LSCI AS AN INNOVATIVE APPROACH FOR
METHODICAL ACTION IN CHILDREN AND YOUTH
WITH EMOTIONAL AND BEHAVIOURAL
DISORDERS

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Proefschrift ingediend tot het behalen van de academische graad
van Doctor in de Pedagogische Wetenschappen

2014
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Orthopedagogische Reeks Gent, nr. 46, 2014
ISSN: 0779/1046
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Lay-Out cover: Stijn Soenen
Foto: Jeroen Brejou
Acknowledgements

I would like to extend my personal thanks to several people for their help in furthering this piece of work. First and foremost, I offer my sincerest gratitude to all the children and adolescents who participated in my studies. Thank you for sharing your opinions and for completing the many surveys. My special thank also goes to all the group workers, teachers and supervisors who participated. Your participation in the LSCI-trainings, your application of LSCI, your efforts to complete the many questionnaires, your opinions that were given during the interviews, and your continuous feedback on the different implementation processes form the foundation of this dissertation.

At the beginning of my dissertation, I would like to thank all the people who assisted me on this journey.

I would like to express my very great appreciation to my promoter, Prof. Dr. Eric Broekaert. Your patience was encouraging, your knowledge was directory. I will always be thankful for the faith you had in me.

A genuine thank you for Prof. Dr. Franky D’Oosterlinck. You are my teacher, my mentor and my friend. Not only did you pave the way for this implementation and research project, but also continuously you gave valuable advice and encouragement. Without your efforts on the field of conflict management for children and youngsters in education and care, this dissertation would never have been written.

A special thanks goes to Eline, who was there since the beginning to help set up the design, and who remained present until now.

Thanks to all the persons who did their part in this work. Koen, Kwang, Sarah, Eline, Sofie and Bert for helping to collect and to analyse the enormous amount of research data. Thanks to Jasmien, for improving my English written texts.

Thanks to Dr. Fecser and Dr. Clara. Your supporting remarks were constructive and offered me a clear view on the direction of my dissertation.

During the previous years I have been blessed with the most friendly, cheerful and helpful colleagues one could wish for. A special thanks goes to Marnick, Marc and Ann. Even when you had to listen to me complaining about all important and unimportant matters, you still showed honest concern for me and my work.
Acknowledgements

Pascal and Annelies, you had the courage to start this research project, to convince many of its usefulness, and to make the necessary investments. To my opinion, what you did was pioneering work, and will have an influence on future care and education for the most vulnerable children and youth.

And finally, thanks to my family and friends for showing interest in what I was doing. Thank you for listening to me talking about my work over and over, but also for stopping me when necessary. The many days or evenings we had together gave me the strength to complete this work.
Preface

In Flanders, children and adolescents with emotional and behavioural disorders are often placed in special institutes. These institutes, often orthopedagogical centres, mostly combine residential care with special education. In recent years, these centres experienced a high level of conflict and crisis situations with the youth enrolled. To improve professionals’ knowledge and skills to deal with these conflicts and crises, conflict management methods such as Life Space Crisis Intervention (LSCI) have been developed. LSCI, an ego-strengthening approach and part of the milieu therapeutic tradition, uses a method that is derived from the work of August Aichorn as well as Fritz Redl and David Wineman (Broekaert et al., 2009), and was brought to Flanders by Prof. Dr. Franky D’Oosterlinck. As a part of his doctoral dissertation, D’Oosterlinck investigated whether this method can contribute to the solution of the problems facing the orthopedagogical treatment centres. The work of D’Oosterlinck can be seen as the foundation of this dissertation.

The major aims of this study were twofold. First, we wanted to gather information about children and youngsters with emotional and behavioural disorders in Flemish care. Secondly, we wanted to investigate the process of implementation of conflict management methods in Flemish institutes for children and adolescents with emotional and behavioural disorders.

Chapter 1, the general introduction, starts with a review of the literature on the characteristics of children and adolescents with emotional and behavioural disorders. Further, the organisation of the Flemish health care and special education system is described, and a description of the two treatment centres who were subjects of this dissertation is provided. Next, and based on an extensive search on studies on conflict management programs, three different focuses of these programs are distinguished.

It was the aim of the first study (chapter 2) to investigate, throughout a three-year project, the effects of the combination of a level system and LSCI.

In chapter 3, staff members of a residential treatment centre and a school for special education reflected on the process of implementation of LSCI. These first two studies, which took place in the Provincial Institute Heynsdaele, can be seen as a pilot-study for a more elaborated research project, which took place in the Orthopedagogical Treatment Centre Sint-Idesbald.

It was the aim of the study in chapter 4, thus the first study in Sint-Idesbald, to search for characteristics of youth with emotional and behavioural disorders, and the specific profiles of these children and adolescents. Starting from different questionnaires
completed by group workers, teachers and youth, mean differences and correlations between the different informants were sought, and a profile for the children and adolescents was developed based on data from each informant.

Based on the results of the study in the previous chapter, an additional study (chapter 5) was designed to look in detail at the nature of youths’ internalising problems, especially with regard to anxiety problems, and to investigate possible relationship between these problems and other problems as perceived by select informants.

Chapter 6 is a qualitative study, containing a needs assessment or pre-implementation evaluation of staff in the organisation. Using a grounded theory approach, the analysis resulted in a pre-implementation model.

In chapter 7, the floor was given to the youth in the centres themselves. In this study, children and adolescents were asked about their thoughts on the most significant helpful elements of treatment.

Chapter 8 reports on the effects of the implementation of Life Space Crisis Intervention on children and adolescents with emotional and behavioural disorders. In this chapter, different quantitative data that were collected over a period of four years are analysed.

Chapter 9 summarizes the findings of the previous chapters and discusses the findings, the limitations and the recommendations.

A summary in Dutch is included at the end.

This dissertation comprises six papers that have been published, and one that has been accepted for publication. The papers are self-contained and as such, the content of some chapters may overlap.
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CHAPTER 1
General introduction
Abstract

The general introduction of this dissertations starts with a review of the literature on the characteristics of children and adolescents with emotional and behavioural disorders, indicating high rates of internalising and externalising problem behaviour, which seems to have increased the last decades. Because of the complex nature of their problems, these youths are often subject to special education or specialised care facilities. Therefore, the Flemish special education and (semi-)residential care system is described, along with its recent developments. In two Flemish treatment centres for youth with EBD, both offering special education and residential care, it was decided to gather information about the target population and to create a setting for implementation of and research on conflict resolution. Based on an elaborated search on studies on conflict management programs, three different focuses of these programs are distinguished: (1) programs that focus on training of children and adolescents themselves in how to handle conflicts; (2) programs that focus on parental skills; and (3) programs that focus on teaching professionals, such as teachers and group workers, conflict management skills. To conclude, this introduction ends with an overview of the aims and the methodology of the dissertation.
Chapter 1

1.1. Children and adolescents with emotional and behavioural disorders

1.1.1. A description
In the Dutch language, a variety of words are used to indicate the concepts of emotional and behavioural disorders (EBD). Examples are ‘deviant behaviour’, ‘psychic handicap’, ‘neurotic behaviour’, ‘dissocial behaviour’, ‘developmental disorder’, ‘socially inappropriate behaviour’,… (Broekaert, 2001).

Van der Ploeg (1990; p. 13) describes EBD as ‘a relative concept that comes up when at that certain time in a certain environment the prevailing norms and rules are broken. The severity of the problem behaviour is further determined by the frequency, duration and magnitude, as well as by the extent to which the person involved psychologically harms himself and/or his environment’. Other definitions can be found in the work of Van den Broeck (2006), who defines EBD as ‘a repeating and persistent patterns of behaviours in which the basic rights of others or important social norms or rules are violated’. Further, Grietens and Hellinckx use the term ‘children with behavioural problems’ as an umbrella term for all children who visibly behave unusual or abnormal aside from the severity, the cause or the context of this behaviour (2005).

1.1.2. Characteristics
Children and adolescents with emotional and behavioural disorders form a vulnerable group in our society. These youths’ problems seem to be chronic (Visser et al., 2003), pervasive (Fergusson & Horwood, 1995; Lahey et al., 1995; Lahey et al., 2002; Leech et al., 2003), and almost as stable as personality traits (De Bolle et al., 2009).

Several studies on the characteristics of these youth with EBD can be found in the current literature, all revealing a highly troubled population of youth and families (Dale et al., 2007) and painting a picture of chaotic childhood marked by experiences of significant stress and trauma (Brady & Caraway, 2002).

Research on these youth often describes their problems in terms of internalising (such as depression and anxiety) and externalising (such as aggression and disruptive behaviour) behaviour. D’Oosterlinck and his colleagues (2006) gathered information about the characteristics of the boys and girls with EBD placed in residential care and day treatment facilities in East Flanders. After data collection from a sample with 517 children, from who 83% were boys and 17% were girls, a behavioural profile was created using the CBCL (Child Behaviour Checklist) scores. Results of this study illustrated that children and adolescents in the sample showed a tendency towards externalising problems and portrayed themselves as aggressive and disruptive. Similarly, Connor and colleagues (2004) looked at
the characteristics of children and adolescents admitted to a residential treatment centre. The results of their study indicate high rates of internalising and externalising psychopathology and aggressive behaviour.

With regard to gender differences, it is generally assumed that boys present more externalising problems behaviours than girls (Duchesne & Larose, 2007; Masi et al., 2004) and that girls present more internalising behaviours than boys (Sohn, 2003; Tambelli et al., 2012; Wasserman et al., 2004).

A large extent of comorbidity between internalising and externalising problems has been reported in several studies. McConaughy & Skiba (1993), for example, reported high comorbidity rates for DSM diagnoses of conduct disorders with oppositional disorders, affective disorders, anxiety disorders, and attention deficit disorders, necessitating multifaceted interventions designed to treat a broad range of problems. They suggest that programs designed to treat only externalising problems run the risk of neglecting co-occurring internalising problems and vice versa. Similar results can be found in various other studies (e.g. Connor et al., 2004; Cunningham & Ollendick, 2010; D’Oosterlinck et al., 2006; Galambos, Barker & Almeida; Kovacs & Devlin, 1998; Liu, Chen & Lewis, 2011; Maughan et al., 2004; McConaughy & Skiba, 1993; Storch et al, 2012; Wasserman et al., 2005). Further, in their research on the co-development of internalising and externalising problem behaviours, Lee and Bukowski (2012) found that although trajectories are interrelated, initial levels of internalising problem is critical to the increasing trend of externalising problems for boys, whereas the reverse is the case for girls.

Several authors also indicate a change in characteristics of this population throughout the years. In his article on future directions of residential treatment, Lieberman (2004) points out how an increasing rate of child abuse and neglect, along with the placement of greater numbers of children in less restrictive environments has resulted in programs dealing with much more seriously troubled youth than they may have experienced in the past. In a Flemish study on the evolution of the demand for care from children with emotional and behavioural problems and their parents, a group of children receiving therapy in the 1970’s was compared with a group of children that was treated in the same program in the 1990’s. Results indicated that children from the 1990’s group displayed more outward problematic behaviour – aggressive, impulsive and antisocial – compared to children from the first group. Further, in the 1990’s group, parents tended to demand care at an earlier stage, more action points in relation to family dysfunction were formulated, and the care demand seemed to be more complex (D’Oosterlinck & Legiest, 2000).
Because of the complex nature of their problems, these children and adolescents, who cannot be seen as a homogenous group (Moht, 2009), have extensive mental health needs (Hukkanan et al., 1999), and are often subject to special education (Long, 1996) or specialized care facilities (Eme & Kavanaugh, 1995; Hussey & Guo, 2005).

1.2. Special education and (semi-)residential care

The youth care in Flanders, which is organized by the Flemish government, is divided into three main sections. First, the Flemish school system includes special education for children and adolescents with different problems, such as emotional and behavioural disorders. The second section is the youth protection service; which consists of a social branch and a legal branch for children and adolescents in problematic educational situations. The third section provides mental health care for children with a handicap, including a psychic handicap such as emotional and behavioural disorders (D’Oosterlinck et al., 2006).

The studies described in this dissertation took place in two Flemish centres for children and adolescents with emotional and behavioural disorders, that have services recognized within the special education system and within the mental health care for people with a handicap. Therefore, these two sections will be further discussed.

1.2.1. Special education

The Flemish special education system offers education to children aged 2.5 to 21 for who it is, because of a handicap, educational problems or learning problems, impossible to attend mainstream education. The main goal of the special education is to strive for a maximum integration or re-integration in society.

In order for a student to be admitted to the system, the Centre for Student Guidance (Centrum voor LeerlingenBegeleiding, CLB) needs to write an application report. This report should include the results of a multi-disciplinary investigation, based on medical, psychological, social, and educational data.

The special education is organised into eight different types, each serving a different target population:

- Type 1: education for students with a mild intellectual disability
- Type 2: education for students with a moderate to severe intellectual disability
- Type 3: education for students with emotional and behavioural disorders
- Type 4: education for students with a physical handicap
- Type 5: education for students who are medically fragile
• Type 6: education for students with a visual disability
• Type 7: education for students with an auditory disability
• Type 8: education for students with learning difficulties

In the secondary special education, next to the eight types, four different educational levels are distinguished (Tielemans, 2006):

• Educational level 1: directed towards social adjustment. These students particularly receive social education aimed at integration in a protected environment.
• Educational level 2: directed towards social adjustment and preparation for working. This level consists of general education, social education and vocational training and aims at integration in a protected living and working milieu.
• Educational level 3: directed towards practising a profession. Students receive the opportunity to get acquainted with different professions through theoretical courses, vocational training and internships.
• Educational level 4: consists of general education, vocational training or art academy. This level is directed towards integration in active professional live or towards further higher education. The nature and the goals of the program are adapted to special education, but should be alike to those in mainstream education.

At present, the organisation of special education as described above are under discussion, and several measures have been proposed already. Examples of these measures are more support for students with special needs in mainstream educational settings instead of referring immediately to special education, or a classification primarily based on students’ needs instead of students’ diagnoses.

1.2.2. (Semi-)residential care

In Flanders, mental health care for people with a disability is subsidized by the Flemish Agency for Disabled Persons (VAPH). The core business of the VAPH is to promote the social integration and participation of people with a disability. Through offering support, the VAPH wants to optimize these people’s autonomy and quality of life. As such, the VAPH subsidizes persons or organisations on three different domains:

• Resources and adjustments: people with a disability can receive a contribution for aid-tools or to make adjustments to their house or car.
• Services and organisations: the VAPH subsidizes services and organisations that offer care to people with a disability
• Personal-assistance-budget: people with a disability who prefer to stay at home can apply for a personal-assistance-budget. With this budget, they can hire assistants.

At the time this research took place, for people to be able to benefit from the services of the VAPH, an application for admittance should be monitored by a Provincial Evaluation Committee (PEC). This committee determines whether the applicant is disabled, and whether he or she is in need of support. The committee bases its decision on a multidisciplinary rapport. The target population of this doctoral study, mainly children and adolescents with emotional and behavioural disorders, are in general admitted to a semi-residential or residential setting based on one or more diagnoses such as ‘attention deficit hyperactive disorder’ (ADHD), ‘conduct disorder’ (CD), ‘pervasive developmental disorder’ (PDD), ‘separation anxiety disorder’ (SAD), ‘reactive attachment disorder’, etc.

A variety of studies on characteristics of children and adolescents in residential care proves that these youths are likely to suffer from serious emotional disorders prior to admission (e.g. Brady & Caraway, 2002; Dale et al., 2007; De Bolle et al., 2009; D'Oosterlinck et al., 2006; Hukkanan et al., 1999). A thorough investigation has been performed by Connor et al. (2004), who examined psychopathology, family characteristics, occurrence of physical or sexual abuse, types of aggressive behaviours, hyperactive and impulsive behaviour, medical and neurological problems, and self-reported drug and alcohol use in 397 youth in a residential treatment centre. Results indicated high rates of internalising and externalising psychopathology, aggressive behaviour, and consistent gender differences, with girls having higher levels of internalising and externalising psychopathology and aggressive behaviour. The sample was characterized by high rates of medical problems including asthma, seizures and obesity, as well as evidence of extensive family dysfunction, including high rates of parental alcohol use, violence, and physical or sexual abuse (Connor et al, 2004). Further, Baker and colleagues (2007) compared mental health and behavioural problems of youth in residential care to mental health and behavioural problems of youth in foster care. The results not only revealed extremely high levels of behavioural and mental health disorders in the sample as a whole, well above the norms for a non-child welfare population, but also that the prevalence of disorder in the residential care population was substantially greater than in the treatment foster care population (Baker et al., 2007).

The last decade, several researches on the effectiveness of residential treatment have been performed. Recently, a meta-analysis of 27 controlled studies including 17,038 youth was conducted to examine the effectiveness of institutional youth care over the past three decades (De Swart et al., 2012). The authors compared institutional evidence-based treatment (EBT) with non-institutional EBT, institutional care as usual (CAU) with non-institutional CAU, institutional CAU with non-institutional EBT, and institutional EBT
with institutional CAU. Results of this study not only showed that institutional youth care can be equally effective as non-institutional youth care, but also demonstrated that it seems more effective to provide youth with EBT during their stay in the institution (De Swart et al., 2012). Although outcome studies of residential treatment vary widely in scope and suffer from an absence of control or comparison groups, poorly defined service units, sampling problems, and improper selection or measurement of outcome criteria and, most importantly, improper aggregation of results (Butler & McPherson, 2007), some similar results can be found (James, 2011). Predictors of poor outcome often mentioned are co-morbid substance use disorder, a history of physical or sexual abuse and early onset of persistent conduct problems and delinquency (e.g. Peterson & Scanlan, 2002). Less severe dysfunction, acute rather than chronic onset of problems (Landsman et al., 2001; Wilmhurst, 2002) and readiness to act (Willumsen & Hallberg, 2003) tend to have better outcomes. Further, it is agreed upon that relationships between the youth and the adults working in the institution are of great importance (Anglin, 1999; Brown et al., 1998; Fox & Berrick, 2007; Johansson & Andersson, 2006; Russel & Phillips-Miller, 2002; Sinclair & Gibbs, 1998). This is in line with the extensive body of literature on therapeutic alliance, which is defined as ‘the working alliance that develops between a client and a therapist, facilitating the occurrence of positive psychological change’ (Horvath & Luborsky, 1993). The quality of this alliance is thought to depend on three essential ingredients: (a) the level of agreement on therapeutic goals, (b) the ability to collaboratively engage in mutually negotiated tasks to meet these goals, and (c) the establishment of a trusting, mutually respectful relationship (Bordin, 1979). A number of studies have found that therapeutic alliance between the youth and staff is predictive of treatment outcomes (e.g. Florsheim et al. 2000; Kazdin, Marciano & Whitley 2005; Kazdin, Whitley & Marciano 2006; Russel & Philips-Miller 2002; Zegers et al. 2006).

Although residential treatment is described by many scientists and practitioners as a service that one uses as a last resort (Whittaker, 2004), the current literature lacks a shared definition of residential treatment. In an attempt to fill this gap, Whittaker provided the field of practice and science with three critical areas of problem solving for defining residential child care and treatment (Whittaker, 2004):

- The “definition and purpose” of residential care and treatment in an overall continuum of child and family service.
- Questions of “intake”: which youth are best served by residential placement?
- Questions of “outcome” indicators: what are reasonable outcomes for the multiple forms of residential care and treatment that currently exist?

Therefore, and with these three areas in mind, the two following paragraphs of this chapter enclose a description of the two treatment centres who were subject of this dissertation.
1.2.3. The Provincial Institute Heynsdaele

On the first of September in 1968, the government of the province East-Flanders established the Provincial Institute Heynsdaele, a home for boys with behavioural problems. A couple of years later, a school was founded on the same campus, which created the possibility for the boys to attend special education close to the residential facility. At present, Heynsdaele is recognized as a special school and residential treatment centre for the care of 70 youngsters with emotional and behavioural disorders, aged 12 to 21. While most youths are referred to Heynsdaele by the social or the juridical branch of the Flemish youth protection service, some of them are in Heynsdaele on a voluntary basis.

The school for special education is recognized as a school for type 3 education, educational level 4. Next to general classes such as language and mathematics, the students can attend vocational training preparing them for jobs as painter, woodworker, steelworker or building constructor. Additional individual support and treatment for the students is provided by a team of educators and crisis intervention staff.

The residential part of the centre is divided into three units. All new youth start in the ‘reception-unit’. The aim of this unit is twofold; first to offer a climate of safety for all youth to adapt to this new environment, and secondly to observe all youth in order to offer them the needed treatment. The goal of the ‘pedagogical unit’ is to specifically offer treatment for diagnosed problems and, as such, to provide the maximum of developmental opportunities. The ‘integration-unit’, which is located off-campus, is designed to prepare the youth for life after their stay in Heynsdaele.

Each of these three units consists of one or more living groups. In each living group, a team of group workers is responsible for counselling in daily life. To each youth in the centre, an individual group worker is appointed who acts as an anchor point during the youth’s stay. In all three units, a chief-educators supervises the different teams, and the orthopedagogue of the centre is responsible for the total of the treatment services in all three units. The social workers, who act as a connecting thread, follow the youth from intake until the end of treatment. Further, the psychologist, the psychiatrist, social workers and paramedics have a unit-exceeding function. Together, they form the specialist services.

1.2.4. The Orthopedagogical Centre Sint-Idesbald

On August 14 1953, the Sint-Idesbald Institute, one of the many initiative of the Brothers of Charity, opened its doors in Roeselare, in the province West-Flanders. Next to a variety of services for adults with a disability or a particular vulnerability, Sint-Idesbald also offers education and (semi-)residential care for minors. From its foundation until the 90’s, children with a mild intellectual disability were the main target population of the centre. Nowadays, the centre serves children and adolescents with a mild to moderate intellectual
disability, autism and, mostly, children and adolescents with emotional and behavioural disorders. The centre serves a wide geographical area in the West of Flanders, and offers a continuum of treatment to approximately 450 youngsters and their families.

The residential part of the centre consists of several groups of each 12 to 14 children or adolescents. These groups are divided into three different clusters, based on the age of the residents. Each group consists of a team of four to seven group workers, and each cluster consists of a team of 3 to 6 social supervisors. Further, a psychiatrist, a team of nurses and a team of therapists are available to assist where needed. Subsequently, the centre has one closed group for youth with extreme emotional and behavioural disorders, and one time-out group where children can stay for a short (one hour) or longer period (up to 5 days).

Two schools are located on campus; one school for children age 3 to 12 (elementary education; type 1, 3 and 8) and one school for youth age 12 to 21 (secondary education; type 1 and 3, educational level 3). The primary school uses a multidisciplinary and development-oriented approach. The secondary school offers general and vocational training and wants to prepare students to jobs such as carpenter, plumber, kitchen-help, shop-aid, gardener, or plumber. In both schools, specialized teachers work on an individual basis with children who need extra support, and a team is available for crisis intervention whenever necessary.

### 1.3. Conflict management in children and adolescents with EBD

Because of the troubling nature of children and adolescents with emotional and behavioural disorders, working with these youngsters is a difficult task. Often discussion arise concerning boundaries, rules, goals, and other matters. Inconsistencies among staff can lead to crisis, but are to be expected in such settings. It is mainly the way of handling conflicts that determines whether a conflict will be constructive or destructive (Johnson & Johnson, 1995). As research shows, ignoring or negatively approaching conflicts leads to distrust, anger, aggression, anxiety and difficult learning situations (Deutsch & Coleman, 1995). Conflicts that are dealt with in a positive manner increase productivity in the classroom and lead to desirable outcomes (Deutsch & Coleman, 1995).

After an elaborated search on studies on conflict management programs, we were able to distinguish three different focuses of these programs. First, we found studies on programs that focus on training of children and adolescents themselves in how to handle conflicts. Secondly, we found studies on conflict management programs that focus on parental skills.
Finally, we found studies on programs that focus on teaching professionals, such as teachers and group workers, conflict management skills.

**1.3.1. Studies focusing on training for children and adolescents**

**Conflict Resolution and Peer Mediation training program**
Using a pre-test/post-test quasi-experimental design, Türnüklü and colleagues examined the effects of a Conflict Resolution and Peer Mediation (CRPM) training program on the empathy skills of 10 and 11 year-old elementary school students. The CRPM program was developed based on current literature and was devised by the researchers as a 31-class-hour training program covering four basic skills: understanding the nature of interpersonal conflicts, communication skills, anger management skills, and interpersonal conflict resolution skills focusing on negotiation and peer mediation skills. The results of this study showed a significant difference between the post-test scores of the boys in the experiment and the control group although no such difference was found among the girls who participated in the study. The authors conclude that that the CRPM training program might be effective in increasing the elementary school students’ levels of empathy (Türnüklü et al., 2009).

**Peer mediation programs**
In 1996, Johnson and Johnson reviewed the research on conflict resolution and peer mediation programs in elementary and secondary schools. Based on the studies they reviewed, the authors conclude that conflict resolution and peer mediation training can increase achievement when it is integrated into academic units, especially when it is conducted in combination with the use of cooperative learning (Johnson & Johnson, 1996).

**Teaching Students to be Peacemakers**
Between 1988 and 2000, Johnson and Johnson performed 16 studies on their conflict resolution program “Teaching Students to be Peacemakers”, probably the most known and most widespread peer mediation program. Based on these studies, which all involved children from kindergarten through ninth grade and were all conducted in rural, urban and suburban settings, a review article was published in 2002 (Johnson & Johnson, 2002). It is concluded that students learn the conflict resolution procedures taught, retain their knowledge throughout the school year, apply the conflict resolution procedures to actual conflicts, transfer the procedures to non-classroom and non-school settings, use the procedures similarly in family and school settings, and, when given the option, engage in problem-solving rather than win-lose negotiations. Further, the studies indicate that conflict
resolution procedures can be taught in a way that increases academic achievement (Johnson & Johnson, 2002).

Also after this meta-analysis was published, other research studies on “Teaching Students to be Peacemakers” were performed. Stevahn and colleagues (2002), for example, compared students who received the program with students who did not. The trained students, compared with the untrained students, learned the integrative negotiation and peer mediation procedures better, applied the procedures more completely, chose an integrative over a distributive approach to negotiation, and developed more positive attitudes toward conflict (Stevahn et al., 2002).

1.3.2. Studies focusing on training for parents

**Triple P**

Probably the most frequently investigated program focusing training for parents is the Triple-P program, or Positive Parenting Program, developed by Sanders. The program was designed to promote positive parenting and caring relationships between parents and children aged between 2 and 16 years (Sanders et al., 2003) and has been described as a Behavioral Family Intervention (e.g., Sanders & McFarland, 2000) with a multi-tiered continuum of service intervention (Sanders et al., 2003).

In 2007, Thomas and Zimmer-Gembeck published a meta-analysis including eleven studies of Triple P. The analysis revealed positive effects, but these effects varied depending on intervention length, components, and source of outcome. All forms of Triple P had moderate to large effects when outcomes were parent-reported child behaviour and parenting, with the exception of Media Triple P, which had small effects. Although all participants in the Triple P studies appeared to have been from middle class or higher SES groups, and although none of the studies has been performed by independent researchers, it is concluded that Triple P meets the criteria for a “probably efficacious treatment”.

In a more recent meta-analysis, Wilson and his colleagues (2012) identified 33 eligible Triple P studies and subjected those to systematic review and meta-analysis with analysis of bias. Results show that mothers generally reported that Triple P group interventions are better than no interventions. The authors report two concerns about these results. First, there is concern given the high risk of bias and poor reporting. Secondly, since much of the published work is authored by affiliates of the Triple P organisation, potential conflicts of interest arise. The authors conclude that no convincing evidence that Triple P interventions work across the whole population or that any benefits are long term could be found.
Parents and Children Talking Together
Leijten, Overbeek and Janssens (2012) examined, using a randomized controlled trial, the effectiveness of the parent training program Parents and Children Talking Together (PCTT) for parents with children in the preadolescent period who experience parenting difficulties. PCTT focuses on the changing parent–child relationship in (pre)adolescence where children strive for increasing autonomy. Instead of focusing on specific topics that may be very age dependent (e.g., substance use), the program aims at teaching parents effective communication skills to cope with the hanging parent-child relationship. The authors used multi-informant and multi-method data from 78 self-referred families with children aged 9–16. Results show that participation in PCTT significantly improves parents’ communication and problem solving skills, and reduced their dysfunctional disciplining behaviour in conflict situations.

Incredible Years program
Another parent training program that has been evaluated is the “Incredible Years program”, which aims at improving parenting practices, parents’ feeling of self-efficacy and parents’ perception of their child’s behaviour. Analyses of variance comparing intervention and control groups with repeated measures (pre- and post-test measures) revealed that the program has a positive impact on parenting practices (reducing harsh discipline and physical punishment, and strengthening praise/incentive, appropriate discipline and positive verbal discipline) and parents’ perception of their child’s behaviour (frequency of behavioural problems and number of problematic behaviours). No change on clear expectations from parents, or on parents’ self-efficacy was observed (Letarte, Normandeau & Allard, 2010).

1.3.3. Studies focusing on training for professionals

Teaching Family Model
As a reaction to the increases in client injuries and occasional deaths relating to the use of physical restraint in child care settings, the Teaching Family Model (TFM) was implemented and investigated in two residential settings. The TFM is a skill-based program of care and treatment, that focusses on the correction of aberrant client behaviour rather than on the suppression or containment of this behaviour. In evaluating the TFM, Jones and Timber examined frequency of restraint, seclusion, and significant incident report data from two child care facilities before and after their transitions to such a program of care and treatment. Results of this study indicate that, while the implementation did not fully eliminate the need for coercive interventions, it did result in statistically an practically
significant reductions in the use of most control procedures studied, as well as in the frequency of problem behaviours (Jones & Timbers, 2003).

**RESPECT program**
The RESPECT program is a school-wide intervention program built around four key principles (1) adults as sources of authority, (2) broad-based, (3) adults act consistently, (4) principle of continuity based on theory, previous research, and experience in the development of disobedience, off-task behaviour, and bullying as well as interventions designed to prevent and reduce these problems. After implementation among all the staff and pupils at three primary schools and one secondary school in Norway, Ervestag and Vaaland (2007) used a cohort longitudinal design to evaluate the program. Pupils in the four schools reported a decrease of problem behaviour. This decrease was sustained or continued after the intervention period for some types of behaviour (Ervestag & Vaaland, 2007).

**Therapeutic Crisis Intervention**
Therapeutic Crisis Intervention (TCI), which is developed by Cornell University in 1980, is a highly structured training program that aims at increasing child and youth care staff skills, knowledge, and confidence to respond to both the feelings and behaviour of children when they are upset, in crisis, or at their most destructive (Budlong, Holden, & Mooney, 1993). It is based on the premise that the successful resolution of a child’s crisis is dependent on the adult’s ability to respond in the most caring, therapeutic and developmentally appropriate manner possible (Trieschman, Whittaker, & Brendtro, 1969; Whittaker & Trieschman, 1972). In 2003, Nunno and colleagues investigated the process and impact of implementation of TCI in a residential facility in the United States. The results of this study showed that the implementation of TCI was successfully in substantially reducing critical incidents, significantly reducing documented physical restraints episodes in one unit, and increasing staff knowledge, confidence and consistency in crisis intervention facility-wide (Nunno, Holden & Leidy, 2003).

**Life Space Crisis Intervention**
Life Space Crisis Intervention (LSCI), an ego-strengthening approach and part of the milieu therapeutic tradition, uses a method that is derived from the work of August Aichorn as well as Fritz Redl and David Wineman (Broekaert et al., 2009). It a therapeutic and verbal strategy used to intervene when children are in crisis, and is based on cognitive, behavioural, psychodynamic and developmental theory. The method is used at the moment of the crisis or as soon as possible afterwards. The key component to effective crisis
intervention using LSCI is the ability to understand the youth’s perception of the crisis and his or her role in it (Wood & Long, 1991; Long & Fecser, 1997, 2000; Long, Wood, & Fecser, 2001).

The last decades, several studies on LSCI have been performed, both in the United States as well as in Europe.
A first research took place in 1981. DeMagistris and Imber used LSCI with 8 youth who were placed in a residential because of their disruptive behaviour. Throughout a period of 9 weeks, data were collected with regard to the behaviour and the academic achievement of this small group, and of a group with whom LSCI was not used. The results of this research show that in the experimental group disruptive behaviour decreased and academic achievement increased, while in the control group this remained stable (DeMagistris & Imber, 1981).

Some years later, in 1987, Naslund did 1441 LSCI-conversations with 28 elementary school children with behavioural problems. The study showed that the reason for an LSCI-conversation changed throughout the year. The number of interventions for which ‘confrontation’ was the reason decreased, and the number of interventions for which ‘social skills’ was the reason increased (Naslund, 1987).

A third American research took place in two special schools in New York (Dawson, 2003). While in the first school all staff were trained in LSCI, staff of the second school did not receive training. The number of conflicts decreased in the LSCI school, and remained stable in the second school. Further, in the LSCI school, there were less suspensions, less hours of skipping class, and more students referred to a less restrictive setting. All staff of the LSCI school indicated that they felt more skilled in handling conflicts.

Grskovic & Goetze (2005) used two multiple baseline-across-subjects to evaluate the effects of LSCI on two girls and two boys separately. Data were collected in the classroom over a three-month period. They found a radical decrease in challenging behaviour for each participant after implementation of LSCI.

Forthun, McCombie and Freado (2006) investigated the impact of training in LSCI on the achievement of school staff, and evaluated the impact on students’ behaviour. The trained staff indicated that, due to the training, they took more time to listen to their students, which helped them to better understand students’ problems. As a consequence, the staff felt less stress, were more willing to inquire after incidents. Students appreciated this willingness, which had a positive result on staff satisfaction. The researchers concluded that a change took place from a climate of control and punishment to a climate of cooperation, responsibility and proactive discipline.
Within the scope of her doctoral thesis, White-McMahon (2009) investigated staff perception on the influence of LSCI on the social-emotional development of students with behavioural problems. The results of this study show that students' social-emotional development scores improved. This growth helped students to create a more positive sense of self and allowed them to function more effectively in educational programs as well as in society in general.

The Flemish research tradition on LSCI started at the beginning of the past decade. Within the framework of his doctoral dissertation, Franky D'Oosterlinck started a collaboration between six facilities in the province East of Flanders, with the aim to investigate how LSCI can contribute to the treatment of youth with emotional and behavioural disorders. This thesis resulted in three studies.

In the first study, 5 questionnaires were used to collect data from 100 youth residing in one of the 6 facilities. After a first data collection, a part of the staff in these facilities received training in LSCI. In doing so, an experimental group of youth and a control group was created. Eleven months after the training, data were collected again. Results show that, both in the control group as in the experimental group, youths' emotions and behaviour remained stable. In both groups, youth had a more negative perception on their athletic competencies. As research has proven that youngsters with ADHD who receive positive feedback develop a more negative view of the performances than youngsters who do not receive feedback, this result could be explained by an increase of positive feedback given by staff. Further, a positive effect was found on direct aggression and on hostility in the experimental group. Subsequently, a slight reduction with regard to anxious coping, harm avoidance, separation anxiety and total anxiety was found. It was concluded that implementation of LSCI can contribute to the treatment of children and adolescents with emotional and behavioural problems (D’Oosterlinck et al., 2008).

A second study focused on how staff who were trained in LSCI perceived the implementation. By means of a semi-structured questionnaire data were collected a first time immediately after training, and a second time after one year of LSCI practice. A comparison between these two periods revealed an enhancement of staff members’ knowledge and coping strategies in handling conflicts. Further, participants stated that their conversations with youth were more structured, controlled, and effective. Staff attributed this success to the fact that they gained more appropriate communication skills. A better insight in power struggles and a better control of staffs’ own feelings was mentioned as a surplus value. On the other hand, participants stressed the need for sufficient time and staff in using LSCI, and the need for coaching during the process of implementation. In addition the climate of the organisation has to permit the use of LSCI, and it seems important that all
staff members receive the training. After one year of practice, a majority believed in the value of using LSCI, and in the meaningfulness of training (D’Oosterlinck et al., 2009).

In the third study, attention was focused on the children and adolescents. By means of both participating observation and interviews it was investigated how youth perceive conflicts and how they perceive staff approach to conflicts. Youth indicated that conflicts occur on a regular basis and at critical moments, and that staff often play a role in these conflicts. Authoritarian educators and younger educators get involved into conflicts more easily than educators who treat students respectfully and who maintain an orderly classroom. Youth have high expectations with regard to staffs’ approach to conflicts, and seem to have a sixth sense when it concern empathy, understanding, and trust. The main conclusion is that LSCI helps to reduce destructive and painful thoughts and feelings, and that it allows for a more positive look to emerge regarding youths’ role in the conflict (D’Oosterlinck, Broekaert & Denoo, 2006).

1.4. Aims of the dissertation

The aims of the research project are twofold:

- To gather information about children and youngsters with emotional and behavioural disorders (EBD) in Flemish care.
- To investigate the process of implementation of conflict management methods in Flemish institutes for children and adolescents with emotional and behavioural disorders.

These aims were split up into 5 different research questions:

1. What are the characteristics / problems of children and adolescents with EBD?
2. What is the perception of the different informants on these characteristics / problems?
3. What are the experiences and needs of both staff members and youth?
4. What are the effects of implementation of LSCI on the problems and the behaviour of children and adolescents?
5. How do stakeholder reflect on this process of implementation?
1.5. Research goals and methodology

A total of 7 studies were executed, all contributing to the aims of this dissertation as described above. The first two studies took place in the institute, Heynsdaele, the following five studies took place in the institute, Sint-Idesbald.

Based on the extensive body of literature (Dawson, 2003; DeMagistris & Imber, 1981; Forthun, McCombie & Freado, 2006; Grskovic & Goetze, 2005, Naslund, 1987; White-McMahon, 2009) and building further upon recent Flemish research (D’Oosterlinck, 2006), we chose to implement Life Space Crisis Intervention as a conflict management model in the clinical practice of the residential home and school for special education Heynsdaele. Subsequently, a level-system was developed and, in accordance with the LSCI Safe and Reclaiming School Program (Long & Fecser, 2001), integrated with LSCI.

It was the aim of the first study (chapter 2) to investigate, throughout a three-year project, the effects of the combination of this level system and LSCI. Both at the beginning and at the end of the project, next to standardized questionnaires, data were collected with regard to students’ behaviour and performance. Chi²-tests and independent samples t-tests were used to analyse the data.

Because we wanted to submit the results of the first study to the staff of Heynsdaele, and because we wanted to give the staff the opportunity to reflect on the process of implementation, a qualitative approach was chosen for in the second study (chapter 3). At the end of the project, 22 staff members were interviewed. Semi-structured interviews were used in which the interviewer gave pre-set questions in a predetermined order, but with the flexibility of bringing up new questions as a result of interviewee responses. These interviews were carried out on a one to one basis. Analysis of the collected data allowed us to get an idea of how staff reflected on the process their organisation had gone through.

Based on the project as described in the two previous chapters, it was decided to set up a similar project in the Orthopedagogical Centre Sint-Idesbald. Although the main purpose of this project, implementation of LSCI, was similar to the purpose of the project in Heynsdaele, three major differences must be mentioned. First, while Heynsdaele only serves youth aged 12 to 21, Sint-Idesbald also has services for younger children (from the age 3 to the age of 21). A second difference is the magnitude of the two treatment facilities. In Heynsdaele, approximately 70 youth receive treatment, while in Sint-Idesbald up to 400 children and adolescents are served. Thirdly, and mainly because of the difference in magnitude, the second project was a five-year project instead of three years.

It was the aim of the third study of this dissertation (chapter 4), thus the first study in Sint-Idesbald, to search for characteristics of youth with emotional and behavioural disorders,
and the specific profiles of these children and adolescents. Not only group workers, but also teachers and youth themselves were used as different informants. Based on the individual files of all youngsters, following data were gathered: age, gender, total intelligence, verbal intelligence, performance intelligence, current type of treatment and diagnostic data. Beside information on the minors, also information on sex, age, and years of experience of all group workers and teachers who work directly with the children and youngsters, was collected. Subsequently, CBCL (Child Behaviour Checklist), TRF (Teacher Report Form) and YSR (Youth Self Report) results were added to the database. Mean differences and correlations between the different informants were sought, and a profile for the children and adolescents was developed based on data from each informant.

Since the previous study revealed an apparent presence of self-reported internalising problems, an additional study was executed (chapter 5). This fourth study was designed to look into detail in the nature of these internalising problems, especially with regard to anxiety problems, and to investigate possible relations between these problems and other problems as perceived by different informants. In doing so, the Screen for Anxiety and Related Emotional Disorders (SCARED), a self-report that measures symptoms of the entire spectrum of anxiety disorders, was administered. Results were analysed and compared with results from the CBCL, TRF and YSR.

It is generally assumed that working with this highly troubled population has created a need for intervention models that address students’ socio-emotional needs (Baker et al., 2007; George & Fagt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009). When preparing an organisation to implement evidence based methods as an answer to the complex demands of its target population, it seems critical to obtain a thorough needs assessment or pre-implementation evaluation of staff in the organisation. It was the aim of the fifth study (chapter 6) to execute such a needs assessment. Therefore, a total of 50 staff members of Sint-Idesbald were interviewed. As such, we tried to investigate how staff perceive the children and youth cared for, how they translate this into treatment, what obstacles they experience in doing so, and what they express as critical issues to take into account when implementing an intervention model.

In line with the previous study, we also wanted to give the floor to the youth themselves and at randomly selected 50 children or adolescent to interview. It was the aim of this sixth study (chapter 7) (1) to examine how youth reflect on their own and their peers’ behaviour and (2) to explore youth’s ideas on the most significant helpful elements of treatment.

The seventh and final study (chapter 8) reports on the effects of the implementation of Life Space Crisis Intervention on children and adolescents with emotional and behavioural disorders. A longitudinal design was set up, with data being collected of a period of four
years. Four standardized questionnaires were used to investigate the effects of implementation; CBCL, TRF, YSR and SCARED. Analysis of variance and General Linear Model with repeated measures were used to analyse the data.

In chapter 9, we compile the findings and conclusions from the previous chapters and discuss them in relation to the current literature and to the overall research objectives. The limitations of the studies and recommendations on the level of orthopedagogical treatment, organisational management, scientific research and policy are presented.
References


CHAPTER 2
Effects of the combination of Life Space Crisis Interventions and a level-system at the therapeutic treatment centre "Heynsdaele"-, a special school and home for youth with behavioural and emotional problems

1 This chapter is based on: Soenen, B., Goethals, I., Spriet, E., D’Oosterlinck, F., & Broekaert, E. (2009). Effects of the combination of Life Space Crisis Interventions and a level-system at the therapeutic treatment centre "Heynsdaele"-, a special school and home for youth with behavioral and emotional problems. International Journal of Therapeutic Communities, 30(2), 200-216.
Abstract

In 2005, the Province East-Flanders (Belgium) approved the project “Heynsdaele”. The Provincial Institute Heynsdaele consists of a residential facility and a school for special education for boys aged 12 to 21 with emotional and behavioural disorders (EBD). It was the goal of this project to meet the needs of this target group by using appropriate strategies.

In the process of the project the problem areas of the whole institute were identified, by performing interviews, observing classes and living groups and by collecting documentation on the organisation. Based on the data collected, three problem areas were identified: aggression, illicit drug abuse and non-attendance. In order to address these problem areas, two strategies were implemented. The first, Life Space Crisis Intervention (LSCI), is a therapeutic and verbal strategy used to intervene when children are in crisis. The other, a level-system, was meant to set limits to severe disruptive behaviour, to reward positive behaviour in different levels and to identify non-responsive students.

Regarding the population of this research, several questionnaires showed that the behaviour problems of these youngsters remained stable over the three years of the project, according to teachers, educators and youngsters. Next to that, LSCI and the level system have been proven to have a positive effect on the academic performances and on reducing the disruptive behaviour of the youngsters. During one month in 2006 and 2008, pre-post measurements of school results, conflicts, signalization moments and the amount of non-attendance were registered by educators and teachers. Positive results were found on all of these variables. Because of the promising results of this project, the authors emphasize the value of coaching and supporting staff members in using these strategies in daily practice.
2.1. Introduction

Daily work with youngsters with emotional and behavioural disorders (EBD) is a difficult task. Often discussions arise concerning boundaries to respect, rules to follow, goals to achieve, people, animals and material to respect. These age-related conflicts can lead to crisis, but are a part of normal life. It’s mainly the way of handling conflicts that determines whether a conflict will be constructive or destructive (Johnson & Johnson, 1995). As research shows, ignoring or negatively approaching conflicts leads to distrust, anger, aggression, anxiety and difficult learning situations (Deutsch & Coleman, 2000). Conflicts that are dealt with in a positive manner increase productivity in the classroom and lead to desirable outcomes (Deutsch & Coleman, 2000). Because of the complex nature of their problems, these youth are often subject to special education (Long, 1996) or specialized care facilities (Eme & Kavanaugh, 1995; Hussey & Guo, 2005).

In Flanders, the care and education for children and adolescents with emotional and behavioural disorders is divided into three main sections. First, the Flemish school system includes special education for children and adolescents with different problems, such as emotional and behavioural disorders. The second section is the youth protection service; which consists of a social branch and a legal branch for children and adolescents in problematic educational situations. The third section provides mental health care for children with a handicap, including a psychic handicap such as emotional and behavioural disorders (D’Oosterlinck et al., 2006).

The research project described in this chapter took place in a therapeutic centre offering residential care recognized within the mental health care for people with a handicap and special education for youth with EBD.

2.2. Description of the project

The Provincial Institute Heynsdaele consists of a home and a school for special education, both located at a domain in Ronse, owned by the government of the Province of East-Flanders in Belgium.

The residential facility of Heynsdaele is recognized by the ‘Flemish Agency for People with a Handicap’ to treat 70 youngsters with emotional and behavioural disorders, from the age of 12 to 21. The school of the Provincial Institute Heynsdaele is a school for special education: type 3, educational level 4. Type 3 refers to the problems of the students: severe emotional and behavioural disorders. Educational level 4 means this type of special
education prepares students for employment in the mainstream labour market or for students to attend further mainstream education.

In 2005, the research project was approved by the government of the Province of East-Flanders. This approval resulted in cooperation between the Province of East-Flanders, the Provincial Institute Heynsdaele and the Orthopedagogical Observation and Treatment Centre (OOBC) ‘Nieuwe Vaart’, in Ghent, Belgium. With this project we tried to initialize a process in order to meet the needs of the youth by using appropriate strategies in the home and in the school.

The project started by making an inventory of the problem areas in the institution. Twenty-two staff members (out of 75) and nineteen youngsters (out of 58) were interviewed. Also people from external services (such as the student guidance centre), which work together with the centre, were interviewed. Several observations were performed in the living groups and in vocational and theoretical classes. During classes the observers explained their role and function, but did not participate. In the living groups, this was not possible. Because of the less structured nature, youngsters asked the observers to participate in their ongoing activities. Several meals were shared together with the youngsters. In some groups the observers participated during evening activities, in other groups during activities on Wednesday afternoon. Next to the interviews and the observations, the organisational structures and the way of working of the organisation were studied on the basis of extended documentation collection.

Based on this data, three problem areas were identified: aggression, illicit drug abuse and non-attendance.

