SELF-MANAGEMENT THERAPY ON ADOLESCENTS WITH MALADAPTIVE BEHAVIOURS

BY

EKAETE IKE (MRS.)

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D) IN GUIDANCE AND COUNSELLING

DEPARTMENT OF EDUCATION
FACULTY OF EDUCATION

AHMADU BELLO UNIVERSITY
ZAR1A

2000

DECLARATION

I, Ekaete Ike, hereby declare that this thesis is a record of my own research work. It has not been presented, partially or wholly anywhere, in any previous application, for a higher degree in this university or any other institution. Information derived from the published or unpublished work of others has been acknowledged in the text.



Ekaete Ike

CERTIFICATION

This dissertation, entitled "Self Management Therapy on Adolescents with Maladaptive Behaviours", by Ekaete Ike meets the regulations governing the award of degree of Doctor of Philosophy (Guidance and Counselling) of the Ahmadu Bello University, Zaria and it is approved for its contribution to knowledge and literary presentation.

Prof. S. E. Okon
Chairman, Supervisory
Committee

11/8/2000
Date

DR. F.D. KOLO
Member, Supervisory
Committee

25/9/2000
Date

Dr. M. Musa
Member, Supervisory
Committee

Date

DR. MOH. BEN-YUNUS
Head, Department of
Education

25/12/2000
Date

Prof. S. B. Ojo
Dean,
Post Graduate School.

15/06/01
Date

DEDICATION

This research work is dedicated to the two people who taught me to trust God for grace in the face of every difficulty, and to persevere to successful end, my parents, Ete Thomas and Martha Udo.

Ekaete Ike

ACKNOWLEDGEMENT

This work would not have been possible without the positive contributions of a number of people. My profound gratitude goes to my major supervisor Professor S. E. Okon, whose guidance throughout the course of the work was a constant inspiration. I am highly indebted to Dr. M. Afolabi. He encouraged me to pick up this research and then worked conscientiously to supervise the work, providing both academic and moral encouragement. I very much appreciate Dr. F. D. Kolo's contribution of constructive criticisms and provision of useful literature and I am grateful to him. I thank Dr. M. Musa for reading and directing the data analyses.

My appreciation goes to the Director of Prisons, Kaduna State, Alhaji Bashir, for allowing me to conduct a research in the Borstal Training Institution. For the same reason, I am grateful to the Principal of the Borstal Training Institution, Assistant Commissioner of Prisons Lawal Abubukar. I am thankful to the staff of the Borstal Institution, especially those in the welfare section and the wardens, for offering me their assistance each time and in any way I needed it. Of particular importance was the Vice Principal, Mr. Greg Adinfono, who actually became a part of the research effort and encouraged other staff members to be interested. I am highly indebted to Mr. S. A. Onoja, Madam Chinyere Ogujiofor, and Mr. Nuhu Shata who assisted me at every point. I am thankful to Mr. M. O. Otitoju and Mr. Joel Maidawa of the Institute of Agricultural Research Computer Centre of Ahmadu Bello University, who processed the data.

Lastly and not the least, I am grateful to all the members of my family for their various contributions to the success of this work. I sincerely thank my husband, Prof. E. C.

Ike for his numerous contributions. My thanks go to my son, Mr. Ogemdi Ike and my daughter, Miss Elizabeth Ike. These youngsters tirelessly typed, corrected and retyped this work. May God bless them.

Ekaete Ike.

ABSTRACT

The purpose of this study was to establish the efficacy of Self-Management therapy in modifying maladaptive behaviours among psychologically traumatized deviant adolescents. The study was informed partly by the fact that there is a proliferation of deviant youngsters all over the country and their behaviours have constituted a menace to the society and partly because the existing behaviour intervention programmes among delinquent youths in Nigeria have been found to be ill-effective. There is the need, therefore, to develop an intervention programme in which the deviant youths can have maximum input in their personal rehabilitation, putting their interest first in the helping process.

A sample size of seventy four literate inmates was selected by stratified random sampling from a population of 226 deviants in Kaduna Borstal Training Institution. The survey questionnaire responses and archival records used revealed a sample of ten inmates as traumatized. The 10 traumatized subjects became the sample for the second section of the study, the self-management therapy. An A-B-A multiple single case experimental design was employed for establishing the efficacy of self-management therapy on adolescents with maladaptive behaviours.

The research instrument used for data collection was developed by the researcher. These were two sets of questionnaire CLES/CABI and SELI; and the behaviour monitoring cards. All instruments were validated by a team of experts and an adolescent advisory board. They were also pilot tested. The questionnaires were designed to elicit the current maladaptive behaviours of the youths, traumatic experiences they had gone through and their self-esteem level. The behaviour monitoring cards were used for both motoric- and self-measurement of exhibition or

avoidance of target maladaptive behaviours.

The data collected with these instruments were used for drawing graphs to show behaviour modification trends. Six null hypotheses were tested using t-test statistic to compare the baseline behaviours with the behaviours during therapy.

The major findings of the study are as follows:

1. Self-management therapy is an efficient strategy for achieving behaviour modification among youngsters with maladaptive behaviours. In a country like ours when children are under parental control most of the time it becomes beneficial to the subjects of this study to be able to make their own decision to manage their lives and actually go ahead to do so. The greatest contribution of this study is the ability of the therapy to help the subjects review their past and make effort at modifying their behaviour and thus manage their lives.

2. Given conducive environment, minimum interference from the therapist, and the confidence of the counsellor/therapist, the traumatized deviant adolescents would express their problems earnestly. This too is an achievement of the study because the world of the deviant is so closed that they are suspicious of helpers.

3. The deviants developed interest in therapy as the centre of rehabilitation shifted from the^ offenses they committed against their families and the society to themselves as valuable individuals.

4. Inclusion of family mediation in the rehabilitation process of the trauma-affected deviant youths makes therapy easier and quicker as family mediation helps in explaining painful past and encourages forgiveness.

Since Self-management therapy appeared to be a promising technique for modification of maladaptive behaviours among youths, it was recommended among other things, that it be included in the training of welfare workers and school counsellors. The contribution of the family was found to be pertinent in the process of behaviour modification and rehabilitation of the deviant. So it was recommended that any intervention programme should work closely with the deviants' family. The Federal Government of Nigeria should improve the Borstal Training system. Psychological trauma rehabilitation, intervention and insulation were recommended for inculcation into the counsellors' repertoire; and for extension to benefit students in higher institutions. It was finally suggested that further research should manipulate Self-management intervention among deviant girls, deviant adults and even "normal" individuals. Multiple baseline study was also suggested for individuals who have multiple maladaptive behaviours.

TABLE OF CONTENTS

Page

Title Page..... i

Declaration..... ii

Certification..... iii

Dedication..... iv

Acknowledgement..... v

Abstract..... vii

Table of Content..... x

Appendices..... xiv

List of Tables..... xvi

List of Figures..... xvii

Operational Definition..... xix

Abbreviations..... xxiv

CHAPTER 1: THE PROBLEM.....1

1.1 Introduction.....1

1.2 Statement of problem.....5

1.3 Objective of study.....7

1.4 Research hypothesis.....8

1.5 Basic assumptions.....9

1.6 Significance of study.....10

1.7 The scope.....12

1.8 Summary.....12

CHAPTER 2: REVIEW OF RELATED LITERATURE.....13

2.0 Introduction.....13

2.1 Theoretical framework.....14

2.2 Background information on crisis and the resulting psychological trauma.....18

2.2.1 Classification of critical life incidents and resulting psychological trauma.....19

2.2.1(a) Victimization.....19

2.2.1(b) Loss.....21

2.2.1(c) Family pathology.....23

2.3 Developmental implication of PTSD.....27

2.4 Maladaptive Adolescent Behaviours (M.A.B.s).....31

2.4.1 Suicide.....32

2.4.2 Runaways.....33

2.4.3 Serious school attendance problems.....35

2.4.4 Drug and alcohol abuse.....37

2.5 Psychological trauma and the development of maladaptive adolescent behaviours.....40

2.6 The Nigerian concept of trauma and maladaptive behaviours.....41

2.7 Available intervention programmes among maladaptive youngsters.....44

2.8 Rehabilitation counselling.....51

2.9 Summary.....54

CHAPTER 3: RESEARCH DESIGN METHODS AND PROCEDURES.....55

3.1 Introduction.....55

3.2 The design.....55

3.3 The population.....57

3.4 Sample and sampling procedure.....57

3.5 Instrumentation.....58

3.5.1 Constructing the critical life event survey.....61

3.5.2 Constructing the current adolescent behaviour inventory

(CABI).....62

3.5.3 Constructing the background and current status inventory (BCSI).....63

3.5.4 Procedure for questionnaire distribution 63

3.5.5 The self - management intervention instrument.....63

3.6 Data analysis.....68

3.7 Pilot study.....69

3.8 Limitation of study 70

3.8.1 Possible threat to internal validity of the survey instrument.....71

3.8.2 Selection of subjects.....72

3.8.3 *Reactive effect of experimental arrangement*.....73

3.8.4 Possible threat to the validity of the self-management instrument.....73

3.9 Summary.....75

CHAPTER 4: DATA ANALYSIS.....76

4.1 Introduction.....76

4.2 Data Presentation.....76

4.2.1 Adolescent Critical Life Events.....76

4.2.2 Self-management therapy.....84

4.3 Graphical Presentation of Individual Behaviour

Rating.....97

4.4 Hypothesis Testing.....105

4.5 Discussion.....114

CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS.....119

5.1 Introduction.....119

5.2 Summary of Findings.....121

5.2.1 Demographical data.....122

5.2.2 Self-management Treatment.....122

5.2.3 Graphical data.....123

5.2.4 Results of test of hypothesis.....123

5.2.5 End of therapy.....124

5.2.6 Conclusion.....125

5.3 Recommendations.....126

5.4 Suggestion for further studies.....130

5.5 Summary.....131

REFERENCES.....132

APPENDICES

Appendix I Self-esteem level Inventory 142

Appendix II Sample of (a) Self-monitoring Card (Baseline).....143

(b) Motoric observation (Baseline).....144

(c)Self-monitoring card-smoking

(treatment and withdrawal).....145

(d) Self-monitoring Card-'crossing'

(treatment and withdrawal).....146

(e) Self-monitoring Card – fighting

(treatment and withdrawal).....147

(f) Motoric Measurement Card

(treatment and withdrawal).....148

Appendix III Introduction to Self Management therapy - Group

counselling.....149

Appendix IV Summary of Individual Counselling/

Self-monitoring.....158

Appendix V Blue print of Self-management therapy –

Kaduna Borstal Training Institution.....161

Appendix VI Raw data - Self-monitoring and motoric

measurement (baseline, treatment and withdrawal) 163

Appendix VII Counselling model for self-management therapy

on adolescents with maladaptive behaviours.....171

Appendix VIII Survey questionnaire.....179

Appendix IX Request for statistics 185

Appendix X Letter of invitation to inmates parents to share in the process of their children's rehabilitation 186

LIST OF TABLES

TABLE

4.1 The frequency of traumatic experiences among some inmates of Kaduna Borstal Training Institution....77

4.2 Possible sources of trauma....80

4.3 Frequency of maladaptive Adolescent behaviours among some inmates in Kaduna Borstal Institution....82

4.4 Response to Self esteem level of some Kaduna Borstal Training Institution inmates....86

4.5 Spearman Rank Order Correlation of motoric and Self-report measurement of baseline behaviour of some Kaduna Borstal Training Institution inmates....88

4.6 Spearman Rank Order Correlation of Self-report vs motoric measurement of resistance to maladaptive behaviours....93

4.7 A comparison of deviant adolescents' baseline and treatment mean fighting scores....107

4.8 A comparison of deviant youths' baseline and treatment mean scores for smoking....109

4.9 A comparison of deviant youths' treatment mean scores for bounds breaking....110

4.10 A comparison of the mean fighting scores of deviant youths before therapy and during the withdrawal of token reward from therapy....111

4.11 A comparison of the mean smoking scores of traumatised deviant youths and their mean scores at the withdrawal of token reinforcement....113

4.12 A comparison of the mean bounds breaking scores of deviant youths during baseline and at the withdrawal of token reinforcement....113

LIST OF FIGURES

Figure 1. Subject 3601: Self-management against fighting.....98

Figure 2. Subject 3603: Self-management against fighting..... 100

. Figure 3. Subject 3647: Self-management against fighting..... 101

Figure 4. Subject 3649: Self-management against fighting.....101

Figure 5. Subject 3670: Self-management against fighting.....102

Figure 6. Subject 3579: Self-management against fighting.....103

Figure 7. Subject 3415: Self-management against smoking.....103

Figure 8. Subject 3544: Self-management against bounds breaking.....104

OPERATIONAL DEFINITION

For the purpose of this study, the underlisted operational definitions of the corresponding technical terms will be used.

Affiliation Implication: In this text, affiliation implication refers to what family members enjoy or suffer as a result of the behaviour or activities of a member of that family, for instance the pride and joy of a Nobel prize laureate will be shared by his family members while the family of a thief shares his shame.

Archival Records: Record collected for various purposes and stored in the archives, such records become useful to researchers though they were not actually collected for the purpose of research.

Both directional format: Questionnaire items keyed in both directions (one half positively worded and one half negatively worded) designed to counter response bias from subjects.

Borstal Institution: A training school for the juveniles of age sixteen to 21 who have been referred either from the juvenile court or by child welfare units. Training lasts three years as established by Borstal Act number 29 and 30 of 1960.

Bounds breaking score: The mean number of times the inmate left the borstal Training Institution without permission for a long period of time and still came back.

Cognitive Rigidity: Inefficiency in information search, narrowed down range of perceived alternatives, erroneous assessment of expected outcomes,overlooking of long term consequences, and decision making that fails to take cognizance of the full implication of choices made.

Contingent reinforcement: This is the same as token reinforcement. It refers to a small reward given to the subject of this study as they modify the target behaviour they are meant

to monitor. Contingent reinforcement is offered with the hope that it will influence the behaviour of the subject.

Critical life incident: An event that is outside the range of usual human experience and that would be markly stressing to almost anyone.

Dangerous fighting: Fighting by gangs or individuals who fight without thought as to what happens to the victims. These victims can be seriously wounded or killed and the attackers have no responsibility to take them to hospital. Their delight is in how seriously their victims are maligned.

Demand characteristic of therapeutic situation: This is a paradigm in which the experimental subjects respond in accordance with the experiment's hypotheses and expectations as soon as they become aware of their existence.

Enmeshment: This refers to a situation where two disagreeing persons in a group form factions and one party manages to win the support of the other members of the group, who take sides with the favoured person. Thus they are enmeshed by the favoured person.

Family pathology: A family that often quarrels with little or no solution, fights, gets easily jealous of or misunderstands one another, exhibits hate and dishonesty to each other, is pathogenic.

Fighting scores: This mean weekly fighting engagements by the subject of the study.

Hard drug: Drugs that can cause addiction and eventually can distort the life of the individual who consumes it. They are often forbidden drugs.

Ideal self: Ideas of one's self made up of traits gathered through life.

Just world belief: A case in which an abused or victimized individual simply yields to the situation as it is on the belief that he/she must deserve what he/she has because the whole

world can not be wrong. The world must be just in giving him/her what he/she deserves. This is a self defeating belief.

Life Change Unit(L.C.U.): The level of adjustment of the body as a result of the occurrence of a stressful or traumatic event.

Loss of themes: In this study, loss of themes means loss of cherished situations e.g weaning, leaving home, entering manhood or womanhood, menopause, ageing, school transfer or regular change.

Maladaptive Behaviour: In this thesis maladaptive behaviour is used to mean socially disapproved acting out behaviours that are persistent and fail to respond to normal sanctions of the culture in which it occurs.

Maladaptive Youngsters: Young people who exhibit deviant and self destructive behaviours.

Motoric Measurement: In this study the motoric measurement technique used is "observational quantitative" technique which uses human observers trained to make judgement in the presence or absence of specific behaviours or rate of particular behaviours, in accordance with predetermined behavioral code. This study used observational quantitative type of motoric measurement.

Negative response: An interaction between the traumatised and significant persons which aggravates rather than cushions or ameliorates a painful or frightful situation.

Participant observer: An observer who lives among the subjects as one of them while observing the subjects' behaviours.

Professionals: In the research, professionals are the people involved in looking after the concerns of youngsters, people like teachers, counsellors, child welfare personnel officers and the law enforcement officers.

Remand Home: A centre where young children who misbehave are taken to either by their parents or through warrant of the court for safe keeping till their cases are decided.

Reliability of observations: The extent that two independent observers will agree on the occurrence or non-occurrence of a specific field behaviour or set of behaviours.

Self-management therapy: A counselling strategy in which the client administers the therapy and directs the change effort with minimal assistance from the counsellor.

Significant object loss: A loss of cherished objects, for example parts of the body during accidents; cherished persons e.g. friends, parents,relatives or property

Significant people: People who can influence the emotional, economic, social and even spiritual life of a person. Parents, teachers, close and influential relatives and friends may be referred to as significant persons.

Smoking scores: The mean weekly cigarette smoking engagement of the subjects of this study.

Substance abuse: Substance in this text refers to mixtures or chemicals. Substance abuse is therefore wrong use of chemicals by the adolescents to the point of generating harmful effect.

Suicide ideation: Thought of committing suicide. It includes attempting to commit suicide, planning how to and voicing out the need for or reason why it is useful.

Symptom contagion: A phenomenon in which the effect of trauma spreads from the traumatized to his siblings, family members and associates.

Trauma: In the research, trauma refers to a painful or frightening experience which leaves such memories that are capable of producing emotional pathology.

Trauma insulation: Any behaviour or activity that protects someone from trauma.

Trauma Intervention: Anything done to lessen the pains or fright that accompanies trauma. It can be as little as kind words or encouragement or as big as taking someone in for shelter or treatment.

Traumatized Deviant Youngsters: Youngsters who, having gone through critical life experiences developed emotional pathology which resulted in faulty coping strategies that are self destructive and unacceptable to the societies in which they live.

Withdrawal of contingent reinforcement:A stage of the therapy in which the subjects are not given any of the reinforcement they were given before even when they achieve behaviour modification.

Yeasaying and naysaying: A response bias in which subjects tend to respond in a uni-direction to true-false items irrespective of specific content.

LIST OF ABBREVIATIONS

A.P.A.	American Psychiatric Association
B.C.S.I.	Background and Current Status Inventory
C.A.B.I.	Current Adolescent Behaviour Inventory
C.L.E.S.	Critical Life Events Survey
DMS-III-R	Diagnostic and statistical manual (revised)
L.C.U.	Life Change Unit
M.A.Bs	Maladaptive Adolescent Behaviours
P.T.S.D.	Post Traumatic Stress Disorder
S.E.L.I.	Self-Esteem Level Inventory

CHAPTER 1

THE PROBLEM

1.1 INTRODUCTION

Youngsters with maladaptive behaviours can simply be described as young people who exhibit deviant and self destructive behaviours. Such youngsters are found everywhere - *in the family, at school, on the streets, in the remand homes and in other places where* human beings are found. They exist among all races and in all countries of the world. In most cases they prove to be a serious menace to the society. Parents, teachers and law enforcement officers are very often frustrated by young people who are either overtly or covertly maladaptive, and often times people question the antecedents of such behaviours. Odumesu (1988) asserts, "Maladaptive behaviour is a product of an interaction between a host of economic, social, political and personal forces" (p.3). But these forces need to be streamlined into definite factors in order to plan definite intervention programmes for the youths. Some of the contributing factors of the youths' maladaptive behaviour include poor home background and peer grouping (Nwagwu 1985, Eysenck 1977, Akinboye 1987, Oyehalu 1986, Sadauki 1988). Some attribute it to the stress of growing up, and some to critical life incidents. Johnson (1989) found psychological trauma to be an important antecedent of youngsters' maladaptive behaviour. Odumesu (1988) strongly agrees with this as he observes from his research in the reformatory that most young offenders are orphans and deserted children, juveniles neglected or ill treated by guardians, destitute children or those whose surviving parents are in prison, children of alcoholics or criminals, and wandering children. The experiences generated by these incidents are themselves traumatizing.

Supported by research findings that critical life experiences resulting in psychological trauma can lead to maladaptive behaviour among youths, this study identifies

traumatized maladaptive youths in the reformatory and administers a self - management intervention therapy for their rehabilitation. The choice of this kind of therapy has been informed by the observation from literature that most intervention programmes used among the maladaptive groups do not achieve the desired rehabilitation. A traumatized individual loses the ability to manage himself constructively. Self intervention aims at helping traumatized individuals to reorganize the way they perceive themselves and the world around them. This hopefully may help in reducing the menacing problem of proliferation of maladaptive youngsters about which the society is disturbed.

Adeloye and Aina (1990) have this to say about the proliferation of maladaptive youngsters in Nigeria. "In recent times, Nigeria, like many other countries has witnessed an increasing wave of juvenile delinquency and this has become a matter of concern for guidance counsellors, community leaders and the general public". The level of concern can be seen in the Nigerian government's effort in establishing juvenile courts, remand homes, reformatories and foster homes to curtail and to manage youths' maladaptive behaviours. According to the above researchers (Adeloye and Aina 1990), in Kano alone there were 62 recorded delinquent cases in 1984 and 142 in 1988. This shows an increase in recorded cases and does not exclude the fact that there could be unrecorded ones also. This rapid increase in the number of maladaptive youngsters, as well as the menace they prove to be have prompted parents, researchers, writers and professionals to seek for the related factors to such behaviours. Anderson (1981) points out that the background factors responsible for maladaptive behaviour among youths, particularly suicide tendencies are cumulative in nature. He cites significant object loss in childhood as well as growing up in a hostile environment as correlating factors. Tiecher (1977) cites loss of themes such as parental

death, divorce and separation, step parent problems, parental alcoholism, and frequent school change as correlating significantly with maladaptive behaviour in adolescence. The factors shown to correlate with youngsters maladaptive behaviours are traumatic, according to Johnson (1989).

Another factor identified by other researchers as the antecedent of maladaptive behaviour of youths is the youth's personal and individual inclination (Eysenck, 1977). But probably such inclination may have been triggered by other underlying factors such as past experiences. Okon (1988) stresses that "even the developmental processes at adolescence make the adolescent years of life particularly stressful to the individual". Though he has not suggested a causal relationship to deviant behaviour, according to Nsa (1993) stress can trigger off the ability to make rash decisions, which is the case when deviant behaviours are exhibited.

Although many different factors have been cited as possible antecedents of maladaptive behaviour, some researchers have strongly suggested the authenticity of psychological trauma as a contributing factor. The researcher believes that whatever experience a person has gone through influences his behaviour if that experience had a deep impact on his personal life at the time it happened. In other words a person may remember and react to a particular experience if it was traumatic for him. Such an experience should be the one he could not handle at the life stage in which it occurred so he developed maladaptive mechanisms for coping with them. It is also believed that the adolescent years become the most appropriate time to manifest those maladaptive behaviours since according to Ginott (1976) adolescence is an acting out period in youngsters' lives. It is also in adolescence that an individual has acquired the intellectual capacity to achieve moral

awareness of universal human values and reciprocity (Herbert, 1987:80). Johnson, (1989:23) also holds that more often than not young people's problems seem to become entangled with acting out behaviour which is highly influenced by early life experience (p. 23). Moreover the construct of Post-traumatic Stress Disorder (P.T.S.D)(DSM-111 1980) seems to confirm the suggestion that past experience of youngsters can manifest in deviant behaviour later in life, especially during the acting out period. The age bracket chosen for this study is therefore limited to 15 - 21 years of age which is the later adolescent years. This bears in mind that chronological age does not always tally with mental maturation. A deviant 25 year-old may still have an adolescent mentality.

To the best of the researcher's knowledge little research has been done in the area of self-management rehabilitation for the maladaptive youths in this country. Researches found centre around other areas of adolescent's lives. Ipaye (1980) studying youth/parents relationship stated that adolescents hate the following about their homes: parental authoritarianism, discrimination and unjust punishment. This study did not consider whether the youth's life experiences have contributed to the way they view parental behaviours or how the youths' interpretation of parental behaviour could be directed. As far as the present researcher knows, the study conducted by Johnson (1989) is the nearest one to the present study. Johnson found positive correlation between childhood trauma and adolescent maladaptive behaviour and also established that the nature of the response received from significant people influences the traumatized person's reaction to trauma. He did not work on the ways of cushioning the effect of trauma in the adolescents' lives or on the intervention processes that can rehabilitate the youths with maladaptive behaviours.

The present study aims at identifying traumatized youngsters who exhibit deviant

behaviour, administer trauma - specific self-management therapy to them with the hope of reducing the influence of trauma in their lives, so that they may apply some positive coping strategies as they rehabilitate themselves. The emphasis is on self-help, as opposed to the government intervention programmes.

1.2 Statement of Problem

One of the problems facing the Nigerian society is the increase in the number of maladaptive youngsters and the rise in the seriousness of maladaptive adolescent activities. This problem is articulated by research findings, reports from the news media, the rate of crises in tertiary institutions as well as observation and experiences of many citizens.

The following research reports are but a few of the studies mentioned above. Adeloye and Dare (1995) investigating the wave of delinquency in Nigeria, stated:

> Reports from the news and electronic media reveal the alarming rate of crime wave among Nigerians, especially the youths, both at local and international levels. Cases of armed robbery, drug taking and trafficking, rape, arson, dangerous fighting and even murder have become so endemic that many concerned Nigerians are becoming jittery about the future of this great nation. Several studies have been conducted to alert the nation on the danger inherent in the rising wave of juvenile delinquency in the country (p.87).

Bello (1986) added that 2,253 youths were apprehended and convicted for various offenses between 1979 and 1984 in Lagos State only. As it is true that in the Nigerian Universities there are many youngsters in their late teens, it is necessary to note few of the crises arising in tertiary institutions and add them to the list of deviant behaviours shown by youngsters in the nation. Orhungur (1995) enumerates the following recorded crises in the institutions of higher learning.

- University of Ibadan had student crisis in 1981
- Ahmadu Bello University had them in 1987, 1990 and 1992, to mention a few.
- College of Education Katsina Ala in 1991.
- Ugbokolo, Benue State Polytechnic in 1993.

This list is by no means exhaustive. It consists of just a few of the maladaptive displays by youngsters in Nigerian institutions and it buttresses the fact that the nation is vexed by the problem of maladaptive adolescent behaviours.

Besides, the experiences of the researcher with adolescent counsellees in secondary institutions where she taught, adolescent house helps who most of the time showed deviant behaviours; adolescent armed robbers who attacked her in 1988 and the galore of young offenders, area boys, student cultists shown on national television day after day, she can conclude that the menace of youngsters' maladaptive behaviours is plaguing the society.

Adolescents are everywhere in the society and the maladaptive ones are equally wide spread. Parents, teachers and law enforcement agencies are faced with the uphill task of controlling them. The methods so far applied, namely, punishment, juvenile courts, remand homes and borstal homes seem to be ineffective. As Adeloye and Aina (1990) puts it;

> Most Nigerian correctional institutions have been punishment factories rather than modifying or bringing about change in the behaviour of the inmates at the time of expiration of their term, and this tends to harden the criminals. In the light of this, juvenile delinquents need someone who understands the dynamics of the human personality and who can assist them in living a decent and satisfactory life (P.88).

The correctional institution does not seem to have achieved the rehabilitation of the deviant youths. The police too seem to have failed in correcting the youths. Holins et al.,

(1995) observed that "both the police and treatment-oriented intervention with the young people have the effect of increasing juvenile deviancy". In view of the intensity of the threat of maladaptive youth behaviour in the society and the fact that the existing intervention programmes have failed to achieve sizable intervention, this study has introduced an intervention method in which the deviant youth partakes fully in rehabilitating himself. He monitors his behaviour, rewards himself where he finds himself satisfactory, modifies the behaviour he does not like and manages himself with the view of rehabilitating himself, with minimum help from the researcher.

This method of behaviour intervention has been supported by many guidance psychologists such as McFall (1970), Watson and Tharp (1972), Kanfer (1975), Mahoney et al (1973), Perri and Richards (1977) and it is not new in intervention series. The counselling method is eclectic, integrating the therapeutic strategies of many counselling theories such as Ellis, Kanfer, Philip and others. Many Nigerians would wish that the deviant youths be rehabilitated and the society be rid of their behaviour. This study is an attempt to achieve that wish.

1.3 Objectives of Study

The general objectives of this study is to determine the effectiveness of self-management therapy in modifying maladaptive behaviours among traumatized youngsters. The specific objectives are:

1. To determine the existence of traumatized deviant youths in Kaduna Borstal Institution.
2. To find out the outcome of self-management therapy on the fighting behaviour of adolescents with maladaptive behaviours.

in the smoking behaviour of traumatized deviant youths.

4. To determine to what extent self-management therapy will modify bounds breaking behaviour of traumatized deviant adolescents.
5. To determine the effect of contingent reinforcements in sustaining modified behaviours among deviant adolescents.

1.4 Hypotheses for the Study

In an attempt to establish the effectiveness of self-management therapy in the modification of adolescent maladaptive behaviour among traumatized deviant youths the following null hypotheses have been formulated.

1. There will be no significant difference in the mean fighting scores of traumatized deviant youths before and during self-management therapy.
2. There will be no significant difference in the mean smoking scores of traumatized deviant youths before and during self-management therapy.
3. There will be no significant difference in the mean bounds breaking scores of traumatized deviant youths before and during self-management therapy.
4. There will be no significant difference in the mean fighting scores of traumatized deviant youths before and after withdrawal of token reinforcement during self-management therapy.
5. There will be no significant difference in the mean smoking scores of traumatized deviant youths before and after withdrawing token reinforcement during self-management therapy.

6. There will be no significant difference in the mean bounds breaking scores of traumatized deviant youths before and after withdrawing contingent reinforcement from treatment.

1.5 Basic Assumptions

The following basic assumptions have been made for the study.

1. People look down on and punish maladaptive youths without much consideration about the antecedents of their behaviours.
2. Maladaptive youth behaviour can best be understood as delayed stress response. This is because according to the psychodynamic family theory and Kurt Lewin's Field Theory, man is influenced by his past experience so far as that experience remains alive in the context of his present action (Achebe and Nwoye, 1987: 124).
3. If young people are provided with enough assurance of anonymity to avoid stigma or consequences they will disclose sensitive information about their life experiences.
4. Psychological trauma is universal and sometimes unavoidable. Young people are not insulated from it.
5. Parents and professionals will be of better assistance to their children and clients respectively if they understand more about psychological trauma and its influence on life.
6. Traumatized maladaptive individuals can use self-management intervention strategies to
   scale down the influence of past trauma in their lives.
7. Traumatized maladaptive youngsters can be found in the reformatory.

1.6 Significance of Study

A search of literature by the present investigator indicates that trauma intervention is a virgin field in Nigeria though adolescent delinquency has been with us for long. This study is important therefore in that it will help people to shift emphasis, even if slightly, away from the problem of delinquency to its sources from where the problem can be successfully tackled.

At home and in school the youngsters who exhibit maladaptive behaviours are punished. The society looks down on them and hands them over to the police who eventually drop them in the reformatory after passing them through the nightmare of the juvenile court. Punishment hardly corrects them. Dropping them among other delinquents in the reformatory in most cases helps them learn more serious ways of committing crimes. This research will help the reader begin to think of helping the deviant youths through making them understand the implication of their behaviours to themselves before considering the society. This method may reduce stigma on the maladaptive.

In most intervention programmes, the deviant youngsters lose their self confidence and develop negative self concept. Self management will help them view themselves positively and begin to think of possible ways of self improvement. Since self management training can help them understand themselves better, it can improve their self esteem.

In the Nigerian culture where "children are to be seen and not heard," adults hardly understand young people's feelings. The kinds of experiences that hurt the youths are legion and the youths are unable to express such feelings in words except in action. Parents and people dealing with children and youths need to be aware of the types and frequencies of

trauma in the life of young people. This research will help parents and other people dealing with young people at various levels to recognize incidences of psychological trauma when it occurs among the youths they are in charge of. Professionals such as doctors, counsellors, therapists, social workers and those who come in contact with young people whose lives have been altered by trauma will also benefit from this study.

Effectiveness in dealing with trauma-affected persons requires knowledge. This research will widen the knowledge base of professionals on how to handle psychologically traumatized individuals, during, soon after and long after crisis.

More importantly, this study intends to create awareness that even though deviant youths seem very difficult to handle, if the centre of intervention is shifted from the public, parental and family interest, to that of the deviants' welfare, he might be more willing to contribute in the rehabilitation of himself.

Finally, this research will encourage the inclusion of trauma counselling, intervention and management in the existing therapeutic schemes in Nigeria. This would make therapy more beneficial as trauma-causing events seem to be universal and sometimes unavoidable.

1.7 The Scope

The population of this study were youngsters in Kaduna Reformatory where deviant youngsters from all over the Federation are sent. Among them were sampled out traumatized ones, who eventually made the subject of the study. The age of trauma in the lives of the subjects was disregarded because response to trauma can manifest itself soon

after the trauma during its occurrence, some days, weeks, months or years afterwards. So the scope covers only youngsters who at any time of their lives experienced critical life incidents. The age range of the subjects is between 16 and 21 years because in Kaduna Borstal Home there are people of 25 years though officially 21 years is in the act.

Although young people experience different types of problems this research is delimited to traumatized and maladaptive youngsters who have been picked by the society as exhibiting maladaptive behaviours.

1.8 Summary

This chapter has discussed the menace of maladaptive behaviours of youngsters in the society, and the difficulty in curbing it. It has identified from literature that one of the antecedents of such behaviours can be traumatic experiences. It therefore suggests the administration of trauma-specific self-management intervention as a means of controlling maladaptive adolescent behaviour among the youths. The basic assumptions were distinctly set in the chapter, the objectives were stated and the hypotheses were set. The major contributions that the research would make were stated. The research was delimited and the key concepts have been defined.

CHAPTER 2

REVIEW OF RELATED LITERATURE

2.0 INTRODUCTION

In this chapter literature on critical life incidents, trauma, maladaptive adolescent behaviours and rehabilitation of the maladaptive youngsters are reviewed. Since trauma intervention is relatively new in diagnostic series and particularly virgin in Nigeria, literature on it covers but a few years. Maladaptive adolescent behaviour and its intervention programmes have been long with the world societies. Literature abounds in this area. But this review will attempt to cover only as much as possible of the areas relevant to the present topic. The review of related literature therefore covers the following:

1. Theoretical framework.
2. Background information on crisis and the resulting psychological trauma.
3. Maladaptive adolescent behaviour
4. Trauma and the development of maladaptive behaviour.
5. The Nigerian concept of trauma and maladaptive behaviour.
6. The Nigerian concept of government insulation against trauma
7. The Federal governments' intervention programmes among maladaptive youths
8. Rehabilitation counselling.
9. Summary.

