

A STUDY OF THE EDUCATIONAL THERAPY SERVICE  
IN NEWFOUNDLAND AND LABRADOR

CENTRE FOR NEWFOUNDLAND STUDIES

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**A STUDY OF THE EDUCATIONAL THERAPY SERVICE IN  
NEWFOUNDLAND AND LABRADOR**

by Valerie Elizabeth Anderson - Lane

A thesis submitted in partial fulfillment of the requirements for the  
degree of  
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## ABSTRACT

In 1986, the Department of Education in Newfoundland and Labrador developed a policy concerning its services for behavior disordered students. The teaching unit assigned to provide these services was entitled Educational Therapist.

The purpose of this study was to examine the educational therapist's services offered to behavior disordered students. Educational therapists throughout the Province completed a survey questionnaire regarding their own background, characteristics of the children, and the interventions provided for these students. Fifty-nine therapists responded and provided information about themselves and 306 core behavior disordered children.

The analysis of responses included the characteristics and problems of children labeled behavior disordered in these units; the nature of services and treatments being provided; the training and background of the therapists, as well as their perception of further training needs. Results indicate that educational therapists work with a variety of behavior disordered children.

The training and background of therapists are varied and there is little consensus among those surveyed related to the role and function of the educational therapist. Results would indicate a strong need to further research the effectiveness of these positions along with their appropriate roles in the school system.

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## **CHAPTER 1**

### **Introduction**

#### **Purpose**

The purpose of this study was to obtain a description of educational therapy services in Newfoundland and Labrador.

This description will include:

1. The presenting problems of children being served.
2. Services offered by therapists.
3. The interventions being used to help these children.
4. The training and background of the therapist.
5. Perceptions of the therapists with respect to the delivery model for serving these children.

#### **Background to the Problem**

Over the past five years the Department of Education in Newfoundland and Labrador has developed a unique (teaching) unit to meet the needs of behavior disordered children. Smerdon and Butt (1985) described the rationale for the development of the model for this unit, entitled Educational Therapists. Their review of the literature pointed to the need for unbiased identification procedures, a resource person highly trained in behavior change methods, and the use of

objective measures to evaluate the services offered. The Department of Education (1986) adopted this model and produced a policy statement for school boards and educational therapists to serve as a framework for the implementation of these services.

The Department of Education's policy statement identifies the aim of services to be the retention of the behavior disordered student in the mainstream of the regular class. It describes the educational therapists as ". . . resource persons appointed for the benefit of administrators, teachers, and parents as well as the students themselves." (p. 1). It claims the title educational therapist is used to distinguish their role from that of teachers who are responsible for academic instruction and guidance counsellors whose role is much more broadly based.

The policy statement is essentially provided to school systems throughout Newfoundland and Labrador as a guideline for the development, implementation and evaluation of programs and services for behaviorally disordered students. As such, the policy document provides information and guidance on the following:

- Definition of behaviorally disordered students.

- Criteria for establishing an educational therapy unit.
- Detailed description of assessments and documentation required.
- Competencies required of educational therapists.
- Roles and functions recommended for educational therapists.

While the policy statement provides an excellent outline for the establishment and implementation of educational therapy units, little has been done to date to assess these units in terms of their original mandate. The success of such a program will clearly depend upon the ability of school systems to put programs in place that are effective and efficient for behaviorally disordered children. Success will not only depend upon program development skills of school board personnel, but will also largely depend upon the ability of boards to attract trained personnel in the field of behavioral disabilities.

### **Rationale**

Research in the field of behavioral disorders has suffered because of problems with reporting and inconsistent



definitions (Skiba & Casey, 1985). Studies in both Canada and the United States have reported variations in definitions used by provincial and state departments of Education for the identification of behavior disordered students (Cullinan, Epstein, & McLinden, 1986; Csapo, 1981; Epstein, Cullinan, & Sabatino, 1977). Studies of programs for the behavior disordered have been hampered by incomplete program descriptions in the literature (Grosenick & Huntze, 1983, as cited in Skiba & Casey, 1985). An analysis of research reporting interventions for behavior disordered students since 1977, indicated that a number of important descriptors were missing, such as: the subjects' age and sex; the amount of special education services subjects are presently receiving; and a specific description of the subjects' behaviors (Skiba and Casey, 1985).

With the implementation of the educational therapy unit, it would seem that Newfoundland and Labrador, at least theoretically, would have a solid foundation for providing services to behavior disordered students. However, whether or not actual educational therapy practices follow the guidelines recently printed is another question. This study was aimed at determining the actual services and specific interventions being provided to behavior disordered children who are

involved in these educational therapy units. Because the allocation of therapy units is controlled by the Department of Education, the definition of behavior disordered students will follow the definition outlined in the Department of Education's Policy Manual. The services offered to the students in these units may be affected by a number of other variables. Some of these variables, which were considered in the present study, are reviewed below.

Information concerning the specific children being served by the educational therapist is needed. Variables such as age, sex, and type of problems can influence the interventions and services provided. This information is also valuable in terms of discussing the prevalence of problems in Newfoundland and Labrador.

In order to plan for future programs, the Department of Education will need information on the nature and types of services currently being provided. Identifying the services that are being provided will be to a large extent dictated by the type of placement the child is assuming within the school. This placement is important from a philosophical point of view as well, since the aim of services is supposed to be mainstreaming. The nature of the services offered to the behavior disordered students, will also depend on the

responsibilities therapists are assuming within the schools. Information concerning the responsibilities is important from two perspectives: (1) it will allow one to get a more complete description of the broader services being offered, such as group counselling, classroom guidance, etc. and; (2) it may indicate areas of responsibilities that could interfere with providing services to the behavior disordered students. For example, if the therapists are responsible for teaching other classes or supervising detention, they may be less available for intervention.

The specific type of treatment offered to help a child is also a critical variable. Depending upon the nature and needs of the child involved, the selection and appropriate use of specific therapies will clearly affect the success of the therapy program.

Directly related to the use of therapies is the training and background of the educational therapist. Beare and Lynch (1983) found that the most serious problem for serving the needs of behavior disordered students was a lack of trained personnel. Training and theoretical orientation of the therapists have also been found to affect the type of intervention used (Kestenbaum, 1978 as cited in Algozzine & Lee, 1981). These findings seem logical: therapists who

haven't received training in rational emotive therapy or family counselling are not likely to use these interventions. Similarly, if some therapists' orientations are towards remediation of academic difficulties, it is less likely that they will be offering psychoanalysis. Ideally, interventions used by therapists should be directly related to the nature of the childrens' difficulties. However, one cannot expect an intervention technique that is presently not in the therapists' repertoire. Therefore, it is important to find out how therapists view the adequacy of their present training and their desire for further training in specific areas.

The main purpose of this study was to provide a comprehensive picture of the services being offered to behavior disordered children in Newfoundland and Labrador schools. It was envisaged that by taking the above variables into account, patterns will emerge that will make a valuable contribution not only to the research in this field, but also to the improvement of services.

### **Research Questions**

This study sought to address the following questions.

1. What are the presenting problems of children being served?

2. What kind of services are being provided for children with behavior disorders in Newfoundland and Labrador?
3. What specific types of treatments are being used to help these students?
4. What is the training and background of persons serving these children in the educational therapy units?
5. What types of training is perceived to be needed in order to more effectively help these students?

#### Definition of Terms

**Educational therapist:** A person appointed to the salary unit for a minimum of four students who are deemed (under Revised Regulation 278/82) "emotionally disturbed".

**Behavior disordered student:** For the purpose of this study, a behavior disordered child is a child who is being served in the educational therapy unit. The definition of behavior disordered child employed by the Government of Newfoundland and Labrador is the following:

"A student is deemed behaviorally disturbed if the child frequently demonstrates one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance:

1. A marked inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological, or general health factors.
2. A consistent inability to build and maintain satisfactory inter-personal relationships with peers and teachers.
3. High age and/or sex inappropriate behaviors or feelings within normal situations.
4. A general pervasive mood of acute unhappiness or depression.
5. A tendency to develop symptoms, such as speech problems, pains or fears, associated with personal or school problems."

\*Assessment data from a variety of scales and sources is used to identify a "problem" in one or more of the above areas. Consistency in pointing a student's

inappropriate behaviors between at least three of these sources is taken as sufficient evidence of identification.

**Core student:** A student for whom full documentation exists in school and board office, and therefore one who could be used to substantiate the unit under regulation section 2(3) (a) (iii) of The School Act (Teacher's salaries) Regulation (1982 Amendment).

**Referred student:** A student referred to an educational therapist by self, teacher, parent, or other agencies for evaluation, behavioral program planning, or crisis intervention.

### Limitations

As with most research, some caution must be taken when interpreting the results of this study. The following points highlight the primary research considerations when applying the data herein:

1. The questionnaire allows for a combined measure of facts, definitions, attitudes and perceptions.
2. The study is descriptive in nature.

3. The training and background of respondents varied considerably, creating the possibility of a greater variance on more technical questions.
4. Respondents may inadvertently bias results in favor of answers that are perceived to support their positions.



## CHAPTER 2

### Review of the Literature

#### Historical Overview of Services

A brief examination of the history of services for behavior disordered children, will give one a better appreciation of services that exist today. Prior to 1800, few, if any, systematic attempts were made to teach any type of handicapped children. "Abuse, neglect, cruel medical treatment (e.g., bleeding), and excessive punishment were common and often accepted matter-of-factly for children as well as adults who showed undesirable behavior" (Kauffman, 1981, p.33).

Despite poor treatment and institutionalization, the mid 1800s brought an increased interest in possible explanations of maladaptive behavior. Diagnosis and classification became the focus in the latter part of the century, known as the "descriptive era". During this period, a legal distinction was made between feeble-mindedness (mental retardation) and insanity (emotional disturbance) in England (Stainback & Stainback, 1980).

Unfortunately, in the last half of the 1800s, attitudes towards fatalism developed and the prevailing belief was that insanity was irreversible. As a result, treatment was believed to be useless and asylums became a place to isolate the insane from the rest of society.

In the early 1900's, concern for children with disordered behavior increased tremendously. Community child guidance clinics for emotionally disturbed children were established. As well, public schools began offering mental hygiene courses as a preventative measure for emotional disturbance. The beginning of education for the emotionally disturbed was undoubtedly influenced by the National Committee for Mental Hygiene, established in 1909. One of its members, Thomas Haines, stated that he believed the public schools should be concerned about the welfare of all exceptional children including the "psychopathic" (seriously disturbed) as well as those who exhibit more mild behavior problems (Stainback & Stainback, 1980).

In the 1920s, two organizations were founded that greatly influenced the education of disturbed children in the United States: the Council for Exceptional Children (1922) and the American Orthopsychiatric Association (AOA) (1924). The

Council for Exceptional Children greatly influenced the passage of legislation concerning the education of all handicapped children while AOA did much to encourage research and dissemination of information regarding therapeutic and educational endeavors with behavior disordered children (Kauffman, 1981). Other national organizations such as the Council for Children with Behavioral Disorders (1964), National Society for Autistic Children (1965), and the American Association for the Education of the Severely/Profoundly Handicapped (1974), were founded throughout the century.

An increased interest in the education of these children complemented the growing literature on schizophrenia and other categories of childhood disorders that flourished during the 1930s and 40s. Most of the programs set up for the severely disturbed, at this time were residential in nature. Those children who were considered mildly disturbed were, for the most part, enrolled in special schools or special classes. This segregation of handicapped children, for the purposes of education, began to change drastically in the 60s and 70s. At that time, Wolfensberger (1972), maintained that placement in environments segregated from "normal" individuals did not foster positive gains in the behavior of those people placed in

such environments. This philosophy has been a powerful force in shaping the services we provide for exceptional children today.

In the 1960s and 70s, a move towards normalization began and mainstreaming became the central focus of special education. Essentially, normalization refers to the "placement of the individual into a situation that is as much as possible like the situation he would be in if he were not considered to be disturbed or behavior disordered" (Stainback & Stainback, 1980, p. 50). Mainstreaming may be viewed as the educational counterpart of the movement towards normalization. It is linked to the right of all children to an appropriate education. In the 1960s and 70s, the United States responded to the movement by placing mildly disturbed children in regular classes and the severely disturbed in special classes within the public schools. Mainstreaming did not have a serious impact in Canada until the 1970s, when the CELDIC Report (Roberts & Lazure, 1970) was released. The Commission of Emotional and Learning Disorders in Children, through field visits, examined conventional patterns of services for children with emotional and learning disorders and made several recommendations for changes towards the improvement of such services. At the basis of these recommendations are two

main ideas: (1) the child's needs should be met within the normal environment and through the local community; and (2) if this need is to be met, the people responsible for the children's care must be able to call upon and use adequate consultation and support from staff with highly specialized training and skills. The emphasis is placed on integration of the child in the regular classroom with special education consultant help for the classroom teacher and support services for the child's family.

The authors of this report recommended the following:  
*"that because of the negative effects of separate special education facilities, educational authorities minimize the isolation of children with emotional and learning disorders and plan programs for them that as far as possible retain children within the regular school curriculum and activities."*

(Roberts & Lazure, 1970, p.146)

Although one often views placement in the regular classroom synonymously with mainstreaming, Hammell, Bartel, & Bunch (1984), warn us that such placement should not be misconstrued as "appropriate" education. Placement procedures may vary depending on the needs of the child and

the support services available. Mainstreaming will involve placement of the child in the "least restrictive" environment that will best meet his needs. The Council for Exceptional Children put forward the following definition of mainstreaming at its 1976 international conference:

*"Mainstreaming is an educational placement procedure for exceptional children based on the conviction that each child should be educated in the least restrictive environment in which his or her educational and related needs can be satisfactorily addressed."*

In order to meet the needs of exceptional children in a normalized setting, support services are crucial. The CELDIC Report recommended that support services be available to the classroom teacher as well as to the child's family.

*"We recommend many ways of supporting families; day care, homemaker services, counselling; and we recommend that the classroom teacher have consultation help readily available both in the school and from the community to increase his skill and strengthen his role in working with a child with emotional and learning disorders."*

(Roberts & Lazure, 1970, p.10)

One of the major problems seen by this report was the lack of coordination of services provided for children with emotional and learning disorders. Children were often being treated independently by the education, medical, correctional and social service systems. Poor communication between these different helping services often resulted in fragmented treatments that did not consider the whole child. Because the school is responsible for the day to day care of children, the CELDIC report recommended that the school form the base for organizing and coordinating all the necessary community services. This would enable front line personnel, the regular classroom teachers, to serve the needs of emotional and learning disordered children while having access to special education consultants who are communicating with the other helping professions.

