A study of factors that influence successful treatment outcomes for aggressive/violent youth in foster care

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ABSTRACT

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A STUDY OF FACTORS THAT INFLUENCE SUCCESSFUL  
TREATMENT OUTCOMES FOR AGGRESSIVE/VIOLENT YOUTH IN FOSTER CARE

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Dissertation dated July 2015

This study examines the factors that influence successful treatment outcomes for aggressive/violent youth in foster care. The four interventions that guided the study consisted of Treatment Modality, Counseling Framework, Support Services, and Frequency of Services. Sixty-five (65) survey participants were selected for the study utilizing a non-probability, purposive and convenience sample. The findings of the study indicated that the following computed variables were statistically significant as factors that influence the successful treatment outcomes with aggressive/violent youth in foster care: Treatment Modality and Support Services, and Support Services and Counseling Framework. There was no statistically significant relationship observed between Treatment Modality and Counseling Framework, Treatment Modality and Frequency of Services, nor between Frequency of Services and Counseling Framework, and Frequency of Services and Support Services. Directions and recommendations for future research and practice implications are discussed.
A STUDY OF FACTORS THAT INFLUENCE SUCCESSFUL TREATMENT OUTCOMES FOR AGGRESSIVE/VIOLENT YOUTH IN FOSTER CARE

A DISSERTATION

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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CHAPTER I
INTRODUCTION

The number of child maltreatment reports in the United States is alarming. In 2013, there were 3.4 million reports involving six million children, of which 79.5% suffered neglect, 18% suffered physical abuse and 9% suffered sexual abuse from the more than 670,000 found to be victims (Children’s Rights, 2014). Further, according to the Adoption and Foster Care Analysis and Reporting System, U.S. Department of Health and Human Services (2014), there were over 400,000 youth in America’s foster care system. Equally important to this study is that although there has been a steady decrease in youth violence over the years since the mid-1990s, the numbers that are being served through the juvenile justice systems due to their aggressive and violent behavior are still unacceptably high, with homicide remaining a leading cause of death among youth aged 10–24 years in the United States (Centers for Disease Control and Prevention, 2013).

The literature is quite explicit in the treatment needs and protocol for youth in foster care (Boyd, 2013). Similarly, the literature is rich as it relates to interventions for youth exhibiting aggressive and violent behaviors. However, when there is an overlap – youth in foster care who also exhibit aggressive and violent behavior – there is a near silence regarding evidence based treatment strategies and techniques (Jonson-Reid & Barth, 2003).
Treatment modalities such as individual, group and family therapy, counseling frameworks that include behavioral, cognitive, and reality therapy, as well as frequency of services at once, twice, or three or more times a week are all important when engaging troubled youth. These interventions along with the assistance of support services such as mentoring, probation services, behavioral aide and pharmacological therapy, all have utility in work with this population. However, additional research is needed to mitigate the scarcity of literature for youth in foster care with aggressive/violent behavior (Zastrow, 2012).

This study endeavors to assist in filling this void. Individuals who have been providing therapeutic services to this population and influencing successful outcomes will be surveyed and the subsequent data analyzed in efforts to examine and describe the interventions and treatment strategies that are successful in decreasing aggressive/violent behavior among this population. The Dependent Variable is Successful Outcome with aggressive and violent youth in foster care. The Independent Variables are (a) treatment modalities (b) counseling frameworks (c) support services and (d) frequency of services. Thus, the following objectives of this study have been identified:

1. To examine and describe the treatment modality that hold promise in work with youth in foster care who are exhibiting aggressive and violent behavior.
2. To examine and describe the counseling framework that hold promise in work with youth in foster care who are exhibiting aggressive and violent behavior.

3. To examine and describe the support service associated with effective intervention strategies.

4. To examine the frequency of intervention most likely to produce successful outcomes.

For the purpose of this study, there are several key terms that need to be operationally defined. First, Successful Outcome as it relates to this study has been operationally defined as attaining decreased aggressive and violent behavior with sustained effects after the utilization of therapeutic interventions. Second, Foster Care Youth is defined as a youngster who is in the custody of the Division of Family and Children Services. Finally, Aggression/Violence is defined as the intentional use of actual or threatened physical force to harm a person (Vito & Maahs, 2012).

Effectively caring for and creating a place for youth whose families are unable to provide them with a safe, stable and nurturing home environment is the mark of a mature and evolving society. Youth who are abused, neglected, abandoned and deprived are at risk of experiencing developmental delays. These areas not only include developmental, but also consist of cognitive, social, and emotional milestones (Morrisons, Frank, Holland & Kates, 1999).
Oftentimes it is in the youth’s best interest to be placed in protective custody and rendered services via group homes or family foster care settings. Foster care is a state program that provides temporary substitute care for youth outside of their primary caregivers’ home in settings such as relative care, group home and foster families. The Division of Family and Children Services (DFCS) administers Georgia’s foster care program (Georgia Department of Human Services, 2014).

Occasionally, therapeutic placements are necessary because of the youth presenting with serious emotional problems. Treatment family foster care or treatment facilities are utilized to help resolve and remedy personal problems and behaviors. When foster care youth present with aggressive and violent behavior, clinical practice effectiveness should be employed to address a multitude of issues (Robst, Armstrong & Dollard, 2011).

The aggressive/violent behavior of foster care youth is central to this study; therefore, this behavior must also be examined. Youth violence is a critical concern in our society. In the wake of highly publicized school shootings in recent years, considerable attention and research have been directed to understanding aggression and combating violence among youth in America. It has been proposed that mental health professionals must approach it from a public health perspective, which suggests that instead of simply focusing on the individual who is at-risk for, or engages in violence, what is also considered is the individual’s relationship to his or her surroundings (Prothrow-Stith, 2001).
A national discussion around youth violence began in earnest with the release of the seminal Surgeon General's Report on Youth Violence in 2001. It noted that risk factors increase the probability that a young person will become violent, while protective factors buffer the young person against those risks. The report indicates that there are environmental, community, family and individual level factors. They vary in areas such as poverty, media exposure to violence, the availability of drugs and firearms, community deterioration or disorganization, and access to quality educational and recreational opportunities. On the family level, noted factors are child abuse and neglect, a lack of parental interaction and involvement (Office of the Surgeon General, 2001).

Poor academic achievement and school failure are noted on the individual level. Young people who are consistently absent from school during early adolescence (age 12 - 14) appear to be more likely to engage in violence as adolescents and adults. In addition, leaving school before age 15 has been found to correlate with increased risk as well (Office of the Surgeon General, 2001).

Noted family therapist Dr. Kenneth Hardy (2002) has argued that at some point we are going to have to create a new paradigm in relation to how we respond to the actions of others we are troubled by. He cautions us to focus on being a healer, not a jailer. Hardy (2002) instructs us that youth who have been frequently traumatized act out in violent ways. Further, society's tendency to label troubled youth as either bad or mad too often overlooks the unmourned losses in their lives and the anesthetizing pull of violence.
The State of Georgia contracts with providers to render services to youth who have been removed from their home. These placement services are based on a child's individual need and are provided by a licensed child care provider who have met and abide by rules and regulations as a Child Caring Institution or Child Placing Agency as prescribed by Georgia's Office of Regulatory Services (ORS). However, it is a bifurcated process for agencies servicing youth in DFCS' custody. The State level of the Division of Family and Children Services must also approve these providers. Essentially, a provider can have a license from ORS, but not approved to care for children in the custody of DFCS (Georgia Department of Human Services, 2014).

It has been expressly delineated in the Level of Care Providers Indicator Manual (2003) that it is the responsibility of DFCS to ensure that youth in out of home care achieve certain service objectives and goals. They include, but are not limited to protection from abuse and neglect; improvement of social, emotional and behavioral functioning; academic progress; improvement of child and family relationships and the capacity of families to care for their own children; and minimalization of the amount of time children spend in out of home care, and the number of placements they experience.

Historically, youth in the foster care system were basically provided protection, shelter, food and clothing. Now through appropriate assessments of needs, many have been found to require therapeutic services. Further, the removal from the familiar surroundings of family, friends, schools and community can necessitate the need for therapeutic services as well (Freundlich, Morris & Blair, 2004).
When deprivation is the precipitating issue for removal of the youth from his or her home, the therapeutic milieu must be more attentive to the needs associated with abuse, neglect, homelessness and maltreatment. Further, additional targeted treatment needs such as issues of adjustment and separation anxiety are manifested as a result of the removal. Quite often, pre-existing needs are also evident or revealed through psychological evaluations. The Georgia Division of Family and Children Services (2014) reported that of the 8,807 children in DFCS custody, with many being served in intensive, intermediate, or therapeutic settings because they need treatment for serious emotional problems.

The decision to remove a child from his or her family is not made by a worker in the Department of Family and Children Services. DFCS policy specifically prevents removing a child from his or her home without first obtaining a preliminary protective custody order or through the building of a case for removal. The decision is made by Juvenile Court. The DFCS worker can, however, remove a child in an emergency situation. A judge must then hear the case within 24 hours of the removal (Official Code of Georgia Annotated, 2014a).

An order authorizing a law enforcement officer to take the child into custody will be issued if the judge believes that the circumstances warrants the removal of the child. Moreover, Georgia Juvenile Code allows a law enforcement officer or duly authorized officer of the court to take a child into custody. There must be reasonable grounds to believe that the child is suffering from illness or is in immediate danger from his or her
surroundings and that his or her removal is necessary. Of great concern is that when the youth is placed, oftentimes issues of aggression and violent behavior, nor treatment needs are taken into consideration removal (Official Code of Georgia Annotated, 2014b).

Statement of the Problem

Today’s foster care system is under siege as it relates to the mental health needs of youth it has been charged to care for. The public’s sacred trust must be reclaimed. There must be a restoration of the pure intentions and basic tenets upon which the contemporary foster care system was founded. Youth are presenting with complex, multi-dimensional and layered problems. Moreover, they are entering family foster and group home care at an alarming rate due to an array of deprivation situations. Therapeutic services tend to focus on restoring balance and ensuring safety. When the intersection of youth in need of out-of-home care who presents with aggressive/violent behavior occurs, a different assessment of services and subsequent treatment is warranted (Pecora, Jensen, Romanelli, Jackson & Ortiz, 2009).

Youth with aggressive/violent behaviors who are in foster care require a different treatment protocol that is informed by best practices and standards. Intervention services must not only address issues of deprivation, but additional therapeutic services must focus on decreasing aggression, violent tendencies, and improving overall functioning through therapeutic activities geared toward increasing social skills, teaching conflict resolution, anger management techniques, and the development of healthy coping skills (Pecora et al., 2009).
African-American male youth are more likely to be referred to the juvenile justice system rather than to mental health treatment according to Gottesman and Schwarz (2011). Disturbingly, when there is an identification of mental health issues, according to National Mental Health Association, African-American youth tend to be labeled with more severe diagnoses and are hospitalized at rates two to three times that of white youths. The danger of misguided perceptions is further illustrated in a study by Bridges and Steen (1998), which uncovered the power of racial stereotyping. The study, which looked at a sample of juvenile cases in three Washington State counties, found that portraying juvenile differently led to tougher sentencing recommendations for African Americans. Court reports depicted crimes committed by African-American youth as being caused by internal attributes or character deficits such as being disrespectful toward authority, while White juvenile crime was more likely to be blamed on negative environmental factors such as association with delinquent peers or exposure to excessive family conflict.

Further, And Justice for Some, the second in a series of reports that are a part of the national Building Blocks for Youth (2000) initiative sounded the alarm almost 15 years ago concluding that African-American youth are consistently charged and incarcerated more than white youth. African-American youth are were six times more likely to be incarcerated than white peers with the same background and after being charged with the same offenses. We are still contending with some of the same issues in 2015.
Yet, we must as Boyd-Franklin and Franklin (2000) instructed us that we must teach our sons the ropes in surviving and not self-destructing as they deal with racism that is not only personal, rather at times institutionally sanctioned. Again, little has changed. A report from the American Psychological Association (2012) supported the prevailing concern that youth in foster care are not only at-risk for mental health problems, but perhaps of equal importance is that the field of mental health would benefit from a comprehensive review of not only the needs, but also how the need of these youth are is assessed. In addition, adequate evaluations showing what treatments are working must be determined.

The American Psychological Association (2012) further noted that nearly half (47.9%) of youth in foster care were determined to have clinically significant emotional or behavioral problems. Equally troubling is the mental health status of former foster care youth who have been found to be disproportionately represented as it relates to adult mental health disorders. The CDC (2012) reported that the rate of Post-traumatic Stress Disorder (30% for foster alumni) is alarming. It was nearly double the rate found in U.S. combat veterans and was significantly higher than the 6.9% rate in the comparison group. Likewise, differences were large and significant for diagnoses of Major Depression, Panic Disorder, Phobia, and Generalized Anxiety Disorder.

For youth involved with criminal justice systems with mental health needs are not fairing any better. Skowyra and Cocozza (2007), argued that many of these youth are unnecessarily placed in or referred to the juvenile justice system for relatively minor,
non-violent offenses. Disturbingly, this is often a misguided effort to obtain treatment services that are lacking or hard to access in an already burdened community mental health system.

Further, the Mental Health and Juvenile Justice Collaborative for Change (2014) presented data that has been static over time, indicating that studies have consistently documented 65% to 70% of youth in contact with the juvenile justice system have a diagnosable mental health disorder. Also, over 60% of youth with a mental health disorder are presenting with a substance use disorder. Ignoring or minimizing these mental health issues will not make them disappear. Unfortunately, these youth are at risk at joining the adult criminal justice system which is just as, if not more problematic as it relates to addressing the mental health treatment needs of individual.

The treatment needs of youth in out of home care with aggressive and violent behavior dictate that therapeutic interventions should be integrated, culturally relevant and empirically grounded (Hopps, Pinderhughes & Shankar, 1995). Additionally, there are several policy implications on national, state and local levels. The promotion of healthy family functioning can be attained with federal, state and local funds that support programs that directly involve the families of at-risk youth. Multi-leveled initiatives can be employed in reducing media violence, increasing the involvement of schools and limiting the access to firearms, drugs and alcohol (Kashani, Jones, Bumbry & Thomas, 1999).
Purpose of the Study

The purpose of the study is to examine factors that influence successful outcomes for aggressive/violent youth in foster care. The literature, in general, is clear on points of intervention for youth who are in foster care settings. However, it is quite sparse in empirical data regarding effective strategies to treat youth with aggressive/violent behavior who have been removed from their homes and placed into the foster care system. This study seeks to fill this gap by examining and describing factors that effectively address the treatment needs of this population. To that end, this study seeks to mitigate the dearth of knowledge by providing empirical data that extends frameworks for understanding the treatment needs and factors that are influential in achieving successful outcomes for foster care youth with aggressive/violent behavior.

Research Questions

There are numerous clinical intervention strategies that address the various treatment needs of youth in foster care, and those with aggressive/violent behavior. Identifying, describing and analyzing integrated strategies for youth experiencing both placement in foster care, and demonstrating aggressive and violent behavior is the focus of this study and is guided by the following six research questions:

1. Is there a statistically significant relationship between Treatment Modality and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?
2. Is there a statistically significant relationship between Treatment Modality and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

3. Is there a statistically significant relationship between Treatment Modality and Frequency of Services in achieving successful outcomes with aggressive/violent youth in foster care?