It is pertinent to mention that since this topic covers a wide range of disciplines the literature will be interdisciplinary. Emphasis is laid on rehabilitation counselling because

this is the area of the researchers interest and concern. No attempt has been made to exhaust the review of literature in the areas mentioned, as this would mean drifting too far afield. Though the review is not exhaustive, it has captured the major milestones in each of the areas considered, spanning the last five decades, from Landermann (1944) to Rigby (1996).

2.1 Theoretical Framework

The Concept of Post Traumatic Stress Disorder (PTSD)

One of the constructs that is necessary for understanding the relationship between crisis and subsequent behaviourial changes is Post Traumatic Stress Disorder (PTSD). In discussing the above construct one has to bear in mind that people react to critical incidents in varying degrees. An experience that is moderately difficult for one person can be overwhelming for another. Though there are general responses to crisis as cited by literature, their impact will take into account individual differences. It is also to be noted that the idea of PTSD is based on the fact that symptoms of trauma may appear at times seemingly unrelated to crisis although they sometimes manifest at the time of incidence or in hours or days first following the incident. A different set of symptoms may however occur in weeks, months or years after the incident and these delayed reactions may take any form (Johnson 1989;35).

Delayed Response to Trauma

The idea of post traumatic stress disorder does not seem to be new. It is implied in the ancient writings but it did not appear in the diagnostic series until 1980. The American Psychiatric Association Diagnostic and Statistical Manual, third edition of 1980 (DSM - 111) brought it into the limelight.

The concept of Post traumatic neurosis was introduced in the late nineteenth century and then became a focus of controversy within English compensation laws following the

expansion of rail roads from freight to extensive passenger hauling. In cases involving railroad passenger accidents, post accident symptomatology was argued to be of psychological rather than physical origin, and this clearly had implications for settlements in court (Trimble 1985). Subsequently, controversy over post traumatic symptomatology spread to the battle field, focusing upon whether "post traumatic neuroses" was a legitimate clinical entity or simply a form of malingering. Freud discussed traumatic experiences and their resulting sequelae in some of his writings, on hypnotising as a protective shield or stimuli barrier that provides a threshold for the perception of stimulus (Freud 1920, 1926). He holds that "once the stimulus barrier is breached the pleasure principle no longer functions and the victim regresses to a more primitive functioning in order to master the stimulus". Helplessness, according to him is experienced, and obsessive repetition of traumatic theme occurs. Defensive reactions may be utilized in order to avoid the painful repetitive stimulus (Freud 1939). Elements of Freuds' construct are found in modern theories of post trauma reactions. Modern theories of this construct have their bases in cognitive psychology and learning theory respectively. These theories are useful because they account for three common phenomena associated with post traumatic reactions: These are denial and numbing, reexperiencing, repressive and phobic symptoms which are associated with post traumatic reactions.

Horowitz and Solomon, (1978) discussed two major dynamics that account for the delayed nature of stress response among Vietnam veterans they studied. The first dynamic was "completion tendency" previously discussed by Freud. They agreed with Freud that in order to accommodate to a radically different situation that has changed as a result of traumatic experience, memories, associated information, and implications are assimilated

through a gradual process of integration. As a cognitive process this primarily includes the intrusion of current nightmares, daytime images, and painful emotional reexperiences, unpleasant moods and emotional storms, as well as compulsive behaviourial repetitions. This process may include secondary signs such as aggressive or self-destructive behaviours, fear of loss of control over hostile or violent impulses characterized by impaired social relationships. Among the Vietnamese studied, such behaviour never arose until one year after returning to civil life. The second major dynamic is a denial/numbing tendency, serving as a defense against the intrusion of intolerable ideas and emotions. This tendency consists of denial, numbing, alienation, compartmentalization, and isolation of traumatic experience from every day life. Horowitz and Solomon believed that the denial/numbing tendency interrupts the intrusion/repetition process, accounting for the delayed nature of Vietnam veteran's stress responses. They indicated that intrusion/repetitive process serves the healing function of integration and adaption. The denial/ numbing function seems to protect the individual from having to assimilate too much too soon. Horowitz and Solomon indicated that the difficulty of the veterans' pre-and post Vietnam lives led to such psychological problems as low self worth, shame, depersonalization, frustration and reactive rages and various psychological disabilities. The archival records as well as discussion with deviant boys in the Borstal Home have shown the display of the above symptoms.

A learning theory of post traumatic reaction is provided by Seligman and Garber (1980) in their discussion of learned helplessness. This is useful as it presents a rationale for such symptoms as depression, and phobias. Seligman and Garber describe traumatic situations as those in which adverse consequences follow a situation where the victim perceives little or no control and little predictability. An externalized attribution of control is

learned from the experience forming a learned helplessness. On the basis of this, motivational deficit follows and the victim ceases to initiate adaptive responses. Withdrawal, isolation and depression are logical outcomes, as are anxieties and phobias, resulting from the perception of the world as both threatening and unpredictable. The theory explains why most deviant youths are school drop-outs and blame their behaviour on their parents and guardians. Central to both Horowitz and Solomon's and Seligman and Garber's discussions is the nucleus of post trauma reactions resulting in what are described as maladaptive behavioral changes. These theories can account for diverse phenomena. As a result they complicate understanding of reactions with wide variety of symptoms and signs. The 1987 revised edition of American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III-R) has unified these contemporary theories into a single diagnostic formula. Thus the revised criteria for PTSD are now formalized as given below.

According to this document a traumatized individual is defined as "a person who has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone" p.40. Examples given include

> "serious threat to one's life or physical integrity, serious threat or harm to ones children, spouse or other close relatives or friends; sudden destruction of one's home or community or seeing another person who has recently been or is being seriously injured or killed as a result of accident or physical violence"(p.46).

Persistent avoidance of the stimuli associated with the trauma features of post traumatic stress disorder related to adolescents are:

* premature closure of identity formation
* acting out behaviour (including truancy, substance abuse sexual activity and others)

* self criticism
* fear of repetition of events in future (fate) (p.46).

In general Eth and Pynoos (1985) pointed to the child's progress over developmental lines being accentuated or fixated, as current life circumstances are eroded by traumatic anxiety. They hold that learning can be affected by constant reworking of traumatic memories, relationships can be altered by changes in emotional life and major life decisions can be influenced by focus on the past (p.50).

Terr (1985) mentioned another phenomenon - symptom contagion. This is a phenomenon in which the effect of trauma spreads to siblings, families and associates of these subjects. This seems to explain why one sees brothers and cousins in the Home. Symptoms contagion is a reality, and it is the more reason post-trauma disorders need be given attention. Much has to be known about this neglected human problem. When traumatic incidents occur people are usually overwhelmed and sight is lost of the victims once they have been helped to stand on their feet again. These studies have made it clear that in traumatic situations a great deal of care is needed by the victims and their relatives long after the trauma if they are to stabilize into a normal societal life.

2.2 Background Information on Crisis and the Resulting Psychological Trauma

Whenever a young person is faced with a crisis situation people usually run around to solve the most obvious problems. Psychological trauma to which the victim is exposed is usually relegated to the background. Helpers hardly consider what Psychological feeling a person in crisis is having. This may be due to lack of training and knowledge in the area of

trauma insulation. As Johnson (1989) stated "usually the training of social workers, and police does not cover trauma intervention." Neither does the training of the medical staff cover it. Yet these sets of professionals are those who most of the time take charge in crisis situations. They need knowledge about psychological trauma and its devastating effect on victims.

2.2.1. Classification of critical life incidents and resulting psychological trauma

Researchers have grouped incidents that cause trauma into three broad classes: Victimization, Loss and family pathology.

2.2.1. (a) Victimization:

Victimization consists of incidents such as assault, robbery, rape, incest and serious accidents. Some of the subjects of this study have been victims of assaults inflicted on them by the public, for example, being paraded around as a robber.

In a theoretical discussion Bard and Sangrey (1979) identified three psychological stages through which a victim can pass, namely impact, recoil and reorganization. Their work is particularly relevant to this review as the reaction patterns identified by it can be generalized to other types of trauma.

Impact: According to Bard and Sangrey (1979) victimization experiences tend to be of high intensity and short duration. As a result the first stage of reaction is emotional shock symptoms such as numbness and feelings of vulnerability and helplessness. Landermann (1944) identified some semantic symptoms at the impact of victimization, such as tightness in the throat and shortness of breath, choking and an empty feeling in the abdomen, lack of muscle tone, sleep disturbance and lack of appetite. Lerner (1970) identified a guilty feeling

and a "just world" belief.

The symptoms enumerated above suggest that at the impact of trauma the victim is overwhelmed and may not be able to make decisions about what line of action to take. This means that his reaction may be postponed. The helpers at the time of victimization do not understand all the feelings a victim is having as they hardly seek to relieve those symptoms. In most cases help is stereotyped and hardly meets the victim's psychological demands; for instance, a widow driven from her home, while her children and all property of the family are taken from her by the husband's relatives. In this situation, both herself and the children are traumatized as well as victimized by the loss of a family head/father. Helpers may comfort them by telling them not to cry, without thinking of the degree of trauma and its impact on these individuals.

Recoil: At the stage of recoil a victim tends to deal emotionally with the victimizing event. In most cases the individual alternates between attempting to continue with normal life as though the event did not happen but periodically returns obtrusively to the event in its ramifications. This phase consists of compensatory fantasies, planning, reactions which seem to be a cognitive attempt at regaining equilibrium and compensating for damage done to self. At this phase the victim resorts to blaming self, friends and relatives and even the police, where applicable (Bard and Sangrey 1979). As a confirmation of this it is not uncommon to find Borstal Home boys who are very reactive and full of fantasies.

Reorganization: At this final stage of response to victimization the victim tends to return to psychological equilibrium. Fear and anger become modulated though with occasional flash

backs or extreme agitation. Bard and Sangrey state that recovery at this stage depends on many factors such as prior trauma, support and the extent of violation. But at this stage the victim is able to focus on life enhancing activities rather than just coping. In the Borstal Home some of the victims have come to the stage of reorganization as they recapitulate on their past lives. But at this point they need external help to regain their orientations.

The effect of sexual abuse which is a type of victimization tends to be different from those discussed above. Courtois (1979) and Herman (1981) found sexual abuse victims reporting of depression, guilt and poor self esteem as well as a feeling of inferiority in later life. Other psychological effects of sexual child abuse include interpersonal problems such as isolation, alienation, distrust and promiscuity (Courtois 1979), fear of men, transient negative relationship, (Herman 1981) fear of repeat victimization (Briere 1984) and sexual dysfunction (Kaplan 1979).

Among Nigerian youths there have been various types of victimization producing similar psychological results as the ones recorded above. But unfortunately due to lack of research in the area, pressure of work on the part of professional helpers and general ignorance, trauma insulation is not usually a sizable package in the rescue of victims. Victimized youths are usually exposed to additional psychological trauma from handling.

2.2.1. (b) LOSS

Generally literature related to loss focus on specific losses. Frears and Schneider (1981) have classified losses into apparent and unnoticed losses. Apparent losses come as part of change and include major losses that are obvious like death of relatives, friends, permanent and voluntary separation, illness or injury. Others are dramatic change, such as divorce, moving, change of school, weaning, leaving home, puberty, ageing.

Unnoticed losses are normally not regarded as losses but they generate psychological trauma because they trigger off loss response and demand coping. Such are positive occurrences like marriage, promotion, and achievement. They are traumatizing because they require loss of earlier life style resulting in life change units. In losses, adjustment requires an elaborate process, whereby the subject, gradually, in stages, accommodate to the changed reality. (Ross and Even 1972) outlines five stages through which the subject passes, namely denial, anger, bargaining, depression, and acceptance. Frears and Schneider (1981) however presents them in an elaborate six stages, namely:

1. Initial awareness: This includes, shock, loss of equilibrium and lowered resistance to infection.
2. Strategies to overcome loss: This is a stage of adaptive defence and cycles of holding and letting go.
3. Awareness of loss: The subject explores the extent of loss and its ramification.
4. Completion: a stage of healing acceptance and resolution.
5. Empowering the self: Areas of weakness prior to loss are strengthened.
6. Transcending the loss: This is a period of growth as a result of rehabilitation.

From observation, these stages take a long time to accomplish. By the time a young person passes through these six stages after a loss it is possible that he can develop diverse coping strategies, some of which could be maladaptive, depending on the extent to which helpers have offered cushioning help. Most helpers do not even understand what a person suffering loss undergoes. Some descend on him with advice which is not what the individual needs at that time. Probably what he needs could be just to be allowed to have himself in one piece so that he can organize his thoughts.

2.2.1.(c) Family pathology

Overview of the family:

Over the past years the family has changed in terms of structure and values. Nevertheless it remains a passive formative force in children's development. It is the primary learning milieu for individual behaviour and provides the basic structure for children's values and expectations as they grow towards maturity (Satir 1967). As a result families that show serious disturbances provide a faulty learning environment. It might be necessary at this point to skim through some of the ways families in recent times tend to provide faulty learning environment, thereby contributing in developing a traumatic environment for children. Observation and the media display a galore of complaints "that Nigerian parents of recent have little or no time for the proper upbringing of their children" (Soleye 1993). The situation has actually become more acute since the last ten years of the Structural Adjustment Programme (S.A.P.). Parents run up and down looking for money to make ends meet. But the ends hardly ever meet because the very children that parents struggle to feed, clothe well or give good formal education lose out on a very important count, namely, parental love and care. Ike (1983) in an attempt to find out why more and more married women register in the universities for post graduate work found various but similar reasons for the exercise.

In their responses, the women said they wanted to establish themselves academically in order to obtain professional promotion and then be able to feed, and clothe their children well. Many of them added that they wanted to create an academically stimulating environment for their children. But when asked how satisfied they were leaving their children at home to be catered for by the children's grand mothers, nannies, younger sisters,

their fathers or day care centres, they expressed regrets. Some said they were confused because their homes were in shambles; their children's care givers could not satisfy them (the mothers) or the children. The result was that they were neither at school nor at home. Both the mothers and the children, thus operated under stressful situation. According to Mitchell (1983) stressful episodes generate anxiety that may persist or even recur when the episode has passed but is reactivated by stimuli that reminds the individual of the episode.

The stressful experience recorded from a research among the academically minded mothers can be generalized among professionals, business minded people and other Nigerians who for one reason or another cannot give their children enough psychological protection. Ipaye (1983) looking at another dimension of the problem, emphasized that the preschool children shifted into nursery school by parents who are "either divorced or separated or those who do not want to take the trouble of child rearing are deprived of the emotional and social warmth of their homes". For the children this is traumatic. The statement of Olurontimihin (1974) best describes the condition of such young boarders:

> When a large number of children have to scramble and compete for a single quality parents substitute at the boarding house for toddlers the children cannot learn enough affection, individuality, initiative, morality, self pride and fellow-feeling, even if they succeed very well in acquiring the knowledge of the three Rs. Some of the children become affectionless or psychopathic simply because they have learned very early in life that it is "everybody to himself and God for us all". Some become perpetually miserable adults who cannot give or take love. Some break down mentally. Some manage to escape from the terrible outcome but with bruises (p.124).

The above situation is different from Durojaiye's (1976) description of children brought up under the extended family system, which hardly holds nowadays. He stated that

in the extended family setting the traditional system of child rearing and family life promoted a strong bond of royalty between family members and the children grew into adulthood with a strong feeling of security, cooperation, and mutual help which were inculcated in infancy. He added that such children were confident that help, support and protection would be forthcoming from other members of the family whenever needed. The children thus "developed an apparently healthy and secure personality which was protected against the rough and tumbles of deprivation and want. They become well adjusted both to their environment and with themselves". Few families can boast of this type of upbringing nowadays. And at the other extreme are families, which are permissive and overprotecting towards children. This class of children are likely to be exposed to trauma that the open society offers them whenever they come out of their protected environment to the society.

The family poses as a source of trauma to the child in yet other ways. The ever increasing rate of divorce, separation and family violence traumatize children. The United Nations Secretariat Division for Advancement of Women (U.N.S.D.A.W.) compiled the available information on domestic violence for certain countries in 1990. Each of the 36 countries investigated had high records of family violence. The same United Nations Secretariat reported domestic violence like wife battering in all countries of Europe, Latin America and the Caribbeans, Asia and Pacific Islands, Egypt, Kenya, Nigeria and Uganda, to mention a few.

The high incidence of violence in the family throughout the world and Nigeria in particular has generated concern among professionals for the youths who belong to violent families. Research findings show that children from violent homes can be traumatized and their personality distorted. It is therefore important to state the effect of family pathology on children who belong to them.

The effect of family pathology on young people

Trauma generated among children in many families of the world are shown by Weatherhead (1985) as being injurious to children's personality. There is a large volume of literature on family pathology. But Coleman, et al., (1980) have summarized some of them into four broad categories of family dysfunction which can lead to a high incidence of problems in child development and later, to psychopathology.

They are:

1. Inadequate families: These are families that lack the Physical or psychological resources for coping with normal life stressors.
2. Anti - social families: They have values that differ greatly from those of their communities because they may encourage dishonesty, deceit or other undesirable behaviours.
3. Discordant and disturbed families: These families are characterized by fraudulent interpersonal interactions such as fighting, gross irrationality or enmeshment of family members in parental conflicts.
4. Disrupted families: They have been inadequately adjusted to the loss of family members through death, divorce or separation.

The four types of families described above have been seen to be associated with higher incidence of Psychological disorders leading to various types of maladaptive behaviour and to physical illness. (Bloom, Asher, and White 1978; Heatherington, Cox and Cox 1978, Langer and Michael 1963; Lidz, Felk and Corndison 1965; Wolkind and Rutter 1973).

There are specific patterns of parental influence, which appear to be at the background of the development of family pathology and also form background of children's emotional disturbances and faulty development, Coleman et al., (1980). They include rejection, overprotection, unrealistic demands, overpermissiveness, faulty discipline, inadequate and irrational communication and undesirable parental models. These agree with Weatherhead's (1985) views of the origins of youth maladaptive behaviour. Most of the children found in the Borstal Home reported of the above parental types.

2.3 Developmental implication of PTSD

This subsection intends to review how a psychological trauma can interrupt the normal progress of development, causing more difficult resolution of current life issues and impending growth. The subsection is important in the sense that it provides a frame work for understanding why a trauma can have its particular effect on a person's life.

Human development, psychologist agree, consists of a gradual unfolding of personality wherein new learning and skills transform the individual from one state to another. Erickson (1968) describes this process as one of increasing differentiation, following a universal epigene meaning sequence. Individual's development is shaped by culture and familial influence interacting with genetically based aspect of personality. As social expectations change according to age and as hereditary traits manifest themselves, the individual is confronted with different demands. Each phase has certain inherent tasks that must be resolved to form the basis of further changes. Erickson describes these steps as 'crises'.

> Each successive stage then is a potential crisis. Because of a radical change in perspective. Crisis is used here in a developmental sense to connote not a threat of catastrophe but a turning point, a crucial period of increased vulnerability and heightened potential, and therefore the ontogenic source of general strength and maladjustment (p.96).

Erickson described developmental crisis as ontogenic sources of maladjustment as well as growth. Each successive stage of development resulting from the external demands of environment causes a specific vulnerability. A stage is a time when a given capacity or set of skills requisite for further development as a result of both the acquisition of skills and capacities and the necessary cultural and biological pressure must change. Unlike crisis in the sense of catastrophe where the individuals resolution entails re-establishing a previous level of functioning, crisis here denotes an event or stage the resolution of which involves reaching previously unattained levels of functioning. Development then connotes a process of transformation through stages characterized by specific demands, opportunities and vulnerabilities. As Erickson suggests, adverse condition may affect development in specific ways. This disruption affects not only the stage during which the event occurred but also resolution of tasks in subsequent stages.

Two concepts are worth mentioning at this point before exploring the effect of critical incidents on developmental patterns. These are developmental anxiety and premature restructuring. In the discussion of the assessment of trait versus state anxiety Saarni and Azara (1981) advanced the concept of developmental anxiety. They hold that developmental anxiety represents a reaction to the transition involved in the giving up of old forms of coping that worked at one level of development, and the acquisition of new forms that are appropriate to a new level of development. This acquisition can be a prolonged process of differentiation and experimentation and generate considerable anxiety.

Saarni and Azara interpreted Erickson's crisis' as a growth stage in which developmental anxiety emerges and spurs the organism on afresh and "with a new adaptiveness to synchronize forms of coping with the inherent conflicts of life" (p.579). Thus developmental anxiety decreases or increases along the life span of the individual as that individual attempts resolution of each new set of demands raised by changes of biological and societal expectations.

Elkind (1981) in a book about the 'hurried child' discusses the concept of premature structuring. This concept is a process by which character or personality formation of the youth is accelerated due to the demand of the environment. This constricts future development. Elkind cites child prodigies of slum as examples of children who grow too quickly, deal with grown up demands and stressors too early, and develop certain aspects of their personalities at the expense of others. These children tend to become over-specialized and over differentiated in a manner that provides immediate survival value but closes off further learning and balanced growth. He states that premature structuring has serious consequences when the child reaches adolescence. For instance some Borstal Home inmates narrate stories of their starting to cater for mother and siblings as early as ten years due to father's death.

While development is in itself stressful, when trauma accompanies it, life becomes devastating. This statement is supported by Wilson's (1978) findings among the Vietnam veterans. His findings were that the veterans showed symptoms of trauma about 15 years after exposure to critical life incidents by the war at about 15 years of age. The symptoms of trauma include:

- Interpersonal conflict with significant others

- Much drug use
- Low career and educational aspiration
- Much social and political alienation
- Psychic numbing
- Fits of anger, rage and hostility
- Emotional ambivalence towards loved ones.

The major reasons why boys are deposited in the Borstal Home include: interpersonal conflict with parents and guardians. (They are described as "beyond control"), drugs of all sorts, violence and social alienation, all symptoms of PTSD.

Of particular note is Wilson's support of Erickson's notion of distantation, or withdrawal from the sort of intimacy required to bring affection, sexual pleasure, love and affiliation. Purposeful distantation, which seems to have been a learned adaptive behaviour in Vietnam, proved to be maladaptive at home, isolating the veteran from social support and impending resolution of issues of identity.

Wilson's study supports Erickson's observation that each life stage is characterized by a particular psychological crisis and that each crisis bears the risks of specific types of ego-regressive attributes; "sufficient stress and trauma during a specific stage will increase the risk of failing to master the critical issues and of developing the related ego - aggressive attributes." (Wilson 1978 p.28). The deviant youths seem to have had problem mastering their developmental tasks due to various psychological and developmental crises. In an attempt to cope with their distorted personalities they develop strategies which society describe as maladaptive. This alienates them the more from society, which finally dump them in the reformatory. This of course increases the anxiety and psychic numbness. The

youths cannot help themselves. They need help in the area of human personality management, a reason why self-management therapy may be successful in rehabilitating them.

2.4 Maladaptive Adolescent Behaviours (MABs)

Adolescence is a period in a person's life and it has the special characteristics which qualify a person to be described as an adolescent. It is defined by Herbert (1987:1) as a stage of transition from "irresponsibility to the responsibility; somewhere between the immaturity of childhood and the hoped for maturity of adulthood." Okon (1988:2) defines adolescence as "that period of growth in each individual's life which begins at the end of childhood and closes at the beginning of adulthood". The two definitions imply that adolescence is a transitional period. It is culture and maturation dependent, and it is not biological. But it is a very important life stage which needs to be studied and understood (Okon 1988). Many parents and parent figures do not understand the significance of this life stage. Psychologists agree that this life stage gives a lot of concern to the adolescent and those around him. (Erickson 1965; Herbert 1987; Okon 1988). According to these psychologists the major task facing the adolescent is shaping and consolidating himself as a unique individual, that is development of self identity. This is particularly stressful to the adolescent (Okon 1988). If the task of identity development is tangled up with inability to resolve earlier life developmental tasks the youngster develops a series of coping strategies some of which can be detrimental to later development. Such self destructive behaviour are termed maladaptive. Hence the need to examine the maladaptive strategies in order to

design helpful coping strategies for the adolescent.

Herbert (1987) categorizes adolescent maladaptive behaviour into those that disturb the youngsters themselves such as anxiety, shyness, depression, feeling of inferiority and timidity. The other category is made up of those behaviours that disturb the community. The examples include lying, stealing and aggression. Such self destructive behaviours bring disruption and disrepute to the community for example noncompliance, destructiveness, aggression and drugs.

2.4.1 Suicide

The actual activities classed as maladaptive behaviours are: Suicide and suicide ideation (Frederick 1985a, Hendlin 1985) Peck (1984) asserted that two cases found to be common among 10 - 14 year olds who commit suicide are parental death and high incidents of learning disability, these types of suicide youths were found to be the ones who grew up in families that defensively deny childhood dysphoria. Lustig and Zeitlin (1985) found suicide behaviour among youths who have enormous fear of failing and who had deep separation anxiety. Youngsters found in crisis suicide according to Lustig and Zeitlin (1985) were those reacting to a traumatic experience which were followed by dramatic behaviour change, hostility and signs of confusion. Some youngsters were also found to be attempting to commit suicide as a cry for help though this may result in accidental death. This is why Herbert (1987) warns that attempted suicide, though a cry for help should be regarded as banal because many individuals who have threatened to commit suicide do carry it out in the end. Other antecedents found in suicide youths include significant object losses in childhood (Anderson 1981), growing up in hostile environment and loss of themes (Teicher 1979).

Anderson's three - stage model of suicide provides some indication of why these background events are very significant. Other Psychologists like Weatherhead, Herbert and Hopsin agree with Anderson that the first stage, which is the critical incidents and chronic problems, together form a history that affects development and this is a history of vulnerability to risk. Adolescence itself forms the second stage of escalation of these problems. This is because, they agree, the behavioral changes that occur under the new stress of adolescence frequently serves to undermine social support and increase the experience of stress. The final stage, according, to Anderson, involves a trigger situation culminating in the suicide attempt. Thus a longstanding history of critical incidents provides the context within which a suicide crisis develops.

2.4.2 Runaways

It is important to note here that almost all children in the reformatory are runaways. Justice and Duncan (1976) reported that 10 percent of all American youths run away between age 12 and 17. This according to Walker (1975) amounts to some 1,000,000 children. Back in Nigeria police reports show that a number of children run away from home and school, though the exact number cannot be published because of poor record keeping and unreported cases. There is no consensus in literature surveyed as to why they run away, except general agreement that disturbed family relationships are involved.

Nilson (1981) compared runaway children to a control group in the areas of problem solving ability, coping skills and back ground experiences. The control consisted of non runaway group referrals to counselling services. Although Nilson's procedure for collecting the data were not clarified thus making generalization limited, the following findings were made. Runaways did not differ significantly from the non-runaways with regard to coping

or problem solving skills, but ten times as many had family divorces, remarriages and placement outside the home as background factors for running away.

In a continuation of this study Nilson explored the Psychological profiles of 46 children, 28 of whom were runaways and 18 referrals from the same agency sources who approximated the runaways in terms of "need for supervision" but who had not run away. While family structure was similar in instability and dysfunction in both groups, the runaways tended to have been abused or neglected more. Further, the runaway group tended to act out depressive features, showing higher rates of suicide ideation, gestures and attempts. Russells (1981) in his comparison of Psychological profile of runaways with delinquent referrals other than runaways from the same agencies, found more similarities than differences. Runaways differed from controls only in that there were higher number of runaways from chaotic homes, and a greater percentage of runaways placed in the highest and lowest IQ ranges. Otherwise the groups were similar, showing the following exaggerated adolescent traits: self centredness, immature ego structure, interpersonal difficulties, and defensive self-image. Half of the sample showed depression, while a third showed poor impulse control, regressive tendencies, emotional immaturity and identity conflicts. Some ten percent showed definite self-destructive signs.

On the basis of this research and review of other literature, Russell (1981) made the following generalizations about runaways.

1. Running away is easier and a more socially accepted form of protest "in adolescence today"
2. There appear to be more neglectful, abusive and conflictual homes today.
3. There are a greater number of incomplete inadequately structured families unable to provide the emotional supports to help accomplish the tasks of adolescence.

4. Most runaways manifest immature or incomplete development.
5. Running away can be seen as self harming or a measure taken for protection against parental relationships or the adolescent's own expressions of rage (p.72).

In terms of background and stressors, Russell's study bears further comment. Using his sample of 100 runaways drawn from a population of 2,000 juvenile courts referred for clinical evaluation, Russel reports the following background critical incidents:

1. divorce/separation 49 percent
2. serious parental illness 26 percent
3. severe parental alcoholism 26 percent
4. death of a parent 16 percent

2.4.3 Serious school attendance problems

All children in the reformatory have school attendance problems. In an early comprehensive study of middle class drop outs, Lichter, Rapien, Seibert and Sklanski (1962) differentiated between what they called "Psychological" and "reality" problems underlying serious nonattendance. Reality problems included low IQ Scores, economic needs, and physical illness. Psychological problems which accounted for the majority of dropout behaviour chiefly crystallized around issues of dependency and hostility with parental characteristics projected upon teachers by the students (p.40).

This projective dynamics may explain the reasons students frequently give for non-attendance. These are summarized by Thorneburg (1975). They include:

1. Lack of interest
2. Failing grades

3. Relationship problems with teachers and peers
4. Negative attitude towards school
5. Wanting to find a job.
6. Marriage and for pregnancy
7. Military enlistment
8. Expulsion

The proposed relationship between underlying psychological needs and school nonattendance is given support by the frequency of traumatic background factors among non-attenders. Harris (1980) provides the most thoroughly controlled documentation of this relationship. She showed significantly higher incidence of the following background events among non-attenders and at-risk-for dropout subjects than among the controls:

1. Physical abuse
2. Incest
3. Sexual assaults
4. death of a family member
5. divorce of parents
6. death of friend
7. frequency of school transfer.

In addition, Harris found that dropout-prone students exhibited a higher total number of traumatic events, appeared to be more emotionally disturbed and in need of mental health services, and experienced higher levels of family stress within past year than did controls. Finally Harris found that these students exhibited more of the following maladaptive behaviours:

1. pregnancy
2. running away
3. delinquency
4. substance use/abuse
5. suicide attempts, and
6. self mutilation

2.4.4 Drug and alcohol abuse

Drug and alcohol abuse seem to be complicated issues. Their results are equally complicated and can include many other maladaptive behaviour. Accident, violence (including assault, homicide, suicide), overdose, physical and mental deterioration and disability, relational difficulties and diminished work or school performance are all associated with drug and alcohol abuse during adolescence (Millman, Khuri and Hammond 1981). "This litany, Millman et al note, includes the three leading causes of death among adolescents. Johnson (1989) draws attention to the fact that drug and alcohol abuse differ from other maladaptive behaviours such as running away, gambling, or risk taking, because, in addition to personal psychological dependence, it involves personal dependence. Rehabilitation therefore requires altering physiological as well as psychological cycles. It is not uncommon to find boys who cannot coordinate their thoughts and speech as one discusses with the inmates in the Borstal Home. The records of such inmates always shows heavy drug and alcohol abuse.

Drug and alcohol abuse is complicated in another way. It is difficult to define the beginning of abuse from ordinary use since people have differing capacity for alcohol for instance. And as Millman et al (1981) puts it "substance use has moved through an

epidemic situation in which use is an integral part of rites" in most countries of the world. Besides the use of alcohol and drugs among adolescents is a very pervasive part of the contemporary adolescents culture. Suchkit et al. (1977) estimate that in 1977, 80 to 90 percent of American adolescents were drinkers while Abelson, Fishburn and Cisin (1977) estimated that 15 percent of 14 year olds and 31 percent of 18 - 21 year olds used marijuana, based on the data by U.S. Department of Health. Twenty years later these figures will inevitably be higher. This is not peculiar to the United States. Statements from the news media indicate that Nigeria is in a similar predicament.

Millman analyzing the probable reason for increasing adolescents' drug and alcohol abuse states that alcohol and drug use makes sense to young people because in the process of moving from a position of relative dependence to one of relative independence adolescents normally lack the sense of identity and personal competence to "be adult". In the short run substance use provides peer acceptance, a sense of control and a medicational effect, enhancing self esteem and relieving anxiety and tension. He adds that typical use begins with occasional experimentation in association with friends, usually beginning with alcohol and progressing to marijuana. Some adolescents move on to depressants, stimulants and psychedelics, culminating in opiates or cocaine. While some adolescents stabilize at some point, some may develop a poly-drug abuse pattern that varies according to the availability of drugs, the situation, and the needs of the user. Norem - Hebeison and Hedin (1981) conclude that adolescents derive progressively more support and information from peers, although the extent varies considerably.

Others and much stronger factors responsible for drug/alcohol abuse is neglect or extreme parental styles. These push adolescents into excessive identification with peer

group. This is borne out in the literature concerning background variables antecedent to problematic substance use. Robins, Davis and Wish (1977) documented increased incidents of parental divorce and separation in the backgrounds of substance abusing adolescents. Similarly, Barnes (1979) found higher rate of family pathology among solvent abuses. Family alcoholism has also been found to be predictive of substance abuse. Both victimization and loss during childhood are also predictive of substance abuse. Klagsbrun and Davis (1977) cited earlier, report a high abuse during adolescence. Similarly Harris (1980) in her study of dropout-prone adolescent showed substance abuse to be common among her sample and found high frequencies of both physical abuse and sexual assault in their backgrounds.

To conclude this section of the review it is important to note that the researches discussed provide basic background information on childhood and adolescent crisis, and connection between the two. The major forms of adolescent acting out behaviours have been outlined in a manner designed to give an overview of the central variables and dynamics of each. More importantly these studies point to a relationship between trauma and adolescent crisis that underscores the need for effective management of crisis and illuminates essential dimensions of adolescent crisis and also the need to design a suitable method of intervention.

Studies reviewed relating a range of antecedent experiences to subsequent specific maladaptive adolescent behaviours indicate commonality of antecedents. Studies of adolescent alcohol and drug abuse, runaways, and serious school attendance problems show each to be positively correlated with the incidents of the three areas of the critical life experience: family pathology, victimization and loss. Only suicide was not correlated with

all three. Studies reviewed on suicide correlate that behaviour with family pathology and loss, but not victimization. It should be noted however, that Briere, Runtz and Lightfoot (1978) have associated adult suicide with prior childhood sexual abuse.

