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An Analysis of the Personal and Behavioral Health Impact of a Hybrid Day Treatment Model on Secondary Students

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Approval Page

This dissertation was submitted by Matthew B. Davis under the direction of the persons listed below. It was submitted to the Gardner-Webb University School of Education and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Gardner-Webb University.

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Abstract

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This dissertation, with roots in Cognitive Restructuring Model and Circle of Courage® Model, was designed as a phenomenological qualitative study that gathered the perspective of former students who were enrolled in a specific hybrid day treatment program model. These students were all involved in a day treatment program model in a rural town in western North Carolina. The study specifically evaluated how this experience affected the students in terms of future choices and behaviors. These students participated in individual interviews and data were coded through the use of the *ATLAS.ti* and SPSS software programs. Through coding and analysis, themes were determined and examined for depth.

The research evaluated 18 participants ranging in age from 14-19 discussing the impact of the hybrid treatment program (HTP) program. The participants were asked their view of success related to three areas: intrapersonal view, behavioral impact, and personal impact of the HTP. The research used three areas to evaluate participant perceptions: Rosenberg's Self-Esteem Scale, a one-on-one interview, and behavioral data from participants' current or last-attended schools.

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Chapter 1: Introduction

At-risk youth are characterized by "a combination of poverty, inadequate education, and weak psychological resources" which "results in a litany of human and social disasters: high rates of criminal activity, drug and alcohol addiction, chronic unemployment, psychical and mental illness, dependence on public welfare, and institutionalization" (Carnegie Council on Policy Studies in Higher Education, 1979, p. 249). According to Free (2008), at-risk youth often fall through the cracks of the educational world and wind up in an alternative setting (i.e., jail, institutionalized). Also, an at-risk youth is more likely to have a disability, predominantly in the areas of Attention Deficit Hyperactive Disorder (ADHD), Serious Emotional Disturbance, or Oppositional Defiant Disorder. It is estimated that up to 20% of children and adolescents suffer from a serious mental health disorder (Belfer, 2008; Fawcett, 2013). As reported in the National Comorbidity Survey, it is estimated that youth with a conduct disorder are twice as likely as their nondisabled counterparts to drop out of school (Kessler, Foster, Saunders, & Stang, 1995). Esch et al. (2014) further determined there is a link between Attention Deficit Disorder or ADHD and dropping out of school.

An at-risk student is a student who is unable to participate in academic or vocational services at an acceptable developmental level in his/her school or work (Child and Adolescent Day Treatment, 2015). Day treatment program models were designed to address the specific needs of at-risk students. These needs of at-risk youth often hinder their academic progress. To function successfully at a traditional school or work level, the student must be able to work at an appropriate level.

Nature of the Problem

In North Carolina, there are approximately 25,463 youth at some level of the

adjudication process. The adjudication process includes youth either on probation, completing probation, or residing in a detention center (Perry & Geuice, 2015). According to Perry and Geuice (2015), of the approximately 25,463 youth, 12,403 are considered to be at risk. In 2014, the North Carolina Department of Public Safety spent $21,870,899 on prevention and juvenile services such as Project Challenge. Project Challenge is a community service program for adjudicated youth, therapeutic foster care, as well as numerous treatment programs to prevent many of these individuals from becoming incarcerated adults (North Carolina Department of Public Safety, 2014). The report further stated this can cost taxpayers $29,160 per inmate with roughly 38,000 individuals incarcerated per year in North Carolina. The cost of housing incarcerated individuals results in costing North Carolina taxpayers $1.1 billion annually.

At-risk youth lose months to years of freedom in incarceration. Those who are rehabilitated after a conviction of drug-related offenses or some sexually related crimes miss the opportunity to qualify for certain jobs or financial aid such as Pell Grants which allow individuals to attend college courses at little or no cost. Individuals with prior drug convictions may be eligible for some grants if they are willing to consent to random drug tests and a drug rehabilitation program (U.S. Department of Education, 2017); however, those students with prior felonies who can attend college and gain qualifications for a position continue to struggle with finding a job (Berg & Huebner, 2011). A study conducted by Berg and Huebner (2011) found nearly 60% of employers surveyed in four large United States cities reported they would “definitely not” or “probably not” hire an ex-inmate, regardless of qualifications. Berg and Huebner stressed the importance of intervention for at-risk youth to reduce the likelihood of making negative choices that may result in convictions.

The program. One solution to support at-risk youth is a day treatment program model. A day treatment program is a partnership between a local school agency and a mental health agency that provides both academics and therapy in the form of recreational therapy, one-on-one therapy, and equine therapy. A qualified mental health professional or a licensed therapist must provide the required therapy component within the day treatment program for the program to receive funding.

The treatment component focuses on a variety of skills including self-regulation of emotions and behaviors, improving locus-of-control, management of anger, anxiety, frustration, compliance, social pragmatics and reciprocity, creating and maintaining positive relationships, and developing self-regard (Yi, 2012). Many programs have a licensed therapist on staff, whether full time or part time, based on the number of enrolled students. The classroom must also follow a particular student-to-teacher ratio that is set by Medicaid. In the case of the day treatment in this study, the staff-to-student ratio is 1 to 4. Some governing agencies require a ratio of 1 to 5. To receive reimbursement from Medicaid, the mental health agency must receive authorization by the local management entity prior to a student entering a day treatment program.

The required therapeutic services differentiate a day treatment program from a standard alternative school setting. Students participating in this particular day treatment program receive at least 4 hours of therapy which includes group therapy, recreational therapy, and individual therapy. The day treatment program also includes a community service component. Examples of a community service component include serving in a local food bank or helping in a nonprofit thrift store. Most day treatment programs are additionally paired with a local school system to include the academic component to their students' education. Day treatments in the school setting require an academic teacher in

addition to an exceptional children's teacher for those who have an Individual Education Plan (IEP).

The day treatment program discussed in this study is a hybrid model using two distinctive theoretical based approaches, cognitive restructuring therapy and the model, in conjunction. Cognitive restructuring therapy, also known as cognitive therapy, was developed by Dr. Aaron Beck in the 1960s as a form of depression treatment. The principles identified in cognitive restructuring therapy change a student/patient's negative thoughts, turning them into positive thoughts by identifying his/her distortions (Beck, 1997). The Circle of Courage® model is an approach that focuses on positive youth development. Circle of Courage® was developed by Brendtro, Brokenleg, and Van Bockern (2002). It is grounded in Native American philosophies teaching generosity, belonging, mastery, and independence within a community (Brendtro et al., 2002; Jackson, 2014).

Circle of Courage®. The Circle of Courage® model, developed in 1988 through a collaboration between Martin Brokenleg and Larry Brendto, is a philosophy that encourages the thoughts of courage and strength for children and youth based on four areas: mastery (knowledge), belonging (making connections), generosity (contribution), and independence (confidence; Brendtro et al., 2002). The students are asked to display generosity by exhibiting their willingness to work with others or by giving without expecting reciprocation. Mastery refers to mastering personal behavior. Independence is the student's ability to make personal decisions while accepting the consequences of those actions. Belonging represents how the student feels a part of their community, whether community is defined as their immediate family, school, or neighborhood.

Cognitive Restructuring Model. Based on the Cognitive Restructuring Model

developed by Beck (1979), cognitive behavioral therapy encourages participants to identify and explore recurring thoughts to evaluate their accuracy and practice coping strategies through constant and progressive exposure to the stimulus or event (Williams, Cafarella, Paquet, & Frith, 2015). The theory is based on the premise that "distressing thought can be restructured through the recall of many pieces of evidence that contradict the content of the distressing thought" (Bares, 2007, p. 1). The effectiveness of the cognitive behavioral therapy model is based on understanding the individual patient's perception or interpretation of events (Bares, 2007). As reported by Bares (2007), cognitive behavioral therapy identified several anxiety-provoking situations for the adolescents/children and gave them the various tools to recognize personal self-talk in these situations. According to Bares, this self-talk was used to reduce the amount of anxiety, fear, or depression in these situations.

Hybrid model. The day treatment program in this study utilizes components of both cognitive restructuring therapy and the Circle of Courage® model. Throughout this study, the hybrid program will be referred to as the hybrid treatment program (HTP). Qualified mental health professionals confer with the participants about their actions using cognitive behavioral therapy to recognize the participant's cognitive distortions about personal actions or choices. The program additionally uses the basics of the Circle of Courage® model within their leveled behavioral system. Within this system, students and staff vote each student into one of three levels based on their choices for the week. These levels are based on trust and determine student privileges.

Within the HTP, the students receive 2 hours of academic instruction per day along with a minimum of 4 hours of therapy from a licensed therapist or qualified mental health professional. In the summer, the HTP offers 6 hours of treatment either with a

therapist or qualified mental health professional. During the therapeutic sessions, students work on identifying their strengths and needs based on person-centered plans. Within the person-centered plan, the student, their parent/guardian, and the qualified mental health professional determine the participant's goals (Child and Adolescent Day Treatment, 2015; Ferrell, 2013).

Measurement of success. The overarching goal of a day treatment program is to return the student successfully to his/her home school. Students considered successful would return to their homeschool with little to no discipline referrals. The referral should not include major incidences such as violence, cursing, threatening, or bullying. Additionally, students successfully completing the HTP should adopt the components of Cognitive Restructuring Model. Successful completion includes the student recognizing personal cognitive distortions and making informed decisions based on reality, both at school and at home. Students may be able to rationalize and demonstrate appropriate behavior at school but may leave school and hit their parents, steal, or do drugs because of cognitive distortions about life at home. In this case, the HTP may be seen as unsuccessful due to the behaviors demonstrated at home. Students who willfully recognize cognitive distortions and consciously change those into positives are more likely to make the needed changes permanently than those students who feel forced to change their behavior, such as those with court orders or those pushed by parents to make a change.

The Research Problem and Justification

Over the last decade, an increased number of school systems have coordinated a behavioral program with an outside agency. The goal is to improve student behavior while at the same time continuing to meet the standards that each state and the Common

Core Curriculum has set forth for educating students in the public school setting (Gibson, 2006). Designed for students who have serious behavioral struggles at school and possibly at home, this type of day treatment program meets this need as it provides a balanced mixture of therapy and academics. Students display disruptive behaviors as young as elementary and preschool. An estimated 9-10% of the elementary student population has a need for services that involve severe behavior difficulties (Gibson, 2006; Walker, Zeller, Close, Webber, & Gresham, 1999). As this population increases, so does the need for programs that effectively help students decrease negative behaviors to become productive members of their school system.

Students who are suspended may be left home without supervision due to working parents. Students who are home without parental supervision often get into more trouble during this time of suspension (Committee on School Health, 2003). Juveniles who were not in school or working have a greater risk of engaging in a wide range of problem behaviors. Some actions include using hard drugs or marijuana, selling drugs, running away from home, joining gangs, committing theft or a serious assault, and carrying a weapon (Committee on School Health, 2003). As the student's negative behaviors become progressively worse, the penalties become steeper until the student drops out, goes to jail, or enters a program such as a day treatment model (Carran, Nemerofsky, Rock, & Kerins, 1996). Students with severe emotional disorders or a mental health diagnosis in a regular school environment tend to have poor educational outcomes, with a reported drop-out rate of approximately 50%.

Students who are in a day treatment setting come in with behaviors that include disruptive behavior disorders. As defined by the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-V), these disorders can include ADHD, Conduct

Disorder, and Oppositional Defiant Disorder. Students with Conduct Disorders are at risk of delinquent behaviors during adolescence and adulthood such as violence, substance abuse, academic failure, antisocial behavior, and risky sexual behavior (Brunk, 1999).

Deficiencies in the Evidence

Kutash and Rivera (1995) found that day treatment was an effective way of reintegrating students with maladaptive behaviors back into a regular school setting while keeping students at their home. Day treatment programs must have an educational component if the program is housed in a public school (North Carolina Department of Public Instruction [NCDPI], 2014). The students who transition from a day treatment program to the regular classroom setting are held to the same testing and curriculum standards that a regular classroom setting must follow (NCDPI, 2014). However, due to time allotment for therapy, academics tend to have less of a focus within these day treatment programs. Ferrell (2013) studied a standard day treatment center in North Carolina which evaluated curriculum practices and philosophies in education. Ferrell found that the program focused on the student first, then the school curricula. Ferrell additionally found that the day treatment program delayed introducing curriculum until the students were considered ready due to behavioral struggles taking precedence over grade-level curriculum.

Jones (2008) researched a day treatment center in central Kentucky to determine if a day treatment center is an effective educational setting. The researcher conducted interviews with students, parents, and staff. Additionally, the researcher conducted observations up to 6 weeks after the student had transitioned back to his/her home school to collect qualitative data. According to the student responses, “the people here set you

straight before you go back, we talk in a group about it, and then after transferring back to the home school, the counselor comes over to check on you for six weeks" (Jones, 2008, p. 104). Parents responded differently than the students. Fifty percent of the parents stated that the day treatment did not do anything to prepare their child to return to his/her home school. Furthermore, several parents reported that their child was unsuccessful in the day treatment setting (Jones, 2008).

At the Center for Child Development at the University of California Irvine, Yi (2012) researched the effectiveness of a day treatment program focusing on student academic and behavioral performance. The focus of the research was an examination of the therapeutic progress of students with disruptive disorders, namely Oppositional Defiant Disorder, Conduct Disorder, and ADHD. Yi inquired about the effectiveness of day treatment in eliminating maladaptive behaviors in at-risk youth and if attendance played a role in student success. Yi also researched the effectiveness of day treatment in prompting academic progress among at-risk youth. Yi found that of the 20 students observed, 13 students showed an increase in active engagement, six students showed a decrease in active participation, and one student showed no change in active participation. The research used a point system to measure behavior, with 100% of the available points being the most positive. Yi additionally found that seven students maintained at least 80% of the possible points throughout the study and 13 students fluctuated under the 80% mark throughout the study. Student attendance and parent attendance had a strong correlation to the student response to change global outcomes. Parent attendance at meetings and events did not show a significant correlation to the parent rating scale of the Swanson, Nolan, and Pelham Questionnaire, fourth edition (SNAP-IV).

According to actual definition, the HTP is considered successful when a student returns to his/her home school with little to no behavioral referrals; however, there is limited research on measuring success posttreatment. Theoretically, if a student completes the day treatment program and returns to the home school with no additional suspensions or negative behaviors, on paper, the student completed the program successfully. However, if this student is then arrested a few months out, this should be considered unsuccessful, although the student did finish the program, which is the criteria for "success." Ferrell (2013) reported having found no studies that examined data on the long-term effectiveness of the impact of day treatment centers on student performance while the students are enrolled, during the transition back to their home schools, or postgraduation. Jones (2008) encouraged future researchers to determine the percentage of day treatment students who graduate high school. Jones also recommended future studies in student academic progress after interventions were removed.

Audience

The implications of this study will be valuable for those who are developing measures to evaluate the effectiveness of a day treatment program. The data collected from this research may be used by local management entities to determine modifications in the therapeutic and academic programs. The data and following analysis will determine if the time and effort dedicated to the program are beneficial to the students who have completed the program and in which areas. This information may be helpful in future program planning by addressing areas of need within hybrid day treatment programs.

Policymakers in both the federal and state positions will benefit from the findings and implications of this study. Policymakers can find this information useful when

evaluating current policies and implementing new ones within the Juvenile Justice System, especially within the area of education continuation for incarcerated students. Policymakers can also use this information for evaluation and implementation of policies for students identified at risk, hopefully helping these students before they become involved with the Juvenile Justice System.

Stakeholders for this study may reach beyond the realm of education and into the mental health field for those who use the North Carolina Treatment Outcomes and Program Performance System (NCTOPPS). NCTOPPS (2014) measures success in the areas of emotional well-being, suicidal thoughts, suspensions or expulsions, and quality of life as the students entered and exited a day treatment program. This study will increase the information gathered from the students by determining how they felt the treatment has impacted personal behavior, interpersonal feelings of success, and personal relationships after exiting the program.

Purpose of the Study

The purpose of this study was to gather the perspective of middle and high school students involved in a collective phenomenon, a hybrid Cognitive Restructuring and Circle of Courage® day treatment program. The study examined how this HTP may have impacted the students behaviorally and personally with regard to their experience in the HTP. The student participants also examined their personal view of success with regard to completion of day treatment.

For the purpose of this study, behavior was defined as a response to external and internal stimuli (Starr & Taggart, 1992). The researcher addressed multiple areas of behavior including student reaction to others, student behavior in the classroom, student behavior at home, and student behavior in the community. Self-esteem, as defined by

Rosenberg (1965), is an objective measure of an individual's self-worthiness/ unworthiness. Rosenberg's Self-Esteem Scale was used to evaluate participant personal views of their self-worth. Behavioral data were also from the participants' current school; or if the student had quit school, the last attended school.

For the purpose of this study, personal impact is defined as student feelings toward personal change within their lives. The researcher views personal change in multiple facets, including the student's outlook on school, work, and life. The researcher asked questions that examined student self-esteem and relationships with others including relationships based on student self- esteem. Finally, the researcher collected and analyzed participant personal views of success. This research attempts to show the influence of this HTP on former students' views of posttreatment.

Research Questions

1. What are student interpersonal views of success after completion of the HTP?
2. What is the behavioral impact on the students after completion of HTP?
3. What is the personal impact on the students after completion of the HTP?

Definitions of Terms

Alternative placement. A program designed to address the needs of students who do not typically have their struggles met in a regular school setting. The students who attend alternative schools and programs are at-risk of educational failure indicated by poor grades, teen pregnancy, truancy, and other similar factors (Carver, Lewis, & Tice, 2010).

At-risk student. A label given to a student if he/she is not successful in a school-based program based on test scores, attendance, or discipline problems (Abbott, 2014).

Behavior. The way in which a person acts in response to a particular situation or

stimulus (Hersen et al., 2005).

Circle of Courage®. A philosophy that encourages the thoughts of courage and strength for children and youth based on four areas of strength: mastery (knowledge), belonging (making connections), generosity (contribution), and independence (confidence; Brendtro et al., 2002).

Cognitive behavioral therapy. A form of psychotherapy in which a person works with a therapist to identify, challenge, and rethink any misperceptions or negative thoughts and their associated undesirable behaviors (Hauswirth, 2014).

Cognitive distortion. A concept from cognitive behavioral therapy and refers to biased ways of thinking about oneself and the world around us (Pratt, 2013).

Extracurricular activities. For the purpose of this study, refers not only to sports but also to any activities outside of the school setting including but not limited to an after-school job, dance, or participation in church groups.

Home school. Refers to the student's assigned district school in which the student should be attending if the student was not attending day treatment. Home schools also include the alternative school setting if the student so chooses to attend over his/her home district school after completion of day treatment.

Local management entities. Responsible for the management and oversight of the public system of developmental disabilities, substance abuse, and mental health services at the community level (North Carolina Department of Health and Human Services [NCDHHS], 2015).

Mental health. An individual's state of well-being where an individual realizes his/her abilities and can cope with the normal stresses of life, making a contribution to his/her community (World Health Organization, 2001).

Mental illness. A diagnosable mental disorder or health condition that causes an alteration in thinking, mood, or behavior. The disorder may be associated with distress or impaired functioning (U.S. Department of Health and Human Services, 1999).

Office discipline referrals. Consist of events in which a school staff member observes a student violating a school rule and submits documentation of the event to the school's administrative leadership who determine the consequence for the student (Irvin et al., 2006).

Successful completion. For this study, includes a student who successfully completes the day treatment program without any significant office referrals and does not return to the alternative school or in-school suspension at the alternative school setting (an alternative to out-of-school suspension) for behavioral reasons.

Self-esteem. Confidence in one's own worth or abilities; self-respect (Hersen et al., 2005).

Separate setting. A situation in which a child spends at least half of his/her school day in special education and away from nondisabled peers (U.S. Department of Education, 2010).

Unsuccessful completion. For this study, includes a student who has more than one office referral that requires out-of-school suspension, in-school suspension, or in-school suspension at the alternative school. It also includes students with one or more referrals for behaviors that have led the student to placement in a day treatment program.

Chapter 2: Literature Review

Purpose Statement

The purpose of this study was to gather the perspective of middle and high school students who were participants in a hybrid day treatment program that included Cognitive Restructuring and Circle of Courage® techniques. The study examined how this hybrid day treatment program may have impacted the students personally as well as in their behavior long term. The student participants explored their personal view of success concerning their successful completion of day treatment.

