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The effectiveness of the Boys Town Educational Model as a school wide intervention

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THE EFFECTIVENESS OF THE BOYS TOWN EDUCATION MODEL

AS A SCHOOL WIDE INTERVENTION

An Abstract of a Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Educational Specialist

Natalie Hahn-Mauck

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May, 2014

ABSTRACT

There are many school-based programs available that claim to provide effective techniques to decrease disruptive behaviors and increase academic engagement. One widely used program is the Boys Town Education Model (BTEM). The problem with widespread use of BTEM is the lack of empirical evidence to support the effectiveness of the program as a systems wide intervention in general education settings. The purpose of this research proposal is to examine the effectiveness of BTEM in comparison to research-based classroom management techniques, such as reinforcement and correction of behaviors, teaching classroom expectations, social skills instruction, and token economies. Six schools will be chosen to receive the BTEM training package in the classroom management techniques listed above provided in their home schools either through Boys Town or provided by the local area education agency (AEA). Results will be examined by analyzing the variance in office referrals and suspension rates from before intervention to after. It is hypothesized that local training and support in classroom management techniques will yield stronger results when examining academic office referrals and suspension rates.

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This Study by: Natalie Hahn-Mauck

Entitled: The effectiveness of the Boys Town Education Model as a school wide intervention

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TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Background

Teachers and other school personnel are given a sufficient amount of training in how to foster the learning and development of America's youth; however, what they possess in academic and development training, they lack in behavioral and classroom management training (McLean & Dixon, 2010). Lack of training in managing externalized behaviors of youth can lead to increased stress for teachers, and help is not always readily available. In many cases, teachers in rural settings have little access to support from professionals trained to manage challenging behaviors displayed by students with externalized or defiant disorders, and some of these teachers feel unprepared to teach students who suffer from defiant or aggressive behaviors (McLean & Dixon, 2010). For school staff to effectively work with this population of students, classroom teachers and staff need training designed to build teacher capacity to manage challenging behaviors displayed by students with ODD and CD, and training in how to provide class wide, primary prevention interventions to inhibit challenging behaviors (Short & Shapiro, 1993). Systems-wide intervention, aimed at increasing teachers' knowledge of working with challenging student behavior and primary prevention, provides an efficient option for schools to consider to address the goals of increasing classroom management and decreasing challenging behaviors.

As shown above, not only do teachers need immediate support, but they also need to develop skills to use throughout their career when working with students who display challenging behaviors. School systems need to support teachers and schools by providing them with research-based intervention techniques designed to help school personnel working with students that display challenging behaviors. First, this research proposal will review research-based techniques developed for students with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Then, a proposal for additional research on specific behavior management techniques will be suggested.

<div align="center">Factors Related to ODD and CD</div>

ODD is characterized by a youth's display of argumentative and defiant behaviors that occur in greater frequency and intensity than that which is considered "normal" for a child or adolescent. A youth must display a pattern of negative behaviors that continues for at least 6 months, and is sometimes accompanied by aggressive behaviors (4th ed., text rev.; *DSM-IV-TR;* American Psychiatric Association, 2000). While ODD is displayed as a disregard for authority and respect, CD is characterized by more severe antisocial behaviors such as physical and verbal aggression, stealing, and a general violation of social norms, including the rights of others (4th ed., text rev.; *DSM-IV-TR;* American Psychiatric Association, 2000). CD is considered the psychiatric version of the legal term delinquent (Gerten, 2000). Even though these disorders are different, they share a

common theme of defiance that is problematic in any setting; however, the effects are intensified in schools, where the expectation is that students will follow school guidelines and expectations for behavior. When students lack the will or ability to follow school protocol, it becomes important for the school staff to be aware of effective methods for working with these students in and out of the classroom.

Due to a number of external factors that affect youth, such as family history of substance abuse or mental illness, ODD and CD can be hard to treat. Children with ODD and CD often come from families whose members have difficulty with alcohol or other drugs, engage in criminal activities, or who have difficulty with mental illness (Short & Shapiro, 1993). Parents of children with ODD or CD often engage in a highly punitive parenting style, or are very inconsistent in their parenting (Short & Shapiro, 1993).   Parenting style appears to be predictive of the type of antisocial behavior displayed by students with ODD or CD.