2.5 Psychological Trauma and the Development of Maladaptive Adolescent Behaviours

The literature cited in this study has established that critical life incidents generate trauma in the lives of their victims; that psychological trauma renders its victims unable to organize themselves. The adverse effects of psychological trauma can manifest themselves first as trauma occurs, immediately after it or a long time - days, weeks, months, years - after the critical event. Johnson (1989) found a positive correlation between childhood trauma and adolescent maladaptive behaviour, confirming the fact that symptoms of psychological trauma can last into later life. The work of Wilson (1978) among the Vietnamese veterans clearly shows the lasting effect of psychological trauma and its long term ability to develop into maladaptive behaviour in the future. The concept of PTSD has also suggested an explanatory construct that is of value in anticipating high correlation of early critical experience and maladaptive adolescent behaviours in general. It seems that trauma occurring during specific developmental stages does create special vulnerability by impeding successful resolution of growth issues during that stage, leaving the individual less able to resolve future issues successfully.

Adolescence is a crucial stage in which successful resolution of issues of identity is particularly stressful and anxiety provoking when underlying issues of trauma, guilt or feelings of inferiority remain unresolved. The anxiety generated by outmoded coping mechanisms and now seemingly insurmountable demands create a propensity to adopt maladaptive coping strategies rather than no strategies at all.

This section of the literature is concluded with the notion that the concept of PTSD can provide direction to use while approaching critical incidents and maladaptive behaviours. Recognizing the possible developmental outcomes of critical incidents would help those working with children and adolescents to plan comprehensive intervention approaches with traumatized youngsters. Similarly by recognizing the likelihood of prior critical incidents in the life of adolescents whose behaviour is maladaptive and problematic, clinicians and professionals can plan intervention that can better address underlying causative and developmental factors.

The summary seems to be that trauma produces psychological disequilibrium that is anxiety provoking. Attempts at coping with this anxiety affect the individual's ability to tolerate the normal anxiety created by developmental transitions. The resulting combination then blocks successful developmental task mastery, and maladaptive attempts to cope with the anxiety would produce further complications. Such attempts can include typical adolescent acting-out behaviours such as premature structuring, extreme sensitivity to emotional issues, or self defeating life choices, which are classed as maladaptive behaviours. It is therefore the aim of this study to attempt an intervention plan in which the traumatized maladaptive youngsters can be fully involved in rehabilitating themselves.

2.6 The Nigerian Concept of Trauma and Maladaptive Behaviour

It has already been noted that the definition of maladaptive behaviour is culture dependent (Adeloye and Aina 1990). Trauma, though universal can as well, to some extent be defined by culture. The mode of intervention in each case would as well depend on the

culture, literacy level and economic status of the people. To obtain the Nigerian concept of these terms, Luka and Shalangua (1995) carried out a study among agencies that handle maladaptive and trauma cases in Nigeria. The senior staff of the government agencies were interviewed and observed. The inmates' case files were also used to obtain the required information. The agencies studied were:

1) The medical social service
2) The social welfare unit of the Borstal Training Institute,
3) The social welfare unit, Kaduna,
4) The psychiatric hospital,
5) The juvenile detention centre (Remand Home)
6) Government law enforcement officers (the Police)

A set of behaviours normally regarded as maladaptive was obtained from the case files of the officers visited. They included:-

(a) Runaways both from home and school
(b) Drug abuse
(c) Fighting with dangerous weapons
(d) Stealing
(e) Homicide
(f) Delinquency
(g) Denied pregnancy. (These are teenage pregnancies that no man has claimed. Luka and Shalangwa 1995).

This list agrees to some extent with the international notion of maladaptive behaviours as seen from literature cited before. But it excludes other tendencies that are also

regarded as such. Suicide and suicide ideation (Peck 1984); loners, acting out depression (Lustigs and Zeitlin 1985), serious school non-attendance, alcohol and substance abuse (Haris 1980), were not mentioned by the officers interviewed. It cannot be concluded that such behaviours are absent among Nigerian youths because they are observed in the society and at schools. So this research will consider them as possible maladaptive behaviours in Nigeria.

The people interviewed did not quite understand the spread of traumatic experiences. Using their case files their responses were limited to what are normally reported to them. Traumatic experiences reported included:

a) Accident victims-from the police and hospital files.

b) V.V.F. victims - from hospital and social welfare files

c) Abandoned children

d) Lost and found children

e) Rape cases (Luka 1995)

All these cases can be classed as loss and victimization but even then the list is not complete. The agencies did not make mention of other losses like loss of themes and unnoticed losses. They asserted that most of the maladaptive cases they receive come from pathogenic families but they did not mention family pathology as a source of trauma.

The trauma intervention processes used by the government agencies vary with the type of trauma. Accident victims are sent to the hospital where possible and they are given medical care. The Psychological aspect of intervention was not mentioned. Lost and found children are advertised in the media for their parents to come for them. V.V.F. victims are given free medical care, some stipend, free clothing and vocational training which is an

aspect of rehabilitation. Raped youngsters are passed through the court where they have to testify to what had happened to them. This in itself is traumatic. In most cases the physical aspects of trauma is catered for but the psychological aspect is neglected (Shalangwa 1995).

2.7 Available Intervention Programmes among Maladaptive Youngsters in Nigeria.

One area of maladaptive youngsters behaviour that has not attracted much attention from several writers is the evaluation of the effectiveness of government intervention programme among maladaptive youngsters. Each year, few writers publish papers on the subject. The result is that the literature on the subject is not much. The purpose of this section is to review the significant works on effectiveness of government intervention programmes among maladaptive youngsters.

In this text intervention programmes are those plans and policies which governments establish to control and treat unwanted behaviours of youths which are capable of threatening lives and property of the society. The government intervention programmes are many. They include:-

The law enforcement agencies

Borstal Training Institutes

Remand centres/Homes

Social Welfare departments

Within any society, most people would agree that any deviant behaviours among its members should be prevented. The problem is how to achieve this goal and by what means. In their studies Hollin, (1995) quoted Morris who described three preventive strategies that

can be applied to all criminal behaviours of young offenders, namely:-

Primary prevention which has the aim of preventing the whole of the population from breaking the law.

Secondary prevention which has the goal of preventing "at risk individuals and groups".

Tertiary prevention. This aims at preventing further offence by those individuals who have already committed an offence.

He maintained that "parents should be trained for better child management", young males living in high crime areas and are therefore judged to be at risk of offending were recommended for intervention programmes by welfare agencies, police and members of the local church. Along with counselling, the intervention programmes include approved access to medical and psychiatric facilities, academic teaching and other community programmes.

The pre-colonial forms of treatment of young offenders in Nigeria was "through flogging, denial of food and razor blade slices on the body which was washed with peppery water". This type of prevention was doing more harm than good to the child. Such measures are tagged child abuse nowadays and are prohibited. In agreement with such prohibition Levitte (1971) opined that "conduct disorder does not respond well to traditional treatment". In his research, Rigby (1996) found that in an attempt to prevent people from dying through the effects of drug in Britain, the government has a drug policy forum whose duty is to keep people safe and raise awareness under the title "Dance Till Dawn Safely". The guidelines stress greater emphasis on reducing overcrowding and over heating in clubs and increasing the availability of drinking water. This policy is permissive and may not

work here in Nigeria since the drug users have their ways of obtaining the drugs, and not always in clubs. Kwajafa (1991) suggesting a more acceptable method of drug abuse prevention said that Nigerian post primary pupils should study drug education as a compulsory subject in the curriculum. This could be effective because all the dangers involved in drug taking and trafficking would be well discussed. The first coherent lists for the control of drug abuse was introduced in the league of Nations 1925 convention. The dangerous drug act of 1951 controls simple narcotics and a few chemically related synthetic substances which are individually made. The United Nations 1988 Vienna Convention ruled against illicit trafficking in narcotic drugs and psychotropic substances. All these were done to control the trafficking in hard drugs. Also surveillance and interception at sea, monitoring of ports, postal systems and commercial transactions (Terry et al. 1957) are other measures taken to control drug abuse.

In their studies, Demers, Orleans, Ockere (1990) found that in North America, counselling by physicians is an effective way to reduce cigarette smoking. Bracht (1994) in a related study found that community based public health intervention programmes have become increasingly important as a strategy for health problems, most notably in the prevention of cardiovascular diseases, cigarette smoking, accident and alcohol related problems. It is to be noted that the above intervention strategies have not been tried in Nigeria. Juvenile delinquent behaviours according to Olurontimihin (1994) should be treated through interaction between the victim and the other members of the family. This suggestion may have an effect on the child because conversing with a child is a unique art with rules and meanings of its own. No parent wakes up in the morning planning to make his/her child's life miserable or humiliate him. Therefore communication

can both treat misconduct in children and prevent its occurrence. This can even help those who are already maladaptive and are placed in the reformatory.

School discipline have been used for treating maladaptive behaviours, such treatment include:

- Detention, extra assignment, grade reductions and exclusion from extra curricular activities.
- Suspension from school, expulsion, corporal punishment, remedial instruction, school based counselling and medication (Shalangwa (1995).

Some of these ideas may work but others such as grade reduction, expulsion and exclusion from extra curricular activities may fail. On grade reduction, the child may feel cheated and show more deviant behaviours. Then expulsion and exclusion from extra curricular activities may give the child a chance to choose an activity such as stealing and other related activities to keep himself busy. Schlebusch (1979) agrees with Shalangwa on this, and suggested school therapeutic treatment since the child or adolescent spends a great deal of his time at school. In order to play a positive role in this regard, he maintained that the educational system should take cognizance of the following:-

(1) "The employment of adequately qualified teaching staff who do not only have the knowledge to recognize conduct disorders as early as possible but who are also aware of the role of the school in preventing and treating of students' misconduct.

(2) Preventive techniques in schools which include provision and development of mental health consultations and extensive psychological guidance services.

(3) Youth training programmes organized in communities to provide recreational activities for the youths. Some of such programmes used in Great Britain are

Cambridge Somerville Youth Study and the Highfields Study. If applied in Nigeria, these suggestions may help the youths to be involved in constructive activity rather than indulge in practicing some destructive activities. Besides these suggestions are preventive and not rehabilitative.

Effectiveness of Intervention Programmes Among Maladaptive Youngsters

Government intervention programmes among maladaptive youngsters of whatever type can only stand a chance of being successful if it is properly implemented. Solid and effective intervention programmes do not magically appear over night, they need planning in terms of human and material resources as well as flexibility to cope with the varying behaviour demands and problems presented by different individuals. Whatever be the intervention programmes it should be geared toward modifying behaviour through positive, caring methods rather than through stringent measures. Hollin. (1995) maintained that rehabilitation is preferable to retribution and harsh punishment. To them, treatment programme should aim at making the young person work at challenging and changing his or her behaviour.

Below is an examination of the effectiveness of different intervention programmes established by the Nigerian government to control maladaptive youngsters:-

The Police

The 1979 constitution section 194 established the Nigeria police force. The functions of the police are to prevent crime, protect property, apprehend offenders, preserve law and order (Syndicate 10 1992 police on course), Sandhu (1977) maintains that in order to prevent delinquency, the police is expected to befriend the youngsters on the street and divert their energies to lawful activities. He should have very sound judgement in choosing the most

appropriate techniques to deal with misbehaved children or adolescents. He observes that the recent police efforts to improve the attitude of junior high school in The United States of America toward law enforcement through lectures have met with some success. Bubaram, (1989) noting methods other than lecture states that the police have ignored the law and therefore ignored the procedure enshrined in the law thereby handling juveniles more or less like the adult offenders. In Aremu's (1988) observation, "the police cause delays in prompt investigation, raise objection to bail, engage in indiscriminate arrest of suspects and torture innocent citizens simply because of receiving tip offs about crimes committed". In support of this view, Kalu and Osinbayo (1990) observes that "corruption within the police force and the level of police collaboration with criminals has risen to a new height", that in one month, "over 400 policemen were arrested or suspended on suspicion in Ganteny, Germany, and nearly 1,800 police officers were convicted for crime committed in their course of duty". This development may not be different in Nigeria since one often hears on radio and television how some law enforcement agents collaborate with criminals for deals. Hollin, (1995) quoting Palamara's study concluded that "both the police and treatment oriented intervention with young people had the effect of increasing juvenile deviancy".

Causes of present public distrust in the police as seen by Okonkwo (1994) are:-

"Dissatisfaction in the handling of reports due to public ignorance of police methods and the law. Rude treatment of citizens who come to police with cases. An unpleasant tone of voice, Rough treatment of suspects and other offenders showing partiality to women, friends and relations in handling cases". In their essays Ogolekwo, (1991) and Okonkwo (1994), Kalu and Osinbajo (1990) conclude that the police work has not been effective in controlling maladaptive youngsters due to some constraints which include:-

Lack of all the necessary tools for effective internal security management, death of serviceable vehicles or communication gadgets, inadequate qualification and training, inadequate manpower, poor service condition and poor police/public relations. Others are, that no special allocation has been given to the police by the government to fight youngsters maladaptive behaviours. The issues raised in this discussion prove that the police men have left much to be desired in terms of preventing maladaptive behaviours in youngsters.

Borstal Training Institute

Borstal Training Institute is a place where youths of prescribed age who have been convicted of a crime can be subjected to training. The legal backing for the establishment of this institution is the Borstal Act No 29 of 1960 and Ordinance No 32 of 1960. The objective of the Institute is to "bring to bear every good influence which may establish in the inmates the will to lead a good and useful life on release, and to fit them to do so by the fullest possible development of their character, capacities and sense of personal responsibility".

The idea of introducing Borstal Training into the country was prompted by the moral laxity, which emerged from the youths who engaged in nefarious activities. The Borstal Training Act provides that where a person is convicted by a high court or a chief magistrate of an offence punishable with imprisonment, if on the day of his conviction he is not less than 16 years but rather under 21 years of age, he is to be sent to a Borstal Training Institute and not the prison. The duration of the term is 3 years. This is aimed at reforming the child's character, through vocational training, religious instruction, general studies and counselling provided to the inmates. Below are the programmes.

Vocational training - There are eight workshops, this includes electrical building,

photographing, Maintenance, carpentry, welding, plumbing and Tailoring. Every inmate must belong to a workshop which enable him to sit for government trade test either at grade I or grade II.

- Recreational and sporting activities. The inmates are provided with recreational and sporting activities in the field of games and sports.
- Religious Instruction - They are offered therapy through religious instruction by the staff and outsiders.
- Counselling: Every inmate has a case file where history of his offenses are traced and necessary counselling offered.
- General studies: There are some of the inmates that were students before their conviction, lectures are given to prepare them to sit for the senior secondary school or junior secondary certificate examinations. This is made possible through the help of youth corpers and other staff.

In spite of all these good intentions for the convicted youngsters, there are loopholes in the implementation of these policies. The Federal Government's gesture in technical education has not been extended to the Borstal Training Institution as observed by Odumesu, (1988) in his research. He continued that there were no new workshops and attention was not paid to the existing structures and equipment. The Borstal home is poorly staffed.

This section of literature review has listed the prominent government intervention programmes among maladaptive youngsters. It has also established how ineffective the programmes have been in correcting the behaviour of the youths concerned. Emphasis is that any form of intervention programme among traumatized maladaptive youths should be

geared towards modifying behaviour through positive, caring methods, rather than through stringent measures. Rehabilitation seems to be preferable to retribution and punishment. It is established as well that treatment programmes should aim at making the young person work at challenging and changing his or her behaviour. This ideas agree with the philosophy of rehabilitation counselling.

2.8 Rehabilitation Counselling

The domain of rehabilitation counselling deals with deviant clients. It makes use of problem solving intervention strategies and is client centred in nature. The desire to psychologically rehabilitate clients stems from the understanding that they are psychologically devastated and need the help of someone else to reorganize themselves. For the purpose of self reorganizing Hackney and Cormier (1979) suggest four strategies that can be used. They are social modelling strategies, role play strategies, cognitive change strategies and self management strategies.

These strategies are designed to help the client acquire desired responses or extinguish undesired ones. The first three strategies are not considered for this research because of their inherent characteristics that will make it difficult for an outsider to operate among prison inmates. Self modelling has been used successfully with prison inmates (Krumboltz, Thoresen and Carl 1976) but this is very cumbersome for a counsellor who lives outside the reformatory and for a system that is highly handicapped due to the lack of facilities. Self management strategies have been chosen for the present research because of the considerations that it is easy as the client requires minimal interference from the counsellor thus eliminating the counsellor as a "middle - man" in the helping process.

Hackney and Cormier (1979) agree with this notion and recommend the strategy. They stated that the characteristic of the strategy is that "the client administers the strategy and directs the change effort with minimal assistance" from the helper. They assert also that self management strategies are among the best strategies designed to strengthen clients' investment in the helping process and that it insures greater chances of client success because of the investment made by the client in the strategy for change (p.143).

These strategies are referred to as self control, (Cautela 1969) self regulation (Kanfer 1975) or self-management.(Mahoney 1979). The strategies selected for this research meet the basic characteristic requirements of rehabilitation counselling which are given by Goldman (1978) as follows;

1. Focus on the clients assets rather than liabilities. The deviant youths in this study are to dictate the behaviour they want to change then begin to work on improving that behaviour. Little attention is given to the opposite of that behaviour as the plan is to help it fizzle out from the behaviour of the deviant youth.
2. Emphasis on practical life functioning goals. The youths are to choose their goals, both long and short term ones in practical terms.
3. Existence of objective problems that are acknowledged by the client.

In the case of the traumatized maladaptive youths of the reformatory, their very presence in the home helps them know that there is some problem with them. Their problem, according to the authors, are intrapsychic and external in nature. Such problems often include the clients view of self as a damaged person and ambivalence about trading an easy dependence for the rigors of trying. Among other problems mentioned are the familial rejection, social ostracism, poverty and pain. The inmate of the Kaduna reformatory are

faced with the these problems. The nature of problems and personalities involved as clients demand that rehabilitation counsellors work with other persons, institutions, professionals and paraprofessionals. It will require the efforts of the law enforcement agencies, the juvenile court, the Borstal Institution, the workers in the home and the research assistants to accomplish a successful research among the sample in this study. It is a team work.

It is important to note that the aim of rehabilitation counselling is not making the client "well or curing the condition, but rather, achieving the highest level of functioning possible. Therefore evaluation of client is in measure of strength. Interest of counselling is toward practical goals of independence and self support. It is thus a question of using a variety of techniques to help clients who have many internal and external problems.

The outcomes of the present study is to be evaluated therefore using the levels of functioning of the deviant youngsters, and the success of the chosen strategy depends on the level of deviation from previous self destructive coping strategies, self acceptance, self worth, change in values and the level of self confidence. Though all these are not easily quantifiable, when they happen in the life of a person, the difference is clear and comparisons can be made. More so according to Hackney and Cormier (1979) this method of behaviour intervention "promotes generalization to life settings of what the client learnt during the research".

2.9 Summary

The literature review has established that critical life incidents generate psychological trauma in the lives of young people. The construct, Post Traumatic Stress Disorder, the literature on the development of adolescent maladaptive behaviours and the

research findings have shown beyond reasonable doubt that traumatic experiences generally relate to adolescent maladaptive behaviour, though it has not been established that specific types of traumatic experiences will relate to specific maladaptive behaviours.

From studies cited it is found that the Nigerian concept of trauma and trauma insulation seems to be incomplete and their idea of maladaptive behaviours is not based on the professional concept of the terms. The government intervention among maladaptive youngsters has been shown to be inefficient. Based on this literature reviewed, self-management intervention therapy has been suggested for the rehabilitation of the maladaptive youngsters since literature has shown it to be an effective way of helping deviant people rehabilitate themselves.

CHAPTER 3

RESEARCH DESIGN, METHODS AND PROCEDURES

3.1 INTRODUCTION

This Chapter discusses the methods and procedures used for the research. The areas considered are:

- The research design
- The Population
- The sample and sampling procedure
- Instrumentation
- Data analysis
- Validation of the instruments
- Limitation of Study
- Summary

3.2 The Research Design

Multiple-single-case-experimental-strategy was used for the research but a survey procedure was used for selecting the sample. Therefore, the research had two parts.

Part one: In part one (the survey section) a questionnaire was used to gather self report of youngsters' background experiences and current behaviours from a population of 74 inmates who could read and write in Kaduna Borstal Training Institution. In this section,

independent variables consisting of experiences that had been overwhelming the adolescents' capacity to cope (critical incidents) were indicated on a checklist, Critical Life Events Survey (CLES). Included in the checklist were wide range of incidents such as death of parents, sexual abuse, divorce/separation of parents and others selected by a panel of youngsters as being most critical. Space was included for repeats and events not included on the list. Maladaptive adolescent behaviours were the dependent variable. This was designated CABI in the questionnaire and included serious school attendance problems, suicide ideation and attempts, fighting, smoking, running away and others. CABI was a self report questionnaire designed to maximize self-disclosure.

Part two: Section two adopted an A-B-A design of single case-experimental-strategy. This consisted of baseline observation, treatment and withdrawal phases. This research design has been recommended by Hersen and Barlow (1977) as a design that allows for an analysis of the controlling effect of a treatment and subsequent removal. The idea behind this research design is that if after baseline measurement (A) the application of treatment and token reinforcement (B) leads to improvement and conversely, withdrawal of reinforcement leads to deterioration in the target behaviour, one can conclude with a high degree of certainty that the observed changes are functions of the treatment. The replication of the A-B-A design in other subjects further strengthens the conclusion as to the power and controlling forces of the treatment.

This phases of the research design can be summarised thus: Baseline (A phase) is followed by therapy (B phase) consisting of counselling with token reinforcement which is followed by withdrawal of reinforcement (A phase), while self monitoring continues. Baseline lasted two weeks after archival record investigation. Treatment lasted twelve weeks and withdrawal lasted another two weeks.

The counselling strategy adopted was eclectic because an integrated theoretical position was needed to interact effectively with the deviant youngsters. Thus rational emotive therapy of Ellis Roger's client-centred therapy and Gestalt therapy were the major counselling approaches used.

3.3 The Population

The population for the study was made up of all the 226 inmates in the Kaduna Borstal Institution. The Borstal Institution takes care of deviant youngsters of 16 to 25 years of age from different States of Nigeria. This age range is accepted for the study based on the views of Herbert (1987) and Okon (1988) that adolescence is a movable thumb and depends on maturation and culture; and Weideger's (1978) view that adolescence is not a biological status like puberty which sets in at the age of 12 and ends at 19, but that it is culture dependent. The age bracket is acceptable also because below 16 years of age children are not accepted in the Borstal Institution, and Kaduna Borstal Institution is the only one in the country.

3.4 Sample and Sampling Procedure

In order to select traumatized youngsters from a population of 226 maladaptive youths of Kaduna Borstal Institution, stratified sampling was first done to pick those who could read and write in English. These were found in the Senior Secondary Classes and the Junior Secondary three class. This measure was necessary because inmates were to fill their

questionnaires, read, understand and fill the self monitoring cards, and discuss with the researcher in English. Seventy four literate inmates became the sample for the first part of the research. This was deemed adequate because to employ the help of an interpreter in this type of study would be too cumbersome and could introduce extraneous variables into the study. It was thought that if necessary, the research could be replicated in vernacular for those who could not join this group.

The sample size for the first section of the study was 74. This number was further stratified into traumatised and non-traumatised groups using the responses from the questionnaire and the information from the archival records collected from the Borstal Institution. After analyzing the record and the questionnaire, 10 inmates qualified to become the actual sample for the self management exercise. This sample size was regarded as acceptable for this research because according to Hersen and Barlow (1977), in applied research like this one, sample size has to be small. They asserted that the researcher has to be realistic in determining variabilities in individuals who differ in terms of response to treatment within an enormously complex human environment. In many cases (Epstein and Hersen 1974; Walker and Buckley 1968; Herson, Eistein, Alford and Agras 1973) single individuals have been used for applied research studies as behaviour modification needs close and individualistic observation and follow up. Besides in this study, the 10 subjects were all that were qualified to be in the sample. The above considerations therefore justify a sample size of ten for the present applied research.

3.5 Instrumentation

Three sets of instruments were used for determining the applicability of self-management intervention techniques in modifying maladaptive adolescent behaviours

among traumatised youngsters. The first set aimed at selecting traumatized adolescents. These were self-report instruments of the subjects. Researchers have generally supported self-reports as valid sources of data regarding sensitive issues (Gelles, 1979; Lourie 1977, Hersen et al., 1973, Hersen and Barlow 1977: 131-132). Adolescents have however been noted to either minimize or exaggerate their chemical use (Harris 1980), so a data collection instrument that minimizes the interpersonal reactive effects of testing situation was deemed necessary. Similarly, those exposed to victimization tend to underreport (Meizelman 1978). So the same consideration applied regarding the need for anonymity in instrumentation.

The following instruments were used in the survey part of the study: (Appendix I)

i. Background and Current Status Inventory (BCSI) meant to find out the background of the inmates.

ii. Current Adolescent Behaviour Inventory (CABI) for determining the maladaptive behaviours exhibited by the youths.

iii. Critical Life Event Survey (CLES) to determine the number of traumatised persons in the sample.

All these are sections of a questionnaire and each section is short and capable of holding the adolescents' interest. Due to its nature, this study required a lot of data regarding previous experiences and current behavioral patterns. No existing test that has been normed fits the requirement of the study. Instruments found on drug abuse were too long and cumbersome to be included in this test package without seriously compromising the inmates' ability to complete the testing. Instruments then had to be designed to meet the test situation. Another requirement was that the test had to be understandable to the adolescent and sufficiently non-threatening so as to encourage truthful responses. The construction of

instruments raising self rating scales was considered valid and reliable because self rating scales have been widely used within the last two decades (Parker, Parker, Brody and Schoenberg 1982, Johnson 1989).

In constructing instruments for this section of the research, Johnson's (1989) method was relied upon though it was not taken verbatim, as the subjects were not similar; and since responses to critical life experiences may differ with culture so also what may constitute trauma to youngsters may be slightly different in different cultures. Items that were thought to be irrelevant to the Nigerian youths were eliminated and those that were relevant were added to the Johnson's (1989) format.

3.5.1 Constructing the Critical Life Events Survey(CLES)

Adolescents are willing to discuss critical life incidents as observed by this researcher through dealing and counselling with adolescents. But this can happen only if they feel comfortable about the context. They need reasonable assurance of confidentiality and a place where they will not have to make public display of their misfortunes. But perhaps more important, they need an organized format in which to present their experiences which can be quite complicated and confusing. They need terminology that is clear and unambiguous. For these reasons an adolescent advisory committee was formed for the construction of C.L.E.S. This was made up of 20 youths whose records in the guidance counsellor's office and disciplinary records in their school portrayed them as deviant. These youngsters come from the Senior Secondary Section of Demonstration Secondary School, Ahmadu Bello University, Zaria. They were chosen partly because their ages ranged with those of the sample of the study and partly because having maladaptive behaviours themselves they could understand what maladaptive youngsters feel. This peer advisory

committee helped construct the questionnaire and determined the language appropriate to it. The 20 youths began by brainstorming the range of events that could befall young people in their process of growing up and that would possibly be traumatic. Similar events were then consolidated, extremely fanciful and widely improbable events were eliminated from the list. The remaining items were ordered according to the group's perception of the severity of the event. Terminology was examined to ensure accessibility and clarity. Finally sixteen items were chosen. Some questions were formulated with 'yes' and 'no' answers using a Likert type scale or in the case of age with numerical answers. These questions were then placed on a grid format so that the respondents could first indicate whether a specific life event had occurred and then answer the various questions concerning that event. The items were then tallied with Johnson's (1987) items for correlating maladaptive adolescent behaviours with childhood trauma. As they were similar, they were all retained.

3.5.2 Constructing the Current Adolescent Behaviour Inventory(CABI)

Literature has shown that self-report has been an acceptable instrument for research but they are mixed about its validity since, as can be expected in maladaptive behaviour situations, subjects have the tendency to underreport cases of sexual abuse and over report cases of drug abuse. On the other hand, for the purpose of sampling the general population, self -reports are the best available (Kidder et al 1976). In order to obtain the most reliable self report possible, the twenty adolescents from Demonstration Secondary School who are identified by the school counsellor as maladaptive from her record were also involved to help construct a non-threatening inventory for this section. On the groups advice the respondents were allowed to evaluate their own maladaptive behaviour patterns. They were to determine the extent of their behaviour, for instance whether their drug use is "heavy" or

their suicidal ideation is "occasional". The number of questions were also reduced to the minimum on their advice. Likert-type scale responses were adopted to allow frequency data to reflect the extent of involvement in the particular behaviour.

3.5.3 Constructing the Background and Current Status inventory (BCSI)

Questions regarding parents' social and economic status and family structure were asked, as well as age and sex. With the exception of age, all responses required only ticking in appropriate spaces.

3.5.4 Procedure for questionnaire administration

The three inventories described above are sections of a questionnaire, forming a package. The questionnaire was administered to the subjects in their classrooms by the researcher and four staff research assistants. The assistants had been trained to answer questions from the respondents and to review the questionnaire upon completion in order to ensure as few missing answers and incomplete responses as possible. The questionnaire was administered to whole classes of junior and senior secondary three to minimize the pressure to withhold information. Names were omitted in order to ensure anonymity.

3.5.5 The self- management intervention instruments

Literature suggests that government interventions among deviant youngsters do not yield positive and long term behaviour modification in the youths concerned. This instrument was chosen in order to produce positive and enduring change in some areas of the traumatized deviant adolescents' lives. Researchers have recommended self-management as a strategy for promoting enduring client behaviour changes through self-directed management. It is also accepted as being "very useful in dealing with a number of client problems and may promote generalization to life settings of what clients learn in the

interview"(Hackney and Cormier, 1979). The strategy is also accepted to be "among the best strategies designed to strengthen clients investment in the helping process" (Hackney and Cormier, 1979)

The self-management instrument was made up of four steps: self-esteem level determination, self-contracting, self-monitoring and token reinforcement. After identifying the sample, group counselling was done. This was meant for structuring the inmates, getting them familiar with the researcher and for bringing them to realistic terms with their situations. At the termination of group counselling an instrument designed to determine the subjects' self-esteem level emerged.

3.5.5.1 Self-esteem Questionnaire (appendix III)

This was a short instrument with four sections and was designed in a both-directional format to counter the bias of "yeasaying and naysaying" and demand characteristics of experimental situation. The instrument aimed at tackling the behaviours and responses emerging from the group counselling. So a premade instrument would not have been adequate. It was therefore, designed by the researcher. The four areas considered by this short questionnaire were: whether the subject liked himself, whether he was satisfied with his present state of life, what his weak and strong points were, and what his ideal self was. These four areas could determine the subject's basic self-concept. The self esteem responses,the archival record materials and the responses from CLES AND CABI were used together for selecting the baseline behaviour of the subjects. They together made it possible to pin a subject down to his particular base line maladaptive behaviour.

3.5.5.2 Self Monitoring

Self-monitoring exercises were designed between the researcher and the individual

subjects, taking care to minimize reactivity. Behaviour to be monitored were selected depending on which behaviour a subject cared to tackle. Subjects were to count the frequency of responses in their self-monitoring cards as used by Johnson and White (1971) and Allen et al., (1964). Self-monitoring was done during baseline (A), treatment (B) and withdrawal (A).

The subject was to monitor himself on a maladaptive behaviour he counted as his weak point. He was to tick in the card everyday whenever he exhibited (baseline) or he resisted (treatment and withdrawal) the target behaviour. He had to bring his card every morning to the staff research assistant who would record his ticks for the previous day and release the card to him. The target behaviours were clearly defined and narrowed down so that overlapping of events was avoided. Thus fighting was defined as angry physical combat such as holding, slapping, tearing, scratching, biting and the like. Smoking was defined as getting hold of cigarette, lighting it, putting it in the mouth and puffing out smoke. "Crossing is a term used in the Borstal Home to mean breaking bounds and leaving the institution premises for a long period without permission. This can be termed running away if the inmate does not come back on his own and has to be fetched by the wardens. The three target behaviours monitored by the subjects were fighting, smoking and "crossing". After agreement on their definitions between the inmates and the researcher the maladaptive behaviours were entered in the card which the inmate kept and columns were allocated for each day. In addition to self-report card, a participant observer selected by both the researcher and the staff research assistants carried a monitoring card similar to the inmate's card. The instrument was for a motoric measurement of the inmate's target behaviour. Each subject had an observer. The motoric measurement was meant to control impression

management and faking on the part of the subject. The participant observers also brought their ticks to the staff research assistant everyday for entering. The two instruments made use of in the baseline monitoring session were the inmates self-monitoring card and the observers' monitoring card. (App IV A & B).

3.5.5.3 Self-contracting instrument (appendix IV C - F)

After the base line monitoring, the subject decided to modify a target behaviour. The instruments used for that was self-contract/monitoring card. This was an index card designed to instruct the subjects on why and how he should fill the card, since the subject had contracted himself to wean himself of the target behaviour thereby modifying that behaviour. The instruction on the subjects' card required them to tick the cards right each time they successfully avoided the target behaviour. The independent participant observer who stayed in the subjects dormitory and was in his class carried similar cards and recorded his observations of the subjects' behaviour modification.

The avoidance of target behaviours was clearly categorised and delineated. Resistance to smoking was defined as getting close enough to see and touch cigarette, but walking away without touching it. Avoidance of fighting was defined as being provoked with abusive angry words, responding or not responding to such words but walking away without physical combat. Avoidance of "crossing" was defined as being outside the boundary of the institution, having the opportunity to go away without permission but returning to the premises. The frequency of "crossing" and smoking depended on opportunity as the Borstal Institution is not fenced and there are access routes to a nearby prison yard and town where cigarettes and even drugs can be obtained. Frequency of fighting depended on being provoked by or provoking others. Since there was no naturally

occurring frequencies for these behaviours like sleeping and waking, which are controlled by night and morning, and since the boys may not have access to reliable time piece the time unit for recording frequencies was 24 hours broken into morning time, afternoon time and evening/night time. Paper and pencil recording facilities were provided to both subjects and observers. These materials were flexible and portable and very easy to understand (appendix IV).

Observers were given numerous opportunities to practice before they were required to start recording in the actual study situation. This was done to make them familiar with the data sheet. They were as much as possible monitored by the staff assistant to ensure that they did what they were meant to do. Such monitoring helped to eliminate interaction between the observers and the subjects. Observers had to be selected among the senior boys to eliminate intimidation by the subjects. They were given index cards which were inconspicuous. The observers were advised to have their cards in their pockets and not expose them to other inmates. They were not to disclose themselves as observers either. For all these they were well paid and made to feel as part of the corrective system rather than of the problem of Borstal Home. This greatly enhanced their cooperation with the researcher. Since they themselves were first trained to monitor themselves and record their gains in behaviour modification, they discovered that it "worked" and so were excited about applying it on others. This agreed with Bijou et al., (1969) that observers may be quite reliable when they are aware that they were being monitored. The staff research assistants monitored the observers carefully. In summary the instruments used for the study were the initial questionnaires consisting of Critical Life Events Survey (CLES), Current Adolescent Behaviour Inventory (CABI) and Background and Current Status Inventory (BCSI), self

esteem inventory, inmates self monitoring cards and observers' data card.