Overview

This literature review is a comprehensive examination of previous research in the areas of importance to the current study. The literature review begins with an overview of secondary education including the challenges and specifics of secondary students who are considered at risk and their recidivism. The theoretical frameworks surrounding the current study are the Circle of Courage® model, cognitive restructuring theory, and cognitive behavioral therapy. The literature review continues to discuss the conceptual framework surrounding the current research including day treatment program models and how these programs impact student behavior, academics, and social relationships. The study discusses time allotment and actual treatment within these day treatment program models. The literature review discusses these programs specific to students with disabilities and concludes with the needs for further research and the proposed research questions.

Secondary education. In 1820, the first public high schools began to become a reality in Boston when Samuel Adams Wells and other influential Bostonians opened the first public high school called the English Classical School (Clark, 2007). This school

created a movement that would open the door for communities all over the United States to found public high schools, especially in the Northeast, Midwest, and South between 1820 and the early part of the 19th century (Clark, 2007). Although not all schools were open to everyone, the programs were labeled as free due to the use of tax money instead of tuition fees to fund the school. The schools had set guidelines that allowed for admissions testing to determine if students were allowed access to the schools (Clark, 2007). Even into the late 1880s, free public high schools were mainly created to serve the upper social class children of the community (Clark, 2007).

By the early 19th century, community leaders, as opposed to professional educators, guided and established high schools (Clark, 2007). This evolution changed with the formation of educational unions. One such union was the National Teacher Association (NEA). Formed in 1857, the NEA helped shift the guidance from community leaders to professional educators in leading and guiding the educational decisions (Clark, 2007). By 1893, NEA addressed the issue of the admittance of only upper social class students in public high schools. A committee of 10 educators led by the president of Harvard University recommended that a standard curriculum is established for all able students no matter their class and geared toward preparing students for higher education. In 1906, the president of the Carnegie Foundation for the Advancement of Teaching suggested that unit of instruction meant meeting five times a week over the course of an academic year for students in a secondary school setting (Clark, 2007).

Although the idea of a standard curriculum was suggested, at the time it was not well received. By the early 20th century, many public high schools received some state government funding but were also governed and developed by the local government

which developed the courses needed to fit the community rather than a standard curriculum (Clark, 2007). Under this national model, students were prepared for the workforce within their community. By 1948, a new study had introduced the idea of moving away from impractical rote memory and moving into the concept of practical education. In this practical educational model, students would use real life skills in all courses. The study suggested eliminating those classes in which functional life skills were not included such as classical literature, foreign language, history, and advanced math (Clark, 2007).

In the 1950s and 1960s, early college admissions programs and testing began to enter the high school setting with the introduction of advanced placement tests in 1955, National Merit Scholarship examinations in 1955, and International Baccalaureate Diploma Programs in 1968 (Clark, 2007). In 1965, the Elementary and Secondary Education Act (ESEA) began to send supplemental federal funds to support low-income students (Clark, 2007).

In the wake of a push for education reform in the 1950s, alternative schools began to take shape including mini-schools, schools without walls, open schools, and internship and apprentice-type programs (Clark, 2007). The idea of early alternative schools included an emphasis on project-based learning and multi-age groups. Though many of the alternative models ended quickly, several ideas led to changes in many of the high school requirements while increasing the number of electives offered. Multiple educational service models allowed for choice by the students in the secondary setting (Clark, 2007). During the Clinton administration, the focus shifted to a National Educational Goal geared to increase graduation rates and mathematics and science scores to be the first in the world (Clark, 2007).

Due to this increased accountability, three distinct types of high schools/ secondary schools were formed: a traditional high school, alternative high schools, and virtual high schools (Clark, 2007). Traditional high schools have a core curriculum in language arts, science, social studies, and math with a variety of electives (Clark, 2007). Classes are separated into a block schedule of four to five classes per day with courses ending each semester or six to seven classes per day which last a full year (Clark, 2007).

As the constraints on goals began to grow, educators believed there was a need for an alternative school setting for many students who were in need of personal attention and a chance to catch up to their grade level (Clark, 2007). Contemporary alternative schools were classified into two types: disciplinary high schools and virtual high schools. Disciplinary high schools operate on the premise set in the 1980s of crime prevention among high school students. The disciplinary alternative high school combines academic instruction with social and behavioral modification activities (Clark, 2007).

Virtual high schools have steadily increased both as a standalone program and in part as a supplement for students in both traditional and alternative school settings (Clark, 2007). Students take courses online to work around scheduling conflicts or allow for advanced placement or college-level courses (Clark, 2007). Virtual high schools are nonprofit alternatives geared to allow students access to rigorous credit-bearing courses from anywhere in the world (Clark, 2007). An estimated 700,000 students are enrolled in virtual high schools or online courses (Clark, 2007).

Secondary education, as it applies to public education, has changed drastically since the 1820s when educational programs were opened by a small group of investors teaching Classical English Education. Changes have come in all forms including where secondary education takes place as well as who is being served in secondary education.

Secondary education has made progress in reaching all students with the addition of the alternative school setting, virtual schools, and early college programs.

Challenges of secondary education. Twenty-first century students enrolled at the secondary level of education have an infinite amount of information available to them through the internet (Jansen & van der Merwe, 2015). With this infinite information available also comes the possibility of risky behaviors including posting personal information, inappropriate pictures, and talking to or setting up meetings with strangers (Dowdell, 2013). These types of risky behaviors can lead to harassment, predators, bullying, and identity theft even among youth (Dowdell, 2013). Risky behaviors are one of many factors contributing to the 5% of adolescents who are impacted by depression which leads to an increased risk of suicide, social and educational impairment, and mental health problems in adulthood (Thapar, Collishaw, Pine, & Thapar, 2012).

One of the risk factors studied by the Center for Disease Control and Prevention was bullying. In 2011, a national survey was conducted by the Center for Disease Control and Prevention of youth Grades 9 to 12 who were asked about bullying. In the study, 20.1% of youth responded that they were a victim of bullying on school property, and 16.2% were victims of electronic bullying (Hertz, Everett Jones, Barrios, David-Ferdon, & Holt, 2015). When students are bullied in multiple areas or multiple contexts, it often leads to psychological and physical effects such as depression; alcoholism; poor social skills; use of illicit drugs; and in extreme cases, suicide (Hertz et al., 2015). Aggressive behaviors have become a major source of struggle in secondary education, with one third of high school aged youth having reported fighting or other acts of violence in the last 30 days (Centers for Disease Control and Prevention, 2010). Violence has increased outside of school; and according to Puzzanchera (2009), 16% of violent

crimes were committed by youth based on data collected by the Juvenile Justice Department. The study assessed 13,613 American juveniles between the ages of 12-18 using the Washington State Juvenile Court Assessment. The study found that school aggression and violence accounted for one of the leading reasons students became repeat offenders in the judicial system between the ages of 12-15 (Asscher, Van der Put, & Stams, 2015).

Substance abuse has become an increasing dilemma among school secondary aged students. Monitoring the Future conducted a study that showed 54.1% of twelfth graders have admitted to being drunk at least once (Falck, Nahhas, & Carlson, 2012). Over 40% of youth in this age group reported drinking alcohol in the previous 30 days (Centers for Disease Control and Prevention, 2010). Many of the students studied have battled an alcohol addiction as young as 12 years old (Centers for Disease Control and Prevention, 2010). Monitoring the Future found that 24.7% of seniors reported using illegal drugs other than marijuana, and 43.8% reported smoking marijuana at least once (Falck et al., 2012). The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2013) found that 6% (78,156) of the 1,249,629 students surveyed were in treatment for the abuse or dependency of alcohol or illicit drugs. Risk factors among teenage youth include bullying, substance abuse, and aggressive behavior. Some of the highest numbers being reported by high school seniors were in the use of alcohol at 54.1% and drug use at 43.8%. These figures are risk factors that have the potential to affect the student's ability to complete high school.

At-risk students and recidivism. The modern American Juvenile Justice System describes delinquent youth as children or adolescents who engage in illegal activity based

on local, state, or federal laws (Granville, 2007). Adolescents who participate in illegal activities often become involved in the American Juvenile Justice System involving the courts, counselors, probation officers, and often victims (Granville, 2007). The cost to the justice system and victims is substantial. In a 2007 analysis, the cost to victims was $15 billion, while the cost to the government was $179 billion in police protection, judicial and legal activities, and corrections (U.S. Department of Labor, Bureau of Labor Statistics, 2008). These offenders are often first-time offenders. In the 1990s a *tough love* approach was used. This tough love approach included boot camps, incarceration, drug test, fines, restitution, and intensive supervision and was called into question as research showed a negative impact on repeat offenders (Aos, Phipps, Bamoski, & Lieb, 2001). Incarcerated offenders may be exposed to older delinquents with severe aggression, which led to an increase in negative behavior (Lipsey & Cullen, 2007). To decrease negative behaviors, Lancaster, Balkin, Garcia, and Valarezo (2011) found two different approaches: a rehabilitation program versus a sanctioned-based program.

Barnert, Perry, Azzi, Shetgiri, Ryan, Dudovitz, & ... Chung (2015) conducted in-depth interviews with incarcerated youth at the Los Angeles County Juvenile Detention Center regarding protective and risk factors for juvenile offenders. Barnert, et al. interviewed 20 participants, 12 females and eight males ranging in age from 12-17. Thirteen of the participants were Latino, and seven were African-American. The location of the study accounted for the demographics of the participants since the Los Angeles Juvenile Detention Center is 95% minority.

Barnert, et al. (2015) separated protective and risk factors in the home, school, neighborhood, and jail. Participants expressed to the researcher that home should be the most protective place; but by contrast, many participants stated that their home was

chaotic, often consisting of fighting and lack of family cohesiveness. Some participants noted that their parents were absent from the home more often than not. Some of the reasons for parent absenteeism included the parent working long hours/multiple jobs, being a single parent, being addicted to drugs, or being incarcerated (Barnert, et al., 2015).

The school was the second area of concern for the participants. The participants acknowledged that school should be a safe place for students to learn practical skills from teachers (Barnert, et al., 2015). The participants, however, also reported that they felt unsafe at school due to bullying and gang activity. Local gangs caused many youth in the participants' community to join the gangs, carry weapons, or skip school to feel safe (Barnert, et al., 2015). Several participants addressed peer pressure, and many reported that it often led to increased delinquency and failure in school and ultimately dropping out (Barnert, et al., 2015).

Participants often described their ideal neighborhood as being quiet and peaceful with parks and neighbors who watch out for each other (Barnert, et al., 2015). In the participants' neighborhood, crime and gangs run the streets; and the neighborhood becomes the last area the adolescents inhabit before going to jail (Barnet et al., 2015). The participants believed their communities promoted crime by not offering adolescents anything else to do, especially those who chose not to go to school or go home (Barnert, et al., 2015).

Incarceration is the last step for the bad choices participants made and is considered to be inevitable for most individuals from their neighborhood (Barnert, et al., 2015). Many participants shared a feeling that an individual's transition from their community to the juvenile detention center is an extension of their neighborhood

(Barnert, et al., 2015). Some reported hating the rules and lack of freedom, while other participants felt that jail is safe and structured and less chaotic than their neighborhood (Barnert, et al., 2015).

The study found three common areas of need from all participants. These included the need for love and attention, discipline and control, and positive role models. Participants felt they needed not only love but attention from their parents. The participants felt that if they received love and attention from their parents, they would be more motivated to please their parents (Barnert, et al., 2015). Participants reported feeling discipline and control as a major need to counterbalance the unsafe and chaotic neighborhoods (Barnert, et al., 2015). The final area of need reported by the participants was the need to have positive role models in the youth's older family members (Barnert, et al., 2015). Participants reported believing that fulfilling these needs would decrease delinquent behaviors at home, in schools, and especially in the neighborhoods Barnert, et al., 2015).

Adolescents are labeled as *crossover youth* when they are involved both in the juvenile justice system and the child welfare system (Herz, Ryan, & Bilchik, 2010). These students are identified as having twice the rate of recidivism as a delinquent youth. Sixty-two percent of crossover youth, as opposed to 30% of delinquent youth, have recurring offenses (Herz et al., 2010). Herz et al. (2010) evaluated 581 offenders for cases that occurred between April and December 2004. Data were collected and examined using a logistic regression model which included measures in the areas of gang involvement, substance misuse/abuse, enrollment in school, truancies, and making progress in placement.

Herz et al. (2010) found a contradiction to most juvenile justice research with

regard to race and gender. There was no significant connection between race and gender in this study. The researcher did find a direct correlation between harsher court outcomes for those who were detained before adjudication, having a prior offense history, having a probation violation, or being charged with violent offenses. With regard to recidivism, the researcher found five domains that increase the probability of future offending: personal characteristics, peer characteristics, school characteristics, family characteristics, and community characteristics.

Attitude toward the justice system often comes from intergenerational experiences. Cavanagh and Cauffman (2015) evaluated male first-time offenders and their mothers to determine the parent and child perception of the juvenile justice system's legitimacy. Cavanagh and Cauffman examined the participant's perception of the juvenile justice system using the Procedural Justice Inventory: Justice System Legitimacy subscale. The offender was also interviewed and self-reported to the researcher antisocial and illegal activity. The juvenile justice system also reported to the researcher if any of the offenders were arrested. Cavanagh and Cauffman found that 63.3% of the offenders reported reoffending, while the juvenile justice system indicated that 30.79% of the offenders were arrested at least once within the year of their first offense.

Cavanagh and Cauffman (2015) found that mothers had a more legitimate view of the juvenile justice system than their sons on average. The researcher also found that the mother's attitude directly correlated to their child's attitude. In this case, if the mother saw the justice system as being less legitimate, her son shared a similar feeling in most cases. Offenders were evaluated to determine if a correlation existed between the offender's view of the legitimacy of the justice system and the likelihood of reoffending. The researcher found that individuals who viewed the judicial system as being less

legitimate were more likely to offend again within 1 year of his first arrest. In the official arrest record, Cavanagh and Cauffman did not find a significant correlation between the offender's mother's attitude toward the justice system and the offender's attitude toward the justice system with regard to the likelihood of the offender reoffending in the first year.

Gardner, Boccaccini, Bitting, and Edens (2015) researched the use of a Personality Assessment Inventory to predict adverse behaviors such as violence, institutional misconduct, and recidivism. The research evaluated 21 published articles, eight unpublished articles, and two conference presentations with regard to a Personality Assessment Inventory and misconduct including recidivism (Gardner et al., 2015). The research concluded that institutional misconduct showed the strongest predictive effects in the area of aggression and antisocial features (Gardner et al., 2015). Twelve of the studies focused on using Personality Assessment Inventory scores as a predictor for recidivism, while the researcher found antisocial features as the largest predictor. Twenty studies focused on violent behaviors using a Personality Assessment Inventory as a predictor. The study found that the most significant predictor of aggression was the aggression and potential violent index, which measures items including explosive expressions of anger, limited empathy, impulsivity, alcohol/drug use, history of antisocial behavior, and anger directed outward (Gardner et al., 2015).

Aalsma et al. (2015) noted that 60-80% of youth who were detained have at least one mental illness. The study cited that 40-70% of youth recidivate within 1 year of their arrest. The study suggests having at least one mental health disorder is one of the highest predictors of recidivism based on a meta-analysis of 23 studies of 15,265 adolescents (Aalsma et al., 2015). Conduct disorders, untreated mental health disorders, ADHD,

abuse, and trauma are also indicators noted by Aalsma et al. The research of Aalsma et al. was part of a larger statewide study of mental health screenings in an Indiana detention center at 16 sites which the researcher collected data on a monthly basis through an electronic system that records each offender as he/she is arrested allowing the researcher to measure recidivism. Aalsma et al. used the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2), an electronic health screening tool, for each detainee. With this system, data are also collected on age, gender, and self-reported race/ethnicity. Using the MAYSI-2, yes and no response questions were asked to each participant. The questions included whether he/she was ordered to undertake a psychological assessment; if he/she was placed in behavioral precaution due to aggressive behaviors; if he/she saw a mental health clinician within 24 hours of intake; and if he/she received behavioral health services in the detention center.

Aalsma et al. (2015) found significant variations among subscale scores on the MAYSI-2 between sites as well as variations in recidivism rates within 1 year of release. Three attributes showed a significantly higher rate of recidivism. These attributes included males, African-Americans, and younger youth than their counterparts (Aalsma et al., 2015). Warning areas related to recidivism included high ratings in the subscales of alcohol and drug use, anger, suicidal ideations, and thought disturbance; while depression and anxiety and somatic thoughts did not show an association with recidivism (Aalsma et al., 2015). Impaired behavioral health also showed an increase in the likelihood of recidivism, parent referral to behavioral health, court-ordered psychological assessment in the community, contact with a mental health professional within 24 hours of the offender being detained, an offender on suicide watch, and aggressive behaviors (Aalsma et al., 2015). Unlike court-ordered assessment in the community, court-ordered

assessment within the detention center did not show a significant effect on recidivism (Aalsma et al., 2015).

Theoretical Framework

Circle of Courage®. The Circle of Courage® model focuses on four areas: belonging, mastery, independence, and generosity. The Circle of Courage® model based on Native American teachings and the Native American sense of family. The circle, which is the symbol for the Circle of Courage® model, is based on the medicine wheel for Native Americans (Brendtro et al., 2002). The circle is extremely sacred to Native Americans as a symbol of interconnectedness that all humans share (Brendtro et al., 2002). The model's central theme is a set of common values that must exist in a community to create an environment that benefits all (Brendtro et al., 2002).

Circle of Courage® also focuses on the theory of positive youth development. Positive youth development is a strength-based approach to working with young people that draws on positive psychology, developmental psychology, developmental epidemiology, and prevention sciences (Baber & Rainer, 2011; Lerner, 2009; Roth & Brooks-Gunn, 2003; Silbereisen & Lerner, 2007). According to Baber and Rainer (2011), the theory of positive youth development focuses on educating, understanding, supporting, and engaging youth rather than just focusing on the student's behavior. Within the Circle of Courage® model, students learn education through mastery, understanding through independence, supporting through generosity, and engaging through belonging. A person-centered plan designed for each student which focuses on how they can support themselves in their treatment. The theory supports the idea that the person-centered plan focuses on competence, confidence, caring, connection, character and contribution.

Harper (2005) examined a day treatment program based on the Circle of Courage® model which focused on self-concept and self-esteem research conducted by Stanley Coppersmith in 1995. Within Stanley's research, the areas of need in a child were significance, competence, virtue, and power (Harper, 2005). These four areas defined by Stanley run parallel to the areas belonging, independence, generosity, and mastery found in Circle of Courage® (Harper, 2005). Harper's study sought to address what characterized the therapeutic use of a level system for students with emotional and behavioral disturbances. The research was collected using an interview system with each of the teacher-counselors from four different day treatment programs using the level system as a means of behavior modification (Harper, 2005). The researcher found that often the level system that was incorporated was effective but had to be modified to make the levels easy to understand and explained for the student to be able to grasp the concept. The second area of concern can transition from the strict level system. The participant must complete specific goals and responsibilities to increase his/her level and earn privileges to move back to society or their home school and having freedom to do as he/she pleases (Harper, 2005).

When working with behaviors, especially those in a residential treatment facility or multiple facilities, Pike, Millspaugh, and DeSalvatore (2005) cited three common elements. An increased number of residents with acute treatment needs were not successful when the residents transferred from one facility to the next. Those who were successful in the program setting often were not successful when returning to his/her home community. The study proposed to design a path to bridge the gap between the residential facility and the community using the Circle of Courage® model. Each new resident began in the belonging stage; then, in no particular order, to mastery,

independence, and generosity. The purpose of this was to allow the residents to feel as though they belonged as part of the group (Pike et al., 2005). Residents progressed to the next phase upon completion of goals and activities at each stage (Pike et al., 2005).

The researcher found that the staff displayed a harder work ethic and buy-in as he/she felt to be more effectively a part of the treatment team. The residents also showed more interest in the new system by expressing the belief that they were allowed to have more control over their treatment (Pike et al., 2005). Resident success rates increased as compared to the old system. The residents expressed that the old system pushed treatment as something they had to do as opposed to the new system addressing treatment as something that would lead them to bigger and better things (Pike et al., 2005).

Cognitive Restructuring Therapy. Cognitive restructuring therapy has been used to help youth identify distortions in their thinking and correct the distortions to focus on reality (Peris et al., 2015). The researcher found significant improvement in youth anxiety through the use of cognitive restructuring therapy when comparing cognitive restructuring to exposure task and relaxation techniques as part of a cognitive restructuring therapy program. The researcher found that cognitive restructuring and exposure task showed the most significant positive increases in this longitudinal study.