Antisocial behavior makes school even more difficult for students with ODD or CD and is correlated with poor academic performance, low participation, disruptive behavior, and dropping out of school (van Lier, Muthen, van der Sar & Crijnen, 2004). Antisocial behavior also increases the likelihood that students with ODD or CD will be alienated from their peers, which is linked to an increase in externalizing behaviors in the future (Short & Shapiro, 1993).   Peer and teacher interactions become increasingly important in the onset and continuation of challenging behaviors related to ODD and CD as children become school-aged (van

Lier et al., 2004). Students are aware of differences in level of disruption amongst peers as early as kindergarten and reinforce disruptive or aggressive behaviors by not challenging them when confronted. In turn, this behavior reinforces disruptive and coercive behavior by allowing for a positive outcome. Students who display disruptive behavior tend to be viewed negatively and are often rejected by non-disruptive peers. This peer rejection can perpetuate the cycle of deviant behavior by limiting peer correction of misbehavior and leading disruptive children to form friendships with similarly deviant peers. Interactions between teachers and disruptive students often centers on correction of deviant behavior. One study used classroom observations to identify the ratio of positive to negative teacher interactions with students. Researchers found that 11% of all teacher interactions with disruptive students included positive attention for appropriate behavior. For non-disruptive peers, this positive attention jumped to 82% of all interactions (van Lier et al., 2004). It is likely that this type of behavior is a cycle that builds from childhood and can be either accelerated or diminished through interactions with others. The above information discussing factors related to ODD and CD provides background for the development of many techniques aimed at diminishing and managing challenging behaviors. Research on effective home, community and school-based techniques will be discussed in the following chapter.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Research supports various techniques to manage the challenging behaviors displayed by students diagnosed with ODD or CD, or students who display behaviors consistent with these diagnoses, such as defiance and opposition toward adults, aggression, and stealing. Some common techniques are parent training (Brestan & Eyberg, 1998; Kelsberg & St. Anna, 2006; MacKenzie, 2007; Short & Shapiro, 1993; Webster-Stratton, 1984), parent-child interaction therapy (Herschell, Calzada, Eyberg & McNeil, 2002; Hood & Eyberg, 2003; Werba, Eyberg, Bogs & Algina, 2006), anger control training (Lochman, Burch, Curry & Lampron, 1984; Sukhodolsky, Golub, Stone & Orban, 2005; Webster-Stratton, Reid & Hammond, 2001), mutisystemic treatment (Center & Kemp, 2003; Gerten, 2000; Karnik & Steiner, 2007), and classroom management (Ervin, DuPaul, Kern & Friman, 1998; Webster-Stratton, Reid & Stoolmiller, 2008). An additional intervention technique for working with students with ODD and CD in the schools is the Boy's Town Education Model (Burke, Oats, Ringle, Fichtner & DelGaudio, 2011; Juliano, Ringle & Woodlock, 2002), which emphasizes self-control and classroom management techniques.

Many of the intervention techniques discussed in this review are based on Cognitive-Behavioral Therapy (CBT) due to strong research support for using CBT techniques for children with aggressive behavioral problems, such as students with ODD or CD. CBT procedures are used to address the social-cognitive deficits in

children who display aggressive behaviors (Lochman, 1992). Social-cognitive

theorists have researched why some children display aggression in relation their

social-cognitive deficits. Some aggressive children are overly sensitive to

interpreting cues as hostile. They may view the intentions of others as more hostile,

or have a skewed image of their own aggression. Aggressive children may consider

action-oriented, nonverbal solutions to social problems first, or even mislabel some

of their emotions as anger (Lochman, 1992). Research indicates that CBT leads to

improvements in classroom behaviors, as well as increased self-esteem and

perceived social competence (Lochman, 1992).

<div align="center">Parent Training</div>

There is research to support parent training as the most effective

intervention for students with ODD and CD (Brestan & Eyberg, 1998). Parent

training programs use differential reinforcement techniques that are designed to

teach parents to monitor deviant behaviors, reward desired behaviors and punish

or ignore undesired behaviors. Behavioral Parent Training (BPT) is one treatment

option that utilizes the theory of parent training. Parents are taught to identify

antecedents and consequences of child behavior and operationally define and

monitor problem behaviors (Chronis, Chacko, Fabiano, Wymbs & Pelham, Jr., 2004).

Parents then learn techniques to reward positive behaviors, such as praise, positive

attention, and rewards, and techniques to decrease negative behaviors such as

ignoring and time out. Typically, parents would meet with a behavior therapist

weekly during the intervention period (Chronis et al., 2004). In Brestan and Eyberg's (1998) review of 82 treatments for ODD and CD, parent training programs and videotape modeling parent training were the only interventions that met the criteria to be classified as well-established (Brestan & Eyberg, 1998).

Videotape modeling parent training includes parents watching short clips of appropriate and inappropriate child-parent interactions followed by a therapist-led group discussion. This treatment was shown to reduce child deviant behaviors and increase parent's self-confidence in their parenting role. This finding is supported by observations of parents and children who receive the videotape treatment. Parents displayed more effective parenting skills and children displayed fewer deviant behaviors than those in the control group (Brestan & Eyberg, 1998).