The first problem area concerns the aggressive behaviour of the youngsters, but also the difficulties staff experience in dealing with this aggression. Both physical aggression and verbal aggression are named.

Statement of a youngster:
‘I’m rather aggressive towards teachers. Often, I would like to hit someone in the face and, at home, I do.’

Statement of a psychologist:
‘Aggression is starting to become more and more a problem. If you compare with the past, the aggression more and more escalates, and becomes more intense. You can’t deny it. And it’s not only the students who fight with each other, but also aggression towards staff. In the past, there wasn’t that much aggression.’
Secondly, both staff and youngsters indicate a lot of drug abuse in the center. The interviews show that staff members often do not know how to cope with this issue.

Statement of a youngster:
‘This is my first school in which so many drugs are used.’

Statement of an educator:
‘But you are powerless to cope with this problem here in Heynsdaele; we are powerless.’

A third problem area concerns students’ non-attendance in classes, and the lack of methods for staff members to deal with this problem.

Statement of an educator:
‘In our system ... detention for example. A student has detention on Friday evening. But what do students do? They leave on Friday afternoon. Then on Monday they are back. Whether you skip 10 or 20 hours of class, it doesn’t matter; the amount of detention stays the same. And then a student skips another afternoon of class, without punishment. That’s how it works here.’

Statement of a teacher:
‘You saw just a moment ago that student just walking around in the hallways. That’s normal. At this time, it isn’t that bad. But at other times, five, six or even seven students are playing around outside. During classes!’

In an attempt to create an answer for these problems areas, both Life Space Crisis Intervention (LSCI) and a level system were implemented and studied in the centre over a two-year period.

2.3. Strategies of the project

2.3.1. Life Space Crisis Intervention
LSCI is a therapeutic, verbal strategy to intervene with children or adolescents in conflict. It is based on cognitive, behavioural, psychodynamic and developmental theory (Wood & Long, 1991; Long & Fecser, 1997, 2000; Long, Wood, & Fecser, 2001), and provides a meaningful way of talking with children in crisis. Both the extreme emotional experience and accompanying personal interpretation of the conflict provide a starting point. Instead of punishing or excluding the youngster for his negative behavior, the adult will start a conversation to find out the origin of the behaviour. Since most conflicts take place in the
life space of the youth, we have an optimal opportunity to use these conflicts as learning moments. Therefore, LSCI will be used at the moment of the conflict, or shortly thereafter, and preferably by an adults who stands close to the youth.

**History of LSCI**

Although LSCI is a relatively new method in its present form, its history goes back a long way in history. The roots of LSCI can be found in the work of the pedagogue August Aichorn (1878-1949), friend and mentor of Anna Freud. Aichorn, whose name will for always linked to the treatment of wayward youth, stressed the importance of the young delinquent’s identification with his counselor (Broekaert, 2000). A second important influence on the development of LSCI is the work of Kurt Lewin (1890-1947), who wanted to make clear that the individual behaviour can best be understood within its social ecology (James, 2008). Urie Bronfenbrenner (1917-2005) elaborated these ecological ideas and developed a model with 4 ecological systems: the micro-, meso-, exo-, and macro-system (Bronfenbrenner, 1977). He poses that problems occur when the different aspects of the system are in conflict, and indicates that working in the actual situation and in the near context of the child could offer a solution. The insights of both Lewin as well as Bronfenbrenner can be seen in the concept of the ‘Life Space’, indicating the importance of working in the ‘here and now’ when conflicts occur.

A well-known student of Aichorn was Fritz Redl (1902-1988). Redl, who was trained by Anna Freud as a psychoanalyticus, moved from Vienna to the United States in 1938. In 1946 Redl started, together with his students and later colleague David Wineman (1916-1955), the Pioneer House, a residential program for young delinquents. Redl developed the concept ‘therapeutic milieu’, with which he wanted to indicate that the caring and supporting climate in an organisation can be used in treatment, in specific when conflicts occur. Together with Wineman he believed that adults who work directly with the youth in conflict situations have the greatest opportunity to therapeutically intervene and bring about a lasting change. Based on their pioneering research Redl and Wineman presented detailed descriptions of the behaviour and the characteristics of the youth they worked with. These descriptions can be seen as the validation for the concept ‘Marginal Interview’, which later changed into the Life Space interviewing (LSI). In 1981, Long, who was trained as a behaviouristic psychologist, published a work on LSI as a needed skill to help educators to let problem youngsters mainstream at school. Further, Long searches for the key elements of LSI and organizes them into teachable concepts, leading to the term Life Space Crisis Intervention.
Goals of LSCI
Using LSCI, the adult will support the youth to come to self-regulating behaviour, meaning that he or she will psychologically strengthen the youth to make the right choices in future, similar situations. Starting from the reactions of the youngster in a stressful situations, four goals are aimed at during an LSCI. (1) to change the youth’s behaviour; (2) to increase self-confidence; (3) to decrease anxiety; and finally (4) to increase understanding of own and others behaviour and feelings. The key component to effective crisis intervention using LSCI is the ability to understand the youth’s perception of the crisis and his or her role in it (Wood & Long, 1991; Long & Fecser, 1997, 2000; Long, Wood, & Fecser, 2001).

The Conflict Cycle as a key element
In 1965 Nicholas Long added the conflict cycle as a key elements of LSCI. As such, he added a cognitive dimension to the method. According to this model, two opposing forces collide during a conflict. The first power consist of the needs of the child, and the second consist of the adult’s expectations. Long looks at crisis as a product of stress, kept alive by the reactions of peers or adults (Long, Wood & Fecser, 2001). A conflict cycle starts when an event in the here and now evokes stress for the child and makes a connection with the youths’ past painful experiences. As a consequence, certain beliefs in the child could rise. Because of the youth’s past experiences, these beliefs often are irrational. These irrational beliefs will provoke certain feelings, such as anger, anxiety, frustration, powerlessness,… Because of their overwhelming nature, these feelings will act as the motive for behaviour. This behaviour, which is often negative in nature, will evoke a reaction from a peer or an adult. When this reactions is perceived by the child as stressful, the youth’s stress will increase and the conflict might escalate into a crisis.

The six stages of LSCI
When using LSCI, the adults and the youth will set up a conversation, starting from a conflict that took place in the here and now. In searching for a way to deal with the problem, the adult and the child go through six different stages. In the first stage, the focus is on the draining off the child’s overwhelming emotions. In stage two, the adult and the child will establish a timeline of the events and the perceptions on these events that led to the crisis. During the third stage, it is determined what the central issue is the crisis is. In these three first stages – which are also called the diagnostic stages – the adult and the child will focus their attention on the facts and it is decided what the key problem is. During this process, the attention often shifts from the incident to a deeper, underlying issue, which is not easily or not immediately expressed by the child. In stage four, the adult will try to give the child an insight in how the crisis has come about. The fifth stage consists of teaching new skills with the goal of enabling the child to handle future similar problems. In the sixth
and last stage, the conversation is winded up, and the child is prepared to re-join his group. These last three stages are also called the reclaiming stages.

The six reclaiming interventions of LSCI
In the third stage of an LSCI, the central issue of the conversation is determined. This means that a choice out of the six different reclaiming interventions will be made. This choice is based on the perception of the youth on the incident, and on the adult’s judgment about the youth’s motivation to change. The following is a summary of the six reclaiming interventions.

- **Reality Rub Reclaiming Intervention**
  This type of intervention is used with youth who misperceive reality. The goal of this intervention is to help the youth to organize his or her thoughts into an accurate logical sequence of events, with the aim to bring order to the confusion and to demonstrate that there is more than the youth sees. Long, Wood and Fecser (2001) distinguish five patterns: (1) blocked perception of reality because of overwhelming feelings; (2) wrong perception of reality based on personal history; (3) limited perception of reality; (4) private construction of reality; and (5) manipulation of reality for one's own benefit.

- **Red Flag Reclaiming Intervention**
  The Red Flag Reclaiming intervention is used with children and adolescents who react in an emotional, explosive manner to normal questions, rules or procedures. These emotional outbursts often are a signal that something is wrong, and often evoke counter aggressive adult behaviour. Central to the Red Flag intervention is the mechanism of displacement. This means that a child will bring in a certain stress – a stress that did not originate in the present situation but earlier – into the here and now. The Red Flag Intervention describes three different sources of stress. A ‘carry-in’ consists of a problem that has its source in the home or community, and has been brought in the school or the institute. A ‘carry-over’ means that a frustration occurs at one time or event and is carried over into another time or event. The third one is the ‘tap-in’ and occurs during an activity that triggers a personal issue; this overwhelms the youth who then acts out. It is the goal of the Red Flag intervention to identify the dynamics of displacement.

- **Symptom Estrangement Reclaiming Intervention**
  This intervention is used in children and adolescent who act aggressive or disruptive and receive pleasure from this behaviour. Often these are youth who act from a different frame of reference, who are highly ranked in social hierarchy, and are skilled in manipulating others. When they pose aggressive behavior, they will protect themselves against guilt by trying to manipulate the conversation or by using justifications such as projection, jumping
to conclusions or minimalizing the behaviour. The adults has to appeal to the youth’s narcissism and to benignly confront their defences and irrational beliefs in an effort to create some anxiety about their aggressive behaviours. To goal is to slowly expose the youth’s self-deception while also maintaining a caring relationship.

- **Massaging Numb Values Reclaiming Intervention**
  Typical in youth who need a Massaging Numb Values intervention is the presence of a predominant feeling of guilt. By acting impulsive, because of peer pressure, or because they are overwhelmed with emotions, these youth will pose disruptive behaviour, and immediately afterwards feel guilty about what they have done. This feeling of guilt can be so dominant that these children or adolescents will do everything they can to search for punishment or rejection. As such, they want to pay off their debt. Very often, these are youth who have, because of their history of rejection, build up a negative self-image. It is the aim of a Massaging Numb Values intervention to help the youth to get the insight that accidents can happen, that people sometimes make mistakes, but that this does not mean that this person is worthless, and as such, to increase the youth’s self-confidence.

- **New Tools Reclaiming Intervention**
  In order to teach new social skills to youngsters who have the correct attitudes towards staff, peer and learning, but who lack the appropriate social skills to be successful, the New Tools Intervention can be used. The goal of this intervention is to teach the child to look at things differently, with as a result that they are able to behave more appropriate in the future. It is aimed at that the youth realizes that that the way in which he or she translates intentions into behaviour did not yield the desired results. Supporting the youth’s positive intentions and teaching achievable and realistic skills are key elements in this intervention.

- **Manipulation of Body Boundaries Reclaiming Intervention**
  The central element of this sixth intervention is manipulation. The Manipulation of Body Boundaries intervention can be used in two different patterns, each characterized by a youth being manipulated by a peer. The first group includes youth who are neglected, isolated or loners and who develop a self-defeating friendship with an exploitative peer. In this relationship, the dependent youth frequently maintains the relationship by acting out his friend’s inappropriate wishes. The second group includes youth who are ‘set up’ and ‘controlled’ by a bright passive-aggressive peer. In this relationship the aggressive youth is unaware of how he or she is being manipulated by his passive-aggressive peer, and reacts inappropriately to the provocation. In both patterns, it is the goal to give the child the insight that he was manipulated by a peer. It is the aim in the first pattern to help the youth to realize that he was exploited, and that this is not what friends do to each other. When dealing with a ‘set-up’, it is the aim to help the youth to realize that he has given out of hands his self-control.
Effects of the combination of Life Space Crisis Interventions and a level-system

Research on LSCI

- Research in the United Stated
The research tradition on LSCI started in the United States in the early 1980’s with DeMagistris and Imber (1981), who used LSCI with 8 youth who were placed in residential care because of their disruptive behaviour. Throughout a period of nine weeks, data were collected with regard to the behaviour and the academic achievement of this small, and of a group with whom LSCI was not used. The results of this research show that in the experimental group disruptive behaviour decreased and academic achievement increased, while in the control group both remained stable (DeMagistris & Imber, 1981).

Some years later, in 1987, Naslund did 1441 LSCI-conversations with 28 elementary school children with behavioural problems. The study showed that the reason for an LSCI-conversation changed throughout the year. The number of interventions for which ‘confrontation’ was the reason decreased, and the number of interventions for which ‘social skills’ was the reason increased (Naslund, 1987).

A third American research took place in two special schools in New York (Dawson, 2003). While in the first school all staff were trained in LSCI, staff of the second school did not receive training. The number of conflicts decreased in the LSCI school, and remained stable in the second school. Further, in the LSCI school, there were less suspensions, less hours of skipping class, and more students referred to a less restrictive setting. All staff of the LSCI school indicated that they felt more skilled in handling conflicts.

Grskovic & Goetze (2005) used two multiple baseline-across-subjects to evaluate the effects of LSCI on two girls and two boys separately. Data were collected in the classroom over a three-month period. They found a radical decrease in challenging behaviour for each participant after implementation of LSCI.

Forthun, McCombie and Freado (2006) investigated the impact of training in LSCI on the achievement of school staff, and evaluated the impact on students’ behaviour. The trained staff indicated that, due to the training, they took more time to listen to their students, which helped them to better understand students’ problems. As a consequence, the staff felt less stress and were more willing to inquire after incidents. Students appreciated this willingness, which had a positive result on staff satisfaction. The researchers concluded that a change took place from a climate of control and punishment to a climate of cooperation, responsibility and proactive discipline.

Within the scope of her doctoral thesis, White-McMahon (2009) investigated staff perception on the influence of LSCI on the social-emotional development of students with
behavioural problems. The results of this study show that students’ social-emotional development scores improved. This growth helped students to create a more positive sense of self and allowed them to function more effectively in educational programs as well as in society in general.

- **Research in Belgium**

The Flemish research tradition on LSCI started at the beginning of the last decade. Within the framework of his doctoral thesis, Franky D’Oosterlinck started a collaboration between six facilities in the province East of Flanders, with the aim of investigating how LSCI can contribute to the treatment of youth with emotional and behavioural disorders. This thesis resulted in three studies.

During the first study, five questionnaires were used to collect data from 100 youth residing in one of the six facilities. After a first data collection, a part of the staff in these facilities received training in LSCI. In doing so, an experimental group of youth and a control group was created. Eleven months after the training, data were collected again. Results show that, both in the control group as in the experimental group, youths’ emotions and behaviour remained stable. In both groups, youth had a more negative view on their athletic competencies. As research has proven that youngsters with ADHD who receive positive feedback develop a more negative view of the performances than youngsters who do not receive feedback, this result could be explained by an increase of positive feedback given by staff. Further, a positive effect was found on direct aggression and on hostility in the experimental group. Subsequently, a slightly positive trend with regard to anxious coping, harm avoidance, separation anxiety and total anxiety was found. It was concluded that implementation of LSCI can contribute to the treatment of children and adolescents with emotional and behavioural problems (D’Oosterlinck et al., 2008).

A second study focused on how staff who were trained in LSCI perceived implementation. By means of a semi-structured questionnaire data were collected a first time immediately after training, and a second time after one year of LSCI practice. A comparison between these two periods reveals an enhancement of staff members’ knowledge and coping strategies in handling conflicts. Further, participants stated that their conversations with youth were more structured, controlled, and effective. Staff attributed this success to the fact that they gained more appropriate communication skills. A better insight in power struggles and a better control of staffs’ own feelings was mentioned as a surplus value. On the other hand, participants stressed the need for sufficient time and staff in using LSCI, and the need for coaching during the process of implementation. In addition the climate of the organisation has to permit the use of LSCI, and it seems important that all staff members receive the training. After one year of practice, a majority believed in the value of using LSCI, and in the meaningfulness of training (D’Oosterlinck et al., 2009).
In the third study, attention was focused on the children and adolescents. By means of both participating observation and interviews it was investigated how youth perceive conflicts and how they perceive staff approach to conflicts. Youth indicated that conflicts occur on a regular basis and at critical moments, and that staff often play a role in these conflicts. Authoritarian educators and younger educators get involved into conflicts more easily than educators who act honest and consequent. Youth have high expectations with regard to staffs’ approach to conflicts, and seem to have a sixth sense when it concern empathy, understanding, and trust. The main conclusion is that LSCI helps to reduce destructive and painful thoughts and feelings, and that it allows for a more positive look to emerge regarding youths’ role in the conflict (D’Oosterlinck, Broekaert & Denoo, 2006).

### 2.3.2. Level System

When working with high-risk populations, a need exists for installing prevention programs that support implementation of crisis management programs (D’Oosterlinck & Broekaert, 2003). In combination with LSCI it was chosen to implement a level system (Figure 1). Behavioural strategies using token economy systems for rewarding and sanctioning either the whole class or individuals within a whole class are effective for reducing behaviour which is disruptive to children’s own or others’ learning (Evans, Harden & Thomas, 2004). Although there are few recent studies on token economy in youth residential treatment, results are promising (Bowers et al., 1999; Wolf et al., 1995). Others, such as VanderVen (1995, 2000, 2009), point out some potential risks of such level systems. When using a level system, it is important that the adult is not seen as an arbitrary dispenser of privileges and favours, then the potential for change is lost.

Goals of the level system used in Heynsdaele are threefold: (1) to set limits to severe disruptive behaviour, (2) to reward positive behaviour in different levels, and (3) to detect non-responsive students.

The level system consists of five levels, each with its own specific focus. In the first level, the focus is set on aggression and bullying; in the second level, the focus is set on care for self, the other and material; in the third level, the focus is respecting regulations and boundaries. These first three levels are each divided into four steps. In the fourth and fifth levels, different goals are formulated for each individual student. To avoid arbitrariness, the content of every level is explained for all students. For each goal, examples of desired behaviour are given. Depending on the level, a student receives certain privileges. In other words, a student in a high level receives more privileges then a student in a lower level. These privileges, or the lack of them, should never take away treatment opportunities such as exercise or time with adults.
Chapter 2

Every student in Heynsdaele starts in the first step of the first level. Based on his behaviour, he receives points for each part of the day. At the end of every week, all the points are listed. If a student collects the minimum amount of points he needs in his step, he can transfer to the next step. If he does not, the student has to stay in the same step for another week.

When a student fails three weeks in a row to transfer to the next step, he goes to the ‘care-level’. For these students, an individual treatment program is designed based on their specific needs.

Figure 1: level system

2.3.3. Integration of both strategies
In this research project, LSCI and the level system were integrated based on the LSCI Safe and Reclaiming School Program, which is organized around three levels of prevention and intervention that combine to create a pyramid model (Long & Fecser, 2001). The level system was established in the first level of the model. This level consists of school-wide baseline concepts and skills for all staff members to use in their interactions with students in order to avoid fundamental differences regarding the definition of problem behaviour. The second level consists of early intervention strategies, such as modified accommodation in the classroom and other techniques which distinguish special education from general
education. The use of LSCI is situated within the third level, next to other individual strategies such as individual therapy or individualized medical treatment.

## 2.4. Method

### 2.4.1. Research goals

The research goals of this study are twofold:

- Research question 1: Does the population of Heynsdaele remain stable over the years? This is important, since the research project covers several years, and youths leave the program and other youths start the program.

- Research question 2: What are the effects of the implementation of LSCI and a level system on the academic performances and on the disruptive behaviour of the youngsters?

### 2.4.2. Subjects and research setting

The centre Heynsdaele is recognized for the treatment of 70 youngsters with emotional and behavioural disorders, age 12 to 21. Most of these youngsters attend special education at the campus. While most youths are referred to Heynsdaele by the social or the juridical branch of the Flemish youth protection service, some of them are in Heynsdaele on a voluntary base. The most common behavioural problems with these youths are aggressive behaviour, delinquent behaviour and a lack of social skills (D’Oosterlinck et al., 2006). All youngsters are boys, and their average age throughout the duration of the project was 14.45 years.

### 2.4.2. Procedure

As described in paragraph “2.2. Description of the project”, the first stage (September-October 2005) of this project concerned an inventory of the problem areas in the institution. Based on interviews with 22 staff members and 19 youngsters, the problem areas ‘aggression’, ‘illicit drug abuse’ and ‘non-attendance’ were defined.

In a second stage (November 2005-May 2006), LSCI was chosen as a strategy for conflict management, and the level-system as described in paragraph “2.3.2.” was developed.

In stage three (November-December 2005), the appropriate instruments to answer our two research questions were looked for. To answer the first research questions “Does the population of Heynsdaele remain stable over the years”, the Child Behaviour Checklist
(CBCL), Youth Self Report (YSR) and the Teacher Report Form (TRF) were chosen. All three questionnaires have proven to be valid and reliable (Achenbach & Rescorla, 2001; De Groot, Koot & Verhulst, 1994; Ivanova et al., 2007; Verhulst, van der Ende & Koot, 1996). Although the CBCL is originally designed to be completed by parents, several researchers were able to show that the CBCL factor model also fits for the judgment of group care workers (Albrecht et al., 2001; Massey & Murphy, 1991; Wherry et al., 1992). All group workers, teachers, and youth were asked to complete respectively the CBCL, TRF, and YSR a first time before implementation, a second time after one year of implementation and a last time after two years of implementation. Further, to detect the effects of implementation of LSCI and the level-system, it was decided to keep track of students’ report cards, and to collect data with regard to the number of conflicts, signalization moments, and hours of non-attendance during a one-month period; once before implementation and once after implementation. These data were collected at the pre-test period (2006) and at the post-test period (2008).

In the fourth stage of the project (June-August 2006), all staff members of both the residential part as well as of the school for special education received the five-day training course in LSCI and were introduced in the use of the newly-developed level-system.

2.4.3. Instruments

- **Child behaviour checklist (CBCL)/Youth Self Report (YSR)/Teacher Report Form (TRF)**

Since the research covers several years, some youths left the programme during the research, and other youths entered the programme. We wanted to know whether the target group in Heynsdaele remained stable. Therefore, a CBCL was filled in for all youths by their individual group worker. The CBCL/6-18 consists of 118 specific questions concerning emotional and behavioural problems, and two open questions concerning other problems. The answers to these questions lead to different scales. The questions about behaviour form the eight problem scales: withdrawn/ depression, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. The first three problem scales form the broadband scale ‘Internalising’, and the last two form the broadband scale ‘Externalising’. All questions about behaviour form the scale total problems. The Dutch version of the CBCL (De Groot, Koot & Verhulst, 1994; Verhulst, van der Ende & Koot, 1996) has proved to be reliable and valid.

After the CBCL, all youngsters filled in a YSR, and the teachers filled in a TRF (Teacher’s Report Form).

The YSR (for ages 11-18) is a questionnaire in which youngsters themselves score statements about emotional and behavioural problems they experience. Many of these
questions are similar to those in the CBCL, supplemented with 14 social desirable questions on which most youths answer positive. The YSR includes the same subscales as the CBCL. The TRF (for ages 6-18) is a questionnaire on which teachers can answer questions regarding schoolwork and emotional and behavioural problems. The TRF consists of 118 questions, from which 93 also appear in the CBCL. The TRF includes the same subscales as the CBCL and the YSR. This makes it possible to compare over the different informants. In general, after completing these questionnaires, behaviour on the different scales is scored within the normal, subclinical or clinical range. A total of all scales is also scored (Verhulst et al., 1996).

All questionnaires were completed during the months of February and March in 2006, 2007 and 2008.

- **Academic performance**

Every year, the students receive six reports of their school results. The results, which are expressed in percentages, are divided into general courses (mathematics, geography, language, biology etc.), vocational courses, physical education, and philosophical courses. At the end of every school year, a sum of all these courses and a total score is calculated. Report of all students were collected at pre-test and at post-test.

- **Conflicts**

Based on the identified problem areas, we wanted to evaluate all the conflicts between youngsters and all the conflicts between youngsters and adults. In other words, did the implementation of LSCI result in a decrease of conflicts? The baseline was outlined in May 2006, six months prior to the implementation of LSCI and the level system. During this month, all staff members were asked to complete a registration form after each conflict. In May 2008, all staff members were asked to do this again. The registration form we designed was based on Dawson’s research in New York (2001) and gave us detailed information regarding the conflict such as place, day and involved student(s) and staff member(s). We described conflicts as the most escalated kind of disturbed relationships, implying a collision and a struggle of different needs and causes harm and/or injury to all parties.

- **Signalizations moments**

Signalization moments are moments or situations that have a warning function because they create a dysfunction of the ongoing activity. We define signalization moments as exceptional because these are situations in which the youngsters question the limits in a way that goes beyond the educational skills that staff need in regular situations. During the month of May in 2006 and during the month of May in 2008, all staff members were asked to register these signalization moments on a daily basis, and to register the event that caused the signalization moment.
**Non-attendance**
One of the problem areas in the centre was non-attendance of classes. It seems not to be easy to motivate the students to attend classes. When they skip class, they often walk around on the campus of the institution, which is disturbing for staff members and students who are participating in classes at that time.
In Belgium, every school is required by the Flemish government for Education to register the hours of students’ non-attendance. When a student arrived late or left the classroom early without permission, the hour was registered as non-attendance.

### 2.5. Results

#### 2.5.1. Research question 1: Does the target group remain stable?
Every year, a CBCL was completed for each youngster by his individual group worker, and a TRF was completed by his teacher. A YSR was also completed by each youngster. These three questionnaires result in a broadband scale on ‘Internalising’, a broadband scale on ‘externalising’ and a scale on ‘total score’.

- **Levene’s test of homogeneity**
A Levene’s test was performed to determine the homogeneity of variances. The following table proves the homogeneity of variances of all scales except for the total score of externalising behaviour scored by the teachers (Table 1).

<table>
<thead>
<tr>
<th></th>
<th>Levene statistic</th>
<th>df1</th>
<th>df2</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>total score CBCL</td>
<td>.227</td>
<td>2</td>
<td>150</td>
<td>.798</td>
</tr>
<tr>
<td>total score externalising CBCL</td>
<td>1.772</td>
<td>2</td>
<td>150</td>
<td>.174</td>
</tr>
<tr>
<td>total score internalising CBCL</td>
<td>.596</td>
<td>2</td>
<td>150</td>
<td>.552</td>
</tr>
<tr>
<td>total score TRF</td>
<td>1.849</td>
<td>2</td>
<td>154</td>
<td>.161</td>
</tr>
<tr>
<td>total score externalising TRF</td>
<td>3.720</td>
<td>2</td>
<td>154</td>
<td>.026</td>
</tr>
<tr>
<td>total score internalising TRF</td>
<td>2.253</td>
<td>2</td>
<td>154</td>
<td>.109</td>
</tr>
<tr>
<td>total score YSR</td>
<td>.151</td>
<td>2</td>
<td>166</td>
<td>.860</td>
</tr>
<tr>
<td>total score externalising</td>
<td>2.829</td>
<td>2</td>
<td>166</td>
<td>.062</td>
</tr>
<tr>
<td>total score internalising</td>
<td>.066</td>
<td>2</td>
<td>166</td>
<td>.936</td>
</tr>
</tbody>
</table>
Effects of the combination of Life Space Crisis Interventions and a level-system

- **Internalising behaviour**
The internalising problems (withdrawn, somatic complaints, anxiety/ depression) slightly decreased according to the youngsters themselves (YSR) and to the teachers (TRF). According to the individual counsellors (CBCL) there was a small increase. None of these differences is statistically significant (Table 2).

Table 2: Internalising behaviour

<table>
<thead>
<tr>
<th>Internalising</th>
<th>2006 (mean T-score)</th>
<th>2007 (mean T-score)</th>
<th>2008 (mean T-score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>58.6</td>
<td>56.2</td>
<td>55.9</td>
</tr>
<tr>
<td>CBCL</td>
<td>61.9</td>
<td>59.6</td>
<td>63.3</td>
</tr>
<tr>
<td>TRF</td>
<td>58.6</td>
<td>59.0</td>
<td>58.5</td>
</tr>
<tr>
<td>Somatic complaints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>58.6</td>
<td>57.2</td>
<td>57.4</td>
</tr>
<tr>
<td>CBCL</td>
<td>56.1</td>
<td>55.1</td>
<td>54.9</td>
</tr>
<tr>
<td>TRF</td>
<td>58.6</td>
<td>57.9</td>
<td>55.0</td>
</tr>
<tr>
<td>Anxiety/depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>59.8</td>
<td>57.7</td>
<td>56.9</td>
</tr>
<tr>
<td>CBCL</td>
<td>65.2</td>
<td>62.6</td>
<td>64.9</td>
</tr>
<tr>
<td>TRF</td>
<td>62.7</td>
<td>62.9</td>
<td>61.4</td>
</tr>
</tbody>
</table>

- **Externalising behaviour**
Regarding the externalising problem behaviour (aggression and delinquency), the scores by youngsters and teachers showed stagnation. The fluctuations reported by the individual counsellors are statistically not significant (Table 3).

Table 3: Externalising behaviour

<table>
<thead>
<tr>
<th>Externalising</th>
<th>2006 (mean T-score)</th>
<th>2007 (mean T-score)</th>
<th>2008 (mean T-score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delinquency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>61.7</td>
<td>61.2</td>
<td>61.0</td>
</tr>
<tr>
<td>CBCL</td>
<td>69.4</td>
<td>65.8</td>
<td>69.3</td>
</tr>
<tr>
<td>TRF</td>
<td>68.9</td>
<td>68.7</td>
<td>68.5</td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>60.6</td>
<td>59.9</td>
<td>61.1</td>
</tr>
<tr>
<td>CBCL</td>
<td>70.1</td>
<td>69.7</td>
<td>71.1</td>
</tr>
<tr>
<td>TRF</td>
<td>64.8</td>
<td>64.9</td>
<td>64.3</td>
</tr>
</tbody>
</table>
• **Social problems, thought problems, and attention problems**
  Over the three years, the scores for the ‘social problems’, ‘thought problems’ and ‘attention problems’ scales remained stable.

• **Total problem behaviour**
  The total scores show the same trend as the scores on the broadband scales and the subscales. None of the differences is statistically significant.

To find out whether the population in Heynsdaele remained stable over the three years of the project, each year three questionnaires were completed. No significant differences were found on any of the scales of these questionnaires. Based on these findings we can state that the problems of the target group remained stable, and changes in behaviour are not a result of changes in the target population of Heynsdaele.

### 2.5.2. Research question 2: What are the effects of the Implementation of LSCI and the level-system?

• **Academic performance**
  At the end of every school year, all students’ reports on their academic performances were collected. The results, which are expressed in percentages, are divided into general courses (mathematics, geography, language, biology etc.), practical courses, physical education and philosophical courses.
  An ANOVA test was used to compare the mean scores of the different school years. In 2007, the points for general courses were 5% higher than in 2006 (p=.022). This 5% increase remained stable in 2008 (p=.303).
  The implementation of LSCI and a level system resulted in a significant 5% increase of students’ points for general courses after one year of implementation. This increase is maintained after the second year of implementation of the two strategies.

• **Conflicts**
  In May 2006 and in May 2008, all staff members in the TC and in the school were asked to register every conflict they had with a youngster, and every conflict the youngsters had among each other. During the pre-test, 199 conflicts were registered. After two years of implementation, only 30 conflicts were registered. A Chi-Square test was performed ($\chi^2(1)=124.721$, p=0.00). This shows a significant decrease of conflicts reported by staff members (Figure 2).
Figure 2: conflicts

![Conflicts graph]

- **Signalization moments**

  Signalization moments are moments or situations which are special because they create a dysfunction of the ongoing activity. Examples of these moments are verbal aggression, physical aggression etc. that need an intervention from another staff member. These moments are spread equally over all weekdays. In 2006, 154 signalization moments were registered; in 2008, 57 signalization moments were registered. A Chi-Square test was performed ($\chi^2(1)=44.592$, $p=.000$) to analyse the difference between the pre-test and the post-test, which proved a significant decrease after two years (Figure 3).

Figure 3: signalization moments

![Signalization moments graph]
Non-attendance

Non-attendance in class was mentioned by staff members as one of the problem areas, because some students used to walk around in the hallways during classes, and disturbed teachers and students in the classrooms.

In order to investigate the effect of LSCI and a level system on the attendance of students in class, data were gathered during the pre-test and post-test. Both in 2006 and in 2008 the registration period covered 21 class days, which is the same as 165 hours of class. During the pre-test all students (n=59) together skipped 1,571 hours of class, which is an average of 26.63 hours per student. During the post-test all students (n=61) together skipped 573 hours of class, which is an average of 9.39 hours per student. A t-test was performed on the average hours per student and showed a significant decrease (p=.000).

2.6. Discussion

2.6.1. General discussion

Based on a thorough investigation with regard to possible problem areas in the centre as experienced both by staff members as well as by youth, it was decided to implement LSCI as a conflict resolution strategy, integrated with a self-developed level-system.

The first aim of this study was to investigate whether the population in the centre remained stable over the three years of the project. Using the CBCL, TRF and YSR we were able to confirm the hypothesis of stability of the problems of children and adolescents with EBD (De Bolle et al., 2009; Lipsey, 1992).

Further, and starting from the different problem areas as defined before implementation, it was the second aim of this study to investigate possible effects of the implementation of the integration of LSCI and the level-system.

One of the problem areas in the centre was the aggressive behaviour of the students. Our results show a significant decrease in both the number of conflicts as well as the number of signalization moments, indicating that LSCI and the level-system are effective in reducing problem behaviour. These results are in correspondence with the research of Dawson (2003), who found a decrease of conflicts in a New York school with LSCI trained teachers, while the number of conflicts remained stable in another New York school with untrained teachers.

Next to the positive outcomes regarding the aggressive behaviour, the implementation of both strategies also had a positive influence on the academic achievement of the students. This finding suggests that, even when academic achievement is the primary goal, it is
beneficial to invest in strategies to reduce disruptive behaviour and to provide teachers with insight and skills to deal with this behaviour. Stipek and Miles (2008) also reported the reciprocal relationship between aggression and academic achievement. Also the fact that the students attended more classes during the post-test than during pre-test has most likely been a positive influence on their academic performance.

From the results of this study we can conclude that working with children and adolescent with EBD remains a difficult task, but that the implementation of LSCI and a level-system has resulted in a decrease of disruptive behaviour and an increase of students’ academic achievement.

In order to maintain this progress made during the project, the authors suggest a further fine-tuning of both strategies. Working with youth who present disruptive behaviour is a subject of continuous change. For that reason, it is important that certain staff members get the responsibility assigned to closely follow LSCI and the level system in order to keep them up-to-date. Subsequently, intensive coaching will be a determining factor for the future. In doing so, the presence of supervisors in the living groups and in the classrooms and a thorough analysis of interventions based on registration, is designated. Because of this value of coaching, we consider it necessary that staff members have a supervisor to support them with questions and difficulties concerning LSCI. In addition, we also promote an annual refresher of the theory and practice of LSCI.

2.6.2. Limitations en implications for further research
This study has several limitations which need to be considered in interpreting the results. During the project, a lot of new staff members were hired. Although all new staff members were introduced to every aspect of the project, this could be at the cost of data reliability. Secondly, because of the relatively small number of participants, it was impossible to set up an experimental design with a control group and an experimental group. A similar research project, but with a greater number of participant is therefore recommended. To measure academic performance, students’ reports were used. These reports are not valid instruments to measure academic performance over a period of years. Some teachers also changed from periodic evaluation to permanent evaluation during the last year of the project. A fourth limitation is the fact that there were only boys involved in the research, meaning that the conclusion cannot be generalized to girls. Finally, the research design only enabled us to investigate quantitative data about the implementation. It would be recommended to set up a design that enables the researchers to also take into account the opinions of different stakeholders, such as staff members and youth, on the process of implementation.
References


CHAPTER 3

Reflections of caretakers on the process of implementation of Life Space Crisis Intervention at a therapeutic centre for youngsters with emotional and behavioural disorders

2 This chapter is based on Soenen, B., Goethals, I., Spriet, E., D’Oosterlinck, F., & Broekaert, E. (2013). Reflections of caretakers on the process of implementation of Life Space Crisis Intervention at a therapeutic centre for youngsters with emotional and behavioural disorders. Psychiatric Quarterly, 84(2), 239-254.
Abstract

Life Space Crisis Intervention (LSCI) is a therapeutic and verbal strategy used to intervene when children are in crisis. It has its roots in the work of Aichorn, Redl, Wineman & Bettelheim, and is part of the milieu-therapeutic tradition. In 2000, LSCI was introduced at the Orthopedagogical Observation and Treatment Centre, a school and day unit for 60 children with emotional and behavioural disorders affiliated with the Department of Orthopedagogics at Ghent University (Belgium). The particular position of orientation towards ‘therapeutic environments’ in the department’s history has encouraged the integration of LSCI in the daily activities of the departments’ school (Broekaert et al., 2009).

In 2003, LSCI was implemented and studied in several Flemish Institutes. Positive effects were found on school results, attendance in the classroom and number of conflicts. In this chapter, the reflections of the caretakers are taken into account. Analyses of these reflections resulted in 4 major themes: content of job and tasks, the youth in the centre, working with the youth in the centre, and cooperation with colleagues and other teams. The results of this analysis will be discussed.
3.1. Introduction

In 2005 “Project Heynsdaele” started as a collaboration between the Provincial Institute Heynsdaele, OOBC Nieuwe Vaart and the Department of Orthopedagogics at Ghent University. The Provincial Institute Heynsdaele is a residential facility and a special school for youth with emotional and behavioural disorders (EBD). All students at Heynsdaele are boys from 12 to 21 years old with emotional and behavioural disorders. It was the aim of this project to initialise a process in order to meet the needs of the youth by using appropriate strategies both in the residential centre and in the school.

Research on the characteristics of youth in Flemish residential care institutes shows the complexity and diversity of the needs of these boys and girls (D’Oosterlinck et al., 2006). In both boys and girls, comorbid disorders are often diagnosed, with neuroleptics the most commonly prescribed medications. Studies have shown that youth with EDB show aggressive and delinquent behaviour and suffer from social problems (D’Oosterlinck et al., 2006). These disorders tend to be long-term (Fergusson & Horwood, 1995; Lahey et al., 1995; Lahey et al., 2002; Leech et al., 2003).

Often, staff members working in educational or therapeutic settings for children with emotional and behavioural disorders lack coping strategies in dealing with conflict and crisis situations (D’Oosterlinck et al., 2009). Both the learning and behavioural problems make it difficult for teachers to provide effective instruction (Sutherland et al., 2008) and often lead to significant negative experiences for those interacting with the youngsters (Gregory & Weinstein, 2004). Nichols and Sosnowsky (2002) argue that special education teachers working with children with emotional and behavioural disorders and students who have poor motivation reported higher levels of stress, in comparison to those who work with students with learning difficulties, multiple difficulties, and intellectual disability. In a recent study, special educators were asked to indicate which of the 10 SEN (Special Education Needs) categorical groupings were the most stressful to teach. The majority of the teachers indicated that teaching children with autism causes the highest amount of stress, followed by students with behaviour difficulties, ADHD and emotional difficulties (Kokkinos & Davazoglou, 2009).

The need for a supportive and consistent methodology to cope with the high amount of conflict and crisis situations is a common experience for staff members working in educational or therapeutic settings for children and youths with emotional and behavioural disorders (D’Oosterlinck et al., 2009). The manner in which these conflicts are addressed determines whether the outcome will be constructive or destructive (Johnson & Johnson, 1995). As research shows, ignoring or negatively approaching conflicts leads to distrust, anger, aggression, anxiety and difficult learning situations (Deutsch & Coleman, 2000).
Conflicts that are dealt with in a positive manner increase productivity in the classroom and lead to desirable outcomes (Deutsch & Coleman, 2000).

### 3.2. Description of the project

With this project, a process was started in order to connect the services of the centre to the needs of the clients, and to support staff members in answering to the needs of the children and their families. By aligning their pedagogical assumptions, a better connection between the school and the residential centre was intended. Therefore, Life Space Crisis Intervention was implemented along with a level system.

### 3.2.1. Life Space Crisis Intervention

Life Space Crisis Intervention (LSCI), an ego-strengthening approach and part of the milieu-therapeutic tradition, uses a method that is derived from the work of August Aichorn as well as Fritz Redl and David Wineman (Broekaert et al., 2000).

LSCI is a therapeutic and verbal strategy used to intervene when children are in crisis. It is based on cognitive, behavioural, psychodynamic and developmental theory (Long & Fecser, 1997; Long & Fecser, 2000; Long, Wood & Fecser, 2001; Wood & Long, 1991). LSCI provides a meaningful way of talking with children in crisis. Both the extreme emotional experience and accompanying personal interpretation of the conflict provide a starting point. The key component to effective crisis intervention using LSCI is the ability to understand the youth’s perception of the crisis and his or her role in it. LSCI promotes the pursuit of the following stages: 1) Drain Off: de-escalate the crisis; 2) Timeline: students in crisis need to talk; 3) Central Issue: select the appropriate reclaiming intervention; 4) Insight: re-frame the student’s perception of the issue; 5) New Skills: plan for success; 6) Transfer of Learning: get ready to resume activity.

The first research on LSCI was performed by DeMagistris and Imber (1980). Their study supports the use of the Life Space Interview as an effective intervention procedure for improving academic and social performance. A more recent pre-post quasi-experimental design study in two schools in New York City showed that frequency of crises decreased significantly in the experimental school. In addition, there was a significant difference in the frequency of crises between the experimental school and the control school at post-test with the experimental school showing a decrease. There was a greater decrease in suspension in the experimental school than in the control school. More students in the experimental school were mainstreamed and transferred to less restrictive settings. Students in the experimental school also had higher attendance rates. Equally important, staff no
longer felt helpless or believed that “nothing works” with these troubled students. They felt empowered with a new sense of professional confidence and skills in helping these challenging students (Dawson, 2003). Grskovic & Goetze (2005) used two multiple baseline-across-subjects to evaluate the effects of LSCI on two girls and two boys separately. Data were collected in the classroom over a three-month period. They found a radical decrease in challenging behaviour for each participant after implementation of LSCI. Forthun, McCombie and Freado (2006) explored the impact of LSCI training on performance of school staff, and evaluated how exposure to LSCI strategies had an impact on student behaviour. Their findings suggest a significant change in staff perception of coping with problem students from one of control and punishment to one of cooperation, responsibility and proactive discipline. D’Oosterlinck, Broekaert and Denoo (2006) performed a qualitative research study about youth experience in LSCI. The most important conclusion of their study is that the LSCI strategy of talking with children and youth in a crisis helps them to reduce their destructive and painful thoughts and feelings. It also allows for a more positive perception to emerge regarding their role in the conflict. Other research by D’Oosterlinck proved the effect of LSCI on aggression and social desirability (D’Oosterlinck et al., 2008) and on educators’ and staff members’ feeling of competence (D’Oosterlinck et al., 2009). Soenen et al. (2009) found positive effects of LSCI on the academic performance of students and on reducing the disruptive behaviour of students.

3.2.2. Level system

When working with high-risk populations, a need exists for installing prevention programmes that support implementation of crisis management programmes (D’Oosterlinck & Broekaert, 2003). Behavioural strategies using token economy systems for rewarding and sanctioning either the whole class or individuals within a whole class are effective for reducing behaviour which is disruptive to a child’s own learning or that of others (Evan, Harden & Thomas, 2004). Although there are few recent studies on token economy in youth residential treatment, results are promising (Bowers et al., 1999; Wolf et al., 1995). Others, such as VanderVen (1995, 2000, 2009), state that level systems reinforce the youths’ distrust of and disengagement from adults rather than encourage positive change. If the adult is seen as an arbitrary dispenser of privileges and favours, especially of his or her attention, and as caring without the barrier of an external construct, than the potential for change is lost. Therefore, according to VanderVan (2009), point and level systems may control at a given moment, but they do little to ensure change. In accordance with the LSCI Safe and Reclaiming School Program (Long & Fecser, 2001), LSCI and a level system were integrated. The LSCI Safe and Reclaiming School Program is organised around three levels of prevention and intervention that combine to create a pyramid model. The level system is situated in the first stage of the model. This stage consists of school-wide baseline concepts and skills for all staff members to use in their
interactions with students in order to avoid fundamental differences regarding the definition of problem behaviour. The second level consists of early intervention strategies, such as modified accommodation in the classroom and other techniques which distinguish special education from general education. The use of LSCI is situated within the third level, along with other individual strategies such as individual therapy or individualised medical treatment.

Goals of the level system used in Heynsdaele are to set limits to severe disruptive behaviour, to reward positive behaviour in different levels and to detect non-responsive students.

The level system consists of five levels, each with its own specific goals. In the first level, the focus is set on aggression and bullying; in the second level, the focus is set on care for self, and others as well as materials; in the third level, the focus is respecting regulations and boundaries. These first three levels are each divided into four steps. In the fourth and fifth level, different goals are formulated for each individual student. The content of every level is explained for all students. For each goal, examples of desired behaviour are given. Depending on the level, a student receives certain privileges. In other words, a student in a higher level receives more privileges than a student in a lower level. These privileges, or the lack of them, should never take away treatment opportunities such as exercise or time with adults.

Every student in Heynsdaele starts in the first step of the first level. Based on his behaviour, he receives points for each part of the day. At the end of every week, all the points are listed. If a student collects the minimum amount of points he needs in his step, he can transfer to the next step. If he does not, the student has to stay in the same step for another week. When a student fails to transfer to the next step three weeks in a row, he goes to the “care-level”. For these students, an individual treatment programme is designed based on their specific needs.

3.2.3. Process
The project started by making an inventory of the problem areas in the institution. Both staff members and youth were interviewed, observations were performed in the living groups and in practical and theoretical classes. Furthermore, organisational structures were analysed based on extended documentation. Secondly, a quantitative design was created in order to research possible effects of the implementation. Analyses of these different quantitative measures, such as different questionnaires and academic performance showed positive results (Soenen et al., 2009).

In 2005, all care takers received a five-day training course in LSCI. During the first day of the training, the philosophy and theoretical framework of the method was explained. In the next three days, the LSCI technique was explained and practised. At the end of the training
course, participants had to complete an LSCI knowledge test and had to perform a role play in which their intervention skills were observed and assessed by the senior trainer. Together with the implementation of LSCI and the level system, the existing crisis intervention team was reorganised in order to facilitate the use of LSCI. It was guaranteed that at all times from Monday through Friday all teachers and educators could reach a colleague to assist when crises occurred.

Subsequently, the project managers started with a process of coaching, both on an individual level with teachers and educators as well as on the level of the organisation. Therefore, project managers visited the centre on a regular basis. They were present in the classrooms and in the living groups to offer support to the staff members and to ensure that both strategies were used as prescribed. At the start of every year, a refresher of the LSCI theory was offered. To guarantee well-embedded coaching, both during and after the project, staff members who work as supervisors were trained to coach their colleagues.

This continuous coaching as provided by the project managers revealed different needs. First of all, staff members stressed a high need for support during daily work, especially when conflicts with youth occurred. Secondly, there was a need to align treatment between the two departments, namely the school and the residential centre. Thirdly, it was stated that tasks and responsibilities of staff members on all levels needed to be clarified. Finally, the need for a specialised and concrete individual comprehensive treatment plan for all youth at the centre was stressed. Because of these needs, three team-days were organised by the project managers and attended by all staff members with a management position. During these team-days, decisions were made regarding task responsibilities of all staff members. Moreover, new structures for communication and cooperation within and between the different teams were created, and the format of an individual treatment plan for all youth was developed.