In response to this need, the Newfoundland Government have established Educational Therapy positions within Newfoundland schools. These positions are intended to address the needs of behaviorally disordered children while also providing consulting services to regular classroom teachers. One of the first problems facing the establishment of these positions was coming to some consensus on the definition of behavioral disorders.

### Definitional Issues

Definitions of deviant behavior have been proposed from a variety of perspectives and disciplines (Clarizo and McCoy, 1983.) At the present time, there is no universally accepted definition and this reality poses a number of problems for research in this field. Winzer (1987) captures the nature and extent of these problems:

*Difficulties in the precise definition of emotional disturbance have created problems in estimating prevalence, identifying characteristics, assessment, etiology, treatments, and educational approaches. Professionals cannot even agree on whether to call these children emotionally disturbed, behaviorally disordered, socially maladjusted, deviant, psychologically impaired, educationally handicapped, character disordered, or delinquent (p.375).*

There are several reasons why defining behavioral disorders is a difficult task. In order to be able to define and identify a behavior that is deviant, disordered, or abnormal, one must first have a clear definition of normal or acceptable



behavior. Garber (1984) points out that we must view "normalacy" from a developmental perspective:

*Whether childhood psychopathological disorders are referred to as deviations from age appropriate norms, exaggerations of normal developmental tasks, or interferences in the normal progression of development, it is clear that some notion of normality in the context of the developmental process is essential.*

(Garber, 1984, p.35)

Children exhibit a variety of behaviors and it is very difficult to label any of these behaviors "abnormal" or "normal" per se. Usually, it is the amount or degree of behavior exhibited in certain situations that differentiates disordered and normal behavior. Unfortunately, agreeing on what amount or degree is abnormal is also a problem.

Another reason behavior disorder is so difficult to define is that it cuts across many other disabling conditions (Bower, 1982). Mentally handicapped, hearing impaired, and learning disabled children often exhibit inappropriate behaviors and/or emotional problems.

Definitional problems also exist because of varying professional perspectives. The field of behavioral disorders has input from medicine, psychiatry, education, social work, and psychology. It is very difficult, if not impossible, to create a definition that would encompass these theoretical orientations.

Even within the educational field there is generally a lack of consensus regarding the definition of behavioral disorders. Epstein, Cullinan, and Sabatino (1977), surveyed departments of education in the United States regarding their definitions of behavior disorders. They found a wide discrepancy between the states' definitions, with one state's definition actually contradicting another's. Csapo (1981) reports that in Canada only six of twelve jurisdictions reported the existence of an official definition and these definitions all varied to some extent.

A consistent definition within any field is very important. Kauffman states:

*The definition one accepts will reflect how one conceptualizes the problem of disordered behavior and, therefore, will determine what intervention strategies one considers appropriate...Furthermore*

*a definition specifies the population to be served and, thereby, has a profound effect on who receives intervention as well as how they will be served.*

(Kauffman, 1981. p.19)

Consistent and objective guidelines for defining and identifying disorders are also necessary for making progress in the research of this field: "In the absence of clear and objective guidelines for identifying disorders, generalizations across studies have been difficult" (Garber,1984. p. 30).

Although numerous definitions of emotionally disturbed/behaviorally disordered children have been proposed in the last twenty years, one definition in particular has had a significant impact on public policy. This definition is the one proposed by Bower (1969). He defined emotionally handicapped children as those exhibiting one or more of five characteristics to a marked extent and over a period of time:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers

3. Inappropriate types of behavior or feelings under normal conditions
4. A general, pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms, pains, or fears associated with personal or school problems.  
(Bower, 1969, pp. 22-23 as cited in Kauffman, 1981. p.20)

The United States Federal Government, under Public Law 94-142, adopted Bower's definition with some modifications. Instead of using the label "emotionally disturbed", the U.S. government added "seriously emotionally disturbed". Not only do children have to exhibit one or more characteristics to a marked degree over a long period of time; these characteristics must also "adversely affect educational performance". In addition to the five characteristics described by Bower, the federal definition includes the following:

*The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.*

(Education of Handicapped Children, Federal Register, §  
Section 121a.5, 1977 as cited in Bower, 1982. p. 55)

The modifications of Bower's definition have been severely criticized on the grounds that we should be serving emotionally handicapped children before they become "seriously" disturbed,(Bower, 1982) and that adding terms such as schizophrenic and autistic are unnecessary since such children obviously would exhibit at least one of the five characteristics to a marked extent and over a long period of time (Kauffman, 1981).

#### **Newfoundland Definitions**

The Department of Education for Newfoundland and Labrador have made a sincere attempt to consistently define behaviorally disordered children throughout the Province. In their policy manual for the "Services for Behaviorally Disturbed Children" (1986), they use the definition proposed by Bower(1969). They also specify fairly detailed procedures for assessing whether a child actually has these characteristics. These procedures include documented information from a variety of sources. To reduce the chance of subjective identification of the child by one source, there must be consistency in pointing a student's inappropriate behaviors between at least three sources. Documentation of children defined as behaviorally disturbed must be presented to the

Department of Education in Newfoundland and Labrador before an educational therapy unit is allocated. A minimum of four children are needed to satisfy the requirements for a unit within a school.

Although the procedures outlined by the Government of Newfoundland and Labrador are not without problems, they represent one of the best efforts to deal with the problems of definition and identification. A study of Newfoundland and Labrador services for behaviorally disordered children is therefore likely to provide a valuable contribution to this broader field of research.

### The Nature of Students "At Risk"

#### Prevalence

A reasonable estimate of the percentage of behavior disordered students who need special education, appears to be in the range of three to six percent of the student population (Kauffman, 1989).

A longitudinal study by Rubin & Balow (1978) found that in any given year, about twenty to thirty percent of the children were considered by at least one teacher to be a problem. In this same study, eleven percent of the boys and

three and one-half percent of the girls (for an average of 7.4 percent) were considered a problem by every teacher who rated them over a period of three years.

A variety of studies point to similar findings. Most children and adolescents display seriously disturbing behavior at some point during their development. Also, more than two percent of school-age children exhibit disordered behavior consistently, over a period of years.

#### Sex of Behavior Disordered Children

McIntyre (1989) reports that five times more boys than girls are identified as having emotional/behaviorial disorders.

Numerous studies have indicated that boys outnumber girls consistently across many forms of behavioral disorders (Campbell & Werry, 1986; Prior & Werry, 1986; Quay, 1986; Schlosser & Algozzine, 1979; Schultz, Salvia, & Feinn, 1974;). Depending on the type of disorder and nature of the study, ratios varied from as low as 1.7 to 1.0, to as high as 10. to 1.

Boys generally outnumbered girls for acting out and more aggressive and immature behavior (Cullinan, Epstein & Kauffman, 1984; Schultz et al, 1974; ). Schultz, Salvia, &

Feinn (1974) found that 36 of the 55 behaviors on the Behavioral Problem Checklist were more prevalent in boys.

Despite this general finding it is helpful to look at the behaviors that do not differ between males and females and those for which females outnumber males.

Schultz et al. (1974) found that boys and girls did not differ on fourteen symptoms, in particular those related to anxiety and withdrawal. More recent research supports these findings, that sex differences are minimal for anxiety-withdrawal disorders (Kauffman, 1989; Quay & LaGreca, 1986).

Girls were rated significantly more frequently than boys on five symptoms, generally demonstrating more neurotic forms of behavior (Salvia, et al., 1974).

Overall, when behaviors are clustered into complete syndromes to form a specific disorder, females outnumber males on only one disorder, that being anorexia nervosa (Kauffman, 1989).

Although this study is limited to third and fourth grade students, other research supports the finding that boys' behaviors are viewed as more disturbing. Schlosser &



Algozzine (1979) found that classroom teachers rated prevalent behaviors in boys as significantly more disturbing.

### Classification Systems

Although one does not want to encourage the labelling of children, it is important to identify common features of their behavior for education, therapy and research purposes.

Research and intervention in the area of behavior disorders has long been hindered because no one classification system has been adopted in the field. As a result, one of the primary problems associated with the research on behaviorally disturbed children is the number of differing classification systems used. While many of the classification systems available have similar characteristics, it is generally observed that most "systems" reflect the setting and theoretical background of the individual classifying. In an attempt to bring more objectivity to these classification systems, researchers such as Quay (1986) are using multivariate statistical techniques to investigate the interrelations among deviant behaviors and to define and clarify these behaviors into distinct categories.

Quay's (1983) approach to classification has received a great deal of support in the last decade (Kauffman, 1981;

Clarizio and McCoy, 1983; Center, 1989; Epstein, Kauffman, Cullinan, 1985). It is a reliable and empirical approach based on the analysis of clusters of behaviors derived from the data of children seen in hospitals, clinics and schools (Center, 1989; Quay and Werry, 1986; Kauffman, 1989). Each cluster of behaviors that occur together and form a pattern is given a name descriptive of the behavior disorder identified.

Quay's classification system has been criticized because of its emphasis on broad dimensions. Clarizio and McCoy (1983) note that this approach makes it very difficult to conclude which particular behaviors can be modified by a particular treatment. Another limitation of Quay's system is that it does not differentiate between severe behavior disorders such as childhood schizophrenia and infantile autism. Other disorders such as anorexia nervosa, do not seem to fit into Quay's system. Like other classification systems, this one relies on reports of children's behavior by concerned adults and may tell us more about their perceptions than about the child's actual behavior.

While numerous other systems can be found in the literature, Quay's analysis appears to be one of the most comprehensive and encompassing of those available. The

following pages outline the six most prevalent behavioral clusters and their characteristic behaviors.

### **Undersocialized Aggressive Conduct Disorder**

The first dimension, undersocialized aggressive conduct disorder, has emerged consistently and has well validated, easily observable characteristics.(Quay, 1986). The most frequently associated behaviors are those generally considered as aggressive, disruptive and noncompliant. A complete description of the characteristics associated with this disorder are outlined below.

#### **Characteristics**

Fighting, hitting, assaultive

Disobedient, defiant

Temper tantrums

Destructiveness

Impertinent, "smart," impudent

Uncooperative, resistant, inconsiderate, stubborn

Attention seeking, "show-off"

Dominates, bullies, threatens

Disruptive, interrupts, disturbs others

Boisterous, noisy

Irritability, "blows up" easily

Negative, refuses direction  
Restless  
Untrustworthy, dishonest, lies  
Hyperactivity

### **Socialized Aggressive Conduct Disorder**

The second pattern of behavior labeled socialized aggressive conduct disorder is characterized by the involvement of peers in illegal and norm-violating behavior. Quay (1986) suggests that it is mainly a phenomenon of older childhood and adolescence. Specific characteristic behaviors are outlined below.

#### **Characteristics**

Has "bad" companions  
Truant from school  
Truant from home  
Steals in company with others  
Belongs to a gang  
Is loyal to delinquent friends  
Stays out late at night  
Steals at home  
Lies, cheats

## **Attention Deficit Disorder**

The third syndrome, Attention Deficit Disorder, earlier labeled Immaturity by Quay (1979), is defined by problems in concentration and attention, impulsivity, lack of perseverance, clumsiness, and passivity. It has also emerged frequently throughout studies in the literature. Quay (1986) notes that although hyperactivity appears on this dimension, it is not central, and behaviors associated with motor underactivity are more frequently evident. A complete characteristic description of this disorder is outlined below.

### **Characteristics**

Poor concentration, short attention span, inattentive, distractable

Daydreaming

Clumsy, poor coordination

Preoccupied, stares into space

Passive, lacks initiative, easily led

Fidgety, restless

Fails to finish tasks, lack of perseverance

Sluggish, lazy

Impulsive

Lacks interest, bored

Hyperactive

Drowsy

### **Anxiety - Withdrawal - Dysphoria**

The second most frequently appearing syndrome is now labeled Anxiety-Withdrawal-Dysphoria. Internalizing behaviors such as anxiety, fearfulness, shyness, social withdrawal, self-consciousness, and crying define this disorder. Other salient characteristics of this disorder are outlined as follows:

#### **Characteristics**

Anxious, fearful, tense

Shy, timid, bashful

Depressed, sad, disturbed

Hypersensitive, easily hurt

Feels inferior, worthless

Self-conscious, easily embarrassed

Lacks self-confidence

Easily flustered

Cries frequently

Aloof

Worries

The four syndromes described thus far are refined examples of the dimensions originally described by Quay (1979). These four well known categories are empirically sound and well documented. Recently, two additional dimensions have emerged labeled Schizoid-Unresponsive and Social Ineptness. Because they have not emerged as frequently as the others four dimensions, these two classifications are not as firm empirically.

### **Schizoid - Unresponsive**

Schizoid-unresponsive is characterized by general unresponsive behaviors. Quay (1986) suggests that the unresponsiveness evident in this pattern is not limited to peer relations, and may represent the extreme of the introversion personality. One may also compare it to Schizoid Disorder in the DSM III classification system. The following outline indicates the behaviors clustered within this dimension.

#### **Characteristics**

Won't talk

Withdrawn

Shy, timid, bashful

Cold and unresponsive

Lack of interest

Sad

Stares blankly

Confused

Secretive

Likes to be alone

### **Social Ineptness**

Social Ineptness is defined by poor peer relations without accompanying anxiety, depression, or generalized unresponsiveness. Quay (1986) suggests that this pattern in children may only be a reflection of a limited repertoire of social skills and may not need to be considered a behavior disorder. The following provides the principle characteristics associated with this disorder.

#### **Characteristics**

Poor peer relations

Likes to be alone

Is teased, picked on

Prefers younger companions

Shy, timid

Stays with adults, ignored by peers



Two other dimensions that have been found in a few studies are Psychotic Disorder and Motor Overactivity. Quay (1986) explains however, that the relatively low prevalence rate of childhood psychosis makes it difficult to clarify by statistical analysis.