Karver and Caporino (2010) conducted an empirical study and found several studies suggested that feedback, assessments, goal setting, and treatment should be done collaboratively to increase participant willingness to participate and the completion of treatment. Several studies indicate that parental perceived expectations and the actual treatment outcomes being mismatched often led to early termination from the program (Karver & Caporino, 2010). Building a therapeutic relationship with the participant has indicated that treatment outcomes may be improved as well as the willingness to engage

with the clinician (Karver & Caporino, 2010).

Scattone and Mong (2013) focused their research on individuals between the ages of 8 and 13 diagnosed with Autism Spectrum Disorder as well as an anxiety disorder. Individuals were diagnosed with an anxiety disorder based on the Anxiety Disorders Interview Schedule Child and Parent Forms (ADIS-C/P; Silverman & Albano, 1996). The researcher used cognitive restructuring as part of the cognitive behavioral therapy to identify distortions in participant thinking (Scattone & Mong, 2013). The ADIS-C/P was administered before and after the 9-week session. After treatment, the researcher found 20 of the 28 participants no longer met the requirements for an anxiety disorder based upon ADIS-C/P (Scattone & Mong, 2013). A notable struggle identified during the research was being able to grasp the concepts of distorted thoughts, especially for those with disabilities. Due to these distorted thoughts, the researcher needed an increased amount of time during the sessions to explain these concepts (Scattone & Mong, 2013).

Shikatani, Antony, Kuo, and Cassin (2014) examined individuals with Social Anxiety Disorders and the effects of cognitive restructuring as a means to evaluate how they viewed the situation. The study focused on individuals who were 17 or older, scored a 19 or higher on the Social Phobia Inventory, and had not received cognitive restructuring or cognitive behavioral therapy for Social Anxiety Disorders previously (Shikatani et al., 2014). A series of questionnaires were given to the participants to measure their stress and anxiety levels. The individuals were then given five prompts without time for practice and were asked to give a speech on each topic to either a video camera, the researcher, or an observer. Two sessions were offered to each participant. The first session was 2 hours and included the speech as well as cognitive restructuring therapy. The second session was a posttreatment session which lasted 30 minutes and

consisted of a post-event processing about their anxiety regarding the speech and the previous session (Shikatani et al., 2014). The researcher found the group given cognitive restructuring therapy showed a decrease in anxiety in the self-reported anxiety as compared to the control group. Shikatani et al. (2014) found that the participants did not show a significant decrease in maladaptive behavior, which was contrary to the original hypothesis.

A study conducted by Eisen and Silverman (1993) investigated the efficacy of cognitive therapy, and relaxation therapy. The investigation examined four children ages 9-13 with Overanxious Disorder. Overanxious Disorder is defined as being unrealistically worried for at least 6 months (DSM-III R, 1987). Overanxious Disorder was eliminated in 1994 with the publication of DSM-IV. At that time, the symptoms of Overanxious Disorder were classified under General Anxiety Disorder (Wagner, 2001). The participants were given 16-20 biweekly therapy sessions including a cognitive behavioral component (Eisen & Silverman, 1993). Three strategies were used in the cognitive therapy. The first stressor was to identify and clarify anxious conditions in anxiety provoking situations. The second stressor was to modify anxious self-talk by creating and implementing a coping plan. The final area was using self-reinforcement when successfully using a coping strategy (Eisen & Silverman, 1993). At the conclusion of the study, the results demonstrated that all four students showed improvement from the parent report, clinician report, and the child self-report measures. Although all participants showed improvements in the study, half of the students continued to be at the clinical level for the somatic subscale. Additionally, the students maintained treatment gains at follow-up evaluations (Eisen & Silverman, 1993).

Fifteen million children and adolescents are diagnosed with mental health

disorders that adversely affect school or the home environment; less than 25% receive treatment (Melnyk et al., 2015). Based on the 2011 Youth Risk Behavior Survey data, depressive symptoms impair daily functions in 37% of girls and 20% of boys (Melnyk et al., 2015). The researcher evaluated 779 randomly sampled adolescents who participated in the Creating Opportunities for Personal Empowerment (COPE) program or the Healthy Lifestyles Thinking, Emotions, Exercise, Nutrition (TEEN) program over 12 months and met the criteria for being considered overweight based on their body type and had depressive symptoms. The COPE program is guided by cognitive therapy, which incorporates physical activity into the individual's thinking and is directly related to how the participant feels. (Melnyk et al., 2015, p. 863).

Evaluations at the 12-month follow-up included a BMI assessment as well as a depression symptoms evaluation. Fifty percent of the eligible youth participated in the study. Those who participated in the COPE program had a significantly higher T-score on the Beck Depressive Inventory as opposed to the TEEN program. The COPE group scores showed a significant difference as the postscores fell within the normal range while the healthy TEEN participants remained in the depressed range. Of the students who were evaluated, 69.6% of the participants felt that the program was helpful. Forty-eight percent of the participants in the COPE program changed their behavior, and 22.6% of the participants indicated their family made changes due to the program (Melnyk et al., 2015).

Rosenberg, Jankowski, Fortuna, Rosenberg, and Mueser (2011) evaluated the feasibility and efficacy of a pilot program based on cognitive restructuring for treating adolescents suffering from posttraumatic stress disorder (PTSD). The study evaluated nine girls and three boys ranging in age from 14-18 with the mean age being 16. Twelve

participants were assessed at the pretreatment, posttreatment, and 3-month follow-up stage. Treatment consisted of 12-16 one-hour sessions per week for eight modules. The treatment focused on the core symptoms of PTSD, relaxation techniques, cognitive restructuring, and anxiety management skills.

Rosenberg et al. (2011) found nine participants completed the treatment program. Although initially 12 met the criteria for entry into the program, three either never began after the pretreatment evaluations were completed or dropped out early for a variety of reasons. Of the nine participants who completed the program, a mean of 6.5 traumas of a possible 16 were reported such as witnessing the death of a loved one or a friend, being hurt by a parent, and being beat up by a friend. The research identified that all 12 participants met the qualifications for PTSD as a baseline; at the first posttreatment assessment, five of nine participants (56%) continued to meet the criteria for PTSD. Eight of the nine participants who completed the program participated in the 3-month follow-up; two of eight participants (25%) continued to meet the criteria for PTSD after treatment (Rosenberg et al., 2011).

Research suggests a direct link between disruptive behaviors and poor academic performance, drug and alcohol misuse, leaving school early (quitting school), and becoming involved in the juvenile justice system (Ruttledge & Petrides, 2012). In the Ruttledge & Petrides (2012) study, teachers were asked to group 22 students from three schools with disruptive behaviors in groups based on the negative behavior such as fighting, refusing to complete classwork, bullying, negative self-concept, the difficulty of following routines, or talking out disrupting class. Each group met with a researcher and his/her teacher for six 1-hour sessions. The participants worked through material based on material from “Think Good, Feel Good” (Ruttledge & Petrides, 2012; Stallard, 2002)

and “Anger Management: A Practical Guide” (Faupel, Herrick, & Sharp, 1998, Ruttledge & Petrides, 2012). Each session began with a check-in, a game, a homework activity, cognitive behavior strategy, an explanation of new homework, and a cool-down activity (Ruttledge & Petrides, 2012). Participant outcomes were measured using the Beck Youth Inventory, Trait Emotional Intelligence Questionnaire-Adolescent Short Form, Strengths and Difficulties Questionnaire, and the Teacher Behavior Checklist (Ruttledge & Petrides, 2012).

Based on the Beck Youth Inventory, the researcher found that no significant change was made in the area of anxiety and depression (Ruttledge & Petrides, 2012). A significant change was made in the area of anger, behavior disruption, and self-concept based on a pretreatment baseline and the 6-month follow-up. The Trait Emotional Intelligence Questionnaire-Adolescent Short Form showed a significant difference from the pretreatment baseline to the post assessment to the 6-month follow-up. The Strengths and Difficulties Questionnaire participant survey, parent survey, and teacher survey showed no significant difference in peer problems and emotional symptoms. The parent survey revealed no significant change in the area of prosocial behavior. A significant change was identified in the parent, participant, and teacher surveys in the area of conduct problems and hyperactivity from the pretreatment assessment to the 6-month post assessment. The teacher and participant survey demonstrated a significant change in the area of prosocial behavior. The teacher behavior checklist identified a significant change in student behavior from pretreatment to posttreatment. The results indicated that cognitive behavioral group is an effective intervention for disruptive behaviors.

Goldstein et al. (2013) researched the development of an anger management treatment program for females in the juvenile justice system. The program design was

inconclusive due to the limited number of participants (Goldstein et al., 2013). The program evaluated the Juvenile Justice Anger Management for girls. The study focused on relational aggression such as excluding others and starting rumors. Girls were reported to be more likely to commit crimes against family or friends (Goldstein et al., 2013; Puzzanchera, 2009). Due to this, Goldstein et al. (2013) focused on rebuilding and strengthening broken relationships using the Juvenile Justice Anger Management program.

The program was sixteen 90-minute sessions over the course of 8 weeks led by two facilitators (Goldstein et al., 2013). The treatment incorporated cognitive restructuring, problem solving and skills training (coping, emotion regulation) with the focus of the first three sessions being the identification of differences between anger and aggression. The fourth session focused on cognitive restructuring by changing the perspective of the participants, with the next several sessions focused on recognizing triggers and focusing on coping skills instead of aggressive tendencies (Goldstein et al., 2013).

Initial findings of the study led to misleading data, resulting in changes to the program design. Initially, six offenders were sought for treatment; but of the six, parent permission was only given for two. Of the two participants, only one completed the 2-week follow-up survey. The second participants were released for good behavior.

A second study has been planned with the revised program working with 90 females who were adjudicated at three facilities in Pennsylvania and New Jersey to increase the validity of the Juvenile Justice Anger Management program (Goldstein et al., 2013).

Cognitive behavioral therapy. Cognitive behavioral therapy is used in many areas within the education setting including the day treatment program referenced in this study. Many individuals are in need of behavioral treatment, especially those in a day treatment setting. Thirty percent of adults and 19% of children and adolescents in the United States show severe psychological distress and are in need of treatment (Beshai & Dobson, 2014; Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 2009; Olson, Lopez-Duran, Lunkenheimer, Chang, & Sameroff, 2011). Cognitive behavioral therapy was found to reduce symptoms of common childhood psychological problems such as depression and anxiety (TADS, 2004; Weisz, McCarty, & Valeri, 2006).

The Figure shows a visual of the cognitive behavioral therapy model.

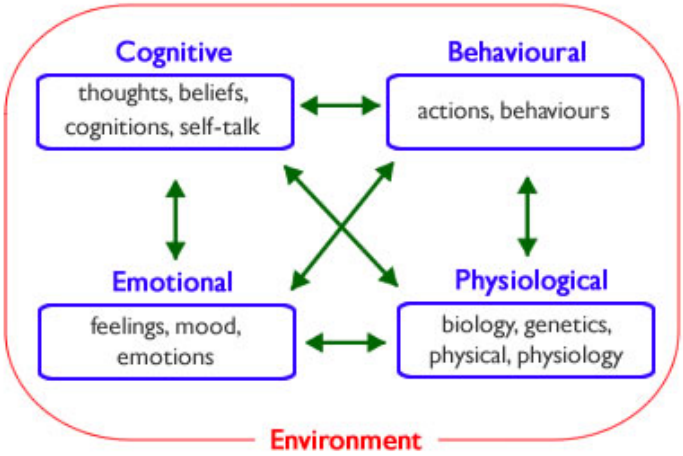

Figure. Cognitive Behavioral Therapy Model (Dorter, 2014).

Durlak, Rubin, and Kahng (2001) researched outcomes for students ages 5-13 with behavioral and social difficulties which examined the effect of age on cognitive behavioral therapy outcomes. The researcher found that the oldest group, the 11- to 13-year-olds, benefited the most. This group showed the most positive results from cognitive behavioral treatment than other age groups. The researcher suggested that

children did not have the logical deductive reasoning skills before the age of 11 or the ability to stay engaged in the cognitive behavioral therapy process.

In a research study conducted by Oldershaw et al. (2012), participants aged 12-18 who were identified as having or engaging in self-harming behaviors were offered 112 sessions of cognitive behavioral therapy. The research compared three groups: individuals who self-identified as being self-harmers who received cognitive behavioral therapy in a 12-session program geared toward individuals who self-harm; those identified as being self-harmers who did not receive therapy, by either refusing or not pursuing treatment; and a healthy control group. Oldershaw et al. found a significant improvement in the cognitive behavioral therapy group in relation to time in the study.

The group was evaluated at two different times during the program, once in the middle of the program and once at the end of the program. The second evaluation showed significantly improved scores. Students who received cognitive behavioral therapy showed a significant difference from those receiving no therapy, while those in the healthy control group did not show a significant difference from those receiving cognitive behavioral therapy (Oldershaw et al., 2012).

Cognitive behavioral therapy is often used in a group therapy session to combat disruptive behaviors (Larmar, 2006). The researcher conducted a group-based intervention in a school in a large metropolitan area in Brisbane (Larmar, 2006). The researcher had 12 participants, seven male and five female students in the seventh grade. The program split the group into two groups: four males and two females who identified as having disruptive behaviors, while the other six students had exemplary behavior and acted as role models for the students with disruptive behaviors. The program had a designed curriculum based on a cognitive behavioral therapy model developed by

Kaplan's and Carter's (1995) process with nine sessions lasting over the course of 9 weeks. Each session lasted 1 hour and 30 minutes a piece (Larmar, 2006).

The results of the study found that group therapy showed a positive means of incorporating cognitive behavioral therapy to school age students. A textual analysis of participant comments yielded group work to be a positive learning experience. Of the participants, two displayed behaviors that were disruptive only on occasion but when prompted actions ceased; and one individual did not feel accepted into the group and stopped attending after the third session. The rest of the participants responded well in the group without behaviors (Larmar, 2006).

School-based interventions have increased across several countries to treat behavioral difficulties while continuing to serve students in an academic setting (Liber, De Boo, Huizenga, & Prins, 2013). One hundred seventy-three participants ages 8-12 participated in the study. There were 136 boys and 37 girls. The participants mostly lived with both biological parents; 45 lived in a single-parent household, and 17 lived in a divorced household in which at least one parent had remarried. Seventy teachers, 13 trainers, and 22 co-trainers participated in the study. The researcher used the following evaluations to measure the effectiveness of the intervention: the Teacher Report Form, Strength and Conditioning Questionnaire, Disruptive Behavior Disorders Rating Scale, and Peer Measurement of Internalizing and Externalizing Behavior.

The nine-session cognitive behavioral therapy program called Keep Cool Stay in School was used as the primary intervention for this study (Liber et al., 2013). The program was a manualized social cognitive behavioral treatment program designed to focus on social skills and cognitive restructuring techniques through role play, modeling, and positive reinforcement for positive behavior. Parents were included for one session

midway through the program. Teachers of the participants also received 10 sessions of training: five were active teacher support, and five were educational teacher support.

Results compared a control wait-list group to the participants who received the intervention. Significant outcome measures were found among all those involved at the posttreatment follow-up but were not identified at the end of the intervention especially in the area of disruptive behaviors (Liber et al., 2013). A significant effect on the teacher's ability to handle and work with oppositional problems was more prevalent from the Educational Teacher Support as opposed to the Active Teacher Support. The results show 108 participants (63%) were in the clinical range for the Teacher Report Form Externalizing Scale; 30 of the participants (18%) were borderline clinical range; and 33 (19%) were in the normal range at pretreatment. At posttreatment, there was a significantly lower rate of children scoring in the borderline range. At posttreatment, 77 (45%) scored in the clinical range; 35 (20%) scored in the borderline clinical range; and 59 (35%) scored in the normal range. At the follow-up, 63 (44%) were in the clinical range; 28 (20%) were borderline clinical range; and 52 (36%) were in the normal range (Liber et al., 2013).

Individuals with ADHD are more likely to have disruptive disorders than typically developing peers (Boyer, Geurts, Prins, & Oord, 2015). A clinical trial among 16 centers was conducted using a random sample of 159 participants ranging in ages from 12-17 to decrease disruptive behaviors. The participants were diagnosed with ADHD and attended a secondary school. They were given a nonpharmacological treatment and assigned to a plan my life group which worked on organizational skills needed for adolescent life or the Solution-Focused Treatment program in which students were allowed to choose what struggles they needed to address. The focus of the

treatment was on areas of success for the participant as opposed to areas of conflict (Boyer et al., 2015). Participants were assessed using five areas: parent rating scale of ADHD, planning, being able to care for oneself or executive function, comorbid symptoms, and general functioning within the participant's society (Boyer et al., 2015). Each group began with eight student sessions and two parent sessions which lasted between 45-60 minutes each. Both treatment models required the participant as well as the therapist to use a workbook to be consistent.

The plan my life treatment program is based on a cognitive behavioral therapy model in which students are given a fixed program that focused on planning skills and organizational strategies in which the participants were allowed to choose the ideas that the individual felt were needed at that time. Negative thoughts often happened during the session geared toward the strategy. As the negative thoughts arose, the staff challenged the beliefs and helped to formulate a new theory. Each session addressed the previous session and included successes, possible areas of improvements, and cognitive thoughts since the last meeting (Boyer et al., 2015).

The Solution-Focused Treatment program allowed the participants to discuss struggles they encountered that week, and the staff guided the participant to a solution using a set of fixed questions to address a solution (Boyer et al., 2015). Questions included what subject did you choose; how is the present situation a problem; how would you like it to be; what solution have you used in the past; what possible solutions did you use in the past; does the current situation have advantages; when do you want to change the current situation; and what is your plan (Boyer et al., 2015, p. 1080)?

Results showed that there were no significant differences between dropouts and completers as well as treatment conditions and demographic characteristics at the

baseline scale. The therapist did not report a preference toward the plan my life or Solution-Focused Treatment program but felt that plan my life was a better fit for students with ADHD over the Solution-Focused Treatment program. However, the results indicated that no significant differences existed between student growths in both programs. Indicators in the study showed a marginal improvement in the plan my life program over the Solution-Focused Treatment program. Post assessment was given at a 3-month follow-up evaluation. The teacher measure showed a significant improvement in the measure of executive function and decrease in ADHD symptoms. The study indicated that all participants demonstrated a positive increase in these areas; but the study also indicated only 15.2% of the participants showed enough growth to be identified in the normal range clinically for their same age peers (Boyer et al., 2015).

Cognitive behavioral therapy is used in many settings to treat anxiety and other mental health diagnoses, especially in day treatment and hospital facilities (Suszek, Holas, Wyrzykowski, Lorentzen, & Kokoszka, 2015). The study used a randomized control sample of 199 participants with anxiety, personality, or depressive disorders. The participants were separated into three groups: a psychodynamic group therapy, cognitive behavioral therapy group, and a waitlist control group. After a 12-week waiting period, the control group began receiving treatment. Group sessions lasted 90 minutes with a total of 70-80 hours for the 12-week program. The psychodynamic group focused on mirroring behaviors to allow participants to identify behaviors, fantasies, and problems of other participants; the participants are sharing their struggles with the group and helping make an association between other members through sharing. The group cognitive behavioral therapy program was designed to treat in a naturalistic setting with a mixed diagnosis of anxiety disorder and a comorbid personality disorder. Five primary

measures were used: the State-Trait Anxiety Inventory, Hamilton Anxiety Rating Scale, Clinical Global Impression – Severity Scale, Clinical Global Impression – Improvement Scale, and the Mini-International Neuropsychiatric Interview 5 (Suszek et al., 2015). Insufficient evidence was not found to support the efficacy of the use of the group forms of both the cognitive behavioral therapy and psychodynamic therapy, although most studies indicate that the use of cognitive behavioral therapy in the group form is comparable to the individual form of cognitive behavioral therapy (Suszek et al., 2015).

Student absenteeism refers to students who miss school without permission from the school. Often, this is due to environmental, social, or psychiatric reasons and is a major issue in the western culture (Walter et al., 2010). Participants in the study had to meet specific criteria to qualify for the program. Participants must have been between 12-18 and have had 14 or more absences from school that were unexcused or 50 skipped classes in the last reporting term. Also, the participants had to meet the ICD-10 criteria for one of the following disorders: specific phobia or other anxiety disorder, depressive episode, or mixed disorder of conduct and emotions. The study took place between January 2004 and April 2008. During that time, 224 of the participants were referred by parents, and 147 completed the program (Walter et al., 2010).

Each group had 10 participants. Inpatient sessions lasted 4-10 weeks based on the severity of the participants in the group. Cognitive behavioral therapy was provided in the groups as well as individual sessions. After completion of the program, 80 participants (59.9%) received outpatient therapy using the cognitive behavioral therapy treatment model for an average of six sessions within the course of 6 weeks. The results were determined using the following assessments: anxiety/depression adolescent rating, anxiety/depression parent rating, disruptive behavior adolescent rating, disruptive

behavior parent rating, and learning behavior rating (Walter et al., 2010).