4. Is there a statistically significant relationship between Support Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

5. Is there a statistically significant relationship between Frequency of Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

6. Is there a statistically significant relationship between Frequency of Services and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

**Null Hypotheses**

1. There is no statistically significant relationship between Treatment Modality and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.
2. There is no statistically significant relationship between Treatment Modality and Support Services in achieving successful outcomes with aggressive/violent youth in foster care.

3. There is no statistically significant relationship between Treatment Modality and Frequency of Services in achieving successful outcomes with aggressive/violent youth in foster care.

4. There is no statistically significant relationship between Support Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.

5. There is no statistically significant relationship between Frequency of Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.

6. There is no statistically significant relationship between Frequency of Services and Support Services in achieving successful outcomes with aggressive/violent youth in foster care.

**Significance of the Study**

Sometimes children enter the custody of the Department of Family and Children Services through volunteer measures of the parents and oftentimes they are removed. According to latest available statistics from the Georgia Department of Human Resources (2013), every day, 33 children are the victims of confirmed abuse or neglect; 200 incidents of child abuse and neglect are reported daily; 65 children died from abuse and
neglect in 2011; on any given day, about 7,500 children are in the foster care system and; 13,658 children came through the foster care system during state fiscal year 2013. Further, about 44% are white, and 51% are African-American. The remaining 5% come from other ethnic backgrounds.

There are negative consequences in not examining the full range of intervention models that address aggressive/violent behavior among youth. This study is significant in its approach and attention to youth in foster care. It endeavors to collect, interpret, and present data that supports an integrated therapeutic service delivery model that reflects the most promise in decreasing aggressive/violent behavior among this population. The variables that will be subjected to the data analysis consist of (1) treatment modality (2) counseling framework (3) support services and (4) frequency of services (Pecora et al., 2009).

While there are several evidenced-based prevention and intervention programs, as well as micro-leveled models of treatment that show empirical effectiveness in work with aggressive/violent behavior youth, the literature is silent regarding the implementation of strategies and techniques that show effectiveness in treatment of youth in foster care (Mental Health and Juvenile Justice Collaborative for Change, 2014). This study is a valid attempt to examine and describe these treatment modalities. The research findings and subsequent recommendations will be instructive to the community of out-of-home care service providers, other members of the helping profession, educators and policy makers – all in efforts to meet these youth at the point of their needs.
CHAPTER II
REVIEW OF LITERATURE

This literature review provides a conceptual and theoretical framework of factors that influence successful outcomes for youth exhibiting aggressive/violent behavior. The chapter endeavors to systematically present a scholarly foundation that supports the need for the study. Numerous empirical studies and programs that demonstrate effectiveness in decreasing aggressive and violent behavior are reviewed. In addition, a review of risk and protective factors is presented. A theoretical framework is presented that represents an integrated approach since the researcher supports that understanding and successfully treating aggressive and violent behavior is guided by multiple treatment theories and theoretical frameworks.

Finally, an in depth and exhaustive literature search was conducted utilizing multiple databases and library catalogues for current literature that focus on factors that influence success for this population. Individual and combinations of keywords were used. As anticipated, while the outcome of the review yielded numerous books and article, specific literature that dealt with youth in foster exhibiting aggressive and violent behavior was not fruitful. This further validates the need for this study in efforts to add to the knowledge base and fill this vast literature gap. An examination of variables and related materials became the most appropriate course of action in completing this chapter.
Treating Aggressive and Violent Behavior

According to Cohen (1994), aggression crosses many diagnostic categories: conduct disorders, learning difficulties and developmental disturbances. These issues challenge clinicians in developing effective treatment strategies. Many of these strategies, which may include behavior modification, medication, individual or group therapy, fail to change the cycle of aggression. Residential treatment is often employed to bring about sustain change. Further, youth with persistent aggressive behavior may need a substitute family in order to provide them with what they lack to facilitate healthy development. Additionally, an environment other than family foster care or short-term residential treatment is needed to help these youth become disentangled from unhealthy relationships that they experienced with their primary caretakers. The need is to provide an environment that allows them to establish their own integrated and cohesive selves (Blake & Hamrin, 2007).

Chiland, Young and Kaplan (1994) suggested that the best way to end violence among youth is to simply cultivating it. Since we teach violence to our children, we can stop it. Our prevention efforts should focus on teaching youth how to manage severely aggressive feelings. Youth must learn to postpone the impulses until they have a chance to consider and examine the effects of their impulsive acts and examine or formulate healthy alternatives. Psychosocial education should be the first line of defense (Pappadopulos, Rosato, Correll, Findling, Lucas, Crystal & Jensen, 2011).
Further, youth have little education concerning their emotions; rather aggression has become an ingrained response. In light of effective therapeutic interventions and various strategies, aggression can yet be complicated by noxious influences such as poverty, abuse, and other highly influencing environmental factors. It is a complicated issue that warrants more than a simplistic approach to treatment (Chiland et al., 1994).

Youth who are in out-of-home care with aggressive and violent behavior require various therapeutic intervention services. The literature summarily addresses attending to aggressive and violent behavior from different perspectives. Children who have been removed from their parents’ care and placed in foster care have increased risks of developing emotional problems and maladaptive behaviors (Morrison et al., 1999).

Silver, Amster and Haecker (1999) argued that when a youth has multiple foster placements, other issues arise as a result having to contend with various caregiving styles, routines and the risk of depression. Beyond ensuring that youth are benefitting from a safe, stable and nurturing environment, appropriate therapeutic services must also become a part of treatment and service plans when aggressive and violent behavior is a presenting problem.

Therapeutic outcomes suggested by Jongsma, Peterson and McInnis (2000) in The Adolescent Psychotherapy Treatment Planner should be considered for this population. Individualized assessments must occur before the real work of rehabilitation must occur. Clearly articulated goals must be developed with the youth. Noteworthy outcomes should include the reduction of verbal outburst and aggressive behavior, as
well as the frequency and intensity. Further, the termination of violent acts, specifically, should be central to treatment planning. Youth should be expected to terminate acts of violence and learn skills that enable them express their anger in acceptable manners. Additional goals should address developing positive coping mechanisms, conflict resolution skills and learn to control aggressive impulses.

**Risk and Protective Factors**

Risk Factors increase the probability that a young person will become violent, while Protective Factors buffer the young person against those risks. It is important to note that no single risk factor or set of risk factors is powerful enough to predict with certainty that youths will become violent. The Centers for Disease Control and Prevention (2014) delineated a comprehensive list of risk factors. On the community level, risk factors include the availability of drugs and firearms is noted. Additionally, the media portrayal of violence as well as economic and social deprivation is noted. Community disorganization is also a factor.

Family risk factors include a families with a history of high-risk behavior. Youth often model behavior demonstrated by adults. Issues related to substance abuse, violence and other problematic behaviors contributes to the risk factors on this level. Conflict between parents, as well as their attitudes increases risk (Centers for Disease Control and Prevention, 2014).

Among school risk factors are early and persistent antisocial behavior, Academic failure beginning in late elementary school and lack of commitment to school. Individual
and peer group risk factors include rebellious behaviors. Youth who have friends who engage in the problematic behaviors is also risk factor. There is also an early initiation of problematic behaviors (Centers for Disease Control and Prevention, 2014).

The literature has identified the several protective factors that include strengthening the family and supporting important social institutions that play a role in their lives. Further, there is a need to promote delinquency prevention. Interventions must be timely and effective when delinquent behavior has been identified. Small peer groups that exist in communities and school settings must be identified and appropriate services rendered (Office of Juvenile Justice and Delinquency Prevention, 2004).

Protective factors do not guarantee that a young person will not become violent. They reduce the probability that groups of young people when facing a risk factor or factors will become involved in violence. Mental health and other professionals involved in work with youth dealing with aggressive/violent behaviors must not settle on protective, nor simply on risk factors as a total solution to this problem. In the absence of protective factors or when risk influences a youth to the point of aggressive and violent behavior, effective treatment protocols are needed (Office of Juvenile Justice and Delinquency Prevention, 2004).

**Treatment, Intervention and Prevention Programs**

There are many communities and school based prevention and intervention programs in use across the country that are aimed at reducing youth violence. However, the majority of them are untested, so outcome measures are not known. According to
Hoagwood (2000), many community programs have no scientific evidence of their effectiveness. Hoagwood (2002) further argued that promoting these untested practices is more than harmless; it can have adverse effects. Youth may be inappropriately placed in groups, rendering treatment therapeutically ineffective. There must be specificity in matching interventions to treatment needs. Programs that simultaneously address the full scope of issues related to youth violence are the most effective. Programs must be comprehensive, focused on multiple risk factors and all the institutions that affect the youth’s life.

In addressing the multiple psychosocial factors connected to aggressive and violent behavior in youth, this literature review has identified several programs that have met high scientific standards of program effectiveness. Each program met rigorous evaluation standards that include a strong research design, evidence of a statistically significant deterrence (or marginal deterrent) effect, replication at multiple sites with demonstrated effects, and evidence that a deterrent effect was sustained for at least one year post-treatment (Blueprints for Healthy Youth Development, 2014).

An excellent mentoring program is Big Brothers Big Sisters. Its history dates back to the early 1900s with men and women volunteering to work with troubled and disadvantaged youth who appeared before New York Children’s Courts. Today, the community-mentoring program typically targets youth 6 to 18 years of age from single parent homes. According to McGill (1997), a 1991 report revealed that the program, working with nearly 500 agencies, supervised more than 70,000 youth and adults in one-
to-one relationships. Utilizing a case management approach, applicants are carefully screened, then matched and supervised. The most important component of the intervention is the match between the adult and youth, who interact from three to five hours per week for a year or longer. The theoretical rationale of Big Brothers Big Sisters is that the consistent, supportive and caring presence of a mentor makes a significant difference in the social and emotional development of youth.

Public/Private Ventures, a Philadelphia youth development research firm, evaluated Big Brothers Big Sisters through four studies over four years. There were 1,138 youth (ages 10 to 16) from eight agencies enrolled in the study for 17 months, with 957 actually used in the analysis sample. Information was collected from the youth, parents and Big Brothers Big Sister case managers during the time of the random assignment to either the treatment or control group (baseline), when they were matched with a mentor and at follow up. The youth in the control group were placed on a waiting list, while those in the treatment group were matched with a big brother or big sister. The youth remained matched for an average of 12 months and 70% of the matches met on an average of four hours during each meeting, which occurred three or four times a month (McGill, 1997).

At the end of the evaluation period, Big Brothers Big Sisters as compared to non-participating youth, 46% were less likely to initiate drug use during the study period and 27% less likely to initiate alcohol use than the control group. Additionally, almost one-third less likely than the control group to hit someone. It was also noted that participants
were better than control group youth in academic behavior, attitudes, and performance and had higher quality relationships with their parents or guardians than control youth. Finally, they had higher quality relationships with their peers at the end of the study period than did control youth (McGill, 1997).

It is also important to note that the recruitment effort of Big Brothers Big Sisters is particularly interested in more males and African-American men becoming volunteers due to the large number of children of color being referred for service. McGill (1997) acknowledged success at the local level in engaging more African-American males as mentors when Big Brothers Big Sisters has partnered with African-American professional organizations. Efforts to recruit more males in general are through campaigns that convey messages that being a big brother doesn’t require special skills. Although this program was initially evaluated in 1997, it is still rated as a Promising program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

As previously suggested, violent behavior has to be viewed from an ecological perspective. Youthful offenders are impacted by a complex system of relationships: familial, peer, school, and community. Multisystemic Therapy (MST) focuses on the factors in both the youth and family’s ecology. The major goal of MST is the empowerment of parents and youth through skill building, coping strategies and resources. There are also favorable outcomes at cost savings when MST is compared to
mental health and juvenile justice services at an average cost of $5,000 per youth. In addition, findings from randomized trials revealed MST to be equally effective with African-American families as with White families, and with younger adolescents as with older adolescents (Henggeler, Mihalic, Rone, Thomas & Timmons-Mitchell (2001).

A major thrust of MST is that barriers to service access are removed by the use of the home-based model of service delivery and treatment plans/goals are parent driven. Grounded in social and ecological models of behavior, MST provides intensive, individualized and comprehensive services to the youth and family by therapists (usually master’s level) utilizing family, structural, and cognitive behavioral therapies. Therapists are available 24 hours a day, seven days a week. Caseloads for therapists are from four to six families and treatment last from three to five months (Henggeler et al., 2001). There have been numerous randomized clinical trials conducted providing evidence of MST’s effectiveness. The first study was published in 1986.

According to Henggeler, Rodick, Borduin, Hanson, Watson and Urey (1986), there has been approximately 20 additional randomized trials conducted across North America and Europe. Extensive trials with substance abusing juvenile offenders and chronic/violent juvenile offenders were conducted in South Carolina and Missouri. These randomized studies further demonstrate the effectiveness of MST with other populations. Evaluation outcomes of MST have demonstrated that for serious juvenile offenders there was a reductions of 25 – 70% in long-term rates of rearrest, 47 – 64 % in out-of-home placements and extensive improvements in family functioning. Decreased mental health
problems for serious juvenile offenders is also indicated. MST continues to be recognized as a Model program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

Oregon based, Multidimensional Treatment Foster Care offers an alternative to institutional, residential and group home placement for serious delinquent youth in need of out-of-home care. This program rests on the Social Learning Theory. Youth are placed in a family setting for six to nine months alone or in two’s. Multidimensional Treatment Foster Care parents are paid a monthly salary and stipend to cover additional expenses. The parents are trained and supported by case managers, as well as provided with weekly supervision and support meetings with other program parents. Each youth has an individualized treatment plan with clear measurable goals (Chamberlain & Mihalic, 1998).

The level of supervision is high at home and school. The treatment approach is multi-modal, whereas youth are exposed to positive role models and peers. Moreover, there is significant attention given to interpersonal and behavioral skills training. The youth’s parent(s) is also involved in the structured program, with the aims that when the youth returns homes, the parent would have developed more skills and resources for a healthier home environment (Chamberlain & Mihalic, 1998).
Evaluations of Multidimensional Treatment Foster Care youth compared to control group youth demonstrate that they spent 60% fewer days incarcerated at 12 months follow-up and had significantly fewer subsequent arrests. They ran away from their programs, on average, three times less often, in addition had significantly less hard drug use in the follow-up period. They also had quicker community placement from more restrictive settings. The first of the two studies on this program not only showed its feasibility as compared to incarceration, it also demonstrated cost effectiveness and better outcomes for children and families. The cost per youth is $2,691 per month with an average stay of seven months (Chamberlain & Mihalic, 1998). Sixteen years later, Multidimensional Treatment Foster Care is still ranked as a Model program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

Functional Family Therapy is a program that utilizes phases and steps to target intervention and assessment activities. The phases consist of Engagement and Motivation, Behavior Change, and Generalization. During Engagement and Motivation phase, the focus is on building unity within the family through reducing negativity and increasing respect among family members. The next phase, Behavior Change, is characterized by communication training, parenting skills and other individualized techniques aimed at improving family functioning. Family Case Management focuses on the individualized family needs in the Generalization phase. Empirically grounded,
Functional Family Therapy integrates theoretical perspectives and draws from years of direct clinical practice experience (Alexander, Parsons, Sexton, Barton, Bonomo, Gordan, Grotpeter, Hansson, Harrison, Mears, Mihalic, Ostrom, Schulman, & Waldron, 2000).

