Teaching LSCI to Adolescents

Introduction: For young people who grow up in hostile environments, impulsive responses to emotionally charged situations become habitual (Henley & Long, 1999). The problem behaviors of youth are often perceived as pathology or deviance and may be treated with coercion, punishment and exclusion. These methods create greater divisions in social connectedness as youth are increasingly cut off from supportive mentors and pro-social peers. They gravitate toward other alienated young people who share a hatred of adult authority and institutions. These youth may isolate themselves or explode in violence, evoking further punishment and rejection (Long, Fescer & Brendtro, 1998).

Unless students are psychologically empowered to take responsibility for their behavior with alternative choices for changing them, they will rely on outside authority and controls for the management of their behavior (Fecser & Joyce, 2002). When students receive punishment for their misbehavior, there is often a negative association with the person who administered it, thereby increasing the likelihood that the student will feel justified in their negative responses (Lovitt, 1978). Penalties alone become meaningless in the mind of the child, because it does not facilitate accepting responsibility for their difficulties or the changes necessary to improve behavior (Campbell & Revering, 1997). Similarly Beck and Dolce-Maule (1998) state that emotional well-being is central and does not come from punishment, but from teaching responsibility and belonging.

Physical restraint or locked seclusion are responses to aggressive or potentially violent children and are used as a means of intervening when the child's behaviors have escalated to the point that the safety of the child or others is significantly compromised. This level of external control is usually preceded by an aggressive/oppositional child who is given a directive from a staff member which may be predictably followed by increased noncompliance or deviance. Repeated instruction or additional directions by staff in reaction to this behavior tends to further escalate the deviance or aggression. Physical restraints and/or locked timeout may subdue the behavior, yet traditionally, the child does not learn new skills in dealing with difficult situations and feelings. Additionally, physical restraints or other coercive interventions may either provide secondary reinforcement through the staff attention or physical contact that is involved, or may be viewed as punishing to those who are participating in them (Jones & Timber, 2002).

Strategies which react to problem behaviors are contrasted with Life Space Crisis Intervention which capitalizes on a crisis as the opportunity to make changes and re-teach positive coping skills. LSCI employs a strength-based approach to problem-solving which entrusts the youth in a careful analysis of the cyclical difficulties that are perpetuated by their lack of understanding (Long, Fecser and Brendtro, 1998). Early interventions and post-crisis teaching strategies, such as those used in Life Space Crisis Intervention, will produce more effective results in changing maladaptive behaviors than simply providing consequences that may or may not make sense to the individual receiving them. Because students begin to understand their patterns, they are less able to blame the adult who instituted the consequence for their problems. Instead of an ambiance of control, the classroom that uses LSCI reflects a belief that students carry the seeds for change within themselves (Henley & Long, 1999). Beck

& Dolce-Maule (1998) found in a three-year study conducted at a residential day treatment school that within the first year of implementation of LSCI strategies, the major instances of disruptive behavior, i.e., physical aggression, running away and property destruction decreased dramatically.

Setting: Northwest Village School (NVS) is the special education program of Wheeler Clinic, a community behavioral health agency located in Plainville, Connecticut. Referrals to NVS are made through the public school systems for students age 5 through age 21, with a wide variety of social/emotional issues. The behavior management system within NVS has drawn heavily from behavioral models, especially in using rewards for appropriate behavior and consequences for negative behavior, to create change and shape behavior. The aspects of programming designed to control aggressive or out of control behavior can include therapeutic holds and locked seclusion when the safety of the child or others is compromised. Physical interventions are one portion of the behavior management and treatment system of NVS and staff are trained extensively due to the importance of experience in this area. Within recent years the value of more cognitive and affective approaches are being realized as a means of increasing a student's internal controls. Verbal de-escalation techniques, student processing of feelings as well as re-teaching management of emotions are receiving greater attention in staff training, especially through the therapeutic talking strategy of Life space Crisis Intervention (LSCI).

Subjects: This project focused on the behavior management data collected from the high school team of students age 13-18 in Northwest Village School. The team is compromised of fifty students with social/emotional and learning problems. Students present with a wide range of psychiatric, behavioral, cognitive and social emotional issues that impede their ability to learn in a traditional academic setting. Though there were slight student population changes between each school year, the admission criteria and presenting issues, (i.e. academic refusal, swearing, threatening, leaving the area, physical aggression, etc.) remain similar. There are five classrooms with an average of 10 to 14 students in each, with one head teacher and approximately 2 to 3 teacher assistants.

Methodology: Staff records each student occasion of Level III intervention, physical holds and locked seclusion, using a behavior management log sheet. The administrator of the team monitors the process while it is occurring as well as the review of the log sheets in any given month. The Quality Assurance Coordinator within Wheeler Clinic then compiles the log sheets. A baseline was established from December, 2009 through January, 2010. The teaching of the LSCI group curriculum was implemented during the months of February, March and April, and post-intervention data was gathered in the months of May and June. The LSCI group curriculum is designed to teach adolescents the basic concepts of LSCI. It is designed to help students learn about patterns of self-defeating behavior and the skills to avoid falling victim to these patterns.

Each session is designed to be completed in 50 minutes. However, due to the severe behavioral problems of these students, each lesson was divided into two parts and taught on every Tuesday and Thursday morning as part of the morning routine.

Also, at the end of the study, all students were given an LSCI Group Curriculum Evaluation Form (Appendix A).

Procedure: Dr. Mitchell Beck provided LSCI certification training to all Northwest Village High School staff involved in the study. The teachers in all five classes provided the LSCI Group Curriculum to the students in their classrooms.

Results: The Level III data comparison indicates an overall reduction in the number of Level III events with the teaching of the LSCI group curriculum to the high school students (see figure 1).

Figure 1

Month	Seclusions	Holds	Time
December	5	4	Baseline
January	7	1	"
February	2	2	Int.
March	12*	3	"
April	2	1	"
May	5	1	Post
June	1	0	Post

*Two-week State Assessment Testing.

Discussion: It is important to note that this reduction in Level III behavior occurred even at the end of the school year.

There were 17 students involved in the training that were graduating seniors. Even with the excitement of graduation, the number of incidents went down. It is also noted that the incidents of locked seclusion rose dramatically during the month of March. This was due to the stress experienced by the students during a two-week period when the annual State assessment tests were administered.

It is important to note that during the baseline there were 12 seclusions and five therapeutic holds. During the three-month intervention period, there were 16 seclusions and six therapeutic holds (that figure includes the two week testing period). The critical factor is the two-month post-intervention timeframe where there were only six seclusions and one therapeutic restraint.

It would appear that over time, the LSCI curriculum will promote greater internal controls, thereby reducing the more external interventions.

In analyzing the self-evaluation form (Appendix A) that is administered to all the students at the end of the study, it seems that all the students felt that learning the LSCI group curriculum had a positive effect on them. This was especially significant in response to questions 5 and 6 in the area of taking responsibility for their behavior and learning to control their feelings before they act out.

Not all students completed this self-evaluation.

Conclusions: The LSCI group curriculum did have a positive and significant impact on reducing the number of seclusions and therapeutic holds at Wheeler Clinic, Northwest Village School. Moreover, even two months after the conclusion of the intervention, seclusions and therapeutic holds continued to be low.

Recommendations:

- It is recommended that the elementary LSCI curriculum should be conducted at the elementary level.

- It is recommended that both LSCI curriculum be implemented at the beginning of the school year, instead of in the spring sessions as school is finishing for the year.

- To insure quality of the program, ongoing training and supervision of staff in LSCI should be continued by a senior trainer in LSCI.

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