3.3. Method

The objective of this research was to gather the reflections of all care takers who work with youngsters with emotional and behavioural disorders. The implementation of LSCI at the therapeutic centre has been an ongoing process, and in this article we want to analyse care takers’ reflections on this process.

This study was carried out in the Therapeutic Treatment Centre Heynsdaele (Ronse, Belgium). The TC Heynsdaele is recognised as a special school and residential treatment centre for the care of 70 youngsters with emotional and behavioural disorders, ages 12 to 21. While most youths are referred to Heynsdaele by the social or the juridical branch of the Flemish youth protection service, some of them are in Heynsdaele on a voluntary basis. As research of D’Oosterlinck et al. (2006) has shown, the most common behavioural problems
Reflections of caretakers

in youths with EBD are aggressive behaviour, delinquent behaviour and a lack of social skills. All youngsters in Heynsdaele are boys, and their average age throughout the duration of the project was 14.45 years old.

A qualitative approach was chosen for this study because when studying human experiences and understanding about their lives and world it seems important to talk to them, with the purpose of trying to understand the world from their point of view (Hellzen et al., 1999). In 2008, at the end of the project, 22 staff members were interviewed. Semi-structured interviews were used in which the interviewer gave preset questions in a predetermined order, but with the flexibility of bringing up new questions as a result of interviewee responses. The interviews were carried out on a one to one basis. General information about anonymity and confidentiality was given to the interviewees. Furthermore, permission to tape-record and to transcribe the interviews verbatim was asked, to which all interviewees consented. The authors carried out the first reading of the text, to get a sense of the whole and to develop ideas for further analysis. In this way, a temporary tree structure was developed out of the raw material. Next, the text was divided into meaning units, which are the constellation of words and statements that relate to the same central meaning. Graneheim and Lundman (2004) consider a meaning unit as words, sentences or paragraphs containing aspects related to each other through their content and context. To increase the trustworthiness of the findings, further analysis was performed in cooperation with other researchers. Two independent groups consisting of two researchers each analysed the fragments of the text by means of the text analysis software package MAXqda2. They compared and discussed the results and consequently refined and attuned the definitions of categories of the tree structure. Later, the two separated groups recoded the material into the definitive tree structure, after which a new comparison and discussion of the results took place.

3.4. Results

Analysis of the interviews revealed four different categories in which experiences of staff members can be divided: content of the job and tasks, the youth in the centre, working with the youth in the centre, cooperation with colleagues and other teams.

3.4.1. Content of the job and tasks

In the first category, staff members describe the content of their job, i.e. the different tasks they have to do. Although there seems to be an overlap in the tasks of teachers and educators, different focuses are noticeable. While in the statements of teachers the focus is on transfer of knowledge, in the statements of educators the focus is on supporting the
youth in daily life. When listening to staff members who have a management position, the focus is on both the policy of the organisation as well as on coaching and support of teachers or educators. Common for the three groups of staff members is the great amount of administrative work.

Statement of an educator:
“Helping the boys to make the right choices, helping them to live together with the other boys and the educators, mediate between the boys and their families. I think these are my most important tasks.”

Statement of a teacher:
“I have a schedule which consists of 22 hours of teaching.”

Statement of a teacher:
“We have a broader task then teachers in mainstream education, because we have students with emotional and behavioural problems. Our job is not only teaching the curriculum, but also talking with the students when they have problems. So we have similar tasks as teachers in mainstream education, but also other problems like social values. Therefore, sometimes we have to ignore the curriculum.”

3.4.2. The youth in the centre
Within this category staff members mention both the complex background of the youth as well as their disruptive behaviour. Aggression, drug abuse and skipping classes are examples of this disruptive behaviour.

Statement of a teacher:
“And then sometimes you arrive at the playground, and they just start calling you names. For no reason, without a previous conflict. Even if they haven’t seen you yet that day.”

Statement of a teacher:
“There are boys who skip classes all day. They make noise day after day, they create difficulties. Day after day.”

Previous statements make clear that disruptive behaviour still occurs in the centre. Nevertheless, many staff members indicate positive developments following implementation of the level system and LSCI. There is not only a decrease in the disruptive
behaviour, but also an increase in youths’ willingness to talk about their problems and behaviour.

Statement of an educator:
“But the severe aggression has decreased. Maybe it’s difficult to measure, but it’s different nowadays. It has changed.”

Statement of a teacher:
“The boys are more open towards us. If they have a problem, they will come to us to talk about it.”

3.4.3. Working with the youth in the centre
Statements within this category refer to how staff members experience their daily work with the youth in the centre, or how they experience the work of their colleagues. Analysis of this category revealed four different subcategories: negative experiences, positive experiences, evolutions since the project started, and recommendations for the future.

Negative experiences concerning working with the youth in the centre
Staff members indicate different reasons for their negative experiences with the youth. Some say that because of a lack of individual moments with the boys, they do not have enough opportunities to build relationships. The complex nature of the youths’ problems, in combination with a lack of resources, makes it difficult to find or to adopt the right strategies to deal with their disruptive behaviour. Others criticise their colleagues for not using the strategies which were offered during the project. They suggest that their colleagues are not motivated to use the strategies, or that they do not have enough knowledge and skills to use the strategies. Finally, a lack of time is experienced as a major barrier in working with youngsters in the centre.

Statement of a staff member with a management position:
“What I don’t see enough is communication with the boys. They (the educators) give an enumeration of the facts, but they don’t listen to the boys. I think the educators should make time to have individual moments. That’s what these boys need, that’s how they will create a positive relationship.”

Statement of an educator:
“A problem in the school, is the fact that some teachers miss the fundaments. They don’t have enough background or enough knowledge to work with these kids.”
Statement of an educator:
“We still have a lot of work in understanding the problems of the boys. I have the impression that teachers think everything works like in mainstream education. But that’s not possible. With our boys, that’s really not possible.”

Statement of a teacher:
“As you can see at to registrations (of the LSCI’s), we don’t have enough time. If I leave my classroom to have an LSCI with a student, someone else has to take over.”

Statement of an educator:
“In our group, we have some boys with problems that are too difficult for us. And there is no one here to support us with these problems, and that’s a shame.”

Positive experiences concerning working with the youth in the centre
Experiences are seen as positive because people feel that they, or their colleagues, are using the ‘right attitude’, but also because they see positive results with the boys.

Statement of a staff member with a management position:
“With some teachers, I can see that they have the right attitude and the right feeling for these boys. It’s all about being correct and being righteous.”

Statement of an educator:
“The way of starting a conversation: asking what has happened, who as involved... building up the timeline... using the different stages... that’s something I try to do because it works. Maybe not with all the boys, but it works.”

Evolutions since the project started
In a third subcategory staff members reflect upon the developments they have noticed since the start of the project.
The project resulted in the development of a shared approach in the centre, namely the use of LSCI and an level system. As a result of this shared approach, more clarity was created for both staff members as well as the youngsters. Staff members have been taught strategies to deal with difficult situations, and youngsters know what to expect after they were involved in conflicts.
Even though the methods which were implemented are not always used in exactly the same way as presented in the LSCI training, many staff members notice a positive change in the behaviour of the adolescents. Subsequently, several teachers and educators mention that they feel more empowered dealing with the disruptive behaviour they encounter on a daily basis. All these aspects taken together resulted in a better atmosphere in the centre.
Statement of an educator:
“At the start of the project, it was mentioned that we didn’t have a shared vision, that we all had different opinions about the job. Now I can see a positive evolution.”

Statement of a teacher:
“The way of talking with the boys…. I won’t get angry when a conversation doesn’t go like I want it to go. That’s how the LSCI training has helped me. Maybe not all of it, but some elements. Now I can end a conversation like I want it to end.”

Statement of a teacher:
“As a result of the last years, we know that we have to stay calm when conflicts occur. We don’t have to start yelling and shouting. We have to stay calm if we want to keep the situation under control.”

Statement of an educator:
“With LSCI... we have a shared approach, now we all use the same techniques, now we all talk about the same.”

Statement of a staff member with a management position:
“Now we have less exclusion and a longer length of stay.”

Statement of an educator:
“Compared with three or four years ago, things are more clear for everybody now, and there is a better atmosphere. That’s my opinion.”

**Recommendations for the future**
This last subcategory consists of recommendations, both short term and long term, interviewees gave for the future of the therapeutic centre.
A first trend we could find was that staff members stress the need to work more on an individual basis with the boys, in order to work on their relationships. Since the problems of the youth in the centre are very diverse and complex, this individual way of working could help staff members to take into account the specific problems of a specific youngster. Secondly, we found that staff members had many ideas to adjust and improve the application of the two strategies (LSCI and the level system) which were implemented during the project. Because of the complexity of the strategies, frontline staff members stressed a need for a constant support in their use of the strategies. Subsequently, it is stated by the interviewees that the use of both strategies should continuously be evaluated and
adjusted when necessary in order to find a balance between both strategies and in order to strengthen the process of implementation.

Statement of an educator:
“We should really talk with our boys. We don’t have a lot of resources to help them. And that’s why these conversations are really important.”

Statement of an educator:
“We should offer more specific treatment. We should be more specialised... in autism for example.... So we can work more specifically.”

Statement of an educator:
“I’m convinced that the strategies are useful, and that we have to keep using them, but we also have to keep evaluating and reconsidering them. Every year, we should do an evaluation.”

Statement of a teacher:
“When a student is involved in a conflict, we have to be able to have a conversation immediately. It would solve a lot of problems... otherwise the conflict could escalate during the day.”

Statement of a staff member with a management position:
“We know from experience.... We have had other projects in the past. In the beginning, everybody was very excited. But when the project stopped, everything was lost. And that would be a shame.”

3.4.4. Cooperation with colleagues and other teams
Within this category staff members reflect upon how they experience the communication and the cooperation not only within their own team, but also between the different teams and between the different parts of the therapeutic centre (school and home). Analysis of this category revealed four different subcategories: negative experiences, positive experiences, evolutions since the project started, and recommendations for the future.

Positive experiences regarding cooperation
When staff members are given the opportunity to have their own input, and when they have the feeling their opinions matter when decisions have to be made, cooperation is experienced as positive. The better the relation with colleagues, the better cooperation is experienced. Therefore, cooperation within one’s own team is perceived as more positive than cooperation between teams. Finally, many staff members indicate that they take
initiative themselves to communicate with colleagues from other teams, which creates a more positive work environment.

Statement of an educator:
“Our team is our strength. We can say everything to each other. If we have a problem, we can discuss it with our colleagues. And that’s something our boys notice, they see we are a good team.”

Statement of a teacher:
“I make a lot of efforts to make sure we have a good communication. You can’t just wait for it. If I need information to do my job, then I will ask for this information.”

Statement of an educator:
“Like yesterday, I sent a mail to our director because we had some problems in our group, and she invited me to think about a solution.”

Negative experiences regarding cooperation
The different focus of the school (education) and the residential centre (treatment) is very often perceived as a barrier to good communication and cooperation. Teachers state that educators do not understand the job of a teacher, and vice versa. Some staff members even speak of a reciprocal distrust between the two departments. Although the two departments (school and residential setting) are located on the same campus, this is perceived more as a weakness than a strength.

Next to a lack of time, practical issues such as a shared computer network result in another barrier for communication and cooperation. This lack of good communication and cooperation is often seen as the cause of many problems.

Statement of a teacher:
“Many problems could be avoided with a better communication.”

Statement of a teacher:
“They (directors) asked us (teachers) to give more information to the educators. But since they don’t come to us, we don’t go to them.”

Statement of a staff member with a management position:
“A big problem we have, is that we don’t know each other’s job. We don’t understand each other.”

Statement of an educator:
“Since we work with different computer systems, we don’t know what’s happening on the other side.”

Evolutions since the project started
A general agreement is that although communication and cooperation has positively evolved since the beginning of the project, there is still room for growth. Communication has become more structured and systematic, and decision-making is more shared than before. On the other hand, the creation of new structures for communication did not guarantee the correct use of the structure.
Some staff members, especially frontline staff, mention a decrease in informal communication.
Many interviewees agree that, because everybody uses the same strategies in dealing with the youth’s behaviour, all staff members speak a common language which improves their willingness to cooperation.

Statement of an educator:
“Cooperation between school and residential setting is getting better. It’s growing, it certainly can improve, but it’s getting better.”

Statement of a teacher:
“I wonder... I think the new information; the new structures for cooperation are not well enough communicated to us. If we don’t know the new structures, they can’t expect us to use them.”

Statement of an educator:
“It’s better than some years ago. Meetings are more systematic. We even have a calendar for our meetings, so now we have a better view.”

Statement of a staff member with a management position:
“The good thing is... we are all trained in LSCI. Not only in ‘knowing’, but also in ‘speaking’. If someone describes a conflict with a LSCI-word, we all understand.”

Recommendations for the future
Many interviewees agree on the need for a more efficient and better organised communication within the centre, which could be developed just effectively using the newly created structures. Informal communication between people from the two departments should be stimulated, for example by inviting colleagues to visit the living
groups or classrooms on a regular basis. Further, technology such as a shared computer network also could improve communication and cooperation. Finally, in order to have sufficient support and feedback on the use of LSCI and the level system, staff members recommend that one colleague or supervisor should function as a contact person with regard to these strategies.

Statement of a teacher:
“I receive many calls from people from the residential centre. I don’t have a problem with that, but if everything would be better organised, than we could win a lot of time.”

Statement of an educator:
“We don’t expect teacher to visit our group all day, but just sometimes, so we can just talk about things. That would be a positive thing.”

Statement of an educator:
“Just using the protocols of the meetings... We have to make sure that, whenever a meeting is planned, that this meeting actually takes place and that everybody is present.”

Statement of a teacher:
“Actually, there should be one person we can contact when we have questions. One person who knows the system very well, and who is able to support us.”

3.5. Discussion

An analysis of caretakers’ reflections on the process of implementation of LSCI and a level system was performed. In order to do so, caretakers of a therapeutic centre for youngsters with emotional and behavioural disorders were interviewed at the end of a three-year project. Analysis of these reflections revealed four themes: content of job and tasks, the youth in the centre, working with the youth in the centre, and cooperation with colleagues and other teams.

Although there seemed to be different focuses between the job content of a teacher and the job content of an educator, all staff members indicated a great amount of administrative work. The boys who lived in the centre were described as having a very complex background, which resulted in disruptive behaviour such as aggression, drug abuse and
non-attendance. During the project, staff members experienced a greater willingness of the boys to talk about their problems.

Generally speaking, care takers reflected positively on the process of implementation, since it enabled all staff members to reflect on and act with their boys based on a shared philosophical and theoretical framework. This finding is consistent with previous research on LSCI, in which the need for LSCI training of all staff members was stressed, in order to achieve a total experience (D’Oosterlinck et al., 2009).

Staff no longer feel helpless or believe that “nothing works” with these students, but are empowered with a new sense of professional confidence. Both the strategies offer support to staff members as well as to the youngsters. Similar results were found in previous research on LSCI in a school in which 87.5% of staff reported that they felt able to manage crises following implementation of LSCI (Dawson, 2003). Participants of another study on LSCI in a school setting noted that they were better able to control their feelings of anger. Beyond this, school personnel felt that their training and experience with LSCI helped them to improve their relationship with children (Forthun, McCombie & Freado, 2006). We believe that when care takers feel more capable of addressing students’ need they will feel less anxiety when confronted with challenging behaviour (Hastings & Brown, 2002) and will experience more satisfaction in doing job (Stalker et al., 2007).

Subsequently, care takers also stressed the need for a more individualised approach. We agree with Connor and his colleagues (2004), who argue that residential treatment needs to progress beyond the “one size fits all” approach and needs to develop a more specific and empirically proven treatment for the specific needs of this population. Simultaneously, we also believe in the tradition of “the group as method” approaches, which are mostly applied in therapeutic communities for children and in the new school movement (Broekaert et al., 2009).

Although the process of implementation resulted in a shared approach, staff members indicated that communication and cooperation should be more structured, more systematic and more shared. When a collaborative environment, as described by the staff members, could be developed, this would have the potential to benefit teachers by preventing burnout, heightening teachers’ sense of efficacy, and improving teacher’s knowledge base (Brownell et al., 1997).

From the results of this study we can deduce that working with youngsters with emotional and behavioural disorders remains a difficult task. But, although problems still occur, the climate has become a more positive one.

In order to maintain the positive progress, and since working with these youngsters is constantly subject to change, the authors suggest a constant fine-tuning of the integration of
LSCI and the level system within the daily work at the home and the school. In doing so, the experiences and opinions of all staff members should always be taken into account. Since they are closest to the problems, bringing together those who are asked to implement new practices is perhaps the most direct method of uncovering implementation problems and the most effective way of resolving difficulties that might arise (George et al., 1995). Together with George and Fogt (2005) we also want to emphasise that research-based practices in schools are necessary but not likely to be implemented or sustained over time unless proper organisational structures are in place to support them. Therefore, not only LSCI and the level system should be constantly evaluated, but also the organisational changes which started as a result of the process of implementation of the two strategies.

Care takers who are confronted with disruptive behaviour of youngsters will need ongoing support of their colleagues and supervisors, not only regarding their use of LSCI, but also emotional support. Intensive coaching with a presence of supervisors in living groups and in classrooms will be a determining factor for the future application of LSCI. This need for support is also emphasised by George et al. (1995), who found that when teachers of students with emotional disorders perceived supervisory support as ‘adequate’ or ‘more than adequate’, there was a greater likelihood that they planned to remain in the field. A thorough analysis of interventions based on extended registrations of these interventions could serve as a fundament to organise coaching. In addition, we also promote training in LSCI for all staff members, and an annual refresher of the theory and practice of LSCI.

This study has several limitations which could impede the generalisation of our findings. Although many aspects of the work and organisation in this centre are similar to other Flemish centres, and although the behaviour of youngsters with EBD and the challenges working with these youngsters brings along is very similar all over the world; it is not possible to generalise these findings to other centres since this research took place in only one centre. According to Krippendorff (2004), a text never implies one single meaning, just the most probable meaning from a particular perspective. Thus, our interpretation should be seen as one possible interpretation of care takers’ reflections.

During the project, a number of new staff members were hired. Although all new staff members were introduced to every aspect of the project, this could influence the reliability of the findings. Finally, although participants’ anonymity was guaranteed not all care takers volunteered to participate in this study. As a result, it is possible that important reflections were not captured in the analysis.
References


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CHAPTER 4
Problem behaviour in a Flemish therapeutic centre for children and youth with EBD: Group workers, teachers, and youth as different informants

Abstract

In this chapter, we search for characteristics of youth in Flemish care institutes for youth with emotional and behavioural problems. Group workers, teachers, and youth themselves are used as different informants. Data were collected in a therapeutic centre in West Flanders, which offers residential care and day treatment. Based on individual files of all youngsters and on employee data, information regarding type of treatment, age, gender, IQ, and job experience was gathered. The CBCL (Child Behaviour Checklist) was completed for each child by a group worker, the TRF (Teacher Report Form) by a teacher, and the YSR (Youth Self Report) by the youths themselves. Correlations between the different informants were sought, and a profile for the children and adolescents was developed based on data from each informant. The results show the complex nature of the problem behaviour of youth in care. Disagreement between the informants was found, especially regarding internalising problem behaviour. The need for multiple informants in clinical practice is underscored. A re-thinking of the organisation of living groups in Flemish care centres is suggested.
4.1. Introduction

Children and adolescents with emotional and behavioural disorders require special treatment programmes which meet their social/emotional needs and address their problems. Specifically, children in residential settings are a highly complex and poorly understood population, often subject to multiple child-service systems including health, child welfare, and special education (Hussey & Guo, 2005). They are a highly vulnerable group and have extensive mental health needs (Hukkanan et al, 1999).

More boys than girls are affected (3:1 or 4:1) (American Psychiatry Association, 1987; Fagot & Leve, 1998; Van der Ploeg & Mooij, 1998). High comorbidity rates are reported for DSM diagnoses of conduct disorder with oppositional disorders, affective disorders, anxiety disorders, and attention deficit disorders (McConaughy & Skiba, 1993; Teplin et al, 2002; Wasserman et al, 2005). The high prevalence and degree of severe disorder in the residential population represents a demanding and difficult burden of treatment and care, which should not be underestimated (Baker et al, 2007).

Findings from a Dutch follow-up research indicate continuity of behavioural and emotional problems in clinically referred children and adolescents, and that these problems should be viewed as chronic conditions (Visser et al, 2003). A recent Flemish research (De Bolle et al, 2009) proved that internalising and externalising problem behaviour was almost as stable as personality traits, suggesting that childhood psychopathology is more persistent than generally assumed.

4.1.2. Different informants

When assessing children and youth’s problem behaviour, different informants can be used. The decision about what type of person should be the informant and how many informants are necessary usually depends on the context such as the home or school, or the age of the child as an indicator of level of maturity (Rubio-Stipec et al, 2003). Research on informant (dis)agreement is ambiguous. Stanger & Lewis (1993) investigated agreement between mothers, fathers, teachers and children. They found that children generally reported the most problems and teachers the least. Agreement was lowest for rater pairs involving teachers on internalising problems. Handwerk and his colleagues (1999) on the other hand, found that parents rate the emotional and behavioural problems of their children as more severe than the children did themselves. In looking for agreement between parent, teacher, and male adolescent ratings of externalising and internalising problems, Youngstrom, Loeber & Stouthamer-Loeber (2000) proved that both youths and caregivers reported significantly more externalising problems than teachers. All three informants reported reliably different levels of internalising problems; youth reported the most, followed by caregivers, with teachers reporting fewer problems. In several researches, agreement
between adults and youngsters on externalising problem behaviour is greater than agreement on internalising behaviour (Andrae, Lenz, & Lehmkuhl, 2009; Cai, Kaiser, & Hancock, 2004; Duhig et al, 2000; Epstein et al, 2004; Grietens et al, 2004; Hawley & Weisz, 2003; McConaughy et al, 1994; Salbach-Andrae et al, 2009; Stanger, 1993; Yeh & Weisz, 2001; Youngstrom, Findling, & Calabrese, 2003).

Some studies indicate that discrepancies between informants constitute important risk factors for adverse development, since these discrepancies may make it difficult for them to cooperate and actively participate during the treatment process, and influence treatment processes and outcomes (De Los Reyes, & Kazdin, 2005; Ferdinand, van der Ende, & Verhulst, 2004; Yeh, & Weisz, 2001). On the other hand, results also reinforce the need for multiple sources of information when assessing emotional and behavioural problems in children (Clay, Surgenor, & Frampton, 2008; Comer & Kendall, 2004; Epstein, et al., 2004; Ferdinand, van der Ende, & Verhulst, 2004; Ferdinand, van der Ende, & Verhulst, 2006; Rubio-Stipec et al., 2003; Stanger & Lewis, 1993; Youngstrom, Findling, & Calabrese, 2003; Youngstrom, Loeber, & Stouthamer-Loeber, 2000).

### 4.1.3. Youth care in Flanders

In Flanders, the Dutch speaking part of Belgium, youth care is divided into three main streams. (1) the school system including special education for children with severe emotional and behavioural disorders; (2) youth protection services with a social and judicial branch for children in problematic educational situations; (3) mental health care for children with a handicap, in this case children with emotional and behavioural disorders. In many youth care services, both education and care are located at the same domain.

The current Flemish referral system selects children with outspoken externalising and problematic behaviour for special health care and special schools. There seems to be no place for these children in the mainstream schools and primary support systems in Flanders. They are relegated to youth care because the mainstream system is not sufficiently equipped to cope with their disruptive, aggressive behaviour.

A recent research, which involved all placements in six of the seven (semi-) residential centres for emotional and behavioural disorders in East Flanders, shows the complexity and diversity of the needs of these boys and girls (D’Oosterlinck et al., 2006). In the Flemish mental health care system, there are more boys than girls, mostly placed in residential care. Boys show a low IQ, however, they still score higher than girls, and are more often diagnosed with ADHD, conduct disorders and pervasive developmental disorder. Both boys and girls suffer from comorbidity and most commonly take neuroleptics. Analyses of CBCL (Child Behaviour Checklist) data, filled in by the group workers, revealed that these
children and youngsters have a high externalising and social behavioural profile, show aggressive and delinquent behaviour and suffer from social problems (D’Oosterlinck, 2006).

The aim of our study is twofold. Firstly, we want to look at the characteristics of children and youth who are placed in a residential setting for youth with EBD in West Flanders, and / or attend the school for special education which is connected to this centre. Secondly, we want to see if there are specific profiles when using group workers, teachers and youth as different informants.

4.2. Method

This research, which took place from March to June 2009, involved all children and adolescents placed in a therapeutic centre for children and youth with EBD in West Flanders and can be seen as part of an extensive research design. Based on previous findings on Life Space Crisis Intervention (LSCI) (D’Oosterlinck et al., 2008; D’Oosterlinck et al., 2009; Soenen et al., 2009), the centre chose to implement this strategy (Long, Wood & Fecser, 2001) as a strategy for conflict management. At the time of this research, the institute offered day treatment, education and residential treatment to 442 children and youngsters with emotional and behavioural disorders and their families.
Prior to the implementation of LSCI, we wanted to investigate the characteristics of the children and youngsters in the centre, and look at the specific profiles of these children and youngsters, by using group workers, teachers and youth as different informants.

4.2.1. Data gathering

File data
Based on the individual files of all youngsters, following data were gathered: age, gender, total intelligence, verbal intelligence, performance intelligence, current type of treatment and diagnostic data. All these data were gathered by psychologists, social workers and pedagogues who are employed at the centre, under supervision of the authors. The human resource department of the centre provided the authors with information on sex, age, and years of experience of all group workers and teachers who work directly with the children and youngsters.

Instruments
Subsequently, CBCL, TRF and YSR results were added to the database. The CBCL/6-18 (Child Behaviour Checklist) consists of 118 specific questions concerning emotional and behavioural problems, and two open questions concerning other problems. The answers to
these questions lead to different scales. The questions concern behaviour and form together eight problem scales: withdrawn/ depression, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. The first three problem scales form the broadband scale ‘Internalising’, and the last two form the broadband scale ‘Externalising’. All questions together form the scale ‘Total problems’. The Dutch version of the CBCL (De Groot, Koot & Verhulst, 1994; Verhulst, van der Ende & Koot, 1996) has proved to be reliable and valid. Although the CBCL was designed to get an image of the problem behaviour of children and youngsters as reported by parents, Albrecht et al. (2001) were able to show that the original CBCL factor model based on parental judgement of child behaviour also fits for the judgement of group care workers. This means that the eight narrow-band syndromes as well as the two broad-band syndromes can be used to interpret the CBCL scores of group care workers. Therefore, a CBCL was completed for all youths by their individual group worker.

The YSR (for ages 11-18) (Youth Self Report) is a questionnaire in which youngsters themselves score statements about emotional and behavioural problems they experience. Many of these questions are similar to those in the CBCL, supplemented with fourteen socially desirable questions to which most youths answer positively. The YSR includes the same subscales as the CBCL. All children and youngsters were asked to complete a YSR. This took place during class time, under the supervision of one of the authors and a master student in Orthopedagogics. The children and adolescents had the opportunity to ask questions about individual items, but were not allowed to seek clarification about how they should respond. Children and adolescents who were absent, were asked to fill in a YSR after they returned.

The TRF (for ages 6-18) (Teacher Report Form) is a questionnaire on which teachers can answer questions regarding schoolwork and emotional and behavioural problems. The TRF consists of 118 questions, from which 93 also appear in the CBCL. The TRF includes the same subscales as the CBCL and the YSR. All class teachers were asked to complete a TRF for each of their students.

4.2.2. Data analysis

File data
The age groups were reduced into two categories: a category with age 6 to 12, and a category with youngsters age 13 to 18. The reason for this distribution is the fact that at 13, children pass from primary school to secondary school. Based on the clinical borderline, intelligence scores were grouped in a category with scores below 70 and a category with
scores above 70. The different types of treatment were divided into residential care and day treatment. Due to dated or incomplete data, other diagnostic information was excluded.

The age groups of the group workers and the teachers were reduced to a category of group workers younger than 36 (= mean age) and a category of group workers older than 36. The same was done for years of experience of staff, with a mean of 13 years for group workers and 10 years for teachers.

**Questionnaires**
Using a One-sample t test, with the clinical cut-off of 60 for the total and broadband scores, and 65 for the narrowband scores as test value, we wanted to test whether mean scores of all three questionnaires differed from this clinical cut-off score. Next, an independent samples t-test was performed with youths’ ‘gender’, ‘age’, ‘intelligence’ and ‘treatment type’, ‘age informant’ and ‘experience informant’ as grouping variable. Finally, ANOVA of repeated measures with Bonferroni correction for multiple comparisons were used to examine the differences in mean scores between informants.

Inspired by the work of D’Oosterlinck et al. (2006), three different profiles were developed; one on the basis of the CBCL, one on the basis of the TRF and one on the basis of the YSR. Correlations (Pearson Correlation Coefficient) between the ‘total score’ and the two ‘broadband syndrome scales’ (internalising, externalising) were measured for the CBCL, TRF and YSR. The strongest correlation found between ‘total score’ and the broadband syndrome was correlated with the remaining syndrome scales, and this strongest correlation was withheld. These remaining variables were used to construct the profile.

### 4.3. Results

#### 4.3.1. File data

The sample (n = 434) shows a ratio of boys and girls of approximately 3-1 (71.80% – 28.20%). The majority (65.60%) of them is older than 12, with a mean age of 13.35. About half of the youngsters in the sample are placed in residential care, whilst the other half is offered day treatment. Mean intelligence scores are 77.12 (IQ), 77.96 (VIQ) and 82.16 (PIQ). For gender and age, no significant differences were found on IQ scores. Youth in residential care have a significant lower verbal intelligence (p=.022) than youth in day treatment. The descriptives of the file data are presented in table 1 and table 2.
Table 1: descriptives of data file

<table>
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<th>Mean</th>
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</tr>
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<tr>
<td>Age youngsters</td>
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<tr>
<td>Verbal IQ</td>
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<td>77.96</td>
<td>11.62</td>
</tr>
<tr>
<td>Performance IQ</td>
<td>339</td>
<td>82.16</td>
<td>11.92</td>
</tr>
<tr>
<td>Total IQ</td>
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<td>77.12</td>
<td>10.16</td>
</tr>
<tr>
<td>Age group worker</td>
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<td>36.28</td>
<td>11.84</td>
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<tr>
<td>Experience group worker</td>
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<td>12.70</td>
<td>11.42</td>
</tr>
<tr>
<td>Age teacher</td>
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<td>Experience teacher</td>
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<td>4.07</td>
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Table 2: frequencies of data file

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<tr>
<td></td>
<td>+12</td>
<td>65.6</td>
</tr>
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</tr>
<tr>
<td></td>
<td>Boy</td>
<td>71.8</td>
</tr>
<tr>
<td>Treatment</td>
<td>Residential</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Day treatment</td>
<td>54</td>
</tr>
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</table>

4.3.2. Questionnaires
Table 3 shows that mean scores on CBCL ‘externalising’ (p=.000) and CBCL ‘total’ (p=.020) are significant higher than the clinical cut-off score of 60. Mean scores on CBCL ‘internalising’ (p=.000), TRF ‘internalising’ (p=.000), TRF ‘externalising’ (p=.001), TRF ‘total’ (p=.000), YSR ‘externalising’ (p=.000) and YSR ‘total’ (p=.025) are significantly lower than the clinical cut-off score of 60. A One-sample t test with a cut-off score of 65 on the narrowband syndrome scales shows that all scores are lower than the clinical cut-off, with the exception of CBCL ‘delinquency’ (p=.443).

Table 3: mean scores and one-sample t-test

<table>
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<th>Sig. (2-tailed)</th>
<th>Mean difference</th>
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<tr>
<td>CBCL internalising</td>
<td>55.37</td>
<td>.000</td>
<td>-4.62</td>
</tr>
<tr>
<td>CBCL externalising</td>
<td>64.47</td>
<td>.000</td>
<td>4.47</td>
</tr>
<tr>
<td>CBCL total</td>
<td>61.75</td>
<td>.020</td>
<td>1.74</td>
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<tr>
<td>TRF internalising</td>
<td>54.15</td>
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<td>-5.84</td>
</tr>
<tr>
<td>TRF externalising</td>
<td>57.93</td>
<td>.001</td>
<td>-2.06</td>
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<td>TRF total</td>
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<tr>
<td>YSR internalising</td>
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<tr>
<td>YSR total</td>
<td>58.66</td>
<td>.025</td>
<td>1.34</td>
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</table>
Group workers scored girls significantly higher on ‘somatic complaints’ than boys, and youth with IQ scores below 70 scored significantly higher than youth with IQ scores above 70 on the syndrome scale ‘attention problems’. No significant differences were found on the CBCL when using gender or age of the youngster, treatment type, or gender, age and experience of the group worker as grouping variable.

On the TRF, teachers scored girls higher than boys on ‘total score’, ‘anxious/depressed’, ‘somatic complaints’ and ‘social problems’. Children and youth in residential care were scored higher on ‘externalising’, ‘total score’, ‘aggression’, ‘delinquency’, ‘social problems’, ‘thinking problems’ and ‘attention problems’ than children and youth in day treatment. Female teachers scored their student higher on ‘somatic complaints’. Teachers younger than 36 scored students higher on all scales, while teachers with less than ten years experience on the job scored their students higher on ‘internalising’, ‘externalising’, ‘total score’, ‘withdrawn/depressed’, ‘anxious/depressed’, ‘somatic complaints’ and ‘social problems’. No significant differences were found when using ‘age of the youth’ or ‘intelligence’ as independent variable.

When looking at the YSR, girls had higher scores on ‘internalising’, ‘withdrawn/depressed’, and ‘anxious/depressed’ than boys. Children and youngsters in residential care had higher scores than children and youth in day treatment on all scales except ‘somatic complaints’. Younger children had higher scores than older children on ‘internalising’, ‘somatic complaints’, ‘social problems’, and ‘thinking problems’. When using intelligence as a grouping variable, results show that youth with a TIQ above 70 had higher scores than youth with a TIQ below 70 on the broadband scale ‘internalising’ and on the narrowband scale ‘somatic complaints’.

Further, an ANOVA of repeated measures with Bonferroni correction for multiple comparisons was used to examine the differences in mean scores between informants (table 4-5). Results of this test indicate that problem behaviour on the internalising broadband scale is scored higher by children and youngsters themselves than it is by group workers or teachers. On the externalising scale, mean scores of the CBCL were significantly higher than mean scores on the TRF or on the YSR. Total scores of the CBCL are significantly higher than on the TRF and the YSR, whilst total scores on the YSR are higher than total scores on the TRF.
<table>
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<th>Dependent Variable</th>
<th>(I) informant</th>
<th>(J) informant</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
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<tr>
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<td></td>
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Table 4: differences in mean scores between informants (1)
### Table 5: differences in mean scores between informants (2)

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<th>(I) informant</th>
<th>(J) informant</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.</th>
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<th>Lower Bound</th>
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<td>.62179</td>
<td>.000</td>
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<td>4.1904</td>
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### Correlations between CBCL & TRF at the 0.01 level

The total CBCL score correlates with the total TRF score (r=.315; p=.001). On the broadband scales no correlations were found. With regard to the syndrome scales,
Correlations were found only for ‘withdrawn’ \((r=.347; \ p=.000)\), ‘aggression’ \((r=.356; \ p=.000)\), and ‘delinquency’ \((r=.401; \ p=.000)\).

**Correlations between CBCL & YSR at the 0.01 level**
Only for the broadband scale ‘externalising’ a correlation was found \((r=.306; \ p=.005)\). The syndrome scales which correlate are ‘aggression’ \((r=.433; \ p=.000)\) and ‘anxious/depressed’ \((r=.343; \ p=.002)\).

**Correlations between TRF & YSR at the 0.01 level**
For the TRF and the YSR, correlations were found for all scales. Correlations were stronger for externalising behaviour \((r=.502, \ p=.000)\) than they were for internalising behaviour \((r=.274, \ p=.000)\).

**Figure 1: mean scores broadband scales**

**Behaviour profile**
Using Pearson correlations, a profile was developed for all youth, based on data from each informant. Correlations between the ‘total score’ and the two ‘broadband syndrome scales’ (‘internalising’, ‘externalising’) were measured for the CBCL, TRF and YSR. The strongest correlation found between ‘total score’ and the broadband syndrome was correlated with the remaining syndrome scales, and this strongest correlation was withheld.

**Behaviour profile with the group worker as informant**
The strongest correlation was found between ‘total’ and the broadband syndrome ‘externalising’ \((r=.872, \ p=.000)\). When comparing ‘externalising’ with the six remaining syndrome scales (‘withdrawn/depressed’, ‘anxious/depressed’, ‘somatic complaints’, ‘social problems’, ‘thinking problems’, and ‘attention problems’), the correlation with the syndrome scale ‘attention problems’ was the strongest \((r=.559, \ p=.000)\). In order to clarify
these correlations, a cross table was compiled, with each variable divided into two groups: clinical or not clinical. This led to the profile ‘externalising-attention problems’ (EA), based on questionnaires with the group worker as informant (table 6). This construction leads to three groups:

1. low EA-profile: youth with scores within the normal range for both ‘externalising’ as ‘attention problems’ (n= 45; 28.1%)
2. intermediate EA-profile: youth with clinical scores for either ‘externalising’ or ‘attention problems’ (n= 63; 39.4%)
3. high EA-profile: youth with scores within the clinical range for both ‘externalising’ as ‘attention problems’ (n= 52; 32.5%)

Table 6: the profile ‘externalising-attention problems’ (EA)

<table>
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<th>CBCL externalising</th>
<th>CBCL attention problems</th>
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<td>normal count</td>
<td>normal</td>
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<tr>
<td>45</td>
<td>8</td>
</tr>
<tr>
<td>% of Total</td>
<td>34.4%</td>
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</table>

When selecting the data on gender of the youth, age and experience of the group worker, the profile is the same. When the group worker is male, when the youngsters are younger than 12, or when the youngster have an IQ below 70; the profile based on the CBCL is ‘externalising-social problems’.

**Behaviour profile with the teacher as informant**

When correlating the broadband scales with the total score of the TRF, the strongest correlation was found between ‘total’ and ‘externalising’ (r=.889, p=.000). When correlating ‘externalising’ with the remaining syndromes scales, the correlation was strongest with ‘attention problems’ (r=.757, p=.000). Similar as with the CBCL, these correlations lead to the profile ‘externalising-attention problems’ (AE) (table 7).

1. low EA-profile: youth with scores within the normal range for both ‘externalising’ as ‘attention problems’ (n= 166; 53.0%)
2. intermediate EA-profile: youth with clinical scores for either ‘externalising’ or ‘attention problems’ (n= 114; 36.4%)
3. high EA-profile: youth with scores within the clinical range for both ‘externalising’ as ‘attention problems’ (n= 33; 10.5%)
Group workers, teachers, and youth as different informants

Table 7: the profile ‘externalising-attention problems’ (EA)

<table>
<thead>
<tr>
<th>TRF externalising</th>
<th>TRF normal count</th>
<th>TRF % of Total</th>
<th>TRF clinical count</th>
<th>TRF % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal</td>
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<td>53.0%</td>
<td>113</td>
<td>36.1%</td>
</tr>
<tr>
<td>clinical</td>
<td>1</td>
<td>0.3%</td>
<td>33</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

The profile ‘externalising-attention problems’ remained applicable when controlling for age, gender and IQ of the youth, and for age, experience and sex of the teacher.

Behaviour profile with the children and adolescents as informant

In contrast with the CBCL and the TRF, the correlation on the YSR between ‘total’ and the broadband scales was strongest with ‘internalising’ (r=.838, p=.000). ‘Internalising’ correlated strongest with the syndrome scale ‘thinking problems’ (r=.696, p=.000), which results in the profile ‘internalising-thinking problems’ (IT) (table 8) when the youth himself is the informant.

1. low IT-profile: youth with scores within the normal range for both ‘internalising as ‘thinking problems’ (n= 129; 50.6%)
2. intermediate IT-profile: youth with clinical scores for either ‘internalising or ‘thinking problems’ (n= 89; 34.9%)
3. high IT-profile: youth with scores within the clinical range for both ‘internalising as ‘thinking problems’ (n= 37; 14.5%)

Table 8: the profile ‘internalising-thinking problems’ (IT)

<table>
<thead>
<tr>
<th>YSR internalising</th>
<th>YSR normal count</th>
<th>YSR % of Total</th>
<th>YSR clinical count</th>
<th>YSR % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal</td>
<td>129</td>
<td>50.6%</td>
<td>85</td>
<td>33.3%</td>
</tr>
<tr>
<td>clinical</td>
<td>4</td>
<td>1.6%</td>
<td>37</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

The profile remained applicable when controlling for treatment type. When controlling for sex and IQ, boys and youth with an IQ score below 70 had the profile ‘internalising-social problems’. Children younger than 12 had the profile ‘externalising-social problems’.
4.4. Discussion

The group of children and youngsters in our sample show a boy–girl ratio of 3:1. About half of the sample is in residential care, while the others are in day treatment. The average IQ of youth in our sample is about 25 points below the normal range, but also 10 points below results of comparable research in Flanders (D’Oosterlinck et al., 2006). A possible explanation could be found in the historical context of the centre. While nowadays the primary focus of the centre is on treatment for youth with emotional and behavioural disorders, in the past the focus was on treatment for youth with mild mental disability.

On the YSR, girls had higher scores on ‘internalising’, ‘withdrawn/depressed’, and ‘anxious/depressed’ than boys did. Scores were higher for girls on ‘somatic complaints’ when using the CBCL, and on ‘total score’, ‘anxious/depressed’, ‘somatic complaints’ and ‘social problems’ when using the TRF. No significant gender differences were found on the externalising scales. These findings correspond with other studies (Handwerk & Marshall, 1998; Slobodskaya, 1999; Sohn, 2003; Wasserman et al., 2005), although some have found higher scores on the internalising scale for boys than for girls (Brady & Caraway, 2002).

Youth themselves score higher on the internalising scales than adults do. Correlations between youth and adults were also stronger for externalising behaviour than they were for internalising behaviour. When using data from group workers, teachers and youth as different informants to develop a behaviour profile, results show a similar tendency. The profile constructed using the CBCL or the TRF indicates that youth in our sample show aggressive and delinquent behaviour and suffer from attention problems (externalising – attention problems profile). On the other hand, the profile constructed using the YSR indicates that youth are withdrawn, anxious/depressed, have somatic complaints and suffer from thinking problems (internalising – thinking problems profile).

Our findings correspond with several other studies, which have shown that disagreement between youth and their caregivers is low for internalising problems (Andrae, Lenz, & Lohaus, 2009; Grietens et al., 2004; Hawley & Weisz, 2003; McConaughy, Mattison, & Peterson, 1994; Salbach-Andrae et al., 2009; Stanger & Lewis, 1993; Youngstrom, Loeber, & Stouthamer-Loeber, 2000) and that internalising scores on self-reports are higher than on reports of caregivers (Youngstrom, Loeber, & Stouthamer-Loeber, 2000). Together with others, our explanation for these discrepancies lies in the assumption that externalising problems are more easily observed and more disturbing than internalising problems (Mesman & Koot, 2000; McConaughy & Skiba, 1993). Subsequently, children may see internalising behaviours as salient serious problems that are thus more likely to be perceived and reported by the children, since these problems cause them distress (Karver, 2006).
We want to stress that these common found discrepancies between different informants should never evolve into a discussion about whose perception is right and whose is wrong. The discrepancies do not necessarily imply a distortion, but rather reflect the complex nature of a child and his or her problems, as it is presented and experienced in different realities. Nevertheless, we agree with authors who state that discrepancies between informants may hinder the abilities of informants to participate in treatment and to work together on the goals of treatment (De Los Reyes & Kazdin, 2005; Hawley & Weisz, 2003; Yeh & Weisz, 2001).

Therefore, we underscore the common assumption that information from different informants is needed in clinical practice (Barbosa, Tannock, & Manassis, 2002; Epstein et al., 2004; Rubio-Stipec et al, 2003; Silverman & Ollendick, 2005; Stanger & Lewis, 1993; Vierhaus & Lohaus, 2008).

A remarkable finding worth mentioning is the difference in correlations between YSR and TRF on one hand, and YSR and CBCL on the other hand. While only few correlations are found between YSR and CBCL (‘externalising’, ‘aggression’, ‘anxious/depressed’), for the TRF and the YSR, correlations were found on all scales. A possible explanation could be found in the context in which teachers and group workers work with children and youngsters. A classroom is a structured environment with approximately 8 students and one teacher. This setting is characterized by clear expectations, but also offers students a safe environment and multiple opportunities to express their inner mental state. In living groups on the other hand, up to 14 children live together in a less structured environment. Taken into account the complexity of the problems of youth in Flemish therapeutic centres, we believe that especially the size of the living groups may create a barrier for youth and group workers to interact in a safe and treatment-oriented way. If the Flemish government wants therapeutic centres to work effectively with their youth in groups, more funding has to be provided in order to reduce group sizes and use individualized educational and learning approaches which can be integrated within the Flemish tradition of ‘the group as method’.

Finally, it is important to stress the main limitations of our study. First, although the narrow-band syndromes as well as the 2 broad-band syndromes can be used to interpret the CBCL scores of group care workers, the CBCL was originally designed to be filled in by parents instead of group workers. Therefore, it would have been useful involve parents as informants. Secondly, all data were gathered in one therapeutic centre. Although the centre represents the majority of care for youth with emotional and behavioural disorders in the West Flanders, generalization of results should be interpreted carefully. Finally, due to pragmatic reasons, only three different questionnaires were used in this study. It would be a simplification to reduce problem behaviour of youth in Flemish care to the scores, correlations and profiles resulting from only these questionnaires. Because of the relatively high scores on the internalising scales, and especially because of the informant
disagreement with regard to these problems, it is recommended to investigate the nature of these internalising problems more thoroughly.
Group workers, teachers, and youth as different informants

References


CHAPTER 5:
Anxiety in youth in Flemish Care: a multi-informant study

This chapter is based on Soenen, B., D’Oosterlinck, F., & Broekaert, E. (accepted) Anxiety in youth in Flemish Care: a multi-informant study. The International Journal of Therapeutic Communities.
Abstract

The objective of the study described in this chapter is to investigate the prevalence of anxiety in youngsters with emotional and behavioural disorders, and its relation to other problems, using different informants. Data were collected in a Flemish treatment centre. Educators completed a Child Behaviour Checklist (CBCL) for each child, teachers completed a Teacher Report Form (TRF), and youth themselves completed a Youth Self Report (YSR) and a Screen for Child Anxiety Related Emotional Disorders (SCARED). Analyses indicated an explicit presence of anxiety. A clear relation was found between anxiety symptoms and internalising problem behaviour on the YSR, whereas only a slight relationship was found with the CBCL, and practically no relationship was found with the TRF. Only few correlations between anxiety and externalising problems were found. Finally, youth themselves indicated strong correlations between anxiety and thought problems, whereas educators indicated strong correlations between youths’ anxiety and social problems. Implications for practice are discussed.
Children and adolescents with emotional and behavioural disorders (EBD) form a vulnerable group in society, in which high comorbidity rates are often reported (D’Oosterlinck et al., 2006; McConaughy & Skiba, 1993; Teplin et al., 2002; Wasserman et al., 2005). These youths’ problems seem to be chronic (Visser et al., 2003), pervasive (Fergusson & Horwood, 1995; Lahey et al., 1995; Lahey et al., 2002; Leech et al., 2003), and almost as stable as personality traits (De Bolle et al., 2009). Because of the complex nature of their problems, these children and adolescents, who cannot be seen as a homogenous group (Moht, 2009), have extensive mental health needs (Hukkanan et al., 1999), and are often subject to special education (Long, 1996) or specialized care facilities (Eme & Kavanaugh, 1995; Hussey & Guo, 2005).