Targeting youth aged 11 to 18 presenting with the full range of maladaptive behaviors such as Conduct Disorder and Oppositional Defiant Disorder, Functional Family Therapy is relatively short term; 8-12 hours of direct time for youth and family, and generally no more than 26 hours for severe problems. Since it’s inception in 1969, Functional Family Therapy has sought to not only stop bad behaviors, but also to draw on family’s strengths as an avenue in improving family functioning. The 90-day cost range from $1,350 to $3,750 for an average of 12 home visits per family (Alexander et al., 2000).

Thirteen studies and 28 years of data and clinical experience provide significant empirical support of Functional Family Therapy’s effectiveness with youth and families. Clinical trials demonstrate that the program is capable of, but not limited to effectively treating adolescent with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorder, and who are delinquent and or violent. It demonstrated effectiveness in preventing further incidence of the presenting problem and preventing younger children in the family from entering the system of care. Adolescents were prevented from penetrating the adult criminal system. Functional Family Therapy is also being adopted in more multicultural contexts. Preliminary data
from one site indicates that no difference in re-offense rate among the different ethnic/racial groups which included African-American, Hispanic/Latino, European American and a few Asian American and American Indian youth (Alexander et al., 2000). Although the Functional Family Therapy program was initially evaluated in 2000, it is still rated as a Model program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

The Incredible Years: Parent, Teacher, and Child Training Series targets children from ages two to eight, who are at risk for and/or presenting with conduct problems. Granted, all children with behavior problems do not become criminals. Most chronic serious offenders display behavioral problems during childhood. The Series may be used in Head Start, day care and kindergarten through grade three and in mental health centers as treatment approaches for children with early onset of behavior disorders such as Conduct Disorder (Webster-Stratton, Mihalic, Fagan, Arnold, Taylor & Tingley, 2001).

The Incredible Years Series consists of three curriculums: parents, teachers and children. The Series focuses on the risk factors known to be related to the development of Conduct Disorder in children. Incredible Year Training for Parents has three programs; BASIC, ADVANCE and SCHOOL. The BASIC program provides parents with skills that promote a child’s social competence and ways to handle misbehavior. The ADVANCE program addresses parent interpersonal skills. The SCHOOL or Supporting
Your Child’s Education program covers an array of useful strategies to improve a child’s academic performance and establishing relationships between the parent and teachers. Incredible Years for Teachers assist teachers in developing effective classroom management skills. The Series for children emphasizes social, emotional and behavior skills (Webster-Stratton et al., 2001).

There were six randomized control group evaluations of the parent series, and two of the teacher and child training, respectively. Some of the significant findings were that parents demonstrated increases in school bonding and involvement and increase in positive family communication and problem-solving. For teachers, there was a reduction in peer aggression in the classroom and increases in children’s positive affect and cooperation with teachers, positive interaction with peers, school readiness and engagement with school activities. There was an increase children’s appropriate cognitive problem-solving strategies and more prosocial conflict management strategies with peers and increases in social competence and appropriate play skills. A reductions in conduct problems at home and school was also noted (Webster-Stratton et al., 2001). The Incredible Years Series continues to be recognized as a Promising program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

The Bullying Prevention Program is designed to provide intervention measures that reduce and prevent bullying. The intervention takes place in the school setting and is
administered by school staff. The program targets elementary, middle, and junior high school students. There are also individualized interventions for students who are identified as bullies or victims of the behavior (Olweus, Limber & Mihalic, 1999).

School level, the class level, and individual level represent the program implementation components. The school-wide component consists of anonymous questionnaires being administered. An assessment of the nature and prevalence of bullying is made. Subsequent activities include a conference day to discuss bullying, planning interventions, forming a coordinating committee, and increased supervision of problematic areas where bullying is occurring. The classroom component involves the establishment and enforcement of class rules to counteract bullying. Further, regular class meetings are introduces. The individual component focuses on students who have been identified as bullies or victims of bullying. Parents are involved in discussions, as well as additional assistance afforded by teachers, counselors, and school-based mental health professionals (Olweus, Limber & Mihalic, 1999).

The Bullying Prevention Program involved 2,500 children in 42 schools from the city of Bergen, Norway. This initial study was conducted from 1983 to 1985 and has numerous program replications in other countries, including the United States. A more recent replication and evaluation in the United States occurred in South Carolina involving 6,388 elementary and middle school students (Olweus, Limber & Mihalic, 1999).
Olweus, Limber & Mihalic (1999) identified several positive outcomes of the Bullying Prevention Program. They include a reduction in boy’s and girl’s reports of bullying, as well as victimization. There was a significant reduction in students’ reports of general antisocial behavior such as vandalism, fighting, theft and truancy. Outcomes also included significant improvements in the social climate of the class, as reflected in students’ report of improved order and discipline, more positive social relationships, and a more positive attitude toward school work and school. Fifteen years later, the Bullying Prevention Program is still ranked as a Promising /Model program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the Study and Prevention of Violence, Institute of Behavior Science at the University of Colorado – Boulder (Blueprints for Healthy Youth Development, 2014).

The PATHS (Promoting Alternative Thinking Strategies) Curriculum targets aggression and behaviors problems in elementary school-aged children. The comprehensive program promotes emotional and social competencies, as well as enhances educational processes in the classroom. The program primarily focuses on youth in the school and classroom setting (Greenburg, Kusche & Mihakic, 1998).

PATHS is a multi-year program that is designed to be implemented in the 5th grade. The program was field-tested and researched with children in regular classroom setting as well as special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mild mentally delayed, and gifted). Three controlled studies with
randomized versus experimental groups have been conducted (Greenburg, Kusche & Mihakic, 1998).

This program is based on five conceptual models. The ABCD (Affective-Behavioral-Cognitive-Dynamic) Model of Development placed emphasis on promoting optimal development of the individual. The eco-behavioral systems focus on the way that teachers use the curriculum. Additionally, it emphasizes the manner in which teachers generalizes the skills to in efforts to facilitate a wholesome classroom environment. The third model involves neurobiology and brain organization. The forth and fifth models involves psychodynamic education and psychological issues in terms of emotional awareness (Greenburg, Kusche & Mihakic, 1998).

Greenburg, Kusche and Mihakic (1998) identified several outcomes for PATHS. They include improved self-control, understanding and recognition of emotions and increased ability to tolerate frustration. Youth demonstrated the use of more effective conflict-resolution strategies and improved thinking and planning skills. There was also noted decreases in anxiety and depressive symptoms conduct problems and symptoms of sadness and depression. Also noted were decreased conduct problems and including aggression. Overall, PATHS has demonstrated improved protective factors and reduce behavioral risk. The program has also shown cross-rater reliability. Although this program was initially evaluated in 1998, it is still rated as a Model program in the evidence-based Blueprints for Healthy Youth Development initiative at the Center for the
Culturally Competent Practice

As our nation continues to experience enormous growth in the diversity of our population, the need for culturally competent and sensitive practice is more evident. Various national, state and local agencies and professional organizations are recognizing that the concept of cultural competence extends far beyond the outdated confines of race and ethnicity. The National Association of Social Workers (2001) has developed profession-wide cultural competence standards specific to its practice. The standards definition of cultural competence extends to all people of all cultures, languages, classes, races, ethnic background and religions, as well as other diversity factors who receive respectable services. These services recognizes and values their worth. This includes individuals, families and communities. They are affirmed and their dignity remains intact.

Greater and more meaningful cultural competence is very important and needed in our work with African-American male youth by virtue of the aforementioned disparities. Too many are at the threshold of joining the status and facing many of the same issues of African-American men such as social, economic and psychological stressors, high risk for development of disturbances in psychological functioning and being less likely to receive mental health treatment. Minority males have been considered the most overwhelmed population (Hopps, Pinderhughes & Shankar, 1995).
Leonard, Lee and Kiselica (1999) recommended that educators of mental health professionals provide culture-specific approaches in their curriculums. Eurocentric models do not take into consideration the Black experience. Manhood, Rites of Passage and Boys to Men programs are important in their instructional role of providing young African-American youth with cultural expectations through creative ritual ceremonies and self-esteem building activities. Organizations, program directors and facilitators are encouraged to continue these valuable endeavors and work to provide empirical data of their model's long-term effectiveness with African-American male youths.

**Treatment Modalities**

This section provides an analysis of the usefulness of various treatment modalities in terms of individual, group and family therapy. Each approach has utility in attempts to extinguish or decrease aggressive and violent behavior among youth. Further, the type of therapeutic engagement such as Behavioral, Cognitive and Reality Therapy is also investigated. Just as the treatment modality is informed as the result of a comprehensive assessment, the counseling framework requires due diligence to determine which approach to use. The treatment modality and the counseling framework that is selected must be an informed choice that fits the situation and youth, not a case in which there is a useless “one size fits all” approach. At various stages of assessment and treatment, the need may arise to engage youths in any of these therapeutic milieus as deemed necessary and conductive to the youths’ short term and long term plans of care.
Individual Treatment: Behavioral Therapy

Individual therapy involves the therapist and the youth. This type of engagement could also exist alongside group and family therapy. The driving force is the needs of the youth and desired outcomes. For example, a goal could be for the youth to develop better communication skills when dealing with peers, a parents or authority figures. Before engaging in group work or family therapy, the youth may have to do work first as an individual before becoming involved with others in a therapeutic setting (Zastrow, 2012).

The behavior change for youth in foster care who are presenting with aggressive and violent behavior starts with establishing a baseline of the youth’s behavior. This is developed in Behavior Therapy in order to determine the nature of the undesired behavior as well as the frequency (Sharf, 2012). Individual therapy involves applying behavioral techniques when the behavior has been observed and measured. The measurement could simply be a scale of 1 to 10, with 10 being the very difficult behavior. Sharf (2012) provides the example of a youth who may be given privileges such as watching television after bedtime if screaming behavior decreases. Further, it should be noted that on the individual level, there is room for negotiation. Specific strategies are developed after a sound assessment and establishment of the desired behavior. Reinforcement of the desired behavior may require others workers in a group home setting to be aware of the treatment goal and the desired outcomes.
Individual Treatment: Cognitive Therapy

For youth with aggressive and violent behavior, decreased aggression and violence are clearly the desired goal of individual treatment. Naturally, placement in foster care may challenge the therapeutic process due to this added issue may also be a focus of therapy. The use of Cognitive Therapy in Individual Treatment rests on the idea of educating clients. For youth who are the focus of this study, it would amount to assessing the cognitive distortions that lead to undesired behavior (Sharf, 2012). Helping youth decease aggressive and violent behavior with the use of Cognitive Therapy may lead a therapist to begin addressing thought processes and perceptions of the youth before the unwanted behavior occurs. The focus would then become helping the youth to understand these drives, motivations and disruptive emotions, and invariably develop more healthy coping skills and conflict resolution strategies.

Individual Treatment: Reality Therapy

The employment of Reality Therapy from as an Individual Treatment Modality framework also has immense utility. The goal would be for the youth to develop an understanding that he or she is responsible for their lives, what they do, feel, and think. According to Sharf (2012), it is based on Choice Theory. The therapeutic underpinning of Reality Therapy in working with youth individually is helping them to gain control over their behavior and make new and oftentimes difficult choices. Further, Sharf (2012) argued that the behaviors of youth must be responsible and does not impede others from achieving what they seek. Clearly, aggression and violent behavior is quite the opposite.
This behavior disrupts others. In Individual therapy, a therapist would seek to educate the youth in determining, realistically, what they want, and subsequently, if the behavior leads to the desire.

**Group Treatment: Behavioral Therapy**

The use of group counseling has the capacity to assist youth in foster care who are presenting with aggressive and violent behavior on many fronts. Group therapy is often used as a supplement to individual therapy (Zastrow, 2012). On some occasions, it is the only treatment, when identified as the most useful after a thorough assessment of needs and treatment planning. According to Sharf (2012), part of the usefulness of group work is that the clients have compatible behavior that is the focus of the therapeutic intervention. For example, youth who are experiencing anxiety associated with grief due to the death of a parent should not be included with youth experiencing sexual molestation. In the instance of this study, it is recommended that all of the group participants are dealing with aggression and violence behaviors.

Sharf (2012) argued that social-skills training is a good focus area for group therapy through the incorporation of role playing skills. Further, the group experience, when properly constructed, provides a safe environment for modeling behavior from either the therapist and or other group members (Zastrow, 2007). Members of the group have the opportunity to practice the desired behavior and receive immediate feedback from other members. One useful aspect of group work is also the use of homework, in which members are provided situations to practice and incorporate in daily activities.
learned during group. The power of group work is also the use of reinforcement. This affords members with a sense of camaraderie and support. This has benefits for youth who are in living in group home settings as well.

**Group Treatment: Cognitive Therapy**

When group work is approached from a cognitive framework. The focus becomes, according to Sharf (2012), centering on specific, structured, and problem-oriented changes. This approach is also associated with psycho-educational processes. Individuals must be able to understand their behavior through ongoing tracking of thoughts, feelings and the behaviors that is targeted for change. The therapist and group members work on new ways of the thinking about their specific situations, as well as new behaviors to incorporate in their daily lives. Sharf (2012) noted that experimenting with new alternatives to old problems, both within and outside of the group, is an important aspect of group cognitive therapy.

**Group Treatment: Reality Therapy**

Reality Therapy is group counseling has been used in a variety of settings. They include junior high and high schools, parent groups, substance abusers, mentally limited adults, and incarcerated adolescents and adults. This therapeutic approach for youth in foster care settings who are presenting with aggressive and violent behavior is ideal. The engagement of group participants involve cutting of discussions about past behavior and excuses for current behavior. Each group member makes a plan and members, as well as the therapist provide follow up regarding execution and process. The common element
and benefits of Reality Therapy consist of support, a sense of belonging, empowerment and encouragement (Sharf, 2012).

Hopps, Pinderhughes and Shankar (1995) argued that groups are the intervention of choice for work with oppressed populations and should not be viewed as detracting from one-on-one clinical practice, but serve as an addition. The group process should not only emphasize cognitive and behavioral interventions. Bemak and Keys (2000) suggested that one of the paradoxes of group work is not focusing on the violent behavior of aggressive youth, rather we should address their deeply housed unmet needs. Further, attending to their unshared feelings, and isolation in a group setting can be helpful in facilitating connectedness to other youth. This has utility in reducing violence and promotes a more comprehensive mental health. Despite the recent emphasis on group work, relatively few clients are treated in this manner as compared with those treated individually.