Results from the study indicated that school absenteeism significantly reduced 2 weeks prior to the postassessment. None of the 147 participants had continuous attendance at the beginning of the study. At the postassessment, 121 (82.3%) regularly attended school or work. At the follow-up period, a statistically significant increase in absenteeism occurred. Although the number of participants was small, this was significant for the findings. The researcher identified this as a possible consequence of the elimination of the therapeutic assistance the participants were receiving. The researcher found moderate to high reductions in the areas of anxiety, depression, and disruptive behavior as well as an improvement in learning behavior from the pretreatment assessment until the 2-month follow-up (Walter et al., 2010).

Conceptual Framework

Day treatment model. In 1922, the American Juvenile Justice System incorporated the first multi-discipline team to work with students (Pumariega & Vance, 1999). The programs began by using social workers instead of teachers and health professionals. A committee, the Joint Commission on Mental Health of Children, was formed in 1964 and was charged with targeting a continuation of services for students with severe emotional disturbances (Pumariega & Vance, 1999). The programs were assigned with making these services more effective. Knight (1995) found the formation of this committee, along with other policies, led to the deinstitutionalization of facilities that housed individuals with severe emotional disorders, increased services for mental health, and reduced the cost of mental health services. In the 1970s and 1980s, the shift was made to a more hospital-based model. Funding was split to pay for the hospital services (Knight, 1995).

The cost of a day treatment program in 1999 cost the funding agency $40 a day per individual for 3 hours of mental health services (Ryan, Sherman, & Robinson, 1999). Though the cost has risen as well as the amount of time to 4 hours a day, this form of treatment continues to be the least restrictive and cost effective form of service compared to hospitalization treatment for mental health disorders (Kaskutas, Witbrodt, & French, 2004).

Day treatment programs are designed to allow for therapy and education in the least restrictive environment outside of a residential setting. Child and Adolescent Day Treatment (2015) stated that a facility must be licensed to provide structured therapy based on the individual need of the child or adolescent. A student must have Medicaid or Health Choice and must be between the ages (NCDHHS, 2015). The student must show a need that is severe enough to keep the student from successfully participating in a traditional school setting. Students were approved for services by the local management entity based on their need for services. Students can also be denied due to a lack of need or from a lack of documentation of other interventions tried by their home school or other agencies. In many states, day treatment is the most intensive nonresidential program that can be provided over an extended period (Child and Adolescent Day Treatment, 2015). After the student enters a day treatment setting, the local management entity expects the student to make a certain amount of progress as well as the staff to document the student's progress daily. Students are given additional time in day treatment on an individual basis. Students can be given more time if the local management entity feels that the student is making progress but still shows signs of need or denied more time for making adequate progress or a student not showing progress.

As the individuals move through the day treatment program, the theory is that the

students enter the program in an area with multiple cognitive distortions, and the therapeutic staff should work with the student to become aware of their behaviors. The therapeutic staff work through the distortions until the student reaches an area in which the student feels under control of his/her own distortions, and the therapist should work toward understanding the student's behavioral triggers.

Levels. The HTP program focuses on meeting students at their current stage based on their behaviors. Students are leveled in the day treatment program based on what stage they are currently in during the time of treatment. Students move through the levels up and down based on behaviors. "The notion of *levels of change* recognizes that individuals can experience multiple problems that exist at different levels: symptom/situational, maladaptive cognitions, interpersonal conflicts, family/systems problems and interpersonal conflicts" (Whitelaw, Baldwin, Bunton, & Flynn, 2000, p. 708). Students in the program can be voted to different levels by their peers based on where the students currently are in the program.

Isaacs and Goldman (1985) researched several day treatment programs working with a level system which allowed students to move up and down the program based on a point system in which the students earned points and could bank points in order to move up in the program. This Pennsylvania program, called ADVANCE, sent a questionnaire requesting information on 10 different measures to 220 former ADVANCE clients (Isaacs & Glodman, 1985). Of the 220 former clients, 59 responded to the questionnaire.

The results indicated,

> The majority of respondents (71 percent) returned to school or enrolled in an educational program after leaving. Approximately half (45 percent) were attending school or an education program. Seventy-five percent of both looked

> for employment and were hired. Nineteen percent were fired or laid off; of those fired all sought further employment. Thirty-five percent were employed, either full or part-time (86 percent reporting responsible attendance on the job). Twenty-eight percent reported an increase in either alcohol or drug intake. Twenty-five percent reported community participation. Thirty-five percent reported that they were in counseling or therapy. Six percent reported convictions, incarceration or some type of institutionalization. Eight percent stated that the services they received at ADVANCES had helped them to deal more effectively with their problems and that they would recommend the program. (Isaac & Goldman, 1985, p.60)

Brammer and Sandorsky (2000) studied two different forms of service: an outpatient program and a day treatment program. The program studied 143 students, including 93 males and 50 females. The outpatient facilities were located in the Texas Panhandle, while the day treatment program was located at a local middle school in Amarillo, TX. Brammar and Sandosky found that using a child behavioral checklist, there were significant changes from the initial child behavioral checklist given upon entrance into the program. One finding that tended to be significant between the two models was that weekly treatment and daily treatment showed little significant difference in effect for this study (Brammar & Sadosky, 2000).

Welburn, Dagg, Coristine, and Pontefract (2000) researched a 12-week day treatment program. The study lasted 2 years with 84 participants who completed the program. The program met four times a week for 3 hours at a time and worked with 15 participants at a time. The program then started over with a second group after 12 weeks. The individuals participated in five areas of therapy: psychotherapy, cognitive behavioral

therapy, assertiveness training, life skills training, and health promotion. The individuals were given a questionnaire at the initial intake and the same questionnaire upon exiting the program.

The study found that upon entering the program, the individuals were, on average, approximately one standard deviation above the mean for psychiatric outpatients. The study indicated individuals had a very high level of distress. After completion of the program, the participant's level of distress was significantly reduced and comparable to outpatient norms. The most notable of the findings were in three areas: social alienation, defectiveness, and vulnerability to harm (Welburn et al., 2000).

Behavioral impact. Substantial evidence exists that links children who have disruptive behavior problems to a risk of early peer rejection (Coie, Dodge, & Coppotelli, 1982; Gresham & Little, 1993; Pardini, Barry, Barth, Lochman, & Wells, 2006). Once their peers reject these children, they are at even greater risk for further adverse outcomes. Such results include delinquency, academic difficulties, and severe internalizing and externalizing problems (Coie, Terry, Lenox, Lochman, & Hyman, 1995; Miller-Johnson, Coie, Maumary-Gremaud, Lochman, & Terry, 1999; Parker & Asher, 1987; Pardini et al., 2006).

Academic impact. Academic impact, along with behavioral impact, is the main concern for administrators and teachers as a student returns from a separate setting such as a day treatment or residential setting, thus the researcher identified and analyzed the effects of transitioning students with emotional disturbances from a residential day treatment setting. Levin (2009) used academic and psychoeducational tests to measure the students. Levin used student GPA, Woodcock-Johnson scores, and WISC scores to find student academic ability, IQ, and the academic performance of the students after

transitioning from a residential day treatment setting.

Social acceptance. For students to become part of a group, many feel as though they must do something to be accepted by the group, especially if the student is transitioning from another school or setting. Adolescents begin to mimic the behavior of his/her social group which include negative behaviors (Fortuin, Van Geel, & Vedder, 2015) Defiance is even more pronounced as a student is transitioning from a day treatment setting where such behaviors may carry a stigma of being the type of behavior that may have led the student to the day treatment setting initially.

For students to continue to feel a part of this group, many fall into peer pressure, thus ignoring the consequences that may follow (Fortuin, Van Geel, & Vedder, 2015). These behaviors cause a major setback for many of the students who have begun the transition process and could easily alter the effectiveness of the transition.

To successfully transition from a day treatment program, a student must learn independence especially outside of the confines of a day treatment program. Within this process, the student transfers from a classroom of no more than six students and one Qualified Mental Health Professional to a classroom with up to 30 students. A student must have the independence to identify and control his/her own actions when the student is not being as highly monitored and is freely socializing with other students. Students are challenged to monitor and maintain appropriate behavior as if no adult is monitoring. Students with severe behaviors, such as becoming physically violent when they become upset, must have a sense of independence that they are responsible for their own conduct.

Time and treatment. When comparing the time in treatment to the participant success in treatment, Jerrott, Clark, and Fearon (2010) studied 32 males and eight females with ages that ranged from 5-13. The day treatment program employs a cognitive

behavioral approach using a token economy and skill-building groups with a focus on social skills training, anger management, processing of school difficulties, hygiene, and relaxation training (Jerrot et al., 2010). The study focused on child symptoms using the Child Behavioral Checklist, Connors Parent Rating Scale-Revised: Short Form and parent stress using the Parent Stress Index and Eyburg Behavior Index. Students participated in the program between 10-16 weeks for 4 days a week, totaling at least 40 treatment days. Students then transitioned out of the day treatment program down to 1 day a week. The treatment program also studied a waitlist group as a control for the study.

The study found that the treatment group noted large effects, except the area of parent stress. The researcher noted both the control group as well as the treatment group exhibited disruptive or antisocial behaviors at the clinically significant level. Both groups were given pre and post assessments in the areas of behavior, parent stress, and Connor's Parent Rating Scale for Behavior and Hyperactivity Disorder. The purpose of the assessment was to compare the growth made in day treatment to the growth made by maturing and with age. Treatment scores at admission versus discharge indicated a decrease in both social and externalized behavior as measured by the Conners' Parent Rating Scale-Revised: Short Form. The treatment group moved into the nonclinical level, while the waitlist group did not make significant improvements. The stress level was the only area in which both demonstrated no significant difference between the treatment group and the waitlist group at discharge.

Clark and Jerrott (2012) studied the long-term effects on students who exited day treatment. The study followed students 2.5 to 4 years after the students exited day treatment. The program sample for the study consisted of 28 students with 21 males and

seven females. The students participated in the program for an average of 36 treatment days. Data were collected during admission, at discharge, and follow-up. The study found clinically significant levels of behavior problems when the students entered the program based on the parent rating scales. The data showed a significant decrease in all areas of the admission, discharge, and follow-up except for the parent stress inventory. The parent stress inventory did not show a significant decrease. The study found at the follow-up that a majority of the children continued to struggle with severe symptoms. Of the students who participated in the study, 79% had at least one behavioral symptom (i.e., oppositional defiance, depression) that fell within the clinical range (T>65).

Antonsen et al. (2014) studied a day treatment program that served 113 patients for the study. The patients attended the program for an average of 24 months. The patients were young adults. The patients were evaluated at a 6-year follow-up. The study found statistically significant differences in the individual's psychosocial functioning after treatment. Additionally, the study found the greater increase between 18 months and 3 years in psychosocial functioning. The study also found that during the 3 to 6-year period patients began to show a significant decrease in psychosocial functioning level. Rehner and Plotner (1999) studied 119 students in three groups of students ranging in ages from 5 to 12 years. The students were split between a self-contained group, outpatient group, and pullout group. The self-contained received both therapy and academics in one classroom, while the pullout group spent time in a regular academic classroom and were pulled out of class to receive mental health therapy. The outpatient group was seen at the office on an outpatient basis. The groups of students in the day treatment program spent the entire school year in therapy during school hours, while the outpatient group met at a time other than normal school hours.

The researchers found that there were no significant differences between the self-contained group and the pullout group. Both groups showed a much higher behavioral growth than the outpatient group. Students showed nearly identical scores in behavioral functioning at the completion of the year. At the midyear review, all groups showed a significant break in progress for all intervention models. The study found that the self-contained group had significantly more behaviors than the pullout group in the beginning, but both completed the year behaviorally equal. One primary concern was the lack of growth from November to May by all three groups except the self-contained group; however, all groups completed the program at the same behavioral functioning level (Rehner & Plotner, 1999).

Van Bokhoven, Matthys, Van Goozen, and Van Engeland (2006) cited several studies dating back to the 1960s that have shown the effects of delinquent outcomes on students with Disruptive Behavior Disorders which include Conduct Disorder and Oppositional Defiant Disorder. Research suggests the struggles with Disruptive Behavior Disorders continue throughout an adolescent's life and into adulthood (Van Bokhoven et al., 2006); and of the participants within Robins's (1966) study, two thirds of the boys and half of the girls became delinquent. In a study conducted by Satterfield and Schell (1997), it was found that 53% of hyperactive boys with Conduct Disorder as opposed to 13% of hyperactive boys without Conduct Disorder had single or multiple adolescent offenses. Furthermore, 26% of the hyperactive boys with Conduct Disorder engaged in adult criminal activity (Van Bokhoven et al., 2006).

Based on these statistics, the researcher evaluated a group of adolescents who had received day treatment or inpatient services for Disruptive Behavior Disorders. The program consisted of five girls and 42 boys either in the residential or day treatment

setting, both receiving cognitive behavioral therapy as well as social problem skills training. Treatment and academics were continued using a partnering school system and, for those who qualified, special education services as well. The participants received either inpatient or day treatment; but in some cases, both services were given. Participants received the serves between 8 months to 2.8 years with the average length of stay being 1.7 years. Of the participants, 87% agreed to a follow-up along with 90% of the caregivers. Of the participants, 15% were institutionalized, and 6% lived independently with professional supervision. The rest of the individuals lived at home with their parents/guardian, with grandparents/foster parents, or independently (Van Bokhoven et al., 2006).

Students with disabilities. Preliminary findings from the University of Minnesota conducted by The National Center for Educational Statistics indicated that of 646,500 students being served in an alternative school setting, an estimated 12% are students with disabilities, typically students with learning disabilities or emotional or behavioral disabilities (Lehr, 2004). This estimation is a higher percentage than the normally reported maximum of 10% of students with disabilities in a regular classroom or school setting in the United States (Lehr, 2004). According to Lehr (2004), students with emotional or behavioral disabilities are the most common individuals to be in an alternative school. Lehr reported on a study conducted by the Enrollment Options Project that found Minnesota's alternative programs had 50% of the students with a disability at the alternative school. These students reported emotional and behavioral disabilities. As these students struggle to control their negative behaviors, many students additionally receive help with controlling their behaviors in a specific day treatment setting.

Need for Further Research

Ferrell (2013) identified a need for more research on the impact on students post graduation from a day treatment center/program. The researcher also noted that little to no research existed on student preparedness for post graduation such as college or employment as well as preparedness for transition back to school.

Jones (2008) also addressed that future research needed to examine student continued academic growth after exiting day treatment. Student effectiveness also needed to be measured about what percentage of students complete high school. Oestmann (2000) indicated that larger groups of students should be measured to determine outcomes. The researcher also stated that future research was needed to compare different day treatment models.

Yi (2012) offered several areas for further research. The researcher found the need for a longitudinal study on a particular program at University of California Irvine Child Development Center day treatment. The researcher further indicated the need for a parent exit survey and a teacher exit survey. A survey from both groups would allow for a comparison to eliminate inconsistencies. Billings (1998) suggested that a great deal of research is needed to address interventions for transitioning youth back to the regular setting/community. The researcher also suggested some of the issues include self-efficacy and belonging as well as social competence and interpersonal relationships. Policymakers and program designers will have the ability to use the research to find a connection between student experience and view of success to determine future programs' measures of success.

Research Questions

1. What are the students' interpersonal view of success after completion of the

hybrid day treatment program model?

2. What is the behavioral impact on the students after completion of the hybrid day treatment program model?
3. What is the personal impact on the students after completion of the hybrid day treatment program model?

Chapter 3: Methodology

Many students have entered a day treatment program and have exited successfully according to the criteria set forth by the local management entity and local school system expectations. Based on the program guidelines and these expectations of success, students both current and past can be evaluated. Having little to no negative behaviors, including those exhibited before and leading to day treatment placement, is one such criterion. For students with truancy issues, an increase in school attendance is also an expectation for success. While all of these success measures are important in program evaluation, there continues to be limited research addressing current and prior day treatment student perspective and their interpretation of personal successes in relationship to the program. The purpose of this study was to gather these perspectives of middle and high school students involved in a collective phenomenon, a hybrid Cognitive Restructuring and Circle of Courage® Day Treatment program (HTP). The study specifically attempts to examine how this HTP may have impacted the students behaviorally and personally with regard to their experience in the program. The student participants examined personal views of success with regard to completion of the program.

Program Description

Housed within an alternative middle/high school setting in Western North Carolina, the NCDHHS granted authorization to the HTP as a state mental health outpatient facility. Based on the NCDHHS, Division of Health Service Regulation Mental Health Licensure and Certification Section (2016), criteria for authorization include floor plans of the structure, zoning requirements, fire marshall and building inspection information, and sanitation inspection if food is served. An annual

recertification process keeps the HTP current with this authorization.

A teacher, three qualified mental health professionals, and a part-time therapist serve as staff at the secondary HTP. The daily schedule includes four or more hours of therapy, mostly conducted within groups, which focus on social and emotional development. Based individually on the student's determined person-centered plan needs and goals, the therapist provides one-on-one cognitive behavior therapy sessions. Developed by the therapist, qualified mental health professional, parent, and student, the person-centered plan includes strengths and needs for the student, goals, and a framework for meeting those goals. Two daily academic sessions last 90 minutes each and cover all areas of academics needed for the grade level in a condensed format. As students complete person-centered plan goals or reach the end of their authorized time within the program, they begin the transition process. Students are gradually allowed to attend classes outside of the HTP setting as a means of transitioning back to their home school or the alternative school setting based on the needs and progress of the student.

Participants

In order to qualify for HTP services, participants must have a referral from either a mental health professional, i.e., psychologist, therapist, or the participant's home school administration (NCDHHS, 2015). The participant must also have at least one mental health diagnosis based on the DSM-V criteria. Evidence must be shown by the school that other measures have been tried before referring a student to a day treatment program. A school must have exhausted all of the resources available before considering a day treatment program, as this setting is one of the most restrictive environments according to the Individuals with Disabilities Education Act (IDEA) of 1975, which is reauthorized every 5 years unless otherwise needed (Felton, 2014). The participant must have either

Medicaid or Health Choice to be approved for payment of mental health service as private insurance typically does not pay for day treatment services. Once the participant meets the above three criteria, a qualified mental health professional submits the participant information to the local management entity for service approval. Within the current study, several participants were identified as exceptional children within the county, which allowed benefits of an IEP, while others were serviced under a 504 plan, allowing for accommodations and modifications to ensure school success. Those numbers are indicated within Table 1.

Table 1

Student Services Identification

Identification	Number of Participants
Exceptional Children	15
504 Plan	1
No disability or 504 Plan	2

The students range in academic ability and functional skills as some students have been identified with learning or emotional/behavioral difficulties. Of the students who participated, 83% have an IEP (mostly diagnosed with a Serious Emotional Disability), while 5% of the students have a 504 plan. A 504 plan qualifies students who have a disability for classroom accommodations who otherwise do not meet the requirements for an IEP under IDEA. Of the 18 students, 11% did not have an IEP or a 504. Usually, the students must have a 504 plan or an IEP to demonstrate what strategies have been used at the student's home school prior to referral to the HTP. "Individuals with Disabilities Education Act (IDEA) of 1975, required students with disabilities to be educated in the Least Restrictive Environment (LRE)" (Anderson, Kutash, & Duchnowski 2001, p. 106). However, since the law was passed in 1975, there has been widespread disagreement on

exactly how to define least restrictive environment. The purpose of this debate is a focus on the place (e.g., general education, resource room, separate setting) where students with disabilities should be educated (Daniel & King, 1997). Congress (2004) in Individuals with disabilities education act defined least restrictive environment as, to the maximum extent appropriate, a child with a disability be included in public or private institutions with children who are not disabled. Least restrictive environment includes the amount of time in specialized classes, separate schooling, or other forms of removal of children with disabilities from the regular educational environment. Based on this definition, the least restrictive environment is the amount of time away from nondisabled peers (IDEA, 2004).

Students in a day treatment program facility come in with a behavior plan or a behavioral goal that exceeds that of students in a regular classroom setting. Students enter with multiple write-ups from their home schools due to behaviors that are extremely defiant or in some cases violent; however, other students come to a day treatment program with severe anxiety that has caused a student to shut down. Severe anxiety often results in excessive absences, self-harming behavior (i.e., cutting, talk of suicide), or severe antisocial behavior. Many of these students may not have write-ups but often have just as many struggles academically, socially, and emotionally as their violent and oppositional counterparts.