5.1.1. Internalising and externalising behaviour
Research on characteristics of children and adolescents with EBD often describes the problems experienced by such young people in terms of internalising (such as anxiety or depression) and externalising (such as aggression) behaviour, and the co-development of internalising and externalising behaviours. With regard to gender differences, there is general consensus that girls present more internalising behaviours than boys (Sohn, 2003; Tambelli et al., 2012; Wasserman et al., 2005), and that boys present more externalising behaviours than girls (Duchesne & Larose, 2007; Masi et al., 2004). Comorbidity between internalising disorders, externalising disorders and other problems are described in the literature. McConaughy & Skiba (1993), for example, reported high comorbidity rates for DSM diagnoses of conduct disorders with oppositional disorders, affective disorders, anxiety disorders, and attention deficit disorders, necessitating multifaceted interventions designed to treat a broad range of problems. They suggest that programs designed to treat only externalising problems run the risk of neglecting co-occurring internalising problems and vice versa. Further, Galambos, Barker and Almeida (2003) investigated trajectories of change in externalising and internalising problems in early adolescence. They collected data on five occasions in a 3.5 year period in a sample of 112 youths and found evidence for the stability of both internalising and externalising problems.

Although there is consensus about the comorbidity of internalising and externalising problem behaviour, less can be found about their co-development. An exception is the study of Lee and Bukowski (2012), who investigated the developmental progression of the association between internalising and externalising behaviour in a sample of 2,844 fourth-graders over four years. Their findings suggest that there was an increase in internalising problems and decrease in externalising problems over time among boys; there was also an increase in internalising problems but no change in externalising problems over time among...
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girls; and a greater increase in internalising problems was related to a smaller decrease in externalising problems. The authors conclude that, although trajectories of internalising and externalising problems are interrelated, initial level of internalising problem behaviour is critical to the increasing trend of externalising problems for boys, whereas the reverse is the case for girls.

Recently, much attention has been given to anxiety disorders, as a part of internalising problems. In the mid 90’s, Bernstein and his colleagues (1996) gave an overview of the growing number of studies on anxiety, suggesting the importance of not discounting symptoms as short-lived or insignificant in young children. Research on gender differences with regard to anxiety disorders consistently shows evidence of higher rates of anxiety in girls than in boys (Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Crocetti et al., 2009; Essau, Conradt & Petermann, 2000; Hale et al., 2005; Hale et al., 2011; Muris et al., 1998; Simon and Bögels, 2009; Su et al., 2007; Wasserman, 2005). Findings with regard to age, on the other hand, have been conflicting. While some authors found that anxiety rates increased with age (Essau, Conradt & Petermann, 2000), others found a decrease (Hale et al., 2011; Muris, Schmidt and Merckelbach, 2000; Su et al., 2007).

Youth with anxiety disorders are heavily symptomatic and comorbidity frequently occurs, not only with other anxiety disorders or other internalising disorders (Essau, Conradt & Petermann, 2000), but also with externalising disorders (Masi et al., 2004; Silverman & Ollendick, 2005; Simon & Bögels, 2009), yet little is known about the relationship between anxiety disorders and disruptive behaviour.

5.1.2. Different informants

When assessing internalising and externalising problem behaviour in children and adolescents, multiple informants, such as teachers, parents and youth themselves, are needed in order to examine possible discrepancies (Clay, Surgenor & Frampton, 2008; Comer & Kendall, 2004; Ferdinand, van der Ende & Verhulst, 2004; Ferdinand, van der Ende & Verhulst, 2006; Rubio-Stipec et al., 2003; Soenen et al., 2011; Stanger & Lewis, 1993). A multitude of research on informant disagreement shows a consistent pattern of low agreement between adults and youths (Lacalle, Ezpelata & Doménech, 2012; Youngstrom, Loeber & Soutamah-Loeber, 2000), and that this disagreement is greater for internalising problem behaviour than for externalising problem behaviour (Andrea, Lenz & Lehmkuhl, 2009; Epkins, 1996; Grietens et al., 2004; Hawley & Weisz, 2003; Soenen et al., 2011; Yeh & Weisz, 2001). In other words, the more symptoms are observable and the more symptoms are causing management problems, the more salient they are to teachers, educators or parents (Comer & Kendall, 2004; Salbach-Andrea et al., 2009). Although these reoccurring discrepancies do not necessarily imply a distortion in perceptions, but...
rather reflect the complex nature of the problems of these youth, as presented and experienced in different realities (Soenen et al., 2011), they may hinder effective treatment. When youth and adults seem to disagree on the specific problems that should be targeted in treatment, this will contribute to difficulties in the therapeutic alliance (Blakeley-Smith et al., 2012), and as a result, the ability to work towards common treatment goals (Yeh & Weisz, 2001) and the child’s motivation for treatment may be undermined (Hawley & Weisz, 2003).

5.1.3. Aims of the study
This study took place in an Orthopedagogical Centre (OC) for children and adolescents with EBD in the West part of Flanders, and involved a total of 247 participants. The OC, which is divided into two schools and a (semi-)residential care facility, offers education and day treatment as well as residential care to these youth and their families.

This study builds on a previous study within the same sample, which investigated the characteristics of the target population using group workers, teachers and youth as different informants (Soenen et al., 2011). In this first study, the Child Behaviour Checklist (CBCL) was completed for each child by a group worker, the Teacher Report Form (TRF) by a teacher, and the Youth Self Report (YSR) by the youth themselves. In looking for agreement between group worker-report, teacher-report and self-report, correlations were computed. While some correlations between youths and adults were found for the externalising scale, almost no correlations could be seen for the internalising scale. Further, using Pearson correlations, a profile was developed for all youth, based on data from each informant. Correlations between the ‘total score’ and the two ‘broadband syndrome scales’ (‘internalising’, ‘externalising’) were measured for the CBCL, TRF and YSR. The strongest correlation found between ‘total score’ and the broadband syndrome scale was correlated with the remaining syndrome scales, and this strongest correlation was withheld. The profile constructed using the CBCL or the TRF indicates that youth in the sample show aggressive and delinquent behaviour and suffer from attention problems (externalising–attention problems profile). On the other hand, the profile constructed using the YSR indicates that youth are withdrawn, anxious/depressed, have somatic complaints and suffer from thinking problems (internalising–thinking problems profile).

Based on this first study, which showed disagreement between the informants, especially with regard to internalising, the current study was designed to look into detail in the nature of these internalising problems, especially with regard to anxiety problems, and to investigate possible relations between these problems and other problems as perceived by different informants. Prior to collecting more detailed self-reported information using the
Screen for Anxiety and Related Emotional Disorders (SCARED), following research questions were examined:

- What is, based on self-report and demographic data, the nature of the anxiety problems in this sample?
- Which other problems as reported by youth themselves are related to these anxiety problems?
- Which other problems as reported by teachers or group workers are related to the anxiety problems as indicated by youth?
- Are the ratings of problems as reported by different informants linked with the prediction of the self-reported anxiety scores?

5.2. Method

Under supervision of the authors, the social workers, psychologists and supervisors of the centre collected, based on the individual files of the youth, information with regard to age, gender, and type of received care. Type of received care was divided into education plus day treatment and education plus residential treatment. In addition to this general information, a team of researchers also collected four different questionnaires. Prior to this data gathering, which took place from March to June 2009, written consent was obtained from all youth and their parents or their legal guardian.

5.2.1. Questionnaires

Screen for Child Anxiety Related Emotional Disorders (SCARED)
The SCARED is a self-report that measures symptoms of the entire spectrum of anxiety disorders which may occur in children and adolescents according to DSM-IV (Muris et al., 2007). The instrument is primarily designed for clinical psychologists, psychiatrists or practitioners in related professions who want to evaluate children or adolescents from the age of 7 to the age of 19 on the presence of anxiety disorders (Muris et al., 2007), but can also be useful for research purposes (Bodden, Bögels & Muris, 2009; Muris et al., 2001). The SCARED consists of 69 items, using a likert-scale for respondents to indicate how often they experience a symptom: ‘never or almost never’, ‘sometimes’, and ‘often’. Results not only give a total score, but also an indication of the possible presence of panic disorder, social phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), separation anxiety disorder (SAD) and specific phobia (animal phobia, medical phobia, situational phobia). Once a SCARED
is completed by a youth, two different results are obtained for all of these DSM-related subscales: (1) the total score and subscales scores are derived by summing relevant items; and (2), depending on age and sex, these scores result in a classification for each subscale (low, normal, elevated, risk). Several studies have shown that the SCARED possesses good internal consistency and differentiates clinically anxious children from normal children, both on the total score as well as on the subscales, providing support for the psychometric properties (Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Crocetti et al., 2009; Hale et al., 2011; Monga et al., 2000; Muris et al., 2004; Myers & Winters, 2002; Simon & Bögels, 2009; Su et al., 2007).

All children and adolescents were asked to complete the SCARED during class time, under the supervision of the first author and a clinical psychologist. All youth had the opportunity to ask questions about individual items, but were not allowed to seek clarification about how they should respond. Those who were absent because of illness were asked to complete the SCARED after they returned.

Child Behaviour Checklist (CBCL) / Teacher Report Form (TRF) / Youth Self Report (YSR)

The CBCL is a checklist designed to get an image of behavioural and emotional problems in children and adolescents from the age of 6 to the age of 18. Although the rating scale is designed to be completed by parents, Albrecht and colleagues were able to show that the CBCL factor model also fits for the judgment of group care workers (Albrecht et al., 2001). The CBCL consists of 118 items, with 3 response options (Not true; Sometimes or Somewhat true; Very true or Often true), with regard to emotional and behavioural problems, resulting in scores on 8 syndrome scales and 2 broadband scales. The Internalising broadband scale consists of the syndrome scales Withdrawn, Anxious/Depressed and Somatic Complaints, and the Externalising broadband scale consists of the syndrome scales Aggressive Behaviour and Delinquent Behaviour. Separated from the broadband scales are the syndrome scales Social Problems, Thought Problems and Attention Problems. Subsequently, the latest version of the CBCL also incorporates 6 DSM-oriented scales (DSM-Affect Disorder, DSM-Anxiety Disorder, DSM-Somatic Disorder, DSM-Attention Deficit and Hyperactivity Disorder, DSM-Oppositional Defiant Disorder, DSM-Conduct Disorder). The Dutch version of the CBCL has proved to be reliable and valid (De Groot, Hoot & Verhulst, 1994; Verhulst, van der Ende & Koot, 1996). The CBCL was completed for all youngsters by their individual group worker.

The TRF is a questionnaire in which teachers answer questions with regard to schoolwork and emotional and behavioural disorders. The TRF consists of 118 items, of which 93 also
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appear in the CBCL. The TRF includes the same subscales as the CBCL and the YSR. All class teachers were asked to complete a TRF for each of their students.

The YSR is a questionnaire in which youngsters themselves score statements about emotional and behavioural problems they experience. Many of these questions are similar to those in the CBCL and TRF, supplemented with fourteen socially desirable questions to which most youths answer positively. The YSR includes the same scales as the CBCL and TRF. All children and youngsters were asked to complete a YSR in a similar manner as they completed the SCARED.

5.3. Results

5.3.1. Demographics
Data were obtained from 247 participant, 181 boys (73.3%) and 66 girls (26.7%). The mean age of youth in the sample was 12.51 (SD=2.77), ranging from age 6 to age 18. 51.2% of the participants were in residential care, 48.8% were in day treatment. Between boys and girls, no significant differences were found with regard to age (t=-.427; p=.670) and type of care (Chi²=.658; p=.417). Youth in residential care were younger (mean age=11.62) than youth in day treatment (mean age=13.46) (t=5.49; p=.000).

5.3.2. The nature of the anxiety problems
In an attempt to answer the first research question, results on the SCARED were examined in detail. The frequencies of the four different classifications (low, normal, elevated, risk) of all SCARED subscales (n=247), show that, when adding the percentages of ‘elevated’ and ‘risk’, the highest sum of percentages can be found in the subscales ‘Situational phobia’ (32.7%), ‘Post Traumatic Stress Disorders’ (30.8%) and ‘Social phobia’ (26.3%). On all SCARED scales, girls had significant higher scores than boys. When using an independent samples t-test to compare mean scores of youth in residential care and youth in day treatment, youth in residential care had higher SCARED scores for ‘separation anxiety’ (t=3.78; p=.000) and for ‘PTSD’ (t=2.39; p=.017). Except for the subscales ‘Animal phobia’ and ‘GAD’, negative correlations were found between age and scores on the SCARED subscales. The results are presented in table 1.

5.3.3. SCARED & other self-reported problems
After analysing SCARED results separately, we looked for possible relations between the SCARED and the YSR. Table 2 present correlations between the subscales of the SCARED
and the different broadband scales, syndrome scales and DSM-oriented scales of the YSR. As expected, the table shows strong correlations between the SCARED and the different internalising scales of the YSR. Conversely, no correlations with the externalising scales were found. Further, strong correlations were found between the syndrome scales ‘social problems’, ‘thought problems’ and ‘attention problems’. It is remarkable that correlations between the SCARED and the syndrome scale ‘thought problems’ are often stronger than correlations with the internalising scales of the YSR.

Subsequently, the three SCARED subscales with the highest frequencies (situational phobia, posttraumatic stress disorder, social phobia) were recoded into each two categories. The first category consisted of the scores in the ‘low’ and ‘normal’ range, the second category consisted of the scores in the ‘elevated’ and ‘risk’ range. An independent samples t-test was performed to examine whether, and on which subscales, youth with SCARED scores in the highest category have higher scores on the YSR then youth with SCARED scores within the lowest category. Table 3 shows that this is true for all internalising YSR subscales, with the exception of ‘somatic problems’, but also for the syndrome scales ‘social problems’ and ‘thought problems’.

### 5.3.4. SCARED & problems as reported by group workers and teachers

To answer the third research question, we looked for possible correlations between the SCARED and the CBCL, and between the SCARED and the TRF. Table 4 present correlations between the subscales of the SCARED and the different broadband scales, syndrome scales and DSM-oriented scales of the CBCL. Between the SCARED and the CBCL, less correlations can be seen when compared to the correlations between the SCARED and the YSR. Most subscales of the SCARED correlate stronger with the externalising subscales of the CBCL then with the internalising subscales, but the strongest correlations can be seen with the syndrome scale ‘social problems’. Table 5 presents the correlations with the TRF. Only few correlations can be found, they appear to be less strong than the correlations between SCARED and YSR or CBCL, and no clear pattern can be seen.

Again, the three SCARED subscales with the highest frequencies (situational phobia, posttraumatic stress disorder, social phobia) were recoded into each two categories (low & normal and elevated & risk). An independent samples t-test with these categories of the SCARED subscale ‘situational phobia’ as independent variable and the scores on the different CBCL scales as dependent variables showed that youth with scores in the highest category of situational phobia had higher scores on the CBCL broadband scale ‘internalising’, on the CBCL syndrome scale ‘social problems’ and on the CBCL DSM-oriented scale ‘Oppositional Defiant Disorder’ than youth with scores in the lowest category.
Table 1: SCARED

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequencies SCARED classifications</th>
<th>Sex</th>
<th>Type of care</th>
<th>Correlations SCARED scores with age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Normal</td>
<td>Elevated</td>
<td>Risk</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>N</td>
<td>24</td>
<td>163</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>9.7</td>
<td>66</td>
<td>7.7</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>N</td>
<td>39</td>
<td>154</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>15.8</td>
<td>62.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Animal phobia</td>
<td>N</td>
<td>9</td>
<td>185</td>
<td>27</td>
</tr>
<tr>
<td>Medical phobia</td>
<td>N</td>
<td>45</td>
<td>149</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>18.2</td>
<td>60.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Situational phobia</td>
<td>N</td>
<td>15</td>
<td>151</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6.1</td>
<td>61.1</td>
<td>12.1</td>
</tr>
<tr>
<td>Social phobia</td>
<td>N</td>
<td>21</td>
<td>161</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>8.5</td>
<td>65.2</td>
<td>10.1</td>
</tr>
<tr>
<td>OCD</td>
<td>N</td>
<td>70</td>
<td>123</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>28.3</td>
<td>49.8</td>
<td>9.7</td>
</tr>
<tr>
<td>PTSD</td>
<td>N</td>
<td>18</td>
<td>153</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.3</td>
<td>61.9</td>
<td>12.6</td>
</tr>
<tr>
<td>GAD</td>
<td>N</td>
<td>48</td>
<td>145</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>19.4</td>
<td>58.7</td>
<td>8.5</td>
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<tr>
<td>Total</td>
<td>N</td>
<td>39</td>
<td>161</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>15.8</td>
<td>65.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

*: significant at 0.05  
**: significant at 0.01
## Table 2: correlations SCARED and YSR

<table>
<thead>
<tr>
<th></th>
<th>Broadbandscales</th>
<th>Internalising subscales</th>
<th>Externalising subscales</th>
<th>Subscales</th>
<th>DSM scales</th>
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<tbody>
<tr>
<td>Separation anxiety</td>
<td>.391**</td>
<td>.142</td>
<td>.364**</td>
<td>.345**</td>
<td>.323**</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>.414**</td>
<td>.115</td>
<td>.364**</td>
<td>.422**</td>
<td>.316**</td>
</tr>
<tr>
<td>Animal phobia</td>
<td>.125</td>
<td>.126</td>
<td>.175*</td>
<td>.057</td>
<td>.168</td>
</tr>
<tr>
<td>Medical phobia</td>
<td>.241**</td>
<td>-.007</td>
<td>.160</td>
<td>.255**</td>
<td>.190*</td>
</tr>
<tr>
<td>Situational phobia</td>
<td>.416**</td>
<td>.091</td>
<td>.339**</td>
<td>.472**</td>
<td>.349**</td>
</tr>
<tr>
<td>Social phobia</td>
<td>.351**</td>
<td>.041</td>
<td>.278**</td>
<td>.318**</td>
<td>.288**</td>
</tr>
<tr>
<td>OCD</td>
<td>.336**</td>
<td>.118</td>
<td>.298**</td>
<td>.397**</td>
<td>.292**</td>
</tr>
<tr>
<td>PTSD</td>
<td>.390**</td>
<td>.079</td>
<td>.310**</td>
<td>.349**</td>
<td>.283**</td>
</tr>
<tr>
<td>GAD</td>
<td>.373**</td>
<td>.108</td>
<td>.324**</td>
<td>.368**</td>
<td>.341**</td>
</tr>
<tr>
<td>Total score</td>
<td>.456**</td>
<td>.117</td>
<td>.390**</td>
<td>.437**</td>
<td>.378**</td>
</tr>
</tbody>
</table>

*: significant at 0.05
**: significant at 0.01
### Table 3: independent samples t-test YSR

<table>
<thead>
<tr>
<th></th>
<th>Situational phobia</th>
<th>PTSD</th>
<th>Social phobia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low &amp; normal</td>
<td>Elevated &amp; high</td>
<td>Low &amp; normal</td>
</tr>
<tr>
<td>Intern. Mean</td>
<td>58.40</td>
<td>64.36</td>
<td>58.80</td>
</tr>
<tr>
<td>t value</td>
<td>-3.525**</td>
<td></td>
<td>-2.986*</td>
</tr>
<tr>
<td>Extern. Mean</td>
<td>56.74</td>
<td>58.60</td>
<td>56.92</td>
</tr>
<tr>
<td>t value</td>
<td>-1.149</td>
<td></td>
<td>-0.93</td>
</tr>
<tr>
<td>Total Mean</td>
<td>57.78</td>
<td>63.00</td>
<td>58.23</td>
</tr>
<tr>
<td>t value</td>
<td>-3.293**</td>
<td></td>
<td>-2.549*</td>
</tr>
<tr>
<td>Anx/depr Mean</td>
<td>58.13</td>
<td>64.36</td>
<td>59.07</td>
</tr>
<tr>
<td>t value</td>
<td>-4.331**</td>
<td></td>
<td>-2.340*</td>
</tr>
<tr>
<td>Withdr. Mean</td>
<td>57.91</td>
<td>61.91</td>
<td>58.13</td>
</tr>
<tr>
<td>t value</td>
<td>-2.801**</td>
<td></td>
<td>-2.506*</td>
</tr>
<tr>
<td>Som Mean</td>
<td>60.05</td>
<td>62.78</td>
<td>59.72</td>
</tr>
<tr>
<td>t value</td>
<td>-1.703</td>
<td></td>
<td>-2.601*</td>
</tr>
<tr>
<td>Aggr. Mean</td>
<td>59.22</td>
<td>59.60</td>
<td>59.21</td>
</tr>
<tr>
<td>t value</td>
<td>-.320</td>
<td></td>
<td>-.379</td>
</tr>
<tr>
<td>Delinq. Mean</td>
<td>57.17</td>
<td>58.87</td>
<td>57.58</td>
</tr>
<tr>
<td>t value</td>
<td>-1.280</td>
<td></td>
<td>-.325</td>
</tr>
<tr>
<td>Soc. Prob. Mean</td>
<td>59.26</td>
<td>64.31</td>
<td>60.03</td>
</tr>
<tr>
<td>t value</td>
<td>-4.114**</td>
<td></td>
<td>-2.211*</td>
</tr>
<tr>
<td>Thought Mean</td>
<td>56.86</td>
<td>61.11</td>
<td>57.07</td>
</tr>
<tr>
<td>t value</td>
<td>-3.055**</td>
<td></td>
<td>-2.785**</td>
</tr>
<tr>
<td>Attent. Mean</td>
<td>56.91</td>
<td>59.58</td>
<td>57.54</td>
</tr>
<tr>
<td>t value</td>
<td>-1.975*</td>
<td></td>
<td>-.520</td>
</tr>
<tr>
<td>Affect Mean</td>
<td>58.56</td>
<td>62.29</td>
<td>58.78</td>
</tr>
<tr>
<td>t value</td>
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<td></td>
<td>-2.210*</td>
</tr>
<tr>
<td>Anxiety Mean</td>
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<td>61.64</td>
<td>58.10</td>
</tr>
<tr>
<td>t value</td>
<td>-3.748**</td>
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<td>-1.081</td>
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<tr>
<td>Som. Dis. Mean</td>
<td>60.33</td>
<td>62.42</td>
<td>59.90</td>
</tr>
<tr>
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<td></td>
<td>-2.400*</td>
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<tr>
<td>ADHD Mean</td>
<td>55.95</td>
<td>57.76</td>
<td>56.51</td>
</tr>
<tr>
<td>t value</td>
<td>-1.668</td>
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<td>-.140</td>
</tr>
<tr>
<td>ODD Mean</td>
<td>55.44</td>
<td>56.33</td>
<td>55.62</td>
</tr>
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<td>-.361</td>
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<tr>
<td>CD Mean</td>
<td>59.70</td>
<td>60.98</td>
<td>60.00</td>
</tr>
<tr>
<td>t value</td>
<td>-1.020</td>
<td></td>
<td>-.268</td>
</tr>
</tbody>
</table>

*: significant at 0.05  
**: significant at 0.01
When using the SCARED subscale ‘Posttraumatic Stress Disorder’ as independent variable, results show that youth with scores in the highest category of posttraumatic stress disorder had higher scores on the CBCL syndrome scales ‘anxious/depressed’ and the DSM-oriented scale ‘Anxiety Disorder’. With the SCARED subscale ‘social phobia’ as independent variable, no significant differences in CBCL scores were found. All analyses with the CBCL are presented in table 6. As table 7 shows, we failed to find significant differences in TRF scores when using the three SCARED subscales as independent variable.

5.3.5. Prediction of self-reported anxiety scores

Multiple linear regressions were used to determine the predictors of the scores on the three SCARED subscales with the highest frequencies (situational phobia, posttraumatic stress disorder, social phobia). Only the scales of the YSR, CBCL and TRF that significantly correlated with the three SCARED subscales were withheld. For each questionnaire (YSR, CBCL & TRF), the variables were entered in the regression equation in one single step using the default method.

**YSR**
The first regression model significantly predicted the scores for the SCARED subscale ‘situational phobia’ ($F(8,135)=6.34; p=.000$), accounting for 27% of the variance, with only the subscale ‘social problems’ as a significant predictor. The second model significantly predicted the scores for the SCARED subscale ‘PTSD’ ($F(8,136)=4.18; p=.000$), accounting for 18% of the variance. No significant coefficients were identified. The third regression model predicted the scores for the SCARED subscale ‘social phobia’ ($F(8,135)=4.47; p=.000$), accounting for 21% of the variance. The YSR subscales ‘internalising’, ‘total’, ‘somatic problems’ and ‘social problems’ were identified as significant predictors. Results are presented in table 8.

**CBCL**
The first regression model significantly predicted the scores for the SCARED subscale ‘situational phobia’ ($F(8,109)=3.13; p=.003$), accounting for 18% of the variance, with only the subscale ‘delinquent behaviour as a significant predictor (table 8). The model with the SCARED subscale ‘PTSD’ as the dependent variable was not significant. Because no correlations were found between the CBCL and the SCARED subscale social phobia, no regression analysis was performed.

**TRF**
Because the lack of correlations between the SCARED and the TRF, no regression analyses were performed.
Table 4: Correlations SCARED with CBCL

<table>
<thead>
<tr>
<th></th>
<th>Broadbandscales</th>
<th>Internalising subscales</th>
<th>Externalising subscales</th>
<th>Subscales</th>
<th>DSM scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation anxiety</td>
<td>.236*</td>
<td>.261*</td>
<td>.270**</td>
<td>.140</td>
<td>.222*</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>.255**</td>
<td>.231*</td>
<td>.246**</td>
<td>.221*</td>
<td>.148</td>
</tr>
<tr>
<td>Animal phobia</td>
<td>.021</td>
<td>.024</td>
<td>.049</td>
<td>-.009</td>
<td>.002</td>
</tr>
<tr>
<td>Medical phobia</td>
<td>.053</td>
<td>.169</td>
<td>.154</td>
<td>-.026</td>
<td>.061</td>
</tr>
<tr>
<td>Situational phobia</td>
<td>.245**</td>
<td>.204*</td>
<td>.281**</td>
<td>.195*</td>
<td>.182*</td>
</tr>
<tr>
<td>Social phobia</td>
<td>-.004</td>
<td>.053</td>
<td>.037</td>
<td>-.037</td>
<td>.050</td>
</tr>
<tr>
<td>OCD</td>
<td>.217*</td>
<td>.237**</td>
<td>.281**</td>
<td>.188*</td>
<td>.186*</td>
</tr>
<tr>
<td>PTSD</td>
<td>.191*</td>
<td>.156</td>
<td>.179</td>
<td>.208*</td>
<td>.082*</td>
</tr>
<tr>
<td>GAD</td>
<td>.179</td>
<td>.191*</td>
<td>.214*</td>
<td>.211*</td>
<td>.151</td>
</tr>
<tr>
<td>Total score</td>
<td>.211*</td>
<td>.232*</td>
<td>.256**</td>
<td>.167</td>
<td>.166</td>
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</table>

*: significant at 0.05
**: significant at 0.01
Table 5: Correlations SCARED with TRF

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<th>Internalising subscales</th>
<th>Externalising subscales</th>
<th>Subscales</th>
<th>DSM scales</th>
</tr>
</thead>
<tbody>
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<td>Separation anxiety</td>
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<td>.009</td>
</tr>
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<td>Medical phobia</td>
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<td>Social phobia</td>
<td>OCD</td>
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<tr>
<td>.020</td>
<td>.016</td>
<td>.054</td>
<td>.014</td>
<td>.052</td>
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<td>.043</td>
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<td>.033</td>
<td>.023</td>
<td>.080</td>
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<tr>
<td>-.022</td>
<td>.022</td>
<td>.060</td>
<td>-.010</td>
<td>.004</td>
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<td>.077</td>
<td>.030</td>
<td>.077</td>
<td>.039</td>
<td>.108</td>
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<tr>
<td>.103</td>
<td>.117</td>
<td>.166*</td>
<td>.082</td>
<td>.084</td>
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<td>.092</td>
<td>.060</td>
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*: significant at 0.05  
**: significant at 0.01
Table 6: independent samples t-test CBCL

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<td></td>
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<td>Elevated &amp; high</td>
<td>Low &amp; normal</td>
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<td>Mean</td>
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<td></td>
</tr>
<tr>
<td></td>
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<td>58.80</td>
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<td>t value</td>
<td>-.709</td>
<td>-.730</td>
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<tr>
<td>Total</td>
<td>Mean</td>
<td>60.46</td>
<td>63.69</td>
</tr>
<tr>
<td></td>
<td>t value</td>
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<tr>
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<td>Mean</td>
<td>59.86</td>
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</tr>
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</tr>
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<td>t value</td>
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<td>Mean</td>
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<td>Delinq.</td>
<td>Mean</td>
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<td>Mean</td>
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<td>65.20</td>
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<td>61.51</td>
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*: significant at 0.05  
**: significant at 0.01
Table 7: independent samples t-test TRF

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<th>Social phobia</th>
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<td>Elevated &amp; high</td>
<td>Low &amp; normal</td>
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<td>54.13</td>
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<td>Total</td>
<td>Mean</td>
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<td>56.04</td>
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<td>Mean</td>
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<td>-.391</td>
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<td>56.31</td>
</tr>
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<td></td>
<td>t value</td>
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</tr>
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<td>Delinq.</td>
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<td>59.61</td>
</tr>
<tr>
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<td>Mean</td>
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<td>58.15</td>
</tr>
<tr>
<td></td>
<td>t value</td>
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<td></td>
<td>t value</td>
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</tr>
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<td></td>
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*: significant at 0.05

**: significant at 0.01
Table 8: multiple linear regression coefficients

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<th>PTSD</th>
<th>Social Phobia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
<td>β</td>
</tr>
<tr>
<td>YSR Internalising</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>YSR Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>YSR Somatic</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>YSR Social prob</td>
<td>.07</td>
<td>.03</td>
<td>.24</td>
</tr>
<tr>
<td>CBCL delinquent</td>
<td>.09</td>
<td>.05</td>
<td>.30</td>
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</tbody>
</table>

5.4. General discussion

5.4.1. Discussion
The aim of this study was twofold. First, we wanted to investigate the presence and the nature of anxiety problems in youth in Flemish care. Secondly, we wanted to investigate which other problems are related to this anxiety, using youth themselves, group workers and teachers as different informants.

Analyses of the data obtained via the SCARED indicated an apparent presence of anxiety symptoms in our sample, in particular with respect to situational phobia, PTSD and social phobia. In line with numerous other studies, our sample revealed higher anxiety scores for girls than for boys (Birmaher et al., 1997; Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Connor et al., 2004; Crocetti et al., 2009; Doerfler, Toscano & Connor, 2009; Essau, Muris & Ederer, 2002; Hale et al., 2005; Muris et al., 1998; Muris et al., 1999; Muris et al., 2001; Muris et al., 2004; Muris, Schmidt & Merckelbach, 2000; Simon & Bögels, 2009; Sohn, 2003; Su et al., 2007; Tambelli et al., 2012; Wasserman et al., 2005), and a decline of anxiety with age (Muris et al., 1998; Muris et al., 1999; Schmidt & Merckelbach, 2000).

It is also noteworthy that youth in a more intensive type of care (residential treatment) had higher scores on the SCARED than other youth. Although this is in accordance with other studies, such as Bakers et al. (2007) comparison between residential treatment centers and therapeutic foster care, we do not know whether this means that youth with the most severe problems receive the most intensive treatment, or that an intensive type of treatment such as residential care paves the way for anxiety problems in youth.
Further, a clear relationship was found between anxiety as reported on the SCARED and internalising problem behaviour as reported on the YSR, which can be seen as a good indicator of the validity of both questionnaires. Since often comorbidity between anxiety symptoms or depressive symptoms and externalising behaviour is described (Baker et al., 2007; Cunningham & Ollendick, 2010; McConaughy & Skiba, 1993; Roza et al., 2003; Tambelli et al., 2012; Tanaka, Raishevich & Scarpa, 2010), we expected to find, although maybe modest, some correlations between youth-reported anxiety and externalising behaviour, but surprisingly failed to do so on the YSR.

Compared to the YSR, less correlations could be found between SCARED and CBCL or TRF. The low correlations, or even lack of correlations with adult-reported internalising behaviour also seems to correspond with current literature (Andrea, Lenz & Lehmkuhl, 2009; Comer & Kendall, 2004; Foley et al., 2005; Grietens et al., 2004; Stanger & Lewis, 1993; Youngstrom, Findling & Calabrese, 2003), and are demonstrative of teachers’ and educators’ difficulties of recognizing youth-perceived inner mental state. We did find correlations between the SCARED and the externalising broadband scale of the CBCL, but these results, taken together with the lack of correlation with the internalising broadband scale, seemed to be in contrast with three studies on the reliability and validity of the SCARED, which all proved that the SCARED correlated better with the internalising than with the externalising scores (Monga et al., 2000; Muris et al., 2004; Su et al., 2007). An explanation possibly could be found in the fact that, although the CBCL also fits for the judgment of educators (Albrecht et al., 2001), in all three validation studies parents and not educators were used as informants.

Further, both on the CBCL as on the YSR numerous correlations between the SCARED and the syndrome scale ‘social problems’ were found. We believe these results could suggest not only that youth express their feelings of anxiety more in socially maladjusted behaviour than in aggressive or disruptive behaviour, but that this is also how it is perceived by educators.

Probably the most striking results, in terms of informant disagreement, can be found with regard to the syndrome scale ‘thought problems’. No correlations were found between the SCARED and the syndrome scale ‘thought problems’ on the TRF nor on the CBCL. On the YSR, however, this syndrome scale correlates the strongest of all syndrome scales with the self-reported anxiety. This result showed a clear relationship between anxiety and cognitive problems as perceived by youth themselves – a relationship which Beers and De Bellis (2002) also found in children with PTSD – but also that this clear relation goes unnoticed by teachers and educators.
Finally, the independent samples t-test with the CBCL showed that youth with high scores on 'situational phobia' have higher CBCL scores on 'social problems' and 'ODD', but youth with high scores on 'PTSD' have higher scores on the CBCL scales 'anxiety problems' and 'anxiety disorder'. These results support the idea that the nature of the anxiety in youths seems to determine group workers capability to recognize these anxieties.

5.4.2. Recommendations

First, it seems obvious that the apparent presence of anxiety symptoms in youth with emotional and behavioural disorders stresses the need for treatment and individual treatment plans to address these problems, and to not only focus on externalising or social problems.

Secondly, the informant discrepancies as described above reflect the complex nature of a child and its problems as they are presented and experienced in different realities (Soenen et al., 2011). Nevertheless, we agree with several researchers who state that when the key participants of treatment do not agree on the problems to be targeted, this will result in a lack of agreement on goals to be achieved and on desired outcomes (De Los Reyes & Kazdin, 2005; Ferdinand, van der Ende & Verhulst, 2004; 2006; Hawley & Weisz, 2003). Therefore, and together with many others (Clay, Surgenor & Frampton, 2008; Comer & Kendall, 2004; Lacalle, Ezpelata & Domenéch, 2012; Rubio-Stipec et al., 2003; Stanger & Lewis, 1993), we want to underscore the need to collect information from different informants in clinical practice.

Further, when professionals want to help youth dealing with both their emotional and behavioural problems, we want to stress the need to install clear intervention programs. Our results suggest that these programs should not only focus on the social or behavioural level, but also take the cognitive functioning of youth into account.

Our data revealed that youth in a more intensive type of care (residential treatment) had higher scores on the SCARED than other youth. Further research should investigate whether this means that youth with the most severe problems receive the most intensive treatment, or that an intensive type of treatment such as residential care paves the way for anxiety problems in youth.

5.4.3. Limitations

This study has several limitations that should be considered when interpreting the results. First, this research took place in only one treatment centre. Although it’s plausible to expect that our findings are also applicable to other, similar centres, we want to stress that no two treatment centres are the same, and results cannot be generalized to other centres.

Secondly, in this research we collected data from children and adolescents, their teachers and their group workers. Although favourable when wanting to obtain a more complete view, because of pragmatic issues we were not able to collect data provided by parents.
5.4.4. Conclusion

Based on a previous study, which showed disagreement between the informants, especially with regard to internalising, and based on the growing interests in anxiety problems, the current study was designed to look into detail in the nature of these internalising problems, especially with regard to anxiety problems, and to investigate possible relations between these problems and other problems as perceived by different informants. Analysis indicated a clear presence of anxiety problems, with the highest anxiety scores for situational phobia, posttraumatic stress disorder and social phobia. These anxiety scores seemed to be related with some group worker report of youths’ problems, but not with teacher-report. Youth themselves indicated strong correlations between anxiety and thought problems, whereas educators indicated strong correlations between youths’ anxiety and social problems. Based on the results of our study, it is concluded (1) that individual treatment plans must also address these problems, and to not only focus on externalising or social problems; (2) that, because of the informant discrepancies, a need exists to collect information from different informants in clinical practice; and (3) that clinical practice needs interventions programs that focus not only on the social or behavioral level, but also take the cognitive functioning of youth into account.
References


CHAPTER 6
Implementing evidence-supported methods in residential care and special education: a process model\textsuperscript{5}

\textsuperscript{5} This chapter is based on Soenen, B., D’Oosterlinck, F., & Broekaert, E. (2014) Implementing evidence-supported methods in residential care and special education: a process-model. \textit{Children and Youth Services Review}, 36, 155-162.
Abstract

This chapter presents the findings of a qualitative study in a Flemish centre for children and adolescents with emotional and behavioural disorders. The change with regard to the demand for care of this highly troubled population has created a need for intervention models that address students’ socio-emotional needs. When preparing an organisation to implement such intervention models, it is critical to obtain a thorough needs assessment or pre-implementation evaluation of staff in the organisation. Fifty interviews with different staff members were performed, guided by three research questions: (1) How do staff perceive the children and youth cared for, including the behaviour, needs and demands of these youths?; (2) How do staff try to translate this demand for care into treatment, and what obstacles could possibly stand in the way?; and (3) What are, according to staff, critical issues to take into account when implementing EBP, both on the individual level and on the level of the organisation? Using a grounded theory approach, the analysis resulted in a pre-implementation model. In the following chapter, this model will be discussed and illustrated with quotes of staff themselves.
Chapter 6

6.1. Introduction

Children and adolescents with emotional and behavioural disorders (EBD) often require special treatment programmes to address their problems. Although the number of children who reside in substitute care is small in comparison to the total child population (less than 1%), they are increasingly troubled and present multiple problems at intake (Whittaker, 2004). These problems should be viewed as chronic conditions (Visser et al., 2003) and seem to be almost as stable as personality traits (De Bolle et al., 2009). Research on youth in these settings, who are described as a highly vulnerable group with extensive mental health needs (Hukkanan et al., 1999), often describes their problems in terms of internalising and externalising behaviour. Connor and colleagues (2004) for example, examined the characteristics of children and adolescents admitted to a residential treatment centre. The results of their study indicate high rates of internalising and externalising psychopathology, aggressive behaviour, and consistent gender differences, with girls having higher levels of internalising and externalising psychopathology and aggressive behaviour. In a comparative study between youth in residential treatment and youth in treatment foster care, Baker et al. (2007) found that the prevalence of disorders in the residential treatment centre population was substantially higher than in the treatment foster care population. Youth in residential care were more likely to be anxious/depressed, aggressive, and delinquent, and less likely to have attention problems than the youth in treatment foster care. Further, D’Oosterlinck and his colleagues (2006) gathered information about the characteristics of boys and girls with EBD placed in residential care and day treatment facilities in East Flanders. After data collection from a sample of 517 children, 83% were boys and 17% girls, a behavioural profile was created using CBCL (Child Behaviour Checklist) scores. Results of this study illustrated that children and adolescents in the sample showed a tendency towards externalising problems and portrayed themselves as aggressive and disruptive.

Several authors also indicate a change in characteristics of this population in time. In his article on future directions of residential treatment, Lieberman (2004) points out how an increasing rate of child abuse and neglect, along with the placement of greater numbers of children in less restrictive environments has resulted in programmes dealing with a higher amount of more seriously troubled youth than they have been experienced in the past. In a Flemish study on the evolution of the demand for care for children with emotional and behavioural problems and their parents, a group of children receiving therapy in the 1970’s was compared with a group of children treated in the same programme in the 1990’s. Results indicated that children from the 1990’s group displayed more outward problematic behaviour – aggressive, impulsive and antisocial – compared to children from the first group. Further, in the 1990’s group, parents tended to demand care at an earlier stage, more
action points in relation to family dysfunction were formulated, and the care demand seemed to be more complex (D’Oosterlinck, 2000).

Not surprisingly, the nature and the negative evolutions of the problems of these children and adolescents place the caregivers of these youth under enormous pressure, resulting in high turnover rates. The extensive literature on staff turnover has provided the field with consistent and meaningful insights into factors that could enhance the retention of professionals. Examples of influential factors on the individual level are low salaries (Colton & Roberts, 2004), the balance between work and personal life (Smith, 2005), job moral and job satisfaction (Colton, 2005), the perceptions of the children and youth cared for (Colton & Roberts), and behaviour management approach (Albrecht et al., 2009). Examples of influential factors on the organisational level are training (Colton, 2005; Colton & Roberts, 2004), administrative support and adequate time for paperwork (Albrecht et al., 2009), the implementation of evidence-based practices (Aarons et al., 2009), and supervision, both by supervisors (Cearly, 2004; Colton & Roberts, 2007; Gersten et al., 2001; Smith, 2005) as well as by peers (Colton & Roberts, 2007; Gersten et al, 2001).

Further, it is generally assumed that working with this highly troubled population and the change in regard to the demand for care has also created a need for intervention models that address students’ socio-emotional needs (Baker et al., 2007; George & Fogt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009), especially to cope with the high amount of conflict and crisis situations (D’Oosterlinck et al., 2009). Research has shown that staff members feel empowered when confronted with conflict and crisis if they are trained in conflict management methods, and have an insight in the specific behaviour of youths with EBD (Dawson, 2003; Lindsay, 1998).

At present, literature on the implementation of such methods is scarce. Starting from the debate between the psychoanalytically-oriented individual approach and the milieu therapy approach, the two dominant approaches that historically have shaped the standard treatment models used by most residential centres, the Sanctuary Model of residential care was developed (Abramovitz & Bloom, 2003; Bloom et al., 2003; Rivard et al., 2003). This model addresses trauma exposure as a central organising life experience. The Sanctuary Model puts these fundamental attributes of healing into operation via a conceptual framework called “S.A.G.E.,” an acronym that stands for Safety, Affect Management, Grieving, and Emancipation (Abramovitz & Bloom, 2003). Next to the S.A.G.E. framework, other important elements are: building a patient-staff treatment partnership; flattening the organisational hierarchy; integrating community and therapy education; promoting community building based on SAGE principles; and expecting patients and staff to share responsibility for maintaining a safe, nonviolent milieu. Research on the
implementation of this model showed that successful implementation requires not only the implementation of new treatment protocols, but also change in the program philosophy and milieu toward a nonviolent and community-oriented paradigm, change in the organisational culture, and change in attitudes and behaviour of youth and staff as community members (Rivard et al., 2003).

Within the field of substance abuse treatment, Simpson developed a program change model, including four key elements that are typically involved in the process of change. The first stage is “exposure”, usually involving training through lecture, self-study, workshops, or expert consultants. The second stage, “ adoption”, represents an explicit intention to try an innovation, including both formal decision made by program leaders and subtle levels of commitments made by individual staff. “Implementation” comes next, implying that there is a period of trial usage of the new innovation to allow testing of its feasibility and potential. The fourth and last stage moves to practice, reflecting the action of incorporating an innovation into regular use and sustaining it (Simpson, 2002; Simpson, 2004; Lehman, 2011). Based on this model, Lehman, Greener and Simpson (2002) developed a tool for the assessment of organisational functioning and readiness for change (ORC). Results of surveys of over 500 treatment personnel from more than 100 treatment units support its construct validity on the basis of agreement between management and staff on several ORC dimensions, indicating that the ORC can contribute to the study of organisational change by identifying functional barriers involved (Lehman, Greener & Simpson, 2002).

Since implementation of such models is a complex process that is often fraught with unanticipated events, conflicts and resolutions (Aarons & Palinkas, 2007), several concerns should be taken into account to improve the probability that conditions are adequate to implement these practices (McLeskey & Billingsley, 2008).

Recently, Aarons and his colleagues have performed some studies on implementing evidence-based practices (EBP) in mental health care, supporting new optimism that successful implementation can lead to both positive organisational outcomes and ultimately to better client outcomes (Aarons et al., 2009). In an elaborated study, which included 301 mental health service providers from 49 different programmes, the association between attitudes towards adopting evidence-based practices and organisational culture and climate were examined. Correlation analyses showed that constructive culture was associated with more positive attitudes towards adoption of EBP and poor organisational climates were associated with more negative attitudes. The authors conclude that organisations may benefit from taking into consideration how culture and climate affect staff attitudes towards change in practice (Aarons & Sawitzky, 2006).

In an attempt to understand the implementation process in the child welfare system, Aarons and Palinkas (2007) interviewed case managers who were actively involved in
implementing an EBP in order to reduce child neglect. The results of their study suggest that careful planning is but a part of the process of implementation, and that implementation is viewed as an adaptive undertaking. Further, it is deemed unrealistic to assume that implementation is a simple process, that one can identify all of the salient concerns, be completely prepared, and then implement effectively without adjustments. As a consequence, it has become clear that being prepared to implement EBP means being prepared to evaluate, adjust, and adapt in a continuous process that includes give and take between intervention developers, service system, organisations, providers, and consumers (Aarons & Palinkas, 2007).

When preparing an organisation to implement evidence based models as an answer to the evolving complex demands of its target population, it seems critical to obtain a thorough needs assessment or pre-implementation evaluation of staff in the organisation. Currently, studies of this type are scarce. In an attempt to add to this small body of literature, we conducted a qualitative study - involving professionals in residential care and special education – guided by the following research questions:

- How do staff perceive the children and youth cared for, including the behaviour, needs and demands of these youths?
- How do staff attempt to translate this demand for care into treatment, and what obstacles could possibly stand in the way?
- What are, according to staff, critical issues to take into account when implementing EBP, both on the individual and on the organisational level?

### 6.2. Method

Youth care in Flanders, which is organised by the Flemish government, is divided into three main sections. The first is the youth protection service, which consists of a social branch and a legal branch for children and adolescents in problematic educational situations. The second section provides mental health care for children with a handicap, including a psychological handicap such as emotional and behavioural disorders. Thirdly, the Flemish school system includes special education for children and adolescents with different problems, such as emotional and behavioural disorders (D’Oosterlinck et al., 2006).

The study described in this article took place in a Flemish centre for children and adolescents with emotional and behavioural disorders, that provides services recognised within the mental health care system for people with a handicap and within the special education system.
The centre is located in the West part of Flanders, and offers a continuum of care and education to youth and their families in the province of West-Flanders. Although the centre also serves children and adolescents with autistic disorders or with intellectual disability, only the staff who work with youth with emotional and behavioural disorders were involved in this study.