Services provided to youth in groups have several positive aspects as delineated by Wodarski and Wodarski (1998). Individuals in this type of treatment modality engages in activities that occur throughout daily interactions. Interactions in the larger society will require them to have the necessary skills to navigate the many institutions impacting their lives. For youth in foster care exhibiting aggressive and violent behavior, this often means returning to homes and communities that have not changed. Group work affords the ability to test behaviors in a safe and support environment. Further, feedback from peers is immediate and role models are available demonstrate the desired behavior.
The introduction of group work as a specialized area of social work with children emerged in the early 1970’s and expanded to include focus areas such as mental health, poverty, and dysfunctional family situations (Fatout, 1996). Treatment groups exist for the following purposes of education, growth, remediation and socialization. Hirayama and Hirayama (2001) argued that group work is effective in fostering resiliency in children. They propose adopting an eco-systems framework that include group, family, and community or social support network because it is known to facilitate protective mechanisms in its utility of the three ecological levels.

Group work in social work practice can be utilized to accomplish an array of objectives. They include effects on participants, collective problem solving, and change on social situations. Participants could re-socialized as well as acquiring a better sense of self, identity, belonging and support. Working with others help with developing skills needed for collective problem solving and group thinking (Zastrow, 2012).

**Family Treatment**

At times it is necessary for youth and their parents, guardians or caregivers to come together in the therapeutic environment to address the aggressive and violent behavior that is the cause of conflict and dysfunction. Often, the treatment process starts with individuals receiving individual counseling first. Many of the same counseling frameworks – Behavioral, Cognitive and Reality Therapy – used in the engagement of youth are used in the family therapy (Zastrow, 2002).
Family therapy as we know it today has undergone significant changes over the years. According to Sharf (2012), the current practice of family therapy has its foundation in a variety of theoretical, practical, and research approaches to helping children, married couples, and individuals. Well beyond the views and underpinning of Freud and other early subscribers of psychoanalysis, who would often treat parents and children separately, counselors now realize the importance of attending to the entire family ecology. The shift from blaming parents for children’s problems began in the 1950s. The movement to usher in counseling frameworks such as Family System Therapy, Structural Family Therapy and Strategic Therapy commenced. These frameworks sought to address the interaction among family members, power relationships and communication patterns.

Behavioral parent training seeks to help parents empower themselves in bringing about change within the family unit. Sharf (2012) noted that parents are taught how to make a careful and detailed assessment of the youth’s problem. Specific strategies are then utilized to modify and reinforce behavior in their child or children. Although issues related to the problematic behavior of youth is the catalyst families seeking the assistance of a counselor, often the need for individual and or parent therapy is needed. Parents are engaged in various behavior altering techniques that have been taught by the therapist. Having other parents or caregivers who are dealing with some of the same issue provides an opportunity to garner needed support. Parents need be emotionally healthy in order to effect positive and long lasting chance for the unit and youth (Sharf, 2012).
Further, the hallmark of Cognitive Therapy is education. One of the challenges in this counseling framework is getting parents to a position in which an intervention can occur. This often involves the counselor attending family issues like anger, frustration, and other disruptive behaviors. Much of the work centers on the cognitive distortions that exist by individual members of the family unit, as well as the family as the identified client. Situations are reframed and beliefs are coached into useable descriptives that are accessible by members of the family unit, instead of the reliance on blame and finger pointing. Suggestions are made for each member of family in ways to bring about family change outside of the therapy sessions (Sharf, 2012).

The values and wants of the family as a unit and individual members is the focus of Reality Therapy. This approach requires the use of a comprehensive assessment of how the family as a whole is meeting the needs of the youth, as well as other family members. A recognition of individuality is presented by the counselor, just as the need to consciously engage in activities as a family to foster interaction. Reality Therapy in group sessions seeks to assess how family members interact with each other, then assist the family in developing skills and viewpoints that foster an environment of family harmony as well as how to attend to individual needs without conflict that infringes on the decided goals of the family. As argued earlier, the need for individual therapy for the youth, as well as parents, together or individually, may have to be a part of the treatment plan before any type family therapy is attempted or may be determined to be appropriate during treatment (Sharf, 2012).
Counseling Frameworks

The foundation of Behavioral Therapy is formed from three distinct approaches: Operant and Classical Conditioning, and Social Learning Theory. The study of Behavioral Therapy cannot be mentioned without the acknowledgement of these groundbreaking approaches in understanding behavior and the response to outside stimuli. According to Sharf (2012), behavior therapy has its roots in experimental psychology and the study of the learning process in humans and animals. This is in contrast to other theories of psychotherapy. As we have come to understand and appreciate, the work of one researcher was used to build upon and enhance the work of others from a theoretical and practical framework. John Watson, for example, work involving human behavior was influenced by Ivan Pavlov. B.F. Skinner examined how environmental factors were influential in the shaping of an individual’s behavior. Further, Albert Bandura (social cognitive theory) sought to understand how individuals learned through perceptions and observations located within ones environment (Sharf, 2012).

While one might find it odd that the study of human behavior can be traced to the study of a salivating dog, it was indeed instrumental in forming a foundation in the study of human behavior and subsequently Behavioral Therapy. According to Farmer and Nelson-Gray (2005), although a few physicians used approaches that are similar to behavior therapy as it is practiced today, there was no systematic study of behavior that led to principles of behavior change until the work of Ivan Pavlov. Classical Conditioning, also called respondent conditioning, is the result of Pavlov’s work with
dogs. He observed their salivation before receiving food. He uncovered that dogs responded to what they had learned from their environment as it relates to a sound or the sight of food (Sharf, 2012).

Pavlov would present a sound or light as the conditional stimulus for a few seconds before providing the food. The food became the conditional stimulus for the dog. As a result, the actual salivation by the dog at the sight of food became the unconditional response. Finally, when the food and light or sound were presented together, the dog began to salivate. The behavior was eventually learned. Ultimately, according to Sharf (2012), this research further informed the scientific findings, emergence and development of learning processes.

The work of B.F. Skinner, Operant Conditioning, has been instrumental and perhaps groundbreaking in the conceptualization and practical applications of what we know today as Behavioral Therapy. While Edward Thorndike is also closely related to Operant Conditioning, it was Skinner who propelled its application to humans. Thorndike derived that consequences that follows behavior helps with learning. This theory was developed through his experiments with cats as a subject. Skinner, who also experimented with animals saw differences between Classical and Operant Conditioning to the extent that the latter is a learning framework that can change behavior by changing consequences. It does, however, have to be systematic. He used what has become known as the “Skinner Box” and pigeons in which they were taught to peck at a certain colored box, and not another in order to receive a certain amount of food (Sharf, 2012).
The findings related to Classical and Operant Conditioning are based on behavior that can be directly observed. Social Cognitive Theories, in contrast, are concerned with behaviors that are considered to be covert – taking place within the individual, therefore cannot be seen. Social Learning Theory and the term cognitive-behavioral cannot be mentioned without a reference to Albert Bandura, a major contributor to the field. Two important concepts in this theory are observation and modeling (Sharf, 2012).

Bandura (2007) emphasized the role of thoughts and images in psychological functioning. He proposed a triadic reciprocal interaction system involving the interactions among the environment, personal factors including memories, beliefs, preferences, predictions, anticipations, and self-perceptions; and behavioral actions. The general idea is that these three factors interact with each other. Further, each still operate in a manner in which one will impact the remaining two. The observation of others is central to Bandura’s Theory. Additionally, cognitive structures, which are a part of the self-system that influences the thoughts, behaviors and feelings of individuals. The cognitive structures include self-awareness, self-inducements, and self-reinforcement (Martin, 2004).

The applicability of Behavioral Therapy with the target of this study (youth in foster care with aggressive and violent behavior) has been demonstrated. The functionality of identifying the problematic behavior, in addition to keen assessment and planning, has immense potential in causing the undesired behavior to end or decrease. The initial step is to observe the behavior, then modeling appropriate responses to
stressors. Ensuring that youth who are the subject of the intervention develops a strong sense of self-efficacy will aid in achieving the expressed goals of treatment with this population (Zastrow, 2012).

Cognitive Therapy

Cognitive Therapy is associated with the work of Albert Beck, a physician. After a career that included a focus in pathology and neurology, Beck later was certified in the field of psychiatry. He has had a stellar career in the field which has resulted in the publication of more than 500 articles and 25 books related to Cognitive Therapy (Sharf, 2012). As a psychoanalyst, he began to observe and identify negative themes in the thoughts of his clients ranging from defeat to inadequacy. The focus, thus became what people said to themselves, as well as their own internal communications.

His early work was with individuals who suffered from depression. In later works, his concepts were applied to a larger range of disorders. He observed how individuals would ignore positive information about themselves, choosing instead to attend to negative information. Beck argued that a lot of negative beliefs demonstrated by individual had developed at early stages in life. He concluded that anxiety disorder, for example, is rooted in prominent themes of abandonment and the threat of failure (Sharf, 2012). The work of Albert Ellis (the importance of beliefs) and Jean Piaget (the development of cognition) were both influential in the development of his theoretical approach.
Sharf (2012) argued that psychoanalysis and Cognitive Therapy share the view that behavior can be affected by beliefs that individuals have little or no awareness of. The assertion is that automatic thoughts often lead to distress and frustration. Therefore, the goal of Cognitive Therapy is to help individuals change inaccurate assumptions about themselves. This is achieved by direct interaction. It is also important to note Beck’s holistic view of clients. He indicates that psychological distress can rarely be attributed to only one causation, rather, biological, psychological and social factors that interact collectively may be impactful. This is extremely useful in working with youth exhibiting aggressive and violent behavior and speaks directly to the need of addressing all of the issues and institutions negatively impacting their lives (Zastrow, 2007).

In short, the fundamental goal of Cognitive Therapy is to restore clients to a more effective level of functioning through the removal of distorted thinking. Individual’s cognitive distortions and misperceptions are challenged, tested, and discussed to bring about more positive feelings, behaviors, and thinking. The way the client processes information is important. Skilled therapists must be able to address the automatic thoughts, as well as how these thoughts are perceived, organized and related responses. The three levels of changing cognitive schemas are reinterpretation, modification and restructuring. The skilled therapist guides the clients through each level (Beck, Freeman, & Davis, 2004).
Reality Therapy

The basis of Reality Therapy is choice. This therapeutic approach helps people control their behavior and assumes that people are indeed responsible for what they think, do and feel. Ultimately, they are responsible for their own lives. The focus is not so much on a person’s past, rather the here and now. The current actions of the individual and their ability to make better informed decision is at the center of the therapeutic process. Further, attention is given to what the client wants, in addition to their current behavior and in order to achieve these goal. The foundational ideas of psychoanalysis and mental illnesses are rejected, whereas the affirmation of social conditions that affect all human are embraced (Glasser, 1980).

Reality Therapy has been become the counseling framework of choice for mental health workers engaging individuals with drug and alcohol problems, as well as setting like correctional institutions. Glasser (1989) identified five basic psychological needs that are useful in understanding the applicability of Reality Therapy and attending to the need of clients: survival, belonging, power, freedom, and fun. Survival includes the basic things we do to take care of ourselves such as eating and ensuring that we have shelter. The need for belonging exist in all cultures and includes basic needs such as the need to love and to share. The need for power can become conflictual with our need for belonging. Freedom has to do with how we wish to live our lives, and includes other important factors such as whom we desire to associate with and our ways our expression. Fun includes laughing, and activities like reading sports, and joking. As it relates to
identifying and understanding what we want, which is vital a part of the therapeutic process, collectively, these five needs are achieved through our perceptions, which informs our behavior (Sharf, 2012).

Reality Therapy takes an educational approach by helping clients clearly define their wants. It is the counselor’s role to assess the client’s behaviors and needs and subsequently assist them in developing healthy ways to achieve the specified goal. According to Sharf (2012), this process begins with developing a friendly relationship with the client. The wants, needs and perceptions of the client, as well as their total behavior, are all examined within the context of the individual’s values. While the friendly relationship is in place to demonstrate the counselor’s interests and commitment, it remains professional and therapeutic. Excuses are not accepted, yet argumentative situations are avoided. The client is instill with a sense of the counselor not giving up on them (Glasser, 1989).

This particular counseling framework has usefulness for youth who may have been failed by the many institutions that have impacted their lives and have contributed to them being in foster care. Their issues and needs are complex. Additionally, youth with aggressive and violent behavior are often difficult to engage in the therapeutic process, thus, the tenets of Reality Therapy may be quite useful in work with this and other difficult populations.
Support Services

Mentoring as an augment to services for youth not only in foster care, but youth in general is a very promising practice. In the absence of having the full support of a parent or relative, it can be helpful in youth developing prosocial skills, making and maintaining a meaning relationship with a caring, support and concerned adult. There are highly structured and formal mentoring program administered by civic organizations, clubs, schools and agencies. Likewise, there are informal networks headed by the faith community and neighborhood groups. While mentoring is not a new intervention or proactive program, it is becoming used more frequently with youth in foster care (Fowler, Toro & Miles, 2011).

Therapeutic mentoring, according to the Substance Abuse and Mental Health Services Administration (2010) involves structured, strength-based support service between a therapeutic mentor and a youth. It is one-on-one contact that involves addressing and building pertinent life and social skills. Further, the objectives of this type of mentoring is to not only be a support service, but to also intervene if necessary, to prevent or address additional problems or behavioral issues. The Substance Abuse and Mental Health Services Administration (2010) also noted that basic requirements for this staff should be a bachelor’s degree in a mental health or human services field, completion of a therapeutic training program and a successful background check. Other activities of a therapeutic mentor include, but are not limited to supporting, coaching, and training the youth in age-appropriate behaviors. Additional competencies that are focused on include
interpersonal communications, problem solving and conflict resolution. This level of mentoring can have immense purposes when other services linkages are being rendered for youth with aggressive and violent behavior.

Rhodes (2002) argued that while psychotherapy and mentoring are quite different, both requires a caring relationship. The quality of the mentoring bond has a lot to do with a close and trusting relationship. Just like in the therapy relationship, the mentee needs to be motivated, involved and cooperative. It must become a therapeutic partnership. Additionally, Rhodes (2002) noted that positive change in mentoring appears to be partially determined by factors such as activities that are enjoyable to the youth. The purpose is to instill hope and engender trust between the youth and mentor.

Cavell, Christian, Malcolm and Faith (2009) argued that additional research is needed for mentoring programs that are providing services to school age youth who are highly aggressive. Anecdotal testimonies are not enough. A good research design and robust research with outcomes measured over time is needed. Ultimately, the goal is for youth to start exhibiting healthy behaviors and cultivating relationships with family.

The Annual Review of Treatment Effectiveness, a report by the Texas Juvenile Justice Department (2011), reviews the youth services that are in place to help rehabilitate and reestablish youth in society who are in its care. Their mentoring program is comprised of volunteers. It was noted that one of the benefits that they are experiencing is the rate at which youth are obtaining GED or high school diplomas. Forty-two percent of non-mentored youth who were released from one of their facilities earned a GED or
high school diploma within 90 days; however, 48.7% who were mentored earned theirs (Texas Juvenile Justice Department, 2011).

Finally, the report indicates that the mentoring program is demonstrating gains in recidivism for re-arrest and re-incarceration. For example, it is reported that 51.9% of the non-mentored youth were re-arrested within one year after release. This was in comparison to 40% of the youth who were mentored for 181 days or more. Further, a five year review indicated similar encouraging numbers for mentored youth versus non-mentored youth. While the goal of mentoring us to prevent behaviors from escalating to the point where a youth will have to be incarcerated, the Texas Mentoring Program shows promise as an intervention (Texas Juvenile Justice Department, 2011).