### Psychotic Disorder

Psychotic Disorder is characterized by extreme deviation from normal patterns of thinking, feeling and acting. Some researchers (Center, 1989) go on to divide the disorder into two groups, distinguishable mainly by age of onset: *infantile autism* (diagnosed prior to thirty months of age); *childhood schizophrenia* (diagnosed after thirty months). Quay (1986) suggests there is some support statistically for the distinction of two separate syndromes. Specific characteristics of this disorder are outlined below.

#### Characteristics

Incoherent

Repetitive speech

Bizarre, odd, peculiar

Visual hallucinations

Auditory hallucinations

Strange ideas, behavior

### **Motor Overactivity**

The Motor Overactivity dimension is characterized by excessive motor activity that is accompanied by attentional or conduct problems. The following describes the principle characteristics of this disorder.

#### **Characteristics**

Restless, overactive

Excitable, impulsive, can't wait

Squirmy, jittery

Overtalkative

Hums and makes other odd noises

### **Services Provided for Behavior Disordered Children in Canada**

Over the past fifteen years, education and treatment of behavior disordered children have undergone dramatic changes. A great deal of concern has been focused on the unnecessary segregation of all handicapped pupils, including those labeled behavior disordered. Placement in an educational setting that is the least restrictive environment has been one of the guiding principles that have dramatically changed the

educational service delivery system. Behavior disordered students are presently being served in a "continuum" of placements including special schools, special classes, resource rooms, and regular classes. (MacMillan & Kavale, 1986).

In the last three decades, provision of services for behavior disordered children in Canada has rapidly unfolded. This development is attributed to a number of provincial and national reports stressing the need for educational services (Csapo, 1981; Winzer, 1987). The CELDIC Report, Commission of Emotional and Learning Disorders in Children, ( Roberts & Lazure, 1970) recommends that local educational authorities assume responsibility for the education of all children within their jurisdiction. The SEEECC Report, Standards for Education of Exceptional Children in Canada, (Hardy, McLeod, Minto, Perkins, & Quance, 1971 ) recommends government support for the training of personnel, research development, and the overall improvement of facilities for children with problems. The report also recommends that teachers of exceptional children have the following competencies: knowledge of children with behavioral and social disorders; a minimum standard of performance in diagnosis and prescriptive teaching; the ability to develop and implement appropriate

programs in dealing with the problems of behavior disordered children (Csapo, 1981).

Following these reports, Csapo (1981) studied the extent of public school services for emotionally disturbed children in Canada. This study involved a 19-item questionnaire which was sent to the Director of Special Education or its equivalent in the Departments of Education of the ten provinces and two territories. The most frequently occurring mode of service delivery was found to be the special class, resource room, and homebound instruction. However, Csapo suggests that this mode of service delivery is changing with many provinces aiming to maintain the behavior disordered child in the regular classroom with support services.

At the time of Csapo's study, Newfoundland was not one of the six jurisdictions which reported the existence of an official definition of emotional disturbance. In terms of terminology used, Newfoundland was one of six jurisdictions that favored the term "severely emotionally disturbed". The types of services provided by Newfoundland for these children included: the special class, resource room, academic tutoring, guidance counselling, school social worker, psychiatric consultation, and payment for private school program. At that time, the maximum number of children in a special class was

six. When a resource teacher was involved a case load of 1:4 was recommended. Newfoundland was reported to have special education qualification requirements for specially trained teachers and that this training was available in the province.

Since this report in 1981, the Department of Education in Newfoundland and Labrador has attempted to make some major changes in its policy concerning the servicing of emotionally disturbed children. In the following section, Newfoundland's policy for serving behavior disordered children and the philosophy underlying these policies, will be discussed.

### Newfoundland Policy

Special Education salary units for "behaviorally disturbed" (note the terminology change since 1981) students in Newfoundland and Labrador are distinguished from other special education units by the term "educational therapist". A need to distinguish educational therapists' roles from other personnel roles such as those of teachers and guidance counsellors, arises from the philosophy and aims of the service the therapist provides. The principal aim for these services is to retain the behaviorally disturbed student in the mainstream of the regular program (Government of Newfoundland and Labrador, Department of Education, 1986).

Although providing "least restrictive" services and mainstreaming may be said to be the goal of many special education programs, the focus of their services is mainly on academic remediation. The focus of the services provided by educational therapists is "behavioral change".

The philosophy or rationale surrounding the educational therapist position is found in an article by Smerdon and Butt (1985). In this article, "A Working Model for Students Who Don't", Smerdon and Butt describe a successful pilot project of the Terra Nova Integrated School Board designed to meet the needs of behavior disordered children. They suggest that if these children are to be served by the school, school boards need teachers who are trained to cope with emotionally maladjusted children and the "resource personnel (educational therapists) who work directly with the identified students also need specific and detailed training in behavior change methodology" (Smerdon & Butt, 1985. p. 81).

Although these children are not achieving academically, Smerdon and Butt suggest that they are cognitively able to achieve and therefore do not need "special education" in the traditional sense. They suggest that the children need to participate in the regular school setting and be taught with their peers, while at the same time, receive counselling from

the educational therapist. Besides working individually with the child, the educational therapist would also serve as a consultant in designing classroom programs with teachers and administrators, to accommodate students.

At the present time, the service delivery model proposed by the Government of Newfoundland and Labrador is basically that of a resource person who provides therapy to the behavior disordered child while at the same time consults with teachers, administration, family and any significant others in the child's life. This type of service delivery model has not always been favored by professionals. In the past, regular classroom teachers' attitudes toward mainstreaming these students have been decidedly negative (Beare, 1981). When regular and special educators were asked to rate the acceptability of treatment alternatives for behavioral disorders they ranked self-contained special education classes the highest and counselling second (Epstein, Matson, Repp, & Helsel, 1986). However, this study failed to offer variations of special education placement such as the resource room. It will be important to find out how behavior disordered children are actually placed in the schools and what type of service delivery model is preferred by the therapists.

### Specific Interventions

The literature on behavior disorders discusses a variety of different methods of treatment. Despite the variety of treatments reviewed, it is commonly agreed that;

*" the decision of which therapy is best for a particular patient(student) remains a critical issue in the field of behavioral disorders"*

(Algozzine & Lee, 1981).

Most researchers also agree with Winzer (1987) who notes that;

*Methods of intervention for these children have been largely developed according to various theoretical perspectives. No one method has proven effective for all emotionally disturbed children. Indeed, a consensus on intervention is as elusive as a universal definition of the problem.*

(Winzer, 1987, p. 398)

Although the placement of behavior disordered students is an important consideration, it is even more important to understand what is being done for such children regardless of the setting. There are several intervention approaches



designed to alter problem behavior. The therapies usually fall under five categories represented by the corresponding conceptual models: (1) medical, biogenic or biophysical, (2) psychoeducational, sociological approaches, (3) psychodynamic, (4) ecological, (5) behavioral (Kauffman, 1981; MacMillan & Kavale, 1986; Winzer, 1987). These categories are described below.

### **Biophysical/Biogenic Model**

This model assumes that psychopathology/behavior disorders are caused by CNS dysfunction or some physiological flaw within the individual. Genetic factors, brain dysfunction, food allergies and biochemical imbalance are examples. A further assumption of this model is that disordered behavior can be brought under control through physiological means such as drugs and diet (Kauffman, 1989; MacMillan & Ravale, 1986).

### **Psychodynamic**

The psychodynamic model is based to a large extent on the tenets of psychoanalytic theory. It assumes that disordered behavior is a symptom of underlying mental problems representing imbalances in the child's personality (Kauffman, 1989). These mental problems are believed to be the results of difficulties during a child's early development.

A great deal of importance is placed on understanding the unconscious motivation for behavior. It assumes that intervention cannot be successful until this underlying unconscious conflict is understood. Individual psychotherapy is the preferred treatment.

### **Behavioral**

The behavioral approach has two major assumptions: it considers the behavior itself to be the major issue, and it assumes that behavior has been learned. Disordered behavior is viewed as inappropriate learned responses. Interventions within this model rely on learning principles to teach more appropriate behavior. The manipulation and change of environmental antecedents or consequences are important components of this approach (Kauffman, 1989; MacMillan & Kavale, 1986).

### **Psychoeducational Approach**

The psychoeducational approach is similar to the psychodynamic model in that it is also concerned with unconscious motivations and underlying conflicts. However, it differs in its approach to intervention. The psychoeducational approach does not view the necessity of resolving and

understanding unconscious motivations developed in the past. It deals with what is happening with the individual in the present. Emphasis is on the child gaining insight into their present behavior and changing it to more appropriate behavior in future situations.

### **Ecological Approach**

The ecological approach emphasizes the interrelationships between individuals and their environments. Disturbance is believed to be the result of a mismatch between the individual and the ecosystem in which he resides. The emphasis is not placed on the individual's behavior itself but on the entire ecosystem as a whole. Intervention is directed at all of the facets of the child's milieu and emphasizes behavioral and social learning concepts.

### **Prevalence of Intervention Approaches**

MacMillan and Kavale (1986) note that intervention methods used with behavior disordered students vary greatly. They point to the difficulty of obtaining reliable estimates regarding the prevalence of approaches because of the move towards educating behavior disordered children in the least restrictive environment. As a result, "prevalence estimates of

the different intervention strategies can be made reliable only from special classes for the behavior disordered."

MacMillan and Kavale (1986), in their review of prevalence studies, suggest that the trend in educational treatment of behavior disordered students is towards more behavioral interventions as opposed to those psychodynamically oriented. At the same time, they indicate that two other classifications, psychoeducational and eclectic interventions, have emerged as being very popular. Both of these interventions use components of the other theoretical models and are not 'pure' in that sense. They note:

*"The large percentage of programs that fall within an eclectic (including psychoeducational) classification suggests that educational programs for behavior disordered students more often than not do not fall clearly within the parameters defined by any single theoretical model. The theoretically "pure" program is represented in only a minority of programs." (p. 591).*

### **Counselling Therapies and Techniques**

Counselling has been defined as a process "to help individuals toward overcoming obstacles to their personal growth, wherever these may be encountered and toward

achieving optimum development of their personal resources." (American Psychological Association, Division of Counselling Psychology, Committee on Definition, 1956, p. 283 as cited in Thompson & Rudolph, 1988).

Thompson and Rudolph (1988) offer a working definition of counselling:

*"Counselling is a process involving a relationship between two people who are meeting so that one person can help the other to resolve a problem. One of these people, by virtue of his or her training, is the counsellor; the person receiving the help is the client."* (p. 13)

Thompson and Rudolph (1988) note that numerous therapies and techniques as well as combinations therein are addressed in the counselling literature. The following section outlines the major counselling therapies highlighted in the literature as well as an overview of their methodological focus.

### **Reality Therapy**

William Glasser was the founder of reality therapy. This therapy focuses on the client learning more effective behavior

to meet his/her present social and emotional needs. The method is well-defined and involves the following steps: (1) establishing a relationship with the client; (2) examining the client's present behavior; (3) helping the client evaluate present behavior by determining if it is helping them get what they want out of life; (4) developing plans for alternate behavior; (5) getting the client to commit himself to one of the plans; (6) evaluating the results of the commitment; (7) providing logical consequences for client's behavior; (8) continue to work with the client through the preceding steps.

### Person-Centered Therapy

The founder of person-centered therapy was Carl Rogers. Person-centered therapy is based on the assumption that clients have the potential, and therefore should have complete responsibility for their own personal growth. It is a non-directive approach in which counsellors use the following methods: (1) active and passive listening; (2) reflection of thoughts and feelings; (3) clarification; (4) summarization; (5) confrontation of contradictions; and (6) general or open leads that help client self-exploration (Thompson & Rudolph, 1988, p. 67).

### **Gestalt Therapy**

The founder of gestalt therapy was Fritz Perls. This therapy is experiential, stressing the individual's awareness of the here and now and teaching them to assume responsibility for themselves. An emphasis is placed on the integration of the person's inner state and behavior so that they may give full attention to meeting their needs appropriately. It offers a range of techniques and methods to help individuals experience the present and become aware of their feelings (Corey, 1986; Thompson & Rudolph, 1988).

### **Rational-Emotive Therapy**

Albert Ellis was the founder of rational-emotive therapy. The theory underlying this approach is based on the assumption that an individual's thinking and belief system is at the root of his personal problems. The two main goals of rational-emotive therapy are: (1) to show individuals how their irrational beliefs and attitudes are creating problems for them, and (2) to teach them how to rid themselves of these beliefs and replace them with rational ones. This method of counselling is direct, didactic, confrontational, and verbally active. Therapeutic strategies are typically eclectic.

### **Cognitive Behavior Therapy**

The cognitive behavioral approaches developed by Maultsby, Beck and Meichenbaum share the underlying assumption of Ellis' original work, that a reorganization of one's self-statements will result in a corresponding reorganization of one's behavior (Corey, 1986). These approaches are distinguishable mainly by the techniques they use to help individuals change their thoughts.

### **Behavioral Counselling**

Key figures associated with the development of behavioral therapy include Ivan Pavlov, John B. Watson, Edward Thorndike, Edward C. Tolman, Joseph Wolpe, L. Krasner, and Arnold Lazarus. The individual most noted for translating the theories of other behaviorists into an applied and useful technology was B. F. Skinner. (Corey, 1986; Thompson & Rudolph, 1988).

Behavioral therapy is based on learning principles and assumes that all behavior is learned and can be relearned. Basically, effective behavior is reinforced while maladaptive behavior is extinguished. Behavioral therapy includes several techniques and is used with both covert processes, such as



cognitions and emotions, as well as traditional overt behavior problems. Methods include contingency contracting, shaping, biofeedback, modeling, token economies, systematic desensitization, hypnosis, flooding, counterconditioning and aversive conditioning (Thompson & Rudolph, 1988).

### Psychotherapy

The key figure associated with psychotherapy was Sigmund Freud. The primary goal of psychotherapy is to make the unconscious, conscious. Several methods are used to unveil repressed material. The five basic techniques are (1) free association; (2) interpretation; (3) dream analysis; (4) analysis of resistance, and (5) analysis of transference (Corey, 1986).