3.5.5.4 Reinforcement

Token reward was used as an external reinforcement aimed at increasing the occurrence of the desired behaviour. The subjects were allowed to select appropriate rewards from a list offered by the researcher for themselves - things that are truly reinforcing. Rewards were current, potential, material, and verbal-symbolic ones depending on the behaviours required to be achieved. Rewards selected were acceptable to the subjects and were something they wanted for example, slippers or body cream, or even "you have done so well this week. Congratulations".

3.6 Data Analysis

Part one: CLES and CABI: The data collected from these instruments were annualized into frequencies and percentages and were used for identifying traumatised youngsters.

Part two: (a) Self-esteem level data were annualized into frequencies and percentages too.

(b) **Self-management and motoric measurement data:** since self-report is prone to biases of faking an impression management, motoric response system was used to determine the reliability of the subjects' self-report. Both the self-report and the independent participant observers report (motoric measurement) were correlated using Spearman's rank order correlation technique. The formula

$$p=1 - \frac{6 \Sigma D^2}{N (N -1)}$$

was used where N = Number of cases and

D = Difference in ranking.

(c) **The baseline, the treatment and the withdrawal data.** These data were arranged into frequencies which were used in drawing graphs. Behaviour modification trends were read from the graphs.

(d) **Hypothesis testing:** The t-test statistic at 0.05 level of significance and 12 degrees of freedom was used to test for the difference between baseline behaviour mean scores and those of the treatment, as well as those of the withdrawal state. Hypothesis was tested for individual subjects since the research design is multiple-single-case in nature.

3.7 Validation of the Instrument

Pilot Study

The instruments used in this study were pilot tested for adequacy of direction, clarity of questions, content concept and administrative time. From the response got from the pilot study, language used in the items were adjusted. The pilot study also revealed that not all adolescent behaviours regarded as maladaptive by the adults are really so, and that among deviant boys there are traumatized ones. More importantly the pilot study was used for establishing the validity of the instrument.

Validity

According to Coffman (1971), in educational measurement, the validity of a testing instrument is a sufficient qualification for it's use as a testing material. In this study the instruments were validated in a number of ways. The survey instrument was constructed with the help of a team of adolescent advisory board. This became necessary because the society of the deviant is a closed one and it is impossible for those who are outside it to feel

the way they do. Twenty youths who were termed maladaptive in the normal secondary school helped to construct a non threatening anonymous instrument for the survey section of the research. They brainstormed and selected such incidents as can be termed traumatic as well as serious maladaptive behaviours. They advised that it is only the deviant that would likely state the level of abuses that they have engaged in, so they should be asked to state their level of maladaptive behaviours. The board therefore selected an adequate content for the instrument. The instrument was compared with that of Johnson (1989) which was used for correlating childhood trauma and adolescent maladaptive behaviours. They were similar. The self-monitoring cards were constructed as recommended by Hackney and Cormier (1979).

All instruments were finally passed through a team of experts who scrutinized them and gave their comments and corrections which were implemented. The self-management instrument was pilot tested in the Borstal Institution among the senior boys because the prison situation under which they live is not replicable outside. This did not in any way contaminate the instrument as these boys finally became part of the research team. After the instruments had been passed through the above content and face validation they were considered acceptable for use in collecting data for the research. Reliability and validation of various instruments are fully discussed in the next section on the Limitation of Study.

3.8 Limitation of the Study

In order to assess the specific limitation of the study possible sources of invalidity were explored and refuted.

3.8.1 Possible threat to internal validity of the survey instrument

For the first section of the study the only instrument used was the questionnaire. This remained constant across the group being tested. One possible source of instrument invalidity was the procedure involving help in filling in portions of the questionnaire that some subjects may have found confusing. The subjects were free to choose either the researcher or any one of the assistants to provide clarification. The risk of contamination was controlled by training of the assistants on how to clarify each question and how to project a warmly empathic but neutral position regarding content items. Missed responses were minimized by visual check by assistants, but subjects were first shown how to fold the questionnaire in a way to hide content from the assistants view.

Another possible source of instrument invalidity concerns the reliability of the instrument itself. It was not known whether subjects would answer items concerning critical incidents the same way upon retest. This problem was compounded by the nature of the material being sampled. Obtaining a test-retest reliability coefficient would not be helpful in this case because the contaminating reactive effects of testing Pretest/posttest difference on retrospective self-report regarding material of a highly sensitive nature are quite likely to differ. Taking the test for the first time could well initiate a process of further recall within the subject. This has been termed the 'preamble effect' by Cantril (1944) in his discussion of measurement of change agent. The issue of adequacy of the instrument reduces to whether other methods (such as open - ended question, personal interviews or interviews with others) would likely be better. It was determined that the value of anonymity as well as the structure and the focus of the questionnaire offset the possible values of interviewer rapport or a more open-ended questionnaire. Further, interviewing others or searching records presented

practical difficulties due to the fact that subjects were from all parts of the country. It would be almost impossible to find the relevant others to interview.

3.8.2 Selection of Subjects

As to the extent to which the sample adequately represented the population of adolescents in Nigeria, it must be made clear that Nigeria has one Borstal home which is in Kaduna, and deviants convicted all over the country are sent there. It is believed that any random sample got from such a place should be representative of the population. Consequently the result of the study can be generalizable to the whole country.

3.8.3 Reactive effect of experimental arrangement

Of the several possible methods of sampling the data the format of anonymous questionnaire was adopted on the following basis; First some information about critical events involving unpleasant memories and associations; subjects are likely to be unwilling to disclose such sensitive information publicly because of fears of stigma, embarrassment and rejection. To talk about an event with another person somehow raises a new issue of the meaning of the event and the adequacy with which one dealt with it then and now. Further description of current behaviour frequently amounts to admissions of guilt, (legal or moral) and raises fears of social or legal consequences as well as personal rejection by the interviewers. For this reason an anonymous questionnaire was chosen because that would be most likely to elicit accurate information by minimizing reaction of nondisclosure to the social pressure of interviewers. Second, scaled responses as well as checklists were constructed to help subjects in organizing and presenting their experiences. This was deemed necessary because of inhibit effects on memory and expression of painful or embarrassing experiences. Finally, in order to minimize the reactive effects of perceived

adult censure, youth corps research assistants assisted in administering the questionnaire and were available to answer questions regarding items and procedural clarification. These experimental arrangements were adopted as recommended by the panel of peers who helped construct the questionnaire and were asked to comment on how the research could be done in a non-threatening way. It was felt that the above arrangements maximized the likelihood of sampling accurate information and minimize the possibility of reactive effects contaminating the data. On the basis of the above arguments, it was considered that the study design remained sound and the result generalizable.

3.8.4 Possible threats to the validity of the self-management instrument

Internal validity of a research design such as this can be threatened by history, maturation, testing, instrumentation, experimental mortality and reactive or Hawthorne effect. Other biases that may be peculiar to this study which uses self report are demand characteristics of the therapeutic situation, impression management and faking, "yeasaying and naysaying" and observer bias. In this section, the various validity and reliability problems are tackled.

3.8.4.1 Internal validity of self management instrument

The A-B-A multiple single case study design is so called because though 10 subjects are studied, each is taken individually. So the design is multiple and experimental in nature. Therefore, it can be prone to the validity problems of experimental studies, namely, history, maturation, testing, instrumentation and reactive effect. But the long sequence of observation and repeated measurement provide information that rule out all such threats except, perhaps, history. For an example, if a marked difference between observations is due to, say testing, it is possible to inspect all other intervals before and after that point to look

for testing trend and accept or reject it (Kidder, 1976:80). Therefore, the multiple nature of the instrument is able to take care of the internal validity. Even the factor of history was strictly watched during the study period through the multiplicity of observations.

3.8.4.2 Demand characteristics artifact

Demand characteristics refers to a situation where experimental subjects respond in accordance with the experimenter's hypothesis and expectation as soon as they become aware of their existence. Studies by Horton, Larson and Master (1972) and Johnson and Lobitz (1972) indicate that even data obtained under naturalistic conditions may be affected by this artifact. In this research, this artifact was controlled in two ways, namely, withdrawal strategy and introduction of motoric response system. The motoric measurement was correlated with the subjects' self reports. Besides, the hypothesis of the study was not disclosed to the inmates and this too helped to counter demand characteristic in this area.

In the case of the self esteem level of the inmates, both -directional question format were introduced at the point of ideal self. These control methods ensured that resulting data reflected changes due to treatment variables per se, rather than the artifact of demand characteristics of the therapeutic situation, Barlow et al., (1972) used some of these control methods and came out with reliable results.

The multiple nature of the design permits the investigator to test the plausibility of several rival explanations of result. It also provides identical information about other subjects and thus permits one to test the threat of history. If treatment coincides with events going on in the Home which could influence the behaviour of the subjects, if all subjects are exposed to it, the effect of such incident should appear in all observations. If it does not, then history is not the cause of the effect.

3.8.4.3 Impression management and faking

Impression management and faking is a situation where subjects give self report that will favour them. In the present study impression management and faking may be said to occur if the inmates report resistance to the target behaviour during the treatment phase while they have not actually avoided the target behaviour. Akin to faking bias is the social desirability bias in which the subject responds to items in terms of what is socially acceptable, like avoidance of smoking.

During the self-management section of the study, the above biases were controlled by using long duration and continuous monitoring recommended by Braginski and Braginski (1967). Inmates monitored themselves continuously in a 24-hour-day before submitting their card to the staff assistant. The staff assistants also had their eyes on the inmates as it had previously in the literature (p.60) been noted that this type of study has to be a team work to achieve maximum success. The controls ensured the reliability and validity of the self-management instruments. On the bases of all the above considerations it was concluded that the study design remained sound and the result generalizable.

3.9 Summary

In this chapter the research design was discussed, the population was described and the sample and sampling procedure were treated. The instruments were fully discussed. The data analysis procedure was illustrated, pilot study was discussed and the limitation of study was also fully examined.

CHAPTER 4

DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

In this chapter the data collected for the study are analyzed and discussed and the findings are stated. The research was carried on in two parts so the findings are also discussed in two parts, namely: the survey and the experimental sections. The following are the contents of the chapter.

Part one: The survey section which includes Adolescent critical life events, Current adolescent behaviour inventory.

Part two - Self-management therapy, consisting of :

- determination of self esteem level
- baseline observation
- individual counselling and self contracting
- monitoring and behaviour modification
- graphical representation of individual behaviour modification rating, and
- hypothesis testing.

4.2 DATA PRESENTATION

4.2 Part One: The Survey section

4.2.1. Adolescent Critical Life Events Survey (CLES)

The 74 literate inmates of the Borstal Institution were the sample for part one of the study and the survey questionnaire was administered to them. Seventy four copies of the

questionnaire were distributed by the investigator and four trained staff research assistants who helped the subjects in explaining the questionnaire and seeing that as little mistakes as possible were made, and as few as possible items were left unattended. 74 questionnaires were completed and returned. The following table is the data on the spread of traumatic experiences among the subjects.

TABLE 4.1 THE FREQUENCY OF TRAUMATIC EXPERIENCES AMONG SOME INMATES OF KADUNA BORSTAL TRAINING INSTITUTION (FROM CLES)

Frequency of traumatic Experiences Passed Through N = 16		No. of inmates Passing Through Them
No. of Experience	Percentage	
16	100	0
15	93.75	0
14	87.5	0
13	81.25	0
12	75	1
11	68.75	2
10	62.5	4
9	56.25	2
8	50	1
7	48.75	17
6	37.5	7
5	31.25	13
4	25	9
3	18.75	7
2	12.5	8
1	6.25	3

The total number of traumatic experiences listed in the questionnaire were 16. Inmates were to state those they had experienced. No inmate experienced 100 percent of the critical situations listed. No inmate experienced one or two. 64 of them had experienced three to seven critical life events. This ranged from 6.5 to 43.75 percent. Ten inmates experienced eight to twelve critical life events. Thus 10 inmates experienced 50 to 75 percent of the listed traumatic events.

According to Holms and Rahe (1967), the effect of traumatic experiences on any individual going through them is cumulative; they release on their victims life change unit (LCU). Death of someone close releases 63 L.C.U. and most of the subjects of this study had lost some one close. The authors emphasized that L.C.U. of 200 - 299 in a life may result in moderate crisis with 50 percent chance of illness L.C.U. of more than 300 results in trauma with 80 percent chance of illness. The 10 subjects mentioned above have undergone at least eight traumatic experiences in their teen age lives. It is considered that a young man who has undergone eight critical life incidents is very likely to be traumatized, going by Holms and Rahe's prediction. Eight to twelve traumatic experiences were accepted by the researcher as high enough to alter the subjects' normal life style. These 10 inmates who appeared to be highly traumatized therefore became the subjects for self-management therapy.

TABLE 4.2: POSSIBLE SOURCES OF TRAUMA AS REPORTED BY THE SUBJECTS OF THE STUDY

Sources	No. of inmates experiencing it	%
Parental divorce and separation	4	40
Parental neglect	4	40
Step-parent problems	3	30
Alcoholism in the family	2	20
Permissive up-bringing	1	10
Parental death	2	20
Assault by parents or peers	4	40
Previous encounter with the law Enforcement agents	3	30

Table 4.2 indicates that family pathology (displayed in various forms has been the major source of trauma among the subjects of this study. 40 percent of them have passed through parental divorce or separation; 40 percent parental neglect, and 30 percent step-parent problems. Alcoholism in the family was experienced by 20 percent of the subjects, assault by parents or peers was experienced by 40 percent of them and parental death by 20 percent. Permissive upbringing reported by another 10 percent is also family pathology because children need direction from authority figures in the family. Thirty percent experienced previous encounter with law enforcement agent prior to deposition to the Borstal Institution. This is more serious encounter than mere passing through the juvenile court. Some of them

have been in police custody for months, some have been paraded around as thieves but got rescued by the police.

It is important to note here that sources of trauma are not mutually exclusive. Some inmates had faced more problems than one. For instance, the people whose parents were divorced or separated also had step parent problems. Some of them have also been neglected and had problems with the law enforcement officers before coming to the Borstal Home. Family pathology seems to be the major source of trauma among these subjects. This agrees with Russells (1981) findings that parental divorce/separation, serious parental illness, severe parental alcoholism and parental death were the background stressors that led to running away. The findings here also agree with Coleman (1989) who include parental rejection, overprotection and unrealistic demand as antecedents of youthful maladaptive behaviours. Neglect and extreme parental styles according to Hebeison and Hedin (1981) are strong factors responsible for drug/alcohol abuse as these push adolescents into identification with peer groups. Robin et al., (1977) also documented increased incident of parental divorce and separation in the background of substance abuse adolescent. Barnes (1979) found higher rate of family pathology among solvent abusers. Family situations that are found to be significantly related to maladaptive behaviour are, victimization which is also rampant in step-parent problems, and loss during childhood are related to substance abuse (Klagsbrun and Davis, 1977, Harris 1980). When the maladaptive adolescent behaviours displayed by the subjects of this study are tallied with literature findings it becomes easy to see that the subjects were traumatized and that they exhibit prominent maladaptive behaviours as shown in Tables 4.3.

4.2.1.2 CURRENT ADOLESCENT BEHAVIOUR INVENTORY (CABI)

TABLE 4.3 : FREQUENCY OF MALADAPTIVE ADOLESCENT BEHAVIOURS. (DATA FROM CABI AND ARCHIVAL RECORDS)

Maladaptive Behaviour	No. Involved	%
Cigarette smoking	5	50
Indian Hemp smoking	7	70
Stealing	7	70
Hard drugs-addiction and pushing	5	50
Runaway	5	50
School attendance problem	10	100
Gambling	5	50
Dangerous fighting	7	70
General rebellion against instituted authority	10	100
Murder	2	20
Laziness	7	70
Alcoholism	9	90

Table 4.3 indicates that all the inmates studied have been rebellious against instituted authorities, and have had school attendance problems. Seventy percent (70%) of them have been involved in Indian hemp smoking while fifty percent (50%) were involved in cigarette smoking. It is not surprising that fewer of them smoke cigarette since, in drug use, victims graduate to the use of harder drugs as they remain longer in drug abuse habit. Fifty percent

(50%) of the inmate studied were either drug addicts or were themselves selling and smuggling the drugs. They confessed that to deal in drugs one must take the drugs as a means of advertisement. Those of them who "pushed" drugs were also addicted to them.

Fifty percent (50%) of the subjects were runaways. Some of them spent much of their times in club houses or in hotels gambling (50 percent) and drinking. Ninety percent (90%) of them have actually been alcohol drinkers in varying degrees. Twenty percent (20%) of them have murdered during drug business according to their verbal reports and archival records.

Obviously few of these kinds of people would be hardworking. So 70 percent of them had records of laziness. 70 percent were violent fighters. They exhibit this maladaptive behaviour in the Borstal Home frequently as will be seen later in part two of the study. The display of maladaptive behaviours recorded in the Kaduna Borstal Home agrees with both those recorded in the literature (Herbert 1987; Nilson 1981; Lichter et al., 1962), and those accepted in the Nigerian government agencies that handle cases of maladaptive youths (Luka and Shalangua 1995). But the list of the inmates maladaptive behaviour goes beyond the literature in that some of the inmates have committed murder.

This has introduced a new dimension to the series of maladaptive behaviours among Nigeria youths. Suicide ideation was mentioned by some but there was no record or indication of suicide attempts, despite their seemingly hostile home environments, which literature has associated with suicide (Teicher, 1979). Probably the lack of suicide attempts among the subjects might be associated with the fact that they have become so notorious that fear of failing would have no effect on them. Lustig and Zeitlin (1985) found relationship between enormous fear of failing with separation anxiety and suicide. These subjects may

have been so used to failure and anxiety that they do not drive them (the subjects) towards suicide any more. Besides, suicide, though it occurs from time to time in the Nigerian society, majority of Nigerian youths do not seem to consider it the solution to their problems.

The first section of the research has determined the frequency of traumatic experiences the subjects have passed through. It has also determined those that are highly traumatized, who have now become the subjects for the next stage of the study. Although many factors have been suggested by experts as being antecedent of adolescent maladaptive behaviours, this study selected trauma among them for the testing of the efficiency of self-management therapy as a method for behaviour modification. The section treated sources of trauma and identified the various adolescent maladaptive behaviours exhibited by the inmates in Kaduna Borstal Institution. The next section is the self management therapy starting with group counselling.

4.2.2 Part two: Self-management Therapy

The information and discussion on self management therapy are presented under the following sub-headings:

- **Group Counselling**
- **Determination of self-esteem level**
- **Baseline Observation**
- **Individual Counselling and Self-Contracting**
- **Self-monitoring and Behaviour Modification**
- **Graphical representation of individual behaviour rating**
- **Hypothesis testing**

4.2.2.1 Group Counselling (Appendix V)

Group counselling lasted four weeks. Rational emotive therapy technique was applied at this phase of the therapy. The group counselling helped in structuring the inmates getting them familiar with the researcher and bringing them to realistic terms with their situations. In the process of group counselling the inmates got to know the importance of positive self concept. They were allowed to discuss freely on self concept and self-esteem and about various experiences and how those experiences could affect one.

There was general encouragement that despite the mistakes one has made and the contribution of significant adults in the family, and the societal treatment of any person, there is hope if such a person can alter his thinking, and begin to think rationally of himself and his experiences. At the end of group counselling inmates were given a short questionnaire which helped the researcher to determine their level of self-esteem. This level of self esteem was meant to help the researcher in individual counselling and determination of behaviour to be modified.

4.2.2.3 SELF-ESTEEM LEVEL

The inventory on self-esteem rating had four sections. The questions were organized in both directional format to counter the problem of "yeasaying" and "naysaying". The four sets of data collected from this inventory are shown on table 4.4.

TABLE 4.4 : RESPONSES TO SELF ESTEEM LEVEL OF SOME INMATES OF THE KADUNA BORSTAL TRAINING INSTITUTION

	Item	Frequency	%
4.4a .Self appreciation Level	Love self	7	70
	dislike self	3	30
	Total: Frequency = 10, % = 100		
4.4b Satisfaction with present state of life	Satisfied	0	0
	not satisfied	10	100
	Total: Frequency = 10, % = 100		
4.4c Ideal self	Positive ideal self	1	10
	Negative ideal self	9	90
	Total: Frequency = 10, % = 100		
4.4d Weak points	Bad temper and fighting	7	70
	Smoking and stealing	2	20
	Lack of self control and breaking bounds -"crossing"	1	10
	Total: Frequency = 10, % = 100		

The four sets of data point to one thing, self concept and self esteem rating of the inmates. Seventy percent (70%) of them expressed self love in terms of their looks and what they can do, like playing football. But when asked whether they were psychologically satisfied they joined the 30 percent that did not like themselves to reject or dislike their present state in life. None of the subjects liked the confinement and treatment received in

the Borstal Home. None of them wished to remain in that condition. When they were asked to make a choice if they were given the opportunity for a change, 90 percent of them made negative choices, for an example, refusing to go to school in the belief that the brain can no more absorb formal education. The interpretation of this is that the inmates have low self esteem and low self concept since they seem not to be able to make constructive choices.

To establish the level of reform they have acquired in the reformatory so as to determine what behaviour to modify they were asked their present weak points. Seventy percent (70%) of them seem not to have learnt the art of living in harmony with one another yet. Their weak point was fighting. In section one it was seen that one of the maladaptive behaviours with which they came into the Borstal Institution was dangerous fighting. Literature also signifies this as a recognized adolescent maladaptive behaviour in Nigeria as indicated by (Luka and Shalangua (1995). 20 per cent of the sample studied were still smoking and stealing. 10 percent had not yet acquired enough self control to stay in the premises of the institution. Such break bounds. The data in Table 4.4 were used as the bases for individual counselling and baseline observation.

4.2.2.4 Baseline Observation

Base line data were collected on the bases of the weak points indicated by the inmates. The self management therapy uses self report as the major data collecting instrument. But specialists in applied research and behaviour modification (Mcfall and Hammen 1971; Johnson and White 1971, Epstein, Miller and Webster, 1974, Stollach 1967) have outlined the many biases that can be encountered in self observation. In order to establish the reliability of self report collected from the inmates, independent observers were assigned to monitor them as well. The data presented in Table 4.5 are both the baseline data

supplied by the subjects and those supplied by the independent observers. Each inmate was observed by a separate participant observer. The data from the inmate and the observer were eventually correlated to obtain correlation coefficient between them. Each of the 10 inmates are treated individually from this point.

TABLE 4.5: SPEARMAN RANK ORDER CORRELATION OF MOTORIC AND SELF REPORT MEASUREMENT OF BASELINE BEHAVIOUR OF SOME INMATES OF KADUNA BORSTAL TRAINING INSTITUTION

S/N	Variables	Spearman r	Level of Significance
1.	Im1 vs OB1	0.85	.001
2.	Im2 vs OB2	0.71	.01
3.	Im3 vs OB3	0.68	.01
4.	IM4 vs OB4	0.84	.001
5.	IM6 vs OB5	0.71	.01
6.	IM7 vs OB6	0.64	.01
7.	IM7 vs OB7	0.92	.001
8.	IM8 vs OB8	0.36	.01
9.	IM9 vs OB9	0.76	.001
10.	IM10 vs OB10	0.87	.001

IM = Inmates self report measurement.

OB = Observers motoric measurement.

The data presented above indicates a set of significant correlation coefficients between the measurement of the participant observers and the self-report of the inmates at the baseline level.

The high correlations observed are similar to that of Williams, Barlow and Agrass (1972). These authors found the relationship of motoric measurements of depression by nursing assistant observers and self report of ten severe depressives. The correlation obtained ranged between 0.67 and 0.82. These are as relatively high as the ones obtained in this study. On the other hand, Cooke (1966) found as low a relationship as 0.35 between motoric measurement and self-reports of phobic undergraduates. The correlations obtained in this study are therefore not unusual. The high correlation between the inmates self-report and the motoric report indicated high reliability of the inmate data. As a result all the 10 subjects were admitted into the next stage of the therapy namely individual counselling and self-contracting.

4.2.2.5 Individual Counselling and Self-Contracting

Each subject met with the researcher once a week. They were divided into three groups for this purpose but each of them met the staff research assistant everyday to submit their self-contract cards. From the data collected in self-esteem questionnaire and baseline data it was evident that the subjects needed client-centred counselling (Rogers, 1951) because they seemed to view themselves as damaged persons and were ambivalent about trying new coping strategies. This agrees with Hackney and Cormier's (1979) views that rehabilitation counselling is client centred in nature.

The subjects appeared to be in dire need of acceptance and they appreciated it when given. This is understandable since for months, and sometimes years some of them have not

been visited by their parents, while some are usually sent provisions once a while through a junior sister or brother. The inmates appear to have got much of negative evaluation and judgment, too. The researcher therefore thought that the element of judgment should be eliminated. They were accepted by the therapist with unconditional positive regard, as recommended by Rogers, (1951).

As seen at the beginning of the individual therapy (app VI) the researcher needed to be genuine, down to earth and consistent. This was necessary because the subjects were already victims of many conflicts. It was necessary, for instance to introduce the therapist as a fellow human being with mistakes in order to identify with the subjects. More importantly the therapist had to act as a mother consistently.

Although it is impossible to fully understand the youths world, the counselling relationship in this case demanded that the therapist saw into the inside of the youngsters as they expressed their experiences. They were accorded enough empathy to allow them express themselves as fully as they could. Without such expression, therapy would not have been progressive. The acceptance, congruence and understanding had to be expressed to the subjects naturally verbally and non-verbally. This made them loosen up their feelings. Consistent structuring of the subjects made it possible to establish a close relationship between the researcher and the subjects who looked forward to their meeting days with the therapist. It was interesting to see that by using the above Rogerian techniques the youngsters unfolded their experiences and eventually discussed them freely. "Unfolding" is used here because initially they were unwilling to "communicate their experiences" to the researcher as they were fearing the danger of exposure to the Borstal Institution authorities. At the beginning of therapy they did not seem to desire change because they used their

different maladaptive behaviours as defence mechanisms.

In the second therapy period it was possible to allay their fears by telling them that the researcher had nothing to do with the government or the Borstal Institution. They were told that she was only a teacher who was interested in the affairs of young people and would like to see them straighten out and become real leaders of tomorrow. They were each encouraged to understand that the researcher was not judging them as it is normal for human beings to make mistakes. This and some other such persuasions helped them begin to freely express self-related experiences. But much of the times there was little or no acceptance of fault for those behaviours emanating from those experiences. It was most often their parents who were responsible for their bad behaviours. But both the researcher and each of them began to recognize some contradictions in their experiences. These contradictions were discussed. Through the discussion both past and present experiences were brought up.

At this point rational emotive therapy was enforced. The subjects were made to understand that things happen to us personally only when we behave in relation to them - when we construe them - not when we just react to them. They were then made to realize that whatever the contribution of significant people into their present situation were, they must have also had some part to play, possibly a greater part than the people they blame, otherwise the behaviour of those people would not have affected them so deeply.

Such explanations helped them to question the wisdom in their responses to their experiences. As differentiation of feelings increased, contradiction became a matter of concern to the subjects themselves. They began to see at what point they contributed to the problem they were facing. At this point, responsibility for behaviour problem were no more something to be denied, feared and resisted. They began to see their various maladaptive

behaviours as irrational and then contract themselves to wean themselves of and finally stop such behaviour. It is to be noted that all these discussions were verbal attempt to bring each inmate to understand the need to contract himself to resist maladaptive behaviour by himself. It was not data based because it was done individually using the same method in each case. The stages of the inmates response to therapy agreed with Roger's (1954) stages of personality modification. Thus these stages appeared to be acceptable as being genuine.

After each inmate had succeeded in contracting himself to modify a particular maladaptive behaviour, he was issued an index card (app IV C) to use in the daily self-monitoring. To establish the reliability of their records of behaviour modification, an independent participant observer surreptitiously monitored him and kept his own motoric measurement. Below is the correlation of the inmates' self-report measurement against the motoric measurement of the participant observers.

TABLE 4.6: SPEARMAN RANK ORDER CORRELATION OF SELF-REPORT VERSUS MOTORIC MEASUREMENT OF RESISTANCE TO MALADAPTIVE BEHAVIOURS

S/N	Variables	Spearman r	Level of Significance
1.	Im1 vs OB1	0.95	.001
2.	Im2 vs OB2	0.87	.001
3.	Im2 vs OB2	0.77	.001
4.	Im4 vs OB4	0.88	.001
5.	Im5 vs OB5	0.87	.001
6.	Im6 vs OB6	0.94	.001
7.	Im7 vs OB7	xxxxxxxxxxxx	xxxxxxxxxxxx
8.	Im8 vs OB8	0.93	.001
9.	Im9 vs OB9	xxxxxxxxxxxx	xxxxxxxxxxxx
10.	Im10 vs OB10	0.87	.001

Table 4.6 shows a high correlation between the inmates' self-monitoring and observer's motoric measurements. This indicates the reliability of the inmates self-report. Therefore, the inmates' self-report were regarded as authentic and were therefore used for the next stage of the study.

As therapy proceeded it became apparent that the attention of the parents of the subjects was needed so that parents and children might talk together with the therapist. This was because as seen in a previous section, family pathology was antecedent in most of the maladaptive behaviours. The copy of the letter sent to parents to visit the Borstal institution

for discussion among parents child and the therapist is in appendix VIII Two parents responded. One of them was the parent of inmate A3568.

During the first two individual counselling with subject A3568 the following were discovered, that:

- inmate A3568 was neglected by the father
- he was angry with the father for the neglect
- he resorted to stubbornness against the father.
- the father ignored and neglected him the more, out of his own anger.
- Inmate A3568 became more angry and resorted to rebellion which he showed by smoking, going with peers of dubious characters, fighting, stealing and refusing to go to school. Father got embarrassed and more angry and then dropped him in the Borstal Institution.

During therapy he was brought to see the irrationality of harming himself and his future because of parental neglect. He realized that it was more rational to go to school, develop himself and relate to the father, not as a dependent person; that he should use the opportunity given him by the father to develop himself and his independence. The therapist suggested his talking to his father so that the father may understand how he felt. Meeting was arranged and after communication between him and his father each person understood the other better. Mutual apologies were rendered. The father promised to find him a school and started negotiating for his release. He was eventually released and his therapy was terminated. This is why he has no correlation record in Table 4.6. In this case self-management therapy achieved its purpose, namely modification of subject A3568's behaviour.

Inmate A3564 also has no record. After the first two individual counselling encounters subject A3564 agreed to contract himself to reduce and finally stop smoking. He was given his index card. On the third encounter he returned the form unfilled. When asked why , he asserted that after both the group counselling and the first two individual sessions with the researcher he stopped smoking as he was reminded that even "Federal Government of Nigeria has warned that cigarette, smoking is injurious to health". He had now found out that cigarette smoking does him no good. All effort to make him fill the card failed. But it was not convincing that he had stopped smoking since there was no evidence from him. His observer brought some record. He said he had not seen him smoke so he ticked the whole week indicating resistance to smoking. There was nothing to compare his record with. One could have believed both of them. But in a research situation it is difficult to document inmate A3564's claims since there are no empirical data to show the claim. Therefore he was technically dropped. He voluntarily attended all his counselling sessions. But all along he was very bitter against his father. He stated that his father is an alcoholic who had shot him with a gun once, that he sent him into "drug pushing" which led him into drug abuse. But it was the same father that dumped him in the Borstal Home. He could not forgive his father. A letter posted to the father to come to the Borstal Home was not replied. The therapy of this subject was complicated by lack of home response. By the time therapy was ended along with all the others he was still wishing he could be allowed to revenge himself on his father. He was a difficult case. The remaining eight subjects proceeded into the next stage of the therapy for self monitoring and behaviour modification.

4.2.2.6 Self Monitoring and Behaviour Modification

Self monitoring and behaviour modification lasted 14 weeks. During this period

Inmate A3564 also has no record. After the first two individual counselling encounters subject A3564 agreed to contract himself to reduce and finally stop smoking. He was given his index card. On the third encounter he returned the form unfilled. When asked why , he asserted that after both the group counselling and the first two individual sessions with the researcher he stopped smoking as he was reminded that even "Federal Government of Nigeria has warned that cigarette, smoking is injurious to health". He had now found out that cigarette smoking does him no good. All effort to make him fill the card failed. But it was not convincing that he had stopped smoking since there was no evidence from him. His observer brought some record. He said he had not seen him smoke so he ticked the whole week indicating resistance to smoking. There was nothing to compare his record with. One could have believed both of them. But in a research situation it is difficult to document inmate A3564's claims since there are no empirical data to show the claim. Therefore he was technically dropped. He voluntarily attended all his counselling sessions. But all along he was very bitter against his father. He stated that his father is an alcoholic who had shot him with a gun once, that he sent him into "drug pushing" which led him into drug abuse. But it was the same father that dumped him in the Borstal Home. He could not forgive his father. A letter posted to the father to come to the Borstal Home was not replied. The therapy of this subject was complicated by lack of home response. By the time therapy was ended along with all the others he was still wishing he could be allowed to revenge himself on his father. He was a difficult case. The remaining eight subjects proceeded into the next stage of the therapy for self monitoring and behaviour modification.

4.2.2.6 Self Monitoring and Behaviour Modification

Self monitoring and behaviour modification lasted 14 weeks. During this period

inmates brought their self-monitoring cards to the staff research assistant who recorded their ticks every morning. At another arranged time various observers brought their observation cards to the staff assistant to also record their ticks against the inmate ticks. Once in a week the researcher collected the ticks and the weeks index cards and compared the two. The various ticks were discussed with the inmates. They were first given verbal reinforcement where the rate of resistance of maladaptive behaviour was impressive. Where there was no improvement there was no reinforcement and there was no rebuke either. But the inmate was asked the circumstances that led to his breach of contract. As the circumstances were discussed he was asked to think of what he could have done to avoid exhibiting the behaviour. He had to examine the situation and offer suggestions on what he could do any time such circumstances recurred so that he would not break the contract again.