Youth in foster care are already at risk in many ways. They have been removed from everything that is familiar. When aggression and violent behavior is a presenting issue, a host of remedies will have to be employed to sustain or return the youth to a level of acceptable behavior. Mentoring, when appropriately resourced and monitored can be value add for other therapeutic services. The challenge for agencies and other well-meaning groups and individuals is to ensure that proper training takes place, good matching and the use of committed and vetted individuals (Williams, 2011).

Probation Services

Probation services provide a valuable supplement to other therapeutic services that are utilized to help reduce aggressive and violent behaviors and produce successful outcomes for foster care youths. The introduction of a juvenile probation officer to the
therapeutic milieu is a result of the youth being involved in bad behaviors and activities that brought them to the attention of the juvenile court system. The involvement of the probation officer could vary from being infrequent meetings, check-ins and reporting in person of by phone to stricter measures such as set times to report in person, and or call, mandated groups, individual and or family therapy (Maschi & Schwalbe, 2012).

Juvenile probation officers also conducts needs assessments, provide individual, group and or family counseling. The focus of juvenile courts and probation officers is to provide an array of services, referrals or collaborative partnerships that prevent further involvement with the courts, and reduce risk to the community. Not only is intervention efforts stressed, preventive measures are progressive in the area of rehabilitation (Maschi & Schwalbe, 2012).

Another service provision of probation services is crisis intervention and mediation of family or interpersonal conflicts. Additionally, refers are made to community resources that meet the youths identified needs. While monitoring of the youths full participation in school, resource programs and compliance with their provisions of probation are some of the duties of the probation office, they are also responsible for much of the direct services that are a part of the youth’s overall treatment plan. Yet, there has been a call to move the profession toward reintegrating social work into the corrections field (Peters, 2011).

Some of the requirements of the juvenile probation officer’s position consist of a working knowledge of theories and principles of counseling; theories and principles of
childhood and adolescent development and behavior; theories and principles of sociology, psychology, and or criminal justice; methods and techniques used to conduct a child and adolescent counseling and mental health evaluations and; community resources and programs associated with children and adolescents (Peters, 2011).

**Behavioral Aide and Wraparound Services**

Behavioral Aides are often positioned beneath the large umbrella of therapeutic services called Wraparound Services. The Encyclopedia of Behavior and Cognitive Behavior Therapy (2005) describes it as a philosophy of care. It includes clearly articulated planning processes that are used to build constructive relationships and support networks among students and youth. These youth often present with emotional or behavioral disabilities. Services are provided to the youth and or their families. Beyond the term Behavioral Aide, other job titles exist, from Behavior Specialist to Behavior Technician. They work with state, county, and private agencies.

The State of Georgia Behavior Specialist (2013) duties and responsibilities include, but are not limited to an assortment of services such as conducting psychological assessments, providing individual and group therapy, as well as serving on multidisciplinary teams. These specialist also assist in the development of behavioral modification programs, providing social and supportive services to the youth and psychoeducational information to families. Treatment plans are monitored for compliance and case management services may be provided. Also, there may be a need to provide crisis intervention services. This type of intervention programming that targets foster care
youth with aggressive and violent behavior has immense utility due to its multidisciplinary approach, crossing the lines of juvenile justice, child welfare, educational and various private and public mental health agencies.

The Wraparound model being used by Milwaukee is instructive in its design and approach. According to Kamradt (2000), Wraparound Milwaukee is tailored to the need of each youth it serves and is based on the managed care model. Other key components are the unconditional care, flexibility, as well as child centered and family focused and culturally competent services. Further, Kamradt (2000) noted that specifically when working with youth the juvenile justice and child welfare systems, the following components are paramount: strength-based approach to children and families; family involvement in the treatment process; needs-based service planning and delivery; individualized service plans; and outcome-focused approach.

The Milwaukee Wraparound project came out of the need to find alternative ways to deal with their troubled youth. According to Kamradt (2000), child welfare and juvenile justice placements had record proportions. There were more than 350 youth were in placements on an average day at a cost of more than $18 million per year. Other structural and design aspects of the program include: care coordination, the family and child family team, a mobile crisis team, and a provider network.

The outcomes of Milwaukee Wraparound are encouraging, having experienced a 60% decrease in the use of residential services, going from an average census of 364 youth to less than 140 (Kamradt, 2000). Further, there was a decrease in inpatient
psychiatric hospitalization by 80%. Due to a decrease in cost, the savings have resulted in
more youth being able to be served. The measurement of youth’s functioning increase at
the six month and one year review mark, going from a high range of impairment to
moderate levels of impairment. The clinical outcomes were measured by the Child and
Adolescent Functional Assessment Scale (CAFAS), which is the standard assessment
tool to measure children and youth’s mental health functioning at home, school and in the
community. Reduction in recidivism rates was also noted (Kamradt, 2000).

Pharmacological Therapy

Aggression has been a particular target of pharmacological treatment. Stimulant
drugs such as Ritalin and antidepressants such as Prozac are among the medications
prescribed (Hoge, 2001). The use of pharmacological treatment for aggression and mood
disturbances is becoming more and more common place. This treatment option has firmly
taken a place among the milieu of services and resources sought by parents and service
providers working with youth exhibiting aggressive and violent behavior. King (2000)
argues that aggression is among the most common psychiatric referrals. As with the
application of any medication, a comprehensive assessment and diagnostic examination
is necessary.

Provides of therapeutic services must be cautious and cognizant of the fact that
treatment of aggression and violent behavior is a complex issue and not rely on a singular
intervention. King’s (2000) research examined the use of pharmacological treatment for
aggression in persons with autism. He concluded that the use of medication will be
advanced by adopting uniformity in effective diagnosis and treatment and also cautions against a one size fits all approach. Finally, King (2000) argued that “although open clinical trials are useful in identifying directions for study, controlled trials, particularly those employing placebo, remain the crucial building blocks in the construction of solutions” (p. 443).

Glancey and Knott (2003) completed a comprehensive review of articles through PubMed and PsycINFO to examine the use of pharmacological treatment for aggression. They concluded that double-blind placebo-controlled trials with carefully selected diagnostic groups are needed to fully guide clinicians in their work with this group of individuals and the use of medication and the treatment protocol.

Randi Hagerman (1999), a medical doctor whose practice has focused on individuals with Fragile X Syndrome, suggested that in the absence of success with other forms of treatment, medication may be helpful in alleviating aggression. Common features of the disorder include mood instability, problem with impulse control and an overreaction to stimuli. Further, she advocates the use behavior modification via counseling in conjunction with psychotropic medication. Hagerman (1999) also cautioned that the type of medication is informed by the underlying symptoms. Medications such as Ritalin, Clonidine, Prozac, Zoloft, Depakote, Lithium and Zyprexa are not interchangeable.

Findling (2003) offered that aggressive behavior is common among people. He suggested that in the most cases the behavior should not be automatically assumed to be
pathological. Again, the need for effective diagnostic assessment is needed. These assessments may indeed sometimes reveal the presence of one or more psychiatric conditions such as conduct disorder, oppositional disorder, disruptive behavior disorder and ADHD. However, the use of psychosocial interventions can adequately address many of the destructive acts and physical altercations that many young people display as they progress to adulthood.

Finally, Peter Doskoch (2001) provided several instructional conclusions worth considering in making an informed decision to introduce medication into the treatment of aggression. First, the Food and Drug Administration hasn’t approved any specific drug for treating aggression. Second, there are no definitive instrument that has been identified to measuring or assessing aggression. Third, a psychiatric evaluation must also be perform in order to assess whether or not there are other presenting issues such as psychosis, depression, and or anxiety. If these other problems are adequately treated, the issue of aggression may be resolved. Fourth, there should be periodic reevaluations and medications adjusted appropriately since aggressive behavior is intermittent. Finally, the first approach should be non-pharmacological interventions such as behavioral management techniques and strategies.

Frequency of Services
The frequency of services has immense utility when addressing the needs of youth in foster care with aggressive and violent behavior. The Level of Care (LOC) system was introduced in Georgia in 2003 and went in effect February 1, 2004. In addition to the Department of Human resources, the Department of Juvenile Justice also partnered with Providers of residential care to better care for youth based on the child’s need. The system established a range of payment rates that took into consideration levels of care and services determined to meet the individualized needs of youth (Georgia Department of Human Resources, 2003).

Rappaport and Thomas (2004) argued that a well-developed assessment of youth will define the therapeutic approach as it relates to aggressive and violent behavior. Further, they contend that focusing on the youth’s current level of functioning, as well as relationships is paramount. The LOC system seeks to address these issues through a comprehensive assessment that will provide guidance in not only the type of treatment needs, but also the frequency.

The LOC system in Georgia was modeled after the nationally recognized Child and Adolescent Level of Care Utilization System (CALOCUS), an instrument developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists. The CALOCUS rose from the progressive development of needs of youth with emotional disturbances and managed care principles. The CALOCUS, according to Huffine, Jewell Hutton and Sowers (2010), offers a
framework for outlining the services and resources needed to address the therapeutic needs of youth.

Critically important as it relates to minority youth, cultural relevant practice is also addressed. Cultural competency is vitally important in the use of the instrument. There must be attention given to cultural factors and how they may impact the youth. There may be a need to seek additional assistance through a consultant. The role of cultural and their impact on individual, as well as the family’s functioning should not be minimized (Huffine et al., 2010).

The CALOCUS consists of six dimensions that determine the intensity of the service need. Hoffine et al. (2010) noted the following dimensional rating system: Risk of Harm; Functional Status; Co-morbidity; Recovery Environment; Resiliency and Treatment History; and Acceptance and Engagement. Risk of Harm is the dimension that is used to assess the youth’s risk of self-harm, as well as a being a potential victim of physical or sexual abuse. It also includes risk for neglect or violence. Functional Status measures the youth’s ability to adequately function in expected age-appropriate roles in addition to how their daily activities have been impacted by the presenting problem.

Co-morbidity is the dimension that measures the existence of other disorders in four areas: Developmental Disability, Medical, Substance Abuse, and Psychiatric. Recovery Environment has two scales: Environmental Stress and Environmental Support. Resiliency and Treatment History also measures how the youth and or family have responded to past treatment efforts. The Acceptance and Engagement dimension
measures the youth's as well as their family's acceptance and engagement (Hoffine et al., 2010).

Germane to this study is the frequency of care for youth with aggressive and violent behavior. The levels associated with the CALOCUS range from Level Zero, which is for Basic Services and Prevention Maintenance, to Level Six, which recommends Secure, 24 Hours Services with Psychiatric Management. Other levels consist of Levels Two consists of Outpatient Services; Level Three, Intensive Outpatient Services; Level Four, Intensive Integrated Services Without 24-Hour Psychiatric Monitoring; and Level Five, None-Secure 24 Hour Services with Psychiatric Monitoring (Huffine et al., 2010).

Georgia’s Minimum Standards for Level of Care System Indicator Manual (2003) identified moderate levels of impulsivity and aggression in Level Three and notes the benefits of individual, family and or group therapy. Treatment Services also include access to specialized services. Further, Level Four indicates moderate to serious emotional and or behavioral management problems. Level Five notes serious to severe emotional and or behavioral management problems with aggression, fighting, defiance and impulsivity indicated as moderate to high.

There is an increased emphasis placed on individualized plans of care and integrated support services. The CALOCUS advocates for clinical services averaging approximately three days per week, with psychiatric consultation to the treatment or child and family team occurring regularly starting at Level Three. Level Four recommends that
the provision of services being afforded more frequently and for more extended and
flexible periods of times than at lower levels. As the Level of Care moves to Levels Five
and Six, clinical services must be comprehensive and reflects proper consideration given
to the safety of the youth and community at large. Well defined crisis plans, as well as 24
hour monitoring and observation are noted (Huffine et al., 2010).

Filtering these programs and interventions strategies and techniques through the
lens of therapeutic activities and protocol that influence successful outcomes for
aggressive and violent youth in foster care gave rise to several themes that are germane to
the efficacy of conducting this study using the selected independent variables. The
literature review has positioned the researcher to pursue an evaluative and theoretical
synthesis of clinical practice (Rossi and Freeman, 1994). The objectives are: (1) to
examine and describe the treatment modality that hold promise in work with youth in
foster care who are exhibiting aggressive and violent behavior; (2) to examine and
describe the counseling framework that hold promise in work with youth in foster care
who are exhibiting aggressive and violent behavior; (3) to examine and describe the
support service associated with effective intervention strategies and (4) to examine the
frequency of intervention most likely to produce successful outcomes.

Theoretical Framework

There is an array of theories across various disciplines that seek to explain the
multiple pathways and contributing factors that lead to aggressive and violent behavior.
From the fields of social work, psychology, sociology and criminology, contrasting and
similar perspectives chart the course of this issue. Therefore, an integrated conceptual framework and theoretical rationale has more utility for the purpose of this study. The leading frameworks that are frequently encountered are reviewed.

Rational Choice Theory is a modification of classical theory. It suggests that criminal behavior is predicated on the use of calculations, reasoning, and rational consideration of choices. Recent discussions of this theory link it with learning theory, or differential association theory. Clearly, humans act on the basis of reasoning and calculation; however, often this thinking is flawed and ill conceived. People are imperfect and susceptible to making mistakes in judgment, interpretation of events, and in their assessments of situations (Shoemaker, 1996).

There is a divide in the scholarly community regarding this theory. Some feel it that it is rooted in early life experiences and methods of coping (Gottfredson & Hirschi, 1990). Others contend that it is a result of choices made in navigating personal and environmental influences and they subsequently influence future decisions (Sampson & Laub, 1993). These choices extend to social and occupational issues and are subject to change depending on the situation, and perceptions.

Biological and Biosocial Theories posits that delinquent behavior is caused by internal mechanisms. This theory has existed for many decades, however, the internal workings has been source of debate (Fink, 1938). Many early theorists did not differentiate between biological and psychological characteristics, arguing that the criminal mind is affected by biological makeup. The general belief is that there is a
predisposition to criminality (Booth & Osgood, 1993). This predisposition interacts with environmental factors. Prior scholarly inquiry asserted that biological factors actually caused the delinquent behavior (Shoemaker, 1996).

As with many early theories, the biological approach has been reconsidered and examined over the years and has resulted in various changes. Traditional views tend to prefer the predisposition explanation, rather than earlier themes that focused on the evolutionary concepts. This trend reflects the interdisciplinary approaches that are seen in many fields of study that are tackling the issue of delinquency (Moffit, 1990). Personality and environmental conditions are more readily embraced. Recent theory and research while not totally dismissing biological factors, are more inclined to focused on concrete areas of cognitive development and learning capabilities in terms of biological influences and the relationship to antisocial and behavior of juveniles (Shoemaker, 1996).