Up to 12 students at a time are served within the HTP. Students rotate out of the HTP through completion of the program or loss of authorized funds based on the criteria set by the local management entity. HTP participants range in age from 12-17 during the time of service. Upon reaching age 18, students are automatically exited from funding and thus the program, as the students are then considered adults and no longer

adolescents. During a normal period within the HTP, an average 75% are male students, with 25% female. Additionally, the majority of students are considered Caucasian at 85%, with the other 15% considered minorities; however, although the number of males significantly outweigh the number of females who have been served by the program, the study found more females willing to participate in the study than males. Male participants accounted for 39%, while females accounted for 61% in the study. In addition, all participants within this study were Caucasian, since all of the students who were considered of minority either refused or did not return the invitation to participate.

Table 2

Participant Gender

Gender	Number of Participants
Male	7
Female	11

Seventy-five students have been served in the HTP program since 2009. Each of these students spent between 6-18 months enrolled in the program, according to their authorization as set by the local management entity (NCDHHS, 2015). Grades have ranged from fifth grade to the tenth grade and ages from 12-17, as well as a mixture of race, gender, and ethnicity. The students often live in a variety of housing situations including two-parent homes, single parent homes, grandparent as caregivers, therapeutic foster care, group homes, and foster care.

Students who have completed the HTP program successfully qualified as participants within this study. Successful completion encompasses meeting person-centered plan goals and transitioning out of the program to the prior home school or the alternative school setting without being exited early from the HTP. If a student has been

in the HTP for over a year without adequate progress toward goals, the student may be exited. Students who exited early due to lack of progress towards person-centered plan goals, excessive amount of time within the program, negative behaviors resulting in a higher level of care, or loss of funds for continuation within the program were not eligible for participation within this study. No student was invited to participate who was currently in transition. A student in transition continues working with the HTP team in moderation and has not fully exited day treatment.

Since the participants invited to join the study had either recently graduated or were currently middle or high school HTP students, their ages ranged from 13-19. The participants must have exited the HTP at least 30 days prior to the research. Permission from the local servicing agency was granted to the researcher to initially contact parents of students under the age of 18 via phone. Once the initial contact was made with parents and participants, signed consent or assent forms (Appendix A), in addition to signed consent forms (Appendix B) for any participant under the age of 18, were obtained by the researcher and securely stored during the duration of the research.

Research Methodology

Phenomenology. Qualitative research as defined by Creswell (2009) is a strategy in which the researcher identifies human experience about the phenomenon in which the participant experiences. Although there are several specific methods to qualitative research analysis, phenomenology, in particular, fits the current study. The purpose of a phenomenological study is to evaluate participant feelings toward an event. Phenomenology is appropriate when one common phenomenon needs further exploration. To get a true perspective of how students view success within the HTP, the use of phenomenology would be appropriate. Since all of the participants in the current

research study attended the same HTP program, this method allowed a common experience to be expressed through individual interpretations, views, and evaluations of the HTP experience including personal, behavioral, self-esteem, and unknown themes.

The common phenomenon. Upon entering the HTP, a student's parent or guardian must sign a contract agreeing to actively participate in their child's services. Parents of students in the HTP are required to have daily communication with the program staff. This communication between home and school exists through "pass along" notebooks that are the students' responsibility. The parent/guardian must sign off on the "pass along" for the student to receive credit within the HTP. Two sections are addressed in the "pass along" daily, a teacher section which includes information about the student's academics and a mental health section which discusses the student's positive and negative behaviors for the day. The parents/guardians can receive an overview of the child's day based on this information.

In addition to these daily progress notes, the parent or legal guardian must also attend a monthly Child and Family Team meeting with their child and the HTP mental health staff. The purpose of this meeting is to update the student's goals as well as any other information within the person-centered plan. Although this meeting is only required once a month, parents can request a meeting at any time. Progress and current issues are addressed in this face-to-face format. The student takes on a leadership role through at least part of their meetings. Leading the meetings is an earned privilege within the HTP's leveled system and is designed to allow for more freedoms as the students demonstrate more independent responsibilities.

The HTP program has a three-tiered behavioral level system. In weekly tribal council meetings, students are adjusted based on that week's behavior. Status within the

system is critical in the program because it governs student privileges. These rankings include levels of Fish, Wolf, and Eagle.

The lowest ranking of participants is Fish. This classification does not include privileges, thus the student must seek permission to execute a task and must be in plain sight of a staff member at all times. These students must wear the school uniform at all times. At this level, students often struggle to recognize their behavior as being negative and often have difficulty with taking accountability for personal actions. As the student behavior begins to de-escalate and trust begins to form between the student, his/her peers, and the staff, the student has a chance to request a level change.

Independence is increased at the Wolf level. At this stage, the student is allowed to wear regular clothes on Fridays, purchase extra drinks at lunch, and bring an electronic device to school. At this level, students must be escorted everywhere while at school and stay in staff's sight at all times. From a mental health standpoint, students at this level have begun to recognize some personal cognitive distortions and are working on solutions to these behaviors.

The student gains the most independence at the final stage. An Eagle has often reached the final stages of the program and are preparing to exit the HTP. A student at this level receives the same privileges as his/her peers who are not in a day treatment setting. A student at this level often goes to transitional classes without a staff member, runs errands, and has earned the privilege to go outside or eat in the lunchroom without a day treatment staff member. A student at Eagle status can demonstrate leadership by leading a therapy group or an educational topic that the student has mastered. From a mental health standpoint, a student at this level of change has begun to recognize most personal cognitive distortions and demonstrates change not only in the day treatment

setting but within the transition classes and community.

Weekly group meetings allow students to present to the group their weekly behaviors, both the positive and the struggles. The student asks to be adjusted according to the behaviors demonstrated that week (up, down, or stay the same level). The student's peers are then allowed to give feedback on what they have observed that week before the group votes. Only Wolves, Eagles, and staff are allowed to vote. These weekly transition meetings allow the student to be adjusted within levels and receive feedback to make personal improvements.

Instruments

Participants in this study completed several methods of communication to effectively gather their perspectives of the HTP program.

Interviews. Creswell (2009) suggested several different types of interviews including group interviews, open-ended questions in a one-on-one setting, and interview questions with yes/no choices. These interviews could be structured, allowing of answers only within a particular parameter, or unstructured, allowing the interviewee to answer openly. For the purpose of this study, an unstructured open-ended interview was used within the parameters of the interview questions. The interviews were conducted one-on-one to allow the students to share thoughts, feelings, and ideas about a specific question without being led to answer a question or given predetermined responses. A group interview were not used as it limits the potential for all participants to respond.

The interviewees were given a choice between interview locations either via phone conference, at the student's home school, or at the alternative school. The interview protocol outlined in Appendix C included the one-on-one interviews with the student participants. Individual interviews allowed the student participants to share their

experiences to collectively explore common themes. The researcher transcribed this information. Interview protocols were then evaluated, and the researcher determined if a further interview was needed to get further clarification from the interviewee. The data were collected and transcribed into the *Atlas.ti* program to identify potential themes.

The personal impact was measured based on the self-esteem survey developed by Rosenberg (1965) to measure an adolescent's self-image. Rosenberg's Self-Esteem Scale (Appendix D) is the most widely used self-esteem scale (Blascovich & Tomaka, 1991). Rosenberg's Self-Esteem Scale was designed to study the self-esteem of high school students using a 10-item questionnaire. Rosenberg's Self-Esteem Scale had a reliability of 92% and on a test and retest reliability given 14 days apart showed a correlation of 85 and 88%, which indicates excellent stability (Rosenberg, 1965). Rosenberg justified the validity by determining Rosenberg's Self-Esteem Scale correlated with other self-esteem measures including the Coopersmith Self-Esteem Inventory.

Rosenberg's Self-Esteem Scale was administered using a paper form of 10 questions. The participants completed the survey prior to the interview. The participants were given the survey by the researcher. The data were collected and evaluated based on Rosenberg's Self-Esteem Scale to determine the participant's self-esteem after completing the HTP program. Data were analyzed and arranged based on high self-esteem scores to low self-esteem scores.

Behavioral data. In order to triangulate data and measure success data were collected from those participants who were enrolled currently in school or who had quit school within the last year. Data were gathered from the participants' last known school to measure the number of referrals and the types of referrals the participants had received. The types of referrals addressed that stood out were the major referrals violence,

bullying, drug, smoking, and alcohol. Other referrals included truancy, cursing, and disrespect. The data were triangulated to determine the correlation between participant view of success and the success they had at their school.

Researcher. During the interview process, the researcher took the primary role of interviewer. The researcher is a current doctoral student in the field of curriculum and instruction with 10 years of experience working with students and adults with special needs. Of those, 4 years have been spent specifically with students in the HTP that is studied as part of this research. There are no current or previous biases toward or including the students involved in the HTP that would influence the researcher in this role.

Data Analysis

Data were collected and analyzed using a mixed-method approach. Qualitative data were gathered from personal interviews with the participants to gain an understanding of participant views of success. After personal transcription by the researcher, the transcriptions were coded and analyzed using the *Atlas.ti* qualitative data analysis software to determine what common themes exist. Within the collective group account, themes were categorized into participant view of success, experience in evaluating the personal change in behavior, and effects on self-esteem. The researcher also looked for unexpected themes based on the questioning as well as correlations between the amount of time in day treatment and personal view of success.

Data were also backed using quantitative methods to measure student self-esteem and behavioral referrals data which were tabulated through the use of the SPSS system, and themes were identified to establish any trends that existed between the participants.

Limitations

The researcher has identified the following limitations that may affect the validity of the research. The sample size of the students who participated may be limited, especially with regard to those who quit school or who were moved to a different level of care. The researcher has also identified the limitation of those students who were willing to participate in the study, especially those who felt limited success in the program. Student willingness to be honest toward the researcher may have been limited, especially when the question addressed personal information. For those participants under the age of 18, parent willingness to allow their child to participate in the research study may have been limited based on parental perceptions of the program. Although students and parents may have been willing to participate and those students may have been given an honest personal account of the program, it was difficult to determine if gains made by the student were directly related to the program or through normal maturation.

Another major limitation was those students who came to the day treatment program in a transition year, whether transitioning from elementary school to a middle school setting (fifth to sixth grade setting) or middle school to the high school setting (eighth grade to ninth grade setting). Though transitions happen every year as the student changes from one grade level to the next, these school transitions tend to be more difficult for those students. Most of the time, prior to coming to the day treatment program, a student within these transitional years have a tendency to have his/her behaviors, whether it be actual behaviors, academic performance, or social skills, stay consistent no matter to which grade level he/she moves. However, there are rare cases where some students struggle with a specific teacher or grade level that leads to a day treatment referral. Though this type of referral is unlikely and often corrected with a

change of classes as a prereferral strategy, there are cases.

Conclusion

Several studies have been conducted on the effectiveness of day treatment for students with behavior and mental health struggles. Few studies, however, have addressed the day treatment model from the student's view. The study addressed both students and teachers/administrators to give a comprehensive view of the research questions. This research study directly addressed the students who completed the HTP. The study will identify common themes that exist between the students who successfully completed the program regardless of the amount of time in the program or the amount of time that had passed since the participant exited the program.

Chapter 4: Research Findings and Analysis

"An Analysis of Personal and Behavioral Health Impact of a Hybrid Day Treatment Model on Secondary Students" proposed to gather the perceptions of success from students who had been involved in a hybrid day treatment program model. Furthermore, the study identified commonalities within participant responses in the areas of student interpersonal views of success, behavioral impact, and personal impact after completion of the program. A complete list of 32 students were identified as possible qualified participants for this study. Qualifications included successful completion of the hybrid day treatment program model as indicated by Medicaid and a collaboration between the school system and therapy agency, including successful initial transition to their home school or alternative school within the past 6 years and at least 30 days prior to the study. Twenty of those students initially agreed to participate in this study. However, four of these students did not return correspondence after initial verbal consent, and two of these students withdrew consent prior to beginning the interviews, leaving 18 students who participated for a participation rate of 56.25%. These participants had a varied gamut of time spent within the hybrid day treatment program model, time out of the program, and schools to where they transitioned after the program. Table 3 indicates the time each participant spent in the HTP as well as a total number of participants within time groupings.

Table 3

Time in HTP

Time in HTP	Participant Number	Total Number of Participants
Less than 6 months	*P2*	1
Greater than 6 months, Less than 1 year	P1, P3, P6, P7, P9, P11, P16, P17, P18	9
Greater than 1 year, Less than 18 months	P4, P5, P8, P10, P13, P14	6
Greater than 18 months	P12, P15	2

All 18 participants of the study fully completed an interview with the researcher that was developed to address the research questions as well as Rosenberg's Self-Esteem Scale (Appendix D). In addition, behavioral data were collected from the school system. This included records from the last physical year unless the student had exited from day treatment less than 1 year prior, in which case behavioral records were obtained from the date of day treatment exit until the date of the end of this study. These participants were assigned numbers P1, P2, etc. for the purpose of reporting data and quotations in order to remain anonymous.

Quantitative Findings

Quantitative data were collected via two separate means, Rosenberg's Self-Esteem Assessment Scale (Appendix D) and behavioral data collected from participant home schools. Within this section, these behavioral data, Rosenberg's Self-Esteem Scale data, home school transition information, and participant indication of success will be reported. Behavioral data included documented student referrals since their time out of the day treatment program and within their home schools. These referrals included instances where the participant was referred to the office for violation of a school policy

and written up for this infraction. A correlation of 0.5253 existed between the participant's Rosenberg's Self-Esteem Scale score and the number of behavioral referrals. Table 4 displays each participant's discipline referrals after their exit from the HTP.

Table 4

Participant Discipline Referrals

	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18	To-tal
Cursing				1			1												2
Tobacco						1					1		2						4
Drugs													1						1
Insubordina-tion	1			2	3	2					1				2				11
Theft											1								1
Weapon											1								1
Fighting			1																1
Bullying									1										1
Vandalism									1										1
Cellphone	1									1					1				3
Alcohol								1											1
Total	2	0	1	3	3	3	1	1	2	1	4	0	3	0	3	0	0	0	27

Rosenberg's Self-Esteem Scale was designed using a Likert scale format of four options within its 10 questions. The options for participant choices were strongly agree, agree, disagree, or strongly disagree. Participants read the questions and answered based on how they viewed themselves. When scoring the survey, the questions were given a numerical value of zero to three for questions 1, 3, 4, 7, 10 (Table 5). "Strongly Disagree" was scored as 0 points; "Disagree," 1 point; "Agree," 2 points; and "Strongly Agree," 3 points. Scores were reversed for item numbers 2, 5, 6, 8, and 9 on Rosenberg's Self-Esteem Scale, with "Strongly Disagree" scoring 3 points; "Disagree," 2 points;

"Agree," 1 point; and "Strongly Agree," 0 points (Table 6). Scoring in this way allowed for more weightiness within answers that indicated a higher self-esteem. The results of participant responses on Rosenberg's Self-Esteem Scale are discussed in Table 5 and Table 6.

Table 5

Rosenberg Self-Esteem Survey Responses

RSES Item	Strongly Agree	Agree	Disagree	Strongly Disagree
On the whole, I am satisfied with myself.	5	10	2	0
I feel that I have a number of good qualities.	4	12	1	1
I am able to do things as well as most other people.	9	7	1	1
I feel that I'm a person of worth, at least on an equal plane with others.	5	10	2	1
I take a positive attitude toward myself.	5	9	3	1

Table 6

Rosenberg Self-Esteem Survey Reversed Scored Responses

RSES Item	Strongly Agree	Agree	Disagree	Strongly Disagree
At times I think I am no good at all.	2	4	6	6
I feel I do not have much to be proud of.	1	1	11	5
I certainly feel useless at times.	1	6	5	6
I wish I could have more respect for myself.	2	6	7	3
All in all, I am inclined to feel that I am a failure.	1	3	8	6

The participants within this study had ranges in scores from 4-30, with 30 being the highest possible. The higher the reported score on this scale, the higher the perceived self-esteem is for the participant. These composite scores are indicated within Table 7.

Table 7

Rosenberg Self-Esteem Survey Composite

Participant Number	Composite Score
P1	18
P2	19
P3	14
P4	21
P5	27
P6	30
P7	21
P8	30
P9	19
P10	20
P11	29
P12	11
P13	18
P14	22
P15	17
P16	4
P17	15
P18	15

The norm range for self-esteem scores falls between 15-25 on Rosenberg's Self-Esteem Scale. A score falling below 15 is considered low self-esteem, and scores above 25 indicate high self-esteem (Florián-Vargas, Honores, Bernabé, & Flores-Mir, 2016; Rosenberg Schooler, Schoenbach, & Rosenberg, 1995). Based on these data, four participants would be considered having high self-esteem, 15 participants had average self-esteem, and three had low self-esteem, with a mean score of 20 within the participant sample. Within these various levels of self-esteem among the participants, there was also a variety in their transition experiences. Table 8 displays Rosenberg's Self-Esteem Scale composite scores as they compare to participant location of transition.

Table 8

Rosenberg's Self-Esteem Scale Composite Compared to Transition Location

Participant Number	Composite Score	Home School	Alternative School	Quit School
P1	18	X		
P2	19			X
P3	14			X
P4	21		X	
P5	27	X		
P6	30		X	
P7	21	X		
P8	30	X		
P9	19	X		
P10	20	X		
P11	29			X
P12	11	X		
P13	18	X		
P14	22	X		
P15	17			X
P16	4	X		
P17	15	X		
P18	15		X	
	Total	11	3	4
	%	61	17	22

Of the 18 participants within this study, 11 returned to their home schools, three continued their education at the local alternative school, and four quit school. The data were correlated with participant Rosenberg's Self-Esteem Scale scores to determine if a correlation existed between participant transition location and participant Rosenberg's Self-Esteem Scale scores. No deviation was given for the students who were in the alternative school as opposed to their home schools, as students are allowed to be at the alternative school through choice. A correlation of 0.650432778 existed between Rosenberg's Self-Esteem Scale and participant current enrollment status in school. Based on this correlation, a strong positive correlation exists between student Rosenberg's Self-Esteem Scale score and the student staying in school. The correlation demonstrated that the higher the student's Rosenberg's Self-Esteem Scale score, the more likely the student stayed in school after exiting day treatment. In addition, participant composite scores on Rosenberg's Self-Esteem Scale were compared to their perceptions

of success in Table 9.

Table 9

Rosenberg's Self-Esteem Scale Composite Compared to Perception of Success

	Composite Score	Successful*	Unsuccessful	Undecided
P1	*18*	X		
P2	*19*			X
P3	*14*	X		
P4	*21*			X
P5	*27*	X		
P6	*30*	X		
P7	*21*	X		
P8	*30*	X		
P9	*19*	X		
P10	*20*	X		
P11	*29*	X		
P12	*11*		X	
P13	*18*	X		
P14	*22*	X		
P15	*17*	X		
P16	*4*		X	
P17	*15*	X		
P18	*15*	X		
		14	2	2
	%	78	11	11

Note. *Success as defined by the participant after completion of the HTP.

Within this comparative of Rosenberg's Self-Esteem Scale composite score and perception of success, the participants personally responded to the questions, "Do you feel that you are successful or unsuccessful after exiting the day treatment program? How?" Eleven participants responded similar to P8, who can be quoted saying, "Successful because with every issue I did have I do not have the issue anymore or I do not do those things anymore." Two participants responded similarly to P16 who stated, "When I can bring in money and take care of myself instead of relying on someone else, then I will have a reason {to feel successful} because I will be able to depend on myself instead of other people." Two participants responded undecidedly to the direct question

of success. P2 said, “I do not know. I quit school but I am controlling my anger better. I do not get as angry as I did.” The data showed a 0.735179184 correlation between participant Rosenberg’s Self-Esteem Scale composite score and participant personal response to the question of success. In addition, behavioral data were collected on the participants.

Behavioral data were collected from each of the students’ current or last attended home school. The researcher gathered behavioral data from the last physical year for the participants who are currently enrolled in school. For those participants who had quit school at the time of the study, the researcher gathered available behavioral data from the last school the participant attended. Within this composite behavioral data, there were 11 reported referrals for insubordination; four tobacco referrals; three cellphone referrals; two referrals for cursing; and one referral each for drugs, theft, weapons, fighting, bullying, vandalism, and alcohol. A total of 27 referrals were reported at the time of the study. Insubordination, which is defined by the school as refusal to follow teacher or administrator directions, had the majority of the referrals reported by the school. Further data were collected through qualitative methods.