Both BPT and videotape modeling parent training are readily used in the treatment of ODD and CD and are shown to be equally effective (Webster-Stratton, 1984). When assessed in a comparative evaluation of the two parent training programs, both groups of parents showed significant improvements in attitude and behavior over the wait list control group and the children in the treatment groups showed a greater reduction in deviant behaviors when compared to the control group of children. These results were sustained at a 1-year follow-up for both groups (Webster-Stratton, 1984). The BPT program requires much more time and attention from the group facilitator than does the videotape-modeling program, and for that reason videotape-modeling may be more appropriate for the school setting.

Parent-Child Interaction Therapy

Parent-child interaction therapy (PCIT) is a treatment for preschool-age children with disruptive behaviors that could result from ODD or CD. It incorporates the principles and techniques used in play therapy into behavioral parent training (Werba et al., 2006). PCIT has parents practice relationship enhancement skills and discipline skills with their child in play situations. PCIT interventions are based on the idea that externalizing behaviors originate from multiple child and family factors (Herschell et al., 2002). Some of the child factors are temperament, misunderstanding social cues, and genetic differences. Family factors related to externalizing behaviors are stressful life events, parental dissonance about childrearing, single-parent status, and low socioeconomic status (Herschell et al., 2002). Family factors, such as parenting skills, can impact a child's behavior. Parenting behaviors play an important role in the outcome of children and, subsequently, present a need for researchers to focus on parenting style when working with children that display disruptive behaviors (Herschell et al., 2002).

Research demonstrates significant improvements in child behavior problems upon completion of PCIT (Herschell et al., 2002). Parents show an improvement in their interaction style with their children, as well as being able to manage their child's behavior. Parents report high levels of satisfaction with the program and more confidence in their parenting skills (Herschell et al., 2002). The effects of PCIT

also generalize to other members of the family, including the behavior of untreated

siblings (Herschell et al., 2002).

 Positive maintenance results were found for families who participated in a

follow-up study of PCIT three to six years after treatment (Hood & Eyberg, 2003).

Children not only maintained behavioral gains but also continued to gain as time

progressed. Parental confidence was also maintained over the follow-up interval

(Hood & Eyberg, 2003). These results indicate that PCIT is an effective treatment

option for conduct problems, both during treatment and for many years that follow.

Schuhmann, Foote, Eyberg, Boggs, and Algina's (1998) study supported the

effectiveness of PCIT in their research examining the effectiveness of PCIT with

families of preschool-age children with ODD. The researchers found that parents

that received PCIT interacted more positively with their child and were more

successful getting compliance than the control group, and children showed

statistically and clinically significant improvements in behavior. Parents reported

significant improvement in their child's behavior at home and many no longer met

the criteria for ODD. Parents reported feeling more confident in their ability to

manage challenging behavior for all of their children, including those not diagnosed

with ODD, and less stressed (Schuhmann et al., 1998). What PCIT lacks is the ability

to be solely school-based because the implementation of treatment relies on parent

involvement. While this treatment is effective if implemented with fidelity by

parents, this is not always possible due to parental time constraints, motivation to participate, or belief that behavior problems are the responsibility of the school.

<div align="center">Multisystemic Treatment</div>

Some researchers believe that focusing on parent training alone is insufficient in managing children's challenging behaviors. The Mutisystemic treatment (MST) approach focuses on the problems of the adolescent in the context of multiple settings, such as family, school and community (Center & Kemp, 2003). This treatment is problem focused and highly individualized for the issues faced by a particular youth. MST offers therapists that are available to families 24/7 and that work towards building support for the family as well as building skills necessary for managing the child's negative behaviors (Karnik & Steiner, 2007).

MST provides a family and community based alternative to the traditional individual or group treatment provided to youth with defiant behaviors (Ogden & Hagen, 2006). The basis for this program is the idea that adolescents' behaviors must be considered within the social systems of their daily lives, and not in isolation from their normal environments (Ogden & Hagen, 2006). MST uses the family as the starting point for treatment and those implementing the intervention will address the predictors of defiant behavior specific to the youth; for instance the MST therapist will look at the school, family/home life, and community and determine which, if not all, of these environments are contributing to a child's defiant behaviors. From there, the MST therapy would focus more specifically on these

negative environments and address how to improve them. This treatment is shown

to be highly effective in reducing negative behavior relapses, minimizing the

severity of crimes, and diminishing the number of out of home placements, while

also increasing family cohesion (Ogden & Hagen, 2006).