Scholars, policymakers and laypersons frequently embrace Psychological Theories. According to Shoemaker (1996), differences in personalities and intelligence directly affect delinquency. The develop of intelligence tests (IQ tests), while a source of debate in terms of validity and reliability, still factor into the equation of separating individuals who offend from those who do not. Shoemaker (1996) cautioned that, while the hypothesized indirect connection between IQ and delinquency more than likely does exist, the force of the relationship is relatively weak and more operative for some juveniles than for others. Nonetheless, the link between IQ and delinquent continues to
flourish in many academic arenas, despite the important considerations of environmental exposures, racial, moral and emotional judgment.

To counteract the trend of associating IQ and delinquency, a conscious and scholarly thrust should be in the areas of longitudinal data, multiple indicators of delinquency or antisocial behavior such as self-reports, teacher evaluations and parental assessments should be employed. Appropriately conceived and administered areas such as environmental conditions could be captured in studies and mitigate variations in social and economic influencing factors in our society (Sampson & Laub, 1993).

Social Disorganization Theory suggests that environmental factors have a direct correlation with delinquency. The assumption is that delinquency is a result of a breakdown of institutional, community-based controls. Individuals are not viewed as being totally disoriented, rather they are responding to the various disorganized conditions in their environment (Sampson & Groves, 1989). Another prevailing assumption is that rapid industrialization, urbanization and immigration processes all play a role. Grounded in the ecological approach, the social disorganization theory, also proffers that socially disorganized areas lead to the development of criminal values and traditions (Finestone, 1976).

Social Learning Theory as positioned by Bandura (1986) emphasized that aggression is a learned behavior that is acquired through the modeling process. The acquisition of the behavior by children is from observing family members, media personalities or characters, and or individuals in the environment. Social Learning
Theory also seeks to explain the origins of aggression and how it is maintained. As a learned behavior, aggression is subject to prevention, intervention and treatment protocols.

Clearly, there is a plethora of theories used to explain delinquency, aggressive and violent behavior. The literature is flooded with contrasting perspectives. Therefore, clinicians and service provides must not be wedded to a single perspective in our work with individuals and efforts to arrest this behavior. We must take an eclectic lens to assessment, prevention and treatment, thus avoiding the pitfalls of a “one size fits all” ideology. This perspective should be fully embraced when providing services for youth in foster care who is also presenting with aggressive/violent behavior.
CHAPTER III

METHODOLGY

This chapter presents the methods and procedures that were used to conduct this study. The following topics will be discussed: research design, description of the setting, sample and population, instrumentation, treatment of data, and limitations of the study.

Research Design

The research design is descriptive and exploratory. A research design is a clear expression of how the research problem will be explored. It provides the framework for gathering, processing and interpreting the observation. It is the plan and framework for the investigation and area of inquiry (Runyon, Coleman & Pittenger, 2000). The research design is the formal roadmap. Overall, this is a study of effectiveness in clinical practice, which is commonly referred to as impact or outcome evaluation (Rossi & Freeman, 1994).

A research questionnaire technique for obtaining data was utilized. The questionnaire consisted of two sections that sought information regarding demographics and background of participants, and treatment modalities, counseling framework, support services and frequency of services. The research design affords for the descriptive
analysis of the demographic characteristics of the participants in the study, as well as the examination of statistical relationship and significance of factors that influence successful outcomes for youth with aggressive/violent in foster care. Therefore, the study has elements that are descriptive (Bloom, Fischer & Orme, 1999) and quantitative in nature and design (Jordan & Franklin, 1995).

**Description of the Site**

This study was conducted in the Metropolitan Atlanta area in the State of Georgia. The surveys were administered in three different social service agencies. These agencies were selected because of their work with youth in the foster care system. The Atlanta area and the selection of these agencies also afforded the potential of greater participation from workers who are involved with youth in foster care who exhibit aggressive/violent behavior to the degree that clinical intervention is needed and is able to be provided, as well as the other variables explored in this study.

**Sample and Population**

When therapeutic services cannot be implemented by the State, they must be contracted and coordinated with an outside service provider to ensure that the needs of the youth are meet in a timely manner. The State of Georgia enters into contract with these providers of residential, family foster care and therapeutic services. These various providers employ workers such as social workers, counselors, therapist and psychologist who render therapeutic intervention, prevention and treatment of youth. Sixty-five (65)
respondents, collectively, from three different agencies were selected utilizing non-probability, purposive and convenience sampling.

For the protection of human subjects, names or any other potentially identifying characteristics of the participants were not collected on the questionnaire. All analysis focused on group analysis. Further, no attempt will be made to identify individuals. All subjects are adults and voluntarily completed the questionnaire.

Instrumentation

Questionnaires have long been considered one of the most efficient ways of collecting data. They can be administered with relative ease to large groups of people. Computers have also made it quite easy to analyze the data, as well as draw comparisons and conduct evaluations. Large responses can be summarized quickly and the process is relatively inexpensive (Cummings & Worley, 2001).

The instrument for collecting data was developed by the author. It is a 21 item, non-standardized questionnaire to assess clinical experiences with youth in foster care who exhibits aggressive/violent behavior. There are presently no empirically validated, actuarial instruments that can be used to accurately gather this information. However, a number of categorical variables have been identified based on research data and consensus in professional clinical opinion. The variables are Treatment Modalities (individual, group and family therapy), Counseling Frameworks (behavioral, cognitive, and reality), the assistance of Support Services (mentoring, probation services, behavioral
aide and pharmacological therapy) and Frequency (once, twice, or three or more times a week).

A four-level Likert-type scale is included in Sections II of the questionnaire to determine the relative intensity of the participant’s responses as delineated in the objectives and research questions. The scale ranges are: 1- Strongly Disagree, 2- Disagree, 3-Agree and 4-Strongly Agree. Assigning a pre-coded number to each response increases the utility in terms of ease and speed in transferring the data into the computer file. The instrument, The Successful Treatment Outcomes for Aggressive/violent Youth in Foster Care Survey, was tested and piloted through the following procedures:

1. Questions underwent several drafts to improve clarity and format.
2. A pilot test to further determine clarity of the questionnaire items and instructions was submitted to clinicians who provide therapeutic services to youth in foster care who exhibits aggressive/violent behavior.
3. A draft was submitted to the dissertation committee.
4. Upon completed revisions and final approval from the dissertation committee, the questionnaire was utilized for data collection and analysis.

The questionnaire is divided into the following two sections. Section I is Demographics. This section contained 8 questions that provided the researcher with characteristics of the sample. It includes questions regarding gender, age group, highest
educational degree, degree area, annual income, licensure, years of experience working with the identified population, which is operationally defined as youth in the foster care system who exhibits aggressive/violent behavior. The participants were asked to place an "X" next to the appropriate item. In addition, they were instructed to choose only one item. Questions 1 through 8 captured the demographical information.

Section II is Treatment Modality, Counseling Framework, Support Service, and Frequency of Service. This section examined the various clinical interventions, treatment models and strategies employed that provide successful outcomes with this population. The participants were asked how much they agree or disagree with the subsequent statements in the questionnaire and to write the appropriate number in the blank beside each statement. This section consisted of 13 questions. Questions 9 through 21 specifically solicited information regarding successful outcomes (dependent variable) in working with the population. There are three questions that measured the use of the three treatment modalities, three questions that measured the utilization of the presented counseling frameworks, four questions that measure support services, and three questions that measured frequency of interventions.

Validity refers to the extent of matching, congruence or goodness of fit (Jordan & Franklin, 1995). Further, it refers to the extent to which a test measures what it purports to measure. Reliability is concerned with questions of stability and consistency. It means that you are measuring something consistently and dependably. Moreover, it refers to the consistency with which a measurement technique produces the same
outcome (Jordan & Franklin, 1995). Theoretical approaches were used to inform the interventions, as well as provide the basis for operational definitions of outcome measures. This type of undergirding supports an instrument being deemed to possess content validity (Hopps, Pinderhughes & Shankar, 1995). Further, pilot testing, clinical reviewers, as well as several researchers were used to determine the instrument’s content and construct validity.

**Treatment of Data**

A non-probability, purposive and convenience sample was utilized. Non-probability sampling refers to case selection rather than random sampling. Convenience sampling refers to cases that are conveniently available. In Purposive sampling, researchers purposively select those believed will give the best information as participants (Patten, 2002). It is purposive in that the researcher sought out agencies who are known for their work with the population. Likewise, it is convenience because the researcher has knowledge of available individuals in these agencies to participate in the study.

The participants are individuals who have intimate knowledge of the youth’s therapeutic pathways and subsequent outcomes. Numeric codes were assigned to each returned questionnaire. The questionnaires were reviewed for completeness and legibility. Upon completion of collecting all usable data, the analysis and interpretation began.
A combination of descriptive and inferential statistical techniques was utilized in the treatment of the data. Frequency runs of all research variables was conducted to summarize information. Bivariate correlation was used to measure the degree of relationship between each independent variable and the dependent variable. The Pearson’s correlation coefficient (Chi-square) was utilized to compute and examine the association between variables.

Descriptive analysis was used to describe the sample population, demographic data, show frequency counts, and percentage responses in each category. The Statistical Package for the Social Sciences (SPSS) 19.0 for Windows was used to codify, analyze and summarize the data.

**Limitations of the Study**

There are possibly three limitations of the study. The first limitation is the number of participants. Secondly, convenience sampling techniques may or may not represent the full range of human service professionals serving the targeted population of youth. A larger population that is randomly selected and perhaps has longitudinal aspects could potentially yield a more diverse and inclusive data set, as well as demonstrative of recidivism and sustain effects, thus subsequently affecting the study outcomes. Lastly, questionnaires have several disadvantages worth noting. Since the responses are prearranged, the opportunity to probe for additional information is limited or not possible. This also limits the ability to garner additional clarification if needed. Since they are self-reports, the risk arises that respondents may offer socially acceptable answers. In
addition, they are oftentimes quite impersonal, as argued by Cummings and Worley (2001). These limitations offer support for continued and expanded research design and population, and the exploration of micro-level interventions that has demonstrated promise in decreasing aggression and violence among youth in foster care systems.
CHAPTER IV
PRESENTATION OF FINDINGS

This chapter presents the findings of the study in order to describe and explain the factors that influence successful outcomes for youth with aggressive/violent behavior in foster care. The variables that guided the study consisted of Treatment Modality (Individual Therapy, Group Therapy, and Family Therapy), Counseling Framework (Cognitive Therapy, Behavioral Therapy, and Reality Therapy), Support Services (Mentoring, Behavioral Aide, Probationary Services, and Pharmacological Assistance), and Frequency of Services (One Hour, Two Hours and Three Hours). The findings are organized into three sections: demographic data, frequency of responses, and research questions and hypotheses.

Demographic Data

This sections provides an analysis of the respondents in the study. A profile has been assembled using descriptive statistics to measure frequencies of responses. The following was analyzed: gender, racial category, highest educational degree, annual income, years of experience working with youth, and licensure.

The targeted participants for the study consisted of individuals who work with the population. The 65 respondents were selected from three social service agencies in the Metropolitan Atlanta area that provides services for youth in the foster care system. A
non-probability, purposive and convenience sample was utilized. Non-probability sampling refers to case selection rather than random sampling. Convenience sampling refers to cases that are conveniently available. Purposive sampling purposively seeks out and select those individuals and agencies believed capable of providing the best information as research participants in the study (Patten, 2002). Table 1 provides the demographic profile of the respondents in the study as indicated by the noted variables.

Table 1. Demographic Profile of Study Respondents

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<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
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<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Female</td>
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</tr>
<tr>
<td>Bachelors</td>
<td>9</td>
<td>14.0</td>
</tr>
<tr>
<td>Masters</td>
<td>47</td>
<td>72.0</td>
</tr>
<tr>
<td>Doctorate</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>9.0</td>
</tr>
</tbody>
</table>
Table 1 continued. Demographic Profile of Study Respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td>12</td>
<td>18.0</td>
</tr>
<tr>
<td>Counseling</td>
<td>27</td>
<td>42.0</td>
</tr>
<tr>
<td>Psychology</td>
<td>9</td>
<td>14.0</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>5</td>
<td>8.0</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>18.0</td>
</tr>
<tr>
<td><strong>Annual Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>11</td>
<td>17.0</td>
</tr>
<tr>
<td>$30,000 - 39,999</td>
<td>15</td>
<td>23.0</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>14</td>
<td>21.0</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>19</td>
<td>30.0</td>
</tr>
<tr>
<td>Over $60,000</td>
<td>6</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>Years Experience Working With Youth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 3 years</td>
<td>8</td>
<td>12.0</td>
</tr>
<tr>
<td>4 to 6 years</td>
<td>18</td>
<td>28.0</td>
</tr>
<tr>
<td>7 to 10 years</td>
<td>18</td>
<td>28.0</td>
</tr>
<tr>
<td>11 to 15 years</td>
<td>4</td>
<td>6.0</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>17</td>
<td>26.0</td>
</tr>
<tr>
<td><strong>Licensure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Master Social Worker</td>
<td>4</td>
<td>6.0</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td>19</td>
<td>30.0</td>
</tr>
<tr>
<td>Associate Professional Counselor</td>
<td>4</td>
<td>6.0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>6.0</td>
</tr>
<tr>
<td>Not licensed</td>
<td>34</td>
<td>52.0</td>
</tr>
</tbody>
</table>

As indicated in Table 1, the typical respondent of the study was a Black-African American female between thirty and thirty-nine years old. Further, the master’s degree
was the highest earned degree in Counseling. Regarding years working with youth, 28% were noted for both, four to six years, as well as seven to ten years. The annual income was between $50,000 to $59,999 dollars. Slightly more than half of respondents (52%) indicated no licensure.

**Frequency of Computed Variables**

Treatment Modality, Counseling Framework, Support Services and Frequency of Services are computed variables. This section examines the sub-facets of each variable and frequencies. How each variable was computed in order to determine the true value is discussed.

Table 2 is a frequency distribution for the computed variable Treatment Modality. It consists of Individual Therapy, Group Therapy, and Family Therapy. To determine the true value of Treatment Modality, the sum total of the set was divided by three.

<table>
<thead>
<tr>
<th>Treatment Modality Sub-facets</th>
<th>Disagree</th>
<th></th>
<th>Agree</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>2</td>
<td>3.1</td>
<td>63</td>
<td>96.9</td>
<td>65</td>
<td>100.0</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>3</td>
<td>4.6</td>
<td>62</td>
<td>95.4</td>
<td>65</td>
<td>100.0</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>0</td>
<td>0.0</td>
<td>65</td>
<td>100.0</td>
<td>65</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 2 indicates whether or not the respondents disagree or agree that Individual Therapy, Group Therapy, and Family Therapy have been beneficial in achieving successful outcomes in work with this population. The majority of respondents (96.9%) agreed that Individual Therapy has been beneficial. Similar results were noted for Group Therapy (95.4%). However, 100% of respondents indicated that Family Therapy has been beneficial in achieving successful outcomes in work with aggressive/violent youth in foster care.

Table 3 is a frequency distribution for the computed variable Counseling Framework. It consists of Cognitive Therapy, Behavioral Therapy, and Reality Therapy. To determine the true value of Counseling Framework, the sum total of the set was divided by three.