Two schools are located on campus; one school for children age 3 to 12 (elementary education) and one school for youth age 12 to 21 (secondary education). The primary school uses a multidisciplinary and development-oriented approach, integrating therapeutic work with individual therapies. Specialised teachers work on an individual basis with children who need extra support. The secondary school offers general and vocational training and aims to prepare students for jobs such as carpenter, kitchen-help, shop-aid, gardener, or plumber.

The residential part of the centre consists of several groups, where 12 to 14 children or adolescents live together during the week, but can also stay during the weekends and the holidays. The groups are divided into three different clusters, based on the age of the residents. Each group consists of a team of four to seven group workers, and each cluster consists of a team of three to six supervisors. Further, a psychiatrist, a team of nurses and a team of psychologists are available to assist where needed.

At the time of the study, 402 children and adolescents were in care, 117 girls and 285 boys. The mean age of the youth was 13.55 (SD=3.06), ranging from 3 to 19. Two hundred and eighteen youth only attended one of the schools, 184 were also placed in residential care. The centre employed 255 staff, technical and administrative staff not included. Table 1 provides more detailed information of staff characteristics.

<table>
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<th>Table 1: staff characteristics</th>
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<tr>
<td><strong>Residential staff</strong> n=110</td>
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<td><strong>Staff day school</strong> n=145</td>
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<td><strong>All staff</strong> n=255</td>
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<td><strong>Mean age</strong></td>
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<td><strong>Training</strong></td>
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In this study we wanted to collect information with regard to how staff perceive the needs of the youth they work with, and how they look at possible obstacles and critical issues prior to implementing EBP. Therefore, this study has an explorative nature, with the aim of collecting perceptions in this relatively uncultivated domain (Mortelmans, 2010). The overall choice for a qualitative approach was based on an interest in understanding the
insider perspectives of staff working in residential care or in special education. The research strategy rested on a number of semi-structured interviews with staff, in which the researcher gave pre-set questions in a fixed order, but with the possibility of asking side-questions based on the interviewees’ response. By using semi-structured interviews, we had the opportunity to explore the topics indicated by the interviewees further, without losing sight of the original goals of the interviews (Herzog, 1996).

From the 255 staff members, 50 were selected at random and asked to participate in the study. Although no one refused to participate, three planned interviews were cancelled because the interviewee did not show up at the appointment. Before the interviews started, general information with regard to confidentiality and anonymity was provided. Although each of the participants was informed that he or she had the right to refuse, all of them gave permission to be interviewed and to tape-record the interviews. The average length of the interviews was about one hour, and all interviews were tape-recorded and transcribed verbatim afterwards. The mean age of the participants was 39.51 (SD=10.85), ranging from 24 to 59. The mean years of working experience was 15.11 (SD=10.50), ranging from 1 to 37. Twenty-three interviewees were male, and 24 were female; 20 interviewees were employed in the schools and 27 in the residential centre. A closer look at the level of training shows that 5 interviewees attended vocational secondary education, 34 had a bachelor’s degree and 8 had a master’s degree. The sample consisted of 4 directors, 15 supervisors, 15 teachers and 13 group workers.

Because we wanted to make knowledge claims about how individuals interpret reality instead of testing hypotheses about reality (Suddaby, 2006), and because we wanted to develop a theoretical model out of our data, we opted for a grounded theory approach. Grounded theory’s aim is to explore basic social processes and to understand the multiplicity of interactions that produces variation in that process. Fundamental to grounded theory is the belief that knowledge may be increased by generating new theories rather than analysing data within existing ones (Heath & Cowley, 2004). When using a grounded theory approach, data analysis is like a discussion between the actual data, the created theory, the memos and the researcher. Such discussion takes place when the data are broken down, conceptualized and put back together in new ways (Backman & Kyngäs, 1999). As a start of the analysis, the first author and two trained researchers carried out a first reading of the materials, to form a general impression and to acquire some ideas for further analysis. This first reading resulted in some potential themes, as identified by the three researchers separately. Discussion among the three researchers provided a deeper understanding of the materials and the potential themes. After this first reading and discussion, a model was developed that contained the main themes that emerged from the interviews. Further, the text was divided into meaning units, which are groupings of words or statements containing aspects related to each other through their content and context (Graneheim and Lundman, 2004). Subsequently, the three researchers each carried out a
second reading of the text, using the software package Nvivo to organise the meaning units into the model. In doing so, a better overview of the collected data was created (Stewart and Shamdasani, 1990). After comparing and discussing the results, and after constantly refining and attuning the definitions of the categories, a definitive model was created.

The findings below are descriptive, and are illustrated with quotes of the staff members. Each quote is followed by the number of the interview.

6.3. Results

Analysis of the 47 interviews revealed four different themes: ‘working with the target population’, ‘working with colleagues’, ‘vision of the organisation’, and ‘preconditions for implementation’. In three of these four themes, different subthemes were discovered. Because these four themes were interrelated, we were able to draw them into a pre-implementation-model (Figure 1).

6.3.1. Vision of the organisation

For many interviewees, the vision of the organisation should be the driving force for daily work, and should determine how staff work together and how staff work with the children and adolescents in the centre. Staff underlined the importance of installing a **clear, univocal and shared vision**, which was often lacking at the time of the interviews. The written vision often does not link up to reality and is often not known to staff, therefore, it is not a point of departure for the day-to-day operations.

“They all act as they think. I know that most of them try their best, but there is no general idea on how to do things. It’s like freewheeling.” Interview 42; female teacher

Further, **two important aspects of a valuable vision** are mentioned. A first aspect is the general policy of the organisation, which concerns for example how the organisation wants to stress its distinctive features compared to other organisations, or how the organisation anticipates the current and future trends in residential care and special education. A second aspect concerns the pedagogical and educational perspective, which should offer well-thought guidelines on how to regard the youths, their behaviour and all possible aspects of treatment.

“We don’t have a vision with regard to the problems of the children, so we all react to their behaviour at random and there is no consistent approach.” Interview 45; male supervisor
Figure 1: pre-implementation model
Finally, the **history of the organisation** seems to be of great importance in how the current vision is articulated. The organisation was founded in the 1950s as a residential centre for children and adolescents with a mild intellectual disability, and has established a long tradition of working with this target population. Since the last decade, the population has shifted to children and adolescent with emotional and behavioural disorders. As a consequence, the current pedagogical and educational beliefs are not yet adapted to the current target population of the centre.

“We started working with students with EBD about 10 years ago. And some teachers... they were just confronted with these new problems. I think some teachers are still traumatised and still haven’t accepted that they now have to teach students with EBD.” Interview 29; male teacher

### 6.3.2. Working with colleagues

Because of the variety of people working in the centre and their variety in backgrounds, the topic of ‘cooperation and working together’ was salient in our analyses. Within this second central theme, four interrelated subthemes emerged: ‘cooperation within the entity’, ‘cooperation between the entities’, ‘necessary conditions and suggestions concerning cooperation’, ‘shared approach’.

When looking closer at the subtheme **shared approach**, several interviewees mention the lack of a shared approach. Staff seem to react in different manners to the behaviour of the youth, resulting in stress for both youth and staff. While a majority of the interviewees clearly express the need to establish a shared approach to youths’ behaviour –

“We need an univocal approach, we need to have consistency for all of the children.” Interview 22; female group worker

– some are afraid that this could lead to uniformity without personal contribution.

“The goal is to all move in the same direction, to all act in the same way when problems occur, but I think that is utopian. We are all different people and all of us have different styles.” Interview 14; male teacher

As a second subtheme, staff reflect upon **cooperation** as a necessary condition to establish a shared approach. Many negative staff reflections on cooperation within their entity of the centre emerged, such as a ‘close-mouthed atmosphere’, where ‘information is not passed to one another’. Further, there seems to be an area of tension between formal and informal communication. On the one hand, ample channels for formal cooperation, such as weekly team-meetings or daily briefings, and ample means for formal communication such as mail and intranet exist, but they are not used as agreed upon. On the other hand, informal ways of cooperation, such as making agreements during coffee or cigarette break are perceived as
valuable, but seem to take the upper hand. As a result, many staff do not work together but alongside each other. Positive reflections on cooperation within the same entity often depend on the individuals and on the distance of staff within the hierarchical structure of the centre.

“The atmosphere amongst the colleagues is good. We all get along, and we all communicate well.” Interview 46; male supervisor

Cooperation between the different entities - in most of the examples this concerns the cooperation between the school and the residential part of the centre - is often perceived as problematic, except when staff from both entities get along with each other on a personal level. Sometimes practical obstacles hinder effective and efficient cooperation – the kids are in their groups when we have time to meet, and the kids are in our groups when they have time to meet – but the biggest obstacle is the seemingly unbridgeable gap in points of view between the two entities. The tension between the school’s focus on teaching subject matter to the students, and the residential part’s focus on treating emotional and behavioural problems through daily life situations appears to be incompatible.

“The culture of the residential centre and the culture of the school are totally different. That’s what I’ve experienced when I worked in both. And it still is. Teachers are teachers, and group workers are group workers, and they each have their own purposes.” Interview 29; male teacher

Finally, another recurring subtheme is the cooperation with the therapeutic department, which is an autonomous department within the centre. From a strong belief in offering privacy and safety in a therapeutic alliance, the staff from the therapeutic department hold on to professional confidentiality and are reluctant to share information with their frontline colleagues. Analysis of the interviews shows that this refusal to share information is a source of frustration for many teachers and group workers.

When asked what they see as necessary conditions to establish effective and efficient communication, three topics are mentioned by interviewees. The most prominent topic is a culture of open communication, without hidden agendas and with opportunities for all to express their opinions.

“I think, when you never express your opinion and you always... I cannot image one could function well in a group when one does not agree with the opinions of the group.” Interview 27; female group worker

Secondly, a staff with the right mentality is an important condition. Components of this mentality are ‘trust in intentions and capacities of colleagues’, ‘respect for one’s opinion and work’, and ‘the willingness to compromise’. Finally, clear and unambiguous rules, and
keeping to those rules – just as you would expect from the youth – is articulated as a third condition.

### 6.3.3. Working with the target population

Within this third central theme, four different and interrelated subthemes emerged during analyses: ‘needs and background of youth’, ‘behaviour of youth’, ‘knowledge and skills of staff’, and ‘staff approach’.

When talking about youths’ problems and background, diagnoses such as ADHD, conduct disorder, psychotic disorders, autistic disorder are often mentioned. Further, staff refer to the problematic home situation of their pupils, which is often characterised by traumatic experiences, poverty, violence, and a lack of love, affection and structure.

“Most of them come from a terrible home situation, where they didn’t get any love, affection or trust”. Interview 14; male teacher

These problems and background are translated in youths’ behaviour. This behaviour is described by staff in terms of physical aggression such as fighting, kicking, beating, smashing windows,…; verbal aggression such as shouting, foul language, calling names, and other disruptive behaviours such as lying, stealing, using drugs, smoking, drinking, being impolite, being stubborn, running away, lack of motivation at school,…

“They don’t have the skills to explain things with words, so they solve their problems with their fists.” Interview 15; female teacher

“Also physical aggression... mostly as a consequence of a verbal conflict that got out of hand.” Interview 20; male supervisor

According to the interviewees, these behaviours take place on a daily basis, which is more than in the past, are mostly directed towards other youngsters but often also towards staff, and usually have a great impact on staff.

“... and the verbal aggression amongst each other ... I think it’s their way of life.” Interview 35; male teacher

“Aggression towards other kids and towards us. Last year 3 or 4 times towards us.” Interview 24; female group worker

“When they attack you... that’s quite something. It doesn’t happen that much, but if it does it has a lasting effect.” Interview 29; male teacher

The larger the group, and the less structured the activities, the more negative behaviour occurs. Examples of such stressful places or situations are the playground, the transition from one activity to another, lunchtime, gym class, on the bus,….
For some staff, there is a clear link between the youth’s behaviour and his or her background. According to these interviewees, the aggressive and disruptive behaviours often have their origin within the dysfunctional family context and acts as a symptom for internalising problems such as anxiety, low self-esteem, etc.

“Sometimes the aggression stems from their traumatic past. Like situations where they re-live the past. That happens. And it goes together with feelings of uncertainty, anxiety, loneliness, feeling abandoned, feeling like getting the blame....” Interview 13; male supervisor

In a third subtheme, staff reflect on their knowledge and skills to deal with this behaviour. Many staff feel that they are not well-equipped enough to work with the youth in the centre, especially when conflicts occur; they often lack theoretical knowledge about the problems of the youth, but mainly lack concrete skills to deal with this behaviour. Especially teachers indicate that their bachelor education prepared them for teaching in general, but not for educating children and adolescents with such severe emotional and behavioural problems.

“Many children have a lot on their minds. Problems that I think, as a teacher you’re not schooled enough to help them deal with.” Interview 16; female teacher

Another frequently mentioned cause of this current lack of knowledge and skills is the shift from the target population of youth with mild intellectual disabilities to a target population of youth with emotional and behavioural disorders in the centre, without the necessary training or education for staff.

“Our population has changed that much, that most people couldn’t adapt, because it went to fast.” Interview 8; male supervisor

Not surprisingly, many interviewees express the need for additional training. This additional training should not focus on theoretical frameworks, but should offer practical guidelines that can be used in daily life in the centre. Experiences with previous trainings, which were perceived as too vague, too theoretical and sometimes even a waste of valuable time, indicate that the content of future trainings should be well-considered to answer staff needs.

These issues regarding knowledge and skills will obviously have their impact on staff approach to youths’ behaviour. An analysis of statements within this fourth subtheme represents three areas of tension between staff’s ideas on how to approach youths’ behaviour.

A first area of tension has to do with the content material at school. It is a common criticism from group workers within the residential part of the centre that their colleagues at the schools are too focused on the subject matter instead of on developing social skills and attitudes, and that their approach is too much based on didactics. These group workers think
that teachers set their expectations too high, and that they disregard the nature of the children’s and adolescents’ problems.

A second area concerns the tension between an approach based on control and an approach based on relationship. Some staff prefer the more behaviouristic methods, such as level-systems, punishment, strict rules, and even sometimes physical power, and believe that it has to be made clear that the adults are in charge and the youth has to obey.

“When I’m in front of the class, I demand discipline. Constantly. It really exhaust me, but that’s my job, that’s what I choose to do.” Interview 39; female teacher

On the other hand, other staff do not believe in a restrictive approach, and prefer an approach based on relationship, which is mainly established through offering a safe environment, communication and listening to youths’ needs.

“Our students are allergic to power and hierarchy. What we have to do, is offer them safety and a relationship based on trust.” Interview 28; male teacher

Although some interviewees said that an approach based on control and an approach based on relationship should be combined, in general, this tension between is one between persons and not within persons.

A third area concerns the tension between working on an individual basis and group-based working. The younger youth are, the more staff prefer group-based working; the older youth are, the more staff want to work on an individual basis. Further, the ‘individual-group tension’ seems to be a tension within people, and not between people. Many staff would like to have the opportunity to work more on an individual basis, but do not want to leave their colleague alone with the rest of the group.

Further, most staff had shared ideas both on helpful approaches currently used as on current shortcomings. Offering structure and the use of clear methods are perceived as helpful elements. The most commonly occurring shortcomings are the lack of opportunities for individual therapy, the lack of space, the shortage of staff, the lack of opportunities to work with parents and the lack of support after transition. Another important shortcoming is seen in the way conflicts are handled. Predominantly, there seems to be a variety in manners how staff deal with conflict, ranging from ignoring the incident to using physical power.

“So I just grab them and drag them outside if I need to. They know I will use physical contact when I need to.” Interview 12; female supervisor

Further, the disruptive behaviour of one child always impacts the functioning of the whole group. In these situations, most interviewees just want the disruptive child to be removed, so they can continue the group activity.
“We are not used to talking to kids after a conflict occurs. Most of the times, they are sent to the quiet room, and when they calmed down they just go back to their group.” Interview 18; female supervisor

Finally, some fragments in the interviews mentioned recent evolutions with regard to the approach toward youths’ behaviour, such as the establishment of a new time-out unit. Interestingly, while directors reflected positively on these evolutions, other staff were somehow more suspicious, stating that results had yet to be seen.

6.3.4. Preconditions for implementation

A first precondition for a successful implementation concerns the infrastructure of the organisation. A first barrier with regard to the infrastructure is the lack of separate or quiet rooms. Both in the school and in the residential centre youth are together with 12 to 14 others in one room, and it would be an improvement to have some rooms available for youth to be on their own or to have the opportunity to discuss certain issues privately. In addition, the fact that not all children and adolescents have their own bedroom is perceived as outdated and as an intrusion on their privacy. A second barrier has to do with the size of the organisation, which is an impediment for staffs’ attempts to create a homelike atmosphere.

A second precondition has to do with the resources of the organisation. Although some staff talk about resources to buy materials such as toys, sports equipment or didactic material, most staff talk about the staff shortage as a result of the limited resources. An interesting difference between teachers and group workers is that group workers stress the need for more group workers while teachers stress the need for more paramedical staff who could intervene when problems occur.

“When children in the group want to ask you something, but you are busy with some other kids... because we have 13 kids in our group, so we need more group workers.” Interview 50; female group worker

As a final, but not less important precondition, interviewees mention coaching and support. There is a general consensus that more coaching and support is necessary, especially when staff are confronted with aggression. Not only more coaching for frontline staff is needed, but also the coaches themselves need to be coached and supported.

“When you work with troubled youth, you have to take care of your staff, but also of those who take care of your staff. And sometimes these people are overlooked.” Interview 9; female supervisor
Both coaching and support from direct colleagues as well as from supervisors is perceived as valuable, although not yet sufficient at present and often too much dependent on the individual staff member. The more a supervisor is perceived as an involved person close to the group and the group workers or teachers, the more his supervision is perceived as helpful.

Finally, all interviewees were very positive about the continuous permanency system that was established, and recently elaborated in the organisation. Because of this system, frontline staff can call for immediate help at all time. This certainty that someone is available to support or to remove the aggressive child when needed offers a feeling of safety and peace of mind.

“When they started with the system... and I think this is true for all groups... people had the feeling that they did not stand alone. And the knowledge that they could call someone at any time made them more at ease.” Interview 3; female director

6.4. Discussion

6.4.1. General discussion

The implementation of evidence based practices in optimising and innovating care for children and adolescents with EBD is proposed to rely on both organisational and individual factors (Moore, 2002; Rogers, 1995). While the most EBP’s provide guidelines to approach the target population, the results of our study indicate that a variety of factors should be taken into account prior to and during the process of implementation, and that implementation will not occur on a tabula rasa (Aarons & Pakinkas, 2007). Using a grounded approach, these factors were put together in a model, showing the relationship between (1) the vision and beliefs of the organisation, (2) cooperation among colleagues, (3) working with the target population, and (4) preconditions for implementation.

Maybe the most significant factor for a successful implementation is the vision and the beliefs of the organisation, the vision and the beliefs of the staff, and how both are aligned. Participants of our study indicated the need for a clear vision, both on organisational processes as on pedagogical beliefs. In their recent study, Hicks and colleagues (2009) provide an overview of the internal management and use of resources in residential child care. Using both qualitative and quantitative analyses, they examined variations in the functioning of a sample of 45 children’s homes in England. Results showed that in homes where the manager had clear, well-worked-out strategies for working with behaviour and education, staff had higher morale, felt that they received clearer and better guidance, and
felt that the residents behaved better (Hicks et al., 2009). Earlier, Penland investigated ‘organisational readiness’ for successful implementation of quality management systems. Next to strategic leadership and positive culture, vision perspective is an important factor on which preparation for improvement must focus. Penland concludes that the process of implementation does not come easily and often challenges basic individual beliefs and values. Therefore, organisations must determine whether the staff understand the organisational vision, and if they are willing to make the necessary improvements to achieve it (Penland, 1997). Similar ideas can be found in the work of Anglin (2004), who emphasised the importance of a clearly articulated framework for creating and assessing individual residential programmes (Anglin, 2004).

As a consequence, when an organisation decides to train its staff in evidence based intervention models, management should make sure not only that the model fits within the vision and beliefs of the organisation, but also that the vision and beliefs become an integral part of the training.

Once the vision and beliefs are established in the organisation, and known by all staff, the foundation is laid for a constructive cooperation, resulting in a shared approach. Although there will always be competing interests and intentions within an organisation as complex as a group home, and full congruence can best be understood as an ideal state that can never be actually achieved in reality (Anglin, 2004), the results of our study stress the need to pay abundant attention to cooperation among staff. Participants in our study often experienced cooperation as very difficult, especially with staff members from another entity of the organisation. Further, and in agreement with other studies (e.g. Hicks, 2008), the establishment of a climate of cooperation seems to depend on the critical balance between formal and informal communication and cooperation between staff members. An organisational climate with a culture of trust, respect, and openness in communication seems to be a necessary precondition for successful cooperation in special education and residential care.

In a third part of our model, staff reflect on their own approach to youths’ behaviour. Staff mentioned a variety of negative behaviours such as verbal and physical aggression, often originating from the youth’s background. These behaviours have increased over time, and often have an impact on staff which should not be underestimated. Further, not only did many staff feel not skilled enough to deal with youths’ behaviour, our study also revealed conflicting opinions on how to do so. These findings confirm the generally accepted idea that staff are in need of extensive training in clearly elaborated and practice-focused intervention models. Because of the presence of conflicting opinions, trainings in such methods should pay attention to the underlying beliefs of these methods.
For implementation to be successful, interviewees mentioned several preconditions. Next to the outdated infrastructure, and especially the lack of individual rooms for all youth, the pressing staff shortage is a barrier which can be found in many studies (e.g. McLeskey & Billingssey, 2008; Moses, 2000; Colton & Roberts, 2007).

The last, and maybe most important precondition which emerged from our analysis concerns coaching and support. The effect of support has extensively been discussed in the current literature, both on retention of staff (Gibbs, 2001; Rhoades et al., 2001; Smith, 2005) as well as on empowerment (Anglin, 2004; Baker et al., 2005; Cearley, 2004, Gersten et al., 2001; Moses, 2000, Rhule, 2005). Cearley (2004) for example, investigated in a sample of 85 child care workers the effect of several factors, such as supervisors’ help-giving behaviour, length of time as a child welfare employee and type of degree. Results of this study indicated that child welfare workers perceived their supervisors’ help-giving behaviours as the only factor that influenced their perceived empowerment (Cearley, 2004). Moreover, Aarons and colleagues examined the effect of evidence-based practice implementation and on-going fidelity monitoring on staff retention in a children’s services system and even suggested that that implementation of the EBP without on-going consultation and support could lead to the perception that the new service model is just another change with attendant paperwork and administrative demands.

6.4.2. Conclusion and recommendations

Although most EBPs will focus on certain skills of staff and certain behaviours of youth, our study revealed that, when an implementation process is started, several other aspects will have to be taken into account. Before the process of implementation starts, the vision and beliefs of the organisation, the vision and beliefs of staff, and the vision and beliefs on which the EBP is based should be mapped and aligned with each other. Further, managers should pay attention to the formal and informal ways of communication, and offer safe channels for staff to express their opinions. Finally, a well thought-out plan on how to support staff throughout the process of implementation should be developed. To achieve all of this, an assessment instrument should be developed. Such an instrument could help managers of organisations not only to get an idea of the readiness for change, but also to get an insight in critical elements on the organisational and individual level (e.g. vision, communication) that need more attention before the process of implementation can start. We believe that the model described in this study can be the foundation for such an assessment instrument.

Secondly, as it is important to place problem solving in the hands of those closest to the problems (George & Fogt, 2005), the active participation of staff will be critical during the process of implementation. Therefore, small groups of stakeholders should be put together to gather information on how the process is evolving and to make suggestions on how the
process could be adjusted. In doing so, the four aspects of the model presented in our study could serve as a steppingstone.

Thirdly, because of the very close collaboration between the school and the residential part of the centre, no distinction was made between these two parts of the centre in the analysis of our results. Although we think the model is applicable for both, only a comparison between the school and the residential part of the centre could give a decisive answer.

Finally the complexity of the model presented above suggests that the process of implementation can never be a simple process, and that unexpected problems at unexpected fields could arise. Therefore, it seems impossible for any organisation to be totally prepared to anticipate all obstacles it may encounter during implementation.

6.4.3. Limitations

This study has several limitations that need to be considered when interpreting the results. First of all, although it is plausible to expect that many of the emerging themes in this research are also applicable for other, similar therapeutic centres, we want to emphasise that these results come from one treatment centre only. As no two treatment centres are the same, results cannot be generalised to other centres. Secondly, in this article only the reflections of staff working in the centre were studied. In order to obtain a complete view on the pre-implementation needs, other stakeholder’s perceptions, such as youth, parents, and external partners should be considered. To conclude, according to Krippendorff (2004), a text never implies one single meaning, just the most probable meaning from a particular perspective. Thus, our interpretation should be seen as one possible interpretation of staff reflections.


A process-model


CHAPTER 7
The voice of troubled youth: children’s and adolescents’ ideas on helpful elements of care

6 This chapter is based on Soenen, B., D’Oosterlinck, F., & Broekaert, E. (2013). The voice of troubled youth: Children’s and adolescent’s ideas on helpful elements of care. Children and Youth Services Review, 35, 1297-1304
Abstract

This chapter presents the findings of a qualitative study in a Flemish centre for children and adolescents with emotional and behavioural disorders. The aim of this study was twofold. First, we wanted to examine how youth reflect on their own behaviour and that of their peers. Secondly, we wanted to know what, according to the youth, are the most significant helpful elements of treatment. Analysis shows a continuum of negative behaviour, ranging from relatively ‘normal’ disruptive behaviour such as arguing, up to serious disruptive behaviour such as physical aggression. This behaviour has a negative influence on the climate of the organisation. ‘Availability of staff’, ‘nearness of staff’, ‘a clear set of rules and boundaries’, and ‘some time on my own/some alone time’ are perceived as helpful elements of treatment. ‘Strictness’, ‘not listening’, and ‘inappropriate staff attitudes and interventions’ are perceived as counterproductive elements of treatment. Results are discussed and recommendations both on the orthopedagogical as well as on the scientific level are formulated.
7.1. Introduction

This article presents the findings from a qualitative study of children and adolescents with emotional and behavioural disorders (EBD) in Flemish residential care and day treatment. In this study, we wanted to give the floor to the youth themselves about how they experience their stay in the care centre.

Children and adolescents with emotional and behavioural disorders form a troubling but also vulnerable group in society. In the literature, various studies describing the nature of their problems can be found. Along with many others, both Connor et al (2004) and Sohn (2003) report high levels of internalising and externalising problems in their study samples. Recently, D’Oosterlinck and his colleagues (2006) gathered information about the characteristics of the boys and girls with EBD placed in residential care and day treatment facilities in East Flanders. After data collection from a sample with 517 children, from who 83% were boys and 17% were girls, a behavioural profile was created using the CBCL (Child Behaviour Checklist) scores. Results of this study illustrated that children and adolescents in the sample showed a tendency towards externalising problems and portrayed themselves as aggressive and disruptive. Several studies also report high comorbidity rates, for example for DSM diagnoses of conduct disorders with oppositional disorders, affective disorders, anxiety disorders, and attention deficit disorders (McConaughy & Skiba, 1993; Teplin et al., 2002; Wasserman et al., 2005). Problems of youth with EBD seem to be chronic (Visser et al., 2003), almost as stable as personality traits (De Bolle et al., 2009), and pervasive (Fergusson & Horwood, 1995; Lahey et al., 2002; Lahey et al., 1995; Leech et al., 2003). Combined, these studies paint a picture of highly troubled children and adolescents, who cannot be described as a homogeneous group (Moht et al., 2009). Therefore, they run a higher risk of being placed in special education (Long 1996) or in specialised care facilities (Eme & Kavanaugh, 1995).

When working with children and youngsters with emotional and behavioural disorders, a need exists to install clearly elaborated and structured methods to deal with the problem behaviour (D’Oosterlinck et al., 2009).

Because of residential placements’ high costs and high impact on the life of children and adolescents, we want to stress the need for studies focusing on the effectiveness of such methods and agree with Long (2009), who states that research studies no longer are a choice but a necessity. In doing so we should also take into account the perspective of the children and adolescents who stay in care. After all, the final goal of youth care is to help these youngsters with the issues they are dealing with; and as Currie states “what these adolescents have to say cuts to the heart of what is needed to improve the attractiveness and effectiveness of treatment for them” (Currie, 2003, p. 835).
Although there is a paucity of studies on youths’ ideas with regard to the treatment they receive in scientific literature, we were able to find some studies. Currie (2003) performed a qualitative study on a group of adolescents who entered a residential substance abuse treatment programme during the year 2000, in order to examine what occurs during and after drug treatment. He found that when the programme provided something that was genuinely substantive and supportive, that tackled a real-world problem or need, it was warmly received by its residents and seemed, at least to a degree, to “work” for them. This was concretised in providing shelter and structure, helping residents to address the family problems that were often at the core of their current troubles, offering aftercare and a general atmosphere of attentive support. On the other hand, elements of the programme that felt overtly confrontational, punitive or demeaning seemed least helpful. More recently, D’Oosterlinck, Broekaert & Denoo (2006) performed a qualitative study about youths’ experience on conflict management. Interviews with 13 boys and girls showed that these youths figured out that the best solution to a conflict is to talk it over with the others involved or to talk with an educator to restore a good atmosphere in the group.

In a Swedish study, Johansson and Andersson (2006) interviewed six adolescents about their experiences 2-3 years after they had left residential care. Although it was concluded that the six individuals perceived their residential treatment in their own unique ways, situations and persons were vividly remembered. The adolescents referred less to the experience of treatment as to the experience of living in an institution. It was the relationships with the adults and the other youth and the experiences in the living environment that were most important to these youth.

In another study, also using a qualitative approach, Freundlich and colleagues (2007) explored the perspectives of young adults formerly placed in congregate care while currently in foster care and other stakeholders on issues related to the safety of youth in congregate care environments. The majority of young adults in this study reported violence at the hands of peers and some staff, the stealing of personal belongings and inappropriate staff conduct. A consistent theme that emerged from interviews with both staff as youth was that staff did not provide consistent quality care or supervision, suggesting that far greater attention must be given to the staffing of congregate care settings (Freundlich, Avery, & Padgett, 2007).

Recently, Rauktis and her colleagues (2011) investigated youth perceptions of restrictiveness in out-of-home care. A focus group methodology with 40 youths involved revealed that youth defined restriction as ‘rules’. Youth characterized these rules as either positive or negative with the majority characterized as negative. Frequently identified negative characteristics were that rules were often arbitrary and did not make sense to the youth, changed frequently and were inconsistent. Further, rules were perceived as not individualized, inflexible and often developmentally inappropriate. Another important factor that emerged from the study is the youth’s connection to the individuals who are making or enforcing the rules. Even when rules were inconsistent or interfered with a
youth’s sense of autonomy, the presence of a positive and caring relationship with the adults seemed to moderate their negative feelings about the rules.

In an attempt to help to add to the literature with regard to experiences of children and adolescents in residential care and in day treatment, a qualitative research design was set up in order to find an answer to the following research questions:

- How do children and adolescents with emotional and behavioural problems, placed in a treatment centre, reflect on their own behaviour and their peers’ behaviour?
- What are, according to youth in the therapeutic centre, the most significant helpful elements of treatment?

### 7.2. Method

The youth care in Flanders, which is organised by the Flemish government, is divided into three main sections. The first is the youth protection service; which consists of a social branch and a legal branch for children and adolescents in problematic educational situations. The second section provides mental health care for children with a handicap, including a psychic handicap such as emotional and behavioural disorders. Thirdly, the Flemish school system includes special education for children and adolescents with different problems, such as emotional and behavioural disorders (D’Oosterlinck et al., 2006).

The study described in this article took place in a Flemish centre for children and adolescents with emotional and behavioural disorders, that has services recognised within the mental health care for people with a handicap and within the special education system.

The centre serves a wide geographical area in the West of Flanders, and offers a continuum of treatment to approximately 450 youngsters and their families. The residential part of the centre consists of several groups of each 12 to 14 children or adolescents. These groups are divided into three different clusters, based on the age of the residents. Each group consists of a team of four to seven group workers, and each cluster consists of a team of 3 to 6 social supervisors. Further, a psychiatrist, a team of nurses and a team of psychologists are available to assist where needed. Mean age of all staff was 38.80 (SD=10.86), ranging from 21 to 61 years old. Staff in the residential part (mean=36.79; SD=11.68) were significantly younger (t=2.541; p=.012) than staff in the schools (mean=40.32; SD=9.98). Table one provides more information with regard to the gender, age and level of training of the staff. Subsequently, the centre has one closed group for youth with extreme emotional and behavioural disorders, and one time-out group where children can stay for a short (one
hour) or longer period (up to 5 days). The centre also has two schools located on the campus, one school for children age 3 to 12 (elementary education) and one school for youth age 12 to 21 (secondary education). The centre does not have a particular treatment model or philosophy, but tries to apply an integrative approach in bringing together elements from various theoretical schools such as milieu-therapy, psychoanalyses, cognitive-behavioural strategies and token-economy systems.

Table 1: staff age, sex and level of training

<table>
<thead>
<tr>
<th></th>
<th>Residential staff n=110</th>
<th>Staff day school n=145</th>
<th>All staff n=255</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>36.79</td>
<td>40.32</td>
<td>38.80</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>83</td>
<td>144</td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>62</td>
<td>111</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational secondary education</td>
<td>26</td>
<td>40</td>
<td>66</td>
</tr>
<tr>
<td>Bachelor</td>
<td>70</td>
<td>101</td>
<td>171</td>
</tr>
<tr>
<td>Master</td>
<td>14</td>
<td>4</td>
<td>18</td>
</tr>
</tbody>
</table>

Although we have some knowledge and insights about youth with emotional and behavioural problems, in this study we wanted to collect information with regard to youth in special education or care in specific. Since little is known about how these youth experience their treatment, this study has an explorative nature, with the aim of collecting insights on this relatively uncultivated domain (Mortelmans, 2010).

When we want to study human experiences and understand their lives, and if we want to try to understand the world from their point of view, Hellzen and his colleagues (1999) state that it is important to talk to them. Therefore, we chose a qualitative approach to find an answer to the research questions of this study. The research strategy rested on a number of semi-structured interviews with the youth in the centre in which the researcher gave pre-set questions in a determined order, but with the possibility of asking side-questions based on the interviewees’ response. By using semi-structured interviews, we had the opportunity to explore the topics indicated by the interviewees further, without losing sight of the original goals of the interviews (Herzog, 1996). In total, 50 interviews were carried out, each on an individual basis.

To choose interviewees at random, first all youth in the centre were given a unique number (from 1 to 450), and subsequently, using an online random numbers generator, 50 youth were selected, and general information with regard to confidentiality and anonymity was given. Although each of the participants was informed that he or she had the right to refuse, all of them agreed to be interviewed and to tape-record the interviews. In our sample we had 35 boys and 14 girls (because of illness one youth was missing in the definitive
sample). Mean age of the interviewees was 13.29 (SD=2.73), ranging from 7 years old to 18 years old. Mean IQ scores were 75.18 (SD=9.45), ranging from 60 to 97. Of the 49 youth in the sample, 28 were in residential care and 21 were in day treatment. Table two gives further information with regard to length of stay.

Table 2: length of stay

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>20</td>
<td>40.8</td>
</tr>
<tr>
<td>Between 1 and 2 years</td>
<td>10</td>
<td>20.4</td>
</tr>
<tr>
<td>Between 2 &amp; 3 years</td>
<td>6</td>
<td>12.2</td>
</tr>
<tr>
<td>Between 3 &amp; 4 years</td>
<td>3</td>
<td>6.1</td>
</tr>
<tr>
<td>Between 4 &amp; years</td>
<td>4</td>
<td>8.2</td>
</tr>
<tr>
<td>Longer than 5 years</td>
<td>6</td>
<td>12.2</td>
</tr>
</tbody>
</table>

The average length of the interviews was about one hour, and all interviews were tape-recorded and transcribed verbatim afterwards.

As a start of the analysis, three researchers carried out a first reading of the text, to get a general impression and to acquire some ideas for further analyses. This approach resulted in some different potential themes, as identified by the three researchers separately. Discussion between the three researchers provided a deeper understanding of the data and the potential themes. After this first reading and discussion, a first tree structure with main categories of themes that emerged was developed. Further, the text was divided into meaning units, which are groupings of words or statements containing aspects related to each other through their content and context (Graneheim & Lundman, 2004). Subsequently, two groups of two researchers each carried out a second reading of the text, using the software package MAXqda2 to organise the meaning units into different categories (themes). In doing so, a better overview of the collected data is created (Stewart & Shamdasani, 1990). After comparing and discussing the results, and after constantly refining and attuning the definitions of the categories, a definitive tree structure was created. Further, all meaning units were recoded into the definitive tree structure, separately by the two groups of researchers, and followed by discussion until both groups’ codes were aligned.

The findings presented below are descriptive, and are illustrated with quotes of the youth themselves. They have to be read as a qualitative exploration of the experiences of the children and adolescents in the centre with regard to their behaviour, the behaviour of their peers, the therapeutic milieu in the centre and the strategies that are used in treatment.
Furthermore, these are reflections of a sample of the youth, recorded at a particular time and at a particular place.

7.3. Results

It is important to stress that this study does not constitute an evaluation of the Orthopedagogical Centre or its treatment model. It is, however, a qualitative exploration of some of the dynamics of treatment as lived by a particular group of youth, at a particular time.

First, results with regard to youths’ reflection on their own and their peers’ behaviour will be presented. Secondly, youths’ ideas with regard to helpful elements of treatment and elements of treatment that are counterproductive will be presented.

7.3.1. Reflections on behaviour

The youngsters in the centre are very open and talkative with regard to their own behaviour and the behaviour of the other youngsters. Analyses of the data revealed three different themes with regard to behaviour. First, youth talk about the ‘general climate in the centre’; secondly, this climate is concretised in ‘different kinds of behaviour’; finally, youth give their ‘ideas on reasons for their behaviour’.

First of all, youngsters talk about how they experience ‘the climate in the institution’. Most of the youth in the centre agree that the groups and the classes are too noisy. They talk about how other youngsters can be very boisterous, how they can annoy the others and how this creates a lot of turmoil in the group. One of the boys describes how an at first sight insignificant situation, such as slamming the door has a negative influence on the climate:

Youth 33, boy, 14 years old, residential care

“When they slam the doors... like when you are relaxing on the couch, and then suddenly that door, it always scares me. I can’t get used to it. And sometimes it’s really loud. One time, the sign with the name of our group even fell of the door. Because they slammed the door that hard.”

This atmosphere makes the youth nervous and tense, as a result, it is difficult for them to concentrate on their work when they are in the classroom, or relax when they are in one of the residential groups.

Youth 16, boy, 13 years old, residential care

“If, for example, there are some idiots in my class, than I get more noisily. I wouldn’t be if the others were normal. It’s strange to say, but I adapt to my
environment. When someone else is acting like an idiot, I get more nervous. And actually, there are a lot of idiots in my class.”

The above experiences are concretised by some ‘specific types of behaviour of youth’. Although most of these types of disruptive behaviour can be seen in most schools, it seems that the extent of their occurrence makes the difference with mainstream education. Truancy, for example, is mentioned very often, especially with older students. They play truant for various reasons: because they want to have a cigarette, because school is boring, because the subject matter is too difficult, because others asked them to run away from school,….

In addition to truancy, the children often talk about how they sometimes ‘just misbehave’. When asked to describe ‘misbehaving’, the most frequent answers were arguing with teachers or with educators, being disobedient, not listening to educators when they have to do something, being stubborn, being impolite, and smoking where or when they are not allowed to.

Youth 46, boy, 16 years old, residential care
“In school, when I don’t understand what the teacher is talking about, or when I just don’t feel like it anymore, then I just sit on top of my desk and I don’t listen anymore. Or I start irritating the others.”

Further, ‘verbal aggression’ is often mentioned as common behaviour. Within this category, bullying seems to be an important issue. Youngsters say they are the victim of bullies because of their physical appearance, because of poor hygiene, because of jealousy over boyfriends or girlfriends,….

Youth 26, boy, 17 years old, residential care
“There is this boy in school, and it’s already his fifth year in this school, but it all started during his first year. Ever since his first year, he is being bullied. That boy has a big nose, so that’s why they always call him ‘potato-nose’. For five years already.”

Verbal aggression is not only used to bully, but also to provoke others. Many youngsters know very well what they have to say to another for him or her to lose control. Some are experts in passive aggression and know how to push the others’ buttons. The victims of these manipulations often react in a verbal counter-aggressive way, or as one of the boys says: ‘they know how to get me angry’.

The last and maybe most challenging category of behaviour youngsters talk about is the physical aggression that occurs in the centre. In the interviews, many fights, stories about children who get beaten up, examples about how property is destroyed etc., are mentioned,
Not only aggression among the boys and girls occurs, but also aggression towards staff members.

Youth 13, boy, 12 years old, residential care
“They challenge me I get angry, because they say things that are not true. And then I can’t control myself anymore.

Interviewer: When they challenge you it becomes difficult to stay calm, and then...
R: Then I just get angry. And I can’t take it anymore. That’s my weakness. And then I get really upset, and I do things ... then I just don’t know what I’m doing. Just because I can’t take it anymore.
I: What kind of things do you do?
R: Throwing with sticks for example.”

Youth 29, girl, 15 years old, day treatment
“A couple of months ago, when I was still in residential care, some of the other kids smacked a teacher.”

This aggression seems to occur at places and times when there is not much supervision from the adults, such as the playground or the refectory, although the physical aggression also can occur in more structured environments such as the classroom.

While the previous categories covered the experience with regard to the behaviour of youth in the centre, in this category youth talk about their feelings and thoughts and about ‘how these feelings and thoughts can influence their behaviour’. Many of the experiences that the boys and girls shared with the researchers concerned their family. Some students say that they miss their parents and their siblings, and say that they want to live with their family as soon as possible. Others talk about all the problems that have occurred within the family (e.g. violence, abuse, financial problems).

Youth 13, boy, 12 years old, residential care
“R: And I’m very tense because there are a lot of fights at home. With my brothers and my dad.
I: That’s hard for you?
R: I always start shaking. On the playground earlier I was thinking about my mom and dad all the time.”

Many of the youth also talk about the negative beliefs they have about themselves, indicating the presence of a low self-esteem, often as a result of past experiences.
Youth 13, boy, 12 years old, residential care
“Sometimes I think they all hate me. I often have thoughts that aren’t real, for example the idea that everybody hates me. But some of them really hate me. And that’s why I also hate them. Sometimes things happen that I don’t like, and then I think that everybody hates me.”

7.3.2. Ideas on helpful elements
The analysis of the interviews showed several different themes with regard to ideas on helpful elements in treatment: ‘availability of staff’, ‘nearness of staff’, ‘a clear set of rules and boundaries’, and ‘some time on my own/some alone time’.

Youth perceive the ‘availability of staff’ as positive in different aspects. First, youth appreciate the extra help they receive in the classroom with regard to the subject matter. Especially when compared to mainstream education, youth want the pace to be adapted to their own learning needs, and want to have the opportunity to ask for more clarification when they have troubles to understand the subject matter.

Youth 47, boy, 17 years old, residential care
“Teachers have to give a lot of explanation. Not like in a normal school, because in a normal school they explain things only once. I like it when a teacher explains things very slowly, so I can understand. They have to explain things a couple of times for me to understand.”

Further, and most mentioned in the interviews, is the need for staff to be available when youth want to talk about the problems they experience. When youth have problems in the classroom or in the residential groups, such as fights or when they are bullied; or when they have problems at home; they believe in communication with the adults in the centre to deal with these issues.

Youth 4, girl, 10 years old, residential care
“R: In our group, you can say everything that’s on your mind.
I: Can you give an example?
R: For example when there is a fight, and I hit someone, than they (educators) will take me aside and they will talk with me because this helps me.”

Youth 35, girl, 17 years old, residential care
“R: Now things are getting better, because we have a talk every Thursday; about how things are going at home, or personal questions. And I’m happy I can talk about these things.
I: With whom do you talk about this?
R: With X.
I: Who is X?”
R: She is an educator; she is my individual educator.
I: And how do you feel about that?
R: Good, because at home I can’t talk about these things, they’re not open for these talks.
I: So you found someone here to talk with and that’s a good thing for you.
R: Yes, she is my individual educator and she knows a lot of personal stuff about me. Like she knows I can lose my temper when I bottle up my anger so she can help me with that. When she notices something’s wrong she invites me to talk about it. And talking really helps for me.”

Although some youth prefer to talk with their teachers or their educators, who they see on a daily basis, whilst others prefer to talk with staff who are not that closely involved in their daily life, such as a psychologist or a social worker, two characteristics of staff they prefer to talk with are mentioned. First, and also most mentioned, youth need to be able to trust the adults. When asked what ‘trust’ means for them, all youth answered that trust is about respecting your privacy and knowing you can talk about your problems without the adult telling about your problems to others.

Youth 47, boy, 17 years old, residential care
“But this one teacher.. he knows how to keep things silent. When he says ‘I will keep this to myself’, than you know for sure that he will really keep it to himself; he won’t tell anyone else. I know I can trust him.”

Next to trust, another characteristic of these staff is that youth know that they will be understood by these staff. The better the relationship with the staff, and the better the staff knows the youth, the more youth know these staff will understand them.

Youth 35, girl, 17 years old, residential care
“With some you hit it off and with some you don’t; some don’t understand you and others do. And of course you go to the one who understands you. And then the one who doesn’t understand me asks ‘why don’t you want to come and talk to me?’, but then I say: ‘you don’t understand me, if I talk with you, you always get me wrong’.”

Closely related to the availability of staff is the ‘nearness or closeness of staff’. A first helpful aspect of staff being near is the possibility to do things together. Youth want to have fun together with staff members and want to do pleasant activities in order to create a safe bond between themselves and the staff. Both activities on an individual basis as well as activities with the whole group are mentioned.

Youth 15, boy, 11 years old, residential care
“I: There are different educators in your group...
R: And one of them is more important to me and that’s X.”
I: He is one of your educators?
R: Yes.
I: And can you tell me why he is more important to you?
R: Because he is my individual educator.
I: And the two of you get along well?
R: Like when it’s Christmas we go shopping for presents together. First we have to pick a card with a name, and you have to buy a present for the kid whose name is on your card.
I: So you know already for who you are going to buy a present.
R: Yes, but I can’t tell you because it’s a secret.
I: It’s a secret, I understand.”

Youth 5, boy, 9 years old, day treatment
“R: She (teacher) plays with us on the playground. And also in the classroom. We always ask her to play with us.
I: And then she does?
R: Yes. Then we play hide-and-seek. Or tag.”

A second aspect of ‘nearness’ has to do with the presence of teachers and educators, especially at crowded places such as the playground and the refectory. When teachers are around, and when there is sufficient surveillance, youth are convinced that fewer conflicts occur.

Youth 2, boy, 12 years old, day treatment
“I: Suppose you could change anything you want in the school, what would you change?
R: I would change that they (teachers) watch more for fights. They have to watch out for fights all the time. And then our school would be fun.”