MST is shown to be effective at reducing problem behaviors for at least two

years following the treatment (Ogden & Hagen, 2006). Parents rated their children

significantly lower on a scale of total problems. They also reported a larger

decrease in internalizing problem behavior over the control group who did not

participate in MST (Ogden & Hagen, 2006). The youth who participated in MST had

significantly less delinquent behavior over the two years after treatment than the

control group and were rated by teachers as having less acting-out problems in the

classroom (Ogden & Hagen, 2006).

MST is a very extensive program for a community to maintain. A study by

Henggeler and colleagues (1997) examined the effectiveness of MST in a more real

world setting without the immense clinical supervision that is required within the

original design of MST treatment. The need for MST experts could hinder the use of

the program in school systems due to financial constraints (Henggeler, Melton,

Brondino, Scherer & Hanley, 1997). MST requires weekly consultation with an

expert and many current therapists are unwilling to embrace a program that is so

time intensive. Ogden and Hagen (2006) also emphasize that the positive outcomes

of MST are directly linked to treatment fidelity of the program's implementers and

the parents. Henggeler et al. (1997) examined whether MST is effective without the

extensive consultation and fidelity checks. The researchers found that MST is not

effective without intensive fidelity checks throughout the course of the treatment.

Eliminating the weekly feedback from an expert led to less fidelity to MST protocol

which led to a lack of positive results at a 1.7 year follow-up (Henggeler et al., 1997).

This study emphasizes the need for future research in developing a cost-effective

treatment protocol that could more readily be disseminated to school systems.

Results suggest that MST is effective in decreasing the severity of future

offenses (Center & Kemp, 2003); however, it is not possible for MST to be

implemented in schools for every student with ODD or CD. Parent training, PCIT

and MST require a commitment from family members. These treatment options

have been proven effective if implemented with treatment fidelity; however, other

options must be considered when commitment and fidelity from parents is not a

feasible option.

Anger Control Training

Providing youth with anger control training is another direct care option that

could be utilized in schools. There are two parts to anger control training, social

problem solving training (SPST) and social skills training (SST). Research supports

that both aspects of anger control training, SPST and SST, produce comparable

results when aimed at reducing aggression and other conduct problems

(Sukhodolsky et al., 2005). SPST was more effective at reducing "hostile attribution

bias, a tendency to assume hostile intent in ambiguous situations of provocation"
where SST was more effective at improving anger control skills (Sukhodolsky et al.,
2005, p.21). Both aspects of anger control training are important for the overall
success of the intervention; however, this study illustrates that deviant behaviors
can be broken down to the specific behaviors that need the most improvement
(Sukhodolsky et al., 2005). This technique assists school personnel in implementing
interventions targeted at a particular child's challenging behaviors, which prevents
schools from using unnecessary time and resources for an intervention that may not
be matched to the individual's needs.

Cognitive-Behavioral Therapy (CBT) has been shown to be a promising
intervention technique for children with aggressive behavioral problems. The
principles behind anger control training stem from CBT procedures that can be used
to address the social-cognitive deficits in children with aggressive actions
(Lochman, 1992). Social-cognitive theorists have researched why some children
display aggression. Some aggressive children are overly sensitive to interpreting
cues as hostile. They may also view the intentions of others as more hostile, or have
a skewed image of their own aggression. Aggressive children may consider action-
oriented, nonverbal solutions to social problems first, or even mislabel some of their
emotions as anger (Lochman, 1992). Research on CBT indicates improvements in
classroom behaviors, as well as increased self-esteem and perceived social
competence (Lochman, 1992).

Lochman and his colleagues (1989) developed an anger coping intervention based on CBT principles. The aim of the program was to reduce the ongoing behavioral problems displayed by children with aggression, which reduces their high-risk status for future offense (Lochman, Lampron, Gemmer, Harris, & Wyckoff, 1989). The anger coping intervention focuses on altering student's social cognitive processes to improve social problem-solving skills (Lochman et al., 1989). Researchers found that anger coping groups reduce disruptive-aggressive off task classroom behavior, as well as aggression at home. Lochman et al. (1989) also cite an increase in the self-esteem of the youth. Treatment effects were even larger when a goal-setting procedure was included and when the treatment was lengthened to include more sessions. There is additional research that adds a teacher consultation to the anger coping program; however, this component did not increase treatment effects (Lochman et al., 1989). This addition did, however, increase teacher's interest in the program and their responses to the intervention were much more positive.

A three-year follow-up study indicated that anger control groups based on CBT produced long lasting effects on some areas of functioning (Lochman, 1992). One secondary prevention effect was that high-risk boys who received the anger control therapy had lower levels of substance abuse than the control group. The treated group of boys with aggression also had higher levels of self-esteem and lower rates of negative solutions to social problems (Lochman, 1992). These results

are important because self-esteem appears to be a moderator for other outcomes. For instance, untreated boys who were considered aggressive and had low levels of self-esteem became more disruptive and aggressive in the classroom than did their treated counterparts (Lochman, 1992). While these results are significant, the intervention failed to have an effect on the students' general behavioral defiance, such as talking back or ignoring prompts from parents/teachers. The results of CBT interventions may be strengthened by including parents and other significant others in the program (Lochman, 1992).