Table 3. Counseling Framework Sub-facets

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Behavioral Therapy</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reality Therapy</td>
<td>2</td>
<td>3.1</td>
</tr>
</tbody>
</table>
Table 3 indicates whether or not the respondents disagree or agree that Cognitive Therapy, Behavioral Therapy, and Reality Therapy have been beneficial in achieving successful outcomes in work with this population. There was total consensus (100%) among the respondents for Cognitive Therapy and Behavioral Therapy. As it relates to Reality Therapy, 96.9% of respondents were in agreement.

Table 4 is a frequency distribution for the computed variable Support Services. It consists of Mentoring, Behavioral Aide, Probationary Services, and Pharmacological Assistance. To determine the true value of Support Services, the sum total of the set was divided by four.

Table 4. Support Services Sub-facets

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Mentoring</td>
<td>4</td>
<td>6.2</td>
<td>61</td>
</tr>
<tr>
<td>Behavioral Aide</td>
<td>2</td>
<td>3.1</td>
<td>63</td>
</tr>
<tr>
<td>Probationary Services</td>
<td>9</td>
<td>13.8</td>
<td>56</td>
</tr>
<tr>
<td>Pharmacological Assistance</td>
<td>18</td>
<td>27.7</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 4 indicates whether or not the respondents disagree or agree that Mentoring, Behavioral Aide, Probationary Services, and Pharmacological Assistance have been
beneficial in achieving successful outcomes in work with this population. A majority of the respondents were in agreement that each sub-facet have been useful in achieving successful outcome in work with this population. The results are: Mentoring, 93.8%; Behavioral Aide, 96.9%; Probationary Services, 86.2%; and 72.3% for Pharmacological Assistance.

Table 5 is a frequency distribution for the computed variable Frequency of Services. It consists of One Hour, Two Hours and Three Hours of contact per week. To determine the true value of Frequency of Services, the sum total of the set was divided by three.

Table 5. Frequency of Services Sub-facets

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>One Hour</td>
<td>58</td>
<td>89.2</td>
<td>7</td>
</tr>
<tr>
<td>Two Hours</td>
<td>29</td>
<td>44.6</td>
<td>36</td>
</tr>
<tr>
<td>Three Hours</td>
<td>5</td>
<td>7.7</td>
<td>60</td>
</tr>
</tbody>
</table>

Table 5 indicates whether or not the respondents disagree or agree that One Hour, Two Hours and Three Hours of contact per week has been sufficient in achieving successful outcome with this population. The majority of respondents (89.2%) disagreed
that One Hour of contact was sufficient. Slightly more than half of the respondents (55.4%) agreed that Two Hours were sufficient, whereas a majority (92.3%) also noted that Three Hours of contact hours were sufficient.

**Research Questions and Hypotheses**

Research Question 1: Is there a statistically significant relationship between Treatment Modality and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 1: There is no statistically significant relationship between Treatment Modality and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.

Table 6 is a cross-tabulation of the computed variables Treatment Modality and Counseling Framework. Treatment Modality consists of Individual Therapy, Group Therapy and Family Therapy. Counseling Framework consists of Cognitive Therapy, Behavioral Therapy and Reality Therapy. The table shows the association of how treatment was delivered (modality) and the specific types of therapies (framework) and whether or not there was a statistically significant relationship between the two variables.
Table 6. Treatment Modality and Counseling Framework

<table>
<thead>
<tr>
<th>Counseling Framework</th>
<th>Treatment Modality</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>3.1</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>2</td>
<td>3.1</td>
<td>61</td>
<td>93.8</td>
<td>63</td>
<td>96.9</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>3.1</td>
<td>65</td>
<td>96.9</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

df = 1 \qquad p = .798

As indicated in Table 6, there was no statistically significant relationship observed between Treatment Modality and Counseling Framework \((p=.798)\) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis is accepted as it relates to these two variables.

Research Question 2: Is there a relationship between Treatment Modality and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 2: There is no significant relationship between Treatment Modality and Support Services in achieving successful outcomes with aggressive/violent youth in foster care.
Table 7 is a cross-tabulation of Treatment Modality and Support Services. It shows the association of how treatment was delivered (modality) and the specific types of supportive services and whether or not there was a statistically significant relationship between the two computed variables.

Table 7. Treatment Modality and Support Services

<table>
<thead>
<tr>
<th>Treatment Modality</th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>3.1</td>
<td>14</td>
</tr>
<tr>
<td>Agree</td>
<td>0</td>
<td>0.0</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>3.1</td>
<td>63</td>
</tr>
</tbody>
</table>

df = 1  \quad p = .012

As indicated in Table 7, a statistically significant relationship was observed between the two variable (p=.012) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was rejected.
Research Question 3: Is there a statistically significant relationship between Treatment Modality and Frequency of Services in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 3: There is no statistically significant relationship between Treatment Modality and Frequency of Services in achieving successful outcomes with aggressive/violent youth in foster care.

Table 8 is a cross-tabulation of Treatment Modality and Frequency of Services. It shows the association of how treatment was delivered (modality) and the number of contact hours for services (frequency) and whether or not there was a statistically significant relationship between the two computed variables.

Table 8. Treatment Modality and Frequency of Services

<table>
<thead>
<tr>
<th></th>
<th>Treatment Modality</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Agree</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Frequency of Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>1 1.5</td>
<td>57 87.7</td>
<td>58 89.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>1 1.5</td>
<td>6 9.2</td>
<td>7 10.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2 3.1</td>
<td>63 96.9</td>
<td>65 100.0</td>
<td>df = 1</td>
<td>p = .069</td>
<td></td>
</tr>
</tbody>
</table>
As indicated in Table 8, a statistically significant relationship was not observed between the two variable \( (p=0.069) \) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was accepted.

Research Question 4: Is there a statistically significant relationship between Support Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 4: There is no statistically significant relationship between Support Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.

Table 9 is a cross-tabulation of Support Services and Counseling Framework. It shows the association of the type of supportive services and how treatment was delivered (modality) and whether or not there was a statistically significant relationship between the two computed variables.
Table 9. Support Services and Counseling Framework

<table>
<thead>
<tr>
<th>Support Services</th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Counseling</td>
<td>2</td>
<td>3.1</td>
<td>0</td>
</tr>
<tr>
<td>Framework</td>
<td>14</td>
<td>21.5</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>24.6</td>
<td>49</td>
</tr>
</tbody>
</table>

As indicated in Table 9, a statistically significant relationship was observed between Support Services and Counseling Framework (p = .012) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was rejected.

Research Question 5: Is there a statistically significant relationship between Frequency of Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 5: There is no statistically significant relationship between Frequency of Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care.
Table 10 is a cross-tabulation of Frequency of Services and Counseling Framework. It shows the association of the number of contact hours (frequency) and the type of counseling (framework) and whether or not there was a statistically significant relationship between the two computed variables.

Table 10. Frequency of Services and Counseling Framework

<table>
<thead>
<tr>
<th>Counseling Framework</th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.5</td>
<td>57</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
<td>1.5</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>3.1</td>
<td>63</td>
</tr>
</tbody>
</table>

\[
df = 1 \quad p = .069
\]

A statistically significant relationship was not observed between Counseling Framework and Frequency (p=.069) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was accepted.
Research Question 6: Is there a statistically significant relationship between Frequency of Services and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

Hypothesis 6: There is no statistically significant relationship between Frequency of Services and Support Services in achieving successful outcomes with aggressive/violent youth in foster care.

Table 11 is a cross-tabulation of Frequency of Services and Support Services. It shows the association of the number contact hours (frequency) and the type of supportive services and whether or not there was a statistically significant relationship between the two computed variables.

Table 11. Frequency of Services and Support Services

<table>
<thead>
<tr>
<th>Frequency of Services</th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Support Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>14</td>
<td>21.5</td>
<td>2</td>
</tr>
<tr>
<td>Agree</td>
<td>44</td>
<td>67.7</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>89.2</td>
<td>7</td>
</tr>
</tbody>
</table>

\[ df = 1 \quad p = .797 \]
As indicated in Table 11, there was no statistically significant relationship between Frequency and Support (.797) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was accepted as it relates to these two computed variables.

In sum, the null hypothesis was accepted as it relates to Treatment Modality and Counseling Framework being useful in achieving successful outcome with aggressive/violent youth in foster care (Research Question #1). The null hypothesis, however, was rejected for Research Question #2 - Treatment Modality and Support Services. For Research Question #3 - Treatment Modality and Frequency of Service, the null hypothesis was accepted. The null hypothesis was rejected for Research Question #4 - Support Services and Counseling Framework. Finally, the null hypothesis was accepted for Research Question #5 - Frequency of Services and Counseling Framework, and for Research Question #6 - Frequency of Services and Support Services when examined as being useful in achieving successful outcomes with aggressive/violent youth in foster care.
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

This research study was designed to answer six questions concerning factors that influence successful treatment outcomes for aggressive/violent youth in foster care. This chapter contains the conclusions and recommendations. Recommendations are provided to further inform, provide directions and advance the work started in this study, as well as to provide a framework for social workers and other human service practitioners engaged in rendering services to this population. Each research question is presented along with a summary of the significant findings of the study. The conceptual and theoretical frameworks are addressed.

For the purpose of this study, Successful Outcome was defined as attaining decreased aggressive and violent behavior with sustained effects after the utilization of interventions. Foster Care Youth was defined as a youngster who is in the custody of the Division of Family and Children Services. Aggression / Violence was operationally defined as the intentional use of actual or threatened physical force to harm a person. The Dependent Variable for the study is Successful Outcome with aggressive and violent youth in foster. The Independent Variables are (a) Treatment Modality, (b) Counseling Framework, (c) Support Services and, (d) Frequency of Service. In order to determine the
factors that influence successful treatment outcomes for aggressive/violent youth, the six interventions were examined.

Research Question 1: Is there a statistically significant relationship between Treatment Modality and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

Treatment Modality consisted of Individual Therapy, Group Therapy, and Family Therapy. Counseling Framework consisted of Cognitive Therapy, Behavioral Therapy and Reality Therapy. The sub-facets for each computed variable were analyzed. As noted in Table 2, the majority of respondents (96.9%) agreed that Individual Therapy has been useful in achieving successful outcomes in work with aggressive/violent youth. A majority was also noted among respondents for Group Therapy (95.4%), and 100% for Family Therapy. The sub-facets for Counseling Framework revealed that 100% of the respondents noted that Cognitive Therapy and Behavioral Therapy was beneficial. There was a 96.9% agreement respondents that Reality Therapy was useful.

Individual Therapy consists of one-on-one treatment involving the youth, whereas, Group Therapy involves the youth and two or more peers participating in treatment together. Family Therapy engages the youth along with his or her family members in treatment. The conceptual and theoretical frameworks that informed Treatment Modality is Social Learning Theory. The foundation of this theory provides the rationale that therapeutic treatment via various modes can be applicable to changing
behavior. Since behavior is learned, it can be unlearned through individual, group or the engagement of family members with timely and appropriate intervention protocols.

The various frameworks that served as the focus of this study are supported by Rational Choice and Psychological Theories. Individuals with aggressive/violent behavior who are in foster care are challenged with not only the presenting problematic behavior, but also the complications of being in the foster care system. The inclusion of these theoretical frameworks acknowledges that a “one-size-fits-all” perspective does not take into consideration the importance of individualized and thorough assessments that should guide the selected therapeutic intervention as it relates to Cognitive, Behavioral or Reality therapies. As noted in Table 6, when the chi-square statistical test for significance was applied, the null hypothesis was accepted as it relates to Treatment Modality and Counseling Framework (p = .798), indicating there was no statistically significant relationship observed between the computed variables at the .05 level of probability.

Research Question 2: Is there a statistically significant relationship between Treatment Modality and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

The sub-facets for each computed variable, Treatment Modality and Support Services were analyzed. Support Services consist of Mentoring, Behavioral Aide, Probationary Services, and Pharmacological Assistance. As noted in Table 4, when
responding to whether or not these services had been beneficial in achieving successful outcomes in work with this population, a majority of the respondents were in agreement that each sub-facet had been useful. The results are: Mentoring, 93.8%; Behavioral Aide, 96.9%; Probationary Services, 86.2% and; 72.3% for Pharmacological Assistance.

Selecting the appropriate menu of support services can only occur after a comprehensive assessment that seeks to understand and contextualize the individual and collective social institutions impacting the aggressive/violent behavior demonstrated by the youth. Hence, an eclectic array of interventions may be required. Biological and Biosocial Theory, as well as Psychological Theories, Social Disorganization and Social Learning theories all have utility in developing a treatment plan of Support Services as examined in the study which consisted of Mentoring, Behavioral Aide, the assistance of Probationary Services and Pharmacological Assistance. As indicated in Table 7, a statistically significant relationship was observed between the two variable (p=.012) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis is rejected.

Research Question 3: Is there a statistically significant relationship between Treatment Modality and Frequency of Services in achieving successful outcomes with aggressive/violent youth in foster care?

Frequency of Services were examined at One Hour, Two Hours and Three Hours of contact. Respondents were asked if they agreed or disagreed whether these frequencies of
services had been beneficial in achieving successful outcomes in work with aggressive/violent youth in foster care. As noted in Table 5, the majority of respondents (89.2%) disagreed that One Hour of contact was sufficient. A little more than half of the respondents (55.4%) agreed that Two Hours were sufficient. A majority (92.3%) was also noted for Three Hours of contact being sufficient.

Determining the Frequency of Services should occur after a thorough assessment of the youth's needs. An examination of all services should also be explored to not only adequately address the clinical needs of the youth, but to also ensure that a seamless service delivery model is not overwhelming for the youth. As noted earlier, one hour of conducted was deemed insufficient for this population. As indicated in Table 8 the null hypothesis was accepted, indicating a statistically significant relationship was observed between the two variable (p=.012) at the .05 level of probability when the chi-square statistical test for significance was applied.

Research Question 4: Is there a statistically significant relationship between Support Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

The frequency of the sub-facets Support Services and Counseling Framework were each noted earlier in this chapter. Table 3 and Table 4 provide a summary of whether the respondents agreed or disagreed that these computed variables were useful in achieving successful outcomes for foster care youth with aggressive/violent behavior.
The cross-tabulation of Support Services and Counseling Framework was conducted to determine the association of the type of supportive services and how treatment was delivered (modality) and whether or not there was a statistically significant relationship between the two variables.

Supportive services must be coordinated, timely and appropriate. The services examined in this study are delivered by different providers of therapeutic services and agencies. The appropriate type of therapy must be in concert with these services. They must complement each other and not serve as a distraction to the youth. Interdisciplinary team meeting and conferences with the youth being at the center of treatment planning would greatly diminish any potential service fatigue that the youth may experience. As noted in Table 9, a statistically significant relationship was observed between Support Services and Counseling Framework (p = .012) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was rejected.

Research Question 5: Is there a statistically significant relationship between Frequency of Services and Counseling Framework in achieving successful outcomes with aggressive/violent youth in foster care?

Frequency of Services and Counseling Framework represents another possible combination of variables to be cross-tabulated to determine significance. The frequency of the sub-facets Frequency Services and Counseling Framework were also noted earlier.
in this chapter. The frequency of each sub-facet as it relates to the computed variable is noted in Table 3 and Table 5, as well as the percentages of agreement when examining their usefulness with youth.