Subjects were given material rewards if, for four consecutive days they did not break the contract. In the Borstal Home inmates are not allowed to handle money to avoid their misuse of it. So their material rewards consisted of items like soap, pomade, slippers, depending on individual choice. They were not allowed to receive food items. Therapy was extended for 14 weeks to allow the inmates opportunity to modify their behaviour gradually, count whether there was any benefit to themselves in terms of self concept and level of self esteem. The weekly evaluation with the researcher also helped them congratulate themselves if they had gained some respect and acceptance among inmate as a result of modified behaviour. At the end of 14 weeks graphs were drawn to compare inmate baseline and experimental data. The graphs for each inmate are displayed and discussed in figures 1 - 8.

4.3 Graphical Representation of Individual Behaviour Rating

This section deals with the frequency of the subjects behaviours. The following have to be noted about the graphs.

(a) The Baseline - A - is the natural frequency of occurrence of the target behaviour under study. The baseline lasted two weeks and the data are the two weeks daily mean.

(b) Increasing baseline indicates increasing maladaptive behaviour. Decreasing baseline shows deterioration in maladaptive behaviour. Increasing baseline is therefore a negative trend while a decreasing baseline is a positive trait.

(c) Treatment - B - is inmates self-report on the monitored target behaviour - it measures resistance to maladaptive behaviour.

(d) Increasing trend in B means increased resistance to target maladaptive behaviour. It is a positive trend. A decreasing trend during treatment phase shows deterioration in resistance to target maladaptive behaviour and is therefore a negative behaviour trend.

- The first set of graphs are the comparison of baseline and treatment data. The postulate of Herson and Barlow (1977) that when A and B phases run in opposite directions there is an indication of change in behaviour of the subject does not hold true in this case. If the A and B phases run in the same direction there is change in behaviour because the baseline illustrates exhibition behaviours while the treatment indicates resistance to maladaptive behaviour.

- The withdrawal phase A is a period of two weeks. It is resistance to target behaviour, but without reinforcement.

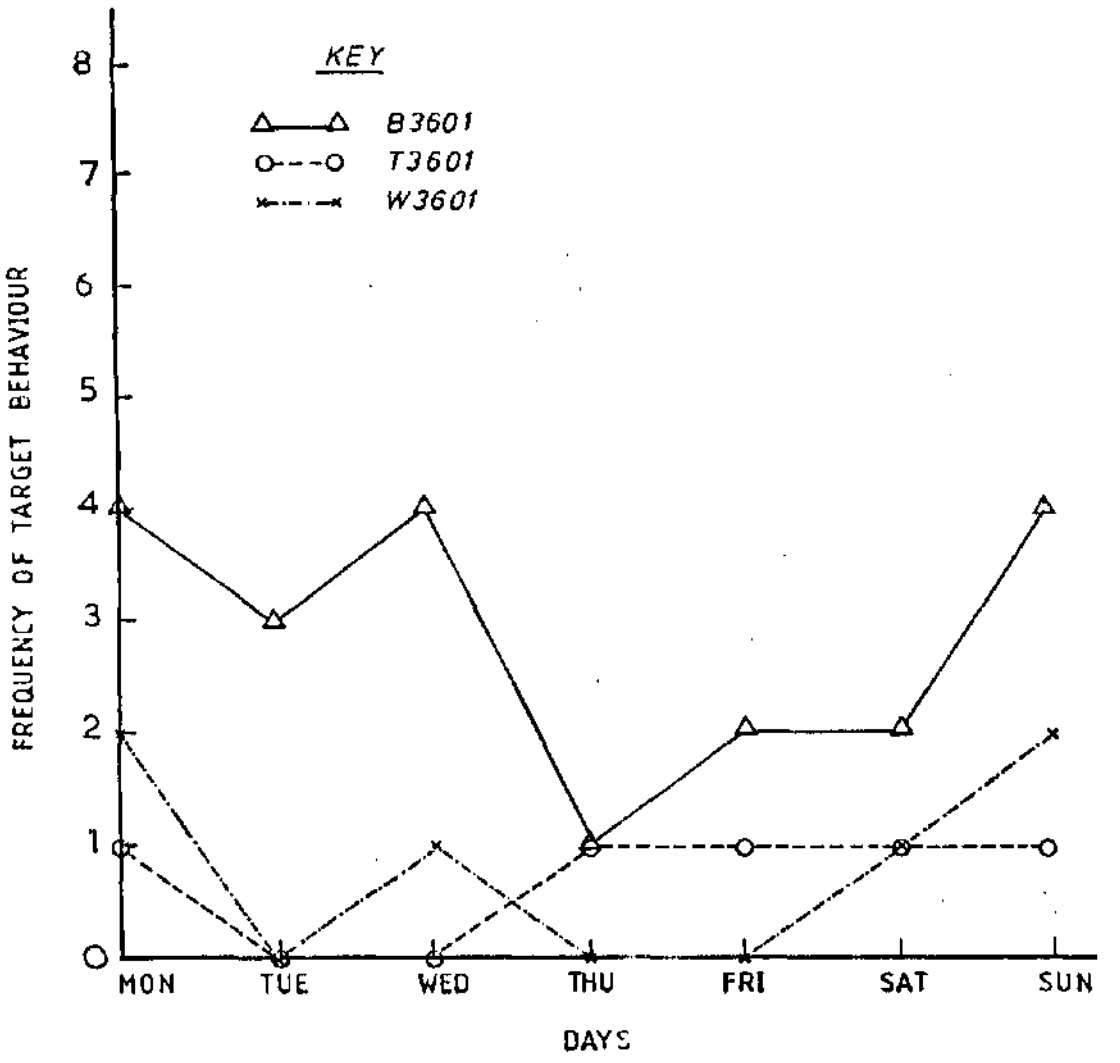


Fig • 1. Subject 3601: Self-management against fighting.

- If A persists as a continuation of B the subjects may have internalized the behaviour started in B and can continue to display it without reinforcement. If it is divergent with B, the interpretation may be that the modification in behaviour was due to reinforcement and when it was withdrawn the subject relapsed to the baseline behaviour. There could be another trend in which the graph assumes the B trend (treatment trend) but at a lower level than B. In that case it would be necessary to establish whether the level of behaviour modification is significant using statistical analysis. It must be remembered that the aim of rehabilitation counselling is not to make the client "well" or to "cure" the condition, but rather to achieve the highest level of functioning possible; and that the success of the self-management strategy is determined by the level of deviation from previous self destructive coping strategies and the ability of the subject to generalize what he learnt during treatment to life setting. Let it be noted here that straight line kind of improvement is not realistic since human behaviours are unpredictable and so reflect characteristics that vary with prevailing circumstances. A more natural situation would be some kind of fluctuating improvement or deterioration in the target behaviour. But whether improvement or deterioration has happened is indicated by the end of the graph.

4.3.1.Self Management Records of Subject 3601

Key to figures one to eight

B = Baseline

T = Treatment

W = Withdrawal of contingent reinforcements

This subject contracted himself to modify his fighting behaviour. figure one is the

graphic representation of his effort to keep the contract. Archival records and self esteem - self concept investigation established that the inmate fought frequently in the Borstal Institution. Baseline observation (Appendix IX) confirms that he fights three times a day on the average.

A careful examination of the baseline graph reveals a high fighting rate at the beginning, a decreasing trend and then an increasing trend. The baseline is relatively variable. This resembles "patterns frequently got in applied research" (Herson and Barlow, 1977 : 79). But the last three days clearly show increase in fighting. It is therefore possible to predict what the inmate's fighting behaviour would be if intervention is not introduced.

Implementing a programme of intervention has revealed a change from the projected increase in fighting. At the beginning of treatment provocation/fighting seems to drop from four to one a day. Later it dropped to zero a day. By the fourth day it rose to two and stabilized there.

Avoidance of fighting implies that subject did not provoke others into fighting him and he withdrew from fighting those who provoked him. Either way he has acquired self control as far as fighting is concerned. It can therefore be stated that the treatment has resulted in the modification of fighting behaviour. At the withdrawal of reinforcement there seems to have been slight increase in resistance to fighting. This suggests that the subject may have been exposed to more provocation. But he resists fighting. The withdrawal phase shows increasing resistance to fighting. The increasing trend of the graph suggests that the subject still controlled himself even when reinforcement has been withdrawn. This can be interpreted that his behaviour modification may not have been a function of reinforcement; that he has acquired and internalized a new behaviour that is different from his baseline

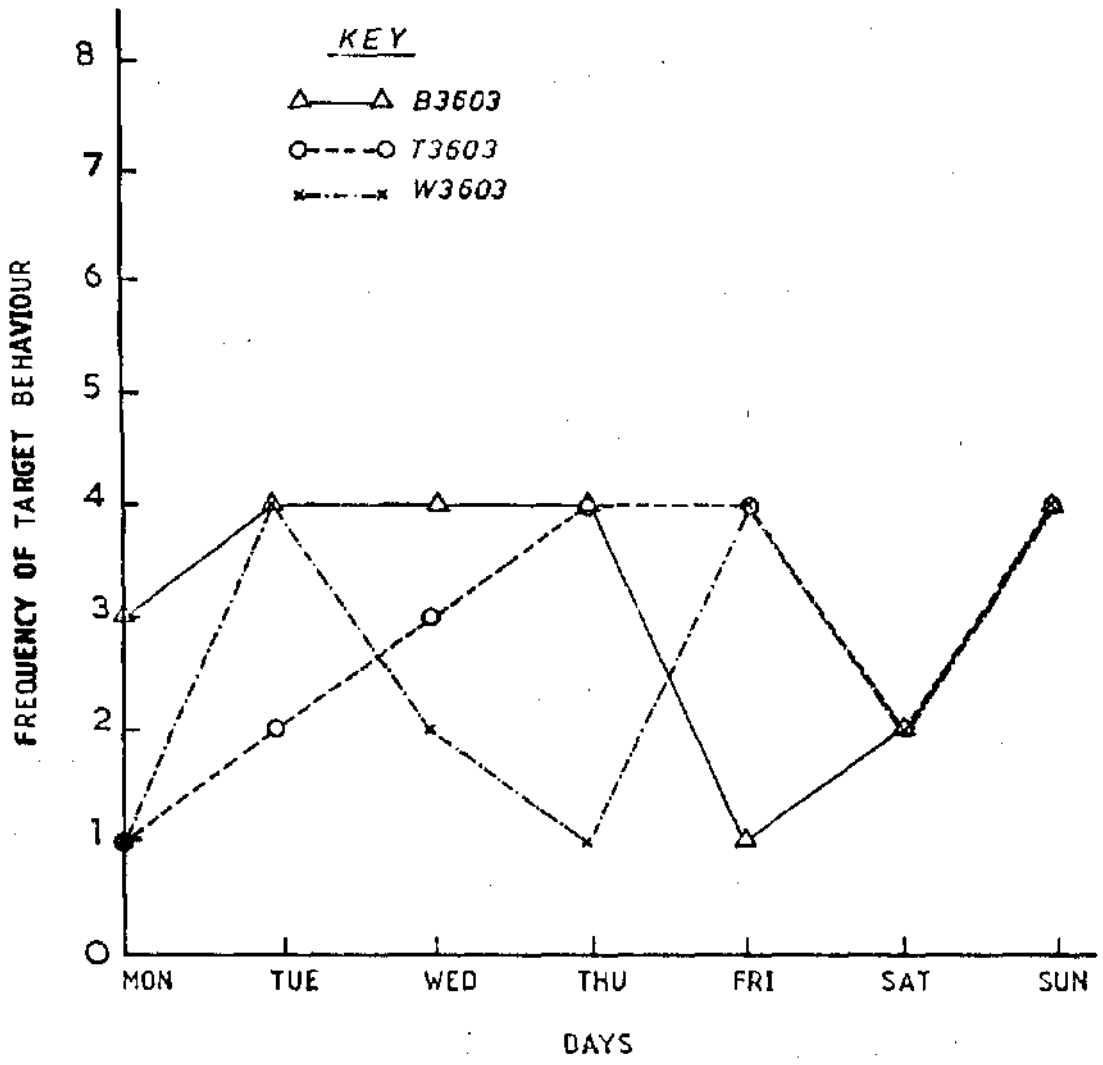


Fig. 2. Subject 3603 : Self-management against fighting.

behaviour. As far as this graph and this subject is concerned self-management therapy appears to have achieved behaviour modification, thus making the therapy efficacious.

4.3.2 Self-Management Records of Subject 3603

Figure two is the graphical representation of this subjects process of self-management. He contracted to wean himself of fighting and finally stop it. Before therapy he fought three times a day on the average. The baseline graph reveals a plateau of four mean fighting a day, then an increase. This predicts increased frequency of fighting for this inmate. During treatment, provocation/fighting dropped to one. This suggests that at the introduction of therapy the subject reduced his provocation of others and absorbed others provocation without fighting. His resistance to fighting remains on the increase as the treatment graph terminates on an increasing trend. Obviously the therapy has modified his fighting behaviour.

At withdrawal the graph shows an extremely variable trend. This indicates that the subjects fighting behaviour became erratic at the withdrawal of token reward. Nevertheless his resistance to fighting remains on the increase. The probable interpretation of this subject's behaviour is that self-management therapy has helped him modify his fighting behaviour at the treatment stage. Withdrawal of contingent reward seems to have given him some instability. But he seems to have evened out towards the end of the withdrawal period. It is hard to say with certainty what the effect of contingent reinforcement might have been in the case of this subject. But it can be said that self-management therapy aided his modification of his fighting behaviour and helped him remain modified, to some extent at the withdrawal of reinforcement.

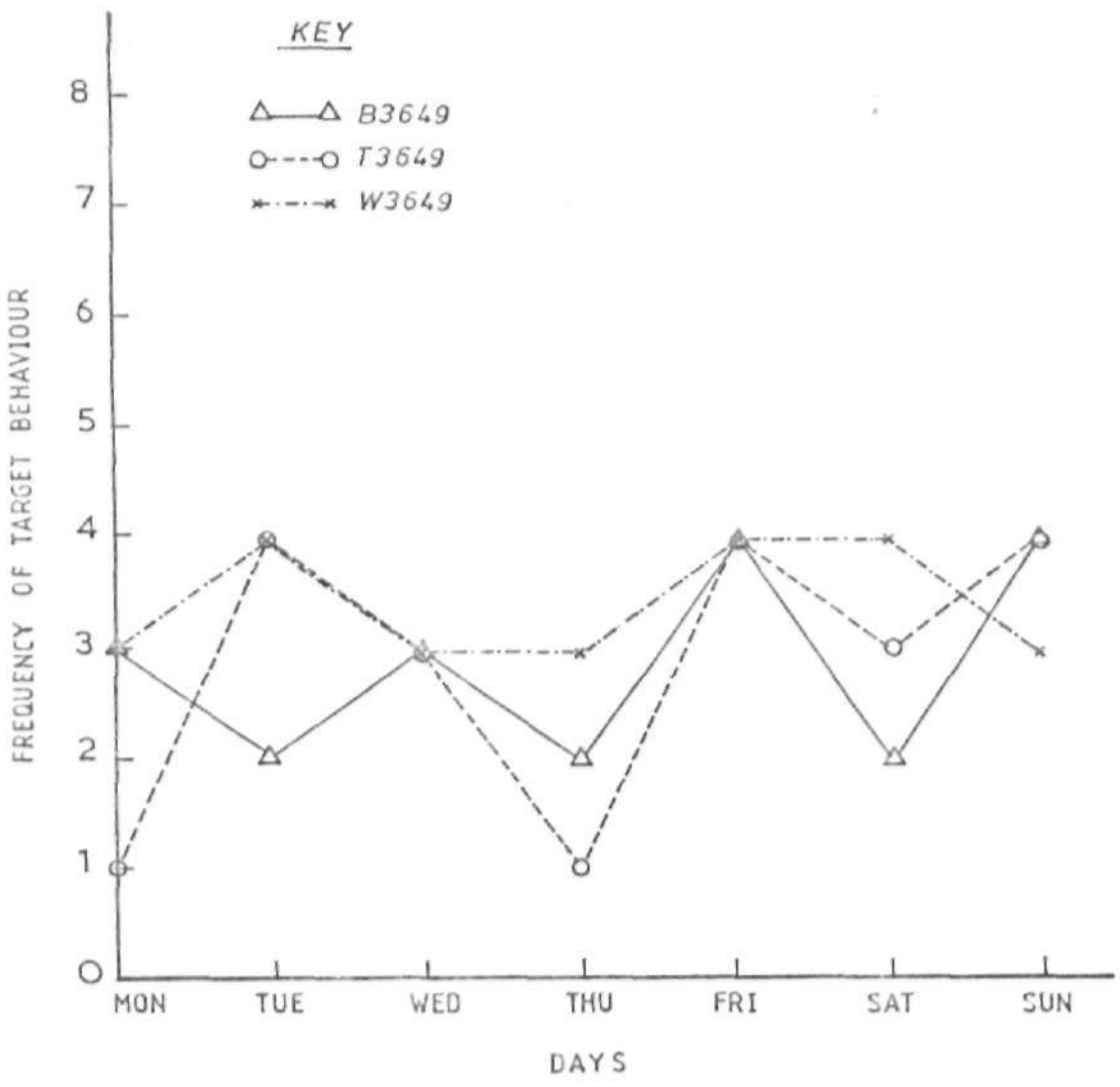


Fig. 3. Subject 3649 : Self-management against fighting.

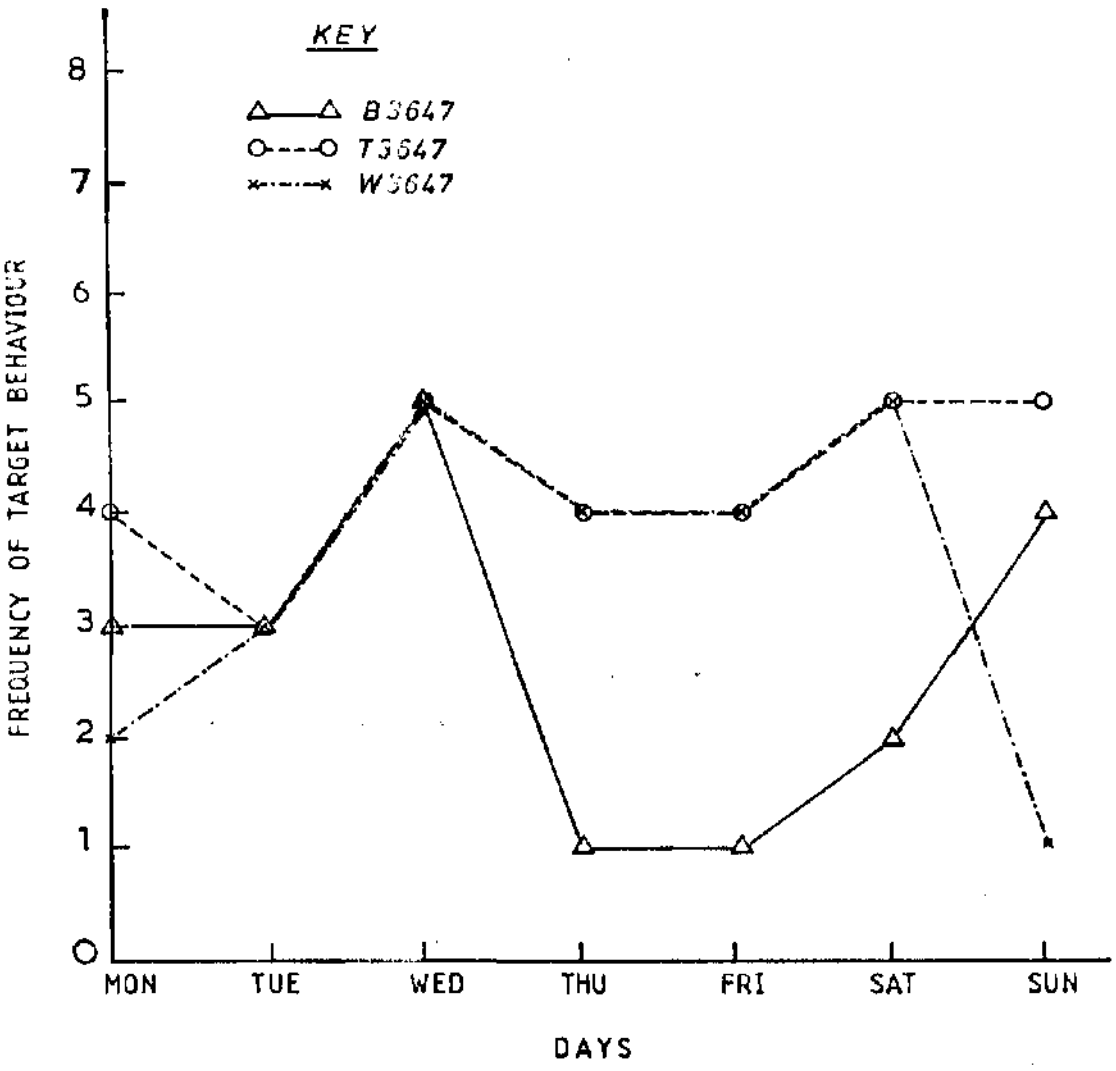


Fig. 4. Subject 3647 : Self-management against fighting.

4.3.3.Self-Management Records of Subject 3647

Figure three is the graphical illustration of the progress of self-management by subject 3647. He contracted himself to reduce and finally stop fighting. The subject had a mean daily fighting rate of 2.7 before therapy. The baseline graph shows a decreasing-increasing trend, predicting that the subject will continue to indulge in fighting if there is no intervention. During therapy, resistance to fighting has been high with a fairly stable trend. This indicates that he was exposed to several opportunities to fight but he avoided fighting. At the withdrawal of reward, resistance to fighting falls sharply from four to two, it rises again and stabilizes at a high rate of four but his resistance again drops sharply to one (graph W3647).

The graph shows evidence of response to therapy. Treatment seems to have helped the subject modify his fighting behaviour. But the withdrawal of the contingent reinforcement seems to have affected his resistance behaviour. At withdrawal there was low resistance to fighting, high resistance and then a drop. It appears as if withdrawal of reinforcement has lowered his resistance, suggesting that much of the modification may have been a function of the reinforcement, and the resistance to fighting may not have been internalized.

4.3.4. Self-Management Records of Subject 3649

The progress of self management by subject 3641 is displayed graphically in figure four. He contracted to reduce and finally stop fighting. His mean daily fighting rate was 2.9. The baseline graph is highly variable but a careful examination reveals an increasing rate, predicting an increase in fighting. The treatment phase is equally variable and erratic and also continues on an increasing trend. This suggests that his resistance to fighting is

increasing during treatment. This can be interpreted that the treatment has modified his fighting behaviour. In the withdrawal phase the graph is more stable than in the baseline and treatment phases. There seems to be some resistance to fighting even after token reinforcement had been withdrawn. But the graph runs in the opposite direction from both the baseline and the treatment. This suggests that probably as the effect of treatment wanes he is deviating from the behaviour he learnt during treatment his fighting behaviour is moving towards that of the baseline.

In effect this means that his avoidance of fighting could have been due to reinforcement. As reward was withdrawn he gradually reduced the behaviour he had learned during therapy. He does not seem to have internalized the behaviour and may likely return to high rate of fighting. Probably an extension of treatment might help him internalise *resistance to fighting.*

4.3.5 Self-Management Records of Subject 3670

The graphical representation of the self-management process of subject 3670 is shown in figure five. This subject contracted himself to reduce fighting and finally stop it. His mean daily fight is 2.7. The baseline trend is a steadily decreasing one. This suggests a reduction in fighting habit. From the graph, fighting has actually been reduced to two a day and seem to have stabilized at that during the baseline period. During treatment the graph shows an increase, a drop at the middle and then an increase at the end. This is an increasing - decreasing - increasing trend which suggests fluctuation in the behaviour modification programme. The increase at the end of therapy suggests an improvement in behaviour modification.

When reinforcement was withdrawn the subject maintained the behaviour learned

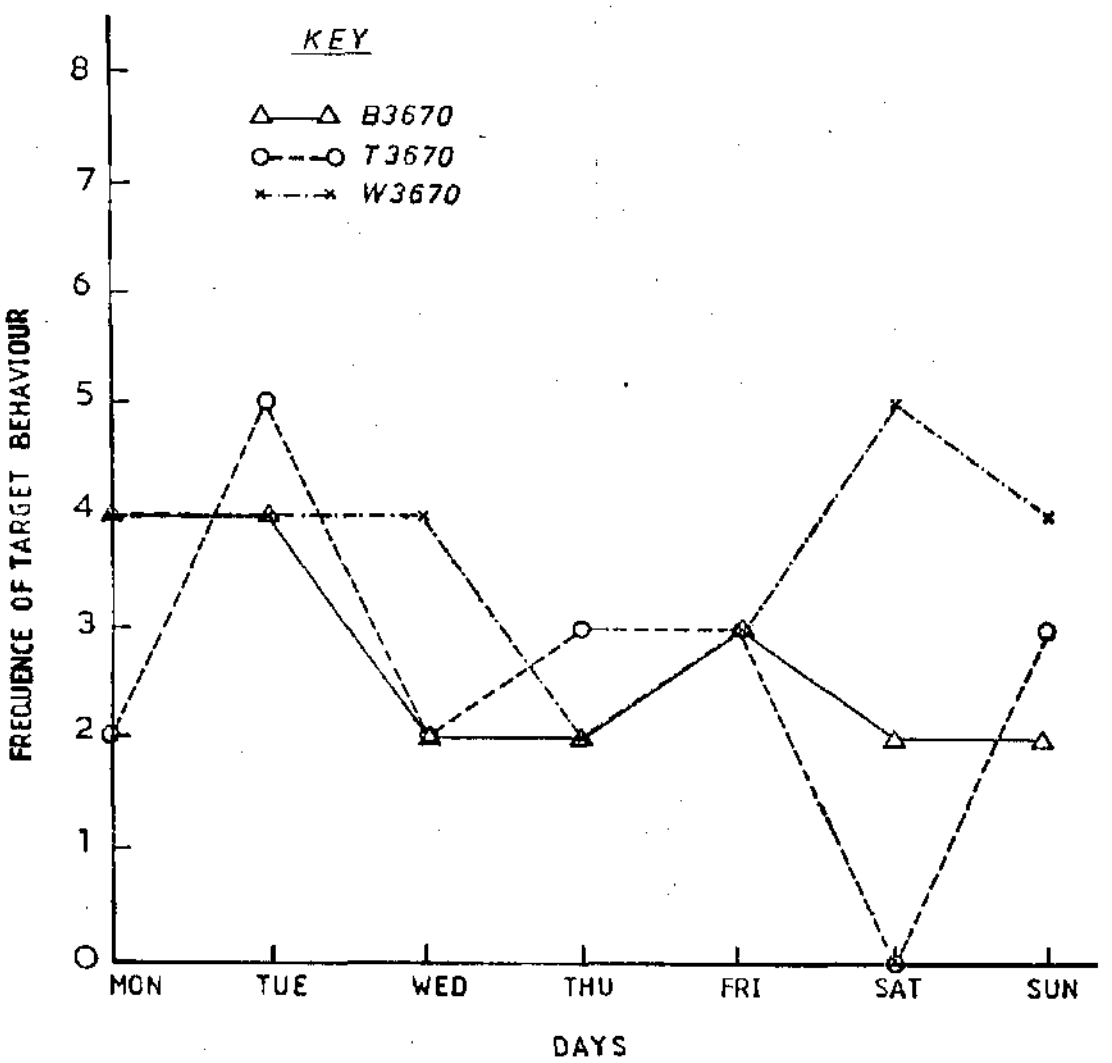


Fig - 5. Subject 3670: Self-management against fighting.

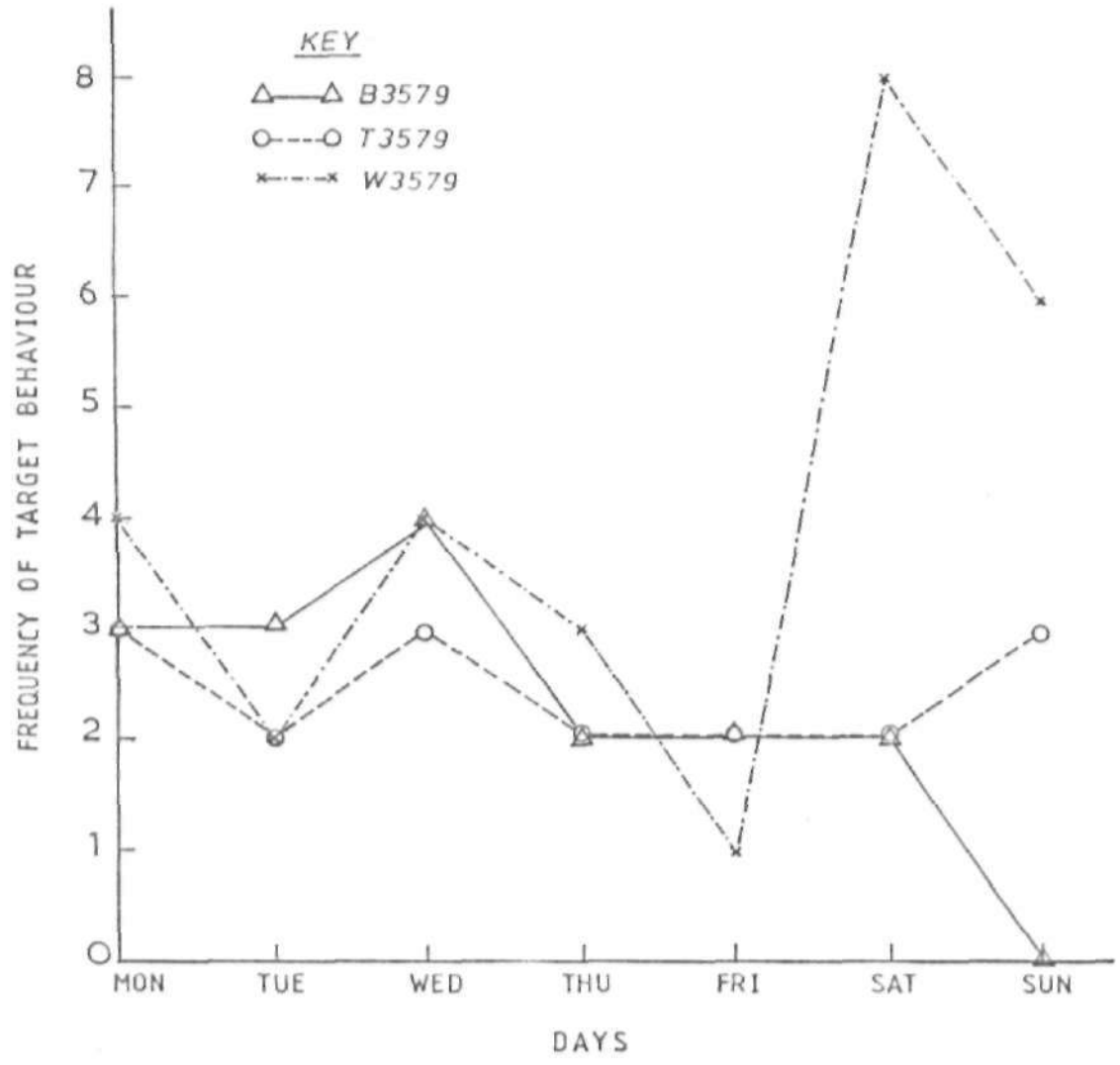


Fig. 6. Subject 3579 : Self-management against fighting.

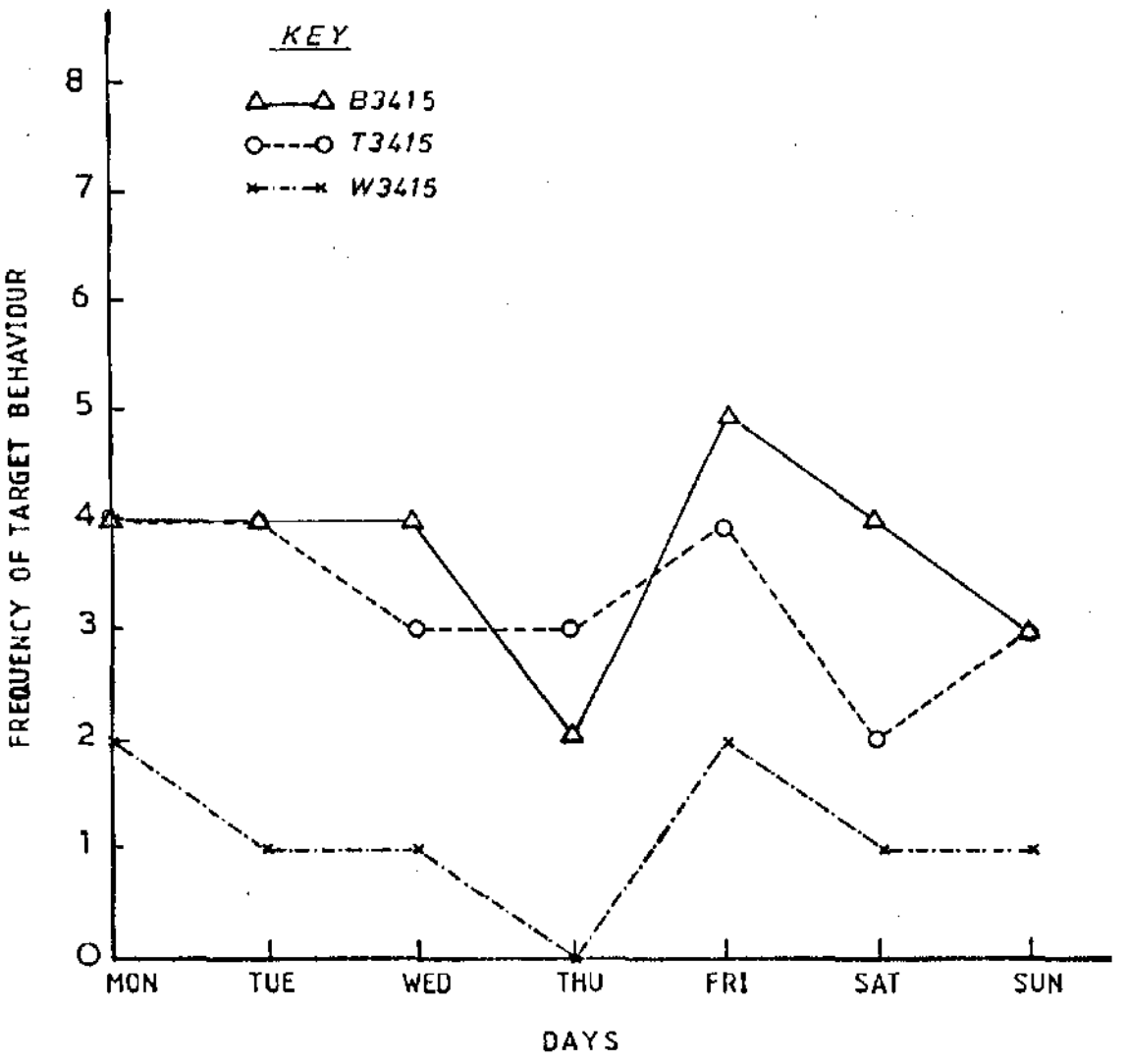


Fig. 7. Subject 3415: Self-management against smoking.

during treatment for some time as shown by graph W3670 for the first three days. He later depreciated on the fourth day and improved, and declined again on the fifth and sixth days. If he continues to decline in his resistance to fighting the prediction is that he may eventually begin fighting. This prediction means that his modification of fighting behaviour could have been a function of the contingent reinforcement.