Results of CBT interventions could be expanded into the home if parents were given resources to understand and manage their child's behaviors. Negative parenting poses the largest threat to the effects of child training treatments (Webster-Stratton et al., 2001). Negative parenting, which can be described as critical statements and physical force, was the only risk factor that negatively impacted student's abilities to improve their anger control skills (Webster-Stratton et al., 2001). Stressful family situations (parental depression, divorce, etc.), which were considered a risk factor, did not impact children's ability to learn anger management and social skills (Webster-Stratton et al., 2001). This suggests that implementation of child centered interventions may be reliant on parents with capable parenting skills. If this factor is not in place, it may be necessary to use a parent-training program instead, or in conjunction with, the child-centered intervention.

Multimodal Interventions

Even though parent training, anger control training, and MST have shown success when used alone, some research suggests that interventions should be multimodal and include aspects of all of these interventions (Gerten, 2000). Gerten (2000) suggests that multimodal interventions should be focused on "teaching family management techniques to parents, decreasing academic deficits, and remediating the peer-related and adult-related interactional social problems of the child" (p.134) which suggests that interventions should not be only be focused on different environments that affect a child's behaviors, but also on multiple intervention techniques that work together in the best interest of the child.

The Coping Power program is one example of a multicomponent treatment option (Lochman & Wells, 2004). This program includes behavioral parent training along with social skills training and self-control training for the youth. The basis for this program is the idea that children's aggressive acts stem from cognitive distortions in encoding incoming social information, including the intentions of others (Lochman & Wells, 2004). The coping power program is shown to reduce the rates of substance abuse and aggression. It has also shown to increase social competence and teacher's ratings of behavior. These effects were maintained at a one-year follow-up study. The researchers found that over the course of the year after treatment the youth in the treatment group had less delinquent behavior and greater positive teacher ratings of their behavior in school (Lochman & Wells,

2004). The parent component of the coping power program had the greatest impact on the youths' delinquent behaviors. This study emphasizes the importance of family support in working with defiant youth. The reality, however, is that family support is not always present.

When the cycle of defiant and conduct disorders is understood, there is an even greater implication for multiple and well-integrated treatment options for these children. For school systems to effectively work with this population, not only must classrooms be equipped to manage challenging behaviors displayed by students with ODD and CD, but also some level of primary prevention is needed to avoid more profound difficulties in the future (Short & Shapiro, 1993). This makes sense from a financial standpoint as well. It is more cost effective to focus on primary risk factors than it is to let defiant behaviors manifest into full blown conduct disorder and subsequently, pay to have these students placed in special education or become incarcerated, which is the case for many in this population (Center & Kamp, 2003). In summary, if efficient and cost-effective training options are available, schools should consider these methods before using options requiring additional resources.

<center>Classroom Management</center>

One intervention technique developed specifically for schools is the improvement of classroom management skills (Ervin et al., 1998). As discussed earlier, teachers are rarely given the proper training to effectively teach students

with ODD or CD. Classroom management skills' training ensures that teachers have skills that directly influence their ability to manage their classroom, as opposed to other intervention techniques that put the teacher in a passive role. Ervin and her colleagues (1998) suggest that by teaching teachers how to manipulate variables in their classrooms, they could effectively diminish problem behaviors. The researchers suggested a process that includes a functional assessment of student behavior in which the function of the behavior is identified and interventions matched to the function are then put in place by the teacher. It is important to note that this study included only two participants who received services through Boys Town, both with comorbid ODD and ADHD. The researchers found that problem behaviors were reduced for both participants and satisfaction ratings illustrate a positive response to the intervention by both the teacher and students.

In a similar study, teachers were also asked to promote parent-school involvement along with learning effective classroom management skills. Teachers were observed using more positive classroom management strategies and students had fewer conduct problems and more appropriate social and emotional skills (Webster-Stratton et al., 2008). By increasing teacher's classroom management techniques early on, teachers are able to avert future student conduct problems.