Play therapy is a technique similar to free association. It is used with children younger than twelve years because of their limited cognitive development and ability to verbalize their thoughts and feelings. Through nondirective free play, children reveal the types of interactions in their lives; they are able to express feelings they are otherwise unable to verbalize; they can act out feelings of anger and hostility constructively; and it can be an effective method for teaching social skills (Thompson & Rudolph, 1988). Thompson and

Rudolph also include bibliotherapy and storytelling as psychotherapeutic techniques for children.

### **Transactional Analysis**

The founder of transactional analysis was Eric Berne. Transactional analysis is best described by Corey (1986) as:

*“. . . an interactional psychotherapy that can be used in individual therapy but that is particularly appropriate for groups. This approach is set apart from most other therapies in that it is both contractual and decisional. It involves a contract developed by the client, that clearly states the goals and direction of the therapy process. It also focuses on early decisions that each person makes, and it stresses the capacity to make new decisions. Transactional analysis emphasizes the cognitive, rational, and behavioral aspects of personality and is oriented towards increasing awareness so that the client will be able to make new decisions and alter the course of his or her life.” (Corey, 1986, p. 149).*

Transactional analysis has a vocabulary of its own and is full of terms, diagrams and models. Teaching techniques are

used to help clients understand the principles of transactional analysis so that they can use them to improve their own behavior. Concepts taught through transactional analysis include: (1) definition and explanation of ego states; (2) analysis of transactions between ego states; (3) positive and negative stroking; (4) I'm OK, You're OK; (5) games and rackets; (6) scripts (Thompson & Rudolph, 1988, p. 179).

### Adlerian Therapy

The key figure associated with Adlerian therapy was Alfred Adler. One of the basic assumptions underlying this therapy is that clients are having problems because of their faulty beliefs and goals. The therapist looks for what is wrong with the client's thinking or "private logic", and helps them change how they feel and behave.

The therapeutic process has four stages:

- (1) establishing the proper therapeutic relationship;
- (2) exploring the dynamics operating in the client through analysis and assessment;
- (3) encouraging the development of self-understanding (insight);

(4) helping the client make new choices (reorientation).

(Corey, 1986).

Adlerian therapists choose a variety of methods to complete this process.

### **Family Therapy**

There are several different theorists associated with family therapy and there are as many types of family therapies as there are therapists.

A common assumption among the various family therapies is that families consist of interdependent parts and when one part has a problem the entire system is adversely affected. It is necessary to treat the whole family if change is going to be effective and long lasting.

Family therapy is often divided into two schools: structural family therapy and strategic family therapy.

In structural family therapy, the goal is to change the family's organizational structure as a way of resolving the identified problem.

Strategic family therapy is based on the assumption that symptoms of disordered behavior are developed and maintained by the family's ineffective problem solving ability.

Virginia Satir based her family therapy on the assumption that families have problems because of poor communication. Her goal is to teach families better communication skills so that they may resolve conflicts more effectively.

Techniques used by family therapists are borrowed from other therapies previously discussed.

### **Group Counselling**

The theories and principles of various individual therapies can be applied to group counselling. Group therapy is different from individual therapy in that it provides direct opportunities for children to unlearn inappropriate behaviors and learn new ways of relating to others through interaction and feedback in a safe, practice situation with their peers (Thompson & Rudolph, 1988).

Four types of groups described by Thompson and Rudolph (1988) include:

- (1) The common-problems group consisting of children working on the same difficulty. Examples of this are weight problems, family divorce.
- (2) The case-centered group consisting of children working on different problems. Each child has the opportunity to receive the group's full attention to his or her problem.
- (3) The human-potential group provides an opportunity for children to develop their positive traits and strengths. It focuses on building stronger self-concepts in children.
- (4) The skills-development group is directed to specific behavior and skills such as assertiveness and communication. (adapted from p.260).

In summary, one would hope that the services offered by individual therapists would depend on the nature of the child's problem. However, as Kestenbaum points out:

*"Type of treatment has typically been shaped to the theoretical orientation of the therapist; it is not always based on methodological study of all the*

*neurological and psychological deficits in a particular child."*

(Kestenbaum, 1978 as cited in Algozzine & Lee, 1982 p.359)

### Who Are Serving Behaviorally Disturbed Children?

#### Role

Smerdon and Butt (1985) provide a description of the therapist's role as follows:

*The work of the Educational therapist is varied. Because of the low student ratio, the Educational therapist has ample time to develop complete behavior change programs for maximum effectiveness: the Therapist sees the students for individual and group counselling, is able to provide long-term family counselling services and works extensively with other agencies, such as Social Services, R.C.M.P., medical personnel and others in the helping professions. Through efforts with other agencies, a healthy and functioning "team approach philosophy" to problem children prevails in the area..."*

(Smerdon & Butt, 1985 p.82)

### Training and Background

The CELDIC Report (1970) in emphasizing a coordinated effort between professionals dealing with behavior problem children has implications for the training of specialists working with these children. Because communication between different service systems is believed to be essential, the report recommends that professionals in this field should receive training that cuts across or at least combines different disciplines. For example, professionals who are trained in education could do field placements in a hospital or correctional setting. The report also recommends inter-disciplinary seminars. Inter-disciplinary training is suggested to benefit the communication between consulting professionals. Specific training in consultation techniques as well as techniques for communicating specifically with parents are recommended. In order to be more specific about training needs, the report recommends an examination of the training and development of existing personnel as well as a closer look at specific job descriptions to determine the training appropriate. The CELDIC report represents a shift in thinking, not unlike that found in other areas of special education. It is a move which requires a team approach that includes professionals from a variety of disciplines who serve



as consultants to each other and whose main function is to help teachers and parents more effectively meet the needs of these children.

Obviously, a person who is offering the services suggested will need training in specific areas. Originally, the Terra Nova Integrated School Board advertised for individuals with the following qualifications:

1. a master's degree (or equivalent) in counselling.
2. a good background in psychology (at least a major at first degree level)
3. a strong emphasis on a variety of behavior change techniques
4. good experience in working with children who exhibit maladaptive behaviors.

(Smerdon & Butt, 1985 p.82)

Because the demand for educational therapists exceeds the supply of professionals with a Master's degree, the Department of Education for Newfoundland and Labrador has indicated qualifications in the form of the following competencies:

1. Assessment and diagnostic skills in cognitive and personality areas of behavior.

2. A high level of counselling/behavior change skill preferably encompassing a variety of counselling techniques rather than adherence to one particular "school" or method.
  3. Good consulting skills with parents and colleagues in schools as well as from other professions.
  4. The ability to write clear and relevant reports of all interventions and maintain records of all interventions with students which can be passed without additional information to other similarly qualified personnel.
- (pp.4, 5)

The policy does suggest that a Master's degree with the above competencies should be regarded as the "desirable minimum qualification". (p.5). It also goes on to say the following: "... initial training as a teacher with particular emphasis on courses dealing with exceptionalities, and a variety of classroom management strategies is desirable". (p.5).

The competencies listed by the Department of Education are directly related to the services and responsibilities outlined for the therapist. These include the following:

1. Identification and diagnosis of children with behavioral problems.
2. Individual child counselling with children in the unit and referred children. This includes therapy, advocacy, psychoeducational assessment, and record keeping.
3. Supporting the school staff including: consultation with teachers, crisis intervention, provide classroom management, and provide in-service education.
4. Family Consultation including: consulting with the parents, assessing the home situation, providing family therapy where needed, providing liaison between the home school and community.
5. Community liaison. (pp. 6-14).

These responsibilities give one a view of the services deemed desirable for behavior disordered students by the Government of Newfoundland and Labrador. However, research of policy is only one step: research of actual practices must follow.

Whether or not a therapist can fulfill the responsibilities outlined in the policy will clearly depend on

the extent and type of training he/she has received. In a study by Beare & Lynch (1983) the respondents indicated that their most pressing problem in delivering services to behavior disordered students was a lack of trained personnel. It is important to discover areas of training that therapists' believe are desirable in order to enhance their services. It is also important to find out the therapists' perceptions of the adequacy of their present training.

### Teachers Perceptions of Training Needs

#### Teacher Competencies

In the literature, most of the specialists working with behavior disordered children in the school system are special education teachers. Rizzo and Zabel (1988), in their discussion of training issues, suggest that special education teachers should receive training for regular classroom teaching for the following reasons: (1) Most behavior disordered children spend at least some time in the regular classroom; (2) Most of these students come out of the regular classroom for special help but the goal is to return them to the regular class. In order to effectively mainstream behavior disordered children, special educators must be familiar with the regular

education environments. Rizzo and Zabel (1988) summarize their recommendations by noting:

*"They must be knowledgeable about normal patterns of cognitive, physical, and social child development, about academic curricula and grade and age level expectations. In addition, they must be able to communicate with regular educators."*  
(p. 289).

Hewett (1967) also suggested that a background in regular education should be a prerequisite to special training.

Most literature on the topic of special competencies for teaching students with behavioral disorders has consisted of the opinions of special education teachers or teacher educators. In one study, Mackie, Kvaraceus and Williams (1957), (as cited in Rizzo & Zabel, 1988), asked seventy-five teachers to rate the importance of eighty-eight competencies for working with socially and emotionally maladjusted children. The following six areas of competencies were rated as being "very important" :

- (1) Knowledge and ability to establish and operate stimulating, flexible, tension-free classrooms capable of meeting a child's individual needs.

- (2) Ability to use differential diagnoses and to interpret psychological tests, reports, and case histories.
- (3) Ability to counsel students with regard to their attitudes and problems.
- (4) Ability to manage a child's individual social behavior and develop self-control.
- (5) Knowledge of the causes of behavior problems and of students' psychological needs.
- (6) Ability to work with other professional groups.

(Rizzo & Zabel, 1988, p. 291).

Polsgrove and Reith, (1979), as cited in Rizzo and Zabel (1988), devised a comprehensive list of 138 competencies which were rated for importance by special education teacher educators. The competencies were divided into seven categories: assessment, behavioral management, communication/consultation, personal, instructional, administrative, and cognitive. The following list provides the competencies most highly regarded by the teacher educators.

### **Assessment competencies.**

1. Correctly selects, administers, and interprets various informal and standardized instruments for assessing students' social performance (e.g., behavioral checklists, sociograms, anecdotal records).
2. Correctly administers and interprets various informal measures of students' academic performances (e.g., criterion-referenced measures, teacher-made tests, permanent-product information).
3. Uses appropriate informal and formal observation systems/techniques for collecting data on students' academic and social behavior.
4. Selects appropriate academic and social behaviors for intervention programs with students.
5. Uses assessment information to place students in appropriate instructional sequences.
6. Realistically appraises influence of situational variables that may affect an intervention program.

### **Behavioral management competencies.**

1. Arranges antecedent and consequent stimuli to change behavior in desirable directions.
2. Can establish and maintain a structured learning environment for students.

3. Uses various strategies for developing students' self-control.
4. Designs, implements, and evaluates effective behavior management programs for students.
5. Selects and successfully employs appropriate management strategies in various situations.
6. Arranges physical environment to facilitate management possibilities.
7. Selects appropriate reinforcers for use in motivating students.
8. Designs management programs to facilitate generalization and maintenance of acquired behaviors.

**Communication/consultation competencies.**

1. Establishes and maintains open communication with students, other teachers, administrators, and parents.
2. Follows proper legal procedures regarding assessment, placement, programming, and consultation with parents and other professionals.

**Personal competencies.**

1. Remains calm in crisis, inflammatory, or provocative situations.
2. Provides an acceptable model of self-control for students.



3. **Maintains flexibility** in managing students' behavior and in administrating their academic programs.
4. **Objectively evaluates** students' behavior.
5. **Expresses joy and enthusiasm** under appropriate circumstances.

#### **Instructional competencies.**

1. **Accurately analyzes** students' strengths and weaknesses in given areas for planning an instructional sequence.
2. **Adapts instructional materials** for meeting long- and short-term objectives.
3. **Provides effective individual and small group instruction.**
4. **Uses various strategies** (e.g., modeling, imitation, rehearsal, inquiry, prompting, cueing, feedback, consequence, discussion, lecture) in isolation or in combination for providing appropriate instruction for students.
5. **Selects and writes appropriate long- and short-term academic and social goals** based on assessment information.
6. **Selects appropriate placement** for students in instructional sequences based on assessment information.

7. Uses continuous assessment to modify instructional activities for meeting students' instructional needs.
8. Teaches personal development skills such as: self-control, self-help, communication, taking responsibility, self-confidence, problem-solving, aesthetics.

#### **Administrative competencies.**

1. Establishes and maintains a resource room, self-contained classroom, or residential school classroom and itinerant class for students.
2. Develops and implements appropriate IEP's for students.
3. Keeps appropriate records on students.
4. Functions as a member of a team for planning social and educational interventions with students.

#### **Cognitive competencies.**

1. Demonstrates knowledge of general child development.

(Rizzo & Zabel, 1988, pp. 294-295).

In the conclusion to Rizzo and Zabel's (1988) study, four major skill areas were noted as being necessary for teachers of emotionally disturbed/ behavior disordered children: (1) skill in establishing a structured classroom environment,

providing clear-cut expectations and limits, yet with flexibility in meeting the needs of students; (2) ability to work with other professions in the treatment process; (3) ability to effectively manage children's behavior; and (4) objectivity, warmth, tolerance, and emotional stability. (Polsgrove & Reith, 1979, p. 32, as cited in Zabel, 1988, p. 178).

Rizzo and Zabel (1988) suggest that the trend in the issue of teacher competencies has shifted from understanding or explaining behavior disorders to learning specific skills for effective intervention. They note however, that strategies for helping such students cannot be indiscriminately applied. They should be directed by an understanding of the student's behavior problems and needs.

### **Teachers' Perceptions of Training Adequacy**

One way of evaluating the adequacy of teacher preparation has been to survey practicing teachers on their perceptions of competence and the nature and value of their training. Zabel (1987), in reviewing Gersh and Nagle's (1969) work, found that teachers felt inadequate in educational diagnosis and remedial teaching. As well, they had difficulty applying behavioral controls and felt they did not have enough

experiences for practicing methods and techniques. In another study, Luthemeir (1983), as cited in Zabel (1987), found that just over half of the public school teachers for behavior disordered children rated their preparation programs as "adequate".