The frequency of services has immense utility in decreasing and arresting aggressive/violent behavior. Equally important is the selection of the most appropriate Counseling Framework. There has to be a proper fit in how often to provide therapy, as well as which therapeutic approach to utilize. As indicated in Table 10, a statistically significant relationship was observed between Counseling Framework and Frequency (p=.069) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was accepted.

Research Question 6: Is there a statistically significant relationship between Frequency of Services and Support Services in achieving successful outcomes with aggressive/violent youth in foster care?

Table 4 and Table 5 provide a summary of the whether the respondents agreed or disagreed that these computed variables were useful in achieving successful outcomes for foster care youth with aggressive/violent behavior. The frequency of each sub-facets were noted earlier in this chapter. When there is convergence of support services in conjunction with other therapeutic intervention, as well as the coordination of how many contacts to make with the youth, appropriate planning is a must. The treatment plan could quickly fall apart, leaving the youth once again being failed by the various institutions
impacting his or her life. Hence, as indicated in Table 11, there was no statistically significant relationship between Frequency of Services and Support Services (.797) at the .05 level of probability when the chi-square statistical test for significance was applied, therefore the null hypothesis was accepted as it relates to these two computed variables.

The accuracy and comprehensiveness of a therapeutic assessment of the presenting problem and needs of the youth informs the Treatment Modality, Counseling Framework, Support Services and Frequency of Services. During the introduction and presentation of the variables being used that guided this study, it was argued that there was a plethora of theories used to explain delinquency, aggressive and violent behavior, as well as contrasting perspectives. It was also suggested that clinicians and service providers should not be wedded to a single perspective in our work with individuals and efforts to arrest this behavior, rather an eclectic lens to assessment, prevention and treatment should be employed. The results of this study supports this argument.

In sum, the outcomes for Treatment Modality when examined with Support Services, and when Counseling Framework is examined with Support Services, a measure of insight into what has been deemed useful in work with these youth is provided. However, as noted by the acceptance of four null hypotheses addressed in this study, there are other areas that are not as illuminating. The examination of Treatment Modality and Counseling Framework, as well as the various analysis of Frequency of Service and Support Services when explored as factors that influence successful treatment outcomes for aggressive/violent youth in foster care, a less than clear pathway
as an intervention is suggested. This is also the case for Treatment Modality and Frequency of Services, as well as Counseling Framework and Frequency of Services.

**Recommendations**

Redirecting and counteracting the unfavorable behaviors of youth can be overwhelming and difficult work. It can be doubly so for youth with aggressive/violent behavior in our foster care system due to the complexity of needs. This work must be grounded in change with an empirical foundation. Delivered services must instill a sense of wellbeing and leave this vulnerable population with their dignity and self-respect intact. Also, paramount to influencing positive outcomes for youth in foster care who are exhibiting aggressive/violent behavior is conducting a comprehensive assessment of the youth, their strengths and various impacting systems – negative and positive – which subsequently should lead to a well-developed treatment plan that demonstrates achievable and measurable goals.

We must move beyond what is comfortable and familiar. Work with youth in foster care who are exhibiting aggressive/violent behavior requires a service delivery system that is comprehensive and integrated. Developing and putting into practice effective intervention and prevention strategies will require an ecological approach that builds on youth's strengths and assets and take into account the contexts in which they live. The most instructive analogy relates to building a house. A hammer is a very necessary tool in building a house; however, it takes several other tools to complete the
task. A hammer alone cannot do the required work. This study has illuminated several useful tools.

The journey of acquiring knowledge through conjecture and assumptions can be brief; however, to enter the arena of knowledge that is theoretically supported and grounded in sound research practices and methods of inquiry requires ordered and measured steps, which will extend the journey. This study employs such an assumption. It is a systematic investigation rooted in empirical research and analysis. There are good practice methods being employed every day that render services to youth in foster care who are exhibiting aggressive/violent behavior. Further, most services provided by social service agencies are executed with the utmost sincerity and intent, but many do not have evaluative proof of effectiveness.

The overarching significance of this study is to support these endeavors with the required data in efforts to afford best practices to the larger clinical and social services community who revere, appreciate and expect practice methods that are empirically and evidenced-based. To do less is to not fully support and embrace the potential change and boundless future of these youth. The following recommendations are offered:

1. Schools of Social Work should explore ways to make aspirant Social Workers more aware of career opportunities in work with this population as it relates to therapeutic services.

2. Research that examines additional Counseling Frameworks should be employed to cover the full scope of possible therapies that may also hold promise in work with this population.
3. Other types of Support Services should be the focus of additional research to ensure that youth are receiving the vast array of services deemed appropriate and necessary.

4. The quantity and quality of contact hours with these youth warrants additional examination in efforts to further inform human service practitioners about what is working.

5. On the micro-level, workers providing services to this population should continue evaluating their practice in efforts to ensure that a difference is being made, how and why.

6. On the mezzo-level, public and private agencies should ensure continued training in best practices and standards as it relates to successful outcomes for youth in foster care who are presenting with aggressive/violent behavior.

7. On the macro-level, local, state and federal governmental organizations should aggressively work toward ensuring appropriate funding levels to ensure this vulnerable population is receiving appropriate and adequate services delivered by skilled individuals who are well compensated for the important work they do.
APPENDIX A
IRB APPROVAL

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

November 23, 2014

Mr. Curtis L. Todd <curtistodd@aol.com>
School of Social Work,
Clark Atlanta University,
Atlanta, GA 30314.

RE: A Study of Factors that Influence Successful Treatment Outcomes for
Aggressive and Violent Youth in Foster Care.

Principal Investigator(s): Curtis L. Todd
Human Subjects Code Number: HR2014-11-554-1

Dear Mr. Todd:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed
your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Extended Approval Code is HR2014-11-554-1/A
Type of Review: Expedited.

This permit will expire on November 22, 2015. Thereafter, continued approval is
contingent upon the annual submission of a renewal form to this office.

The CAU IRB acknowledges your timely completion of the CITI IRB Training in Protection
of Human Subjects – “Social and Behavioral Sciences Track”. Your certification is valid
for two years.

If you have any questions, please contact Dr. Georgianna Bolden at the Office of
Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

[Signature]

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. Office of Sponsored Programs, “Dr. Georgianna Bolden” <gbolden@cau.edu>
December 2014

Dear Selected Participant:

As a part of my research program in the Whitney M. Young Jr., School of Social Work at Clark Atlanta University, I am seeking therapeutic service information about youth in the foster care system whose presenting problem includes aggressive / violent behavior. The purpose of the study is to learn more about intervention strategies employed to effectively serve this population. The survey will only take 5 to 10 minutes to complete.

All responses are confidential; therefore do not put your name on the survey. Your responses will be grouped with the responses of other participants. Your participation is strictly voluntary. You are welcome to ask questions regarding the study and your participation in it. You are free to stop participating at any time. Please respond to all questions.

Please complete and include the attached Consent Form when submitting your questionnaire. Thank you in advance for your participation. I appreciate your candid response.

Sincerely,

Curtis L. Todd, MSW

Enclosure: Survey

Consent Form
Appendix B
(continued)

TITLE

SUCCESSFUL TREATMENT OUTCOMES FOR AGGRESSIVE / VIOLENT YOUTH IN FOSTER CARE SURVEY

PRINCIPAL RESEARCHER

Curtis L. Todd, MSW

UNIVERSITY AFFILIATION

Whitney M. Young, Jr., School of Social Work
Clark Atlanta University
SUCCESSFUL TREATMENT OUTCOMES FOR AGGRESSIVE / VIOLENT YOUTH IN FOSTER CARE SURVEY

Section I. Demographics. Please provide the following background information. All analysis will focus on groups, and no attempt will be made to identify individuals.

Place an X next to the appropriate item. Choose only one answer for each question.

1. Gender: 1) Male 2) Female

2. Racial category that best describes you:
   1) Asian 2) Black/African American 3) Native American
   4) White 5) Other (Please Specify)

3. Your age group: 1) below 20 2) 20–29 3) 30–39
   4) 40–49 5) 50–59 6) over 60

4. Your highest educational degree: 1) Bachelor’s 2) Master’s
   3) Doctorate 4) Other

5. Your degree is in: 1) Social Work 2) Counseling 3) Psychology
   4) Marriage & Family Therapy 5) Other

6. Your annual income: 1) $20,000–29,999 2) $30,000–39,999
   3) $40,000–49,000 4) $50,000–59,000 5) over $60,000
Appendix B (continued)

7. Years of experience working with youth:  1) none  2) 1 to 3 years
    3) 4 to 6 years  4) 7 to 10 years  5) 11 to 15 years
    6) Over 15 years

8. Licensure:  1) LMSW  2) LCSW  3) LPC  4) ALC
    5) MFT  6) Other  7) Not licensed

Section II. Treatment Modality, Counseling Framework, Support Service, and Frequency of Service. The following statements are drawn from research on youth in foster care, and youth exhibiting aggressive / violent behavior. This section asks about the various treatment modalities, counseling frameworks, support services and frequency you have employed and/or observed that provided successful outcome(s) with this population. The term “population” refers to youth in foster care exhibiting aggressive / violent behavior.

How much do you agree or disagree with the following statements?

Write the appropriate number in the blank beside each statement. Please respond to each statement.

1= Strongly Disagree  2= Disagree  3= Agree  4= Strongly Agree

______________

Treatment Modality

___ 9. Individual Therapy has been beneficial in achieving successful outcomes in work with this population.

___ 10. Group Therapy has been beneficial in achieving successful outcomes in work with this population.

___ 11. Family Therapy has been beneficial in achieving successful outcomes in work with this population.
Appendix B

(continued)

Counseling Framework

___12. Cognitive Therapy has been successful in work with this population.

___13. Behavioral Therapy has been successful in work with this population.

___14. Reality Therapy has been successful in work with this population.

How much do you agree or disagree with the following statements?

Write the appropriate number in the blank beside each statement. Please respond to each statement.

1= Strongly Disagree  2=Disagree  3=Agree  4=Strongly Agree

Support Service

___15. Mentoring Support has been useful in achieving successful outcomes in work with this population.

___16. The use of a Behavioral Aide has been useful in achieving successful outcomes in work with this population.

___17. Assistance from Probationary Services has been useful in achieving successful outcomes in work with this population.

___18. Pharmacological Assistance has been successful in work with this population.
Appendix B
(continued)

Frequency of Service

19. One contact hour per week has been sufficient in achieving successful outcomes in work with this population.

20. Two contact hours per week have been sufficient in achieving successful outcomes in work with this population.

21. Three or more contact hours per week have been sufficient in achieving successful outcomes in work with this population.

Thank you very much.
APPENDIX C
CONSENT FORM

Successful Treatment Outcomes for Aggressive/Violent Youth in Foster Care Survey

Consent Form

You are invited to be in a research study of identifying and describing factors that influence successful treatment outcomes for aggressive and violent youth in foster care. You were selected because of your background and experience working with youth. I ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Curtis L. Todd, a doctoral student in the Whitney M. Young, Jr., School of Social Work at Clark Atlanta University.

The purpose of the study is to investigate clinical practice effectiveness with youth who are in foster care who present with aggressive/violent behavior. The research questions will explore treatment modalities, counseling frameworks, support services and frequency of interventions as they relate to decreasing and/or resolving aggressive/violent behavior among these youth. If you agree to be in this study, I ask that you complete the brief survey in its entirety, as well as complete and submit the consent form. There are no indicated risk associated with your participation.

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file; only the researcher will have access to the records. At the end of this study, questionnaires will be destroyed via shredding within a year.

Your decision whether or not to participate will not affect your current or future relations with the researcher or Clark Atlanta University. Your participation is strictly voluntary. You are free to withdraw at any time without affecting the aforementioned relationships. At any point in completing the survey, you may withdraw from the study by simply shredding it.

The researcher completing this study is Curtis L. Todd. I can be contacted via email at curtistodd@aol.com or by phone at 404-372-5147. You may also use this contact information if you have questions later. My academic advisor at Clark Atlanta University is Dr. Richard Lyle. His contact information is rlyle@cau.edu, or 404-880-8006. If you have any questions now, or later, related to the integrity of the research, you are encouraged to contact Dr. Georgianna Bolden at the Office of Sponsored Programs, (404-880-6979) or Dr. Paul I. Musey, (404-880-6829) at Clark Atlanta University.
Appendix C
(continued)

Statement of Consent: I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: __________________________ Date: __________

Signature of Investigator: __________________________ Date: __________
APPENDIX D
SPSS PROGRAM ANALYSIS

Title: SUCCESSFUL TREATMENT OUTCOMES FOR AGGRESSIVE / VIOLENT YOUTH IN FOSTER CARE SURVEY
Subtitle: Curtis L. Todd

DATA LIST FIXED/
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GENDER 4
RACE 5
AGEGRP 6
EDLEVEL 7
DEGREE 8
INCOME 9
YEARSEX 10
LICENSEUR 11
INDIVTHE 12
GROUPTHE 13
FAMTHE 14
COGTHE 15
BEHTHE 16
REALTHE 17
MENTSUPP 18
BEHASUPP 19
PROBSUPP 20
PHARSUPP 21
ONECONHR 22
TWOCONHR 23
THRCNHR 24.

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YEARSEX 'Q7 Years experience working with youth'
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PHARSUPP 'Q18 Pharmacological Assistance has been useful in achieving successful outcome in work with this population'
ONECONHR 'Q19 One contact hour per week has been sufficient in achieving successful outcomes in work with this population'
Appendix D
(continued)

TWOCONHR 'Q20 Two contact hours per week has been sufficient in achieving successful outcomes in work with this population'.

THRCONHR 'Q21 Three hours per week has been sufficient in achieving successful outcomes in work with this population'.

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Appendix D
(continued)
Appendix D
(continued)

MENTSUPP
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

BEHASUPP
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

PROBSUPP
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

PHARSUPP
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

ONECONHR
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TWOCONHR
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

THRCONHR
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TREMO
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

FRAME
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
Appendix D

(continued)

SUPSER
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
FRSFR
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/.

RECODE INDIVTHE GROUPTHE FAMTHE COGTHE BEHTHE REALTHE (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE MENTSUPP BEHASUPP PROBSUPP PHARSUPP ONECONHR TWOCONHR THRCNHR (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE TREMO FRAME SUPSER FRSER (1 THRU 2.99=2) (3 THRU 4.99=3).
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GENDER RACE AGEGRP EDLEVEL DEGREE INCOME YEARSEX

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Appendix D

(continued)

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Appendix D
(continued)

END DATA.
FREQUENCIES
/VARIABLES GENDER RACE AGEGRP EDLEVEL DEGREE INCOME YEARSEX
LICENSUR INDIVTHE GROUPTHE FAMTHE COGTHE BEHTHE REALTHE
MENTSUPP BEHASUPP PROSUPP PHARSUPP ONECONHR TWOCONHR THRCOHśni
TREMO FRAME SUPSER FRSER
/STATISTICS = DEFAULT.
REFERENCES


Georgia Division of Family and Children Services. (2014). Children in foster care. Retrieved from,