A third helpful element according to our interviewees is a set of ‘clear rules and boundaries’. Youth mention that this would create clarity about which behaviour is accepted and which is not. These rules and boundaries have to be clearly articulated in order to avoid discussion, should be righteous and equal for everybody, and should be administered by all staff in the same manner. Combined with sufficient supervision, youth believe that this set of rules and boundaries would guarantee staff to intervene not only more fair, but also more quickly.

Youth 44, girl, 15 years old, day treatment
“I: Could you describe what a good teacher should be like?
R: They have to be strict.
I: So a good teacher can be strict?
R: Yes, because otherwise they would just say things like ‘okay, do what you want’. But if they say that something you did was wrong, you have to learn to accept that.

I: Would things go wrong more if everybody could just do what they want?
R: Some of the kids would take advantage of it, absolutely. So that’s why a teacher should be strict.”

Finally, youth in the centre spent the whole day (day treatment) or even 24 hours a day (residential treatment) in a group with peers and teachers or educators. Therefore, it is not surprisingly that youth mention ‘some time on my own/alone time’ as a fourth helpful element. As the quote below illustrates, the different time-out rooms which are established in both the school as well as the residential part of the centre are perceived as helpful after conflicts occur, but sometimes youth just want to be left alone, without anyone disturbing them.

Youth 37, boy, 17 years old, day treatment
“In time-out you can really think seriously about things, because it’s calm in time-out, there aren’t many others in time-out.”

7.3.3. Elements of treatment experienced as counterproductive

Although we wanted to focus on ideas of helpful elements of treatment, youth in our sample also mentioned elements of treatment they experience as counterproductive, and as ‘standing in the way of the helpful elements’.

These counterproductive elements can be reduced to three themes: ‘strictness’, ‘not listening’, and ‘inappropriate staff attitudes and interventions’.

The most important of the negative elements is what we call ‘strictness’, which encloses the rules and how staff applies these rules. For many interviewees, there is an abundance of rules that do not make sense for the youth.

Youth 14, boy, 12 years old, day treatment
“Like on the playground, as soon as you step over one of the lines, because there are several lines painted on the ground, and as soon as you step over one of these lines you are punished and you have to stand against the wall. That’s stupid.”

These rules are applied too strictly by some staff members which results in an abundance of punishment. For most of the youth there is too much punishment, or the punishment is too hard.

Youth 15, boy, 11 years old, residential care
“R: They will punish you for even the smallest things.
I: Could you give an example?”
R: Like when you are very angry and you say a bad world you will be punished immediately. Then you have to write a lot of pages, and sometimes you even have to write a sentence at least a 100 times.”

On the other hand, some of the children also say that staff members do not punish enough or that the punishment is not severe enough, especially when they talk about punishment for their peers. Further, for many youth not the amount or the severity of punishment, but the idea of injustice determines their perception of punishment. The following quote shows that when youngsters are sanctioned for something they did not do or when the whole group is sanctioned because of negative behaviour of just one of the youngsters, it makes them more angry and it creates mistrust between youth and staff.

Youth 6, girl, 11 years old, residential care
“R: Sometimes all of us have to sit on our chair for 10 minutes, because half of the group is misbehaving.
I: And then everybody has to sit on a chair?
R: It’s always the same, like when we are lining up to go inside and some of the kids are naughty, everybody has to wait just because of them.
I: So then the whole group has to wait…
R: Yes, even those who are doing well.”

Furthermore, ‘staff members who do not listen to youth’ or who do not take the time to understand them are perceived as counterproductive, especially after conflicts or when problems occur.

Youth 35, girl, 17 years old, residential care
“I: You say ‘when I bottle up my anger I will explode’. Can you explain that a little to me?
R: Well, I have epilepsy, you know. When I was in my previous group, I had this individual educator but she never talked to me; she never did any effort. And I had problems all the time, and I bottled up these negative feelings; it was like my head was full of bad feelings and there wasn’t any room for other feelings. And then one time she said something to me, and I reacted in the wrong way and then I exploded. So I was very angry and I yelled things like ‘Are you actually working here?’, ‘Is this what you call individual educator?’, ‘You never talk with me and you never listen to me’.”

A third category of negative experiences described by youth is ‘inappropriate or insufficient staff attitudes and interventions’. Although not mentioned often, some youth talk about staff members reacting in an aggressive manner towards children and adolescents. In all examples given by youth, this aggression occurs after misbehaviour of
the youth and therefore could be unintentional behaviour caused by staff’s powerlessness to deal with a difficult situation in a constructive way.

Youth 17, boy, 14 years old, day treatment
“R: Last year, X (other youth) and I had an argument and he was pulling my hair and calling me names and then the teacher said we had to stop and then he (teacher) smacked me in the face. He just smacked me in the face. And one of the other teachers saw everything but she just let things happen.”

Two other forms of inappropriate of insufficient interventions are mentioned. A first one is when staff constantly complain about youths’ behaviour, for example when one does not clean his room or when one does not wear his safety shoes in the workshop. Secondly, youth have difficulties with staff members who approach them in a negative way or who only think about them in a negative way. Examples are when staff only mention the negative behaviour and never give affirmation for the positive behaviour.

Youth 40, girl, 15 years old, day treatment
“They (teachers) always say things like ‘your work is not good enough’ to the kids even when they really do their best and then the teachers call them names and the kids really feel bad and lose their patience. I would also lose my patience...”

Finally, next to these three themes, few but some statements are made with regard to the infrastructure of the centre ‘The centre is too big; it made me anxious, I was afraid I would get lost’; and with regard to the activities that are offered ‘We never play football’

7.4. Discussion

7.4.1. General discussion
As an answer to our first research question – how do youth reflect on their own and their peers behaviour? – analysis shows a continuum of negative behaviour, ranging from relatively ‘normal’ disruptive behaviour such as arguing or smoking, up to serious disruptive behaviour such as bullying and even physical aggression towards staff and towards peers.

These results are in line with several research studies discussing the complex nature of youth in care (e.g. Connor et al., 2004; D’Oosterlink et al., 2006; Hukkanan et al., 1999; Hussey & Guo, 2005; Sohn, 2003).

We found that most of this disruptive behaviour takes place at times and places where there is few if any supervision from teachers or educators. Others, such as March and his colleagues (2006) also found that fights at school occur when teachers are not watching or in areas where there is no supervision. Similar patterns can be found in studies using reports from Swedish students (Bliding, Holm & Ha’gglund, 2002; Osbeck, Holm & Wernersson,
2003) and in observational studies (Craig & Pepler, 1997; Craig, Pepler & Atlas, 2000). Also causes of bullying, such as a deviant physical appearance, as mentioned by the youth in our study seem to be similar to other studies (Erling & Hwang, 2004; Frisén, Jonsson & Persson, 2007; Thornberg, 2011).

Youth seem to perceive the climate in their groups as a climate characterised by physical aggression, verbal aggression and a general atmosphere of negative commotion and tension, resulting in a constant state of upheaval for many youth.

The children and adolescents in our study not only provided us with a clear and honest image of the disruptive behaviour in the centre, but also supplied some ideas about how their behaviour is influenced by their feelings and thoughts; about the causes of their own and their peers’ disruptive behaviour. For many youth, the climate in the group seems to reinforce negative behaviour. When other children or adolescents are boisterous or are annoying others, a tense atmosphere is created resulting in disruptive behaviour. This comes not as a surprise, giving the fact that up to 14 youth, each with their own problems, have to live and work together 24 hours a day.

Further, results also suggest that the interviewees see aggressive and other disruptive behaviour as likely due to factors within their family, such as financial problems, violence, abuse, etc., often also resulting in a low self-esteem. This is in accordance with Goldsteins (1990) qualitative research with juvenile delinquents who were asked what caused juvenile delinquency, revealing that family dysfunction is the most cited explanation. Although in our research problems within the family was mentioned as the most prevalent factor, we agree with Johnson et al. (2004), who identified the causes of violence on multiple levels including individual, family, interpersonal and community level factors. Nevertheless, we strongly believe in the connection between youths’ internalising problems, possibly by youth themselves only identified as family dysfunction, and their externalising behaviour, and therefore stress the need to take into account possible underlying issues, which cannot easily be observed, as an explanation of youths’ disruptive behaviour.

As an answer to our second research question – what are, according to youth in the therapeutic centre, the most significant helpful elements of treatment? – analysis revealed four themes: (1) availability of staff, (2) nearness of staff, (3) a clear set of rules and boundaries, and (4) some time on my own/alone time. Otherwise formulated, when there are good relationships between youth and staff, when a climate of communication is established in the centre and when rules and boundaries are clearly articulated, treatment seemed to work for the children and adolescents. Conversely, what seemed least helpful is (1) strictness, especially when one is punished with undue severity, (2) staff members who
do not take time to listen to youth’s problems and (3), inappropriate staff attitudes and interventions.

What stands out in the interviews is youths’ belief in positive, trust-oriented relationships with staff as a crucial element of effective treatment. The importance of relationship as a predictor of positive outcome is mentioned in numerous other studies. D’Oosterlinck (2006), for example, formulates that building up a relationship with a child, together with the process of working through a conflict form the foundation for real and long-lasting behavioural change. Similar ideas can be found in the field of child psychiatry, with Perry (2009), who describes the individual differences in how children cope with stress and trauma, but also stipulates that the power of healthy relationships to protect from and heal following stress, distress and trauma is one recurring observation about resilience and coping with trauma. In another example, Hamre and Pianta (2001) followed a sample of 179 children for several years to examine the extent to which teachers’ perceptions of their relationships with students predict a range of outcomes. Their study provided evidence that beyond cognitive functioning and classroom behaviour, children’s ability to form relationships with their teachers forecast later academic and behavioural adjustment. In his study on staff-client relationships, Moses (2000) states that in residential treatment settings engagements based on individualised negotiation of relationships and activities are likely to be more difficult to develop or sustain than is the case in a family setting. In his research he found that a manifest tension between providing personal attention and treating the residents as a group exists. Furthermore, within this population, those who have the most difficulty in relating and are the most in need, are likely to receive the least sensitive caregiving.

More recently, Stanley (2007) did research on young people’s and carers’ perspectives on the mental health needs of looked-after adolescents. In this study, young people emphasised the importance of availability and continuity of staff in describing what they valued in their relationship with carers. Similar to these results, youth in our study describe how relationships can be established through on the one hand doing fun activities with staff, preferably on an individual basis, and on the other hand communication, especially as a way to address issues they are dealing with. This idea is confirmed in a Flemish study investigating verbal strategies for conflict management. By using communication after conflicts, children gained insights by talking about their own behaviour. Concerning the adult who talked with the child, participants in this study highlighted the following qualities to be important attributes of staff: empathy, trust, understanding and good communication skills. This helped to reduce destructive thoughts and feelings and enabled children to gain a more realistic view of their role in specific conflict situations (D’Oosterlinck, Broekaert & Denoo, 2006).
The findings of our study are in line with the extensive body of literature on therapeutic alliance, which is defined as ‘the working alliance that develops between a client and a therapist, facilitating the occurrence of positive psychological change’ (Horvath & Luborsky, 1993). The quality of this alliance is thought to depend on three essential ingredients: (a) the level of agreement on therapeutic goals, (b) the ability to collaboratively engage in mutually negotiated tasks to meet these goals, and (c) the establishment of a trusting, mutually respectful relationship (Bordin, 1979). A number of studies have found that therapeutic alliance between the youth and staff is predictive of treatment outcomes (e.g. Florsheim et al., 2000; Kazdin, Marciano & Whitley, 2005; Kazdin, Whitley & Marciano, 2006; Russel & Philips-Miller, 2002; Zegers et al., 2006).

Rauktis (2005) investigated the trajectory of how relationships between youth and treatment foster care parents develop over the course of a year. Findings suggest that both youth and treatment parents report favourable alliance, although treatment parent alliance is generally higher than youth alliance. Further, the authors found that therapeutic alliance scores typically started high, declined, and then gradually began to increase, suggesting that it takes time for youth to get used to the new treatment setting, but eventually alliance improves.

Manso (2008) explored how youths in a residential setting perceive their relationships with the counsellors. Participants in this study reported feelings of respect, caring, or trust when referring to staff with whom they have a good relationship. Youth were very specific when identifying staff qualities and behaviours that promote building positive relationships: a staff is someone who cares for youth, helps to solve problems, listens and talks to them but, at the same time, is consistent, disciplined, and mature, acts as a good role model for self-control. Youth also identified staff limitations that may cause relationship difficulties: not being creative, losing control, not listening to youth, not being a good role model, giving up youth, or quitting the job. The authors note that the description of the ideal staff tended to focus more on personal rather than professional aspects.

In sum, and supported by the results of our study, we agree with Anglin (1999) who states that therapeutic relationships lie at the very centre of working with youth with emotional and behavioural problems, and that these relationships combine the richness and intimacy of the “personal” with the rigor and goal-directedness of the “professional”. Therefore, all professionals should acknowledge the importance of building trustful, respectful alliances with the youth they are working with.

Results of our also indicate the youths’ need for a structured climate, with ample supervision from adults, in order to establish relations and to create possibilities for communication. Although some of the interviewees were critical with regard to certain rules in the centre, others mentioned how these rules could provide the necessary predictable structure. We agree with Kaufmann (1997) who says that clear identification of
rules and boundaries and consistent application of consequences are mandatory elements for minimizing aggressive behaviour. As long as children and adolescents, because of the unstructured environment they are living in, feel a constant need to struggle to get their basic needs fulfilled, such as safety, engagement in treatment will be difficult for them. On the other hand, a clear set of rules and boundaries could prevent this struggle for basic needs and thereby provide the necessary structure in which interventions could work (Currie, 2003).

7.4.2. Recommendations and limitations

Although when investigating perceptions of 50 different children and adolescents, unanimity will remain utopian, there is no doubt that certain patterns could be found. We are convinced that, taken into account the limitations described below, these patterns can form a starting point for recommendations at the level of the orthopedagogical treatment for youth with emotional and behavioural problems. We plead for the implementation of clearly elaborated and structured methods; both methods with a focus on communication as methods with a focus on providing structured rules and boundaries. These methods should provide a well-considered balance between providing individual attention and treating the youth as a group. Professionalization of frontline staff position based on coaching from their supervisors, together with smaller group sizes and sufficient available staff, will be necessary conditions for this implementation to succeed.

On the scientific research level, we recommend a further investigation of perceptions of treatment of youth in care, with reflections of staff in these centres as a point of departure. Furthermore, a great need exists to study the effectiveness of treatment methods and programmes for children and youth with emotional and behavioural disorders. Collaboration between a research centre and different treatment centres could fill this gap.

This study has several limitations that need to be considered when interpreting the results. First of all, although it is plausible to expect that many of the emerging themes in this research are also applicable for other, similar therapeutic centres, we want to emphasise that these results come from one treatment centre only. As no two treatment centres are the same, results cannot be generalised to other centres.

Secondly, in this article only the reflections of children and adolescents were studied. Reflections of other stakeholders such as staff or parents would be necessary when we want to obtain a more complete view.
References


CHAPTER 8

The implementation of Life Space Crisis Intervention in residential care and special education for children and adolescents with EBD: an effect study

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Abstract

When working with children and adolescents with emotional and behavioural disorders, conflicts are a part of daily life. At present, a variety of conflict resolution or conflict management programs, that can be divided into three categories, are described in the literature. A first category contains programs that focus on training for children and adolescents, and are often curriculum-based. The second category focuses on training for parents, and the third category contains programs that focus on training for professionals. The present study was designed to evaluate the effectiveness of Life Space Crisis Intervention (LSCI), a therapeutic and verbal strategy developed by Long that fits into this third category of conflict management programs. Throughout a four-year project, all staff in a Flemish centre offering residential care and special education were trained in LSCI. On a yearly basis, data with regard to time in program, academic achievement, behavioural problems and anxiety problems were collected. The results show an increase in time spent in program and in academic achievement, and a decrease in youths’ anxiety, indicating that the implementation of LSCI contributes constructively to the treatment of children and adolescents with EBD.
Daily work with children and adolescents with emotional and behavioural disorders (EBD) is a difficult task for their teachers and their educators. Several studies report on the complex nature of these youths’ problems, revealing a highly troubled population (Dale et al., 2007). Further, these youths’ problems seem to be chronic (Visser et al., 2003), pervasive (Fergusson & Horwood, 1995; Lahey et al., 1995; Lahey et al., 2002; Leech et al., 2003) and almost as stable as personality traits (De Bolle et al., 2009).

Studies on the characteristics of children and adolescents with EBD often describe their problems in terms of internalising and externalising problem behaviour and their co-development. With regard to gender differences, there is general consensus that girls present more internalising behaviours than boys (Sohn, 2003; Tambelli et al., 2012; Wasserman et al., 2005), and that boys present more externalising behaviours than girls (Duchesne & Larose, 2007; Masi et al., 2004). Whilst externalising problems have been the focus of studies since decades, recently, much attention has been given to internalising problems, and especially to anxiety disorders as a part of these internalising problems. In the mid 90’s, Bernstein and his colleagues (1996) gave an overview of the growing number of studies on anxiety, suggesting the importance of not discounting symptoms as short-lived or insignificant in young children. Research on gender differences with regard to anxiety disorders consistently shows evidence of higher rates of anxiety in girls than in boys (Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Crocetti et al., 2009; Essau, Conradt & Petermann, 2000; Hale et al., 2005; Hale et al., 2011; Muris et al., 1998; Simon & Bögels, 2009; Su et al., 2007; Wasserman, 2005). Findings with regard to age, on the other hand, have been conflicting. While some authors found that anxiety rates increased with age (Essau, Conradt & Petermann, 2000), others found a decrease (Hale et al., 2011; Muris, Schmidt and Merckelbach, 2000; Su et al., 2007). Although much research still have to be undertaken, it is acceptable to assume that anxiety and externalising problems are interrelated (e.g. Galambos, Barker & Almeida, 2003). In a recent Flemish study for example, it is described how youth with EBD explain how their aggressive behaviour originates in their feelings of anxiety, rejection or loneliness (Soenen, D’Oosterlinck & Broekaert, 2013). As such, in programs designed to treat externalising problems, these internalising problems should not be neglected.

When working with such a troubled population, conflicts and crises are a part of daily life. From the literature we do not only know that these conflicts are inevitable with these “unchangeable” youth, but also that it is mainly the way of handling conflicts that determines whether a conflict will be constructive or destructive (Johnson & Johnson, 1995). In their handbook on conflict resolution, Deutsch and Coleman (2000) describe how conflicts that are ignored or approached in a negative way will lead to distrust, anger,
aggression, anxiety and difficult learning situations. On the other hand, conflicts that are dealt with in a positive manner will increase productivity in the classroom and lead to desirable outcomes (Deutsch & Coleman, 2000).

Therefore, it is generally assumed that professionals working in education or care settings for youth with EBD need intervention models that address students’ socio-emotional needs (Baker et al., 2007; George & Fogt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009), especially to cope with the high amount of conflict and crisis situations (D’Oosterlinck et al., 2009).

At present, a variety of conflict resolution or conflict management programs, that can be divided into three categories, are described in the literature.

A first category contains programs that focus on training for children and adolescents, and are often curriculum-based. “Teaching Students to be Peacemakers”, in which students receive conflict resolution and peer mediation training, is probably the most studied program. In a meta-analysis, including 16 studies with children from kindergarten through ninth grade, and all conducted in rural, urban and suburban settings, it was concluded that students learn the conflict resolution procedures taught, retain their knowledge throughout the school year, apply the conflict resolution procedures to actual conflicts, transfer the procedures to non-classroom and non-school settings, use the procedures similarly in family and school settings, and, when given the option, engage in problem-solving rather than win-lose negotiations. Further, the studies indicate that conflict resolution procedures can be taught in a way that increases academic achievement (Johnson & Johnson, 2002). Another example of a program focusing on training for youth is “Conflict Resolution and Peer Mediation” (CRPM), which was found to be effective in increasing elementary school students’ levels of empathy (Türniklü et al., 2009).

In a second category the focus is on training for parents. Probably the most investigated and the most widespread program is Triple-P, or Positive Parenting Program. The program, developed by Sanders, was designed to promote positive parenting and caring relationships between parents and children aged between 2 and 16 years (Sanders et al., 2003) and has been described as a Behavioral Family Intervention (e.g., Sanders & McFarland, 2000) with a multi-tiered continuum of service intervention (Sanders et al., 2003). Thomas and Zimmer-Gembeck analysed eleven Triple-P studies revealing positive effects, but also concluded that these effects varied depending on intervention length, components, and source of outcome (Thomas & Zimmer-Gembeck, 2007). Although all participants in the Triple P studies appeared to have been from middle class or higher SES groups, and although none of the studies has been performed by independent researchers, it is concluded that Triple P meets the criteria for a “probably efficacious treatment”. More
recently, Wilson and his colleagues (2012) identified 33 eligible Triple P studies and subjected those to systematic review and meta-analysis with analysis of bias. Results of this meta-analysis showed that mothers generally reported that Triple P group interventions are better than no interventions. The authors report two concerns about these results. First, there is concern given the high risk of bias and poor reporting. Secondly, since much of the published work is authored by affiliates of the Triple P organisation, potential conflicts of interest arise. The authors conclude that no convincing evidence that Triple P interventions work across the whole population or that any benefits are long term could be found. Examples of other programs within this second category are “Parents and Children Talking Together” (PCTT) (Leijten, Overbeek & Janssens, 2012) and “Incredible Years Program” (Letarte, Normandeau & Allard, 2010).

The third category contains programs that focus on training for professionals. The “Teaching Family Model” (TFM) is a skill-based program of care and treatment, that focusses on the correction of aberrant client behaviour rather than on the suppression or containment of this behaviour. This model, which was created as a reaction to the increases in client injuries relating to the use of physical restraint, was implemented and investigated in two residential settings. Results of this study showed statistically and practically significant reductions in the application of physical restraint and seclusion intervention, as well as in the frequency of problem behaviours (Jones & Timbers, 2003).

“Therapeutic Crisis Intervention” (TCI) is a structured training program based on the premise that the successful resolution of a child’s crisis is dependent on the adult’s ability to respond in the most caring, therapeutic and developmentally appropriate manner possible (Trieschman, Whittaker, & Brendtro, 1969; Whittaker & Trieschman, 1972). In 2003, Nunno and colleagues investigated the process and impact of implementation of TCI in a residential facility in the United States. The results of this study showed that the implementation of TCI was successful in substantially reducing critical incidents, significantly reducing documented physical restraints episodes in one unit, and increasing staff knowledge, confidence and consistency in crisis intervention facility-wide (Nunno, Holden & Leidy, 2003).

The present study was designed to evaluate the effectiveness of “Life Space Crisis Intervention” (LSCI), a therapeutic and verbal strategy that fits into this third category of conflict management programs.

The research tradition on LSCI started in the USA, with DeMagistris and Imber (1981) and Naslund (1987). Many years later, Dawson (2003) investigated LSCI in two New York City schools, with staff of one school receiving LSCI training and staff of the other school not. After three semesters, the number of conflicts decreased in the experimental school and remained stable in the control school. Further, in the experimental school there were less
suspensions, less hours of skipping class, and more students referred to a less restrictive setting. All staff of the LSCI school indicated that they felt more skilled in handling conflicts. Grskovic & Goetze (2005) used two multiple baseline-across-subjects to evaluate the effects of LSCI on two girls and two boys separately. Data were collected in the classroom over a three-month period. They found a radical decrease in challenging behaviour for each participant after implementation of LSCI. Forthun, McCombie and Freado (2006) explored the impact of LSCI training on performance of school personnel, and evaluated how exposure to LSCI strategies impacted student behaviour. Their findings suggest a significant change in the perception of coping with problem students from one of control and punishment to one of cooperation, responsibility and proactive discipline. Most recently, White-McMahon (2009) investigated staff perception on the influence of LSCI on the social-emotional development of students with behavioural problems. The results of this study show that students’ social-emotional development scores improved. This growth helped students to create a more positive sense of self and allowed them to function more effectively in educational programs as well as in society in general.

Parallel to this American research, several European studies on LSCI were undertaken. Quantitative studies showed a positive effect on direct aggression and social desirability (D’Oosterlinck et al., 2008), a decrease in number of conflicts and in playing truant and an increase in academic achievement (Soenen et al., 2009). Qualitative studies showed that LSCI helps to reduce youths’ destructive and painful thoughts and feelings (D’Oosterlinck, Broekaert, & Denoo, 2006), an enhancement of staff members’ knowledge and coping strategies in handling conflicts (D’Oosterlinck et al., 2009), and that LSCI enabled all staff members to reflect on and act with their students based on a shared philosophical and theoretical framework, which resulted in a more positive climate (Soenen et al., 2013).

8.2. Method

8.2.1. Research goals
Based on the current literature as described above, we formulated three different research questions.

- First, given the increasing attention to anxiety in children and adolescents with emotional and behavioural problems as described in the literature; we wanted to investigate the effect of the implementation of LSCI over a four-year-period on the anxiety of the youth in in a centre offering special education and residential treatment.

- Secondly, it is known that the problem behaviour of children and adolescents with EBD often forms a challenge for the people working with these youths. Therefore,
we wanted to investigate the effect of the implementation of LSCI on the problem behaviour of the youth in a centre offering special education and residential treatment.

- Thirdly, it is known from the literature that the implementation of LSCI results in a better treatment climate. We wanted to investigate whether this could be translated into measurable variables such as time in program and academic achievement.

### 8.2.2. Research setting

The centre where this study took place serves a wide geographical area in the West of Flanders, and offers a continuum of treatment to approximately 450 youngsters and their families. The residential part of the centre consists of several groups of each 12 to 14 children or adolescents. These groups are divided into three different clusters, based on the age of the residents. Each group consists of a team of four to seven group workers, and each cluster consists of a team of 3 to 6 social supervisors. Further, a psychiatrist, a team of nurses and a team of psychologists are available to assist where needed. The centre also has two schools located on the campus, one school for children age 3 to 12 (elementary education) and one school for youth age 12 to 21 (secondary education). Subsequently, the centre has one time-out group where children can stay for a short (one hour) or longer period (up to 5 days).

At the time the study started, mean age of all staff was 38.80 (SD=10.86) years old, ranging from 21 to 61. Staff in the residential part (mean=36.79; SD=11.68) were significantly younger (t=2.541; p=.012) than staff in the schools (mean=40.32; SD=9.98). The centre does not have a particular treatment model or philosophy, but tries to apply a integrative approach in bringing together elements from various theoretical schools such as milieu-therapy, psychoanalyses, cognitive-behavioural strategies and token-economy systems.

At the time the research started, in 2009, 403 youth were treated in the centre. 71.80% were boys, an 28.20% were girls; 45.80% were in residential care (mostly combined with special education on campus) and 54.20% attended special education but did not stay in residential care. The mean age of the population was 13.55 (SD=3.06) years old, ranging from 6 to 19, and the mean IQ was 76.16 (SD=9.84), ranging from 59 to 108. The mean overall length of stay was 29.94 months (SD=24.54) ranging from 1 month to 153 months. Between girls and boys, no differences were found with regard to age, IQ or length of stay. Youth in residential care were younger (age 12.45) than youth in only special education (age 14.45) (t=6.668; p=.000) and had a longer length of stay (36.61 months) than youth only in special education (25.80 months) (t=4.338; p=.000).
8.2.3. Design of treatment: Life Space Crisis Intervention

Life Space Crisis Intervention (LSCI), an ego-strengthening approach and part of the milieu therapeutic tradition, uses a method that is derived from the work of August Aichorn as well as Fritz Redl and David Wineman (Broekaert et al., 2009). It is a therapeutic and verbal strategy used to intervene when children are in crisis, and is based on cognitive, behavioural, psychodynamic and developmental theory. Instead of punishing or excluding the youngster for his negative behaviour, the adult will start a conversation to find out the origin of the behaviour. Since most conflicts take place in the life space of the youth, it is seen as an optimal opportunity to use these conflicts as learning moments. As such, LSCI will be used at the moment of the conflict, or shortly thereafter, and preferably by an adult who stands close to the youth. Starting from the reactions of the youngster in a stressful situation, four goals are aimed at during an LSCI: (1) to change the youth’s behaviour; (2) to increase self-confidence; (3) to decrease anxiety; and finally (4) to increase understanding of own and others behaviour and feelings. The key component to effective crisis intervention using LSCI is the ability to understand the youth’s perception of the crisis and his or her role in it (Wood & Long, 1991; Long & Fecser, 1997, 2000; Long, Wood, & Fecser, 2001).

A central element of LSCI is the model of the conflict cycle, which is based on a cognitive-emotive-behavioural framework. The basic idea of the conflict cycle is that a stressful event for a youth is activated by his negative thoughts and irrational beliefs, and then trigger students’ (negative) feelings. These feelings drive the youth’s behaviour, resulting into negative peer or adult reactions. Staff who are unaware of the dynamics of the conflict cycle may end up mirroring or reinforcing the youth’s negative behaviour (Long, Wood & Fecser, 2001).

A LSCI-conversation consists of six sequential stages. In the first stage, the focus is on draining off the child’s emotions. In stage two, a timeline of the events that led to the crisis, and the perceptions on these events will be established. During the third stage, it is determined what the central issue in the crisis is. In stage four, the adult will try to give the child an insight in how the crisis has come about. The fifth stage consists of teaching new skills with the goal of enabling the child to handle future similar problems. In the sixth and last stage, the conversation is winded up, and the child is prepared to re-join his group (Long, Wood & Fecser, 2003). The first three stages are called ‘diagnostic stages’. The last three stages involve reclaiming strategies. The six LSCI reclaiming interventions are based on six patterns of self-defeating behaviour that are common among youth with EBD: imported problems, errors in perception, delinquent pride, impulsivity and guilt, limited social skills and vulnerability to peer influence (Long, Wood & Fecser, 2001).
8.2.4. Procedure of implementation

In 2007, the directors of the centre decided to implement LSCI in the residential treatment centre and in the two schools, and to set up a research project on the effectiveness of this process of implementation. Prior to implementation, an at random selection of youth (Soenen, D’Oosterlinck & Broekaert, 2013) and staff members (Soenen, D’Oosterlinck & Broekaert, 2014) were questioned about the problems they experienced, the strengths of the centre and the expectations they had from the implementation project. Subsequently, a thorough analysis of the nature of the problems of the youth and the perceptions of different informants on these problems was conducted (Soenen et al., 2011; Soenen et al., accepted).

Further, it was decided that all teachers, educators, supervisors and directors should receive the five-day training course in LSCI. Because of the size of the centre and the number of staff, it was decided to do the implementation step by step, and to spread the trainings over a three year period. In the summer of 2009, all supervisors and all directors of the centre were trained. Further, one third of the frontline staff (teachers and educators) also received the five-day training. The next year frontline staff of another third of the teams were trained; and in the summer of 2011 frontline staff of the last third of the teams were trained. Immediately after the first training, all trained staff were supervised on the use of LSCI by an LSCI-expert who was hired in the centre.

Before the trainings started, a baseline data collection was set up. With this data collection, we wanted to gather information with regard to youths’ time in program, youths’ academic achievement, youths’ problems behaviour as perceived by their educators (Child Behaviour Checklist), teachers (Teachers’ Report Form) and by themselves (Youth Self Report), and youths’ self-reported anxiety (Screen for Anxiety and Related Emotional Disorders). After the baseline in 2009, the same data were collected for the three following years until 2012.

8.2.5. Instruments

Time in program
Based on their individual files, for each youth in the centre the number of months he or she was in program at the time of data collection was listed. When a youth switched, for example from residential care to only special education, we looked at the date of first intake.

Academic achievement
All students who attend the school for secondary special education receive a school report card in June, with the scores they achieved for vocational courses, general courses, religious instruction, physical education and the total score, both for their work and for their
behaviour. The scores of all students were collected on a yearly basis starting from 2009 (prior to implementation) to 2012. It should be noted that these data were only available for students in the secondary school, and not for students in the elementary school.

**Child Behaviour Checklist (CBCL)**
The CBCL is a checklist designed to get an image of behavioural and emotional problems in children and adolescents from the age of 6 to the age of 18. Although the rating scale is designed to be completed by parents, several researchers were able to show that the CBCL factor model also fits for the judgment of group care workers (Albrecht et al., 2001; Massey & Murphy, 1991; Wherry et al., 1992).

The CBCL consists of 118 items, with 3 response options (Not true; Sometimes or Somewhat true; Very true or Often true), with regard to emotional and behavioural problems, resulting in scores on 8 syndrome scales and 2 broadband scales. The Internalising broadband scale consists of the syndrome scales Withdrawn, Anxious/Depressed and Somatic Complaints, and the Externalising broadband scale consist of the syndrome scales Aggressive Behaviour and Delinquent Behaviour. Separated from the broadband scales are the syndrome scales Social Problems, Thought Problems and Attention Problems. Subsequently, the latest version of the CBCL also incorporates 6 DSM-oriented scales (DSM-Affect Disorder, DSM-Anxiety Disorder, DSM-Somatic Disorder, DSM-Attention Deficit and Hyperactivity Disorder, DSM-Oppositional Defiant Disorder, DSM-Conduct Disorder). The Dutch version of the CBCL has proved to be reliable and valid (De Groot, Koot & Verhulst, 1994; Verhulst, van der Ende & Koot, 1996).

The CBCL was completed for all youngsters by their individual group worker, a first time in May 2009 (prior to implementation), and from then on yearly in the month May until 2012.

**Teacher Report Form (TRF)**
The TRF is a questionnaire in which teachers answer questions with regard to youths’ schoolwork and emotional and behavioural disorders. The TRF consists of 118 items, of which 93 also appear in the CBCL. The TRF includes the same subscales as the CBCL and the YSR. Research across many societies has shown that the TRF is reliable and valid (Achenbach & Rescorla, 2001).

All class teachers were asked to complete a TRF for each of their students. Similar to the CBCL, this happened on a yearly basis.
Youth Self Report (YSR)

The YSR is a questionnaire in which youngsters themselves score statements about emotional and behavioural problems they experience. Many of these questions are similar to those in the CBCL and in the TRF, supplemented with fourteen socially desirable questions to which most youths answer positively. The YSR includes the same scales as the CBCL and the TRF, and the YSR syndrome structure has been proven to fit in 23 societies (Ivanova et al., 2007).

All children and adolescents from the age of eleven were asked to complete the YSR during class time, under the supervision of the first author. All students had the opportunity to ask questions about individual items, but were not allowed to seek clarification about how they should respond. Those who were absent because of illness were asked to complete the YSR after they returned. Again, this data collection took place four times, from 2009 to 2012 each time in the month May.

Screen for Anxiety and Related Emotional Disorders (SCARED)

The SCARED is a self-report that measures symptoms of the entire spectrum of anxiety disorders which may occur in children and adolescents according to DSM-IV (Muris et al., 2007). The instrument is primarily designed for clinical psychologists, psychiatrists or practitioners in related professions who want to evaluate children or adolescents from the age of 7 to the age of 19 on the presence of anxiety disorders (Muris et al., 2007), but can also be useful for research purposes (Bodden, Bögels & Muris, 2009; Muris et al., 2001). The SCARED consists of 69 items, using a likert-scale for respondents to indicate how often they experience a symptom: ‘never or almost never’, ‘sometimes’, and ‘often’. Results not only give a total score, but also an indication of the possible presence of panic disorder, social phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), separation anxiety disorder (SAD) and specific phobia (animal phobia, medical phobia, situational phobia). Several studies have shown that the SCARED possesses good internal consistency and differentiates clinically anxious children from normal children, both on the total score as well as on the subscales, providing support for the psychometric properties (Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Canals et al., 2012; Crocetti et al., 2009; DeSousa et al., 2013; Essau, Anastassiou-Hadjicharalambous & Muñoz, 2013; Hale et al., 2011; Monga et al., 2000; Muris et al., 2004; Myers & Winters, 2002; Simon & Bögels, 2009; Su et al., 2007). The SCARED was completed for all youth in the similar way as the YSR.

8.3. Results

In order to look for possible changes in the target population throughout the research project, a comparison of the groups from each year was performed on age, IQ, and sex. An
ANOVA of repeated measures showed no significant difference between the four years of data with regard to age (F=.386; p=.763) and IQ (F=.786; p=.502), and crosstabs with Chi² showed that the girl to boy ratio remained stable (Chi²=3.940; p=.685).

### 8.3.1. Time in program

An ANOVA of repeated measures showed differences for the months in program in the different project-years (F=5.888; p=.001). This effect remained significant after controlling for age (F=4.641; p=.003) and IQ (F=7.038; p=.000). Further, no interaction-effects were found for sex (F=.241; p=.868), type of care (residential or only special education) (F=1.125; p=.338), or school (elementary or secondary school) (F=.784; p=.503). Looking at the individual years using Bonferroni correction for multiple comparisons demonstrates that the time in program was longer after implementation than prior to implementation. Mean months in program and standard deviations are presented in table 1.

<table>
<thead>
<tr>
<th>Project year</th>
<th>Months in program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
</tr>
<tr>
<td>1 (pre-test)</td>
<td>29.94</td>
</tr>
<tr>
<td>2</td>
<td>34.91</td>
</tr>
<tr>
<td>3</td>
<td>35.60</td>
</tr>
<tr>
<td>4</td>
<td>36.78</td>
</tr>
</tbody>
</table>

### 8.3.2. Academic achievement

The results presented in table 2 demonstrate a significant pre-test / post-test difference in the academic achievement of students in the secondary school for all courses except for religious instruction. Subsequently, we conducted a Bonferroni correction for multiple comparisons to examine these differences in academic achievement over the different project years, and found a significant increase after pre-test on ‘points for work’ for the vocational courses (p=.011), general courses (p.039) and total points (p=.001) and on ‘points for behaviour’ for the vocational courses (p=.000) and the total points (p=.001). Further, we sought for interaction-effects with all possible variables (sex, type of care, school), but none were found. Subsequently, results of the ANOVA remained significant after controlling for age, IQ and time in program.
### Table 2: academic achievement (significant results in bold)

<table>
<thead>
<tr>
<th>Course</th>
<th>Project-year mean scores</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1(pre-test) 2 3 4</td>
<td>F p</td>
</tr>
<tr>
<td>Points for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational</td>
<td>62.81 64.84 64.72 65.96</td>
<td>3.337 .019</td>
</tr>
<tr>
<td>work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>68.20 68.63 67.75 70.79</td>
<td>3.051 .028</td>
</tr>
<tr>
<td>Religion</td>
<td>69.23 69.63 70.42 68.68</td>
<td>.634 .593</td>
</tr>
<tr>
<td>Phys. Ed.</td>
<td>63.37 62.23 63.37 67.73</td>
<td>11.390 .000</td>
</tr>
<tr>
<td>Total</td>
<td>63.66 65.71 65.45 67.22</td>
<td>4.856 .002</td>
</tr>
<tr>
<td>Points for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational</td>
<td>61.27 64.35 63.79 65.80</td>
<td>5.967 .000</td>
</tr>
<tr>
<td>behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>67.50 68.45 69.30 70.06</td>
<td>2.360 .070</td>
</tr>
<tr>
<td>Religion</td>
<td>65.27 65.71 67.25 66.48</td>
<td>1.450 .227</td>
</tr>
<tr>
<td>Phys. Ed.</td>
<td>63.07 61.00 63.25 65.61</td>
<td>6.816 .000</td>
</tr>
<tr>
<td>Total</td>
<td>63.75 64.94 65.58 67.16</td>
<td>4.803 .003</td>
</tr>
</tbody>
</table>

### Table 3: CBCL (significant results in bold)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Project year mean t-scores</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1(pre-test) 2 3 4</td>
<td>F p</td>
</tr>
<tr>
<td>Internalising</td>
<td>55.27 56.43 58.72 60.92</td>
<td>8.603 .000</td>
</tr>
<tr>
<td>Externalising</td>
<td>64.22 63.80 65.38 65.14</td>
<td>.714 .544</td>
</tr>
<tr>
<td>Total</td>
<td>61.38 61.78 63.43 64.55</td>
<td>3.674 .012</td>
</tr>
<tr>
<td>Anxious/depressed</td>
<td>57.04 58.32 59.68 62.40</td>
<td>8.534 .000</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>60.33 61.07 63.00 63.40</td>
<td>3.674 .012</td>
</tr>
<tr>
<td>Somatic complaint</td>
<td>53.27 53.34 53.03 54.45</td>
<td>1.527 .206</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>63.46 62.90 64.12 63.89</td>
<td>.510 .675</td>
</tr>
<tr>
<td>Delinquent behavior</td>
<td>65.13 65.33 67.66 67.49</td>
<td>1.869 .134</td>
</tr>
<tr>
<td>Social problems</td>
<td>61.68 62.98 63.60 65.20</td>
<td>3.369 .018</td>
</tr>
<tr>
<td>Thought problems</td>
<td>56.06 56.82 57.47 57.82</td>
<td>1.278 .281</td>
</tr>
<tr>
<td>Attention problems</td>
<td>61.59 60.84 62.22 63.23</td>
<td>1.614 .185</td>
</tr>
<tr>
<td>Affect disorder</td>
<td>58.54 58.01 60.46 61.69</td>
<td>6.648 .000</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>58.77 59.84 61.39 63.57</td>
<td>9.014 .000</td>
</tr>
<tr>
<td>Somatic disorder</td>
<td>52.63 53.17 52.15 54.03</td>
<td>2.386 .068</td>
</tr>
<tr>
<td>ADHD</td>
<td>60.08 60.39 60.27 61.41</td>
<td>.566 .638</td>
</tr>
<tr>
<td>ODD</td>
<td>62.34 62.33 63.11 63.45</td>
<td>.531 .661</td>
</tr>
<tr>
<td>CD</td>
<td>64.91 64.23 66.01 65.41</td>
<td>.828 .479</td>
</tr>
</tbody>
</table>

#### 8.3.3. Child Behaviour Checklist

On all three broadband scales, all subscales and all DSM-oriented scales of the CBCL an ANOVA was performed, demonstrating a significant effect below .05 on the total score, the internalising broadband scale, the social problems scale and all internalising subscales.
except somatic problems. Table 3 presents all the mean t-scores of these scales, and the F and p values of the analysis of variance. The Bonferroni correction performed on these scales showed a significant increase of problem behaviour between the pre-test and the fourth project year.

Because the ANOVA-test only compares the total group of youth in one year to the total group of youth in other years, we also used the General Linear Model (GLM) to examine whether the CBCL t-scores of individual youth changed over the four years. A significant decrease of scores was found for the scales internalising (F=5.174; p=.005), total (F=4.811; p=.007), anxious/depressed (F=4.763; p=.007), delinquent behaviour (F=3.874; p=.017), social problems (F=3.382; p=.029), affect disorder (F=3.001; p=.044) and anxiety disorder (F=4.547; p=.009). Because only a small percentage (n=38) of the total population of our study stayed in the residential part of the centre for the whole time of the research project, these results should be interpreted with caution.

8.3.4. Teacher Report Form
Similar to the CBCL, an ANOVA was performed on all scales of the TRF. As table 4 demonstrates, no significant effects were found, indicating that, according to teacher-report, student problem behaviour remained stable over the four year period of the implementation process.

Table 4: TRF (significant results in bold)

<table>
<thead>
<tr>
<th></th>
<th>Project year mean t-scores</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1(pre-test) 2 3 4</td>
<td>F</td>
</tr>
<tr>
<td><strong>Internalising</strong></td>
<td>53.34 58.88 52.68 53.96</td>
<td>1.950</td>
</tr>
<tr>
<td><strong>Externalising</strong></td>
<td>58.49 58.31 57.08 58.67</td>
<td>1.480</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>56.55 56.13 55.14 56.72</td>
<td>1.741</td>
</tr>
<tr>
<td><strong>Anxious/depressed</strong></td>
<td>55.91 55.79 54.98 56.05</td>
<td>1.680</td>
</tr>
<tr>
<td><strong>Withdrawn</strong></td>
<td>56.17 54.45 56.19 56.08</td>
<td>.196</td>
</tr>
<tr>
<td><strong>Somatic complaint</strong></td>
<td>53.31 53.12 52.44 53.12</td>
<td>1.269</td>
</tr>
<tr>
<td><strong>Aggressive behavior</strong></td>
<td>59.12 59.55 58.30 59.67</td>
<td>1.529</td>
</tr>
<tr>
<td><strong>Delinquent behavior</strong></td>
<td>60.15 60.00 58.86 60.21</td>
<td>1.423</td>
</tr>
<tr>
<td><strong>Social problems</strong></td>
<td>58.01 57.85 57.51 58.58</td>
<td>2.191</td>
</tr>
<tr>
<td><strong>Thought problems</strong></td>
<td>54.28 54.88 53.55 54.57</td>
<td>2.283</td>
</tr>
<tr>
<td><strong>Attention problems</strong></td>
<td>55.63 55.60 54.93 56.02</td>
<td>1.687</td>
</tr>
<tr>
<td><strong>Affect disorder</strong></td>
<td>56.14 56.88 56.16 56.90</td>
<td>1.197</td>
</tr>
<tr>
<td><strong>Anxiety disorder</strong></td>
<td>57.16 56.44 56.17 56.92</td>
<td>1.383</td>
</tr>
<tr>
<td><strong>Somatic disorder</strong></td>
<td>52.91 52.39 51.69 52.12</td>
<td>2.489</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
<td>56.26 56.13 55.59 56.60</td>
<td>1.241</td>
</tr>
<tr>
<td><strong>ODD</strong></td>
<td>58.80 59.99 57.61 58.11</td>
<td>1.339</td>
</tr>
<tr>
<td><strong>CD</strong></td>
<td>58.72 58.77 57.66 59.08</td>
<td>1.454</td>
</tr>
</tbody>
</table>

193
GLM’s run on each scale and subscale (n=93) revealed an effect of project year on aggressive behaviour (F=4.531; p=.005) and affect disorder (F=3.741; p=.014). Pairwise comparison using Bonferroni correction showed an increase of scores between pre-test and the last project year, both for aggressive behaviour (p=.047) as well as for affect disorder (p=.010).

8.3.5. Youth Self Report

As presented in table 5, ANOVA revealed no significant differences for the YSR, with the exception of the DSM-oriented subscale anxiety disorder. Bonferroni correction for multiple comparisons performed on this scale showed no significant differences. These results indicate the stability of self-reported problem behaviour when using the YSR.