<u>Boys Town Model</u>

One development in intervention techniques for students with conduct problems is the implementation of the Boys Town Education Model (BTEM) in

schools (Juliano et al., 2002). BTEM is a school-wide program made up of five steps

aimed at implementing changes in behavior-management practices (Boys Town,

2013). The first step is a needs assessment conducted through observations,

interviews, surveys, and office referral data by Boys Town staff members. Second, a

customized training plan is developed which includes workshops covering well-

managed schools, specialized classroom management, administrative intervention,

and common sense parenting. Third is consultation and technical support, which

includes data collection, development of intervention strategies, and a written

summary that examines progress and provides further recommendations. Step four

is an evaluation of program success, and step five is sustainability through

additional workshops tailored at improving implementation efforts and training

school staff members in how to train new staff in their schools (Boys Town, 2013).

This model was originally used in residential treatment settings to provide

out-of-home mental health services to adolescents, but the philosophy and practices

of Boys Town have been expanded to schools as well. Most of the research

supporting success with BTEM requires students to be separated from their home

and all of the environmental factors that come with it (Juliano et al., 2002). There

are many aspects of the program that seem to be practical options for working with

problem behaviors in schools, such as a method of motivation (point sheets) and

effective praise from teachers; however, the problem is that many schools have

already incorporated aspects of BTEM without sufficient research to support its

effectiveness (Bishop, Rosen, Miller & Hendrickson, 1996).

The premise of BTEM comes from the original Boys Town residential

treatment facility and is aimed at teaching adolescents self-control techniques while

also providing staff positive approaches to address aggressive situations

appropriately (Juliano et al., 2002). Resident students are taught to replace

aggressive behavior with appropriate self-control skills and staff members are

taught de-escalation techniques such as remaining calm, setting clear expectations

and providing youth with alternatives to engaging in aggressive behaviors. The goal

is for youth to internalize skills to help them engage in appropriate behaviors in the

future. Participants in this program show higher levels of appropriate behaviors, as

well as higher satisfaction with their staff (Juliano et al., 2002).

Bishop and his colleagues (1996) evaluated the effectiveness of one aspect of

the BTEM, the Boys Town System (BTS) in a US school setting. The researchers'

motivation for the study grew out of the need for evaluation of the BTS in changing

the behavior of students in the classroom (Bishop et al., 1996). The Boys Town

technique used in this research was a point system that uses both positive

reinforcement and negative punishment. Students eligible for special education and

educated in emotionally/behaviorally disturbed classrooms were taught social skills

that relate to the classroom setting and were given positive reinforcement, in the

form of points, for using these social skills. Teachers also employed negative

punishment by taking points away for inappropriate behavior (Bishop et al., 1996).

Observations of the BTS intervention revealed an increase in on-task behavior for

those participating in the BTS program when compared to the control group. Most

staff members were satisfied with the BTS program. They also noted the benefits of

having multiple classrooms implement the same program, such as increased

communication between programs and the formation of a support network (Bishop

et al., 1996). The BTS program also has benefits from an administrative perspective

because it provides a method for increasing teacher accountability, as well as

providing a method for ongoing data collection (Bishop et al., 1996).

In school settings, an additional component of BTEM that was studied

recently was the "Well-Managed Classroom" (Burke et al., 2011). The Well-Managed

Classroom (WMC) evolved directly from the Boy's Town Family Home Program and

is designed to reduce disruptive classroom behaviors in general education settings

(Burke et al., 2011). While this system is not enough to solve ODD or CD, it provides

a classroom based option for teachers to implement while other, more intense

interventions are put into place for students with behaviors related to ODD and CD.

Teachers were instructed to model prosocial behaviors, set clear expectations for

participation and appropriate behaviors, and consistently enforce expectations.

Burke and his colleagues (2011) found that teachers who implemented the WMC

process with high fidelity reported decreases in disruptive behaviors and increases

in student engagement. The results also indicated that teachers provided more

social and instructional support for their students, which was positively correlated with fewer problem behaviors and improved academic performance. Effective implementation of the WMC also led to decreases in teacher's stress (Burke et al., 2011).

The BTEM program is implemented and supported by staff from Boys Town. System level change is difficult to implement and maintain, and this effort is exacerbated when the impetus of change is external to the school system (Bond, Glover, Godfrey, Butler, & Patton, 2001). While there is research to support various techniques used by BTEM, the program itself has little research to support the effectiveness of BTEM outside of a residential treatment setting. There are many aspects of the program that seem to be practical options for working with problem behaviors in schools, such as the classroom management techniques, including a method of motivation (point sheets) and effective praise from teachers. Further research on the effectiveness of the BTEM as a whole is needed to fully support its use in schools.   The previous research provides limited evidence supporting various aspects of BTEM in schools, such as token economies and classroom management techniques, however there is little support for using the entire BTEM as designed by Boys Town. The above literature review provides evidence to support multiple techniques related to management of challenging behaviors displayed by youth with ODD and CD. Additional research into the effectiveness of BTEM as a comprehensive program is warranted before considering it an appropriate option for schools.