Kavale and Hirshoren (1980) attempted to evaluate teacher preparation programs by looking at the match between the theoretical focus of the training programs and the actual approaches used to treat behavior disordered students. They found that although the majority of teachers considered both their treatment focus and training program to be behavioral, their actual treatment program used techniques reflecting a variety of theoretical models. They concluded that university teacher training programs should reflect a more eclectic stance.

In summary it is useful to recognize that:

*"It is beyond the scope of any single course, practicum experience, or even entire teacher education program to fully prepare prospective teachers in all of the competencies necessary to be effective teachers of behavior disordered students. Different students, circumstances, environments, support services, and*

*teacher responsibilities will demand different personal and professional skills. In a very real sense, a teacher is never fully equipped to deal with every behavioral and instructional challenge posed by his or her students. There will always be new challenges for which teachers have not been fully prepared. The solution is ongoing acquisition and refinement of competence."*

(Rizzo & Zabel, 1988, pp. 293-294)

### **Categorical/Noncategorical Training**

Another major issue in the literature is whether or not teachers working with behavior disordered students should receive the same preparation and training as other special education teachers (Rizzo & Zabel, 1988; Zabel, 1987). Zabel (1987) suggests that there are valid arguments for both categorical and noncategorical teacher training. He recommends common introductory and supporting coursework in areas such as assessments, behavior management, individual educational programming, and working with parents. Once this is completed, teachers dealing with special populations such as behavior disordered children would be involved in more specialized categorical preparation related to this area.

Research by Carri (1985) supports the categorical preparation approach for at least parts of the training for teachers of behavior disordered students. Carri found that teachers of behavior disordered students viewed skills and competencies needed in the public schools as being different from those skills and competencies deemed necessary by teachers of the mentally retarded and/or learning disabled. A possible explanation provided for this difference was that teachers of behavior disordered children were more concerned with social-emotional adjustment of children than with the academic measurement process. Carri (1985) also noted that if teachers are not trained specifically in behavioral disorders they may be concentrating on academic tasks rather than concentrating on the social-emotional difficulties experienced by these children.

The Department of Education in Newfoundland and Labrador (1986) along with Smerdon and Butt's (1985) recommendations for a Master's degree (or equivalent) in counselling seem to be supporting a training approach that has more in common with counselling and psychology than with special education. It may be that the ideal training for 'teachers' or 'therapists' should have components from both programs.

## CHAPTER 3

### Methodology

#### Sampling Procedure

The sample for this study consisted of individuals employed under the title "Educational Therapist" in Newfoundland and Labrador. A list of all of the educational therapists employed at the time of the study in the Province was obtained from the Department of Education and each therapist was sent a copy of the research questionnaire. Of the seventy-five educational therapists, fifty-nine (78.7%) responded.

#### Method of Data Collection

Permission to conduct this study was sought by writing a letter (Appendix A) to the seventeen Superintendents of School Boards employing educational therapists. Once permission to conduct the study was received, a letter outlining the purpose of the study (Appendix B) and a copy of the research questionnaire (Appendix C) were sent to each educational therapist.

After the questionnaires had been in the schools for approximately two weeks, the researcher sent another letter and/or made phone calls to subjects, expressing the importance of participation in the study. They were asked to return all completed questionnaires as soon as possible. All questionnaires were collected before the end of June.

#### **Description of the Questionnaire**

The questionnaire used for this study was developed by the writer in consultation with her supervisors and a colleague whose thesis was also researching the position of educational therapist in Newfoundland and Labrador.

A number of specific questions relating to services provided by the educational therapist and the type of children served by the unit were devised, with the provincial guidelines on services to emotionally and behaviorally disturbed students in mind (Department of Education Policy Statement on the Educational Therapist Position in Newfoundland and Labrador Schools, 1986).

Other areas of interest, such as training and background of the therapist, specific approaches to intervention and specific types of behavior problems were generated from the



research questions discussed in Chapter 1 and as a result of a review of available literature.

The questionnaire encompassed the following primary areas:

- Demographics of the children served.
- The presenting problems of children served.
- Services offered by the therapists along with roles, duties and responsibilities.
- The intervention methods and techniques used to treat children.
- Demographics of the therapists involved.
- Training background and experience of the therapists.
- Perceptions of the therapists with respect to delivery models used.

The majority of the questions included on the questionnaire required the respondents to select a response from a number of different choices. A number of questions also required the respondents to fill in blanks with small amounts of information. Another method asked the

respondents to complete open-ended questions relating to the types of behavior problems exhibited by each child and the treatment used to help them. Two questions required ratings by the therapists.

### Scoring and Analysis of Data

#### Scoring

The scoring for the questionnaire involved assigning numeric values to each part of a question in order to code the data for computer analysis. Before they could be assigned a numeric value, the responses to open-ended questions relating to the specific types of behavioral problems exhibited by each child and the approaches to treating each child's problem(s) were categorized by the writer. The respondents' descriptors of problem behavior were classified according to Quay's (1986) classification system. Those responses that could not be classified by Quay's system were identified as "other." The respondents' descriptions of approaches used to help each core child were organized into categories of treatment whenever possible. These codes were then transferred to coding sheets and entered into a computer file for processing.

### **Analysis of the Data**

The data were analyzed using the Statistical Package for the Social Sciences (SPSSX).

The statistical analyses were mainly of a descriptive nature due to the type of questionnaire used. Frequency distributions were generated for the majority of questions and cross tabulations were calculated across age, gender, and behavioral types.

## CHAPTER 4

### Results and Discussion

This chapter presents a comprehensive analysis of the data gathered to investigate the five research questions outlined in Chapter One. In order to enhance readability and to focus on predominant patterns observed throughout the data analysis, the patterns will be discussed in light of past and present research in the field. The five questions will be analyzed in three sections dealing with the following: (A) The Children Served (B) How The Children Are Served and (C) Who Are Providing The Services?

#### The Children Served

##### Number of Children Served

The reported number of children served was three hundred and six (306). The mean number of core children in the respondents' units was 5.46. (range = 3 to 12). The mean number of referred children was 8.37. (range = 2 to 30). (One respondent actually claimed sixty six referred children. This subject was removed from the data).

**Age**

Of the children described by the respondents, 54.7% were between the ages of twelve and sixteen. Another 34.1% were between the ages of five and eleven. A complete summary of children's ages is found in Table 1

**Table 1**  
**Children's Ages**

<b>Ages</b>	<b>Number</b>	<b>(%) of Children</b>
5 - 8	42	13.8%
9 - 12	94	30.8%
13 - 15	105	34.0%
16 - 20	64	21.0%
Missing data	1	.4%
<b>TOTAL</b>	<b>306</b>	<b>100%</b>

**Grade**

A breakdown of students per grade is provided in Table 2

**Table 2**  
**Students Grade Level**

Grade	Number of Students	Percentage
K-3	57	18.6%
4-6	80	26.2%
7-9	109	35.7%
10-12	47	15.4%
Missing Data	13	4.1%
<b>TOTAL</b>	<b>306</b>	<b>100%</b>

These results indicate that a higher percentage of students in junior high school is receiving therapy services than in primary, elementary or high school. Further research is needed to determine if this period of adolescence is vulnerable for the development of behavior problems or if teachers perceive this age group to be particularly disturbing.

In comparing categories of disorders across grade levels there was a noticeable increase in the reporting of social ineptness and socialized aggressiveness as students moved up

in grade level. These problems may in fact be related. Students who find it difficult to socialize may find a certain level of acceptance in gangs and other anti-social groups. Educational therapists reported fewer undersocialized aggressive conduct disorders as well as attention-deficit disorders as students got older. Specific physical disorders (e.g., anorexia) were rated much more in junior high students than in elementary or senior high students.

### Sex

A large majority, 80.7%, of the students described by the respondents were male. These findings confirm previous research (Campbell & Werry, 1986; McIntyre, 1989; Prior & Werry, 1986; Quay, 1986; Schlosser & Algozzine, 1979; Schultz, Salvia & Feinn, 1974) that more boys than girls are identified as having emotional/behavior disorders.

In comparing categories of disorders between genders, it was noted that a much larger percentage of males were rated as having conduct disorders, attention-deficit disorders, as well as learning disabilities. Females were rated much higher in categories related to anxiety disorders, physical disorders (e.g., anorexia nervosa), and as well had much higher ratings than boys in the unknown category. These results are

consistent with current literature except in the case of anxiety-withdrawal disorders ( Kauffman, 1989; Quay & LaGreca, 1986).

### Type of Disorder

Respondents' descriptions of the children's behavior problem(s) were categorized using Quay's (1986) model. Table 3 provides a summary of the results.

These findings support existing evidence (Kauffman, 1989; Quay, 1986) that conduct disorder is among the most prevalent type of behavior disorder. The most common descriptors used by respondents to describe this disorder were: aggressiveness, temper outbursts, disruptive behavior, acting out, and attention seeking.

Consistent with Quay's (1986) findings, anxiety-withdrawal-dysphoria was the second most frequently appearing disorder. The most commonly used descriptors for this disorder were: depression, anxiety, withdrawal, poor self-esteem, and excessive crying.



**Table 3**  
**Student Behavioral Categories**

Disorder	Primary Problem		Secondary Problem	
	Number	Percentage	Number	Percentage
Undersocialized Aggressive Conduct Disorder	89	29.1%	6	2.0%
Anxiety Withdrawal-Dysphoria	50	16.3%	5	1.6%
Social Ineptness	27	8.6%	2	0.6%
Attention Deficit Disorder	26	8.5%	1	0.3%
Socialized Aggressive Conduct Disorder	22	7.2%	2	0.6%
Schizoid-Unresponsive	13	4.2%	0	0.0%
Motor Overactivity	5	1.6%	0	0.0%
Psychotic Disorder	2	0.6%	0	0.0%
Other*	72	23.9%		

- \* Refers to disorders that do not fit into Quay's (1986) classification system and/or descriptions that are too vague to categorize.

Quay's (1986) description of social ineptness pattern is characterized by poor peer relations without accompanying anxiety, depression, or generalized unresponsiveness. The descriptors more frequently used by respondents reflected a

limited repertoire of social skills. These included lack of social skills, social immaturity, socially inappropriate behavior, and inability to relate to peers. Exact descriptions of the specific behavior labeled 'socially inappropriate' or 'socially immature' would enable one to categorize these descriptions more effectively.

In this study, attention deficit disorder was the fourth most frequently occurring problem. A number of respondents labeled their children's problems as attention deficit disorder while others used descriptors such as: impulsive, inattentive, short attention span, unable to concentrate, highly impulsive and distractible.

Socialized aggressive conduct disorder was comprised of the following descriptions: young offender, delinquent behavior, stealing, trouble with the law, truancy, runaway, drugs and prostitution.

The disorder labeled schizoid-unresponsive was defined in this study by descriptors suggesting excessive withdrawal, schizophrenia, and elective mutism. Elective mutism is not a descriptor used by Quay (1986) but he compares this category of DSM III (1980) with his schizoid-unresponsive dimension.

There were only five children that fit the descriptions of the dimension motor overactivity. Three of these children were described as hyperkinetic, hyperactive and extremely hyperactive. Two other children were described as having Tourette's Syndrome.

Two children in this study were categorized under the dimension psychotic disorder. One child was described as having formal thought disorder while the other was described as having 'autistic-like' tendencies. Children with autism are generally served in classes for the mentally handicapped because of the severity of their problems.

A significant number of children could not be categorized because the descriptors used by the respondents were too vague. As many as 13.7% of the students were simply identified as having behavioral disturbance and/or emotional disturbance. Other vague descriptions included 'parental conflict - poor academic performance', 'emergent socialization, and independent decision-making'. There were other problems that could not be placed in Quay's (1986) system. They included personality disorder, anorexia nervosa, learning disability, sexual and physical abuse, and sexual identity problems.

### Degree of Severity

Degree of severity was measured on a three-point scale, ranging from mild to severe. The respondents rated 48.7% of the children's problems as being severe, 42.5% as moderate, and 8.2% as mild.

### Behavior Disordered Students with Learning Disabilities

Respondents were asked to give their perceptions whether students had a specific learning disability. The respondents indicated that 29.4% of the children appeared to have a specific learning problem. In comparing genders, many more males (31.2%) than females (22%) were rated as having some form of learning disability. These results are consistent with the general research on learning disabilities which would indicate a much higher frequency of learning disabilities in male children.

Learning disabilities and behavior disorders often occur together. Rizzo and Zabel (1988) discuss the learning difficulties associated with attention deficit disorder and also discuss personality and conduct problems associated with learning disabilities. It is difficult to determine whether one

causes the other but it is important to realize that problems in one area places a child at higher risk for the other. Therapists who view the learning problem as a significant contributing factor to the behavior disorder may decide that academic remediation is an important component of therapy.

### How The Children Are Served

#### Introduction

Educational therapists provide a variety of services for behavior disordered students and assume a number of responsibilities in the school setting. Individual and family counselling as well as behavior/personality assessments are duties emphasized by most therapists. Less than half of the therapists were involved in teacher inservice specifically related to behavioral disorders and even fewer were involved in classroom guidance and regular teaching duties. The following section provides an outline of the major categories of service provided by educational therapists.

#### Nature of Duties

##### Behavior/personality assessment.

Of the Educational therapists surveyed, 96.6% provided behavior/personality assessment to the students they serve.

The majority of therapists, 86.4%, provided this assessment for both core and referred children. A much smaller percentage, 8.5%, provided behavior/personality assessment to only the core children in their unit. One therapist surveyed, 1.7%, provided this service to only referred children.

#### **Academic skill assessment.**

Seventy-five percent of the therapists surveyed provided assessment of academic skills to the children they serve. Forty-nine percent of the therapists provided academic skill assessment to both core and referred children, 20.3% provided this service only to core children in the unit, and 5.1% provided it to only referred children.

#### **Intellectual assessment.**

Intellectual assessment was provided to children by 64.4% of the therapists surveyed. Fifty-one percent of the therapists provided intellectual assessment to both core and referred children, 11.9% provided this service to only their core children, while 1.7% provided it for only referred children.

#### **Individual counselling.**

All of the therapists surveyed, 100%, provided individual counselling to the students they serve. A large percentage of

therapists, 93.2%, provided this service to both core and referred students. Only 6.8% of the therapists provided the service exclusively for core students.