Qualitative Findings

One-on-one interviews with the researcher were included in this study to gather qualitative data in the area of perceptions of success. Within the interview protocol, questions 8, 9, and 13 were designed to gather the overall experience of the hybrid day treatment program model as reported by the participants. Interview questions 10, 11, and 12 were used to identify participant success, lack of success, and perceptions of success since being out of the program. Interview questions 4, 5, 6, and 7 went more in depth in the area of success by exploring participant views of success or lack thereof within the

areas of behavior, school/community, social skills, and personal, respectively. Questions 1-3 gained background information on the participants as it related to their time in the program, time out of the program, and school of transition to further disaggregate the data; however, throughout the interviews, participants shared information during specific questions that related to an alternate area of this study or covered several areas of the study. These interviews were coded using the *Atlas.ti* Qualitative Data Analysis Software.

Table 10

Interview Questions Relationship to Research Questions

Research Question Reference	Interview Question Numbers
Background information	1,2,5
Overall experience	8,9,10
Perception of success	10,11,12
Behavioral view	4,10,11
Community/school	5,10,11
Social	6,10,11
Personal	7,10,11
Other information	13

Perceptions of success. Perceptions of success were given by each of the participants. Fourteen of the students felt personal success, while two participants expressed unsuccessfulness. In addition, two participants did not indicate a perception of personal success during the interview process. Table 11 displays which participants expressed views of successfulness, unsuccessfulness, and no indication of success.

Table 11

Perceptions of Success

Personal View of Success	*Successful	Unsuccessful	No Indication
Participant Numbers	P2, P4, P5, P6, P7, P8, P9, P10, P11, P13, P14, P15, P17, P18	P12, P16	P1, P3
Total Number of Participants	14	2	2
%	78	11	11

Note. *Success was defined by the participant as being successful after completion of the HTP.

While participants were mostly quick to indicate their perceptions of personal success, the discussions about success and the personal definition of success for these participants were widely varied. Several perceptions of success existed from the participants, while one area, school behavior, had the most participant responses with seven participants. This area focused not just on school grades but also on how the participant acted at school. P10 included, "I never get called down. I always do my work." P13 said, "I am successful by staying out of trouble, going to class and just following directions." P15 and P17 gave similar statements. P4 indicated that he did not feel unsuccessful though he is back at the alternative school. One student who had recently quit school stated, "I have learned to utilize coping skills overall. I have learned to human better." Though her academics were not successful, she felt successful personally. Three participants viewed success from the standpoint of personally and socially defining success as how he/she interacts with others as well as a view of self. P14 said, "The program made me grow as a person. It made me emotionally better about things that I wanted to do and things that I was told to do." Two participants talked about struggling with bullying prior to entering the HTP. During the interview, P18 said, "I was doing things that I was not being accountable for and being a smart aleck to

everybody, and kind of being a bully to everybody."

While the two participants expressing their feelings of being unsuccessful upon exiting the HTP were in the minority, their reflections are important within the context of this study. Those who reportedly did not feel successful focused their view of success in two areas, school and personal. P12 indicated, "I went to the alternative school and I was unsuccessful. Then I was home schooled and was successful. Then I quit and was unsuccessful again." P16 focused on her personal self-identity, saying, "Success to me is having a reason to be in a community and right now I do not have a reason. Right now I am just kind of floating." She defined success for her as being, "When I can bring in money and take care of myself instead of relying on someone else then I will have a reason because I will be able to depend on myself instead of other people."

P1 and P3 did not give an indication of successfulness or unsuccessfulness during the interview process. Based on interview recordings and transcripts, P1 is currently in school and had one referral for a cellphone violation in which the participant had a cellphone out during class. P3 acknowledged the question about success but indicated that she did not know if she was successful. The participant additionally shared that she was currently not in school or employed but was married and pregnant. The participant did, however, talk about wanting to go back to high school or get a GED. When asked directly about being successful, the participant indicated that she did not know.

Table 12

Success Correlations

		Rosenberg's Self-Esteem Scale	Success
RSES	Pearson Correlation	1	.735**
	Sig. (2-tailed)		.001
	N	18	18
Success	Pearson Correlation	.735**	1
	Sig. (2-tailed)	.001	
	N	18	18

Note. ** Correlation is significant at the 0.01 level (2-tailed).

Participant Rosenberg's Self-Esteem Scale scores were correlated with their personal views of success. Success was given an associated number as follows: -1 for negative perception, 0 for neutral, and 1 for positive perception. The data determined a strong positive correlation of .735 when using the Pearson correlation. The correlation found that the higher the Rosenberg's Self-Esteem Scale score, the more likely the participant response would be of success.

Perceptions of the day treatment program. Individual perceptions of the common phenomenon of the hybrid day treatment program were measured and categorized into negatives and positives. Participants were specifically asked to respond to the questions, "What was your favorite aspect of day treatment" and "What was your least favorite aspect of day treatment?" The data were coded and analyzed to determine themes. The positive perceptions of the day treatment program as indicated by the participants is shared in Table 13, while negatives are shared in Table 14.

Table 13

Positive Perceptions of the HTP

Positives	Number of Coded Responses	Number of Participants	%
Recreation	6	6	23
Status	3	3	12
Staff relationships	3	3	12
Fun	2	2	8
Groups	2	2	8
Missing day treatment	2	2	8
Tribal council	1	1	4
Equality	1	1	4
Equine therapy	1	1	4
Small environment	1	1	4
Helping others	1	1	4
Consequences	1	1	4
Addressing problems	1	1	4
Processing	1	1	4

Positive perceptions of the program focused specifically on relationships and extracurricular activities from the participants. Six participants focused on therapeutic recreation as being a positive aspect. P1 stated, "I like when we went outside and did like a counseling softball game like right or left hand softball or baseball." P5 and P18 also viewed the therapeutic recreation as a positive aspect of the program. Relationships, especially those with staff, were the focus of three of the participants. P12 discussed the staff, who were qualified mental health professionals, and the teachers who worked in the day treatment program, saying, "I especially liked the staff. When I was having a problem they were always very helpful, more than my teachers." P12 also spoke about the push the staff gave her in moving out of her comfort zone, saying, "I am a follower. The staff said look you are a leader. I can now step up and lead now." While many participants spoke of their positive perceptions within the HTP, many also spoke of the negative perceptions within the program.

Table 14

Negative Perceptions of the HTP

Negatives	Number of Coded Responses	Number of Participants	%
Restrictions	5	4	21
Tribal council	4	4	21
Classwork	3	3	16
Status	2	2	11
None	2	2	11
Therapy	1	1	5
Negative behaviors modeled	1	1	5
Beginning	1	1	5
Group	1	1	5

While there were 26 total coded responses for program positives and 20 total coded responses for program negatives, there were several common themes within each. The four participants who responded with restrictions being a negative perception of the program additionally indicated the negative perception of earning privileges. P1 and P4 both had similar statements, with P4 stating, "the dress code and not getting to keep your phone." Both struggled with losing the privilege to have their phone during lunch. Participants who viewed the restrictions as a negative believed that they should not have to earn privileges such as being able to use the drink or snack machine or having to be within staff sight at all times. The negative perception two participants reported as "status" referred to the portion of the program where students are given a status of fish, wolf, or eagle based on behavior and effort. P14 specifically stated "the ranking system . . . the wolf and the eagle and all that. It helped me out but it was definitely the worst." Two participants additionally indicated "nothing" as a negative about the HTP program. The one participant who indicated a negative as viewing negative behaviors modeled suggested that the modeling of negative behaviors from other students within the program had a negative impact on personal perception of the program. P3 referred to her

classmates as the kids when she stated, “I felt that I had more behaviors in front of the kids sometimes than I had before I came.”

Behavioral. Data were collected from the participants based on the interview protocol and the data were coded and tabulated using *Atlas-ti* software. The questions addressing behavior were “How has your time spent in the day treatment program affected you behaviorally”; “What successes have you made as it relates to your day treatment experience with regard to your school/community skills? Socially? And Personally? Explain”; “Have you had behaviors/setbacks that you would regard as unsuccessful since exiting day treatment as it relates to community skills? Socially? And personally? Explain.” These response data are displayed in Table 15.

Table 15

Behavioral Perceptions

Behavior	Coded Responses	%
Getting in trouble	11	14
Behavioral improvement	11	14
Anger improvement	6	8
Attitude	6	8
Written discipline referrals	4	5
Abstaining from arguing	3	4
Risky behavior	3	4
No change	3	4
Decrease in negative behaviors	3	4
Inconsistency	3	4
Aggression improvement	2	3
Behavior worsening	2	3
Personal behavioral awareness	2	3
Anger	2	3
Bullying	2	3
Meanness	2	3
Cussing	1	1
Arguing	1	1
Bad	1	1
Nonconfrontational	1	1
Strategies	1	1
Being good	1	1
Mellowed	1	1
Maintenance	1	1
Alcohol	1	1
Drugs	1	1
Tobacco	1	1

Of the participants who discussed having written discipline referrals, it was indicated by those participants that the number of personal referrals had decreased. Several participants indicated risky behaviors that included drinking alcohol on the weekends, drugs (specifically marijuana), and tobacco (smokeless tobacco specifically). Three responses were coded as inconsistent as the participants indicated having a mixed response to behavioral gains. When asked how the HTP affected the participant's community skills, P1 responded by saying, "sometimes I did well, sometimes not." In

addition, it was noted that two participants felt that after exiting the HTP, their behaviors became worse. P10 discussed, "My behavior and my relationship with my mom since day treatment started has been worse." Participants reported being more aware of their behaviors and recognizing when those behaviors needed to change. Two participants discussed becoming angry after exiting the HTP and struggling with controlling their anger at times. P3 stated, "No I do not feel I am the same. I still have anger issues they are just not as bad." Two participants discussed bullying and participating in bullying after exiting the HTP program. One participant, according to his behavior record, bullied a kid who he felt told on him. P4 said, "I have got into a fight at the high school. I ended up back at the alternative school due to the fight." Two other participants also discussed getting into fights, P3 and P9.

Social. Within the area of social perceptions, communication was overwhelmingly the major immerging theme. Seventeen responses were coded from eight participants discussing a personal improvement in communication skills after exiting the HTP; however, 14 responses were coded from six participants indicating that the participants did not their social skills had been effected as a result of their time spent in the HTP. Six responses from five participants indicated they had become more comfortable around others. Five responses discussed a change in choosing friends. Getting along with others was discussed five times by the participants as an improvement. Two responses were tabulated in the area of making friends. Participants discussed their ability to make friends had become easier since exiting the HTP. One participant responded that he/she had become more accepting of others and felt more accepted by others. Social perceptions post-HTP are displayed in Table 16.

Table 16

Social Perceptions Post-HTP

Social Perceptions	Number of Coded Responses	%	Number of Participants	%
Communication	17	29	8	17
No change	6	10	6	13
Comfort around others	6	10	5	11
Friend choices	6	10	6	13
Getting along	5	9	5	11
Improvement	5	9	5	11
Making friends	2	3	2	4
Accepting	2	3	1	2
Negative peer behavior	1	2	1	2
Fighting/physical violence	1	2	1	2
Better to be around	1	2	1	2
Social concern	1	2	1	2
Drama	1	2	1	2
Friendly	1	2	1	2
Outgoing	1	2	1	2
Open with others	1	2	1	2
Acceptance	1	2	1	2

Specifically within the area of social skills, relationships and relationship building was a prominent theme throughout the interview process, as indicated in Table 16. Four responses were coded discussing a relational improvement with the participant family or parents. One participant felt that her relationship with her mother had worsened while the relationships with the rest of her family had increased. Five responses were tabulated discussing teacher relationships, while three participants felt a positive development in relationships with the day treatment staff. Two responses additionally discussed increased positive relationships with peers.

Table 17

Relationships

Relationships	Number of Coded Responses	Positive Responses	%	Negative Responses	%
Parents/family	5	3	60	2	40
Teachers	5	4	80	1	20
Staff	3	3	100	0	0
Peers	2	2	100	0	0

Personal. Personal effects were discussed in the interview protocol. Seven participants discussed academic growth. The participants discussed an increase in academic focus. Five participants discussed becoming more compliant, specifically being willing to comply with teacher requests. Three of the participants discussed quitting school after exiting the HTP, although another participant quit school but did not mention it during the interview. Two participants discussed being defiant after exiting the HTP, while two participants discussed being able to take direction now without arguing or just doing what he/she wanted to do. Two participants discussed being able to hold down a job and attending school. The participants felt they had done this and stayed "out of a lot of trouble" at school. One participant spoke of having a child and felt that she was successful due to her current goal of working to get her child back. She commented on taking the proper steps to get a job and regaining custody of the child. One other participant had gotten married since exiting the HTP and was currently pregnant but did not talk in depth about this during the interview process. Personal perception codes as they related to functional skills are displayed within Table 18.

Table 18

Personal Functional Perceptions

Function	Number of Responses	%
Academic Growth	*7*	*28*
Compliance	*5*	*20*
Quit School	3	12
Defiance	2	8
Job	2	8
Child	1	4
Academic concern	1	4
Asking for help	1	4
Attendance	1	4
Life skills	1	4
Time on task	1	4

Three participants discussed personal improvements related to choices in friendships and personal life. One student talked about this personal improvement causing struggles with her mother. Two participants discussed an emotional change, with one saying that the program had improved the way she takes care of herself and the way that she interacts with others. Two participants reported taking personal accountability for their own actions. One participant talked about being more accountable for his actions including such behaviors as bullying. Two participants discussed an increase in addressing personal problems. Prior to entering the HTP, five participants did not share or address any behaviors or struggles in their life whether they be behavioral, substance abuse, or depression.

P2 discussed personal change as, “I think overall when I stopped trying to fight it as much and stopped pretending and putting on this fake happy face.” P2 also stated, “I hated therapy and talking about what was wrong.” P4 and P13 were both similar in their thoughts. P13 stated, “I did not feel like I did things wrong before,” although when reviewing his referrals and talking to his home school he had several referrals prior to the

HTP for drugs, tobacco, and skipping class. P13 had a drug and tobacco possession written discipline referral after exiting the program and on his way to the interview was caught with tobacco. After the interview, the participant had to report to the office for this referral. After the HTP, the two participants spoke about their increase in willingness to address these problems as opposed to denying them. Two participants discussed struggles with depression and negative self-esteem and later spoke of self-love since exiting the HTP. The participants felt personal improvement in the area of accepting themselves. Several other areas were discussed once each, including an improvement in treatment of others, an increase in leadership abilities and the desire to lead, and more independence and working independently. Not always having to feel in control was one participant's personal area of change reported after leaving the HTP. Depression was an area of struggle for several participants prior to entering the HTP. Upon exiting the HTP, one participant talked in the interview of continuing to struggle with depression. One participant also mentioned being "sent off" or being placed out of the home after exiting the HTP in order to handle struggles. Another area of focus was the perceived lack of fairness in the HTP and the mainstream setting. Responsibility, self-understanding, and reliability were areas discussed by a participant after exiting the HTP. This included being able to take responsibility for their own actions, having a better understanding of self, and becoming a more reliable person. The coding report for the comprehensive area of intrapersonal skills is included in Table 19.

Table 19

Intrapersonal Skills

Intrapersonal	Coded Responses	%
No change	5	7
Confidence	9	13
Coping skills/dealing	7	10
Humanity	6	9
Self-control	5	7
Empathy	3	4
Helping others	3	4
Respect	3	4
Goals	3	4
Personal improvement	3	4
Personal behavioral awareness	2	3
Emotions	2	3
Accountability	2	3
Addressing problems	2	3
Self-love	2	3
Treatment of others	1	1
Independence	1	1
Leadership	1	1
Balance	1	1
Control	1	1
Depression	1	1
Falsity	1	1
Happiness	1	1
Reliable	1	1
Reflection	1	1
Responsibility	1	1
Self-understanding	1	1

Executive Summary

The data collected from this phenomenological study included participant views and perceptions within the common phenomenon of attending the same HTP program, though at different times. Upon analysis, the research initially showed five major topical areas that appeared throughout the study and which were further detailed in the one-on-one interviews. These areas were experience, behavior, social, personal, and success. Based on information collected from the participants' last attended school,

insubordination was the continued prominent area of negative behavior.

It could be concluded from data analysis that participant experience related directly to their time spent in the hybrid day treatment program. Participants overwhelmingly indicated an enjoyable experience while in the program; however, many reported not feeling a lasting "change" during or after their time in day treatment. Behaviorally, many participants used the phrase "getting in trouble" to express to the researcher an array of risky behaviors both before and after the day treatment process. Socially, 17 of the participants reported gaining effective communication skills. In addition, nine participants reported gaining confidence as their personal view of program successes. Success was an additional commonality, with most participants reporting a feeling of success after the completion of the day treatment program, while that definition of success varied widely between participants.

Of the 18 participants, four reported quitting school. Three participants were at the alternative school and 11 were at their home school. All four of the participants who reported quitting school did not currently have a job. One participant did acknowledge that she planned to start her GED classes soon.

As a means of measuring behavior, data were collected from each of the students' last attended or current school. The data contained a total of 27 referrals within the physical year. Six participants had zero referrals, four had one referral, two had two referrals, five had three referrals, and one had four referrals. Of the referrals, insubordination stood out as the primary referral area with 11 referrals. Major referrals include drugs, weapons, theft, fighting, bullying, and alcohol.

Of the participants, four quit school, three were at the alternative school, one was at the middle school, and 10 were at the high school at the time of the study. A

correlation does seem to exist between the number of write-ups and Rosenberg's Self-Esteem Scale, with a positive correlation of .5253. Likewise, a negative correlation appears between Rosenberg's Self-Esteem Scale and quitting school, with a correlation of -.6504.

Participants reported that they have shown growth in many personal, behavioral, and social areas. Though many responses spoke of changes that occurred with the highest number of themes occurring in the area of personal change, several responses hinted toward a negative change or that no change occurred within the participants. Fourteen responses within the three areas declared that no change occurred after exiting the HTP program.

Chapter 5: Discussion

The purpose of this study was to gather the perspective of individuals who have participated in a common phenomenon, a hybrid day treatment program model, on their views of success as they related to the program. The participants shared similar experiences in terms of therapy, recreational therapy, staff-to-student ratio, physical location, the leveling system, and a combination of therapy and academics. At the end of the research, five areas were determined to be central among the participants in the interview process, Rosenberg's Self-Esteem Scale, and the behavioral data collected from the students' last known or current school if the data were available. Data were collected and triangulated in order to answer the research questions to determine an overall view of success from the perspective of those who have successfully completed the HTP according to the program definition.

Research Questions

1. What are the students' interpersonal view of success after completion of the hybrid day treatment program model?
2. What is the behavioral impact on the students after completion of the hybrid day treatment program model?
3. What is the personal impact on the students after completion of the hybrid day treatment program model?

Five big ideas came from the study, each connecting back to one or more of the research questions. The five themes were experiences, behavior, social, personal, and success. Although not all participants felt the HTP experience made a direct change within their lives, each participant indicated gaining an understanding from the program, whether it be in their daily interactions or within personal feelings and attitudes.

Research Question 1: Interpersonal View of Success

Participants responded in numerous ways to the question of their interpersonal view of success, especially in the area of not feeling a change had occurred during the HTP setting. Many of the participants viewed themselves as successful, with 14 directly stating that they felt they were successful upon exiting the HTP. Two of the participants, P12 and P16, both indicated that upon exiting the HTP, they were not successful. An additional two participants, P1 and P3, did not give an indication of success.

Unsuccessful. P12 and P16 both reported feeling unsuccessful. The data correlated with that of Rosenberg's Self-Esteem Scale as those participants had the lowest reported self-esteem overall, with scores of 4 and 11 on the self-esteem scale. The correlation was 0.735179184 comparing participant self-esteem to their personal view of success. This correlation indicates a strong correlation between Rosenberg's Self-Esteem Scale scores and participant views of success. The higher the Rosenberg's Self-Esteem Scale score, the more likely the participant reported being successful. Participants with lower Rosenberg's Self-Esteem Scale scores were more likely to report being unsuccessful. P12 indicated a feeling of success prior to a change of educational placement, stating, "I felt I was successful until I got to the alternative school. I was successful, then I went to the alternative school and I was unsuccessful." The participant spoke about the shift of feeling that she never fit in at the alternative school and as though she was bullied at the high school. The feeling of being part of a group changed when she came back to the alternative school. P12 also mentioned that now that she has quit school and does not have a job, she feels she is a better person; but the feeling of success is not currently there. P16's response was similar when it came to her feelings of success. She defined success as, "having a reason to be in the community." Her

reflection continued with, “right now I do not have a reason. Right now I am just kind of floating,” when she addressed being part of the community. Her definition of success indicated that when she begins to bring in money from a steady job and is able to take care of herself as opposed to having to have someone else take care of her, she will feel successful.