Table 5: YSR (significant results in bold)

<table>
<thead>
<tr>
<th></th>
<th>Project year mean t-scores</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1(pre-test)</td>
<td>2</td>
</tr>
<tr>
<td>Internalising</td>
<td>59.32</td>
<td>58.68</td>
</tr>
<tr>
<td>Externalising</td>
<td>57.23</td>
<td>57.57</td>
</tr>
<tr>
<td>Total</td>
<td>58.74</td>
<td>59.09</td>
</tr>
<tr>
<td>Anxious/depressed</td>
<td>59.40</td>
<td>59.38</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>59.04</td>
<td>59.51</td>
</tr>
<tr>
<td>Somatic complaint</td>
<td>55.95</td>
<td>59.83</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>59.26</td>
<td>59.61</td>
</tr>
<tr>
<td>Delinquent behavior</td>
<td>57.82</td>
<td>58.36</td>
</tr>
<tr>
<td>Social problems</td>
<td>60.05</td>
<td>61.03</td>
</tr>
<tr>
<td>Thought problems</td>
<td>57.78</td>
<td>59.43</td>
</tr>
<tr>
<td>Attention problems</td>
<td>58.23</td>
<td>59.99</td>
</tr>
<tr>
<td>Affect disorder</td>
<td>59.40</td>
<td>60.09</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>57.75</td>
<td>57.93</td>
</tr>
<tr>
<td>Somatic disorder</td>
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<td>ADHD</td>
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<td>56.43</td>
</tr>
<tr>
<td>CD</td>
<td>59.68</td>
<td>60.30</td>
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</tbody>
</table>

GLM’s executed on the different broadband scales and subscales of the YSR (n=61) showed effects of time on the broadband scales internalising (F=10.788; p=.000) and total score (F=6.535; p=.000); on the subscales anxious-depressed (F=4.103; p=.001), withdrawn (F=2.723; p=.014), somatic problems (F=7.099; p=.000), delinquent behaviour (F=3.373; p=.039), social problems (F=6.677; p=.000) and thought problems (F=3.082; p=.009); and on the DSM-oriented scales affect disorder (F=5.560; p=.002), anxiety disorder (F=7.283;
p=.000) and ODD (F=2.758; p=.050). Comparisons of the different project years all reveal a significant decrease of self-reported problem behaviour, indicating that youth perceive themselves as having less problems, especially on the internalising scales.

8.3.6. Screen for Anxiety and Related Emotional Disorders
The last questionnaire we used for this research was the SCARED. ANOVA on the total score and the different subscales demonstrates different significant differences, which are presented in Table 6. Pairwise comparisons on all significant results revealed significant decreases of anxiety when comparing the pre-test with the data obtained during three other project years. These results indicate a significant decrease of anxiety in our population after the implementation of LSCI, and also that this decrease remains stable in the following two years.

Table 6: SCARED (significant results in bold)

<table>
<thead>
<tr>
<th></th>
<th>Project year mean scores</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1(pretest)</td>
<td>2</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>6.82</td>
<td>5.30</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>5.02</td>
<td>4.19</td>
</tr>
<tr>
<td>Animal phobia</td>
<td>1.00</td>
<td>0.74</td>
</tr>
<tr>
<td>Medical phobia</td>
<td>3.91</td>
<td>3.05</td>
</tr>
<tr>
<td>Situational phobia</td>
<td>2.83</td>
<td>2.15</td>
</tr>
<tr>
<td>Social phobia</td>
<td>5.76</td>
<td>4.99</td>
</tr>
<tr>
<td>OCD*</td>
<td>5.31</td>
<td>3.65</td>
</tr>
<tr>
<td>PTSS**</td>
<td>2.79</td>
<td>2.09</td>
</tr>
<tr>
<td>GAD***</td>
<td>6.04</td>
<td>4.97</td>
</tr>
<tr>
<td>Total</td>
<td>39.50</td>
<td>31.13</td>
</tr>
</tbody>
</table>

*=obsessive compulsive disorder
**=posttraumatic stress disorder
***=generalized anxiety disorder

When performing a GLM to examine whether SCARED scores of individual youth (n=66) changed during the process of implementation similar results were found on the following scales: separation anxiety (F=8.074; p=.000), panic disorder (F=3.905; p=.014), animal phobia (F=3.761; p=.015), medical phobia (F=5.086; p=.003), situational phobia (F=5.744; p=.002), OCD (F=8.822; p=.000), PTSS (F=5.008; p=.004), GAD (F=3.335; p=.025) and SCARED total score (F=6.275; p=.001).
8.4. Discussion

In a Flemish centre for children and adolescents with emotional and behavioural disorders, a longitudinal implementation process with regard to conflict management was set up. All staff members of the centre received a five-day training in LSCI, and, throughout the project, data with regard to time in program, academic achievement, behavioural problems and anxiety problems were collected.

8.4.1. Discussion of the results

A first conclusion is that the overall time spent in program increased, both in the schools as well as in the residential part of the centre. In the light of the literature on the evaluation of the effectiveness of substance abuse treatment, which shows a positive correlation between time spent in program and positive treatment outcomes (Inciardi, Martin & Butzin, 2004; Messina, Wish & Nemes, 2000; Ogborne & Melotte), these results might be an important factor with regard to treatment outcomes for youth with EBD. A possible explanation for our results could be found in previous studies on LSCI, showing that staff no longer feel helpless with their students, but are more empowered with a sense of professional confidence which results in a more positive climate (Soenen et al., 2013). As a consequence, staff do not give up on the youth cared for, resulting in an increased time spent in program. Further, although ‘suspensions’ was not a variable in this study, another explanation could be found in a study made by Dawson, who found that LSCI led to fewer suspension (Dawson, 2003). Thirdly, and in combination with the other findings of our study, it can be interpreted that the more positive climate makes youth feel more safe in the program, which motivates them to stay in the program longer.

The implementation of LSCI also seemed to have a positive effect on the academic performance of students in the centre. It is appropriate to assume that through the use of LSCI a better relationship between student and teacher, which has been found to have positive effect on academic performance (Hamre & Pianta, 2001; Quinn et al., 2006), will be established. This results suggests that, even when academic achievement is not the primary goal of a conflict resolution model such as LSCI, it is beneficial to invest in such models. Similar results can be seen in previous research on LSCI (DeMagistris & Imber, 1981; Soenen et al., 2009) and in research on integrating conflict resolution and peer mediation into an academic course (Stevahn et al., 2002).

When looking at the ANOVA’s performed on the three Achenbach questionnaires (TRF, CBCL and YSR), not many effects could be seen. This is not surprising, since these questionnaires are known to be stable (Achenbach, Dumenci, & Rescorla, 2002; Biederman et al., 2001) and the target population of our study is known to be almost unchangeable (De
Bolle et al., 2009; Lipsey, 1992). An exception on these findings is the increase of anxiety on the CBCL. An explanation for this evolution could be that LSCI helps educators to get a better insight in youths’ problems (D’Oosterlinck et al., 2009), and therefore the increased scores are a more accurate reflection on youths’ actual inner state.

The GLM executed on the TRF and the YSR did show several significant effects. These should be interpreted with care for two reasons. First, the number of youth for who these questionnaires were completed four years in a row is relatively small because of student early drop-out or students completing the program. A second reason for caution when interpreting the results is that, especially concerning internalising problems, it is known that these problem scores decrease as youth get older (Hale et al., 2011; Muris et al., 1998; Muris et al., 1999; Muris, Schmidt & Merckelbach, 2000; Su et al., 2007).

Probably the most important finding of our study is the effect of the implementation of LSCI on the scores on the SCARED, which decreased significantly for the total scale and for almost all subscales. From the perspective of the model of the conflict cycle, which states that a decline of anxiety should lead to a decline of aggression or other disruptive behaviour, this is a very promising result. From other studies we know that the implementation of LSCI leads to a more positive climate in the organisation (Soenen et al., 2013). It is appropriate to assume that this ameliorated climate, in combination with the construction of a more positive relationship between adult and youth through the use of LSCI, leads to the youth feeling more safe and secure, and thus less anxious.

8.4.2. Limitations and implications for further research

This study has several limitations. When conducting an implementation-process as elaborated as the process described in this study, this has an influence on the totality of the organisation starting from the first steps of the process. Directors and staff who are not attached to a certain group, e.g. the therapists or the time-out staff, attended the training at the beginning of the project, a coordinating LSCI-expert is hired, coaching became an important aspect of staff policy,…. As a result, when the research is performed in only one treatment centre, it is impossible to create a clear experimental design with control groups and experimental groups. For future research, we would suggest to engage more than one centre in the design, to eliminate influence between control and experimental groups.

Secondly, although our study took place over a four-year period, we were unable to keep track of students leaving the program, and we had little information about student drop-out. A more longitudinal design would enable future researchers to examine the long-term effects of LSCI.
Further, the process of implementation in our research included more than just training staff members, e.g. the installation of coaching of LSCI. More research should be done on the meaning and the impact of such a process of implementation on the organisation as a whole.

A fourth limitation is the fact that we could not use more ‘behavioural data’, such as number of conflicts. It was our intention to collect such data, but because teachers and educators often forgot or did not have the time to complete the registration forms, data were not reliable enough to use in our study. In future research, the difficulties to collect such data should be more taken into account.

Finally, the LSCI method as it is developed nowadays focuses on training of teachers and educators, and on implementation in education or out-of-home care. Further research should be done to investigate the possibilities to two more domains of conflict resolution. First, it should be investigated whether LSCI could be transformed in a curriculum-based training for children and adolescents. Secondly, research should be done on the possibilities of training of parents, so conflicts can be handled closer to the ecology of the child.

In conclusion, it may be stated that the implementation of LSCI in a residential centre and school for special education results in an increase of time spent in program, an increase of academic performance, and a decrease of self-reported anxiety; and thus positively contributes to the treatment of children and adolescent with EBD.
References


CHAPTER 9
General discussion
Abstract

The last chapter of this dissertation starts with a summary of the main findings. The two studies on the characteristics of youth with emotional and behavioural disorders revealed the complex nature of youths’ problems, but also the difficulties professionals experience to obtain an accurate perception of youths’ problems. Further, the youth in our studies gave several insights on what they experience as helpful and contra-productive elements of the treatment they receive; and staff in our sample provided us with a model which can be used as a steppingstone in implementation processes. Finally, the three studies on the effect of the implementation of Life Space Crisis Intervention showed that this model positively contributes to the treatment of youth with EBD. The results of these studies will be discussed, and recommendations on the level of orthopedagogical treatment, organisational management, scientific research and policy will be presented.
9.1. Introduction

This dissertation focuses on working with children and adolescents with emotional and behavioural problems, and especially on the characteristics of these youths’ problems, professionals’ perceptions of these problems, youths’ and professionals’ experiences and needs with regard to this work, and on the implementation and effect of a conflict resolution program.

In Flanders, these children and adolescents are often treated in centres that offer both special education and specialized residential care. Because of the initiative of the directors of two Flemish treatment centres, we were able to conduct 7 different research studies, guided by the following aims.

9.2. Aims of the dissertation

The aims of the research project are twofold:

- to gather information about children and youngsters with emotional and behavioural disorders (EBD) in Flemish care
- to investigate the process of implementation of conflict management methods in Flemish institutes for children and adolescents with emotional and behavioural disorders.

These aims were divided into 5 different research questions:

1. What are the characteristics / problems of children and adolescents with EBD?
2. What is the perception of the different informants on these characteristics / problems?
3. What are the experiences and needs of both staff members and youth?
4. What are the effects of implementation of LSCI on the problems and the behaviour of children and adolescents?
5. How do stakeholders reflect on this process of implementation

9.3. Main findings

9.3.1. Characteristics of children and adolescents with EBD and different perceptions

In an attempt to find an answer to the first two research questions, a study was executed in the Orthopedagogical Treatment Centre Sint-Idesbald (chapter 4), a centre that offers
special education and residential treatment to approximately 450 children and adolescents and their families.

Based on the individual files of all youngsters, the following data were gathered: age, gender, total intelligence, verbal intelligence, performance intelligence, current type of treatment and diagnostic data. Beside information on the minors, also information on sex, age, and years of experience of all group workers and teachers who work directly with the children and youngsters, was collected. Subsequently, CBCL (Child Behaviour Checklist), TRF (Teacher Report Form) and YSR (Youth Self Report) results were added to the database. The CBCL was completed for all youths by their individual group worker, the TRF by all class teachers and the YSR by youths themselves.

The file data of our sample (n=434) showed a ratio of boys to girls of 4-1, and a mean age of 13.35. Mean IQ scores (77.12) were lower than mean IQ scores of the normal population. No significant gender or age differences were found on IQ scores.

Correlations among the different informants were sought, and based on the work of D’Oosterlinck et al. (2006) a profile for the children and adolescents was developed based on data from each informant.

From the results of this study, it can be concluded that the problems of the youth in our sample are of a complex nature. Further, the analyses of our data showed a clear disagreement among the different informants. The self-reported data showed higher internalising problem behaviour than the group worker or teacher-reported data. Correlations between youth and adults were also stronger for externalising behaviour than for internalising behaviour. Also the profile we constructed for each of the three questionnaires showed a discrepancy between adults and youths. The profile constructed using the CBCL or the TRF indicates that youth in our sample show aggressive and delinquent behaviour and suffer from attention problems (externalising – attention problems profile). On the other hand, the profile constructed using the YSR indicates that youth are withdrawn, anxious/depressed, have somatic complaints and suffer from thinking problems (internalising – thinking problems profile).

It is concluded that these discrepancies do not necessarily imply a distortion, but rather reflect the complex nature of a child and his or her problems, as they are presented and experienced in different realities. As a result, we underscore the common assumption that information from different informants is needed in clinical practice (Barbosa, Tannock, & Manassis, 2002; Epstein et al., 2004; Rubio-Stipec et al, 2003; Silverman & Ollendick, 2005; Stanger & Lewis, 1993; Vierhaus & Lohaus, 2008). Subsequently, it is argued that these results are not surprising given the large group size of up to 14 youth in one group.
We believe this group size possibly creates a barrier for youth and staff to interact in a safe and treatment-oriented way, and therefore we plead for more funding in order to reduce group sizes and use individualized educational and learning approaches which can be integrated within the Flemish tradition of ‘the group as method’.

Because of the high self-reported internalising problems, and because of the informant disagreement with regard to these internalising problems, it was the aim of a second population study to examine the nature of these internalising problems (chapter 5). Building further upon the research described in chapter 4, the SCARED was added as a self-reported measure for anxiety.

First, the analyses showed a clear presence of anxiety in our sample, especially with regard to situational phobia, posttraumatic stress disorder and social phobia. Further, anxiety scores were higher for youth in residential care than for youth who only attended special education. This last result raises the question whether youth with the most severe problems receive the most intensive treatment, or that an intensive type of treatment such as residential care paves the way for anxiety problems in youth.

In line with the results of chapter 4, a clear relationship between anxiety scores on the SCARED and internalising problems on the YSR was found, but no correlations could be found between the SCARED and the TRF, and only few between the SCARED and the CBCL.

A third finding was that strong correlations could be seen between the SCARED and the syndrome scale ‘social problems’ on the YSR and on the CBCL, suggesting that youth express their feelings of anxiety more in socially maladjusted behaviour than in aggressive or disruptive behaviour, and that this is also how it is perceived by educators.

A final result could be seen with regard to the syndrome scale ‘thought problems’. No correlations were found between the SCARED and the syndrome scale ‘thought problems’ on the TRF nor on the CBCL. On the YSR, however, this syndrome scale correlates the strongest of all syndrome scales with the self-reported anxiety. This result showed a clear relationship between anxiety and cognitive problems as perceived by youth themselves – a relationship which Beers and De Bellis (2002) also found in children with PTSD – but also that this clear relationship goes unnoticed by teachers and educators.

It is recommended that, when professionals want to help youth dealing with their emotional and behavioural problems, intervention programs that not only focus on the social or behavioural level, but also take into account the cognitive functioning of youth need to be installed.
9.3.2. Experiences and needs of staff members and youth

It is generally assumed that working with this highly troubled population, and the change with regard to the demand for care has also created a need for intervention models that address students’ socio-emotional needs (Baker et al., 2007; George & Fogt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009), especially to cope with the high amount of conflict and crisis situations (D’Oosterlinck et al., 2009). Further, implementation of such models is a complex process that is often fraught with unanticipated events, conflicts and resolutions (Aarons & Palinkas, 2007), and several concerns should be taken into account to improve the likelihood that educators have the working conditions needed to use these practices (McLeskey & Billingsley, 2008). Therefore, it was the aim of fifth study (chapter 6) to investigate how staff perceive youths’ demand for care, how staff translate this demand for care into treatment, and what staff see as critical issues to take into account when implementing intervention models.

By means of a semi-structured interview 50 staff members were interviewed. Subsequently, and using a grounded theory approach, a pre-implementation model was developed, in which staff discussed critical factors. This model contained four different but interrelated parts: (1) vision of the organisation, (2) cooperation amongst colleagues, (3) approach to youths’ problems and (4) preconditions for implementation. A first critical part according to the staff was to establish in the organisation a clearly articulated vision and set of beliefs. Once the vision and beliefs are established, and known by all staff, the foundation is laid for constructive cooperation. Constructive cooperation seemed to be critical for a shared approach between teams and within teams. Further, staff mentioned a lack of skills in dealing with the youths’ behaviours, but also the existence of conflicting opinions in how to do so. As a result, interviewees emphasized their need for extensive training in clearly elaborated and practice-focused intervention models. Because of the presence of conflicting opinions, trainers must be aware of the theoretical bases of various models. Finally, an up-to-date infrastructure, sufficient staff and coaching and support are mentioned as the necessary preconditions for implementation to succeed.

As a search through the recent literature showed only a paucity of studies including youths’ ideas with regard to the treatment they receive, in the sixth study (chapter 7) we wanted to give the floor to youth themselves about how they reflect on their own and their peers’ behaviour and about how they experience their stay in the centre. The research strategy of this study rested on a number of semi-structured interviews with the youth at the centre, in which the researcher gave pre-set questions in a determined order, but with the possibility of asking follow-up questions based on the interviewees’ response. In total, 50 interviews were carried out, each on an individual basis.
The findings of this study can be divided into three themes. In the first theme youth reflect on their own and their peers’ behaviour. They talked about the climate in the centre, which they often experience as noisy; mention a variety of negative behaviour, such as verbal aggression and physical aggression; and they talk about how their own feelings and thoughts can influence their behaviour.

In the second theme youth gave their ideas on what they experience as helpful elements in treatment. A first helpful element which is mentioned by many interviewees is the availability of staff, especially to talk about the problems youth experience. It is stated that the more the youth trusts the adult and the better the relationship between youth and staff, the more youth know these staff will understand them. Nearness or closeness of staff, i.e. staff who provide supervision and staff who are there to do fun activities, is a second helpful element. A third helpful element youth mentioned is a set of clear rules and boundaries; and finally some ‘alone time’ is the fourth helpful element.

In the third and last theme youth talked about what they see as contra-productive elements of treatment. The first and most often mentioned element was the high level of control characterized by an abundance of rules and punishments that are perceived as unfairly applied by staff. Secondly, staff members who do not listen to youths’ problems are perceived as contra-productive. A last element within this theme is the inappropriate or insufficient staff attitudes or interventions, such as aggression or a negative approach to youth.

Taken together these results demonstrate that a communication-oriented therapeutic relationship between youth and staff, within a structured and safe climate lies at the very centre of working with children and adolescents with emotional and behavioural problems. Therefore, we plead for the implementation of clearly elaborated and structured methods; both methods with a focus on communication as well as methods with a focus on providing structured rules and boundaries.

### 9.3.3. Effects of the implementation of Life Space Crisis Intervention

Based on the extensive body of literature (Dawson, 2003; DeMagistris & Imber, 1981; Forthun, McCombie & Freado, 2006; Grskovic & Goetze, 2005, Naslund, 1987; White-McMahon, 2009) and building further upon recent Flemish research (D’Oosterlinck et al., 2008; 2009), we chose to implement Life Space Crisis Intervention (LSCI) as a conflict management model (Long, Wood & Fecser, 2001) in the clinical practice of two Flemish treatment centres for children and adolescents with EBD.

The first study on the effects of LSCI (chapter 2) took place in the Provincial Institute Heynsdaele, and can be seen as the pilot study for later, more elaborated research. It was
the aim of the study in Heynsdaele to investigate, throughout a three-year project, the effects of the combination of a self-developed level system and LSCI. Both before implementation (2006) as well as after implementation (2008) of both strategies, different data were collected to investigate the effects of the implementation.

The results show a significant decrease in both the number of conflicts as well as the number of signalisation moments, indicating that LSCI and the level-system are effective in reducing problem behaviour. In addition to the positive outcomes regarding the aggressive behaviour, the implementation of both strategies also had a positive influence on the academic achievement of the students. This finding suggests that, even when academic achievement is the primary goal, it is beneficial to invest in strategies to reduce disruptive behaviour and to provide teachers with insight and skills to deal with disruptive behaviour. Although the sample size of this study was small (n=70), it was concluded that the implementation of LSCI and a level-system resulted in a decrease of disruptive behaviour and an increase of students’ academic achievement.

Building further upon the previous study (chapter 2), a second study was performed in the Provincial Institute Heynsdaele (chapter 3). It was the aim of this study to examine the reflections of the staff of Heynsdaele on the process of implementation. In 2008, at the end of the project, 22 staff members were interviewed, using semi-structured interviews. Analysis of the interviews revealed four different categories in which experiences of staff members can be divided: content of the job and tasks, the youth in the centre, working with the youth in the centre, cooperation with colleagues and other teams. In sum, care takers reflected positively on the process of implementation, since it enabled all staff members to interact with their students based on a shared philosophical and theoretical framework. Several staff members stated that they no longer felt helpless or believed that ‘nothing works’ with the youth in the centre, but now felt empowered with a new sense of professional confidence. Further, it was stated that the process of implementation resulted in a shared approach, but interviewees also mentioned that communication and cooperation should be more structured, more systematic and more shared.

From the results of this study we can deduce that working with youngsters with emotional and behavioural disorders remains a difficult task. But, although problems still occur, the climate has become a more positive one.

After the research project in Heynsdaele, a second project was undertaken in the Orthopedagogical Centre Sint-Idesbald. Although the two centres are similar in some aspects, some important differences between the two research projects need to be mentioned. First, while Heynsdaele only serves youth aged 12 to 21, Sint-Idesbald also has services for younger children (from the age 3 to the age of 21). Secondly, youth in Heynsdaele had higher IQ scores than youth in Sint-Idesbald. A third difference is the size
of the two treatment facilities. In Heynsdaele, approximately 70 youth receive treatment, while in Sint-Idesbald up to 450 children and adolescents are served. Fourthly, and mainly because of the difference in size, the second project was a five-year project instead of three years. Finally, because of both the evolving insights from the literature on anxiety (e.g. Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Crocetti et al., 2009; Hale et al., 2005; Hale et al., 2011; Simon & Bögels, 2009) as well as the findings of our studies described in chapter 4 and chapter 5, we decided to add ‘anxiety’ as a variable in our research (chapter 8).

In this last chapter, we tried to find an answer to the following three research questions:

- First, it is known from the literature that the implementation of LSCI results in a better treatment climate. We wanted to investigate whether this could be translated into measurable variables such as time in program and academic achievement.

- Secondly, it is known that the problem behaviour of children and adolescents with EBD often presents a challenge for the people working with these youths. Therefore, we wanted to investigate the effect of the implementation of LSCI on the problem behaviour of the youth in a centre offering special education and residential treatment.

- Given the increasing attention to anxiety in children and adolescents with emotional and behavioural problems as described in the literature; we wanted to investigate the effect of the implementation of LSCI over a four-year-period on the anxiety of the youth in a centre offering special education and residential treatment.

Over a period of four years, data were collected with regard to youths’ anxiety (SCARED), with regard to youth problems behaviour (CBCL, TRF and YSR), and with regard to time in program and academic achievement, which we linked – based on several studies - to the treatment climate.

As an answer to the first research question, the results of our study showed that time in program and academic achievement increased, which could both be explained by the installation of a better climate in the treatment centre, both for staff as well as for the children and adolescents.

Further, while problem behaviour on the TRF and the YSR remained stable, an increase of internalising problem behaviour could be seen on the CBCL-scores. The stability of the TRF and the YSR are not surprising, since these questionnaires are known to be stable
(Achenbach, Dumenci, & Rescorla, 2002; Biederman et al., 2001) and the target population of our study is known to be almost unchangeable (De Bolle et al., 2009; Lipsey, 1992). An explanation for the increase of the internalising problem behaviour on the CBCL can be found in the work of D’Oosterlinck et al., who found that LSCI helps educators to gain a better insight into youths’ problems (D’Oosterlinck et al., 2009), and therefore have a more accurate perception of youths’ actual inner state.

Finally, and answering the last research question, our research showed a significant decrease of anxiety on almost all the scales of the SCARED. Given the findings of the studies described in chapter 4 and chapter 5, and from the perspective reflecting the conflict cycle - which suggests that a decline of anxiety should lead to a decline of aggression or other disruptive behaviour - this is a very promising result. Further, and based on the results of our research as described in chapter 3, it is argued that the ameliorated climate, in combination with the construction of a more positive relationship between adult and youth through the use of LSCI, leads to the youth feeling more safe and secure, and thus less anxious.

In general, it can be concluded from this last study that the implementation of LSCI in a residential centre and school for special education results in an increase of time spent in program, an increase of academic performance, and a decrease of self-reported anxiety; and thus positively contributes to the treatment of children and adolescent with EBD.

9.4. Recommendations

9.4.1. Recommendations on the level of orthopedagogical treatment

**Working with children and adolescents with EBD**

It is known that the problems of children and adolescents with emotional and behavioural problems are of a very complex nature. Although these problems are often expressed in aggressive or disruptive behaviour, very often internalising problems form the foundation of youths’ negative behaviour. If we want treatment to succeed, and if we want to achieve real behavioural regulation in daily work with children and adolescents with EBD, more attention should be given to the feelings and thoughts of the youth, and to how these are interrelated with behaviour. To do so, professional staff will need more time and resources to work on an individual base with youth, integrated within the Flemish tradition of ‘the group as method’. Further, continuous attention should be given to increase staff know-how and insights in the youths’ ‘inside’ and ‘outside’ problems. We believe that formal staff training and education could form a foundation for this, but continuous support and
coaching from supervisors who are closely involved with daily work in the centre will be at least equally important.

**Working through conflict**

When working with children and adolescents in special education or residential care, staff will be confronted with conflict and crisis, caused by the highly disturbing behaviour of the youth. Because of the profound impact of these conflict and crisis situations on both youth and staff, conflict resolution should be an object of attention. We believe some aspects are of crucial value.

First, we believe that working through a conflict always should be a process of communication with the child or adolescent. Secondly, when one wants to achieve behavioural regulation through the use of a conflict resolution model, the building up of the relationship during the conversation will be more important than the practical, solution-focused interventions that are discussed. In other words, multiple solutions can and maybe should be discussed and formulated during the process of conflict resolution, but the relationship between the youth and the professional lies at the very centre of orthopedagogical treatment. Thirdly, if we want to empower staff in working through conflict, clearly elaborated models of conflict resolution, such as LSCI, should be implemented in treatment centres. When implementing such models, formal training can only be a first step, with intensive coaching, teamwork and reflection in the here and now as the necessary next step. Although working with these youth will remain a difficult task for teachers and group workers, and conflict will still occur, we are convinced that through the implementation and use of conflict resolution methods within pedagogics, a more positive climate can be established, which will positively contribute to the treatment of children and adolescents with emotional and behavioural problems in special education and residential care.

In this dissertation, LSCI as a conflict resolution program with a focus on training for professionals has been implemented and studied. When establishing an orthopedagogical conflict-positive climate, attention should also be given to curriculum-based programs with a focus on training for children and adolescents themselves. Further, due to the high costs of residential treatment, but also because of ethical and pedagogical concerns with regard to taking children away from their natural ecology, there is a recent evolution towards treatment closer to the network and ecology of the child and his family. This evolution, which we strongly applaud, raises the need to empower the families in daily life. We believe that conflict resolution programs that focus on training of parents could offer a positive contribution.

In sum, based on the results of our studies, and thus starting from the positive contribution of LSCI to treatment in special education and residential care, attention should be given to
an integrated model of conflict resolution, that not only empowers professional staff, but also youths, their parents, and their ecology.

**Cooperation between different services**

A last recommendation on the orthopedagogical level has to do with cooperation between the different services for children and adolescents with EBD. Both the research project in Heynsdale as well as the research project in Sint-Idesbald revealed a tension between work in a school-setting and work in a residential setting. Although in Flanders schools for special education and residential treatment centres are often located on the same campus, there exists a historical, seemingly fundamental difference, with schools teaching subject matter and residential care offering treatment. In a true orthopedagogical treatment climate, both systems should be more integrated with respect for each other’s identity, and with the goal of complementary service to youth and their families in a conflict-positive environment.

**9.4.2. Recommendations on the level of organisational management**

The implementation of a conflict resolution model such as LSCI is a complex but necessary undertaking that should be well thought-out. Based on our implementation and research project, several recommendations towards the management of treatment centres for youth with EBD can be formulated.

First, it would be a mistake to think that implementation only involves providing training and coaching to staff. Attention should be given to the establishment of a shared vision and set of beliefs on the main goals of the treatment centre, on how clients are looked upon and on how treatment should be organised. The process of implementation of any model will challenge the basic individual and organisational values and beliefs, and implementation can only be successful if the management succeeds in attuning the values and beliefs of the model, the individual staff members, and the organisation as a whole.

Secondly, once a process of implementation has started, traditional structures or practices can be questioned, and practical obstacles might arise. For example, time-out procedures were changed to enable staff to use LSCI, and working schedules had to be adapted to provide the necessary support and coaching for frontline staff. The management of a treatment centre has to pay attention to such obstacles, and has to play the role of facilitator for staffs’ concerns to be solved. In other words, the management plays a critical role as facilitator for the necessary organisational change in implementation processes.
Finally, and especially in larger organisations, we stress the need for a ‘process-manager’ who can survey the process of implementation. This person should act as a source of inspiration with regard to the content of the newly adapted method, but also as the contact person for both the frontline staff as well as the managers in the centre, and as such function as the bridge between organisational policy and the actual application of the treatment model.

9.4.3. Recommendations on the level of scientific research

In the scientific literature, only very few studies on the effectiveness of treatment model in general and conflict resolution models in specific can be found. This is not surprising, since two major concerns arise when performing longitudinal effect-studies in special education or residential care settings.

A first problem has to do with the fact that treatment in such centres always contains more than only the conflict resolution model which is implemented and studied. In addition to the planned implementation, other important changes in the organisation will occur, possibly as a consequence of the implementation process of the model that is the original subject of research. As a result, it becomes extremely difficult to determine what factors contribute to the possible effects. Therefore, more research should be done, not only on possible effects on treatment, but also on the impact of implementation processes on the organisation as a whole.

A second problem concerns the difficulties in creating a research design with control and experimental groups when executing effect research in daily clinical practice. In a school for special education or in a residential treatment centre it is, for several reasons, inevitable that participants in the control group will be influenced by participants in the experimental group. Especially when the implementation has an impact on broader aspects, such as the vision and beliefs of the organisation, a clear distinction between control and experimental groups is impossible. A possible solution for this problem could be the participation of two or more different treatment centres in future effect studies. Therefore, we plead for more and better organised cooperation between different treatment centres on the level of scientific research.

Further, more longitudinal research on the effectiveness of treatment models and programs is needed. We would recommend future researchers to keep track of the participants of their studies, which will open the possibility for follow-up research.

Finally, the relatively small body of research on conflict resolution always addresses models with a focus on training for professional, or on training for youth, or on training for parents. Research should be done on the workable elements of conflict resolution, with the
aim of developing an integrated conflict resolution model that is applicable and trainable for professionals, youth, parents and their ecology.

9.4.4. Recommendations on the level of policy

For several reasons, more resources are needed for the treatment of children and adolescents with emotional and behavioural disorders.

First, as our studies have shown, it is extremely difficult for frontline staff to obtain an accurate view of the youths’ problems, especially their internalising problems. Unfortunately, given the large group size of up to 14 youth in one group, these results are not surprising. We believe this group size possibly creates a barrier for staff to really get to know the youth they work with, and thus also for youth and staff to interact in a safe and treatment-oriented way. Therefore we plead for more funding in order to reduce group sizes.

Secondly, in daily practice, one of the challenges of professionals should be to find the right balance between working with individual children or adolescents and working with the group. Unfortunately, because of the lack of funding in Flemish treatment centres, staff shortage often forces teachers and educators to primarily work with the group, and to look at individual work as only an option in occasional calm moments.

Thirdly, more resources are needed for future research. In special education and residential care, there is not really a tradition of executing research in clinical practice. Different organisations use different treatment models and different treatment methods, but studies on the effectiveness of the models and methods are very rare. The few Flemish treatment centres that have taken the initiative to invest in studying their population or their treatment effectiveness did not receive structural governmental funding, and thus had to use resources at the expense of staffing in the groups or classrooms. In order to guarantee the scientific underpinning of working with youth with EBD, structural governmental funding should be made available.

Finally, because Flanders has a history of out-of-home care, Flemish professionals have built up a great expertise in this area. Recently, there is an evolution towards treatment closer to the network and ecology of the child and his family. Although we strongly applaud this evolution, this also means that expertise from residential work has to be translated into expertise in working closer to the families. Both in the bachelor and master schooling of future professionals as well as in the further training and development of professionals, more attention should be given to this.
9.5. Conclusion

In Flanders, several specialized care facilities for children and adolescents with emotional and behavioural problems exist. Several of these centres offer a combination of residential care, day-care, and special education for youths from the age of 3 to the age of 21.

In line with the current literature (e.g. Brady & Caraway, 2002; Dale et al., 2007), several studies of this dissertation show the complex nature of the problem behaviour of youth in care, with not only high levels of both externalising and internalising problem behaviour, but also with high comorbidity levels (e.g. Connor et al., 2004; Lee & Bukowski, 2012). The complex nature of a child and his or her problems, as presented and experienced in different realities, also seems to lead to informant discrepancies with regard to the problems that need to be treated. This is clearly shown in the different behaviour profiles which we could deduce from data obtained from different informants. These discrepancies may hinder the abilities of professionals and clients to work together on treatment goals (De Los Reyes & Kazdin, 2005; Hawley & Weisz, 2003; Yeh & Weisz, 2001). It can be concluded that more effort should be taken to resolve these discrepancies and, as such, to enable professionals and clients to define and to work together on the goals of treatment. To achieve this, organisations should provide more staff training and coaching on youths’ problems and how to deal with these problems. Further, more funding should be provided in order to reduce group sizes and thus to enable youth and staff to act and communicate in a safe treatment-oriented manner, with respect for an individual approach in the context of the group.

Working with this highly troubled population has created a need for intervention models that address students’ socio-emotional needs (Baker et al., 2007; George & Fogt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009), especially to cope with the high amount of conflict and crisis situations (D’Oosterlinck et al., 2009). Research has shown that staff members feel empowered when confronted with conflict and crisis if they are trained in conflict management methods, and have an insight into the specific behaviour of youths with EBD (Dawson, 2003; Lindsay, 1998). Within the context of this dissertation, Life Space Crisis Intervention was implemented in two Flemish care centres. Several European and American studies (Dawson, 2003; DeMagistris & Imber, 1981; D’Oosterlinck, 2008, 2009; D’Oosterlinck, Broekaert & Denoo, 2006; Forthun, McCombie & Freado, 2006; Grskovic & Goetze, 2005; Naslund, 1987; White-McMahon, 2009) have found positive effects of this method for conflict resolution.
The implementation of such a method is a complex process (Aarons & Palinkas, 2007) that encompasses much more than formal training. From our pre-implementation research, three conclusion can be drawn. Firstly, before the process of implementation starts, the vision and beliefs of the organisation, the vision and beliefs of staff, and the vision and beliefs on which the method is based should be mapped and aligned with each other. Further, managers should pay attention to the formal and informal means of communication, and offer safe channels for staff to express their opinions. Finally, a well thought-out plan on how to support staff throughout the process of implementation should be developed.

Although working with children and adolescents with emotional and behavioural problems remains a difficult task, our studies show that LSCI is effective in reducing problem behaviour, in reducing youths’ anxiety, in reducing students’ drop-out, and in enhancing students’ academic achievement. Further, staff no longer feel helpless or believe that ‘nothing works’ with these youths, but are empowered with a new sense of professional confidence. Otherwise stated, problems still occur, but the climate in the organisation has become more positive.

Conclusively, due to their highly problematic behaviour, there will always be some youth who will benefit from residential care and special education. When treating these youth in such a specialized context, there will always be a need for well-implemented conflict resolution programs. Thereupon, attention should be given to empower youths themselves, their parents and their ecology in handling conflicts. Based on the results of our studies, we believe that the expertise of residential centres and schools for special education, and their staff, could serve as the foundation to establish such an integrated model of conflict resolution.

9.6. Limitations

Although most of the limitations with regard to the multiple studies of this dissertation are already mentioned at the end of each chapter, the following paragraph focusses on some overall limitations of this dissertation.

In all our studies, we gathered information from the children and adolescents in the centres and / or from the professionals who work with these youths. It would have been more powerful if we had taken into account the perspective of parents, both in the studies on youths’ characteristics as well as in the studies on the effect of conflict resolution. Another important variable which was not investigated is detailed information with regard to drop-out. It would have been interesting if we had more information about students’ reasons for leaving the centre.
Although our research covers a period of several years, we were not able to collect follow-up data. It would have been interesting to have more information on possible effects of conflict resolution on former students’ behaviour and well-being after they had left the centre.

Thirdly, all studies took place in only two treatment centres. A similar study as a cooperation between many treatment centres would improve the generalizability of our findings.

Finally, performing effect-research within the context of daily practice is different from research in a more controlled environment. Other focusses in the university courses for future caretakers, staff turnover at the management level of the organisation, new governmental regulations for treatment centres, etc. are just some of the many continuously evolving factors that, throughout the several years of this research, could have had an influence on the results of our study.
References


Abstract

Kinderen en jongeren met gedrags- en emotionele problemen zijn een groep met complexe noden, die vaak terecht komt in voorzieningen die residentiële hulpverlening en / of het buitengewoon onderwijs aanbieden. In het werken met deze jongeren ervaren hulpverleners in deze voorzieningen vaak de nood aan een methodiek rond conflicthantering. Van 2005 tot 2008 liep in een Vlaamse voorziening een pilootproject waarbij Life Space Crisis Intervention (LSCI) als conflicthanteringsmethodiek werd geïmplementeerd en onderzocht op effectiviteit. Op basis van deze onderzoeksresultaten werd vanaf 2008 in een andere voorziening een soortgelijk maar grootschaliger project opgestart. Hierbij werd in eerste instantie in kaart gebracht wat de problematieken van de jongeren zijn, en hoe de verschillende stakeholders kijken naar deze problematieken. Vervolgens werd gekeken naar de noden van zowel de kinderen en jongeren als van de hulpverleners in de dagelijkse werking van de voorziening. Tenslotte werd nagegaan wat het effect is van de implementatie van LSCI op de problemen en het gedrag van de kinderen en jongeren.
Kinderen en jongeren met gedrags- en emotionele stoornissen vormen een kwetsbare groep in onze samenleving. Hun problemen zijn chronisch (Visser et al., 2003), diepgaand (Fergusson & Horwood, 1995; Lahey et al., 1995; Lahey et al., 2002; Leech et al., 2003), en bijna even stabiel als persoonlijkheidskenmerken (De Bolle et al., 2009). De verschillende onderzoeken rond deze jongeren die in de hedendaagse literatuur kunnen gevonden worden spreken van zeer gekwetste jongeren en families (Dale et al., 2007), gekenmerkt door een chaotische jeugd met ervaringen van stress en trauma (Brady & Caraway, 2002).

In onderzoek worden vaak de termen ‘internaliserend’ en ‘externaliserend’ gebruikt om de problemen van deze doelgroep te omschrijven. Op basis van data verzameld bij 517 kinderen en jongeren in Vlaamse voorzieningen construeerden D’Oosterlinck en zijn collega’s een gedragsprofiel (D’Oosterlinck et al., 2006). De resultaten van dit onderzoek toonden aan dat het gedragsprofiel van zowel de jongens als de meisjes in de steekproef wijst op uitgesproken externaliserend en problematisch gedrag. In een ander onderzoek keken Connor en collega’s naar de karakteristieken van kinderen en jongeren opgenomen in residentiële zorg. De resultaten van dit onderzoek wijzen op een hoge mate van internaliserende en externaliserende psychopathologie, en van agressief gedrag.

Op gebied van geslachtsverschillen wordt algemeen aangenomen dat jongens meer externaliserend gedrag vertonen dan meisjes (Duchesne & Larose; Masi et al., 2004), en dat meisjes meer internaliserend gedrag vertonen dan jongens (Sohn, 2003; Tambelli et al., 2012; Wasserman et al., 2004).

Verschillende studies spreken ook van een hoge comorbiditeit van internaliserend en externaliserend probleemgedrag. McConaughy en Skiba, bijvoorbeeld, vonden een sterke comorbiditeit voor de DSM diagnose ‘gedragsstoornis’ met de diagnoses ‘oppositionele stoornis’, ‘affectieve stoornis’, ‘angststoornis’, en ‘aandachttekortstoornis’. Op basis van deze resultaten wijzen de auteurs op het belang van een veelzijdige aanpak om de wijde range aan probleemgedrag te kunnen behandelen. Vergelijkbare resultaten kunnen in verschillende andere onderzoeken teruggevonden worden (bv. Connor et al., 2004; Cunningham & Ollendick, 2010; D’Oosterlinck et al., 2006; Galambos, Barker & Almeida; Kovacs & Devlin, 1998; Liu, Chen & Lewis, 2011; Maughan et al., 2004; McConaughy & Skiba, 1993; Storch et al, 2012; Wasserman et al., 2005).

De voorbije jaren was er een duidelijke evolutie met betrekking tot de karakteristieken van deze populatie merkbaar. Lieberman (2004) toonde aan hoe de stijging van misbruik en verwaarlozing van kinderen, samen met het plaatsen van meer kinderen en jongeren in
Gezien de complexiteit van hun problemen hebben deze kinderen en jongeren, die niet als een homogene groep kunnen gezien worden (Moht, 2009), vaak intensieve hulpvragen (Hukkanen et al., 1999), en worden ze vaak doorverwezen naar het buitengewoon onderwijs (Long, 1996) of naar andere gespecialiseerde voorzieningen (Eme & Kavanaugh, 1995; Hussey & Guo, 2005).

2. Behandeling en onderwijs in Vlaanderen

In Vlaanderen wordt de zorg voor kinderen en jongeren met gedrags- en emotionele stoornissen onderverdeeld in drie domeinen. Het eerste domein omvat het buitengewoon onderwijs voor kinderen met bijzondere leernoden. Ten tweede is er de jeugdbescherming voor kinderen en jongeren in een problematische opvoedingsituatie. Deze jeugdbescherming is opgesplitst in een sociaal en een juridisch luik. Het derde domein omvat de zorg voor kinderen en jongeren met een handicap.

De verschillende onderzoeken die in dit doctoraatswerk omschreven worden vonden plaats in twee voorzieningen die een aanbod hebben binnen het eerste domein (buitengewoon onderwijs) en binnen het derde domein (zorg voor kinderen en jongeren met een handicap).

2.1. Het buitengewoon onderwijs in Vlaanderen

Het Vlaamse onderwijssysteem biedt buitengewoon onderwijs voor kinderen en jongeren die omwille van een handicap, opvoedingsproblemen of leerproblemen moeilijkheden hebben om les te volgen in het gewoon onderwijs. Op basis van een multidisciplinair onderzoek, opgesteld door het Centrum voor LeerlingenBegeleiding (CLB) kunnen leerlingen toegang krijgen tot één van de acht verschillende types, die alle acht een aanbod hebben voor een specifieke doelgroep.

2.2. Residentiële zorg voor kinderen en jongeren met een handicap

In Vlaanderen wordt de zorg voor personen met een handicap gesubsidieerd door het Vlaams Agentschap voor Personen met een Handicap (VAPH). Het VAPH heeft als kerntaak het promoten van de sociale integratie en participatie van personen met een
handicap, en doet dit onder andere door het verlenen van financiële middelen aan voorzieningen die residentiële zorg aanbieden aan kinderen en jongeren met gedrags- en emotionele problemen.

Op het moment dat de verschillende onderzoeken van dit doctoraatswerk plaatsvonden, werden kinderen en jongeren met gedrags- en emotionele stoornissen toegelaten tot deze zorg op basis van een diagnose. Elke aanvraag werd behandeld door een Provinciale Evaluatiecommissie, die oordeelde over de toelating tot een bepaalde zorgvorm.


Aangezien in de huidige literatuur geen overeenstemming is over wat een goede definitie is van residentiële hulpverlening (Whittaker, 2004), geven we hieronder een beschrijving van de twee verschillende voorzieningen waar de verschillende onderzoeken van dit doctoraat werden uitgevoerd.
### 2.3. Het Provinciaal Instituut Heynsdaele

Op 1 september 1968 opende het Provinciaal Instituut Heynsdaele zijn deuren als opvangcentrum voor jongens met gedragsmoeilijkheden. Een aantal jaren later werd op de campus ook een school voor buitengewoon onderwijs opgericht. Vandaag is Heynsdaele erkend voor de residentiële begeleiding van 70 jongeren met gedrags- en emotionele stoornissen.

In de school volgen leerlingen algemene vakken in kleine klasgroepen van gemiddeld zeven leerlingen. Daarnaast krijgen de leerlingen praktijkonderwijs binnen één van volgende zelfgekozen opleidingen: schilderen en decoratie, bouw, houtbewerking, basismechanica of sanitair. Een team van opvoeders zorgt voor individuele ondersteuning wanneer nodig.

Het residentiële deel van Heynsdaele bestaat uit drie units. Alle nieuwe jongeren starten in de ‘onthaalunit’. Binnen het veilige klimaat van deze unit wordt gekeken welke ondersteuningsnoden de jongere heeft. De doelstelling van de ‘pedagogische unit’ is het aanbieden van specifieke zorg om op die manier maximale ontwikkelingskansen te bieden. De ‘integratie-unit’, die zich buiten de hoofdcampus bevindt, wil de jongeren voorbereiden op een leven na het verblijf in Heynsdaele. Elk van deze drie units bestaat uit meerdere leefgroepen. In elke leefgroep is, onder leiding van een groep-chef, een team van opvoeders verantwoordelijk voor de dagelijkse begeleiding van de jongere. De speciale dienst, die bestaat uit psychologen, maatschappelijk werkers, een verpleegkundige, een psychiater en een orthopedagoog, voorziet specifieke hulp binnen alle units.

### 2.4. Het Orthopedagogisch Centrum Sint-Idesbald


Het residentiële deel van de voorziening bestaat uit drie verschillende clusters, verdeeld op basis van de leeftijd van de jongeren. Binnen elke cluster zijn er verschillende leefgroepen, met telkens 12 tot 14 kinderen of jongeren en een team van opvoeders. Aan elke cluster is een begeleidingsteam verbonden, bestaande uit één of meerdere coördinatoren, maatschappelijk werkers, en orthopedagogen. Overkoepelend bieden een psychiater,
verpleegkundigen en therapeuten hulp waar nodig. In Sint-Idesbald is er ook één besloten leefgroep voor jongeren met zeer ernstige gedragsstoornissen (de zogenaamde GES+-werking), en één interne time-out leefgroep waar jongeren voor een kortere periode (enkele uren) of een langere periode (enkele dagen) kunnen verblijven.

Op de campus zijn twee scholen gevestigd – een school voor buitengewoon lager onderwijs en een school voor buitengewoon secundair onderwijs die verschillende beroepsopleidingen aanbiedt. In beide scholen werken leerkrachten zowel groepsgericht als individueel met leerlingen om op die manier de gepaste zorg te bieden, en is een team van crisismedewerkers aanwezig om te ondersteunen op moeilijke momenten.