#### **Group counselling.**

Group counselling was provided by 74.6% of the therapists surveyed. Thirty-nine percent of the therapists provided this service for both core and referred children. The number of therapists who provided this service to only core students was 22%. Those who provided group counselling to only referred children were 13.6%.

#### **Family counselling.**

A large number of the therapists surveyed, 96.6%, provided family counselling for the students served. Fifty-four percent of the therapists who provided family counselling services provided them for both core and referred students. The other 42.4% of the therapists who provided this service provided it for core students only.

#### **Remedial instruction.**

Remedial instruction was provided as a service by 45.8% of the therapists surveyed, with 16.9% of the therapists providing this service for both core and referred children. A

larger percentage, 25.4%, only provided this service to core children. Very few therapists (3.4%) provided remedial instruction to only the referred children. The remaining 54.2% of the therapists surveyed did not provide this service.

#### **Classroom guidance.**

Thirty-six percent of the therapists surveyed provided classroom guidance, 18.6% of these therapists providing classroom guidance to both core and referred children. Another 6.8% provided the service for only core children. A larger percentage, 10.2%, provided classroom guidance to only referred children. The majority of therapists, 64.4%, did not provide any classroom guidance.

#### **Inservice for teachers.**

The services for behavior disordered students in Newfoundland and Labrador may be influenced positively or negatively by services the therapists are providing to others. It is helpful, at this point, to examine services provided by the therapists that are not directly offered to the students themselves.

Eighty-one percent of the therapists surveyed provided some form of inservice to fellow teachers, 30.5% of these



providing inservice concerning both their role as an educational therapist and how to deal with children who have behavioral problems. Another 30.5% of the therapists provided inservice only on their role as a therapist, with 10.2% providing information on how to deal with behavioral problems and other topics.

Other inservice topics included the following: teacher/student counselling and teacher/student relations; child abuse issues such as identifying and dealing with sexual and physical abuse; teenage society; self-concept; anorexia; smoking; Alateen; identification and remediation of learning disabilities; Individual Education Plans (IEP's).

#### Parent education.

Only 20.3% of the therapists indicated that they provided some form of parent education. The majority of therapists (79.7%) indicated that they did not provide the service.

#### Teaching duties.

Only five (8.5%) of the respondents indicated that they do some subject instruction in the classroom. Three (1.7%) of the respondents did not answer this question, while the remaining therapists indicated they did not teach a subject. Of the

therapists who taught a subject; two of them taught Family Life, one taught Adolescent Sexuality and one library (French). The other therapist taught occasional classes in Science and Health periods as a way to observe core children in the regular class setting.

The therapists' participation in teaching duties can be viewed both positively and negatively. Teaching is not a responsibility of therapists and may be seen as taking time away from students who need therapy. Therapists who have been assigned teaching duties without their consent may be particularly resentful and feel that the administration does not understand their role or recognize its importance. However, teaching subjects such as family life, health and sexuality may provide therapists with the opportunity to engage in some preventative measures in the classroom. It also provides an opportunity for therapists to get to know more students and see students in their classroom environment. Teachers who see therapists 'teaching' may also be more receptive to consultation. Perhaps teaching occasional classes in different subject areas would provide therapists with the associated benefits while avoiding the negative consequences.

### Associated duties.

Fifty-three percent of the therapists surveyed said that they had responsibilities other than those associated with core and referred children. The following list presents a categorical reference of the nature and types of duties that therapists were involved in outside of their regular therapy roles:

Supervision Duties: 20.3%

Extracurricular Activities with students: 13.6%

Professional Committees: 8.4%

Classroom Counselling (group guidance classes; teaching study skills, values clarification, behavior modification with classes): 8.4%

Counselling other students (crisis intervention; discipline problems, counselling students in school): 11.9%

Providing Assessment: 6.7%

Teacher Consultation/in-service: 6.8%

### **Other.**

A number of services, other than those listed on the questionnaire, were indicated as being provided by some respondents. These included;

- Involvement with social services and liaison with other agencies.
- Development and implementation of individual behavior programs in the classroom and throughout the school.
- Teacher support.
- Instruction.
- Stress and anxiety management.
- Orientation to Junior High School.
- Sexual abuse awareness and implementation of the Child Abuse Research and Education (C.A.R.E.) Kit.

### **Scope of Duties**

Most educational therapists serve only one school in their district. Table 4 provides a summary of the number of schools served by the therapists surveyed:

2

**Table 4**  
**Schools Served by Therapists**

<b>Number of Schools Served</b>	<b>Number of Therapists</b>	<b>Percentage of Therapists</b>
1	46	78.0%
2	11	18.6%
3	1	1.7%
4	0	N/A
5	1	1.7%
	59	

At the time of this study, the majority of therapists were assigned to only one school. There is reason to believe that as a result of the changes in the allocation procedures for special education units, a number of therapists may be serving more than one school.

Originally, the special education units for behavior disordered children were allocated separately from other special education units. School Boards would document the need for educational therapy units and the Department of Education was responsible for monitoring this documentation and assigning units accordingly. Since this study, special education units have been assigned to School Boards on a per

capita basis. Boards decide how these units are used within their school system. For example, if there were two behavior disordered students in a primary school and three more identified in a high school in a town close by, the Board may hire a therapist to work between these two schools. This factor alone may be responsible for changing the focus and quality of therapy services and may need to be investigated further.

#### **Availability of Support Personnel**

Seventy-five percent of the respondents noted that there was a guidance counsellor assigned to their school, and 94.9% indicated that their school district had an educational psychologist.

Table 5 indicates the amount of time Guidance Counsellors were available to the schools surveyed.

**Table 5**  
**Counselling Time in Schools**

Number of Counsellors	Percentage of Schools With Counsellors	Time Days per week
15	25.4	4+
10	16.9	1
6	10.2	3
5	8.5	2
4	6.8	other
3	5.1	missing
1	1.7	4
44	75.5	

At the time of this study, a large percentage of educational therapists had access to guidance counsellors in their schools. Therapists without guidance counsellors in their schools may have had to assume more responsibilities. This is supported by comments made by therapists, such as:

*"If the school had access to a guidance counsellor or to a remedial teacher I would be freed up to do more personal counselling - especially with the quiet students who are by-passed because there is no obvious (i.e., annoying) behavioral problem."*

*"Sometimes referrals are heavy and one wonders where to draw the line, when you don't have a guidance counsellor on staff, there is a certain amount of work you feel obligated to do. It does create a more positive image."*

There is a very real danger, with changes in allocation procedures, that school boards will assign educational therapists to schools where there is no guidance counsellor so as not to duplicate service. The quality of services for behavior disordered students may potentially diminish should this occur.

### **Preferred Delivery Models.**

Serving the needs of behavior disordered children adequately will depend, to some extent, on the delivery model dictated by the Department of Education and/or individual School Boards. The therapists surveyed were asked to



recommend a delivery model for working with behavior disordered children. The results are summarized below:

- 32.2% chose a consultation and support service model, with the educational therapist working primarily with parents, teachers, and other professionals to maintain the students in the regular classroom.
- 23.7% chose a combination of the above model and the addition of therapy for the child.
- 15.3% chose a resource room type of delivery model with students mainstreamed in a regular class, and the educational therapist being responsible only for therapy.
- 11.9% chose a part-time resource room type of service, with students mainstreamed in a regular class most of the day, but receiving therapy and academic remediation in the resource room.
- 8.5% chose a combination of the above three models including consultation and support, with therapy and academic remediation.
- 3.4% chose other models. For example, a combination of all, depending on the needs of individual students.

1.7% did not choose a model.

There was very little consensus among the respondents for the preferred delivery model. However, the percentage of therapists choosing the consultation and support for parents, teachers, and others was the same as the percentage of allied professional respondents choosing this model in Sheppard's (1989) study (32%). A number of respondents in this study chose a combination of Model A: consultation and support with therapy also provided by the therapist. Sheppard (1989) did not report combination results so it is difficult to make a comparison. Few therapists chose a model that included academic remediation (11%). However, in Sheppard's (1989) study, this model was the second choice overall by respondents. It is not surprising that this model was chosen most often by the teachers in the sample. Teachers, school principals, and coordinators all have somewhat different perceptions about the therapist's role. In the long term it would clearly be helpful for each school system to have input from the therapists and allied professionals for the development of the therapist's role.

## **Placement**

In addition to receiving educational therapy intervention, behavior disordered students sometimes receive help from other special educational services. Respondents were asked to indicate each core child's placement in the school (outside of therapy services). The following is a breakdown of results:

- 51.3% of the core children were mainstreamed full time in a regular class.
- 18.6% of the core children were mainstreamed most of the school day with some academic help from a resource teacher (less than three periods daily).
- 17.6% were mainstreamed part time and received special education part time (three or more periods with the special education teacher).
- 8.2% received full time special education.
- 2.0% of the students did not participate in any school program apart from the educational therapy.
- 1.0% were placed in some other situation.

1.3% were unable to determine.

In summary, 44.4% of the students were receiving both educational therapy and other special education services.

### **Intervention Approaches**

The data for the types of therapeutic approaches used to help the core children was viewed in several ways. One way of examining the data was to look at the percentage of children receiving a given form of therapy. For 13.1% of the children, respondents did not specify an approach. Table 6 summarizes the results.

Table 6

## Intervention Approaches Received by Children

Interventions	Number of Children	Percentage
Individual Counselling (Unspecified)	111	36.3%
Specified Approaches:		
Adlerian Counselling	3	1.0%
Person-Centered Counselling	5	1.6%
Rational-Emotive	3	1.0%
Transactional Analysis	3	1.0%
Gestalt Therapy	2	.7%
Reality Therapy	32	10.5%
Behavioral Therapy	103	33.7%
Cognitive	19	6.2%
Family Counselling/Consultation	85	27.8%
Play Therapy	34	11.1%
Skills Teaching (social skills, communication)	30	9.8%
Group Therapy	22	7.2%
Relaxation	14	4.6%
Role Play	9	2.9%
Drug	9	2.9%
Other	23	7.5%

\* Students often received more than one type of therapy.

Other intervention approaches included: oral reading, understanding self program, bibliotherapy, playing games, plant therapy, general conversation, art therapy, involvement in physical activity, firm kindness, and others.

These findings are consistent with MacMillan and Kavale's (1986) research which suggest a trend towards more behavioral, psychoeducational and eclectic approaches as opposed to psychodynamic interventions.

Another way of viewing the data on intervention approaches was to look at the percentage of therapists using each approach. Intervention approaches are outlined in Table 7.

When asked to indicate the approach used to help the core children in their unit, Behaviour therapy was an intervention used by many therapists (76.3%). Individual and family counselling were also popular approaches. It is interesting to note that although only 59.3% of therapists cited family counselling as an approach for helping the core children with their primary problem, 96.6% of the therapists indicated that they provided family counselling as one of their services.

Data were also viewed in terms of the people involved in the intervention approach. Table 8 provides an indication of

the types of intervention contents (individual or group) used by therapists.

The results in Table 8 indicate that the majority of therapists (at least 76.2%) use interventions that involve more than the child labeled behavior disordered (the 'identified patient'). Most therapists indicated that they worked with more than the individual child. In other words, the approach most therapists used involved the child in context with some aspect of his/her environment.

Table 9 provides an indication of the percentage of children receiving specific therapy groupings.

A review of the case data (Table 9) indicate that 44.1% of the children receive intervention in which the therapist also works with other people in the child's environment. These findings support a trend towards conceptualizing behavior disorders within an ecological model.

**Table 7**  
**Intervention Approaches by Therapist**

Therapy/Approach	Number of Therapists	Percentage
Family counselling/consultation	35	59.3%
Individual Counselling (unspecified)	40	64.4%
Person-Centered	3	5.1%
Rational-Emotive	3	5.1%
Gestalt	1	1.7%
Transactional Analysis	1	1.7%
Adlerian	1	1.7%
Reality Therapy	15	25.4%
Behavior Therapy	45	76.3%
Cognitive	7	11.9%
Skill Training	21	35.6%
Consultation With Teachers	20	33.9%
Play Therapy	18	30.5%
Group	15	25.4%
Role-Play	10	16.9%
Relaxation	8	13.6%
Drug	3	5.1%
Other	14	23.7%
Missing	2	3.4%



**Table 8**  
**Groupings Used by Therapists**

People Involved in Interventions	Number of Therapists	Percentage
Child only	9	15.3%
Individual, family, school, other agency	9	15.3%
Individual and family	8	13.6%
Individual, family, school	8	13.6%
Individual and group	5	8.5%
Individual, family, school, group	5	8.5%
All levels	5	8.5%
Individual, family, agency	2	3.4%
Individual, family, group	1	1.7%
Individual, school, group	1	1.7%
Missing Data	6	10.2%

**Table 9**  
**Groupings by Children**

Therapy Grouping	Number of Children	Percentage
Individual only	124	40.5%
Individual, family, school	38	12.4%
Individual and family	37	12.1%
Individual and group	15	4.9%
Individual, family, school, agency	14	4.6%
Individual and school	11	3.6%
Individual, family, agency	5	1.6%
Individual, family, school, group	4	1.3%
Individual and agency	3	1.0%
Other combinations of above	8	2.7%
Unable to determine	47	15.4%
	306	

### Intervention Focus

When indicating the type of approach they were using to help their core children, 55.9% of the therapists also made reference to the "focus" of some of their interventions. A review of this data resulted in the extraction of three categories: social skills; self-concept and academic skills. An examination of the data for each child's type of intervention showed that 27.5% of the children received intervention with a specific focus. Table 10 provides an indication of the percentage of children receiving a particular intervention focus intervention and the percentage of therapists targetting each focus.

Seventy percent of the therapists who made reference to the focus of their intervention approaches had social skills as one of their targets. Over half of the therapists (51.5%) had academic skills as a target of intervention. Improving these skills may be seen as important by therapists if they view the lack of these skills as contributing factors to the disorder of the child or if they see them as skills to enhance the child's ability to be mainstreamed. Targeting social skills and/or academic skills once again suggests a concern with how the child is relating to his environment.