Successful. Fourteen students identified as being successful after exiting the day treatment program. Success was defined generally by many of the participants as being able to follow directions and complying with requests. The main focus for six participants was the idea of success including school. From those participants’ point of view, success revolved around being willing to do what was asked. P13 stated, “I am successful by staying out of trouble, going to classes, and just following directions.” P10 said, “I never get called down. I always do my work.” P15 defined success as willingness to work at school and improving life goals, specifically, “I have made a better life for me by having better life goals and having better grades, one A and 3 B’s.” P11 had a similar view of success when he discussed, “I want to graduate and find a job somewhere.”

No indication. Two participants upon completion of the program did not give a direct answer to the question of success. P1 indicated that sometimes she feels successful and sometimes she does not feel successful; however, she did discuss that her behavior had improved and she was not “getting in as much trouble at home.” P3 explained in the interview that she was currently pregnant and had gotten married and discussed that before quitting school, she had “stayed out of trouble.” Since her completion of the HTP, P3 received one referral for fighting. Though not directly stated, both participants discussed a feeling of success being defined more as actions rather than personal change

with both discussing behavioral referrals and behaviors at home when asked about success.

Data were collected from participant Rosenberg's Self-Esteem Scale scores and participant reported personal views of success in order to determine if a correlation existed between the two. The student responses were assigned numbers, with a response of unsuccessful given a score of negative one; a neutral response, zero; and a successful response, one. Based on Rosenberg's Self-Esteem Scale score and the student personal view of success, a correlation of 0.735 existed including the neutral responses; while interpreting the data without the neutral responses indicated a correlation of 0.725. A strong correlation is defined by Evans (1996) as a negative or positive 0-.19 being a very weak, .20-.39 being a weak, .40-.59 being a moderate, .60-.79 being a strong, and .80-1.0 as being a very strong correlation. With this, there is evidence that a strong positive correlation exists when comparing participant Rosenberg's Self-Esteem Scale scores to participants views of success. Success was defined by three participants internally more so than outward external change. P4 was vague in his interpretation with, "I do not really feel unsuccessful even though I am back at the alternative school." P2 spoke of success as being an inward change by saying, "I feel that I have been successful. I have learned to utilize more coping skills overall. I learned to human better." Defining her success as a change, P14 stated, "The experience made me grow as a person. It made me emotionally better."

The definition of success by two participants included interactions with others as part of defining success or unsuccessfulness. P18 reported, "I am not doing things that I was before, like not being accountable and being a smart aleck to everybody, and kind of being a bully to everybody," while P9 said, "I felt like I was successful after leaving day

treatment because it taught me a lot of different skills and how to work with people."

Quantitative data. A comprehensive view of the quantitative data is included in Table 20.

Table 20

Comprehensive Quantitative Data

Participant	RSES	Number of Discipline Referrals	In School	Success
P1	18	1	Yes	Undecided
P2	19	0	No	Successful
P3	14	1	No	Undecided
P4	21	4	Yes	Successful
P5	27	3	Yes	Successful
P6	30	3	Yes	Successful
P7	21	1	Yes	Successful
P8	30	1	Yes	Successful
P9	19	2	Yes	Successful
P10	20	0	Yes	Successfu1
P11	29	4	Yes	Successful
P12	11	0	No	Unsuccessful
P13	18	4	Yes	Successful
P14	22	0	Yes	Successful
P15	17	2	Yes	Successful
P16	4	0	No	Unsuccessful
P17	15	0	Yes	Successful
P18	25	3	Yes	Successful

Determining success based on the quantitative data, participant personal perception versus the data collected from participant home schools, success became difficult to define. On paper, the self-esteem based on the normal range between 15-25 (Florián-Vargas et al., 2016; Rosenberg et al., 1995) showed three participants who fell in the low self-esteem range. All of these participants quit school, while one participant who had a high self-esteem also quit school. Outside of the two outlying participants, one who believed she was successful though she had quit school and currently was not working and the one who was undecided with a lower self-esteem and had quit school,

the data showed a consistency with success correlating with higher self-esteem. When success was determined based on the data collected from participant home school information and participant Rosenberg's Self-Esteem Scale score, there was a correlation of 0.525364108. These data were not consistent with the number of referrals and participant self-esteem. The participants did not show a consistency that would be measureable because five participants who had an average to high self-esteem had zero to one referrals, while eight participants had two to four referrals within the last year. A consistent pattern did exist between those with a Rosenberg's Self-Esteem Scale composite score of 15 or less who had zero to one referrals. This accounted for all four individuals.

These findings are not surprising given their root in cognitive restructuring theory. Cognitive restructuring is based on a change in cognitive distortions. Beck's (1979) design of cognitive restructuring was built to change the initial mindset of the individual. When a negative behavior can be self-identified by an individual, it is more likely that individual can change that behavior as he/she is aware of its existence and is not in denial. Additionally, the reported self-esteem by the participants directly connects back to the theory of cognitive restructuring, with the identification of negative distortions causing the individual to shift blame. This presented itself as reports of "others being out to get me" or "they don't like me." A cognition of these negative thoughts can change an individual's perception of reality, in turn increasing the individual's self-esteem by decreasing or eliminating the negative thoughts.

While these findings were not surprising given the cognitive restructuring theory, they were also expected while taking into consideration the Circle of Courage® model. Self-esteem relates to the Circle of Courage® model as a means of two of the four

components: belonging and generosity. Brendto et al. (2002) suggested that an individual must feel connected to their community in order to thrive. Specifically, when a person feels a sense of belonging or being a part of a community, the individual has a sense of purpose within that community. Hersen et al. (2005) defined self-esteem as confidence in one's own worth or abilities, or another term to mean "self-respect." The "belonging" component of Circle of Courage® directly addresses the need for individual self-worth when connecting success to self-esteem. Both Cognitive Restructuring and Circle of Courage® link the sense of belonging reported by the participants to their perception of acceptance within the community. P16 addressed this directly when she mentioned in her interview that in order to feel a sense of success, she must be a productive member of the community, contributing back through working and not relying on government assistance. At the time, she reported not being an active member of the community, thus reporting a lower self-esteem through her dependence. The Circle of Courage® model would indicate that those feelings are typical given her view of society and directly relate to her reported self-esteem.

Research Question 2: Behavioral Impact

In order to fully answer this research question, data were collected from the participants using the interview protocol, Rosenberg's Self-Esteem Scale, and behavioral written referrals. The data were correlated in order to determine the impact of the HTP on the participants who had completed the program as successful under the definition provided by the program. The participants responded in a variety of ways, with a major theme occurring in the area of "getting in trouble."

Of the participants who answered the question referring to behavior, 11 responses from nine participants discussed "getting in trouble" as an impact the program had

specifically on them. Of those nine participants, seven said the program had a positive effect, or the participant was no longer "getting in trouble." Two of the participants felt their behaviors had become worse since exiting the HTP, or at least back to as bad as their behavior was before the program. Three participants reported not feeling a change had been made positively or negatively. A correlation was attempted between participant interview responses and the number of written referrals each participant received. The correlation data demonstrated a virtually neutral correlation at 0.036425905; however, there was information that stood out as being particularly interesting when analyzing the data.

Participants who felt personal improvement in behavior appeared to have the most written behavior referrals. This was based on four referrals in the last year, with three referrals for major referral offenses including tobacco use, insubordination, theft, and a weapon on campus. Insubordination, or the refusal to comply with teacher/administrator requests, had the most referrals for those participants who reported personal behavioral improvement. One student felt that his behaviors had not improved and likewise he had received three referrals which included insubordination and inappropriate language.

Insubordination can be linked back to cognitive restructuring theory in which the participant has distorted thoughts to justify the action. When asked, the participant replies the teacher is unfair or picking on the participant. Helmond, Overbeek, Brugman, and Gibbs (2015) further defined this as a denial of responsibility. P6 mentioned, "I got in trouble in that one class at the alternative school but that is because that teacher does not like me. She does not like anybody." Based on cognitive restructuring theory, this finding was not surprising and should have been expected to be supportive of the research in this area (Helmond et al., 2015).

Although the participants within this study overall reported a decrease in distortions or an increase in identification, acceptance, and using targeted strategies against distortions, there were still several reports indicating these distortions continued after exiting the HTP. This was even more evident among the participants who had later quit school. Due to these findings, there is a basis for the need of a program that continues addressing these issues after the students leave the program, such as that of a step down or bridge program. According to Liber et al. (2013), similar findings were reported within their follow-up of individuals who completed a manualized social cognitive behavioral treatment program. After the completion of the program, 45% were still at the clinical range for distorted thoughts and behaviors according to the teacher externalized report scale. Their publication indicated that this led to a need of ongoing support after the program. This research study had similar findings within the behavioral data as well as participant interview responses. Many of the participants who were having behaviors outside the aggressive range were not attending school regularly or had already quit school. Data could not be recorded from the last year on these students because the students had already quit. P12 and P16 both talked about feeling a lack of support after exiting the HTP. They also both suggested that if staying in the program would have been an option, it could have led to them remaining in school instead of choosing to quit.

Within this study, behavior improvement was also broken down by the participants into three specific areas: anger, general negative behaviors, and aggression. Six participants defined anger improvement as being a major area of impact. P3 did not feel that he acted as bad as he used too. P6 reported feeling that he had changed and additionally that when he was in middle school, he "was raising cane all the time." After

entering the HTP, the participant said he began to view his anger differently and evaluating high school differently as well. Three of the participants reported general personal behavioral improvement. These behaviors included drug use, alcohol use, tobacco use, and insubordination. Two participants went into detail about "always being ready to fight" and "struggling with aggression" but felt that improvements had been made in this area after exiting the HTP. The office referrals supported this finding. One participant did have an office referral for fighting, but it was neither of these students. These three areas seemed to be the focus of the participants who were willing to discuss struggles and successes in behaviors. These participants generally defined behavior as a physical action that followed an emotional reaction. Aggression and/or a variety of risky behavior followed anger as the participants discussed their means of reacting to this anger.

Three participants spoke about participating in risky behavior after school which included alcohol use, drug use, and tobacco use. The three participants had not been caught with the products at school, although four referrals for tobacco, one for drugs, and one for alcohol had been recorded according to behavioral data for the participants overall. The three participants talked about these behaviors as being negatives; but they did not take place at school, but rather after school or on the weekends.

The overwhelming common theme was the participants reported overall behavioral change but at the same time struggling with issues such as attitude, arguing, or feeling that behaviors had become worse. P16 and P2 both discussed the idea of behavior worsening since exiting day treatment. One student talked about how the risky behavior she had experienced left her pregnant. These participants indicated they believed the reason for the worsening behaviors was the lack of levels of accountability that existed in

the HTP after exiting. The students were unable to hold themselves accountable when they were left with no one within the program to hold them accountable. P16 reported, "after leaving I stopped coming to school because no one held me accountable like before." P2 also talked in depth about this same idea, saying, "My mom allowed me to go off with a boy to Tennessee. Things happened." This same participant also said her favorite part of the program was the accountability piece, stating,

> If there was a problem it got addressed and it was not just a smack wrist and told to do better next time. We talked about what happened and we processed what happened. If it was not right after it was very shortly after.

This was until the behaviors became major enough to cause them to become involved in the court system.

Research Question 3: Personal Impact

For the purposes of answering Research Question 3, data were collected from the participants using two methods, Rosenberg's Self-Esteem Scale and one-on-one interviews with the participants based on the interview protocol. When analyzing the data, it was concluded that the area of personal impact can be categorized within two areas, the impact personally and socially.

One major theme that was identified from the study was the connection between participant social lives and participant personal feelings. The connection was evident in six participant responses. Six participants indicated that they had become comfortable around groups of people or around others. Of those six, five of the participants discussed being able to talk to others or not being afraid to talk to others as a result of their time in the HTP. In the area of personal affects, an anomaly was found among those students who responded in the beginning of the interview with "no change" or "not really" in

response to the effects the HTP had on them personally. Two of the five students who responded with no change initially did report changes later in the interview. When asked later in the interview if a personal change had taken place, the participant responded with a change had occurred with the friends they had chosen and being able to talk to others better. The pattern of personal change being a social interaction continued throughout the interview process.

Again, these findings further support the theory of Cognitive Restructuring, especially in the area of acceptance and change. Within Welburn et al. (2000), a similar study, three areas were identified as themes within Cognitive Restructuring including social alienation, defectiveness, and vulnerability to harm. Social alienation also surfaced as a reported theme from the participants in this study after their exit from the HTP. The risk of not being accepted by their peers was reported in some form by six of the participants in multiple responses. The individuals communicated several responses including choosing the right friends to being able to go into a crowd and introduce yourself as opposed to running from the crowd. The Circle of Courage® model connects back to socialization and social interaction in the areas of belonging and generosity, with belonging being a sense of acceptance within the community as a whole or a feeling of connection within a group. Generosity, which was defined by Brendto et al. (2002) as a contribution to society, allows for the connection back to the group. This surfaced within the current study as a participant indicated social alienation by not feeling she had anything of value to offer within the community.

Five participants who did not focus heavily on the social aspect within the interview while responding about personal impact focused on the struggles with parents/guardians. One area that stood out was arguing with their guardian and feeling

they had let their guardians down. Two of the five participants had the fear that since exiting the HTP and an improvement had been made, they would lose the guardian. This could be due to the fact that these two participants had already lost a parent/guardian and had changed the way they viewed their actions due to this fear. One participant felt that struggles had begun after the HTP due to the program's family focus programs which had caused a rift to form between this participant and her mother. Cognitive distortions often have a major role in fears and beliefs. Through the use of cognitive behavior therapy, these thoughts and feelings were identified while the participants attended the HTP. The feeling that loss would happen again was identified as a theme within the current study and within the study conducted by Welburn et al. (2000), which reported defectiveness in relation to participant feelings that personal improvement could lead to a later downfall. Within the current study, two of the participants reported a loss of a guardian/parent again could take the participants back to their previous behaviors and a feeling of fault or guilt. P16 shared a feeling that personal negative behaviors would "cause something to happen to my dad." The participant had lost her mom prior to entering the HTP. The need for a transition or bridge program could be evident within these students who are having serious emotional distortions, especially in feelings of belonging and being part of the group.

Another area with significant coded themes was an increase in confidence, which was reported by eight participants. One area was in being a leader within their social groups. Participant interview responses of an increase in confidence appeared mostly with individuals with higher Rosenberg's Self-Esteem Scale scores, but no significant correlation could be determined between Rosenberg's Self-Esteem Scale scores and confidence. Brendto et al. (2002) spoke of confidence as a connection to independence.

An individual who has mastered independence has the ability to make choices with increased confidence in those choices due the knowledge of how those choices may affect them. Circle of Courage® links participant views of leadership and confidence within all of the areas of the programs. The Circle of Courage® model connects confidence with the participant gaining knowledge or mastery of the situation and in turn gives the participant the sense of belonging to the group. The participants spoke about being leaders in their groups. Brendto et al. would define this as a belonging, where the participant would now have his/her role within the group.

Within the larger theme of personal impact, there were three key areas emerging based on the information gathered from the students. All three key areas were within the realm of social interaction. The participants uniquely indicated that success personally was based on another factor. For some of these participants, personal success relied on their perception of ability to be social with their peers. For others, this idea of personal success was determined by a positive relationship and feeling of connection within their nuclear family. When this was not a part of their success, it led to a fear of losing a family member who may be disappointed in the participant. Participants additionally reported an increase in confidence in a leadership role, which connects back to participant views of making connections.

Linking participant independence with their ability to make healthy choices due to the mastery of their own behaviors links back to the theory of cognitive restructuring. Cognitive restructuring is designed to reduce the participant's need of an outside agency to help the individual recognize the skills needed to handle the situation. When the participant gains a higher level of understanding of personal behaviors and cognitive distortions, the participant may then feel confident less intervention is needed from the

outside agency. The participants within this study talked in detail about making choices they knew were wrong. These varied greatly, from their choice of friends to arguing with a guardian. The participants who felt successful also reported personal recognition of these behaviors and stopping the behavior before allowing the behavior to spiral out of control. Participants reported this in numerous ways, especially when talking about not fighting or having the verbal or physical aggression that they had before entering the HTP. Hauswirth (2014) defined cognitive restructuring as being able to identify those distortions. Within this study, that was presented several times within the context of those who were faced with the choice to fight or rethink a more beneficial next step.

Recommendations

There are several recommendations for future studies. Part of those are ways to formulate a similar study while considering what was learned from the process of the current study. Four major areas need consideration if conducting a similar study: the number of participants, variety of the participants, specific questions to ask the participants, and inclusion of background data in order to gain a proper baseline pre-HTP.

The data size should be increased in order to have a deeper understanding of student perspective of the HTP. One means to address this issue would be to open the research to the other HTP sites ran by the same company. The program researched had two other middle and high school sites in two other counties, but all were within close proximity and within the same state. At the time of the current research study, these additional sites were fairly new at less than two years old. The inclusion of these sites would allow for an increase in the number of participants while obtaining a more complete picture of the program.

Obtaining data from more of a variety of participants in the future may increase

the validity of the study. Talking to students who have graduated may have possibly changed their reported views of the program. Students who had quit and were working full-time would have also increased the validity as a means to determine their personal definition of success. Though race was not included as a measure in the current study, disaggregating the data by race may give a different perspective in how different cultures determine success.

Another recommendation is the use of a survey or interview question that directly addresses participant struggles. Struggles usually present themselves within this group as depression, substance abuse, physical aggression, or anxiety. The struggle with addressing these types of questions with minors is the factor of self-incriminating evidence, boundaries, and deciding whether research is going to do more harm than good to the participant. Although these behaviors are often what may have led to placement in a day treatment program initially and would be a valuable source of information, the means of gathering this information may not be beneficial to the participant.

In future research, background information could prove to be important. The reported data from this study did not have an existing baseline due to the length of stay in day treatment, the time out of the program, and the ability to conduct research prior to approval. If more time existed for the research, a longitudinal study with participants prior to entering day treatment and a measure 30 days after exiting, another one 1 year out, and a final one 5 years out would allow for a clearer and more valid picture of the overall impact as well as a change in student perceptions of the program as a youth to a young adult. An entrance and exit survey would allow for a more in-the-moment realistic reflection from the HTP participants instead of reflection after the fact.

Recommendations for follow-up studies include studies within the teacher and/or

parent view of a successful day treatment experience for their student or child. Data from the current study heavily indicated that relationships with teachers and parental figures were crucial to most of the participants in order for themselves to view personal success. Since the data also indicated that participant personal views of behaviors did not exactly match their behavioral records, it could be determined that an outside view of those in daily contact with the student could have important information to share that would give a more realistic view of success.

Implications

This research study offered several implications for the program, transition, and the education of youth in general. Based on participant accounts of their experiences in the HTP including their favorite aspects and those areas that were discussed as having the most impact, there is an indication of aspects of the program that should continue to be a part of the daily experience. Participants indicated a strong connection between peers and staff as a factor in success, so this component of the program should continue to be fostered intentionally. An overwhelming majority of students reported the recreational therapy time as being their favorite part of the experience as a whole. Stakeholders should take this information into account when making adjustments to schedules within the current and similar programs. In addition, many participants shared how their experience while in the day treatment setting prepared them for having better social skills with an array of audiences, therefore leading to perceived success. It is important to consider which aspects of the program specifically target social skills and intentionally foster those aspects within the program and similar programs as well.

Most of the participants within this study discussed a major setback as being transition away from the HTP and into their home school base. These participants

reported feeling less accountability and more stress in those settings. This further supported the findings of Clark and Jerrot (2012), who found similar struggles when measuring long-term effects of a day treatment participant. Clark and Jerrot defined students who have mental illness qualifying as a disruptive behavior disorder which includes oppositional defiance, ADHD, and Obsessive Compulsive Disorder. The students who completed the day treatment program showed significant positive increases, but 79% continued to show symptoms at the clinical level. Clark and Jerrot also cited that individuals with Disruptive Behavioral Disorders require sustained behavioral treatment over time. This is especially necessary when working with positive youth development as that which was used in the Circle of Courage® model. One key component is the support that must be offered after exiting the program. P12 mentioned this in her interview when she said, "If they would have left me in day treatment I would have finished school. I felt that I was alone and I felt that I was bullied." The support piece that Roth and Brooks-Gunn (2003) talked about was essential to student success in changing the community's attitude or having the student have an understanding of the five C's which are competence, confidence, connections, character, and caring. It is important for stakeholders to take into consideration these real issues that the participants perceive to be challenges to success.