4.3.6 Self-Management Records of the Subject 3579

Figure six is the graphical expression of the self-management exercise of subject 3579. The subject contracted to modify his fighting behaviour. His mean daily fight was 2.3. The graph shows a decreasing baseline. This implies that before the treatment started this subject had started reducing fighting. That is to say that he started behaviour modification before individual counselling. This could be as a result of group counselling.

The behaviour modification observed in the baseline continues during treatment. The behaviour show during treatment is stable and continues on an increasing trend. At the withdrawal of token reward behaviour modification continues steadily with an increasing trend. This is obvious from a stable - increasing trend in the graph W 3579. The interpretation here can be that this subject has internalized his new behaviour of resisting fighting even after provocation. It could also be that he has learned to control himself and not provoke others. Either way he has been able to manage himself with regard to fighting.

4.3.7a Self-Management Records of Subject 3415

Figure seven is the graphical representation of subject 3415's self-management against smoking. The subject contracted himself to modify his smoking behaviour. His smoking was at the average of four cigarettes a day. The baseline graph shows an unstable trend which ends decreasing. A close look at the graph discloses that even with the reducing

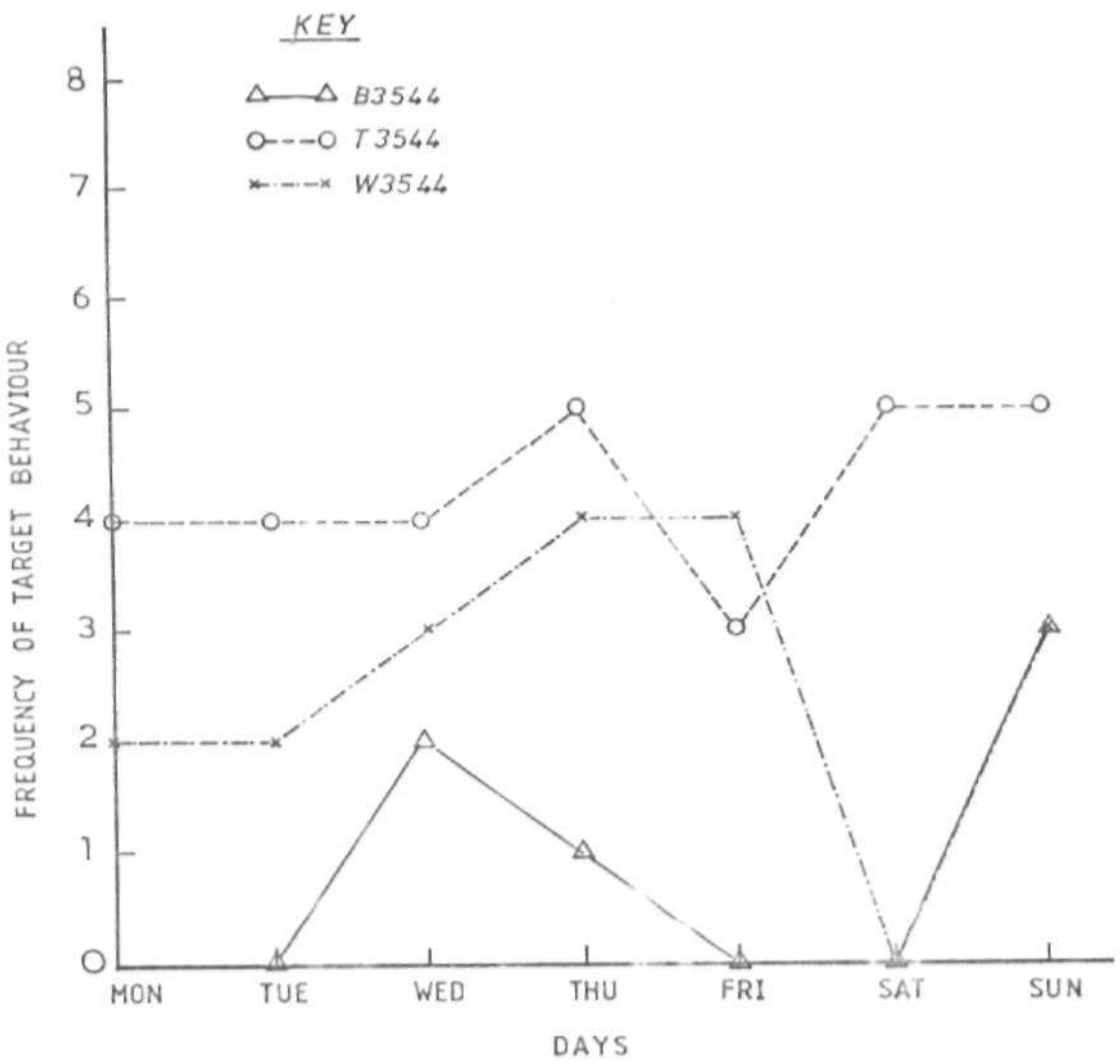


Fig. 8. Subject 3544: Self-manag ment against bounds breaking.

baseline trend he does not smoke less than three times a day despite the Borstal Institution confinement. This is still on the high side of smoking. During treatment 3415 registered smoking on the average of three times a day. Towards the end of therapy it could be predicted that with continued therapy he may strengthen his resistance to smoking. There is therefore some behaviour modification during therapy.

The trend of the withdrawal graph is conspicuously decreasing. The inmate's exposure to cigarette seems to have reduced. Probably, his visits to the place in which cigarettes are obtained is reduced. Thus, when reward was withdrawn he continued reducing smoking. By the end of the whole exercise, the subject seems to have internalised resistance to cigarette smoking. He started behaviour modification soon after group counselling and steadily continued at a slow rate during treatment. As contingent reinforcement was withdrawn he significantly reduced his rate of smoking. This subject has obviously adjusted his smoking behaviour positively during the therapy. this is a pointer to the efficacy of the self-management treatment as far as smoking is concerned.

4.3.8 Self-Management Records of Subject 3544

The self-management graph of subject 3544 is shown in figure eight. This inmate contracted himself to reduce and finally stop "crossing". Unlike all other maladaptive behaviours treated in this study "crossing" needed the inmate to plan carefully before he indulged in it. His mean "crossing" activities during baseline was therefore low, 0.9. The baseline is increasing - decreasing - increasing in nature. The prediction is that if this inmate is left without therapy he will continue breaking bounds. He indicated that lack of self-control was his weak point in his response to one of the items in the self esteem questionnaire. Shortly before therapy, he was put behind the lines for breaking bounds. The

baseline graph truly illustrates his situation of increasing urge to break bounds.

During therapy he systematically reduced "Crossing". The trend of the graph is generally an increasing trend. He seems to have more opportunities to "Cross" but the graph shows his high resistance and stabilization in his behaviour modification. This is evident as shown by a plateau at the end. At the withdrawal of contingent reinforcement the graph continues with the plateau before an increasing trend. There is a drop after which an increasing trend continues. One can interpret this trends to mean that even when the reinforcement had been withdrawn the inmate continued with his modified behaviour. It therefore seems that he has internalized self control. The modification of "Crossing" behaviour therefore was not controlled by reinforcement but it is likely that the self-management therapy has helped him modify his behaviour in the area of breaking bounds.

4.4 Hypothesis Testing

In this section the six hypotheses put forward to help determine the efficacy of self-management therapy in modifying maladaptive adolescent behaviours of some inmates of the Kaduna Borstal Institution were tested. t-test statistic at 0.05 level of significance and 12 degrees of freedom, was employed to test the relationship between baseline behaviour scores and the scores during self-management therapy; and the baseline scores and the scores after the withdrawal of token reinforcement. The behaviour scores during the therapy and at the withdrawal of contingent reinforcement are both compared with the baseline because they both measure resistance to the target behaviour while the baseline measures performance of the behaviour.

The summary of the computation of the scores are displayed in tables 4.7 to 4.12 as follows: Tables 4.7 is used for testing the null hypothesis Ho 01. Table 4.8 is for testing the null hypothesis Ho 02. Table 4.9 for the null hypothesis Ho 03. Table 4.10 are used for testing the null hypothesis Ho 0.4. Table 4.11 is for the null hypothesis Ho 0.5, and Table 4.12 for the null hypothesis Ho 0.6.

4.4.1 Null Hypothesis Ho. 01

Null hypothesis 01 states that there is no significant difference in the mean fighting scores of traumatized deviant boys before and during self management therapy. To test this hypothesis t-test statistics for two independent samples was employed. The data collected for the baseline and treatment are presented in table 4.7 and the data covered six inmates.

TABLE 4.7 A COMPARISON OF DEVIANT ADOLESCENTS' BASELINE AND **TREATMENT MEAN FIGHTING SCORES**

S/No	Var	N	Mean	SD	SE	t	df	P
1	Bas	7	2.86	1.22	0.46	2.71	12	0.035
	Ther	7	1.57	1.13	0.43			
			Not significant P<0.05					
2	Bas	7	2.86	0.900	0.34	-5.28	12	0.002
	Ther	7	6.29	1.70	0.64			
			significant P < 0.05					
3	Bas	7	2.71	1.49	0.57	5.56	12	0.001
	Ther	7	2.71	1.79	0.68			
			significant P < 0.05					
4	Bas	7	2.71	0.95	0.36	-8.33	12	0.00
	Ther	7	6.28	1.38	0.52			
			Significant P< 0.05					
5.	Bas	7	2.29	1.25	0.47	3.49	12	0.014
	Ther	7	6.42	2.56	0.97			
			significant P < 0.05					
6.	Bas	7	3.14	1.21	0.46	2.36	12	0.056
	Ther	7	5.43	2.14	0.81			
			Not significant P >0.05					

Key to the variables in Tables 4.7 to 4.12

Bas = Baseline

Ther = Therapy or Treatment

Wtd = Withdrawal of contingent reinforcement

Var = Variables

N = Number of cases

SD = Standard deviation

SE = Standard error.

In Table 4.9 results of t-test analyses are presented in which the mean scores of the baseline measurement of fighting and treatment measurement against fighting are contrasted. Subsections one to five contain the mean baseline and treatment score as follows: 2.86 and 1.57; 2.86 and 6.29; 2.71 and 2.71; 2,71 and 6.28; 2.29 and 6.24 respectively. There were seven cases in each set of variables. The standard deviations are 1.22 and 1.13; 0.90 and 1.70; 1.49 and 1.79; 0.95 and 1.38; 1.25 and 2.56; respectively. The observed t-values yielded by the analysis are 2.71, -5.28, 5.56, -8.33 and 3.49 respectively. All the t-values were found to be significant at 0.05 level. Thus the null hypothesis was rejected. Therefore there is significant difference in the mean fighting scores of deviant youths before and during self-management therapy. In sub-section six the mean scores are 3.14 and 5.43 with standard deviations of 1.21 and 2.14 respectively. The observed t-value is -2.36. This observed t-value is not significant at 5 per cent level. Thus as far as this variable is concerned the mean fighting scores are different before and during self-management therapy. The null hypothesis is retained in this case. It has to be noted that the null hypothesis remains rejected since it is in only one out of six cases that the mean fighting

scores were different. Therefore there is significant difference in mean fighting scores of deviant youths before and during self-management therapy.

4.4.2 Null hypothesis Ho. 02

Hypothesis 02 states that there is no significant difference in the mean smoking scores of traumatized deviant adolescents before and during self management therapy. The t-statistics used for testing of the hypothesis is shown in table 4.10.

TABLE 4.8 A COMPARISON OF DEVIANT YOUTHS' BASELINE AND TREATMENT

MEAN SCORES FOR SMOKING

Variable	N	Mean	SD	SE	t	df	P
Baseline	7	3.71	0.95	0.36	-1.99	12	0.09
Treatment	7	4.43	1.27	4.81			

Not significant: p>0.05

Table 4.8 is the result of a t-test analysis in which the mean smoking scores of deviant youngsters' baseline and treatment measurements are contrasted. The means for baseline and treatment scores are 3.71 and 4.43 respectively. Their standard deviations are 0.36 and 4.81 respectively and the observed t-value of the analysis is -1.99. This is not significant at 0.05 level. Thus the null hypothesis is retained. Therefore there is no significant difference in the mean smoking scores of deviant youths before and during self management therapy.

4.4.3 Null Hypothesis Ho. 03

There is no significant difference in the mean bounds breaking scores of traumatized deviant youths before and during self-management therapy.

TABLE 4.9 A COMPARISON OF DEVIANT YOUTHS' BASELINE AND TREATMENT

SCORES FOR BOUNDS -BREAKING

Variables	N	Mean	SD	SE	t	df	P
Baseline	7	0.09	1.21	0.46	17.22	12	0.00
Treat.	7	6.71	1.11	0.42			

significant, $p < 0.05$

In table 4.9 the results of the t-test statistic contrasting the mean bounds breaking scores of traumatised deviant youths before and during self management treatment are presented. The baseline mean score is 0.09 and that of the treatment is 6.71. The standard deviation for the baseline is 1.21 and that of the treatment scores is 1.11. The observed t-value of the analyses is 17.22. This is significant at 0.05 level. Therefore the null hypothesis is rejected. There is significant difference in the mean bounds breaking scores of traumatised deviant youngsters before and during self management therapy.

4.4.4 Null Hypothesis Ho. 04

Hypothesis 04 states that there is no significant difference in the mean fighting scores of deviant youngsters before therapy and after withdrawal of contingent reinforcement from therapy. The t-statistics in table 4.12 is employed to test the hypothesis. Six subjects are used in testing the difference between baseline fighting behaviour scores and those of withdrawal of contingent reinforcement.

TABLE 4.10 A COMPARISON OF THE MEAN FIGHTING SCORES OF DEVIANT YOUTHS BEFORE THERAPY AND DURING THE WITHDRAWAL OF TOKEN REWARD FROM THERAPY.

S/N	Variable	N	Mean	SD	SE	t	df	P
1.	Bas	7	2.86	1.22	0.46	6.48	12	0.00
	Wtd	7	0.86	0.90	0.34			
significant P < 0.05								
2.	Bas	7	3.14	1.22	0.46	0.76	12	0.48
	Wtd	7	2.56	1.40	0.53			
Not significant P > 0.05								
3.	Bas	7	2.86	0.90	0.34	1.33	12	0.23
	Wtd	7	3.43	0.54	.20			
Not significant P > 0.05								
4.	Bas	7	2.71	1.45	0.57	0.80	12	0.45
	Wtd	7	3.43	1.51	0.57			
Not significant P > 0.05								
5.	Bas	7	2.71	2.71	0.95	2.05	12	0.86
	Wtd	7	3.71	3.71	0.95			
Not significant P > 0.05								
6.	Bas	7	2.91	1.26	0.47	4.5	12	0.18
	Wtd	7	4.00	2.39	0.90			
Not significant P > 0.05								

In table 4.10 are contrasted a t-test analysis in which the mean score of the baseline measurements for fighting and measurements taken during the withdrawal of contingent reinforcement. In subsection one of the table the mean scores are 2.86 for the baseline and 0.86 for the withdrawal of contingent reward. The standard deviations are 1.22 and 0.90 respectively. Then observed t-value is 6.48. This t-value is significant at 0.05 level. Therefore in this case the null hypothesis is rejected. There is significant difference in the mean fighting scores of this case before treatment and at the withdrawal of contingent reinforcement.

In subsections two to six the mean scores are 3.41 and 2.58; 2.86 and 3.43; 2.71 and 3.43; 2.71 and 3.71; 2.91 and 4.00 for the respective cases. The standard deviations are: 1.22 and 1.40; 0.90 and 0.54; 1.47 and 1.51; 2.31 and 3.37; 1.26 and 2.39 for each case. The observed t-values are 0.76, 1.33, 0.80, 2.05 and -4.5, respectively. These t-values are not significant at 0.05 level thus the null hypothesis are retained in these five cases. There is no significant difference in the mean fighting scores of deviant youths before treatment and at the withdrawal of token reward from treatment. Since the null hypothesis is retained in five out of the six cases used in testing the hypothesis the null hypo thesis stands.

4.4.5 Null Hypothesis Ho. 05

There is no significant difference in the mean smoking scores of traumatized deviant youngsters before therapy and at the withdrawal of token reinforcement from therapy.

TABLE 4.11: A COMPARISON OF THE BASELINE MEAN SMOKING SCORES OFTRAUMATISED DEVIANT YOUTHS AND THEIR MEAN SCORES AT THE *WITHDRAWAL OF TOKEN REINFORCEMENT*

Variable	N	Mean	SD	SE	t	df	P
Baseline	7	3.71	0.95	0.36	12.73	12	0.00
Withdraw	7	1.14	0.69				

Significant: $p < 0.05$

Table 4.11 shows the t-test analysis contrasting the baseline measurement for smoking and the measurement taken through the withdrawal of contingent reinforcement from the treatment of deviant youths. The mean scores are 3.71 and 1.14 with the standard deviation of 0.95 and 0.69. .the observed t-value is 12.73 and this is significant at 0.05 level. Thus the null hypothesis is rejected. There is significant difference in the mean smoking scores of deviant youths before therapy and at the withdrawal of contingent reward.

4.4.6 Null Hypothesis Ho. 06

Null hypothesis 06 states that there is no significant difference in the mean bounds breaking scores of deviant youths before therapy and at the withdrawal of contingent reward.

TABLE 4.12: A COMPARISON OF MEAN BOUNDS BREAKING SCORES OF DEVIANT YOUTHS DURING BASELINE AND AT THE WITHDRAWAL OF TOKEN REINFORCEMENT.

Variable	N	Mean	SD	SE	t	df	P
Base	7	0.85	1.21	0.46	-3.03	12	0.02
Withdraw	7	2.57	1.39	0.53			

Significant $P < 0.05$

In Table 4.12 the results of a t-test analysis are presented in which the mean scores of the baseline measurement of bounds breaking and the measurement during the withdrawal of contingent reinforcement from treatment are contrasted. There are seven cases in each variable. The mean scores are 0.85 and 2.57, with the standard deviations of 1.21 and 1.39 respectively. The observed t-value is -3.03 and this is significant at 0.05 level. Thus the null hypothesis is rejected. There is therefore significant difference between the baseline bounds breaking mean scores and the mean scores of the withdrawal of contingent reinforcement from the therapy.

4.5 Discussion

The aim of this study was to establish the efficacy of self-management therapy in achieving behaviour modification among deviant youngsters. Traumatized deviant youths in Kaduna Borstal Institution were identified and trauma-specific self-management intervention was administered on them.

The strategy is known as self control (Cautela, 1969) self-regulation (Kanfer, 1970) or self-management (Mahoney, 1979). It is a client-centred programme which desires to psychologically rehabilitate the subjects, bearing in mind that they had been psychologically devastated. Its aim is also to help the youth achieve self-reorganization through acquiring desired behaviours and extinguishing the undesired ones (Hackney and Cormier, 1979). The deviant youths therefore require minimum interference from the therapist, thus eliminating the therapist as a "middle man" in the helping process. The youngsters administer the strategy and direct the change effort by themselves. This is done to strengthen their

investment in the helping situation, and ensure a greater chance of success for them.

The objective of the self-management therapy in this study is therefore not to make the youngsters "well" or "cure" them, rather it is to achieve the highest level of functioning possible. As such the evaluation of the subjects is in measures of strength not so much of statistical significance. Infact, Risley (1970) argued that the clinical criteria of significance refers to a comparison between behaviour change that has been accomplished and the level of change required for the subject to adequately function in society. He added:

> This notion of significance departs drastically from statistical significance. Small changes in behaviour of one individual or many individuals usually are not considered to be clinically significant. Even if behaviour change is reliable and clearly related to the experimental intervention, the change can not be necessarily regarded as statistically significant. For example, reducing delusional statements of psychotic patient from 80 to 40 percent of the period observed probably would not be regarded as an important change. Relative to the standard of "normal" social interaction, the effect of the intervention leaves a great deal to be desired. The patient could not function in a community without censure from peers from bizarre statements. To make the change of clinical significance, a much greater reduction in bizarre statements would be required. The precise criterion that makes a given change of clinical importance is difficult to specify because individuals in every day life parents, teachers, peers, colleagues, friends, determine which behaviours are deviant, obnoxious, intolerable or acceptable.(p. 265)

The above quotation has observed that in clinical evaluation of data, statistical significance alone cannot be the criterion for conclusive decision as to whether behaviour modification has been achieved. The authors also states that statistical evaluation could be used as ancillary to other methods of evaluation.

> When a behaviour is altered as evidence by objective data, and when individuals in contact with the client indicate that the original behavioral goal has been achieved, the programme has achieved a change of clinical significance. As an ideal, applied interventions strive for changes that ordinarily surpass statistical significance. Yet, for clinical intervention,

> statistical significance is an ancillary and to many individuals, irrelevant criterion (p. 266).

In the evaluation of the behaviour modification of the subject in this study, three methods were employed, namely:

(1) the frequency data and graphs

(2) the statistical analysis

(3) the human or societal evaluation.

The frequency data and graphs: These were used to determine the flow of behaviour from the maladaptive baseline till the end of therapy, including the period that contingent reinforcement was withdrawn. Graphs that deviated from the deviant baseline indicated positive behaviour modification and thus represented an achievement of a change that is of clinical significance.

Statistical analysis: These were used for testing the null hypotheses. They were used as ancillary to the graphs and they confirmed the findings obtained through the graphs. An example of this is subject A3601. For this subject the baseline graph, B3601 clearly shows increase in fighting behaviour while the treatment graph, T3601 clearly shows decline in fighting and the withdrawal graph, W3601 also indicates decline in fighting. In the statistical analysis, Table 4.9 subsection one, the baseline measurement is contrasted with the treatment measurement. A significant difference in the mean fighting scores of the baseline and the measurement during treatment were found for subject A3601. At the withdrawal stage the same conclusion was arrived at. This resulted in the rejection of the null hypotheses that there are no significant differences in the mean fighting scores at the baseline level, at the treatment level and at the withdrawal level. There is therefore an agreement between the graphs and the statistical analysis. This relationship can be traced in

all the eight cases studied.

The human or societal evaluation: This criterion of deciding on change of significant importance is based on the fact that "individuals in every day life, parents, teachers, peers, colleagues, friends, determine which behaviours are deviant, obnoxious, intolerable or accepted". Thus when individuals in contact with a client whose behaviour has been affected positively by therapy testify to the change, it can be rightly accepted that the behaviour modification goal has been achieved. In this study subject A3568 was released on the agreement of the boy's parents, the welfare officers, and the principal of the Borstal Institution that his behaviour has been modified positively. It was also discovered by the researcher during follow up visits that subject A3544 was released from the Borstal Institution immediately after the therapy. Both A3568 and A3544 are now in normal secondary schools. The integration of the three methods of evaluation that have agreed show that self-management therapy is an efficient strategy for achieving behaviour modification among youngsters with maladaptive behaviours.

Introduction of contingent reinforcement was found to be helpful in inducing deviant youths to modify their behaviours and so rehabilitate themselves. It is probable that if token reinforcement is held long enough in a therapeutic situation and withdrawn gradually rehabilitation might be sustained and the new modified behaviour internalized. Behaviour rehabilitation happens to take long probably because maladaptive behaviours take long time to develop.

Some of the subjects actually modified their behaviours during therapy and sustained it after token reinforcement had been withdrawn. It is believed that in such cases the therapy has proved very efficacious. Some start behaviour modification gradually and steadily

progress even after reinforcement has been withdrawn. It can be concluded that self-management therapy is a useful instrument for behaviour intervention among deviant youngsters. In this conclusion care should be taken because it is a matter of dealing with human beings who are very unpredictable. For instance, one of the inmates refused to monitor himself but gave a verbal information that he had reformed his smoking behaviour. A close look at him could tell that even if he had stopped smoking, he was still dangerous to society since he personally confessed that he wanted to vend his anger and revenge on those who maltreated him. Individual differences should be expected. All the same one contribution of this research work is the ability of self-management therapy to convince the deviant youths that they need a change in their behaviour and help them go ahead and manipulate the change by themselves. In a system like ours in which parents exert so much control over the lives of their children, to the point of sometimes deciding what course they will read in the university despite the children's ability, it is a major contribution of this study to be able to help young people manage themselves. If these deviant ones can manage themselves the "normal" children can manage themselves the more if they are given a chance while the parents relax their "middle men" roles in the lives of their children, direct and encourage them to manage themselves.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 INTRODUCTION

In this chapter conclusions and implication of self-management intervention are presented. Recommendations are also made for more research that will further expound the enhancing effect of self-management intervention. The research was designed to demonstrate the effectiveness of self-management therapy in modifying maladaptive adolescent behaviours. It was very glaring from the data collected and analyzed that self-management intervention would help youngsters with maladaptive behaviour rehabilitate themselves. This is possible if such boys can be brought to terms with the realities around them. Their own situation is very precarious. They are people who do not trust themselves, and trusting others to do them good is not easy for them. So they look at everybody trying to help them with suspicion at the very best. They would not open up to any outsider. So it is difficult to know how and where to start helping them. No wonder traditional helping strategies fail when they are applied on deviant youngsters. Lock them up, they plan more evil out of idleness, punish them, they become tougher as they try to assert their innocence and the injustice done to them. Put them in the reformatory they learn worse habits than they went into that place with. Try to persuade and pet them they outwit the system and continue in what they were doing anyway. Threaten them they threaten the system in return.

They hate the society and any instituted authority. No wonder the police, the court

and the reformatory authorities are their enemies. They must be rebelled against. Delinquent boys believe that if they get reformed through people instruction or threats or punishment, they are doing others a lot of good. Due to cognitive rigidity they fail to understand that whatever suffering their behaviour generates, they are the first to suffer for it; the parents and the society's suffering comes secondary. So they pay deaf ears to corrections.

Another problem of deviancy is that of psychological battering on the part of deviant. They have developed negative self concept and low self esteem. These problems are intrapsychic and external in nature. They view self as damaged persons and are ambivalent about trading an easy dependence for the rigors of trying. Then comes the problem of familial rejection, social ostracism, poverty and pain. These young people need love and understanding devoid of pampering. They need a person who will be supportive but authoritative to handle them. Authority goes with knowledge. But often times people who deal with delinquent youths lack knowledge about antecedents of delinquency as well as human management.

It is not the intention of the researcher to condemn those dealing with deviant youths in any way. Her interaction with such workers in the Kaduna reformatory has shown that some of those workers are quite sincere in their effort to help the boys reform. But it is evident that many of the boys they are dealing with had been highly exposed, very clever and versatile. They need people who are well informed in dealing with maladaptive behaviour and their antecedents. They need people who are current in different strategies of dealing with human beings in psychologically dilapidated situations. Knowing the poor psychological state of the delinquent is one thing, knowing how to help them out is another.

The above discussion implies that to begin finding profitable solution for the numerous deviant youngsters found all over Nigeria there is need to draw their individual attention to the harm they have done to themselves. It might be helpful to deviate from the usual interpretation to the deviant what he has caused the society and his family. Since his interest is not on his family or the society, if he is helped to develop a healthy interest in himself and generate self-love and hope it might help him to believe that he can repair his damaged self. As he is help to discover some strength still remaining in him he improves his self-concept, esteems himself higher and begin to work by himself on his weak points. He will need patience and time from the people around him to be able to gradually wean himself of his weaknesses. In doing this his helper should also think of some acceptable reinforcement that can hold the interest of the deviant on rehabilitation. Reinforcement can be withdrawn when he has begun to enjoy the gains of self-rehabilitation.

5.2 Summary of Findings

The major findings of this work are summarized and discussed under the following headings:

Demographic Data

Self Management Treatment

Graphical Data

Results of Test of Hypothesis

End of Therapy

Conclusion

5.2.1 Demographical Data

The subjects of the study consisted of 74 literate deviant youths of Kaduna Borstal Institution, 64 of them had experience 6.5 to 43.75% of the 16 traumatic situations listed. The remaining ten of them who had experienced 50 percent and above of the listed traumas were enlisted for self-management treatment. The major sources of their trauma were found to be family pathology. Their display of maladaptive behaviour ranged from smoking to stealing to "drug pushing" to gambling, alcoholism, rebellion, school attendance problems run away, murder and dangerous fighting.

5.2.2 Self Management Treatment

The ten subjects were taken through a brief group counselling which enabled them to get familiar with the researcher and the self-management programme. In the second stage of the treatment each of them went through a baseline measurement of their behaviours. They used self-monitoring cards to monitor themselves before individual counselling. As they monitored themselves independent observers were monitoring them surreptitiously, and recording motoric measurement of their performance. Both the motoric and self measurements were finally correlated to ensure reliability. Both measurements correlated very highly. So the subjects self-reports were accepted as reliable and authentic. They became the baseline data for self-management. Graphs were drawn of the baseline data. After the baseline which was used for predicting the subjects behaviour if there was no intervention, individual counselling was started and accompanied with contingency of verbal and material reinforcement. Self-report and motoric reports were once more collected and correlated. The self report proved reliable through correlation and so were used to

determine the inmates behaviour modification rate. Graph drawn of the rate of modified behaviour was compared with the baseline.

Contingent reinforcement was withdrawn afterwards and the subjects were told to continue in self monitoring and behaviour modifications but without expecting reward. Behaviour was also measured during the two weeks of withdrawal of contingency. This was used to establish whether behaviour modification was a function of the token reinforcement or treatment. Before the end of self-management therapy discussion with the deviants' families achieved quick behaviour modification and rehabilitation.

5.2.3 The Graphical Data

There were 24 graphs altogether - three for each inmate. The first graph was the baseline graph with which both the self-management and the withdrawal graphs were compared. All but one of the self-management graphs went in the same direction with the baseline. The base line measured performance of the maladaptive behaviours while the self-management and withdrawal graphs measured resistance to the deviant behaviour. As long as the baseline and the monitoring graphs ran in same direction, it meant that the monitoring graph was showing a trend divergent from the baseline since it measured resistance to the maladaptive behaviour. During self management with reinforcement all but one inmate achieved behaviour modification. At the withdrawal of contingent reward all but one inmate continued with their behaviour modification mostly at decreasing rates. Two of them conspicuously advanced in their modification without reinforcement.

5.2.4 Results of Test of Hypotheses

In this section the result of the test of six hypotheses are summarized. There were significant differences between the baseline mean scores and self-management scores of the target behaviours at 5 percent level of significance and 12 degrees of freedom. However,

the scores between the baseline and most of the withdrawal scores were not significant at 5 percent level of significance.

5.2.5 End of Therapy

Group Discussion

Causes of Maladaptive behaviours as seen by inmates

- Parents not cooperating with their children in the area of discovering their ability and talent and not helping them realize their aims and aspirations.
- Leaving healthy young men idle makes them wonder and do things that are deviant or join bad peers.
- Decision of the children to join bad peer group because their home is not existing enough.
- Homes not offering good examples, for instance, what do you expect from a boy whose father smokes, drinks and pursues other women than his wife?
- Absentee father leaves no role model for the son
- Poor upbringing of children, in which case the child is allowed to wonder about and do what he likes.
- Spoiling of children with care and gifts
- Broken home is a most fertile ground for a child to deviate. Broken homes result in acute insecurity.
- Fighting and quarrelling by parents break children's heart, makes them insecure, ashamed, violent.
- Extreme harshness of parents/military discipline create fear at first and later indifference and much later deviancy.
- Partiality makes the unfavoured give up later and makes them get into deviant

behaviour to reach where the favoured ones are.

- Parental neglect of children either for business venture sake or out of parental selfishness.

What to do to Help the Deviant Boys - Inmates' views

- When boys in Borstal Home do reform, their parents should be made to know so that they can be bailed out, examined and confirmed reformed.
- Borstal Home should be in regular communication with the child's home.

5.2.6 Conclusion

The study has demonstrated that self-management therapy would help deviant boys rehabilitate themselves. It is also clear that if the deviant is given the chance and the tools to rehabilitate himself he could do it. An interesting discovery in this research is that although the delinquent boys look tough and heartless, if someone would get into their world and generate their confidence in himself they would disclose themselves, come down to seek help and actually get to modify their deformed behaviours. The counsellor simply needs patience and unconditional love for the delinquent in order to bring him down to reasoning. The delinquent has had a lot of psychological battering and is living in the realm of self defence. He needs more understanding than pockets of blame. But above all he needs a person who is knowledgable and authoritative enough to redirect his thinking. The deviant goes the deviant way not because he would not like to be better, but because he cannot become better on his own and does not have the confidence and enough trust or knowledge to know whom to go to for help. If someone initiates help and remains patient and loving enough the deviant can yield and work for a change.

The role of the family cannot be over emphasized in the life of the traumatized

deviant youth. As one looks into the archival records of the delinquent young men in the Borstal Institution one finds that their problem started in the family. Someone had been a bad model, some one has neglected him, someone harassed him beyond his coping abilities, someone has misdirected him into unlawful activities for money. He has now grown out of hand and the parents are so dismayed and embarrassed that they do not want him around since he is a disgrace. In any case he is too tough for them to control. He is sent to be reformed in the Borstal Home. Who is there to reform some one parents helped in spoiling? In some cases, it is divorce, separation, fighting and quarrelling in the family that are the causes of maladaptive behaviours. The boy is first embarrassed, then indifferent, then enmeshed, and finally breaks away out of frustration. He finds peace, comfort and acceptance among deviant peers who are having the same problems as he. Who is now to counsel the other?

A very easy way of helping the delinquent modify his behaviour is to make him and his family discuss heart to heart so that forgiveness can be achieved and wounds oiled for healing. It is difficult for the deviant to completely reform himself when he is not sure of where to go back to if he leaves his peers or the reformatory. He needs truthful assurance.

5.3 Recommendations

Following the findings of this study, a number of recommendations seem appropriate and are therefore made. It was a part of this research work to have an open group discussion between the therapist and the subjects at the end of therapy. Their views are part of this research, so the recommendations set below will include their opinions and recommendations.

