primary focus on helping members face their life problems in a more realistic manner and finding more effective ways of coping. The group was led by a therapist and was open ended in nature with space available for twelve members.

Tom realized that staying sober was only the first step in treatment. From there, he must attempt to make positive changes in his life and identify the problem areas he wanted to change. In the group he saw other members face the same life problems as his own. His family were going through difficult times. They could not really understand the new Tom. He realized that his family were still wondering: "How long will he stay sober this time?" Trust issue was a big concern for him and his family. Tom had a difficult time talking about his feelings in the group. By problem solving and learning how to talk about his feelings he began to honestly face himself. Through the group experience he began to test out his feelings with his wife. Communication between him and his wife slowly began to improve.

For a man who "never liked to talk in a group", he now began to take an active role in giving support and

feedback to other members. He felt quite comfortable confronting members who were attempting to work on their problems and alter their lifestyles.

Tom remained a member of the night group for one year during which he saw several positive changes occur in his life. Family support was stronger as they began to trust again. Tom made several new friends through his involvement with community work. For the first time he risked himself in his job and considered a career change, which had always provoked fear and anxiety in the past. His confidence and self-esteem had definitely improved as he learned that life was full of challenges if he was willing to risk and grow. Finally, it was time for Tom to move on. With the assistance of the group leader and the group, he prepared for termination. The transition from being a group member to now moving on alone was a difficult and painful one. Termination was yet another stage in the treatment process.

Stage IV: Maintenance

On leaving the night group, Tom maintained periodic contact with several of the group members through monthly self-help meetings and social activities. From time to time Tom contacted the group leader just to

stay in touch. Through the support of weekly AA meetings he was staying sober.

Family continued to attend Alanon and Alateen supports. Tom realized his problem with alcohol was a life long battle which he had chosen to work on. He knew the road would never be smooth, yet he was confident that he could make it. He would never have to feel alone.

Summary

Tom is only one example of the type of person who avails of the Addictions Program, yet he exemplifies the importance of helping the addicted person on several levels. Addiction takes time to develop. so too, lots of time and patience are needed on the part of professionals for treatment to work. A great deal depends on the motivation of the person yet it is important to recognize the complexity of addiction problems. Each person merits his/her own treatment plan.