CHAPTER 3

STATEMENT OF PURPOSE

Many school systems today struggle to find cost-effective, practical programs to build staff capacity to manage disruptive behaviors displayed by children and adolescents with ODD and CD. When disruptive behavior becomes a system-level issue, the struggle for an effective intervention becomes even more daunting. One program that has gained considerable attention as a means to increase classroom management and decrease disruptive behaviors is the Boys Town Education Model (BTEM).

 While the evidence that does exist for certain aspects of BTEM shows positive results, there is not sufficient research to support its effectiveness over the use of similar techniques, such as classroom management training for teachers and token economies. An important aspect to consider when contemplating the use of BTEM in schools is the cost. For one teacher to go to the Well Managed School and Specialized Classroom Management trainings it would cost $1320, plus travel and boarding (Boys Town, 2013). For an administrator to attend these trainings, plus the Administrative Intervention training it would cost $1725, plus travel and boarding. When this cost is magnified by 20+ teachers, para-educators, and administrators, cost becomes a significant factor.

The purpose of this study is to examine the effectiveness of the Boys Town Education Model in comparison to similar classroom management techniques.

While BTEM is not doing anything new, if their system shows significantly greater decreases in disruptive behavior over the classroom management program then the issue of cost may be nullified; however, this is unknown due to the limited research completed on BTEM as a comprehensive system.

<div align="center">Hypotheses</div>

1. The Boys Town Education Model will yield results similar in effectiveness to a classroom management training program in decreasing challenging student behavior when analyzing office discipline referrals and suspension rates.

2. The Boys Town Education Model and classroom management training will decrease the number of office discipline referrals for physical aggression, verbal aggression, and defiant/argumentative behavior.

3. An analysis of program acceptability will yield greater teacher ratings of program effectiveness and acceptability for the classroom management training group than the Boys Town Education Model group.

CHAPTER 4

METHODOLOGY

<u>Participants</u>

Participants will be approximately 108 teachers from six elementary schools. Participating schools have an average enrollment of 430 students. Student demographics vary by school with an average of 59% minority students, primarily African American and Latino, and an average of 82% of student receiving free or reduced meals.

<u>Procedures</u>

Informed consent will be obtained from each participating teacher. Once consent is obtained, the schools will be split into two groups randomly and will receive training in BTEM or in classroom management techniques such as reinforcing and correcting behavior, establishing clear classroom expectations, social skills instruction, and token economies.

While there is some research to support the use of various portions of BTEM in schools, such as token economies and classroom management, the aim of this research is to examine the effectiveness of BTEM as a comprehensive system when compared to local classroom management training in techniques similar to those taught by Boys Town. Having a no treatment control group as opposed to the classroom management group would have led to additional information about the overall effectiveness of BTEM; however, such a design would have provided no

information about how this program relates to local training on similar behavior

management techniques. Research supports this as an acceptable research design

to examine the causal effects of specific treatment components when conditions are

similar with regard to treatment format and implementation (Mohr et al., 2009).

BTEM Group

Teachers, administrators, school psychologists, social workers, counselors

and support staff from schools chosen to participate in BTEM will attend the Boys

Town Well-Managed Schools 2-day workshop in June 2014. In addition to the Well-

Managed Schools training, school psychologists, social workers, special education

teachers working with students that require external motivation to complete

academic and other non-preferred tasks, have low academic engagement, and a high

number of office referrals, will attend the Specialized Classroom Management 5-day

workshop in June 2014. School principals and other administrators working on

system level interventions will attend the BTEM 2-day Administrative Intervention

Workshop in June 2014. Follow-up will be provided through Boys Town to examine

implementation fidelity and program success.

Classroom Management Group

All teachers, administrators, school psychologists, social workers, counselors,

and support staff from schools chosen to participate in the classroom management

group will receive training in their home schools provided through the local area

education agency (AEA) in the areas of effective correction and reinforcement of

behaviors, establishing consistent classroom expectations, and providing social skills instruction. This will occur in the spring of 2014. Training will involve direct instruction of the classroom management skills addressed above, as well as opportunities for modeling, role play, guided feedback, and development of implementation plans. AEA building staff will be responsible for reviewing implementation plans and developing opportunities for practice to build building capacity, as well as fidelity checks in the classroom. AEA staff will develop opportunities for practice, and additional learning will be provided monthly with the teachers and on an as-needed basis if teachers request assistance. Additional opportunities for practice and learning will be provided if fidelity checks of intervention implementation indicate less than 85% fidelity.