Table 10

## Intervention Focus

Intervention Focus	Number of Children (n=84)	Percentage	Number of Therapists (n=33)	Percentage
Social Skills	29	34.5%	9	27.3%
Academic Skills	25	29.8%	7	21.2%
Self-Concept	17	20.2%	1	3.0%
Social Skills, Self-Concept	8	9.5%	6	18.2%
Social Skills, Academic Skills	4	4.8%	3	9.0%
Self-Concept, Academic Skills	1	1.2%	2	6.1%
Self-Concept, Social Skills, Academic Skills	0	0.0%	5	15.2%
	84		33	

Length of Time in Therapy

The average number of periods spent in therapy per week was 4.1. The time ranged from one period weekly to 24 periods/weekly.

The average time in months that students had been part of the therapy unit was 13.9. The time ranged from two months to sixty months.

### Summary

Individual and family counselling as well as behavioral/personality assessment are duties emphasized by the therapists. It is not surprising that individual counselling was chosen as a duty most often performed by the therapists since allied professionals also rated it as being the most important duty expected of the therapist (Sheppard, 1989). It is also not surprising that behavior/personality assessment was identified as a duty performed by a large majority of therapists since it is required as part of the documentation process outlined by the Department of Education (1986). It also helps the therapist understand the nature of the child's behavior problem and enables him to plan a strategy for intervention. In schools where therapists did not choose behavior/personality assessment as part of their duty, either the school counsellor or district educational psychologist may have assumed this role.

The emphasis on family counselling may have been a result of therapists' view that family problems were

contributing to the child's difficulties. A number of therapists actually suggested that family problems were causing the children's problems. The results of a study on preschool children with behavior problems also indicated that teachers attributed the cause of 'behavioral problems' to the family (Goupil, 1986). A study of the etiology of children's behavioral problems would be a valuable topic for further research.

Less emphasis was placed on academic skill assessment and intellectual assessment. Although psychoeducational assessment is a function of the therapist, as outlined by the Department of Education (1986), academic skill assessment and intellectual assessment may be viewed as responsibilities of the school counsellor and/or educational psychologists. Therapists who do academic and intellectual assessments may do so for any of the following reasons: they may believe a child's learning difficulties contribute to his/her behavior problem; they may be assuming these functions because a school counsellor or educational psychologist is not readily available to the school and/or they are the most qualified individual to perform these duties; or they may have more time available to assume these responsibilities.

Group counselling was a method used fairly often by therapists. It would be beneficial to study the nature of these groups and the techniques employed in this setting.

Remedial instruction and classroom guidance were chosen as duties by less than half of the therapists. It would seem that most of the therapists perceived their role to be more like that of a counsellor than one of a teacher.

Remedial instruction appears to be the responsibility of other special education teachers in the school (44.4% of children receive support from a resource room and special education). At the same time, a substantial number of therapists were doing remedial instruction (45.8%).

Some therapists may be providing remedial instruction if a child's behavior problem is considered a result of learning difficulties. This is supported by one therapist who noted: "I only do remedial work if it is apparent that academic problems are the primary, underlying cause of behavioral or emotional problems." Other therapists may be doing remedial instruction because they believe they should be responsible for all aspects of the special program for behavior disordered students in their schools. Center (1986) along with Chandler and Jones (1983), support this notion. Center (1986) suggests that

programs for behavior disordered students should address academic behavior, social and emotional behavior and career education. If students are receiving academic remediation in therapy as well as special education, there is a danger that services are being duplicated. It also may be more difficult to mainstream students that are being pulled out for two special services.

Classroom guidance is the only service provided that targets a larger percentage of referred children compared to core children. One possible reason for this finding is that individual therapy is not possible if there is a large number of referred children. Therapists may use classroom guidance as a preventative measure as well as a way to reach a larger number of children in less time. Classroom guidance is often viewed as a responsibility of guidance counsellors and this may be the reason a large percentage of therapists do not provide this service.

A small number of therapists (2%) indicated services in the "Other" category. Three of these respondents identified consultative services: providing teacher support, involvement with other agencies such as Social Services, and developing and implementing behavioral programs in the classroom and throughout the school. The other three therapists described



services similar to classroom guidance with students other than core and referred: providing study and exam taking skills, stress and anxiety management to all high school students; doing the C.A.R.E. Kit with K-6 students, and providing study skills and orientation to the Junior High.

### Who Are Providing the Services?

#### Training

The first analysis of training examined the highest level of academic training attained by therapists. Sixty-one percent of the therapists held Master's Degrees or had coursework for their Master's completed. Thirty-six percent of the therapists indicated having a Bachelor's Degree. 3.4% of the therapists did not indicate their level of academic training.

Of those with advanced degrees, 61.1% did graduate work in educational psychology, 13.9% had a graduate degree in Clinical Psychology, and 25% did not specify their graduate program area.

The second analysis of training looked at the major area of study in the therapist's undergraduate degree. Twenty-nine percent of the respondents listed more than one major. Fifty-six percent of the therapists surveyed indicated psychology as

a major area of study in their training. Nineteen percent indicated Special Education as a major area of study. (5.1% of therapists had majors in both special education and psychology). Five percent of the therapists indicated social work or social welfare as a major area. Twenty-five percent of therapists indicated majors or combinations of majors in areas other than psychology, special education, social work or social welfare.

Another way of viewing the data on training was to examine whether or not the therapists had a first degree in education. It was found that only 69.5% had an education degree of some kind. Many researchers ( Rizzo & Zabel, 1988; Hewett, 1967 ) feel that teacher training is a critical component necessary for those working with behavior disordered children. They also feel that teacher training would give the therapist much more credibility when working with other teachers.

In addition to information on the respondents' degree programs and majors, data was collected on other qualifications. Eight percent of the respondents noted some level of formal (certified) training in reality therapy. There was a variety of other training experiences noted, such as psychology courses, studies in criminology, psychiatry

experiences, certificate in hypnotherapy and other similar types of experiences.

A wide variety of courses and workshops taken by the respondents were noted as being helpful to their work. Thirty-two percent of the respondents indicated courses and workshops in reality therapy as being helpful. Twenty-two percent listed family therapy workshops and courses as being helpful. Workshops in Adlerian counselling were listed by 18.6% of the respondents, while 15.3% of the respondents noted workshops on the topic of child abuse, and in particular, sexual abuse. Eight percent of the respondents made reference to various workshops provided by the School Counsellors Association of Newfoundland. Other popular workshop topics taken included: behavior modification (8.5%); cognitive-behavior therapy, 6.8%); testing, diagnosis and assessment, (5.1%) and hypnosis (5.1%). Other things taken and mentioned as helpful included: monthly meeting with other educational therapists; courses in Educational Psychology; suicide prevention workshops; learning disabilities workshops and peer counselling workshops.

The workshops that therapists identified as being helpful to their work involved specific counselling techniques and methods. They also noted workshops on specific social

issues such as child sexual abuse. Assessment courses and/or workshops were only identified by a small percentage. It is difficult to say whether workshops on specific counselling techniques were more popular or just more available to the therapists. Results of the question on desired training suggest that more therapists are interested in learning about specific methods.

Another question that was asked pertaining to the therapists' training, was how they would rate the adequacy of their training in relation to their responsibilities as a therapist. Table 11 outlines the respondents ratings of their own training.

**Table 11**  
**Perceptions of Training Adequacy**

<b>Adequacy Rating</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Adequate	24	40.7%
Somewhat Adequate	18	30.5%
Very Adequate	14	23.7%
Inadequate	1	1.7%
Very Inadequate	1	1.7%
Missing Data	1	1.7%

Although 40% of the therapists rated their training as adequate, it is worth noting that only 24% rated their training as very adequate. Another 34% rated their training as less than adequate.

#### **Background and Professional Experience**

There was very little difference between the percentage of male and female respondents, 49.2% of the respondents were male, and 50.8% were female.

Table 12 represents the percentage of respondents falling in various age ranges.

**Table 12**

**Respondents Age**

<b>Number of Respondents</b>	<b>Percentage</b>	<b>Age</b>
1	1.7%	over 50
6	10.2%	41-50
27	45.8%	31-40
16	27.1%	26-30
9	15.3%	20-25
<hr/> 59		

The nearly equivalent numbers of females and male therapists in this study do not concur with other research on demographic characteristics. Schmid, Algozzine, Maher, and Wells (1984) studied teachers of behavior disordered students and found that 60% were female. Their findings with respect to teacher ages were more similar to this study: 85% of those teachers were under thirty-six years of age. In another study

described by Rizzo and Zabel (1988), 87% of the teachers for behavior disordered children were female. Forty-five percent of these teachers were under thirty, as compared to 42.4% in this study.

The therapists' background was also viewed in terms of their teaching experience, experience as a therapist, and related employment experience. Table 13 provides a global overview of these criteria as well as formal training.

Finally, the respondents were asked to indicate areas of their work for which they would like to receive further training. Thirty-six percent of the therapists desired training in family counselling and 33.8% desired more training in counselling methods and techniques, a result consistent with earlier research by Zabel (1987). (A number of counselling methods referred to techniques for working with younger children). Another area in which 22% of the therapists desired further training was assessment. Seventeen percent of the respondents desired further training in emotional and behavioral disorders and/or learning disabilities.

Other areas identified for further training included: school psychology and the education system; child abuse; the

legal system; developing social skills; alcoholism; working with adolescents and resistant clients, and developing IEP's.

Respondents identified three primary areas of desired training: family counselling methods, individual counselling techniques (especially for working with young children) and assessment. It is interesting to note that these three areas of need were also the three services and therapeutic approaches used most often across therapists. This finding may suggest that because these therapies are used extensively, the respondents feel a need to have a higher level of expertise in them. However, it may also indicate that some therapists are using therapies and strategies for which they have only a moderate level of training. A close look at the training of therapists suggest this to be a strong possibility and it may need further study. Perhaps the most encompassing description of this concern as well as the most thought-provoking description of the training needs for therapists was provided by one of the respondents who stated:

*"More specific and in-depth training is necessary for educational therapists. Family counselling is a must, therefore educational therapists should be trained in that area. At Memorial University of Newfoundland we (those of us who completed the guidance program) were*



*trained as high school counsellors not as educational therapists. I feel totally unprepared to operate effectively at the primary/elementary level."*

This may help explain why only 24% of the therapists rated their training as very adequate. It is evident that many therapists desire further training which is directly related to the services they are providing.

### **Summary**

The majority of educational therapists have graduate level training and/or backgrounds in psychology, special education, and social work. However, 25% of the therapists do not have a degree in these related areas and 30.5% have no teaching degree or teaching experience. Also, the majority of therapists (78%) only had two years experience or less as an educational therapist. This may make it difficult for those therapists to act as consultants to other teaching staff. Sheppard (1989) found that there was overwhelming agreement among allied professionals that the educational therapist should have teaching experience. Teachers may not be receptive to suggestions from professionals who in their view have little understanding of the classroom experience.

Table 13 - Qualifications of Therapist

UNDERGRADUATE TRAINING	DEGREE MAJOR	NUMBER OF THERAPISTS	PERCENT
	Psychology	28	47.5
	Special Education	12	20.3
	Social Work	2	3.4
	Other	14	23.7
	Missing	3	5.4
<b>TOTAL</b>		<b>59</b>	<b>100</b>
GRADUATE TRAINING	DEGREE MAJOR		PERCENT
	Educational Psychology	22	37.3
	Clinical Psychology	5	8.5
	Masters (Unspecified)	9	15.3
<b>TOTAL</b>		<b>36</b>	<b>61.1</b>
TEACHING EXPERIENCE	TIME (YEARS)		PERCENT
	NONE	18	30.5
	1 - 5	20	33.9
	6 - 10	10	16.9
	11 - 15	6	10.2
	16 - 20	3	5.1
	OVER 21	2	3.4
<b>TOTAL</b>		<b>59</b>	<b>100</b>
THERAPIST EXPERIENCE	TIME (YEARS)		PERCENT
	0 -1	25	42.4
	2	21	35.5
	3	6	10.2
	4	3	5.1
	OVER 4	4	6.8
<b>TOTAL</b>		<b>59</b>	<b>100</b>
PRIOR EXPERIENCE	EMPLOYMENT		PERCENT
	Student	17	28.8
	Sp. Ed. Teacher	11	18.6
	School Counsellor	9	15.3
	Teacher	8	13.5
	Social Worker	3	5.1
	Clinical Psychologist	3	5.1
	Other	8	13.6
<b>TOTAL</b>		<b>59</b>	<b>100</b>

## CHAPTER 5

### Conclusions And Recommendations

The educational therapist unit was originally designed to facilitate the implementation of the guidelines contained in the Provincial Policy Manual (1986) with specific reference to behavior disordered children. Programs were to be designed in response to the strengths and needs of students, provided in the least restrictive environment and characterized by effectiveness, comprehensiveness and consistency. While this study and a concurrent study by Sheppard (1989) did not specifically measure the program's effectiveness with children, questions clearly have been raised in terms of current practices as measured against the original intent of the therapy units.

Students currently being served by educational therapists are predominantly male and elementary school-aged. They are most generally rated as having unsocialized conduct disorders although females were more likely to have internalizing disorders such as anxiety withdrawal-dysphoria.

Although these findings are consistent with other research in the field, one cannot help question whether boys

are truly more behavior disordered or if their behaviors are more disturbing to teachers who make referrals. Similarly, one questions whether there are truly less children with anxiety withdrawal problems or if these children are just less bothersome. The use of behavioral assessments and other specific documentation procedures helps to limit the amount of bias when identifying children with behavioral problems, although children are probably not referred in the first place if their behaviors are less intrusive to the classroom.

Perhaps one of the most difficult problems in research with behavior disordered children is the inconsistent labelling of children's specific behavior problems and the use of varied classification systems. This issue continues to present a problem in this research since many respondents appeared to use vague and inconsistent terminologies that were not behaviorally applicable. This may reflect the training of the respondents and/or their specific knowledge of current behavioral literature.

Educational therapists provide a wide continuum of services to students throughout Newfoundland and Labrador. Services provided by the largest number of therapists include individual, group and family counselling, as well as behavioral, academic and intellectual assessment. To a much lesser

extent, therapists also provide remedial instruction to students and as well provide some forms of classroom guidance and even direct classroom instruction in a few cases.