One such solution to the problem could be to continue the staff/student relationship after the completion of the HTP. This may include offering check-ins and support either on a continued scheduled basis or as needed; however, this suggestion is limited due to the funding that pays for the programs. A specific report by the participants was the feeling of a loss of accountability after their transition out of the HTP. A transition component with a link back to the program would be one way to

combat this issue, as would intentional teaching of personal accountability along with accountability partners. This further supports the suggestion cited in Eyberg, Edwards, Boggs, and Foote (1998) who identified these sessions as booster sessions in order to help increase participant goals of continued maintenance of their behavior. Eyberg et al. also suggested decreasing the length of the sessions and increasing the amount of time between sessions. The participant would shift from a full session with a therapist to contact with the therapist via phone or supervised social support groups. The idea according to Eyberg et al. is to prepare the participant for relapses or setbacks with someone to turn to when this happens. Since most students reported not being able to take accountability personally, having someone trustworthy to check in on these students such as a mentor may be a critical factor in continued success outside of the program. This link can be drawn back to the cognitive restructuring theory of handling cognitive distortions. The similar process was identified by Peris et al. (2015), where the individual to whom the participant is connected, typically a therapist, can take the time to work through the cognitive distortions in order to identify the distortion and create a positive solution.

In addition to teaching accountability within the day treatment model, it is a general skill that should be considered when teaching all students. The behaviors that led these students to the day treatment program are some of the same ones they continue exhibiting after their time in day treatment. This would lead one to believe that the problem of taking personal accountability may have ultimately led to the students' placement in the program. If this specific topic was discussed and taught intentionally from a young age, the students may have been able to deal with problem behaviors and find solutions outside the day treatment program model completely. Lewis (2001)

identified with this concept when talking to students about their view on discipline. The research also backed up his findings which found that when teachers support teaching responsibility for learning and being responsible for your peers to not disrupt your learning with his/her behaviors that the amount of behaviors decrease versus that of the teachers who are coercive when the behavior arises.

Limitations of the Study

This study had several perceived limitations. Although 35 individuals were identified as possible participants in the study, only 18 fully participated. Of the 17 who did not participate after being identified as potential candidates, five originally agreed to participation. Two of those did not bring in the needed consent forms, two withdrew consent after signing the consent form, and one did not attend the interview process. Five prospective participants did not have a working number; therefore, the researcher was unable to contact these individuals. Five of the prospective participants refused to participate in the research. In addition, two potential participants expressed interest in participation only after data had been collected and analyzed. Of those two potential participants, one graduated high school and was working full time, and the other quit school but was working full time. This restricted number of participants could be a potential limitation within the study.

Another limitation could be the honesty of the participants to the researcher. Many of participant behavioral referrals did not directly correlate with the reported participant perceptions of their behaviors. In the future, behavioral data, a self-esteem survey, and an interview could be conducted prior to the student entering the HTP. This limitation only allowed for a one-sided nonlongitudinal view of the HTP. Furthermore, a limitation did exist within the research protocol of directness when asking students how

personal feelings, behavior, and view of success were impacted by the HTP. The limitation existed in the concept of not leading the participant to answer a question in a specific manner. At the same time, the participants did respond with changes that were made to those areas. In the future, interview questions could be reworded in order to gather a concrete perspective of individual views.

The final limitation was in the form of the given surveys and interview. A more holistic view of the student behavior could have been conducted in order evaluate participant perception of success and the correlation of data. A survey should have been used to evaluate the behaviors that the student exhibited pre-HTP; however, some of the areas were self-identified anyway by the student during the interview process such as quitting school, drug, alcohol, and tobacco use by an underage individual. More of the participants may have identified with such struggles if questions were asked specifically to address these activities.

Conclusion

The five main areas emerging from this study were experiences, behavioral, social, personal, and success. Each area was shaped by the responses to the research questions above. Upon completion of the HTP, the participants responded, defining each area slightly differently based on participant perceptions of the HTP.

Experience. Personal experience within and after the HTP varied widely among the participants. Many students reported they had "no change" through their time in the day treatment process, although later discussed areas of change. Participants reported not enjoying the process of "Tribal Council" within the day treatment program while enjoying the "status" routine that was a part of it. Participants additionally reported enjoying the recreation part of their day while in the day treatment program.

Behavioral. Many students used the phrase "getting in trouble" to express to the researcher a wide array of risky behaviors both before and after the day treatment process. Many reported an improvement in behavior, with some detailing further. One such improvement noted was in the area of anger. Students learned through their experience in day treatment to make "better" choices in their friendships with peers. Students reported having a better "attitude" after attending day treatment. Students spoke of being more compliant with authority figures after their time in day treatment; however, several students reported discipline referrals upon returning to their home schools after day treatment that either led to alternative education or negative consequences. In addition to those reported, there were several other written behavioral referrals for the participants that were not personally reported. The participants reported a decrease in behaviors, although still having those negative behaviors, just less frequently. Participants also reported having more respect after the day treatment program.

Social. A majority of participants reported gaining affective communication skills through their time in day treatment. Students reported being more comfortable around others after being in the day treatment program. Relationships were discussed at length by the participants, including better parent/family, peer, staff, and teacher relationships through the day treatment program. Students spoke of "getting along" with others. Participants also reported general social improvement and being able to show empathy toward others. Participants also reporting abstaining from arguments. Staff relationships within the day treatment program appeared to be a factor in student perceptions of the program, whether positive or negative.

Personal. Many participants reported gaining confidence in themselves through the day treatment process. Many reported academics as being an indicator of success,

while classwork was a struggle. Participants reported the impact day treatment had on their humanity. One area was the desire to help others. Participants spoke of being able to "deal" with situations better after day treatment while reporting having more self-control. Participants additionally reported generic personal improvement. Participants included making goals after their time in day treatment, where they had not before.

Success. Students majorly reported a feeling of success after the completion of the day treatment program; however, their ideas of success were varied. Inconsistency in success was also prominent throughout the interviews. Success was often tethered to socialization from many of the participants. Several students identified growth in the area of communication as a means to explain how successful they felt. Another significant conclusion from the participants who did not feel successful was the idea of not being able to take care of themselves. They reported their area of struggle as not having a job or not having a high school diploma and wanting to go back and finish a degree as a way to feel successful.

It can be concluded that this study was worthwhile to gain knowledge about student perceptions of their time in a day treatment model while gaining suggestions for improvement and suggestions for focus. Participants reported being mostly successful, although that definition varied widely among participants; and one single definition of success could not be compiled based on their reports. In addition, from this study, several implications for the current program, similar programs, and future programs could be concluded. There were also indications of areas for future research.

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Appendix A

Informed Consent/Assent Form

Informed Consent/Assent Form

Dear Participant,

My name is Matthew Davis and I am a current doctoral student at Gardner-Webb University. I am conducting a study of secondary students' perceptions of involvement in a Day Treatment program. The purpose of this study is to gather the perspective of middle and high school students who have been involved in a specific Day Treatment program model. The study especially attempts to examine how this Day Treatment program model may have effected them academically and personally in regards to their own behaviors and socialization. This letter is serving to invite you to participate this study. If you choose to participate, you can withdraw from the study at any time. Data collection will begin in the fall of 2016 and will conclude by winter 2017. It will involve individual interviews to be conducted face-to-face or by phone, depending on the participants' preferred method of contact. The interview should last approximately 20 minutes. During the interview, you will be asked specific open-ended questions about your personal experiences during and after your involvement in the Day Treatment program. The researcher will record the interviews on a digital audio recording device. The recorder will be stored in a locked secured filing cabinet until the recording is transcribed. The recording will be transcribed immediately after the interview has completed. The digital recording will then be erased from the digital recording device. The hard copy of the transcripts as well as the recording device will be kept in a locked filing cabinet. Following the completion of the study the interview transcripts will be shredded and destroyed. The typed transcripts will be kept on a secured password protected hard drive of a computer until the transcripts are deleted and erased.

Follow-up interviews may be necessary, but if you choose to initially participate in the study, you are not obligated to further participate. Names and identifying information will be kept confidential. Some risk exists when studying youth. Should participation in this study bring up emotions or feelings that need further discussions, all students will be given a handout with the name and contact information for the counselor at his/her home school (attached). By signing, you agree that you have been presented with this information. A copy of this form will be given to you upon request. Thank you for your time!

Matthew B. Davis

mdavis18@gardner-webb.edu

(828)442-3783

Participant Name _____ Participant Signature_____

Age _____ Email address _____ Phone Number _____

Appendix B

Informed Parental Consent Form

Consent Form: An Analysis of the Personal and Behavioral Health Impact of a Hybrid Day Treatment Model on Secondary Students

I am conducting research on analysis of a specific day treatment program on the student's view of success. I am investigating this because the research will help individuals working with a day treatment program to adjust a program as needed in order have the participants feel as successful as possible. If you decide to do this, your child will be asked to participate in a one on one interview with the researcher which will be recorded in order to transcribe the data for themes, your child will also complete a self-esteem survey to measure your child's self-esteem after completing the program.

The researcher will record the interviews on a digital audio recording device. The recorder will be stored in a locked secured filing cabinet until the recording is transcribed. The recording will be transcribed immediately after the interview is completed. The digital recording will then be erased from the digital recording device. The hard copy of the transcripts as well as the recording device will be kept in a locked filing cabinet. Following the completion of the study the interview transcripts will be shredded and destroyed. The typed transcripts will be kept on a secured password protected hard drive of a computer until the transcripts are deleted and erased.

Follow-up interviews may be necessary, but if you choose to initially participate in the study, you are not obligated to further participate. Names and identifying information will be kept confidential. Some risk exists when studying youth. Should participation in this study bring up emotions or feelings that need further discussions, all students will be given a handout with the name and contact information for the counselor at his/her home school (attached). All information is confidential, and no person or school will be identified in the study. All interview sessions are with the research interviewer only, and no individual information shared in the sessions will be used for any reason beyond the research study, nor will it be shared with school personnel. By signing, you agree that you have been presented with this information.

If your child takes part in this project, he or she will have the opportunity to give input on your child's view of success. Taking part in this project is entirely up to you, and no one will hold it against your child if you decide not to do it. If your child does take part, he or she may stop at any time without penalty. In addition, you may ask to have your data withdrawn from the study after the research has been conducted. If you want to know more about this research project, please contact me at 828-442-3783 or email me at mdavis18@gardner-webb.edu. This project has been approved by the Institutional Review Board at Gardner-Webb University. Information on Gardner-Webb University's policy and procedure for research involving humans can be obtained from Dr. Doug Eury at Gardner-Webb University. Thank you for your time!

You will get a copy of this consent form.
Sincerely,
Matthew Davis

Consent Statement

I agree to let my child take part in this project. I know what he or she will have to do and that he or she can stop at any time.

_____ _____
Signature Date

Audio Consent Addition

I agree to audio tape at alternative school during the month of _____, 2016.

_____ _____
Signature Date

I have been told that I have the right to see the audio recording before they are used.
I have decided that I:

_____ want to hear the recording

_____ do not want to hear the recording

Matthew Davis and other researchers approved by Gardner-Webb University may use the transcriptions of recordings made of my child for this.

_____ _____ _____
Signature Date Address

Informed Parental Consent Form

Dear Parent,

My name is Matthew Davis and I am a current doctoral student at Gardner-Webb University. I am conducting a study of secondary students' perceptions of involvement in a Day Treatment program. The purpose of this study is to gather the perspective of middle and high school students who have been involved in a specific Day Treatment program model. The study especially attempts to examine how this Day Treatment program model may have effected them academically and personally in regards to their own behaviors and socialization. This letter is serving to invite your son/daughter, _____, to participate this study. If you choose to allow your child to participate, you or your child can withdraw from the study at any time. Data collection will begin in the fall of 2016 and will conclude by winter 2017. It will involve individual interviews to be conducted face-to-face or by phone, depending on the participants' preferred method of contact. The interview should last approximately 20 minutes. The researcher will record the interviews on a digital audio recording device. The recorder will be stored in a locked secured filing cabinet until the recording is transcribed. The recording will be transcribed immediately after the interview has completed. The digital recording will then be erased from the digital recording device. The hard copy of the transcripts as well as the recording device will be kept in a locked filing cabinet. Following the completion of the study the interview transcripts will be shredded and destroyed. The typed transcripts will be kept on a secured password protected hard drive of a computer until the transcripts are deleted and erased.

During the interview, your child will be asked specific open-ended questions about their personal experiences during and after your involvement in the Day Treatment program. These interviews will be audio recorded and transcribed by the researcher. Follow-up interviews may be necessary, but if your child chooses to initially participate in the study, he/she is not obligated to further participate. Names and identifying information will be kept confidential. Some risk exists when studying youth. Should participation in this study bring up emotions or feelings that need further discussions, all students will be given a handout with the name and contact information for the counselor at his/her home school (attached). By signing, you agree that you have been presented with this information. A copy of this form will be given to you upon request. Thank you for your time!

Matthew B. Davis

mdavis18@gardner-webb.edu

(828)442-3783

Participant Name _____ Parent Name _____

Parent Signature_____ Relationship to Participant _____

Parent Email address _____ Phone Number _____

Appendix C

Interview Protocol

Interview Protocol

Participant _____Grade_____ Age_____Participant # _____
Date_____Time_____Location_____Graduated YES/NO
Participant Consent/Assent on File: YES/NO Parent Consent on File: YES/NO/NA

Briefing: The purpose of this research study is to gather the perspective of middle and high school students who have been involved in a specific Day Treatment program model. The study especially attempts to examine how this Day Treatment program model may have affected you behaviorally and personally in regards to your own behaviors and socialization. Your name and any identifying information will be kept confidential. During the interview, you will be asked a series of open-ended questions about your experience. You can withdraw from participation at any time.

Interview Questions:
1) How long were you enrolled in the Day Treatment program? _____
2) How long have you been out of the Day Treatment program? _____
3) When you left the Day Treatment program, where did you transition? _____
4) How has your time spent in the Day Treatment program affected you behaviorally?

5) How has your time spent in the Day Treatment program affected your school or community skills?

6) How has your time spent in the Day Treatment program affected you socially?

7) How has your time spent in the Day Treatment program affected you personally?

8) What were your favorite aspects of the Day Treatment program?

9) What were your least favorite aspects of the Day Treatment program?

10) What successes have you made as it relates to your day treatment experience in regards to your school/community skills? Socially? And Personally? Explain?

11) Have you had behaviors/setbacks that you would regard as unsuccessful since exiting day treatment as it relates to community skills? Socially? And personally? Explain?

12) Do you feel that you are successful or unsuccessful after exiting the day treatment program? How?

13) Is there anything else you would like to share about your experiences with the Day Treatment program?

Debriefing: Thank you for your participation. The information you provided will be useful for the current research study. You may be contacted if follow up interviews are needed, but remember you are not obligated to participate and can withdraw from the study at any time. Some risk exists when studying youth. Should participation in this study bring up emotions or feelings that need further discussions, all students will be offered the name and contact information for the counselor at his/her home school.

Researcher Notes:

Follow-up interview needed: YES/NO

Appendix D

Rosenberg Self-Esteem Survey

ROSENBERG SELF-ESTEEM SCALE

Reference:

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Description of Measure:

A 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. The scale is believed to be uni-dimensional. All items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree.

Abstracts of Selected Related Articles:

Gray-Little, B., Williams, V.S.L., & Hancock, T. D. (1997). An item response theory analysis of the Rosenberg Self-Esteem Scale. *Personality and Social Psychology Bulletin, 23,* 443-451.

The Rosenberg Self-Esteem Scale, a widely used self-report instrument for evaluating individual self-esteem, was investigated using item response theory. Factor analysis identified a single common factor, contrary to some previous studies that extracted separate Self-Confidence and Self-Depreciation factors. A unidimensional model for graded item responses was fit to the data. A model that constrained the 10 items to equal discrimination was contrasted with a model allowing the discriminations to be estimated freely. The test of significance indicated that the unconstrained model better fit the data-that is, the 10 items of the Rosenberg Self-Esteem Scale are not equally discriminating and are differentially related to self-esteem. The pattern of functioning of the items was examined with respect to their content, and observations are offered with implications for validating and developing future personality instruments.

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest, 4,* 1-44.

Summary – Self-esteem has become a household word. Teachers, parents, therapists, and others have focused efforts on boosting self-esteem, on the assumption that high self-esteem will cause many positive outcomes and benefits—an assumption that is critically evaluated in this review.

Appraisal of the effects of self-esteem is complicated by several factors. Because many people with high self-esteem exaggerate their successes and good traits, we emphasize objective measures of outcomes. High self-esteem is also a heterogeneous category, encompassing people who frankly accept their good qualities along with narcissistic, defensive, and conceited individuals.

The modest correlations between self-esteem and school performance do not indicate that high self-esteem leads to good performance. Instead, high self-esteem is partly the result of good school performance. Efforts to boost the self-esteem of pupils have not been shown to improve academic performance and may sometimes be counterproductive. Job performance in adults is sometimes related to self-esteem, although the correlations vary widely, and the direction of causality has not been established. Occupational success may boost self-esteem rather than the reverse. Alternatively, self-esteem may be helpful only in some job contexts. Laboratory studies have generally failed to find that self-esteem causes good task performance, with the important exception that high self-esteem facilitates persistence after failure.

People high in self-esteem claim to be more likable and attractive, to have better relationships, and to make better impressions on others than people with low self-esteem, but objective measures disconfirm most of these beliefs. Narcissists are charming at first but tend to alienate others eventually. Self-esteem has not been shown to predict the quality or duration of relationships.

High self-esteem makes people more willing to speak up in groups and to criticize the group's approach. Leadership does not stem directly from self-esteem, but self-esteem may have indirect effects. Relative to people with low self-esteem, those with high self-esteem show stronger in-group favoritism, which may increase prejudice and discrimination.

Neither high nor low self-esteem is a direct cause of violence. Narcissism leads to increased aggression in retaliation for wounded pride. Low self-esteem may contribute to externalizing behavior and delinquency, although some studies have found that there are no effects or that the effect of self-esteem vanishes when other variables are controlled. The highest and lowest rates of cheating and bullying are found in different subcategories of high self-esteem.

Self-esteem has a strong relation to happiness. Although the research has not clearly established causation, we are persuaded that high self-esteem does lead to greater happiness. Low self-esteem is more likely than high to lead to depression under some circumstances. Some studies support the buffer hypothesis, which is that high self-esteem mitigates the effects of stress, but other studies come to the opposite conclusion, indicating that the negative effects of low self-esteem are mainly felt in good times. Still others find that high self-esteem leads to happier outcomes regardless of stress or other circumstances.

High self-esteem does not prevent children from smoking, drinking, taking drugs, or engaging in early sex. If anything, high self-esteem fosters experimentation, which may increase early sexual activity or drinking, but in general effects of self-esteem are negligible. One important exception is that high self-esteem reduces the chances of bulimia in females.

Overall, the benefits of high self-esteem fall into two categories: enhanced initiative and pleasant feelings. We have not found evidence that boosting self-esteem (by

therapeutic interventions or school programs) causes benefits. Our findings do not support continued widespread efforts to boost self-esteem in the hope that it will by itself foster improved outcomes. In view of the heterogeneity of high self-esteem, indiscriminate praise might just as easily promote narcissism, with its less desirable consequences. Instead, we recommend using praise to boost self-esteem as a reward for socially desirable behavior and self-improvement.

Ciarrochi, J., Heaven, P. C. L., & Fiona, D. (2007). The impact of hope, self-esteem, and attributional style on adolescents' school grades and emotional well-being: A longitudinal study.

We examined the distinctiveness of three "positive thinking" variables (self-esteem, trait hope, and positive attributional style) in predicting future high school grades, teacher-rated adjustment, and students' reports of their affective states. Seven hundred eighty-four high school students (382 males and 394 females; 8 did not indicate their gender) completed Time 1 measures of verbal and numerical ability, positive thinking, and indices of emotional well-being (positive affect, sadness, fear, and hostility), and Time 2 measures of hope, self-esteem, and emotional well-being. Multi-level random coefficient modelling revealed that each positive thinking variable was distinctive in some contexts but not others. Hope was a predictor of positive affect and the best predictor of grades, negative attributional style was the best predictor of increases in hostility and fear, and low self-esteem was the best predictor of increases in sadness. We also found that sadness at Time 1 predicted decreases in self-esteem at Time 2. The results are discussed with reference to the importance of positive thinking for building resilience.

Scale:

Instructions

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

Scoring:

Items 2, 5, 6, 8, 9 are reverse scored. Give "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Sum scores for all ten items. Keep scores on a continuous scale. Higher scores indicate higher self-esteem.