Prominent among the recommendations in this study is the unquestionable need to introduce trauma insulation skills in the training of welfare workers and law enforcement officers since as at now they are the people who are involved in the care of deviant people. Akin to this is the introduction of trauma management skills as a course in the secondary schools. This would enlighten both the teachers and the students since trauma is universal and some times unavoidable.

Self-management seems to be a very promising area in the treatment of maladaptive behaviours. The rudiments of the administration of self-management techniques are recommended for inclusion in the training of welfare workers and even in training for school counsellors. Every secondary schools and university can boast of at least a handful of deviant traumatized individuals.

The family should be closely involved in the process of rehabilitating delinquent people. In most cases the root of deviancy is in the homes and trying all other ways of solving deviant problems without the home is long and tortuous. Some times the effort may fail. The family has to become a part of rehabilitation exercise.

While discussing with the subjects of this study at the close of the therapy they made the following suggestions:

That in the Borstal Institution setting, parents should be visited by the welfare officers and be given the report about their children. This would be possible if the youths' homes are close enough. If they are far, financial constraint may not allow it. In that case there should be some other ways of regular communication, particularly for parents who hardly come to see their children. They have got to know their children's progress.

At the present when children are visited by their parents, they meet in the presence of

the chief warden. The children suggest that the Borstal Institution should provide a place where parents who visit their children can sit apart and talk. This is a very welcome suggestion because there is need for parents and children to meet alone. In the Borstal Institution the boys are told that they are not in prison. Yet everything is decided for the boys without their input. This action helps to marginalize them and damage their self-confidence the more. They suggest that they should be made to have input in decisions that concern them.

One great problem in the Borstal Institution is lack of equipment in the workshops. The boys are locked in the workshops day after day with nothing to work with. In effect they are left mentally and physically idle. For boys who had before been very active this is a dehumanizing-mental torture. Though the situation desensitizes them from hyperactivity, it does not build them physically, mentally or psychological.

If the Borstal Institution aims at rehabilitating the youngsters, there should be something to occupy them, something new to learn and to do and other kinds of lawful relaxation than club-going, smoking, drinking and others. In other words, as they are removed from the society which was hostile to them and which they hated, they should be put in a less hostile and a more lawfully active community. There should be substitution. It is recommended that the government look critically into the conditions existing in the Borstal Institution.

The government should totally overhaul the Borstal system, supply enough and modern equipments in the workshop; employ qualified teachers who have had some training in handling deviant youths, improve the living condition of the boys by providing them some gainful relaxation such as games and extra curricular activities. They need a wall

around the institution so that wardens can relax their hold on them and let them move freely within the compound. After all, normal secondary schools are fenced. Fencing the deviants' school will not make them feel like prisoners, Locking them in throughout week ends and after classes makes them more like prisoners especially since the wardens have to sit behind their locked doors with whip in their hands. One painful open secret is the fact that the boys share whatever their parents bring for them with the wardens. This has to be checked. It is one way of teaching the boys more corruption.

At the end of Borstal training, boys are just released to their parents without any plan as to how they are going to be occupied. It is recommended that before a boy is released a conference be held between the relevant Borstal staff and the family of the boy. In this conference the following would be established.

- Where the boy is going back to
- What he is going to be doing, like going to school or into labour market.
- Adequate supply of equipment and materials to work with.
- Follow up plans.

There should be a solid arrangement to rehabilitate the boy. If he goes back into his old idle environment he would surely rejoin his peers and practice more efficiently the crimes he learned in the Borstal Institution.

The government should at the end of Borstal training be able to supply the inmate at least one equipment with which to start a new working life as the boy is released from the training. If he was training as a photographer, on being reformed and released he should be assigned a camera. This is likely to be reinforcing and rehabilitating. It is not just enough to station welfare officers in the Borstal Institutions to take care of the welfare of the

inmates. It is strongly recommended that guidance counsellors be employed in the Borstal Institution. The work of a counsellor is far different from that of a welfare officer. Their training is different too. A counsellor provides a shoulder to cry on, which is one of the greatest need of the deviant youths. Finally, trauma - and rehabilitation counselling which enhance the counsellor's efficiency and make counselling service more robust, should be inculcated into the counsellor's repertoire. It needs no further mention that this type of counselling should not only be extended to the student of higher learning, but to all.

5.4. Suggestions for Further Studies

It is hoped that this study will stimulate further research and, as such, suggestion is hereby proffered for investigation in the following areas:

1. The present study did not work with deviant girls because there is no borstal system for them. But deviant girls are also found in the streets of this country. What affects the deviant boys affects them and sometimes the damage on them is greater and more devastating than those of the boys. There is need to investigate to what extent self-management therapy can rehabilitate traumatized deviant girls.
2. An investigation or research on the efficacy of self-management intervention on maladaptive behaviours generated through other antecedents than trauma is suggested.
3. The present research worked on multiple baseline for different individuals. It is suggested that further research considers multiple baseline on one individual while administering self management intervention. This is because maladaptive adolescent behaviours are not mutually exclusive. A person that fights can steal and abuse

drugs at the same time. A concentrated work on one individual will mean that all the facets of his maladaption be taken care of.

4. Although self management therapy should not be too long because of mortality, history, cost, and ethical considerations, it is here suggested that researches in this area be extended a little longer than six months which was used for the present study, in order to give the subject time to reorganize himself and his thoughts gradually and internalize his discoveries.

5. Self-management therapy can be tried on deviant adults also. It is suggested that the therapy be administered to inmates of the adult prisons as well.

6. Self-management is not meant only for deviant people. "Normal" people at one time or the other think and act irrationally. It is suggested that further research includes ministering self-management therapy on "normal" people who act or think irrationally.

5.5 Summary

In this chapter the research findings have been summarised to show the extent to which self-management intervention can rehabilitate traumatized deviant youths in the Kaduna Borstal Institution. Some general conclusions were drawn and appropriate recommendations, based on the findings, as well as suggestion for further studies were made.

REFERENCES

Abelson, H. I., Fishburn, P.M. and Kisin, I. (1977). National Survey of drug abuse. National Institute of drug abuse, United States Department of Health Education and Welfare. Washington D.C.

Achebe, C. C. and Nwoye, A. (1987). Kurt Lewin's Theory of Personality. In A. Uba. Theories Of Personality. Bodija/Ibadan: Claverianum Press.

Adegoke, A. A. (1990). A Comparative Study of Prisoners and non-prisoners on three Personality dimensions. Journal of Research in Counselling Psychology. 2(1):45 - 51.

Adeloye, J. A. and Aina, B.T.Y. (1990). Juvenile delinquency: A case study of Goron-Dutse Remand Home, Kano City. Journal of Research in Counselling Psychology 2(1):52 - 57.

Adeloye, J. A. and Dare, M.O. (1995). Promoting Psychological Health of Juvenile Delinquents in Remand Homes: Counselling input. Proceeding of the 18th National Annual Conference of the Counselling Association of Nigeria. (CASSON), Kano, Nigeria. pp. 87 - 92.

Akinboye, J.O. (1987). Guidance Strategies for handling adolescent and youth problems. Ibadan: University Press.

Allen, K. E., Hart, B., Buell, J.S., Harris, F.K. and Wolf, M.M. (1964). Effect of Social Reinforcement On Isolate Behavior of a Nursery School Child. Child Development. 35,511 - 518.

American Diagnostic and Statistical Manual (1980) (DSM-III) 3rd edition. Washington DC: USA.

Anderson, B. (1981). Self Destructive Behavior in Children and Adolescents. In C.F. Wells and I.R. Stuart (eds) Self destructive behavior in children and adolescents. New York: Van Nostrand Reinhold.

Aremu, O.S. (1988). Congestion of Unconvicted Inmates in Nigerian Prisons: the Role of the Police and Courts. An unpublished project, Nigerian Prison Staff School, Kaduna. pp. 5 - 10.

Barlow, D. H., Agras, W. S., Leitenberg, H., Callahan, E. J. and Moore, R. C. (1972). The Contribution of Therapeutic Instruction to Covert Sensitization. Behavior Research and Therapy. 10:411 – 413.

Bard, M. and Sangrey, D (1979). The Crime Victims book. New York: Basic Book.

Barnes, G. E. (1979). Solvent abuse: A review. International Journal of addiction. 14:1 - 26.

Bello, P. N. (1986). Institutional Treatment of Juvenile Delinquents in Lagos: A case study with implication for Guidance and Counselling. Nigerian Journal of Guidance and Counselling. 2(2):88 - 95.

Bijou, S. W., Peterson, R. F., Harris, F. R. and Johnson, M.S. (1969). Methodology for Experimental Studies of Young Children in Natural Settings. Psychological Records. 19:177 - 210.

Bloom, B. L., Asher, S.J. and White, S.W. (1978). Marital disruption as a stressor. Psychological bulletin. 85:867 - 894.

Bohart, A. C. (1977). Role playing and interpersonal conflict. Journal of Counseling Psychology.24:14 - 24.

Bracht, T. C. (1994). Public Intervention Among Smokers. In C. O. Okonwo. The Police an Social Justice. A seminar paper presented by the National Orientation Agency and the Nigerian Police. Kaduna.

Braginski, B.M., and Braginsky, D.D., (1967). Schizophrenic patients in the psychiatric interview: An experimental study of their effectiveness in manipulation. Journal of consulting psychology. 31:543 - 547.

Briere, J., (1984). The effect of sexual childhood abuse on later psychological functioning: Defining post sexual abuse syndrome. A paper presented at the third National Conference on sexual victimization of children. Washington D.C.

Briere, J., Runtz, M. and Lightfoot, A. (1978). Sucidability in former sexual abuse victims. A paper presented in the American Association of suicidology. Toronto.

Bubaram, U. A., (1989). The cause leading to the conviction of young offenders into Prison. An unpublished Project. Nigerian Prison Staff School, Kaduna. pp. 2-5.

Cantril H (1944). Grudging Public Opinion. New Jersey: Princeton University Press.

Carson, R. C. (1977). Review of R. N. Blackney, (ed). Current issues in transactional analyses. The First International Association, European conference. New York: Brunner/Mazel.

Cautela, J. R. (1969). Behavior Therapy and Self control: Technique and Implication. In Franks (ed) Behavior therapy: Appraisal and Status. New York: McGraw-Hill.

Cimiro, A., Nelson, R. and Lipiski, D. (1977). Self - monitoring procedure. In A. Cimiro, K. Calhoun and H. Adam. Handbook of Assessment. New York: John Wiley, p. 199.

Coffman, W. E. (1971). Essay Examination. In R.L. Thorndike (Ed). Educational Measurement in schools. New York: Longman, Green and Co.

Coleman, J. C., Butcher, J.N. and Carson, R.L. (1980). Abnormal Psychology and modern life. Glenville, Il.: Scott Foresman.

Coleman, F. W. (1984). Helping Siblings and other peers cope with dying. In H. Wass, and C.A. Corr (ed) Childhood Death. Washington D.C.: Hemisphere Publishers.

Cooke, G. (1966). The Effect of Two Desensitization Procedures: An analogue Study. Behavior Research and Therapy. 4:17 - 24.

Couch, A and Keniston, K. (1960). Yeasayers and Naysayers:Agreeing Response Set as a Personality Variable. Journal of Abnormal and Social Psychology. 60:161 - 174.

Courtois C.A. (1979). Characteristics of Volunteer Sample of Adult Women who Experienced Incest in Childhood or Adolescence. Dissertation Abstract International. 40:2194 A - 3195 A.

Dermas, M., Orleans, E. A. and Ockere, M. C. (1990). In A. Shalangwa. Maladaptive Behaviours and Modes of Intervention. A seminar presented in Ahmadu Bello University, Zaria.

Durojaiye, M.O. A. (1986). A new Introduction to Educational Psychology. Ibadan: Evans Brothers Ltd. (pp. 50 - 68).

Ellis, D. P. (1968). The Design of Social Structure to Control Aggression. Dissertation Abstract International 29 (2 – A), 672.

Elkind, D. (1981). The Hurried Child: Growing up Too Fast, Too Soon. In K. Johnson Trauma in the Lives of Children London: McMillan Education Ltd.

Epstein, L. H. and Hersen, M. (1974). Behavioural Control of Hysterical Gagging. Journal of Clinical Psychology. 30: 201 – 204.

Epstein, L.H., Miller, P.M., and Webster J.S. (1974). The Effect of Concurrent Behavior on Self-monitoring. Journal of Behavioral Therapy and Experimental Psychiatry. 5:59 - 63.

Erickson, E. (1968). Identity: Youth and crisis. New York: John Weley and sons.

Eth, S. and Pynoos R.S (1985). Post Traumatic Stress Disorder in Children. American Psychiatric. New York. 20:144 - 150.

Eth, S. and Pynoos R.S. (1985). Developmental Perspective of Psychic Trauma in Childhood. In C. A. Figley (ed.) Trauma and its wake. New York: Brunner/Mazel.

Eysenck, J.H. (1977). Crime and personality. London: Routledge and Kegan Paul. pp. 106 - 114.

Frears, L. H., and Schneider, J. M. (1981). Exploring Loss and Grief Within a Holistic Frame work. Personnel and Guidance Journal. 59 (2), 341 – 345.

Frederick, C.J. (1985a). An Introduction and Overview of Youth Suicide. In M. Peck, N. Farberow and R. Litman (eds.) Youth suicide. New York: Springier.

Freud, S. (1920). Beyond the Pleasure Principle. In J.Strachey (ed.) The Standard edition of the Complete Psychological Works of Sigmund Freud. Vol.18 London: Hogarth.

Freud, S. (1926). Inhibitions, Symptoms and Anxiety. In J. Strackey (ed.) The Standard edition of the Complete works of Sigmund Freud Vol 18 London: Hogarth.

Freud, S. (1939). Moses and Monotheism. In J. Strachey (ed.) The Standard edition of the Complete Psychological works of Sigmund Freud. Vol. 18. London: Hogarth.

Gelles, R. (1979). Methods of Studying Sensitive Family Topics American Journal of orthopsychiatry. 8:408 - 424.

Ginott, H.G. (1976). Between Adolescents and parents. London: Crosby Lockwood Staples.

Goldman, L. (1978). Research method for Counselors: Practical approach in field counseling. New York: John Wiley and Son.

Hackney, H. and Cormier, L.S. (1979). Counseling Strategies and objectives (2nd ed). Englewood Cliff, N.J.: Prentice Hall Inc.

Harris, L. J. (1980). Middle class High school Drop-outs: Incidents of Physical Abuse, Incest, Sexual assault, Loss, Symptomatic Behaviors and Emotional Disturbance. Unpublished doctoral dissertation, Minesota, University of Minesota..

Heatherington, E.M., Cox, M. and Cox, R.(1978). Family Interaction and social and Cognitive development of Children following divorce. Institute of Pediatric Service, Washington, D.C.

Hendlin, H. (1985). Suicide Among Young Psychodynamics and Demography. In M. Peck, N. Faberow and R. Letman (eds.) Youth Suicide. New York: Springier.

Herbert, M. (1987) Living with Teenagers. Oxford: Basal Blackwood.

Herman, J. (1981). Father - daughter Incest. Cambridge: Howard University Press.

Hersen, M. and Barlow, D.H. (1977). Single Case Experimental Designs. New York: Pergamon Press.

Hersen, M., Eistein, R.M., Alford, G.S., and Agras, W.S. (1973). Effect of Token Economy on

Neurotic Depression: an experimental analysis. Behavior Therapy,. 4:392-397.

Holin, R.C. (1995). Management Behavioral Treatment: Police and practice with Delinquent Adolescents. U.S.A.: Routledge & Kagan Paul. pp. 169-171.

Holmes, T.H. and Rahe, R.H. (1967) The Social Readjustment Rating Scale. Journal of Psychosomatic research, 11: 213 -218.

Hopson, M. Defining adolescence. In M. Herbert Living with teenagers. Oxford: Blackwell.

Horowitz, M. J. and Solomon G.F. (1978). Delayed response in Vietnam Veterans. In G.F. Figley (ed.) Stress disorders among Vietnamese Veterans. New York: Brunner/Mazel.

Horton, G.O., Larson, J.L., and Master, A.L. (1972). The Generalized Reduction of Student Disapproval Behavior. Unpublished manuscript, University of Oregon, Eugene.

Ike, E. (1983). Factors Responsible for Increased Enrollment of married Women in Post Graduate Programmes in Ahmadu Bello University, Zaria. An unpublished Post Graduate Diploma in Education (P.G.D.E.) thesis, Ahmadu Bello University, Zaria.

Ipaye, T. (1983). Developmental Tasks of Literate and Illiterate Nigerian Adolescents. Journal of African child studies, 1 : 11 - 17.

Iwuji V.B.C. (1990). Stress and Modern Living: How to Cope with excessive Stress. Journal of Research in Counselling Psychology. 2 (2):1 - 9.

Johnson, K. (1989). Trauma in the Lives of children. London: McMillan Education Ltd.

Johnson, S.M. and Libitz, G. (1972).Demand Characteristics in Naturalistic Observation. Unpublished manuscript, University of Oregon, Eugene.

Johnson, S.M. and White, G. (1971). Self-observation as an Agent of Behavioral Change. Behavior Therapy. 2 : 488-497.

Justice, B. and Duncan, D.F. (1976). Running away: An Epidemic of Adolescence, Adolescence. 1 : 365 -371.

Kalu, A. and Osimbajo, Y. (1990). Narcotics, Law and Police in Nigeria. Proceedings of the Federal Ministry of Justice, Nigeria.

Kanfer, F.H. (1975). Self Regulations: Research Issue and Speculation. In C. Neuringer and J. Michael (eds.) Behavior Modification in Clinical Psychology. New York: Appleton-Century Croft. 3.179 - 220.

Kaplan, H.S. (1979). Disorders of Sexual Desire and Other New Concepts and Techniques in

Sex Therapy. New York: Brunner/Mazel.

Klagsbrun, F. and Davis, D.E. (1977). Substance Abuse and Family Interaction. Family Process 16:149 - 163.

Krumboltz, Z., Thorsen, T. N. and Carl, C. E. (1976). In H. Hackney and L. S. Cormier. Counselling Strategies and Objectives (2nd ed) Englewood Cliff, N. J.Prentice Hall Inc.

Kwajafa, K. J. (1991). Drug Abuse Prevention. In J. A. Luka. Maladaptive Youngsters Government's Intervention programme. A seminar paper presented in Ahmadu Bello University, Zaria.

Landermann, E. (1944). Symptomatology and Management of Acute Grief. American Journal of Psychiatry, 104:141-146.

Laman, M. (1970). The Desire for Justice and Reaction to Victims: Social Psychological studies of some Antecedents and Consequences. In J. Macauley , and L. Bekowitz (ed). Altruism and helping behavior. New York: Academic Press.

Langer, E.J. Jaris, I.L. and Wolf, J. (1975). Reduction of Psychological Stress in Surgical Patients. Journal of experimental Psychology. 1:155 - 166.

Langer, T. S. and Michael, S. T. (1963). Life Stress and Mental Health. New York: Free Press.

Lerner, M. (1970). The Desire for Justice and Reactions to Victory: Social Psychological Studies of Antecedents and Consequences. In J. Macauley and L. Berkowitz (eds.) . Altruism and Helping behaviour. New York: Academic Press.

Levite, M. J. (1994). The Police and the Community. In J. A. Luka. Maladaptive Youngster: Government's Intervention. A seminar paper presented in Ahmadu Bello University, Zaria.

Lichter, S.O. Rapien, E.B., Seibert, F.M. and Sklansky, A.(1962). The Dropout: a Treatment Study of Intellectually Capable students who Drop-out of High School. New York: Free Press.

Lidz, T., Felk, S. and Cornelison, A. R. (1965). Schizophrenia and the Family. New York: International Press.

Lorrie, I.S. (1977). The Phenomenon of the Abused Adolescent: A clinical study. Victimology. 2: 268 - 276.

Luka, J.A. (1995). Maladaptive Youngsters: Government intervention programmes. A seminar paper presented in Ahmadu Bello University, Zaria, Nigeria.

Luka, J. A. and Shalangwa, A. (1995). The Nigerian Concept of Maladaptive Behaviours. A seminar paper presented in Ahmadu Bello University, Zaria.

Lustig, N. and Zeitlin, M. (1985). Bipolar Effective Order: A Delinquency Variable. In M. Peck, N. Faberow and R. Litman (eds.) Youth Suicide. New York: Springier.

Mahoney, M.J. (1979). The Self-management of Covert behavior: A Case Study. Behavior Therapy. 2:575 - 578.

Mahoney, M., Mowra, N. and Wade, T. (1973). The Relative Efficacy of Self-reward, Self monitoring and Self-punishment Techniques for Weight loss. Journal of Consulting and Clinical Psychology. 40:404 - 407.

Mahoney, M. and Thoresen, C. (1974). Self-Control: Power to the Person. (eds.) Monterey: Book/Cole ltd.

McFall, R. M. (1970). Effect of Self-Monitoring on Normal Smoking Behavior. Journal of Counseling and clinical Psychology 35:135 - 142.

McFall, R.M. and Hamman, C.L. (1971). Motivation, Structure and Self-monitoring: The Role of Nonspecific Factors In Smoking Reduction, Journal of Consulting and Chemical Psychology; 37:80 - 86.

Meizelman, K. (1978). Incest: A Psychological Study of Causes and Effects with Treatment Recommendations. San Francisco: Jossey-Bass Publishers.

Millman, R. B., Khuri, E.T. and Hammond, D. (1981). Perspectives on Drug Use and Abuse. In C.F. Wells and I.R. Stuart (eds) Self Destructive Behavior in Children and Adolescents: New York: Van Nostrand Reinhold.

Mitchell J. (1983). When Disaster Strikes: The Critical Incident Stress Debriefing Process. Journal of Emergency Medical Services, 8:36 - 39.

Murkherjee, A. (1980). Educational Psychology. Calcutta: K.P. Bassu Publishing Company.

Nilson, P. (1981). Psychological Profiles of Runaway Children and Adolescents. In C.F. Wells and I.R. Stuart (Eds). Self-destructive Behavior in Children and Adolescents. New York: Van Nostrand Reinhold.

Nsa, A.N. (1993). Stress Insulation as a Tool for Rational Decision Making: A Case Study in Ahmadu Bello University, Zaria. An unpublished PhD Thesis, Ahmadu Bello University, Zaria, Nigeria.

Norem-Hebeison, A. and Hedin, D. (1981) Influence on Adolescent Problem Behaviour. In U. S. Department of Health Services (Ed.). Adolescent Peer Pressure. Washington D. C.: U. S. Department of Health Services.

Nwoke N.O. (1992). Effect of Self-Instructional talk and Multicomponent Approach on Management of combat Stress among Nigerian Soldiers. An unpublished PhD thesis. Ahmadu Bello University, Zaria, Nigeria.

Nwagu, B.G. (1991). Educational Research: Basic Issues and Methodology. Ibadan: Wisdom Publishing Company.

Odumesu, A.O. (1988). Effect of Ineffective Technical Education on the Training and Eventual Rehabilitation of Young Offenders. An unpublished project, Nigerian Prisons Staff School, Kaduna.

Ogolekwo, P. (1991). Police and Public Relations Committee: A New Approach to Crime Control. A seminar paper presented in the police college. Kaduna, Nigeria.

Okon, S.E. (1988). The Teenager in Nigerian Secondary School: Understanding and Guiding their Development. Uyo: Modern Business Press.

Okonkwo, C.O. (1994). The Police and Social Justice: A seminar paper presented in the workshop by the National Orientation Agency and the Nigerian Police. Kaduna

Onyehalu, A.A. (1986). Psychological Analysis of Juvenile Delinquents. Nigerian Journal of Applied Psychology. 1:227 - 236.

Olurontimihin, O. (1994). Some Factors Related to Juvenile Delinquency in Nigerian Children. West African journal of Education 18(2):117 - 128.

Orhungur, M.M. (1995). Causes of Students Crisis in Higher Institutions: an overview of the Phenomenon in Benue State. Proceedings of the 18th annual Conference of Counselling Association of Nigeria (CASON) pp 100 - 106.

Parker, E. Parker, D., Brody, J. and Schoenberg. R., (1982). Cognitive Patterns of Premature Ageing in Male Social Drinkers. Alcoholism: clinical and experimental Research, 6 (1) 46 -52.

Paterson, C N. (1980). Theories of Counseling and Psychotherapy, third edition. New York: Harper and Row Publishers.

Peck, M. (1984). Youth Suicide. In H. Wass and C.A. Corr (eds). Childhood and death. Washington D.C.: Hemisphere Publishers.

Perri, M.C. and Richards, C.S. (1977). An Investigation of Naturally Occurring Episodes of Self-controlled behavior. Journal of Counseling Psychology. 24:178 -183.

Premack, D. (1965). Reinforcement Theory. In D. Levin (ed.) Symposium in Motivation. Lincoln: University of Nebraska Press. 123 - 280.

Rigby, P. (1996). Guidelines for Reducing Overcrowding and Heating in Chibs, The Independence. December 11, p.3.

Risley, T. R. and Wolf, M.M. (1972). Strategies for Analyzing Behavioral Change Over Time. In J. Nesselroade and H. Rees (Eds.) Lifespan Developmental Psychology Methodological Issues. New York: Academic Press.

Risley, T.R. (1970) Behavior modification: An Experimental Therapeutic Endeavor. In L.A. Hermerlynck, P.O. Davidson and L.E. Acker (Eds.) Behavior Modification and Ideal Health Service. Calgary: University of Calgary press.

Robins, L.N. Davis, D.H. and Wish E. (1977). "Dictating Predictors of Rare Events". In J.S. Strauss (ed.) The origins and Cause of Psychopathology. New York: Plenum.

Rogers, C R. (1951). Client-centred Theory. It's Current Practice, Implications and Theory. Boston: Houghton Miffin.

Rogers, C.R. (1954). Personal Communication. American Journal of Psychotherapy. 15:27 - 45.

Ross, S. and Even, A. (1972). The Modification of Extreme Social Withdrawal by Modeling with Guided Participant. Journal of Behavioral Therapy and Experimental Psychiatry. 2:230 - 235.

Russell, D.H. (1981). On Running Away. In C. F. Wells and I. R. Stuart (eds.), Self destructive behavior in children and adolescents. New York: Van Nostrand Reinhold.

Saarni, C. and Azara V. (1981). Anxiety (Developmental). In Rwoody (ed.) Encyclopedia of Clinical Assessment. 2:95 - 102. San Francisco: Jossey - Bass.

Sadauki, A.P. (1988). Juvenile Delinquency is a Bleeding Wound in the Society New Nigerian News paper, December 12, p.9.

Sandhu, S.H. (1977). Juvenile Delinquency: Cause, Control and Prevention, New York: McGraw Hill Inc. P. 43.

Satir, V. (1967). Conjoint Family Therapy. Palo Alto: Science and Behavior Books.

Schlebuch, L. (1979). Conduct disorders in Youths. London: Butherwoth and Col. Ltd. pp. 77 - 78.

Schukit, M.A. Morrissey, E.R. Lewis, N.J. and Buch W.T. (1977). Adolescent Problem Drinkers. In F.A. Seeus (ed) Currents in alcoholism (Vol 2.) New York: Crune and Stratton.

Seligman, M.E., and Garber. J. (1980. Learned helplessness. New York: Academic Press.

Shalangwa. A, (1995). Maladaptive behaviour and modes of intervention. A seminar presented in Ahmadu Bello University, Zaria, Nigeria.

Shamugan E.T. (1981). Abnormal Psychology. New Delhi: Tata McGraw - Hill Publishing Co. Ltd.

Soleye, K. (1993). What the Family means to the Child. A paper presented in the 16th annual conference of Guidance and Counselling, Kano: Nigeria.

Solomon, R.L. (1964). Punishment. American Psychologist. 19 : 239 - 253.

Stollak, G.E. (1967). Weight loss Obtained Under Different Experimental Procedures. Psychotherapy: Theory, Research and Practice. 4:64 - 66.

Teenagers, five others condemned for Armed Robbery, (1986). The Punch, April 10, p. 1.

Tiecher J.D. (1979). Suicide and Suicide Attempts. In J.D. Hoshpitz (ed) Basic handbook of child Psychology 2:120 - 125 New York: Basic Books.

Terr L.C. (1985). Children Traumatized in Small Groups. In S. Eth and R. S. Pynoos. Post-traumatic Stress Disorder in Children. Washington D.C: American Psychiatric Press.

Terry, D. Lidz, T. Cornelison, A, Fleck, S (1957). The Intrafamilial Environment of Schizophrenic Patients: Marital Schism and Marital Skew. American Journal of Psychiatry. 2:163 -171.

Thorneburg, H. D. (1975). Attitudinal Determinants in Holding Dropouts in School. Journal of Education Research. 68:181 - 185.

Trimble, M. R. (1981). Post-traumatic neurosis. Chicester: John Wiley.

Trimble M. R. (1985). Posttraumatic Stress Disorder: History of Concept. In C.R. Figley (Ed) Trauma and its wake. New York: Brunner/Mazel.

Walker, D. (1975). Runaway Youths: An annotated Bibliography and Literature overview. U.S. Department of Health, Education and Welfare, Washington D.C.

Walker, H. M. and Buckley, N. K. (1968). The Use of Positive Reinforcement in Conditioning Behavior. Journal of Applied Behavior Analysis. 1: 245 - 250.

Watson. D., and Tharp, R. (1972). Self-Directed Behavior Change: Self modification. Personal Adjustment. Monterey: Book/Cole Ltd.

Weatherhead L.D. (1985). Psychology and life. London: Arthur James.

Wehlage, N. (1989). Goals For Living: Managing Your Resources. Illinois: The Good heart - Wilco Company Inc.

Weideger, P. (1978). Female Cycle. London: The Women's Press Ltd.

William, J.G., Barlow G.H. and Agras, W.S. (1972). Behavioral Measurement Of Severe Depression. Archives of General Psychiatry. 27:330 - 333.

Wilson J.P. (1978). Identity, Ideology and Crisis: The Vietnam Veteran in transition, Vol. 2. 0Washington D.C.: Disabled American Veteran.

Wolkin, S.N. Rutter, M. (1973). Children Who Have Been "In Care": An Epidemiological Study. Journal of Psychological Psychiatry. 14:97 - 105.

Zung, W. W. K (1965) Self-rating Depression Scale. Archives of General Psychiatry 12:60 - 70.

APPENDIX I

Self Esteem Level Inventory (SELI) of some inmates of Kaduna Borstal Training Institution

Please answer the following questions very honestly. Your answers will determine wether you continue in the research programme or not.
Tick the one that is applicable to you in A and B and fill the rest.

(A) Do you like yourself? yes ( ) no ( )

(B) Are you satisfied with your present state in life?yes ( ) no ( )

(C) What are your strong points? (a)_____
(b)_____
(c)_____
(d)_____
(e)_____

(D) What are your weak points? (a)_____
(b)_____
(c)_____
(d)_____
(e)_____

Tick right (✓) the statement that represents your state of mind at present and leave blank the statements that do not.

P1. I would like to be a respectable citizen __
N2. I love the company of my peers and would like to be with them always __
N3. I am afraid to go back to the society because I do not want to have the previous experiences I was having before __
P4. I would like to be established in future as a business man, a civil servant, soldier or hold some responsible office __
N5. I hate school and I know my head cannot just take in any formal education now. __
P6. I would like to go back to school __
N7. Parents and teachers are boring and I cannot stand them __
P8. I would like to work hard and earn my living __
N9. When I go home, I will see to it that I revenge myself of all that relatives and teachers did to me __
P10. I crave acceptance and love from my relatives and I miss them __

APPENDIX II A

SAMPLE OF SELF MONITORING CARD - Baseline Number_____

You have stated that your weak point is bad temper and fighting. You have also said that you would not like to be fighting anymore. But it will be difficult for you to know when you have reduced fighting if you do not know the rate at which you fight now. This card is to help you know how much you fight before you begin to regulate it. So do not try to restrain yourself. Fight normally but tick (✓) for yourself each time you fight. It will never be counted against you.

	Week One			Week Two		
	Morning hours	After-noon	Evening & night	Morning hours	After-noon	Evening & night
Monday						
Tuesday						
Wednes-day						
Thurs-day						
Friday						
Satur-day						
Sunday						
Total						

APPENDIX II B

MOTORIC OBSERVATION CARD-Baseline Number_____

This card is to record how many times your room mate, number _____ will smoke cigarettes each day.

Observe him quietly, you do not need to let him know that you are observing him. The result of your observation will not be used against the inmate in any way. It is just for research purposes.

Instruction: Tick (✓) in the space provided each time you observe him smoke. If he does it more than once within any given time bracket, tick more than once.

	Week One			Week Two		
	Morning Hours	After-noon	Evening & night	Morning hours	After-noon	Evening & night
Monday						
Tuesday						
Wednes-day						
Thurs-day						
Friday						
Satur-day						
Sunday						
Total						

APPENDIX II C

SELF MONITORING -TREATMENT AND WITHDRAWAL CARD Number_____

I have committed myself to reduce and finally stop smoking. This is because I know that it is better to stop smoking as it is dangerous to my health. I will, therefore, monitor myself and record my progress towards stopping smoking. Any time I see cigarettes, come close enough to be able to use it, can afford it, but do not smoke, I shall tick a right (✓) for myself.

	Week One			Week Two		
	Morning hours	After-noon	Evening & night	Morning hours	After-noon	Evening & night
Monday						
Tuesday						
Wednes-day						
Thurs-day						
Friday						
Satur-day						
Sunday						
Total						

APPENDIX II D

SELF MONITORING - TREATMENT AND WITHDRAWAL Number_____

I have committed myself to reduce and finally stop breaking bounds ("crossing"). This is because I know it is better for me to control myself as it makes me more mature. Any time I have the Opportunity and do not break school bounds, I shall tick (✓) for myself.

	Week One			Week Two		
	Morning hours	After-noon	Evening & noon	Morning hours	After-noon	Evening & noon
Monday						
tuesday						
Wednes-day						
Thurs-Day						
Friday						
Satur-day						
Sunday						
Total						

APPENDIX II F

MOTORIC OBSERVATION CARD - TREATMENT AND WITHDRAWAL

Number_____

This card is to help you record how much your room mate Number_____ is resisting the habit of smoking. It is true that you do not smoke but you can observe your mate for his good and record how much he is resisting cigarette. So any time he comes close enough to cigarette under the circumstances you observed him smoking before, if he can control himself and not smoke, tick() for him. If he is able to resist smoking more than once in a given space of time tick as many times as he has done so.