In addition to the classroom management training, school psychologists, social workers, special education teachers, and support staff working with students with high-motivation needs will attend training in the spring of 2014 that focuses on the development and implementation of token economies. This training will consist of direct instruction, modeling, and time to develop an implementation plan. AEA staff will review implementation plans and monitor implementation fidelity monthly. AEA staff will also be responsible for providing follow-up to this training to ensure teachers feel comfortable with their implementation and have time to ask questions. Principals and other administrators working on systems level interventions will also attend training at the AEA focused on building their school's

capacity to manage disruptive behaviors, building consultation skills for working with teachers, and streamlining office referral policies.

<div align="center">Measures</div>

Pre-test data collection will include an analysis of office discipline referrals (ODRs) and suspension rates, including an examination of the percent of ODRs and suspensions for physical aggression, verbal aggression, and defiant/argumentative behaviors. Program evaluation data comparison will measure program success by decreases in the above areas, as well as program acceptability by school personnel.

Office Referral and Suspension Rates

While a direct measurement of behavior is preferable, it would not be feasible within the current research, due to lack of personnel and the excessive amount of time required to complete this task. Another popular indirect measure of behavior that was considered was a rating scale completed by teachers. This option was not used due to the amount of time required to complete the rating scales for all students and that rating scales do little to inform intervention (McIntosh, Campbell, Russell Carter, & Zumbo, 2009).

The most practical option for collecting data on program success is through ODRs and suspension rates. ODRs are the most common form of existing data used to assess behavior (McIntosh et al., 2009). Teachers use ODRs to document behavior incidents in a systematic manner that includes a common form and clear definitions of problem behaviors that are intended to be handled with or without a

referral. Training on reportable and non-reportable behaviors is provided to teachers and school staff, and a system for compiling and analyzing behaviors is typically implemented by school office staff. Due to ODRs being readily available, they represent an acceptable method for assessing and evaluating BTEM and classroom management training interventions. This method of gathering information on low-frequency, high-intensity behaviors is more realistic in school settings than direct observation or rating scales (McIntosh et al., 2009). Research supports ODRs as a predictor of chronic discipline problems, violent behavior, and school failure. ODRs also have moderate to strong correlations with measures such as teacher rating and self-report of behavior (Irvin, Tobin, Sprague, Sugai, & Vincent, 2004).

Some of the concerns regarding ORDs and suspension rates include: a small number of studies looking at the validity of ODRs in measuring challenging behavior, the reliance on adult behavior to complete ODRs consistently for all students, the possibility of inconsistent ODR submissions, and a disproportionate amount of ODRs for minority students (McIntosh et al., 2009). While the previous concerns are important to consider, the effects can be diminished with an increased focus on ODR protocol and frequent accuracy checks by indirect service providers such as AEA staff, administration, and school counselors. Therefore, ODRs and suspension rates are considered an adequate measure of behavior for this study.

<u>Program Acceptability</u>

Program acceptability will be measured with the Treatment Evaluation

Inventory (TEI). The TEI is a 15 item questionnaire developed to assess teacher's

perception of the effectiveness and acceptability of an intervention, as well as their

general reactions to the treatment. Teacher answers are then summed to measure

overall treatment acceptability (Finn & Sladeczek, 2001). Reliability estimates

suggest good internal consistency for the TEI, with alpha coefficients ranging from

.89 to .97 in multiple studies. Factor analysis was used to validate the TEI. The

results of this factor analysis indicate that interventions are distinguished on the

basis of their acceptability, which demonstrates that the TEI is considered a valid

measure of treatment acceptability (Finn & Sladeczek, 2001).

<center>Data Analysis</center>

The goal of this study is to examine the impact of the Boys Town Education

Model in comparison to classroom management training on student disruptive and

challenging behaviors. Posttest office discipline referrals and suspension rates will

be used to assess change. Specifically, ODR's and suspension rates will be analyzed

to see if BTEM or classroom management training significantly decreases ODRs or

suspension rates, while controlling for the covariate (pretest ODRs and suspension

rates). In addition to a decrease in the rate of ODRs and suspension rates,

information about the reasons for ODRs and suspensions will be examined to gather

information about how different behaviors are influenced by the experimental

groups. The specific behaviors that will be analyzed to determine intervention success are physical aggression, verbal aggression, and defiance/argumentative behaviors. Physical aggression is characterized as any physical act aimed to intentionally harm another, such as hitting, kicking, slapping, or punching. Verbal aggression is any word or phrase that is used to intentionally hurt someone. Defiance and argumentative behaviors are defined as actively resisting authority, being disrespectful, disregarding demands, or possessing an overall challenging attitude toward teachers and staff. Analysis of covariance (ANCOVA) will be used to analyze the data. ANCOVA design is appropriate for this study because it will adjust the posttest means to account for differences between groups on the pretest measures (Dimitrov & Rumrill Jr., 2003).

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