Interestingly, less than half of the therapists surveyed indicated that they used consultation during their interventions and less than half provided inservice to teachers in the school in terms of dealing with behavior problem students. While consultation to teachers was provided by only 33.9% of the respondents, Sheppard (1989) found that consultation with teachers was in fact viewed by 94.2% of principals, the school leaders, as the most important goal of therapy services. Consultation was also chosen as the preferred service delivery model by the majority of school counsellors, special education teachers and principals. Interestingly, most therapists in the present study also preferred the model of consultation and support to parents, teachers, and other professionals. However, regular classroom teachers and the coordinator of special services in Sheppard's (1989) study chose models where the therapist worked mainly with students.

Further study is required to determine the exact nature of this practice and to understand why many therapists are not participating actively in consultation with teachers. If

mainstreaming continues to be the goal of educational therapy services, one would assume that teacher consultation will have to improve. Training needs in this area will also need to be explored.

Clearly, there are distinctly differing perceptions as to the nature and types of services that should be offered by educational therapists. The Department of Education's Policy Statement (1986) on the educational therapist position is also somewhat ambiguous in its suggested mandate that "the major responsibility for the therapist is working with and on behalf of the child identified." (p. 9). Depending upon the interpretation, which clearly has been questioned widely, therapists are offering a variety of services which may or may not be meeting the needs of students identified.

Unfortunately, the issue of the therapist's role in the school appears even further from clarification with recent changes in the Department of Education regarding this position. In essence, these changes will "lump" behavior therapy positions within a group of special education positions allocated on a per capita basis. While the administrative advantages to such an allocation are clear, the increase of board autonomy to allocate these positions and to determine their roles could have serious implications for the

improvement of services to behavior disordered students. Considering the specialized nature of behavioral therapy, it is likely that few boards would have the expertise to design and implement effective models of therapy.

Although the educational therapist unit was designed to serve behavior disordered students, almost half of these students are receiving other special education services within the school. In defense of the creation of the educational therapists position, Smerdon and Butt (1985) noted that a new service was needed for students who did not require "special education" in the traditional sense, but who because of behavior problems could not be successfully mainstreamed into the regular classroom. According to the results of this study, a large number of these students are receiving both services from different personnel. If this is the case, therapists and special education teachers must work very closely together to ensure services are not duplicated unnecessarily and to work towards providing the least restrictive environment for these students.

Although individual and family counselling were provided by the majority of therapists, they expressed a desire to receive more training in these areas. This is not surprising, given that a good portion of the respondents did not have

degrees in counselling or a background in psychology. However, even respondents who had these qualifications expressed a desire and/or need to receive more training in a greater variety of counselling techniques.

At the time of this study, Memorial University's graduate program in counselling (Educational Psychology) only required students to complete one course in individual counselling and one course in group counselling. Family counselling courses were not always offered and were never a required part of the program. There were also no courses offered in behavior therapy or behavior disorders at that time. These factors alone question whether the graduate program in Educational Psychology in Newfoundland and Labrador really satisfies the training requirements of educational therapists. Recommendations of the CELDIC Report (1970) would indicate that professionals dealing with behavior problem children should in fact have broadly based training in a number of disciplines. Rizzo and Zabel (1988) support this recommendation and provide a comprehensive list of preferred competencies for teachers. Should the educational therapy position continue, there will clearly be a need to more closely articulate the competencies required within available university programs.



In summary, the educational therapy position is clearly being used in a variety of different ways, and by people of varying backgrounds, throughout the province of Newfoundland and Labrador. Considering the use and description of children served, the educational therapy position appears to be needed in most school jurisdictions. The change of policy at the Department of Education level may need to be further studied in terms of its effect upon these positions and the children they are intended to serve. Further research may also be warranted in terms of the actual benefits of educational therapists to children and families involved. At this point very little is known about the therapeutic value of educational therapy positions. Clearly if the Government of Newfoundland and Labrador is to continue to invest substantial monies in this area the question of benefit to children will need to be further addressed.

As a follow-up to this research further study is also recommended in the following areas:

- The nature of childrens' needs and the specific disorders involved.
- The effectiveness of specific therapeutic interventions.

- The relationship between therapist training and effectiveness of therapy.
- The relationship between therapist role and successful intervention with children.

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**APPENDIX A**

P. O. Box 48  
Memorial University  
St. John's, NFDL.  
April 3, 1987

Superintendent

"  
"  
"  
"  
"

Dear . . .

We, the undersigned, are presently completing a Master's Degree in Educational Psychology from Memorial University. As part of the requirements for this degree we are involved in a thesis study of the Educational therapy Practice in Newfoundland and Labrador.

As part of this study we intend to distribute two questionnaires: one to all of the educational therapists employed by school boards in the Province, and the other to a sample of teachers, specialists, counsellors and administrators in schools where there are educational therapists.

As you are undoubtedly aware, the position of educational therapist is a relatively new and somewhat unique one intended to provide services for behaviorally disordered children. This research will study the nature of the services and interventions offered by educational therapists, the specific types of problems manifested by the children served and will determine the views held by educational therapists and other professionals of this new educational service.



We are, by this letter, requesting your kind permission to include the staff within your jurisdiction in our sample. Once approval is granted, participation on the part of the individual staff members will be sought on a strictly voluntary basis.

We wish to assure you that we will follow procedures intended to protect the anonymity of all participants and that the information gathered in our study will be examined and reported in such a manner as to conceal the identity of the children, the professionals, the schools, as well as that of the school board involved.

We are enclosing the attached form for your use only if you deem it convenient and appropriate to use it in replying to our request.

Thank you in advance for your anticipated cooperation.

Sincerely,

Supervisor: Valerie Anderson-Lane  
Dr. Kofi Marfo

Supervisor: Nelson Sheppard  
Dr. Glen Sheppard

**APPENDIX B**

Valerie Anderson-Lane  
Box 533, A1B 3S7  
Burton's Pond Apts..  
St. John's, NFDL..  
May 10, 1987

Dear Colleague,

I realize this is a very busy time of the school year as you prepare to complete reports and files on children in your unit. However, I would appreciate a few minutes of your time to read this letter and your consideration to complete the enclosed questionnaire.

Myself and another graduate student, Nelson Sheppard, are presently completing a Master's Degree in Educational Psychology from Memorial University. As part of the research requirement for this degree we are involved in a thesis study of the Educational therapy Practice in Newfoundland and Labrador.

Permission from your School Board has been granted to distribute our questionnaires. The questionnaire enclosed has been sent to all educational therapists in the province. Mr. Sheppard's questionnaire has been sent to a sample of allied professionals in these schools.

As you are aware, the position of educational therapist is a relatively new and somewhat unique one intended to provide services for behaviorally disordered children. The intention of the following questionnaire is to obtain a provincial view of the services and interventions offered by educational therapists and the types of children being served in these units. It also hopes to determine the views held by educational therapists of this new educational service.

I wish to assure you that my colleague and I will follow procedures intended to protect the anonymity of all

participants and that the information gathered in this study will be examined and reported in such a manner as to conceal the identity of the children, professionals, schools, and school boards involved.

Although your participation is voluntary, I would sincerely appreciate it if you would complete this questionnaire and return it by May 30, 1987. A stamped, self-addressed envelope has been included.

Thank you very much for your time and consideration. If you have any questions, please call me at the number below.

Sincerely,

Valerie Anderson-Lane

739-6744

**APPENDIX C**

**A STUDY OF THE EDUCATIONAL THERAPY SERVICE IN  
NEWFOUNDLAND AND LABRADOR**

**General Information**

1. Indicate your school's student enrollment:  
 50-100;  101-200;  201-400;  401-700;  
 701+
  
2. Is there a guidance counsellor assigned to your school?  
 yes;  no  
 If yes, how often is the counsellor at your school?  
 1 day/week;  2 days/week;  3 days/week;  
 4 days/week;  More than 4 days/week
  
3. Does your school district have an educational psychologist?  
 yes;  no
  
4. How many schools do you serve? \_\_\_\_\_
  
5. How many special education units are in your school?  
 (excluding educational therapy units) \_\_\_\_\_
  
6. In what type of school setting(s) are you working?  
 k-6;  7-9;  10-12;  K-12;  Other, please  
 specify \_\_\_\_\_.

**Background Information**

7. Sex:  Male;  Female
  
8. Age (yrs.):  20-25;  26-30;  31-40;  
 41-50;  50+
  
9. Length of experience as an educational therapist:(yrs.)  
 0-1;  2;  3;  4;  4+
  
10. Length of teaching experience prior to becoming an educational  
 therapist: (yrs.):  0;  1-5;  6-10;  11-15;  
 16-20;  21+

11. Please indicate your employment status before you took the position of educational therapist:  
 full-time student;  social worker;  special education teacher;  teacher;  clinical psychologist; clergy  school counsellor;  Other \_\_\_\_\_
12. Degrees Obtained: \_\_\_\_\_  
 Major(s): \_\_\_\_\_  
 Other qualifications: \_\_\_\_\_
13. Please indicate any courses and/or workshops taken which have been helpful to you as an educational therapist:  
 \_\_\_\_\_  
 \_\_\_\_\_
14. How would you rate the adequacy of your present training background, relative to your responsibilities as a therapist:  
 very adequate;  adequate;  somewhat adequate  
 inadequate;  very inadequate
15. If you had the opportunity, for which aspects of your work would you like to receive further training?  
 \_\_\_\_\_  
 \_\_\_\_\_

### Population Served

In this section, a core student is one for whom full documentation exists in school and board office, and therefore one who could be used to substantiate the unit. A referred student is one referred to you by self, parent or other agency for evaluation, behavioral program planning or crisis intervention.

16. Number of core children in your unit: \_\_\_\_\_
17. Number of referred children at any given time. (If this number changes, provide an average.) \_\_\_\_\_
18. Do you have responsibilities other than those associated with core and referred children?  yes;  no  
 If yes, what are they? \_\_\_\_\_



**Information on core students only:**

Before doing the next section, assign each of the core children a letter from A to F (if there are more than 6 core children, put their names in alphabetical order and choose the first six). Please retain the same letter identification for each student throughout this section.

19. Please indicate the age, sex, grade, periods weekly in therapy, and how long (months) each child has been in educational therapy.

	AGE	SEX	GRADE	PERIODS/WEEK	TIME (mnts)
core:A	---	---	---	---	---
B	---	---	---	---	---
C	---	---	---	---	---
D	---	---	---	---	---
E	---	---	---	---	---
F	---	---	---	---	---

20. Specifically describe, in behavioral terms, the primary emotional/behavioral difficulty for which each child is receiving educational therapy and indicate the degree of its severity:

	Nature of Problem	Mild	Moderate	Severe
core: A	_____	---	---	---
B	_____	---	---	---
C	_____	---	---	---
D	_____	---	---	---
E	_____	---	---	---
F	_____	---	---	---

21. Which of these children, if any, seem to have a specific learning disability? (eg. reading disability)  
 ( ) A; ( ) B; ( ) C; ( ) D; ( ) E; ( ) F

22. If a core student leaves the educational therapy unit, how do you sustain the required number of students for a unit?
- identify new students
  - referred students become core students
  - work with referred students only
  - unsure
  - other, please specify \_\_\_\_\_
23. Place a number from the following, next to each core child, which best describes his/her placement, outside of therapy.
1. mainstreamed full-time in a regular class
  2. mainstreamed most of the school day with some academic help from a resource teacher (help for less than 3 periods daily)
  3. mainstreamed part-time/special education part-time ( 3 or more periods daily with the special ed. teacher)
  4. full-time special education
  5. in school only to receive services from the educational therapist.
  6. Other (specify)\_\_\_\_\_
- core: A \_\_\_; B\_\_\_; C \_\_\_; D \_\_\_; E \_\_\_; F \_\_\_
24. If you were asked to recommend one of the following delivery models for working with behaviorally disordered children, which one would you choose:
- A full-time self-contained classroom where therapy is combined with academic instruction by the educational therapist.
  - A part-time resource room type of service with students mainstreamed in a regular class most of the day, but receive therapy combined with academic remediation in the resource room.
  - A resource room type of delivery with students mainstreamed in a regular class, and the educational therapist is only responsible for therapy.
  - A consultation and support service with the educational therapist working primarily with parents, teachers, and other professionals to maintain the student in the regular class.

( ) Other, please specify \_\_\_\_\_  
 \_\_\_\_\_

25. Please indicate the type of approach you are presently using to help each core child with his/her primary problem:

core:

A \_\_\_\_\_  
 \_\_\_\_\_

B \_\_\_\_\_  
 \_\_\_\_\_

C \_\_\_\_\_  
 \_\_\_\_\_

D \_\_\_\_\_  
 \_\_\_\_\_

E \_\_\_\_\_  
 \_\_\_\_\_

F \_\_\_\_\_  
 \_\_\_\_\_

**Services Provided:**

26. Please check which of the following services you provide in your school and also indicate which students you serve:

<b>Services</b>	<b>Core</b>	<b>Referred</b>
(a) Behavioral/Personality Assessment	---	---
(b) Academic Skill Assessment	---	---
(c) Assessment of Intellectual Ability	---	---
(d) Individual Counselling	---	---
(e) Group Counselling	---	---
(f) Family Counselling	---	---
(g) Remedial Instruction	---	---

(h) Classroom Guidance  
 (instruction to a large group  
 on topics such as self-concept, \_\_\_\_  
 sexuality, etc.)

(i) Other \_\_\_\_\_

27. Do you provide classroom instruction for any school subject(s)?  
 yes;  no

If yes, indicate which subjects you teach and how many periods weekly:

subject(s) \_\_\_\_\_  
 periods weekly \_\_\_\_\_

28. Have you provided any of the following inservice to teachers?  
 Your role as an educational therapist  
 How to deal with children who have behavioral problems  
 Other, please specify \_\_\_\_\_
29. Have you provided any parent education groups or programs?  
 yes;  no
30. Please indicate the extent to which your view of the purpose of educational therapy and its responsibilities are shared by the following:

Supervisor at Board level

very similar  similar  dissimilar  very dissimilar

Principal

very similar  similar  dissimilar  very dissimilar

Special Education teacher(s)

very similar  similar  dissimilar  very dissimilar

Regular classroom teachers

very similar  similar  dissimilar  very dissimilar

31. Are there any changes you would like to see with respect to the responsibilities you are presently taking within your school? Please specify and feel free to comment:

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32. Are you familiar with the policy manual prepared for educational therapists by the Department of Education? ( ) yes;  
( ) no

Comments

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**Thank you for your support!**