3. Conflictshantering: verschillende modellen


Op basis van een uitgebreide literatuurstudie rond modellen voor conflictshantering kunnen we een onderscheid maken tussen drie verschillende categorieën van modellen rond conflictshantering, met elk een eigen focus.

3.1. Modellen met focus op training voor kinderen en jongeren

De eerste categorie bestaat uit modellen waarbij de focus ligt op het aanbieden van training of opleiding voor kinderen en jongeren, vaak onder de vorm van een lespakket. Het meest bekende en meeste verspreide model binnen deze categorie is het ‘Teaching Students to be Peacemakers’ programma, ontwikkeld door Johnson en Johnson. Tussen 1988 en 2000 voerden Johnson en Johnson 16 verschillende onderzoeken uit naar dit model. Op basis van deze 16 studies werd een meta-analyse gepubliceerd waarin besloten werd dat jongeren de procedures om met conflicten om te gaan zoals beschreven in het model effectief leren, kunnen toepassen, kunnen transfereren naar andere settings buiten de klas, en meer oplossingsgericht te werk gaan. Verder bleek het model een positieve invloed te hebben op de schoolprestaties van de leerlingen (Johnson & Johnson, 2002). Een tweede meta-analyse, uitgevoerd door Stevahn en collega’s, had vergelijkbare positieve resultaten (Stevahn et al., 2002)
Een ander model binnen deze categorie is het ‘Conflict Resolution and Peer Mediation Training Program’, waarvan de effectiviteit onderzocht werd door Türnüklü et al. (2009).

### 3.2. Modellen met focus op training voor ouders

Waarschijnlijk het meest bekend model binnen categorie waar ouders training of opleiding rond conflicthantering krijgen is ‘Triple-P’, ofwel ‘Positive Parenting Program’. Het programma werd ontwikkeld om positief opvoeden binnen zorgende relaties te promoten (Sanders et al., 2003), en wordt omschreven als een gedragsmatige familie-interventie (Sanders & McFarland, 2000).


### 3.3. Modellen met focus op training voor professionele hulpverleners


Uit de beschikbare literatuur werd dit laatste model weerhouden om verder te bestuderen. De eerste reden voor deze keuze is de lange traditie van deze methodiek; een tweede keuze heeft te maken met de gerichtheid op kinderen en jongeren met gedrags- en emotionele stoornissen; en een derde reden heeft te maken met veelheid aan onderzoek naar LSCI, zowel in Vlaanderen als in de Verenigde Staten.

De methodiek Life Space Crisis Intervention vindt zijn oorsprong in het werk van Fritz Redl en David Wineman, en werd vanaf de jaren 1990 verder uitgewerkt door Nicholas

De onderzoekstraditie van LSCI begon in de Verenigde Staten in 1981. DeMagistris en Imber gebruikten LSCI bij acht jongeren die omwille van grensoverschrijdend gedrag geplaatst werden in een residentiële setting. Gedurende negen weken werden gegevens verzameld met betrekking tot het gedrag en de schoolprestaties van deze kleine groep jongeren, één van een groep jongeren waarbij LSCI niet gebruikt werd. De resultaten van dit onderzoek toonden aan dat in de LSCI-groep het storend gedrag daalde en de schoolprestaties stegen, terwijl dit niet het geval was in de niet-LSCI-groep (DeMagistris & Imber, 1981).

Enkele jaren later, in 1987, deed Naslund 1441 LSCI-gesprekken bij 28 kinderen van lagere schoollijftijd met gedragsproblemen. Dit onderzoek toonde aan dat de reden voor een LSCI gesprek veranderde doorheen het schooljaar. Terwijl het aantal gesprekken waarbij ‘confrontatie’ de reden was daalde, steeg het aantal gesprekken waarbij ‘sociale vaardigheden’ de reden was (Naslund, 1987).

Een derde Amerikaans onderzoek vond plaats in twee scholen voor buitengewoon onderwijs in New York (Dawson, 2003). In de ene school werden de medewerkers opgeleid in LSCI, en in de andere school niet. In de LSCI-school was er een daling van het aantal conflicten, terwijl in de andere school het aantal conflicten stabiel bleef. Daarnaast waren er in de LSCI-school minder schorsingen, konden er meer leerlingen overschakelen naar het gewoon onderwijs, en werd er minder gespijbeld. Alle personeelsleden van de LSCI-school gaven aan dat ze zich vaardiger voelden in het omgaan met conflicten.

Forthun, McCombie en Freado (2006) onderzochten de impact van LSCI-training op de prestaties van schoolpersoneel, en evalueerden de impact op het gedrag van de leerlingen. De getrainde leerkrachten gaven aan dat LSCI ervoor zorgde dat ze meer tijd namen om te luisteren naar hun leerlingen, en dat ze daardoor e hun problemen beter begrepen. Het gevolg hiervan was dat de leerkrachten minder stress voelden, zich kalmer voelden, gedrag van leerlingen beter konden accepteren, en meer bereid waren om de leerlingen te bevragen over incidenten. Leerlingen apperceverden deze bereidheid, wat dan weer een positief gevolg had voor de voldoening van de leerkrachten. De onderzoekers concluderen dat er een verandering plaats vond van een klimaat van controle en straf naar een klimaat van samenwerking, verantwoordelijkheid en proactieve discipline.

In het kader van haar doctoraatsproefschrift onderzocht White-McMahon (2009) de percepties van leerkrachten op de invloed van LSCI op de sociaal-emotionele ontwikkeling.
van leerlingen met gedragsproblemen. Uit de resultaten van dit onderzoek blijkt dat de scores voor sociaal-emotionele ontwikkeling van de leerlingen verbeterden, waardoor leerlingen beter functioneren op school en in de maatschappij.

De Vlaamse onderzoekstraditie rond LSCI ging van start in het begin van het vorig decennium. In het kader van zijn doctoraatsonderzoek startte Franky D’Oosterlinck een samenwerking tussen een zestal Oost-Vlaamse voorzieningen om na te gaan in welke mate LSCI kan bijdragen tot de behandeling. Uit dit doctoraatswerk resulteerden drie deelonderzoeken. Voor het eerste onderzoek werden bij een honderdtal jongeren uit deze zes voorzieningen gegevens verzameld op basis van vijf vragenlijsten. Na deze eerste dataverzameling werden medewerkers van deze voorzieningen getraind in LSCI. Op die manier ontschouwde Franky D’Oosterlinck een groep van jongeren waarbij LSCI wel gebruikt werd (de experimentele groep) en een groep jongeren waarbij LSCI niet gebruikt werd (de controle groep). Na elf maanden werden bij deze twee groepen opnieuw gegevens verzameld op basis van de vijf vragenlijsten. De resultaten tonen aan dat, zowel bij de controlegroep als bij de experimentele groep, de emoties en het gedrag stabiel blijven. Bij beide groepen hadden jongeren een negatiewere perceptie op hun atletische competenties. Verder blijkt uit de resultaten een positief effect op directe agressie en op vijandigheid bij de experimentele groep. Daarnaast was er een licht positieve trend met betrekking tot angstige coping, schadevermijdend gedrag, separatieangst en totale angst. Op basis van deze gegevens concludeerden de onderzoekers dat het implementeren van LSCI positief bijdraagt tot de behandeling van kinderen en jongeren met gedrags- en emotionele stoornissen (D’Oosterlinck et al., 2008).

In het tweede onderzoek lag de focus op hoe de personeelsleden die getraind werden in LSCI de implementatie evalueerden. De resultaten tonen aan dat medewerkers vonden dat hun kennis en vaardigheden met betrekking tot omgaan met conflicten verbeterd waren. Langs de andere kant gaven de medewerkers aan dat er voldoende tijd en mensen moeten zijn om LSCI toe te passen, en dat coaching een werkpunt is naar de verdere implementatie toe. Na een jaar toepassing geloofde de meerderheid in de toepassing van LSCI en in de zinvolheid van de training (D’Oosterlinck et al., 2009).

In het derde onderzoek van dit doctoraatswerk werden de jongeren zelf centraal gesteld, en werd nagegaan hoe de jongeren kijken naar conflicten en naar de manier waarop met deze conflicten wordt omgegaan door de LSCI-getrainde begeleiders. De belangrijkste conclusie van het onderzoek is dat LSCI helpt om destructieve en pijnlijke gedachten en gevoelens te verminderen, én de jongere helpt om een meer positieve kijk te krijgen op hun eigen rol in het conflict (D’Oosterlinck, Broekaert & Denoo, 2006).
4. Doelen

Met dit onderzoek willen we verder bouwen op de onderzoekstraditie van LSCI zoals hierboven beschreven. Enerzijds is het de bedoeling van dit doctoraatswerk om informatie te verzamelen over de kinderen en jongeren die les krijgen in het buitengewoon onderwijs en / of zorg krijgen in een residentiële voorziening erkend door het Vlaams Agentschap voor Personen met een Handicap. Anderzijds is het de bedoeling om na te gaan wat de bijdrage is van een methodiek voor conflictstantering zoals LSCI aan de behandeling van deze kinderen en jongeren.

De algemene onderzoeksdoelstellingen worden als volgt geformuleerd:

- In kaart brengen van de karakteristieken van kinderen en jongeren met gedrags- en emotionele stoornissen in de Vlaamse zorg en onderwijs
- Onderzoeken van het proces van implementatie van conflictstanteringmethodeken in Vlaamse voorzieningen voor kinderen en jongeren met gedrags- en emotionele stoornissen

Deze doelstellingen worden opgesplitst in vijf verschillende onderzoeksvragen:

- Wat zijn de karakteristieken / problemen van kinderen en jongeren met gedrags- en emotionele stoornissen?
- Wat zijn de percepties van de verschillende stakeholders (opvoeders, leerkrachten en jongeren) op deze karakteristieken / problemen?
- Wat zijn de ervaringen en noden van zowel jongeren als hulpverleners op gebied van de behandeling van deze problemen?
- Wat zijn de effecten van de implementatie van LSCI op de problemen en op het gedrag van de kinderen en jongeren?
- Hoe reflecteren de verschillende stakeholders op het proces van implementatie van LSCI?

5. Methodologie en resultaten van de verschillende onderzoeken

Om een antwoord te bieden op bovenstaande onderzoeksvragen werden in totaal zeven verschillende onderzoeken uitgevoerd. De eerste twee onderzoeken vonden plaats in het Provinciaal Instituut Heynsdaele. Gezien het relatief kleinschalig karakter van deze voorziening kunnen deze twee onderzoeken gezien worden als pilootstudies. Op basis van
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dezelfde pilootstudies werden de volgende vijf, meer uitgebreide onderzoeken, uitgevoerd in het Orthopedagogisch Centrum Sint-Idesbald.

5.1. Effecten van de implementatie van LSCI in het Pedagogisch Instituut Heynsdaele – een school en tehuis voor jongeren met gedrags- en emotionele stoornissen (Soenen et al., 2009)

Van 2005 tot 2008 liep het project ‘Heyndaele’, een samenwerking tussen de provincie Oost-Vlaanderen, het Provinciaal Instituut Heyndaele, en het OOBC Nieuwe Vaart. Het was de bedoeling van dit project om, door het implementeren van de geschikte methodieken, een antwoord te kunnen bieden op de noden van de jongeren in het Provinciaal Instituut Heyndsaele.

In een eerste fase van het project werden de probleemgebieden in Heyndaele geïnventariseerd. Hiervoor werden in totaal 41 interviews uitgevoerd, waarvan 22 met medewerkers en 19 met jongeren van Heyndaele. Uit deze interviews konden drie verschillende probleemgebieden worden gedestilleerd. Een eerste probleemgebied betrof ‘agressie’, zowel het agressief gedrag van de jongeren als de moeilijkheden van medewerkers om met deze agressie om te gaan. Een tweede probleemgebied betrof het druggebruik van de jongeren, en een derde probleemgebied betrof het spijbelgedrag van de jongeren en de onmacht die medewerkers hierrond ervoeren.

In een poging om een oplossing te bieden voor deze probleemgebieden werden twee methodieken geïmplementeerd in de dagelijkse werking van Heyndaele. De eerste methodiek is Life Space Crisis Intervention, een verbale methodiek rond conflictantering. Ten tweede werd het gedragsstappenplan geïmplementeerd, dit is een zelfontwikkelde methodiek met als bedoeling het stellen van grenzen aan negatief gedrag, het belonen van positief gedrag, en het detecteren van vastgelopen situaties.

Aan dit implementatieproces werd dan ook een effectonderzoek gekoppeld. Allereerst was het de bedoeling om te kijken of de doelgroep in Heynsdaele stabiel bleef doorheen de drie jaar van het project. Hiervoor werd jaarlijks een Child Behaviour Checklist (CBCL) ingevuld door de opvoeders, een Teacher Report Form (TRF) door de leerkrachten, en een Youth Self Report (YSR) door de jongere zelf. Vervolgens werden zowel voor de implementatie als op het einde van het project gegevens verzameld met betrekking tot de schoolresultaten van de jongeren, het aantal conflicten, het aantal signalisatie-momenten (i.e. momenten waarbij door het gedrag van de jongere de dagelijkse werking verstoord werd), en het spijbelgedrag van de jongeren.
Zowel op de subschalen als op de breedbandschalen van de CBCL, TRF en YSR zijn er geen significante verschillen doorheen de drie jaren, wat wijst op een stabiliteit van het probleemgedrag van de doelgroep in Heynsdaele. Wat betreft de schoolresultaten was er een significante stijging voor ‘algemene vakken’. Deze bevinding wijst erop dat, alhoewel schoolprestaties niet de primaire focus zijn van een conflictanteringsmethodiek, investeren in een dergelijke methodiek een positieve invloed heeft op de schoolresultaten van de jongeren. Het feit dat ook het aantal spijbeluren significant daalde kan hiervoor een verklaring zijn. Verder was er ook een significante daling zowel van het aantal conflicten als van het aantal signalisatiemomenten. Dawson (2003), die een effectonderzoek rond LSCI opzette in twee New Yorkse scholen, vond vergelijkbare resultaten.

Rekening houdende met het relatief kleine aantal proefpersonen en met het feit dat er geen controle groep was, kan uit dit piloot-onderzoek geconcludeerd worden dat de implementatie van LSCI leidt tot een daling van storend gedrag en een stijging van schoolresultaten.

5.2. Reflecties van medewerkers op het proces van implementatie van LSCI (Soenen et al., 2013)

Terwijl het in het vorig onderzoek de bedoeling was om aan de hand van meetbare variabelen op zoek te gaan naar de effecten van de implementatie van LSCI, was het in dit onderzoek de bedoeling om de reflecties van medewerkers rond dit implementatieproces in Heyndaele te onderzoeken. Hiertoe werden op het einde van het project 22 at random gekozen medewerkers bevraagd.

Aan de hand van de analyse van deze semi-gestructureerde individuele interviews konden we een boomstructuur opstellen met de belangrijkste thema’s. In een eerste thema ‘takenpakket en job-inhoud’ werd de nadruk gelegd op de verschillende opdrachten die opvoeders (begeleiden van jongeren in dagelijkse werking) en leerkrachten (kennisoverdracht) hebben. Alle medewerkers vermelden de grote werkdruk die ze ervaren. In het tweede thema spraken medewerkers over de jongeren die ze begeleiden. Ondanks de complexe problematieken, gaven medewerkers aan dat de jongeren minder storend gedrag stellen, en dat ze meer bereid waren om met begeleiders in gesprek te gaan. Het derde thema behandelde hoe medewerkers omgaan met de jongeren. Alhoewel dit werk nog steeds als zeer moeilijk werd aanschouwd, hadden de medewerkers het gevoel dat ze zelf vaardiger waren geworden in het omgaan met probleemgedrag. Samen met een grotere algemene structuur en duidelijkheid in de dagelijkse werking zorgde dit voor een beter
klimaat in de organisatie. Naar de toekomst toe willen opvoeders, leerkrachten en middenkader een beter evenwicht vinden tussen het individueel werken met jongeren en het groepsgericht werken.

Het vierde en laatste thema omhelsde de communicatie en samenwerking binnen de organisatie. Vooral de gebrekkige communicatie en samenwerking tussen de school en het tehuis werd tijdens de interviews vaak benadrukt. Alhoewel er nog steeds ruimte voor verbetering is, geven medewerkers ook aan dat sinds het implementatieproces er veel verbeterd is op vlak van communicatie en samenwerking. Zo ervaren medewerkers de communicatie als meer systematisch en gestructureerd, en het nemen van beslissingen meer gedeeld dan vroeger. Doordat iedereen nu dezelfde methodieken gebruikt in het werken met de jongeren spreekt men een ‘gemeenschappelijke taal’, wat de onderlinge samenwerking heeft bevorderd.

Het kan geconcludeerd worden dat het werken met jongeren met gedrags- en emotionele stoornissen binnen de context van buitengewoon onderwijs of residentiële hulpverlening een moeilijk opdracht blijft, maar dat medewerkers niet meer het gevoel hebben dat ‘niets werkt’ bij deze jongeren. Door methodisch aan de slag te gaan blijken, net zoals bij onderzoek van Dawson (2003), opvoeders en leerkrachten een herwonnen professioneel zelfvertrouwen in hun dagelijks werk. Samen met anderen zijn we ervan overtuigd dat deze resultaten een positieve invloed hebben op de relatie tussen jongere en hulpverlener (Forthun, McCombie & Freado, 2006) en op de voldoening die medewerkers bij hun job ervaren (Stalker et al., 2007).

Om deze positieve evoluties aan te houden pleiten de medewerkers niet alleen voor het constant evalueren van het implementatieproces, maar vooral voor intensieve coaching rond de toepassing van LSCI in de dagelijkse werking.

5.3. Probleemgedrag in de Vlaamse voorzieningen voor jongeren met GES: opvoeders, leerkrachten en jongeren als informant (Soenen et al., 2011)

Dit onderzoek werd uitgevoerd bij de aanvang van het LSCI-project in het Orthopedagogisch Centrum Sint-Idesbald, en had een tweeledige doelstelling. Ten eerste was het de bedoeling om een zicht te krijgen op de karakteristieken van kinderen en jongeren die buitengewoon onderwijs volgen en / of verblijven in de residentiële hulpverlening voor kinderen en jongeren met GES. Vervolgens was het de bedoeling om te kijken of er, op basis van informatie verkregen van verschillende stakeholders, specifieke gedragsprofielen konden opgesteld worden.
Naast het verzamelen van demografische gegevens zoals geslacht en leeftijd werden drie verschillende vragenlijsten ingevuld. Opvoeders vulden de CBCL in, leerkrachten de TRF en jongeren de YSR.

De steekproef (n=434) kende een verhouding jongens – meisjes van vier op één, met een gemiddelde leeftijd van 13.35 jaar en een gemiddeld IQ van 77.12. Deze relatief lage intelligentie-scores kunnen verklaard worden door de historiek van de voorziening, die vroeger vooral werkte met kinderen en jongeren met een licht mentale beperking. Over het algemeen hadden meisjes op de drie vragenlijsten hogere scores voor internaliserende probleemgebieden dan jongens, terwijl er voor de externaliserende probleemgebieden geen significante verschillen werden gevonden. Deze resultaten zijn in overeenstemming met verschillende andere onderzoeken (bv Handwerk & Marshall, 1998; Slobodskaya, 1999; Sohn, 2003; Wasserman et al., 2005).

Vervolgens werden op basis van de CBCL-, TRF-, en YSR-scores, aan de hand van correlatietafellen (Pearson’s correlatiecoëfficiënt), drie gedragsprofielen gecreëerd. Zowel voor de opvoeders (CBCL) als voor de leerkrachten (TRF) bleken externaliserend probleemgedrag en aandachtsproblemen de meest kenmerkende problemen te zijn. Voor de jongeren zelf daarentegen bleken internaliserende problemen en denkproblemen meest kenmerkend te zijn. Deze discrepantie wordt bevestigd in andere onderzoek (bv Andrae, Lenz, & Lohaus, 2009; Grietens et al., 2004; Hawley & Weisz, 2003; McConaughy, Mattison, & Peterson, 1994; Salbach-Andrae et al., 2009; Stanger & Lewis, 1993; Youngstrom, Loeber, & Stouthamer-Loeber, 2000), en kan verklaard worden doordat externaliserend probleemgedrag meer zichtbaar is voor begeleiders (Mesman & Koot, 2000; McConaughy & Skiba, 1993) en doordat internaliserend probleemgedrag voor de jongeren zelf meest impact heeft (Karver, 2006).

Alhoewel deze discrepanties een hinderpaal kunnen vormen voor de begeleiding en behandeling (De Los Reyes & Kazdin, 2005; Hawley & Weisz, 2003; Yeh & Weisz, 2001), mag dit niet evolueren in een discussie over wie het bij het rechte eind heeft. We zijn van mening dat de verschillen tussen de stakeholders niet per se een verstoorde waarneming impliceren, maar de complexiteit van de problematieken van de jongeren reflecteren, en hoe deze problematieken tot uiting komen en ervaren worden in de verschillende contexten.

Op basis van deze resultaten willen we pleiten voor het werken met kleinere klas- en leefgroepen, waar hulpverleners en jongeren in een veilig en handelingsgericht klimaat methodisch kunnen interageren, om zo tot een beter begrip te komen van de te behandelen problematieken.
5.4. Angst bij kinderen en jongeren in de Vlaamse zorg (Soenen, D’Oosterlinck, & Broekaert, accepted)

Uit het vorige onderzoek was gebleken dat er een discrepantie bestaat tussen de percepties van opvoeders, leerkrachten en jongeren, in het bijzonder betreffende de internaliserende problematieken van de jongeren. Om die reden was het de bedoeling van dit vierde onderzoek om dieper in te gaan op de aanwezigheid en kenmerken van angst bij de kinderen en jongeren in het OC Sint-Idesbald.

Als aanvulling op de reeds ingevulde CBCL, TRF en YSR, werd aan de kinderen en jongeren gevraagd om ook de Screen for Anxiety and Related Emotional Disorders (SCARED) in te vullen, een angstvragenlijst die symptomen van het volledige spectrum van angststoornissen zoals beschreven in de DSM-IV meet. In totaal werd de SCARED ingevuld door 247 kinderen en jongeren, waarvan 181 jongens en 66 meisjes.

Een analyse van de data wijst op een duidelijke aanwezigheid van angst bij de jongeren in de steekproef, vooral wat betreft ‘situationele fobie’, ‘posttraumatische stressstoornis’, en ‘sociale fobie’. In overeenstemming met de literatuur (bv Bodden, Bögels & Muris, 2009; Boyd et al., 2003; Connor et al., 2004; Crocetti et al., 2009; Doerfler, Toscano & Connor, 2009; Hale et al., 2005; Muris et al., 2004; Muris, Schmidt & Merckelbach, 2000; Simon & Bögels, 2009; Sohn, 2003; Su et al., 2007; Tambelli et al., 2012; Wasserman et al., 2005) hebben meisjes gemiddeld hogere angstscores dan jongens. Verder blijkt dat jongeren in een intensievere zorgvorm (residentieel) hogere angstscores hebben dan jongeren die enkel buitengewoon onderwijs volgen. Deze bevinding is op zich niet verrassend, maar doet de vraag rijzen of jongeren met ernstigere angstproblematieken intensievere zorg krijgen, of dat een intensieve zorgvorm zoals een internaat net een oorzaak is van angstproblematieken.

Verder was er een duidelijke correlatie tussen de scores op de SCARED en de scores op de internaliserende schalen van de YSR, maar niet met de internaliserende schalen van de CBCL en de TRF. Net zoals bij ons vorig onderzoek wijst dit erop dat het voor hulpverleners moeilijk is om de internaliserende problematieken van kinderen en jongeren te detecteren. Vervolgens werden sterke correlaties gevonden tussen de scores op de SCARED en de scores op de subschaal ‘sociale problemen’, van zowel de YSR als van de CBCL, wat er op zou kunnen wijzen dat jongeren hun angstproblematieken uiten aan de hand van sociaal onaangepast gedrag. Tenslotte werden sterke correlaties gevonden tussen de scores op de SCARED en de scores van de YSR-subscachaal ‘denkproblemen’, terwijl deze correlaties afwezig waren bij de subschaal ‘denkproblemen’ van de CBCL en TRF. Net zoals in het onderzoek van Beers & De Bellis (2002) blijkt hieruit dat er een verband is tussen angst en cognitieve problemen, maar ook dat dit verband niet gezien wordt door de
hulpverleners. Op basis van deze laatste bevinding pleiten we voor interventie- en behandelingsmodellen die niet alleen focussen op gedrag en/of sociale vaardigheden, maar ook op het cognitief functioneren van kinderen en jongeren.

5.5. Het implementeren van methodieken in zorgvoorzieningen: een proces-model
(Soenen, D’Oosterlinck & Broekaert, 2014)

Het wordt algemeen aangenomen dat er binnen het werken met kinderen en gedrags- en emotionele stoornissen een nood is om aan de slag te gaan met methodieken die een antwoord kunnen bieden op de noden van deze doelgroep (Baker et al., 2007; George & Fogt, 2005; Knorth et al., 2008; Moses, 2000; Pazaratz, 2000; Tiesman et al., 2013; White-McMahon, 2009), in het bijzonder in het omgaan met conflicten (D’Oosterlinck et al., 2009). Tot op vandaag is het onderzoek naar hoe dergelijke methodieken geïmplementeerd kunnen worden beperkt. Uitzonderingen hierop zijn het onderzoek naar het ‘Sanctuary Model of Residential treatment’ (Abramovitz & Bloom, 2003; Bloom et al., 2003; Rivard et al., 2003), het onderzoek naar ‘readiness for change’ (Lehman, 2011; Lehman, Greener & Simpson, 2002), en het implementatie-onderzoek van Aarons en collega’s (Aarons & Palinkas, 2007; Aarons & Sawitzky, 2006).

Het was de bedoeling van deze studie om te onderzoeken wat kritische factoren zijn in het proces van implementatie van methodisch werken in een Vlaamse voorziening voor kinderen en jongeren met gedrags- en emotionele stoornissen. Hiervoor werd gebruik gemaakt van een kwalitatief onderzoeksopzet, waarbij 50 medewerkers van Sint-Idesbald individueel bevraagd werden met betrekking tot hun kijk op de noden van de jongeren, hun ideeën om een antwoord te bieden op deze noden, en hun suggesties rond kritische factoren die belangrijk zijn in het implementatieproces.

Door middel van een ‘grounded theory approach’ resulteerde de analyse van deze interviews in een model met vier hoofdthema’s die van belang zijn bij het implementeren van methodieken. Het eerste thema had betrekking op de visie die de organisatie heeft op het werken met deze doelgroep. Uit de analyses bleek dat deze visie het fundament dient te zijn voor het dagelijks handelen, en dat de historiek van de voorziening bepalend is voor de visie. Het tweede thema betrof het samenwerken met collega’s, zowel binnen de eigen dienst als met andere diensten, om zo tot een gemeenschappelijke aanpak van probleemgedrag te komen. In de individuele gesprekken werden verschillende redenen gegeven, zoals onevenwicht tussen formele en informele communicatie of verschil in visie van de diensten, waarom deze samenwerking niet altijd evident is. Daarnaast werden open communicatie, een juiste ingesteldheid en duidelijk afspraken als basisvoorwaarden voor een goede samenwerking genoemd. Het derde thema had te maken met het eigenlijke
werken met de kinderen en jongeren. Binnen dit thema hadden de geïnterviewden het vooral over het gebrek aan kennis en vaardigheden om met de moeilijke problematieken van de doelgroep om te gaan. Hierbij werd een nood aan vorming geuit, niet alleen rond theoretische kaders maar vooral rond praktisch toepasbare handvatten voor het dagelijks handelen. Verder bleken in dit thema drie spanningsvelden tussen medewerkers aanwezig te zijn: (1) spanning tussen de aanpak van leerkrachten, die gericht is op overdragen van kennis en vaardigheden, en de aanpak van opvoeders, die eerder behandelingssgericht is; (2) spanning tussen een controlerende aanpak op basis van een machtsverhouding, en een aanpak gebaseerd op een positieve relaties tussen jongere en hulpverlener; en (3) spanning tussen het individueel werken met jongeren en het werken met de groep. Het vierde en laatste thema omvatte basisvoorwaarden waaraan voldaan moet worden om het implementatie-proces te doen slagen. De drie subthema’s die hierbij genoemd werden zijn: een aangepaste infrastructuur, voldoende materiële en financiële middelen, en voldoende coaching en ondersteuning in de dagelijkse praktijk.

Uit dit onderzoek blijkt dat een geslaagde implementatie meer omhelst dan enkel een opleiding voor medewerkers. Ten eerste moeten de visie van de organisatie, van de medewerkers, én van de methodiek in kaart gebracht worden en op elkaar af er een gestemd worden. Daarnaast moet de organisatie aandacht besteden aan de verschillende vormen van communicatie, en op die manier de juiste kanalen creëren opdat medewerkers hun meningen kunnen uiten. Vervolgens zal aan de vermelde randvoorwaarden, zoals een degelijke coaching en ondersteuning, moeten voldaan worden.

De complexiteit van het proces-model zoals beschreven in dit onderzoek suggereert dat het proces van implementatie nooit een eenvoudig proces zal zijn, en dat onverwachte problemen op onverwachte gebieden zich steeds kunnen voordoen. Alhoewel ons model een handvat kan bieden bij het implementeren van bepaalde methodieken, zal een organisatie zichzelf nooit helemaal kunnen voorbereiden om te anticiperen op alle obstakels die eigen zijn aan een dergelijk proces.

5.6. Jongeren aan het woord: ideeën over werkzame elementen van de behandeling (Soenen, D’Oosterlinck & Broekaert, 2013)

Terwijl in het vorige onderzoek de percepties van de medewerkers centraal stonden, wilden we in dit onderzoek vertrekken vanuit de beleving van de kinderen en jongeren die in OC Sint-Idesbald verblijven of naar school gaan. Hierbij stelden we ons twee vragen: (1) hoe kijken de jongeren naar hun eigen gedrag en naar het gedrag van de andere kinderen en jongeren? en (2) wat zijn volgens de jongeren werkzame elementen in de behandeling en begeleiding die ze krijgen? Om een antwoord te formuleren op deze onderzoeksvragen
werd gebruik gemaakt van een kwalitatief onderzoeksopzet waarbij 50 jonzeren at random gekozen en individueel geïnterviewd werden.

In de interviews spreken de jongeren over een range aan negatief gedrag, gaande van ongehoorzaamheid tot fysieke agressie. Dit gedrag blijkt zich vooral voor te doen op plaatsen en tijdstippen met weinig toezicht van volwassenen, zoals op de speelplaats. De jongeren hebben het in de interviews over een negatief klimaat, gekenmerkt door spanning en agressie, waardoor ze het gevoel hebben steeds op hun hoede te moeten zijn. Deze gespannen sfeer in de klas of leefgroep werkt volgens de jongeren agressie in de hand. Daarnaast geven jongeren ook aan dat de problemen die jongeren thuis ervaren, zoals armoede, geweld of mishandeling, ervoor zorgen dat ze zich slecht in hun vel voelen en zich agressief gedragen.

Als een antwoord op de tweede onderzoeksvraag geven de kinderen en jongeren vier thema’s van werkzame elementen aan. Het eerste thema gaat over de beschikbaarheid van volwassenen, niet alleen om te helpen met bijvoorbeeld huiswerk, maar vooral om te praten wanneer er problemen zijn. Vertrouwen in de volwassene en het besef dat de volwassene de jongere begrijpt zijn hierbij cruciale elementen. Ten tweede hebben de jongeren het over de nabijheid van volwassenen. Hierbij gaat nabijheid over het belang van volwassenen in de onmiddellijke leefomgeving van het kind, om samen leuke dingen te kunnen doen, maar ook om volwassenen die voldoende toezicht houden om op die manier veiligheid te creëren. Het derde thema gaat over duidelijke regels en grenzen, die gelden voor iedereen en rechtvaardig worden toegepast. Een vierde werkzaam element volgens de jongeren is de mogelijkheid om zich even af te zonderen van de groep, zowel na conflicten (bijvoorbeeld time-out ruimte) als in de dagelijkse realiteit (bijvoorbeeld even naar de eigen kamer kunnen gaan).

Tijdens de interviews spraken de kinderen en jongeren ook over zaken die ze zelf als contraproductief ervaren. Een eerste element heeft te maken met opvoeders of leerkrachten die te streng zijn en met afspraken die volgens de jongeren nutteloos zijn. Op zich hebben jongeren geen moeite met straf, maar wel met straf die volgens hen onrechtvaardig is, bijvoorbeeld wanneer de volledige groep wordt gestraft omdat één jongere iets verkeerd doet. Wat jongeren ook als contraproductief ervaren is wanneer volwassenen niet naar hen willen luisteren, in het bijzonder naar aanleiding van conflicten. Ten derde hebben jongeren het over ongepast gedrag van begeleiders, zoals het constant negatief spreken over jongeren of een agressieve begeleidingsstijl.

Een eerste belangrijke conclusie uit dit onderzoek is het belang dat jongeren hechten aan een goede relatie met de hulpverlener als een voorwaarde voor succes in de behandeling. Dit idee kan ook worden teruggevonden in ander onderzoek binnen een residentiële setting.
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(D’Oosterlinck, 2006; Moses, 2000), binnen de setting van gewoon onderwijs (Hamre & Pianta, 2001), binnen het domein van de kinderpsychiatrie (Perry, 2009), en meer algemeen binnen de onderzoekslijn naar de ‘therapeutic alliance’ (Manso, 2008; Rauktis, 2005). Een tweede conclusie heeft betrekking op het belang van communicatie tussen cliënt en hulpverlener, zowel in het dagelijks leven als naar aanleiding van conflicten. Ten laatste kunnen we concluderen dat dit alles dient te gebeuren in een veilig klimaat, met duidelijke en rechtvaardige regels en grenzen.

5.7. Implementatie van LSCI in residentiële zorg en buitengewoon onderwijs: een effect-studie (Soenen, D’Oosterlinck & Broekaert, 2014)

Met dit onderzoek wilden we nagaan wat de effecten zijn van de implementatie van LSCI op de probleemgebieden van de kinderen en jongeren die in het OC Sint-Idesbald verblijven of buitengewoon onderwijs volgen. Hiervoor werden over een periode van vier jaar de medewerkers van de voorziening opgeleid in LSCI en werden jaarlijks verschillende kwantitatieve gegevens verzameld.

Het onderzoek vond plaats binnen de verschillende diensten die het OC Sint-Idesbald aanbiedt voor kinderen en jongeren met gedrags- en emotionele stoornissen. Concreet gaat dit over de lagere school voor buitengewoon onderwijs (type 1 en type 3), de secundaire school voor buitengewoon onderwijs (type 1 en type 3) en het internaat. In totaal waren 403 jongeren betrokken in het onderzoek, waarvan 71.80% jongens en 28.20% meisjes. Van deze jongeren verbleef 45.80% in het internaat, meestal in combinatie met buitengewoon onderwijs, en volgde 54.20% enkel onderwijs op de campus. De gemiddelde leeftijd was 13.55, en het gemiddeld IQ was 76.16. De gemiddelde verblijfsduur was 29.94 maanden. Jongeren die ook op internaat zaten waren jonger (12.45 jaar) en hadden een langere verblijfsduur (36.63 maanden) dan jongeren die enkel het buitengewoon onderwijs volgden (14.45 jaar oud en 25.80 maanden verblijfsduur).


Een eerste bevinding was dat de gemiddelde verblijfsduur langer was geworden. Een mogelijk verklaring hiervoor kan liggen in het gegeven dat hulpverleners zich sterker voelen door een herwonnen professioneel zelfvertrouwen, wat resulteert in een beter
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klimaat. Hierdoor geven hulpverleners jongeren minder snel op én voelen jongeren zich beter in de voorziening, wat resulteert in een langere verblijfsduur.

Verder werd een positief effect gevonden op de schoolresultaten van de jongeren. Het kan aangenomen worden dat LSCI zorgt voor een betere relatie tussen jongere en leerkracht, wat resulteert in betere schoolpunten (Hamre & Pianta, 2001; Quinn et al., 2006).

Op de CBCL, TRF en YSR werden weinig tot geen effect gevonden. Dit is niet verrassend, aangezien deze vragenlijsten zeer stabiel blijken te zijn (Achenbach, Dumenci, & Rescorla, 2002; Biederman et al., 2001), en aangezien de doelgroep van ons onderzoek bijna onveranderbaar is (De Bolle et al., 2009; Lipsey, 1992). Een uitzondering hierop betreft de stijging die werd gevonden op de subschaal ‘angst’ van de CBCL. Een verklaring hiervoor kan zijn dat opvoeders door de implementatie van LSCI een beter zicht hebben gekregen op de internaliserende problematiek van de jongeren.

Tenslotte bleek dat de angstscores zoals gemeten aan de hand van de SCARED significant gedaald waren op bijna alle subschalen. Uit ons vorig onderzoek (Soenen et al., 2013) weten we dat implementatie van LSCI leidt tot een beter klimaat in de voorziening. We kunnen dan ook aanvaarden dat dit verbeterde klimaat, in combinatie met een betere relatie tussen jongeren en hulpverlener heeft geleid tot een groter gevoel van veiligheid bij de jongeren, en dus tot minder angst.

Concluderend kan gesteld worden dat de implementatie van LSCI in residentiële zorg en buitengewoon onderwijs heeft geleid tot een langere verblijfsduur, een stijging van schoolresultaten, en een daling van angst, en op die manier bijdraagt tot de behandeling en begeleiding van kinderen en jongeren met gedrags- en emotionele stoornissen.

6. Besluit

6.1. Algemene conclusies

6.1.1. Conclusie betreffende karakteristieken van kinderen en jongeren met GES

Uit de resultaten van de verschillende onderzoeken kan geconcludeerd worden dat kinderen en jongeren in het buitengewoon onderwijs en/of residentiële hulpverlening in Vlaanderen met complexe problematieken kampen. De kijk op deze problematieken verschilt naargelang de informant. Het gedragsprofiel dat werd gecreëerd op basis van de zelfrapportage van de kinderen en jongeren wijst vooral op een grote internaliserende problematiek, zonder het externaliserend probleemgedrag te willen ontkennen. Daarnaast blijkt er een correlatie te zijn tussen aanwezige angsten bij de jongeren en cognitieve problemen.
Aan de hand van het gedragsprofiel dat werd gecreëerd op basis van vragenlijsten die door opvoeders en leerkrachten werden ingevuld stellen we vast dat het externaliserend probleemgedrag primeert.

Uit deze resultaten besluiten we dat de verschillen tussen de stakeholders niet per se een verstoorde waarneming impliceren, maar de complexiteit van de problematieken van de jongeren reflecteren, en hoe deze problematieken tot uiting komen en ervaren worden in de verschillende contexten. Deze bevinding laat ons toe te stellen dat er in het Vlaams buitengewoon onderwijs en de Vlaamse residentiële hulpverlening nod is aan het implementeren van methodieken, specifiek rond omgaan met conflicten en moeilijke situaties, die niet alleen een focus leggen op het gedrag van de kinderen en jongeren, maar ook op hun denken en voelen.

6.1.2. Conclusies betreffende noden en ervaringen van verschillende stakeholders

Een uitgebreide bevraging bij kinderen en jongeren toont aan dat zij sterke ideeën hebben over wat voor hen belangrijke werkzame elementen van de behandeling en begeleiding zijn. Als conclusie kan gesteld worden dat, in overeenstemming met onderzoek binnen andere settings (D’Oosterlinck, 2006; Hamre & Pianta, 2001 Manso, 2008; Moses, 2000; Perry, 2009; Rauktis, 2005), jongeren nod hebben aan een goede relatie met hun hulpverleners, die de mogelijkheid creëert tot communicatie binnen een veilig klimaat met duidelijke regels en grenzen.

Om te komen tot een hulpverleningsaanbod bestaande uit methodieken die een antwoord bieden op de noden van de kinderen en jongeren zal een voorziening rekening moeten houden met een aantal cruciale elementen die door medewerkers worden aangereikt. In eerste instantie dient het beleid van een voorziening ervoor te zorgen dat de visie van de voorziening, de visies van de medewerkers en de visie achter de methodieken op elkaar worden afgestemd. Ten tweede moet aandacht besteed worden aan formele en informele communicatie, opdat medewerkers op een veilig manier hun mening kunnen uiten. Tot slot zal een doordacht plan nodig zijn rond hoe medewerkers gecoacht kunnen worden in de toepassing van de methodieken.

6.1.3. Conclusies betreffende LSCI als methodiek voor conflicthantering

Uit het pilootonderzoek rond de implementatie van LSCI bleek dat LSCI positieve effecten had op het gedrag van de jongeren, ervoor zorgde dat medewerkers minder dan voorheen het gevoel hadden dat ‘niets werkt’ met deze jongeren en op die manier een herwonnen professioneel zelfvertrouwen hadden, en resulteerde in een gemeenschappelijke aanpak. Uit
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deze onderzoeken kunnen we concluderen dat problemen zich steeds zullen voordoen in het werken met kinderen en jongeren met GES, maar dat het klimaat in de voorziening positiever was geworden.

In het volgende, meer grootschalig onderzoek, naar de effecten van de implementatie van LSCI konden de resultaten van het pilootonderzoek bevestigd worden. Sinds de implementatie van LSCI slaagde de voorziening erin om gemiddeld langer met de jongeren te werken, stegen de schoolresultaten van de jongeren, en was er een significante daling van de aanwezige angsten bij de kinderen en jongeren.

Uit deze resultaten kan geconcludeerd worden dat de implementatie van LSCI leidt tot een verbeterde relatie tussen de jongere en de hulpverlener, tot een positiever klimaat binnen de organisatie, en tot minder probleemgedrag bij de jongeren; en dus bijdraagt tot de behandeling en begeleiding van kinderen en jongeren met GES in het buitengewoon onderwijs en / of de residentiële hulpverlening.

6.2. Aanbevelingen

6.2.1. Aanbevelingen op vlak van orthopedagogisch handelen
Gezien de complexiteit van de problematieken én gezien de discrepantie tussen de percepties van de verschillende stakeholders op deze problematieken moet er meer aandacht besteed worden aan de gevoelens en gedachten van de jongeren, en hoe deze gerelateerd zijn aan hun gedrag. Om dit te bereiken zijn er meer middelen nodig om individueel aan de slag te gaan met jongeren binnen de context van een klasgroep of leefgroep. Verder is er nood aan onderbouwde methodieken waarbij relatie en communicatie centraal staan, specifiek rond conflictantering. Om de implementatie van deze methodieken in de klasgroepen en leefgroepen tot een goed einde te brengen zullen opvoeders en leerkrachten voldoende gecoacht moeten worden. Naast conflictanteringmethodieken die gericht zijn op het opleiden van opvoeders en leerkrachten is er ook nood aan methodieken waarbij ouders en kinderen en jongeren zelf opgeleid worden in het omgaan met conflicten. Op deze manier dient men, vertrekkende vanuit de positieve bijdrage van LSCI tot de behandeling, te komen tot een geïntegreerd model rond conflictantering, waarbij niet enkel professionele hulpverleners, maar ook kinderen, hun ouders, en hun ecologie versterkt worden in het dagelijks handelen.

6.2.2. Aanbevelingen op vlak van het management van een voorziening
Een voorziening die een methodiek wil implementeren zal een complex proces moeten doorlopen. Hoe zou naïef zijn om te veronderstellen dat opleiding voorzien voor
medewerkers voldoende is voor het slagen van dergelijk implementatieproces. In eerste instantie moeten de verschillende visie in kaart gebracht en afgestemd worden. Verder moet er voldoende openheid gecreëerd worden waardoor de traditionele structuren en praktijken in vraag gesteld en eventueel aangepast kunnen worden. Bij dit alles zal een ‘projectverantwoordelijke’ moeten fungeren als brugfiguur tussen het management van de voorziening en de dagelijkse werking.

6.2.3. Aanbevelingen op vlak van wetenschappelijk onderzoek
Tot op vandaag is er een grote schaarste aan onderzoek naar de effectiviteit van behandelingsprogramma’s en methodieken in de Vlaamse zorg en buitengewoon onderwijs. Gezien de moeilijkheden die inherent zijn aan praktijkgericht onderzoek pleiten we voor meer en beter gecoördineerde samenwerking tussen verschillende voorzieningen om op die manier praktijkgericht wetenschappelijk onderzoek mogelijk te maken.

6.2.4. Aanbevelingen op vlak van beleid
Om verschillende redenen moeten er meer middelen vrijgemaakt worden voor de behandeling van en het onderwijs aan kinderen en jongeren met GES. Om ervoor te zorgen dat hulpverleners een beter zicht krijgen op de problemen van de jongeren, en zodoende een betere behandeling kunnen aanbieden, dienen ze in staat te zijn om in een veilig en gestructureerd behandelingklimaat te kunnen interageren met de jongeren. Hiervoor is meer menskracht nodig om op die manier de grootte van de leefgroepen drastisch te reduceren.

Ten tweede zijn er meer personeelsmiddelen nodig om hulpverleners in staat te stellen een beter evenwicht te laten vinden tussen het individueel werken met jongeren en het groepsgericht werken. Het huidige personeelstekort zorgt er immers voor dat hulpverleners slechts op de zeer uitzonderlijke rustige momenten individueel aandacht aan jongeren kunnen besteden.

Ten derde is er nood aan meer middelen om voorzieningen in staat te stellen om onderzoek te doen naar de methodieken en programma’s die ze gebruiken in hun behandeling. Voorzieningen die momenteel inzetten op wetenschappelijk onderzoek moeten dit doen ten koste van personeelsmiddelen van de dagelijkse klas- en leefgroepswerking.

Tot slot is er de laatste jaren een positieve evolutie van residentiële hulpverlening naar meer contextgericht werken merkbaar. Dit wil zeggen dat de expertise die in Vlaanderen is opgebouwd binnen het residentiële werken vertaald zal moeten worden naar het contextgericht werken. Zowel in de opleidingen voor toekomstige hulpverleners als in de opleidingen voor huidige hulpverleners moet hieraan meer aandacht besteed worden.
6.3. Beperkingen van het onderzoek
Per studie werden de beperkingen reeds geformuleerd. Wat volgt is een overzicht van beperkingen die gelden voor het gehele onderzoek.
In de verschillende studies baseerden we ons steeds op de gegevens die we verkregen van de kinderen en de medewerkers van de voorzieningen. Ons onderzoek zou vollediger geweest zijn indien we ook informatie hadden kunnen verzamelen bij ouders. Andere belangrijke variabelen die we niet in kaarten konden brengen zijn de informatie rond drop-out van de jongeren en follow-up informatie over jongeren die de voorziening reeds een tijd hebben verlaten.
Ten derde vonden al onze onderzoeken plaats in slechts twee verschillende voorzieningen. Het betrekken van meer voorzieningen zou de generaliseerbaarheid van onze resultaten verhogen.
Een laatste beperkingen heeft te maken met de moeilijkheden die eigen zijn aan praktijkonderzoek. Gezien de continue veranderingen - bijvoorbeeld nieuwe wetgevingen of nieuwe medewerkers – waaraan een voorziening onderhevig is, is het onmogelijk om een duidelijk onderscheid te maken tussen controle groepen en experimentele groepen. Hierdoor dienen vooral de resultaten van de effectonderzoeken met voorzichtigheid geïnterpreteerd te worden.
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