	Week One			Week Two		
	Morning hours	After-noon	Evening & night	Morning hours	After-noon	Evening & night
Monday						
Tuesday						
Wednes-day						
Thurs-day						
Friday						
Satur-day						
Sunday						
Total						

Self-management Cards have been used and are recommended by Hackney and Cormier (1979)

APPENDIX III

INTRODUCTION TO SELF-MANAGEMENT THERAPY - (Discussion is allowed)

Beginning of group counselling - session I

- Remember you filled a questionnaire for me. In your responses in that questionnaire, I could see that many of you have passed through certain experiences that made coping very difficult for you, e.g., some of you lost your father/mother when you were young.
- Some of you have your parents living separately either through divorce or separation. Some of you have had bad experiences in school or among your friends or parents.
- That your parents are not living together has been a difficult experience for you as you began to manage a step parent or relatives who were not giving you adequate attention.
- Those of you losing a parent had many difficulties trying to cope psychologically and economically.
- When one has situations like these one normally tries to find ways of helping one's self and so may develop some coping strategies. Some of them are helpful but some are Self destructive.
-For instance some boys smoke to feel excited, a little happy.
- They follow friends who will help them talk and forget their difficulties.
- Some, (because parents are not always around because of business,) are sent to relatives who do not care for them adequately.
- Some drink to make them forget their difficulties.

- When these start, they take just a little and as they go deepe they begin to manifest some behaviours that people around them d not like.

- People talk to them but because the company and the substance they take do not allow them to hear, understand and withdraw, the remain where they are. People think they are stubborn and begin t punish them.

- In the end, the whole society turns against such boys. The boy begin to feel insecure and intensify their defensive behaviours t protect themselves and feel secure. They then go from smokin cigarette to smoking hemp and so from drug to drug. Then, they ge farther and farther from their parents, relatives and the society and so they live only with their small clique which helps them t harm themselves more.

- Meanwhile their parents and the society become so upset with the that they do not want to see them anymore. They are sent throug the nightmare of the police and court and finally, the Remand Home.

- In all these there are things we have to note

(1) The society does not want to know what caused the person's behaviour at the beginning.

(2) The society wants to get rid of the person.

(3) The boys cannot help themselves.

(4) The gap between them and the society widens. It seems as if there is no solution.

But there is solution. The solution lies in these persons. Conditions were hard for them. They forgot themselves. They

neglected themselves to bad habits. To change the situation, it is the person concerned who has to adjust his mind. It is he who must accept himself which he rejected for bad habits.

(1) He is to develop confidence in himself and begins to feel secure with out drug or other substances or peers.

We shall stop here today. Next week we will talk about how people can develop self confidence though they may have been forced by the circumstances and the society to loose confidence in themselves while the society turned around to blame them. I believe that any child who is given a right condition to grow in will grow well enough to love himself. But one should not depend on the society to help one. One must help oneself back on the feet.

We are going to work together to achieve that. No force, no punishment, no ridicule. We all must understand that we are all human beings, all Nigerians and we must preserve one another.

We will be meeting together for some weeks. Is there any one here who does not want to be a member of this team?

Session II

Structuring:

Beginning of the days business:

We will start today by looking at the term self concept.

Self concept: how you see yourself.

How you see yourself is important because if you have a strong sense of who you are

(1) You will be able to make decisions that are right for you

(2) You will make plans for doing something about your weaknesses.

- You have certain impressions about yourself. These are your self concept; and it affects the decisions you make throughout life. If you have a healthy self concept you will realistically judge the facts about yourself. You know your strengths and your weaknesses. You feel positive about you good points. You may not like the bad points but you can accept them if your self concept is healthy. But if your self concept is unhealthy you will become proud of your good points and develop poor coping strategies for the bad ones.

Content of Self Concept.

Self Concept = How you see yourself and how you feel about yourself.

This includes

(1) Your personal self e.g., your looks and your abilities.

(2) Your social self i.e. how you view yourself in relation to other people e.g., are you sociable, do you make friends easily or would like to be alone.

(3) Your ideal self i.e. who you would like to be like - your hero e.g., in sports, a television star. e.t.c.

(4) Your extended self - your identification group. You are very loyal to that group e.g., gangs, sport team. If a person in that group is insulted your 'self' reacts.

So your self concept consists of all you know and believe about yourself. Your self concept is the key to your behaviour and personality. How you react when something happens depends on how you see yourself in relation to the situation. Things are right or wrong when you judge them in relation to yourself.

A positive self concept helps you to be self confident, more willing to accept challenges. If your self concept is negative, you may find it difficult accepting yourself.

Formation of Self Concept

- Self Concept is developed throughout life.
- Even as you are here you are developing it.
- Self Concept is based on your values, life experiences, people around you.
- Most of your Self Concept is determined by your response to experiences with other people around you , especially your parents, family, peers.

Experience with family and parents.

- When a child is given care, encouragement, security, love and guidance by parents a positive Self Concept is likely to be developed.
- On the other hand, children who are rejected discouraged and often punished are likely to develop negative Self Concept or image of them selves.

Session 3

Structuring: Researcher welcomes inmates. Ask them of their health, work, games. Any plan for competition? Some of you may end up playing in world cup and olympic for Nigeria. I guess some of you are very good players. -Exchange of views on world cup -France '98. Can we go into business?

For the last two weeks we have been talking about two things (1) Conditions that generate bad coping behaviours in young people. Can you remind us of some of them?

(2) Self concept.

We said that the way we think about ourselves - our self concept determines the way we react to situations

-Our experiences affect our self concept - experiences in our family and in our environment.

Today, I wish to add that we can change our self concepts. This takes time and a lot of work. You change your self concept as you develop and respond to the changing world.

<u>Factors that create a healthy self concept.</u>

(1) High self esteem - people with high self esteem

-feel they are worth while

-act like worthwhile persons

-have self confidence

-feel secure

-trust themselves

-have self respect

-if they make mistakes they can adjust positively.

Low self esteem - lack of self confidence

-feel insecure

-feel threatened by new experiences

-can't cope with mistakes.

Self concept has to be realistic. You know your weak and good points but do not condemn yourself and try to work on your weak points.

Your self concept should be complete. You know a lot about all facets of your life. You know what you can do and what you cannot do then you take advantage of opportunities to try new things.
Your self concept becomes more complete as you grow, meet more people, have more experiences. These help you to know who you are, what you can do and your views about life. Your self concept becomes more stable as it becomes complete. You become more confident and stronger.
Psychological problems are often related to a less stable self concept. Some people go through life without developing stable self concept. Such people are confused about who they are. They can't make choices, they don't know what they believe or what they want in life.
A person with a healthy self concept does not show off with his good and strong points. He is not selfish and proud that he has strong points. He does accept his weakness.
He decides which aspect of himself he wants to improve. He then sets goals based on the traits most important to him. This is the BEGINNING OF SELF-MANAGEMENT PLAN. (Self esteem questionnaire introduced here.)

Summary

Every human being is born into challenges. Some people are

born into an encouraging family and environmental conditions that help them meet these challenges easily. Some people - in fact most people - are born into a hostile environment e.g., fighting, quarrelling homes, divorced parents, separated parents, environments of bad peers - people who are not honest, do not want to work with their hands, smoking, stealing, drinking, fighting, e.t.c. As they experience this type of environment, they develop their goals around such behaviours and decide on what to do with themselves. Some go through a lot of stress to cope with devastating family situations. All these may make them develop destructive coping strategies which result in very unhealthy self concept. They develop low self esteem, lose confidence in themselves, become insecure, become unrealistic and limit their company to gangs who appreciate them as the society rejects them. They cannot therefore develop complete self concept and so cannot make realistic plans for self. But there is hope, there are steps to follow:

(1) They can analyze themselves and pick out the strong/good and weak/bad points in their lives, noting that their present behaviour is not solely their fault.

(2) Accept and be happy for their good points

(3) Decide which aspect of their weakness they want to improve.

(4) Set goals to improve them based on the traits most important to them. By this, they are developing a self management plan.

They may not be able to do this all alone. They need help. In your case, if you want to be a part of self-management plan, the

researcher is here to help you start. I will encourage you as much as possible while you modify your behaviour. And I will have to talk with you individually during your self-management.

Appendix IV

Summarized sample of Individual Counselling/Self monitoring

Therapist - You will recall that we have been talking together for a while now. I have got to know you personally and I believe you know me too.

Patient - Yes.

T - I am a mother and a Nigerian and so I have your interest at heart as if you were my blood child. In my previous discussion with you and through the last questionnaire you filled for me and the self report you just gave me I noticed that there are still some types of behaviour you display which you do not seem to like.

P - Yes.

T - What is that behaviour?

P - Smoking.

T - You told me you smoke to forget your cares and painful experiences you have got through life, and you have smoked for some years.

P - Three tears.

T - Have any of those pains and cares disappeared permanently since you started smoking?

P - No.

T - Do you think it is logical to continue smoking, since, as you can see it does not give you any permanent solution? Besides smoking is injurious to your health (say more about health and smoking)

P - Smoking is not a logical answer to my problems.

T - Smoking appears, as you can see, to be an irrational and illogical way of solving problems. It makes those trying to solve their problems that way seem illogical. You forget problems when you smoke, when you are not smoking the problems wear back on you. Problems need permanent solutions. And you are capable of finding logical and rational solutions to your problems. But to do that you have to first of all accept that cigarette will not help you and so you detach yourself from it. When that has been done you will be helped to apply yourself to more rewarding activities that will enhance your good traits. What do you intend to do now about smoking since you have seen that it does not help you?

P - I will stop smoking.

T - Do you mean that you do not like associating yourself with such smoking any more?

P - Yes, I want to stop it. I have tried to do so before but I went back to it after a day. I want to stop it now.

T - If then you think you are fed up with smoking you have to do something about it. You know no other person can stop smoking for you, you have to stop it. Is that clear? It is your responsibility. You can do it if you want. I will only help you see that you evaluate yourself as you do so. Do you really want to begin?

P - I want to do it if you will help.

T - You now have a goal - to stop smoking. So how are you going to reach that gaol?

Pause for arrangement for the subject.

Alright, I shall then give you something that will help you check wether you are moving towards your goal. In this card you have each day divided into three - morning, afternoon, and night. Morning is from the time you wake up till the one o'clock when you close from school. From the time you close from school till the six o'clock when you have your evening meal is termed afternoon. After your evening meal till when you wake up the next day is night. If at any of these time brackets you are tempted to carry out the behaviour you now want to discontinue but you are able to resist it by controlling yourself, just tick (✓) right for yourself in the space provided. If that happens more than once in that time bracket, tick as many times as it happens. This card is to help you monitor your progress. In the morning you have to bring your card to the instructor assigned to you. She/he will record your progress and give the card back to you so that you can continue. Each time I send for you, you should come with this card.

The statement written in the card is the one you yourself made; that you will gradually stop displaying the behaviour. So it is written out for you so that you can look at it each time you are tempted and remind yourself of your promise.

P - Thank you.

Appendix V

Blue Print of the Self Management Treatment - Borstal Training Institution, Kaduna.

Week 1 Consultation and permission from the Director of Prisons, Kaduna State.

Week 2 Consultation and permission from the Principal of Borstal Training Institution, Kaduna.

Week 3 Selection and training of research assistants from among the staff of Borstal Institution on how to administer the survey questionnaire.

Week 4 to 6 Administration of the questionnaire to the inmates and analysis of the data collected.

Week 7 First interaction with inmates and their teachers (the research assistants)

Weeks 8 and 9 -Introduction of the researcher.

- Introduction of group counselling. Orientation to the programme by explaining trauma, it's sources and it's effect on behaviour, the relationship between behaviour and public treatment of youths with maladaptive behaviours.

Week 10 Review of the previous week's work with few questions to ascertain understanding of instruction on Self Concept.

Week 11 Review of the previous week's work and establishment of self esteem level using questionnaire (SELI).

Week 12 Discussion of self management as a response to traumatic experiences.

Week 13 Introduction to Self-management - Beginning of individual

counselling. Assignment on personal behaviour modification in the form of questions to answer personally.

Week 14 and 15 Review of Self Concept, handling of trauma, Self contracting, Self monitoring.

Introduction to self monitoring card and how to use it.

Fixing of rewards. Assignment on self management - behaviour modification.

Weeks 16 to 27 Discussion and feedback on previous assignments. Reinforcements where necessary. Self monitoring continued with contingent reinforcement.

Week 28 Rounding up reinforcements. Subjects advised to go on monitoring self without token' reinforcement.

Week 29 to 30 Post treatment observation - no contingent reinforcement.

Week 31 Rounding up of activities - Conference, discussion with subjects.

Appendix VI

BASELINE

RAW-DATA - SELF-MONITORING AND MOTORIC MEASUREMENT

Im No	B3601				B3603				B3649			
wk	1		2		1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im
Mo	2	2	1	2	2	1	2	2	1	2	1	1
Tu	1	1	2	2	1	1	2	3	2	1	1	1
We	2	2	2	2	2	2	2	2	3	2	1	1
Th	1	1	1	0	2	2	2	2	2	1	2	1
Fr	1	1	1	1	1	0	2	1	2	2	2	2
Sa	0	0	2	2	1	1	1	1	0	0	2	2
Su	2	2	2	2	2	2	2	2	3	2	2	2

Im No	B3647				B3670				B3579			
Wk	1		2		1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im
Mo	2	1	3	2	2	2	2	2	2	1	1	2
Tu	1	1	2	2	2	2	3	2	1	1	2	2
We	3	3	3	2	2	2	0	0	2	2	2	2
Th	1	0	1	1	2	0	2	2	2	1	1	1
Fr	0	0	1	1	0	1	2	2	2	1	2	1
Sa	2	1	2	1	3	2	0	0	2	1	1	1
Su	3	2	2	2	2	1	1	1	0	0	0	0

Im No	B3568				B3415				B3564			
Wk	1		2		1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im
Mo	1	1	0	0	2	2	2	2	3	3	2	1
Tu	3	2	0	0	2	2	3	2	2	2	1	0
We	2	2	1	1	2	2	2	2	2	2	3	3
Th	2	1	2	2	2	1	3	1	1	1	3	2
Fr	2	2	3	2	3	2	3	3	2	2	2	2
Sa	0	0	1	1	2	2	2	2	2	1	3	2
Su	1	1	2	2	1	1	2	2	2	2	2	2

Im No	B3544			
Wk	1		2	
	OB	Im	OB	Im
Mo	1	0	0	0
Tu	0	0	0	0
We	2	2	0	0
Th	1	1	0	0
Fr	0	0	0	0
Sa	1	0	0	0
Su	2	2	1	1

TREATMENT

RAW-DATA - SELF-MONITORING AND MOTORIC MEASUREMENT

Im No	E3649							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	1	0	0	1	1	1	2
Tue	2	2	2	2	1	2	2	2
Wed	1	2	1	1	1	1	2	2
Thu	0	0	1	1	1	2	1	1
Fri	2	2	1	2	2	2	1	2
Sat	1	2	1	1	3	3	1	1
Sun	1	2	2	2	2	2	1	1

Im No	E3647							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	2	1	2	0	0	2	2
Tue	3	3	0	0	2	2	1	1
Wed	1	2	2	3	1	2	3	3
Thu	2	3	1	1	3	3	1	1
Fri	2	2	2	2	1	2	2	2
Sat	3	3	2	2	1	2	3	3
Sun	2	2	3	3	1	1	0	0

Im No	E3670

E 3670

Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	1	1	1	1	2	2	2
Tue	3	4	1	1	2	2	1	2
Wed	1	1	1	1	1	1	2	3
Thu	1	1	2	2	1	1	1	1
Fri	2	2	0	1	1	2	1	1
Sat	0	0	0	0	2	3	2	2
Sun	0	0	2	3	1	2	2	2

Im No	E3679							
Wk								
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	1	1	2	2	3	1	1
Tue	2	2	0	0	1	1	1	1
Wed	3	3	0	0	2	2	1	2
Thu	2	2	0	0	1	1	2	2
Fri	0	0	1	2	2	1	0	0
Sat	0	0	2	2	5	6	2	2
Sun	2	2	1	1	3	3	3	3

Im No	E3415							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	2	2	2	2	1	1	0	1
Tue	1	1	2	3	0	0	1	1
Wed	0	0	3	3	0	0	1	1
Thu	2	2	1	1	0	0	0	0
Fri	2	2	1	2	1	1	1	1
Sat	0	0	2	2	0	0	1	1
Sun	0	0	2	3	1	1	0	0

Im No	E3544							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	2	1	2	2	2	0	0
Tue	2	2	2	2	0	0	1	2
Wed	2	2	2	2	0	0	2	3
Thu	2	2	2	3	2	2	1	1
Fri	1	1	1	2	2	3	1	1
Sat	1	1	3	3	0	0	1	0
Sun	2	3	2	2	2	3	0	0

Im No	E3601							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	0	0	1	1	1	1	1	1
Tue	0	0	0	0	0	0	0	0
Wed	0	0	0	0	0	0	1	1
Thu	1	1	0	0	0	0	0	0
Fri	1	1	0	0	0	0	0	0
Sat	0	0	1	1	1	1	0	0
Sun	1	1	0	0	0	0	1	2

Im No	E3603							
Wk	1		2		3		4	
	OB	Im	OB	Im	OB	Im	OB	Im
Mon	1	1	0	0	1	1	0	0
Tue	1	1	1	1	2	3	1	1
Wed	1	1	1	2	2	2	0	0
Thu	1	2	2	2	2	1	0	0
Fri	1	2	2	2	2	3	1	1
Sat	1	2	0	0	2	2	0	0
Sun	1	1	2	3	3	3	1	1

WITHDRAWAL

RAW-DATA - SELF-MONITORING AND MOTORIC MEASUREMENT

Im No	E3601				E3603				E3649			
Wk	1		2		1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im
Mo	1	1	1	1	1	1	0	0	1	1	1	2
Tu	0	0	0	0	1	1	1	1	1	2	2	2
We	0	0	1	1	2	2	0	0	1	1	2	2
Th	0	0	0	0	2	1	0	0	1	2	1	1
Fr	0	0	0	0	2	3	1	1	2	2	1	2
Sa	1	1	0	0	2	2	0	0	3	3	1	1
Su	0	0	1	2	3	3	1	1	2	2	1	1

Im No	E3647				E3670				3679			
Wk	1		2		1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im	OB	Im
Mo	0	0	2	2	1	2	2	2	2	3	1	1
Tu	2	2	1	1	2	2	1	2	1	1	1	1
We	1	2	3	3	1	1	2	3	2	2	1	2
Th	3	3	1	1	1	1	1	1	1	1	2	2
Fr	1	2	2	2	1	2	1	1	2	1	0	0
Sa	1	2	3	3	2	3	2	2	5	6	2	2
Su	1	1	0	0	1	2	2	2	3	3	3	3

Im No	E3415				E3544			
Wk	1		2		1		2	
	OB	Im	OB	Im	OB	Im	OB	Im
Mo	1	1	0	1	2	2	0	0
Tu	0	0	1	1	0	0	1	2
We	0	0	1	1	0	0	2	3
Th	0	0	0	0	2	2	1	1
Fr	1	1	1	1	2	3	1	1
Sa	0	0	1	1	0	0	1	0
Su	1	1	0	0	2	3	0	0

APPENDIX VII

COUNSELLING MODEL FOR SELF-MANAGEMENT THERAPY ON ADOLESCENTS WITH MALADAPTIVE BEHAVIOURS.

Preamble

Psychologists have suggested many factors such as peer influence, family pathology, trauma and others as antecedents of maladaptive adolescent behaviours. But this study has chosen one antecedent, trauma as a basis for testing the efficacy of self-management therapy in modifying deviant adolescent behaviours. This choice was made to narrow down the scope of therapeutic delivery. Most traumatised deviant adolescents are likely to have similar history. Underlying their maladaptive behaviours are other deep seated trauma implications. Effective treatment of their symptoms requires addressing and resolving post traumatic issues as well as dealing with deviancy.

Most counselling theories have not given attention to trauma per se as a source of emotional disturbances but a lot has been done on the treatment of neurosis which they generate. The basic psychological problems of the maladaptive youngsters are low self-esteem, regression, displaced aggression, inability to handle both their emotions and the environment, joyless life, denial and unawareness of these problems,which is complicated by cognitive rigidity. The counselling model developed for traumatised deviant youths should endeavour to integrate trauma-specific intervention and available relevant counselling theories which address the above problems.

The self-management therapy takes into account the fact that

the client is already psychologically devastated. So the global objective of therapy is to offer a client -centred enhancement that would help the client reorganise himself through acquiring the desired behaviours and extinguishing the undesired ones. The deviant youth therefore requires minimum interference from the therapist, thus eliminating him as a "middle man" in the helping process. The youngsters administer the strategy and direct the change effort themselves.

In order to achieve this objective the therapist should have a clear understanding of post-trauma reaction patterns and post-trauma treatment. He must be flexible and adept in designing multiphased and multifaceted techniques because of contaminating factors like family problems, running away and others.The therapist sees himself only as an enhancer.

- He accepts the client as a person of worth and gives him warmth and liking. - He does not judge the client positively or negatively.
- He gives the client unconditional positive regard and does not contradict what he says to the client by what he does.
- He accords the client empathy and understanding which enables the client to explore freely.

These attitudes make the therapist be perceived as dependable, trustworthy and consistent. As far as the therapist exhibits the above attitudes and the client can to some extent experience them, constructive personal relationship will invariably occur. This is the centre of self-management therapy - the therapist/client relationship. If the right relationship is not developed, therapy

may not progress or become beneficial to the client.

The present researcher has noticed that once trust is established with the therapist adolescents are anxious to share their experiences enthusiastically. But their interpretations of situations tend to attribute their behaviours to other persons and circumstances. The therapist should facilitate ownership of memories by the use of indirect statements, such as "situations like that could be tough", or generalization, like "a lot of people in this kind of situation can be very angry".

The patient has to be allowed good time to talk without censoring or too much probing because probe is threatening to the maladaptive. The therapist, as far as possible should look at matters from patients' view points and make the best case from his views. Nevertheless the therapist should try to make sense of all the talking by noticing the gaps and repressions as well as observing the nonverbal ques and communications. The therapist points out the gaps and omissions to the client and encourages him to further explain them.

As client opens up he is rewarded in any or all of these ways:

- listening with full, free and exclusive attention
- accepting what the client says without judging or condemning
- understanding and remembering what he has said in the past
- in the face of important revelations that the client is ashamed of or anxious about the therapist remains calm e.g. a deviant disclosing in the process of therapy that he murdered or that he is a bastard. The therapist shouldshow no surprise or repulsion.

- showing empathy at the disclosure of events that sound terrible e.g. critical life events like accidents, loss of close family member, rape and such others.

The therapist is permissive towards the client in terms of enhancing his release of thoughts and not in terms of the actions the client should take, because he is to cooperate with the therapist to design actions to take, so although he is permitted to say all he will, he is restricted in choice of activities. This is why he is made to determine the behaviours he is fed up with and directed to modify them.

As the therapist, without pronouncements suggest the possible implications and relationships in the clients stories, he eventually clearly states possible results of and punishment for antisocial behaviours. He lets the patient know that these punishments occur as life realities and natural outcomes of anti social behaviours. Punishment, of course includes other-inflicted ones like jail term, corporal punishment, and self-inflicted punishments such as illogical ideas, attitudes and self-destructive philosophies. The therapist helps the client to realize that he is a rational personality that has self worth; that he has allowed circumstances and situations to overthrow him and lower him to the level of illogical, irrational thought and ideas; that despite all he has narrated concerning himself, there still remains in him something to hope for and build on so that he can become a self supporting individual. He can rebuild himself through getting rid of illogical irrational thinking and attitudes and substituting them with logical, rational ones.

Therapeutic Processes

Treatment of trauma-related maladaptive behaviour must include trauma-specific intervention. Apart from treatment aspects such as network intervention, hospitalisation or psychopharmalogical interventions which are outside the scope of this work, a comprehensive treatment programme needs include:

1. Reliving: A client relives the traumatic experience, paying attention to memories and circumstances that led up to the events. Reliving is useful in filling out the context of the experiences. This can be done as the therapist allows the client to talk about his experiences without sensor, probing, intimidation or judgement; but with understanding and empathy. What the client perceives must be seen in terms of his perception, understanding and conclusions concerning what transpired because this was his cognitive experience during the event. This recalling of sensory data serves the purpose of calling up the
emotions that were bound up. Such perceptual memories are powerful means of
gaining access to the cognitive and emotional realities that must be processed in overcoming trauma related behavioral problems.

2. Releasing: Once the patient has been enhanced to relive the traumatic situation, the feelings once bound up begin to be released. Among some of the inmates studied the release came in spurts. In some cases they came in an overwhelming flood that even led to tears from the patient.

3. Reorganizing: This has to do with reconstructing the present based on changed perception. It involves considerable personal re-

sorting such as basic changes in:

(i) basic cognitive sets used for interpreting the world and anticipating what can be expected from it.

(ii) emotional reaction experienced during and following the event.

(iii attribution of responsibility and personal control over events.

(iv) attitude towards various persons, places and events.

Reorganizing is compounded by the developmental task of gaining independence from family, which under normal condition is difficult. In the case of the deviant he had wrongly broken from the family. reorganization draws him back to family relationships. This sounds ambiguous to him. The therapist has to employ family strategies that allow for indirect focus on family dynamics.

4. Family mediation: The therapist plays the role of a mediator between family and the deviant, doing advanced work with each of the parties. He plays directive roles for both the family and the child. Family mediation can help ease out tension in both the child and the parents so that each begins to understand the other more. This results in nursing old psychological wounds for healing or healing them forthwith.

Summary and conclusion

The goal of therapy is to help the client forget irrational, illogical ideas and attitudes and replace them with more rational philosophy of living so that he can avoid falling victim to other irrational beliefs and ideas. To arrive at this goal the client is enhanced to relive and release from his system post-traumatic

issues which were partly responsible for his unresolved conflicts. Client is helped to step-by-step reown and reorganise his personality and carry on until he is strong enough to facilitate his own psychological growth. Clients are helped to look for their traits, things they can do and enjoy, improve these traits and find more creative experiences so that they continue to live and have satisfying existence.

The steps of therapy are therefore as follows:

Step I: The client is given opportunity to exhume hurting past experiences and release his bound up memories and emotions.

Step II: The therapist helps client realize that it was illogical, irrational and self-destructive to respond to disturbances with maladaptive behaviours. He demonstrates to the client the relationship between their irrational ideas and their unhappy emotional disturbances.

Step III: Therapist helps client understand that his present condition is not a result of the critical incidents that happened to him but a result of his reaction and response to it and the environment.

Step IV: Client is led to understand that despite his deviant behaviours he still has some positive traits he can improve on. But that will be possible when he has dealt with his illogical, irrational thinking and ideas. At this point it is emphasised to him that the responsibility adjusting his thinking, ideas and philosophy is his. Nobody else can ever do that for him.

Step V: The client expresses his understanding of the situation and his determination to handle his own problems. (Some clients take

a long time to reach this stage. The therapist has to patiently guide the client to this level because the irrational, illogical thinking and philosophies are deeply ingrained in some deviant youngsters.)

At this step the therapist helps the client commit himself to replacing some of his irrational, illogical ideas and beliefs with rational ones. Therapy ends when the client is seen to have acquired a rational philosophy of life. He can be followed up until he can stand on his own facilitating his own psychological growth.

Gentility, patience, discussion on one to one basis acknowledgement of individual differences and home work underlie self-management therapy among trauma affected deviant youths. The skill of the therapist is in his ability to convince the client to take positive action by himself against his illogical philosophy of life. But the task is accomplished in different ways by different therapists according to their background, clients' need and developmental level. The model presented is therefore only a map and not a cook book recipe. It is an attempt to provide a clear statement of clinical direction and an overview of therapeutic applications.

APPENDIX VIII

DEPARTMENT OF EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA

Dear Student,

The researcher is a Ph.D. student in guidance and counselling. She is trying to determine young people who have at any time in their lives had such experiences that made it very difficult for them to control themselves and the situation (traumatic experience). The purpose of searching for such young people is to design some programme for them, which will help them regain their strength and adjust their thinking.

This can only be done through your honest responses to the questions asked in this questionnaire. You are not required to give your name but please answer all the questions as correctly as you know them. Thank you.

You will be given instructions on what to do in each section and you are free to ask questions wherever you do no understand what to do.

Your response will be used confidentially and for academic purposes only.

Section 1:

BACKGROUND AND CURRENT STATUS INVENTORY (BCSI)

Please select from the numbers that are given on the right the one that is TRUE in your case and place it on the LINE provided on the right.

1. Your sex _____

   Male (1)

   Female (2)

2. What adult wehre you living with before you came to this center?

   (a) Biological father and mother (1)

   (b) Only my father (2)

4. What are their occupations? _____

   (a) Business persion (1)

   (b) Civil servant (2)

   (c) craftsman/trader (3)

   (d) Labourer/farmer (4)

   (e) Professional e.g. doctor, teacher, etc. (5)

   (f) Any other: Name (6)

5. Please write:

   (a) Your ethnic group/language

   _____

   (b) Your religion _____

   (c) If no religion indicate _____

Section 2:

CURRENT ADOLESCENT BEHAVIOUR INVENTORY (CABI)

4a. Some young people like you have run away from home. How often have you done so? _____

   i. Never (1)

   ii. Once (2)

   III 2-3 times (3)

   iv. More than three times (4)

b. Have you felt like running away and yet you were prevented? _____

c. How often have you run away from school or refused to attend classes? _____

d. For how long at a time have you runaway from home? _____

   i. One night (1)

   ii. Two night (2)

   iii. Three nights (3)

   iv. Longer than three nights (4)

5. Alcohol and/or drug; if alcohol of drug is something you have tested, please write on the line the number of times that is true about you:

   a. Alcohol _____

   b. Cigarette _____

   c. Indian hemp (weed) _____

   d. Cocaine _____

   e. Others (name) _____

   _____

   _____

CRITICAL LIFE EVENT SURVEY (CLES)

DIRECTION: If any of the following events happened to you tick 'yes' if not tick 'no'. Write your appropriate age when it happened. Write the appropriate number on the right of the rest of the questions:

	EVENT	Did it happen to you? Yes (1) No (2)	About how old were you? 2-4 (1) 5-7 (2) 8-10 (3) 11-13 (4) 14-16 (5)	How much did it affect you? almost insignificant (0) Just little (1) -very seriously (3) -devastating (4)	How did your mother respond to you at that time? -not supportive (0) -just a little supportive (1) -fairly supportive (2) -very supportive (3)	How did father respond to you at that time? number your answer like the mothers own	What about adults e.g. relatives or teachers, how did they respond? number your answers as in mother.	How stable wa. your family at that time? -very unstabl and insecure ((-unstable and insecure (1) -fairly stable and secure (2) - very stable (3)
1.1	death of a parent							

1.2	death of someone close							
1.3	frequent movement of home or change of school							
vi	physical abuse e.g. being beaten or scolded frquently							
v2	sexual abuse/rape							
1.4	Serious accidents e.g. fire road accident, etc.							
v3	Molestation that drove people from home e.g. tribal fighting, religious or political crisis							
v4	Molestation by gangs							

FP1	Foster placement or abandonment by parents							
1.5	Commitment to mental hospital or group home e.g. remand home orphanage or child boarding house							
FP2	Rejected by parent(s)							
FP3	Parental divorce/ separation							
FP4	Alcoholism in the family							
FP5	Incest							
V5	Corporal punishment in front of peers/school assembly ground							
L6	Repeated failing examination							

Were any of the events repeated? If so, fill in the one or two most important:

Any other thing that is not listed above. Fill in the one or two most important.

AHMADU BELLO UNIVERSITY, ZARIA
FACULTY OF EDUCATION
DEPARTMENT OF EDUCATION

APPENDIX IX

DOLE ADMIN: Maj. Gen. U. Bamaiyawa (Rtd.)
HEAD OF DEPARTMENT: Prof. M. J. Shuaibu

Your Ref:

Our Ref:

Date: 12/3/98.

The Principal,
Kaduna Borstal Home,
Kaduna.

Sir,

REQUEST FOR STATISTICS

The bearer of this letter, Mrs. E. Ike is a [illegible] candidate in Guidance and counselling in the above Department.

She is carrying out a study on Self Management Therapy. Kindly allow her to use your students for the study. The Department would be grateful if you allow some of your tutors to help her administer some of the tests.

The data collected will be kept strictly confidential and used only for academic purposes.

Thank you for anticipated cooperation.

Yours Sincerely,

Prof. S.E. Okon.
Head of Guidance and Counselling

APPENDIX X

Guidance & Counselling Unit
Ahmadu Bello University
Zaria.

July 30, 1998.

LETTER TO INMATES' PATENTS

Through: The Principal
Borstal Institution,
Kaduna.

Dear Sir/Madam,

I am from the Guidance and counselling Unit of Ahmadu Bello University. I am interested in helping youths who show delinquent behaviours reconsider their actions, adjust their thinking and modify their deviant behaviours so that they can become law abiding citizens. I have interacted with your son who is in the Kaduna Borstal Institution for the past three months, and I have found that if the job of rehabilitating him is to succeed you have to be apart of it.

I am therefore requesting that you please come to the Borstal Institution where your son is now so that I can discuss with you concerning his progress. He has made some positive adjustments and your cooperation is needed to move him forward. It will be appreciated if you can come to Kaduna Borstal Institution between 15th and 20th August, 1998. Please either reply this letter by phoning this number: 069 - 51696 or writing to:

Mrs E. Ike,
Department of Vocational & Technical Education,
Ahmadu Bello University,
Zaria.

Thank you.

Yours faithfully,

Mrs. E. Ike

APPENDIX X

Guidance & Counselling Unit
Ahmadu Bello University
Zaria.

July 30, 1998

LETTER TO INMATES' PATENTS

Through: The Principal
Borstal Institution,
Kaduna.

14/8/98

Dear Sir/Madam,

I am from the Guidance and counselling Unit of Ahmadu Bello University. I am interested in helping youths who show delinquent behaviours reconsider their actions, adjust their thinking and modify their deviant behaviours so that they can become law abiding citizens. I have interacted with your son who is in the Kaduna Borstal Institution for the past three months, and I have found that if the job of rehabilitating him is to succeed you have to be apart of it.

I am therefore requesting that you please come to the Borstal Institution where your son is now so that I can discuss with you concerning his progress. He has made some positive adjustments and your cooperation is needed to move him forward. It will be appreciated if you can come to Kaduna Borstal Institution between 25th and 29th August, 1998. Please either reply this letter by phoning this number: 069 - 51696 or writing to:

Mrs E. Ike,
Department of Vocational & Technical Education,
Ahmadu Bello University,
Zaria.

Thank you.

Yours faithfully,

Mrs. E. Ike