FORDHAM UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SERVICE

TITLE: **Learning to Cope with Stress through Art: An Evaluation of a School-Based Creative Arts Primary Prevention Program for Children in Elementary School**

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AREA OF CONCENTRATION: **Children and Families**

This manuscript has been read and accepted in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy in Social Work.

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Learning to Cope with Stress through Art: An evaluation of a school-based creative arts primary prevention program for children in elementary school

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A DISSERTATION PRESENTED TO THE FACULITY OF FORDHAM UNIVERSITY SCHOOL OF SOCIAL SERVICE IN PARTIAL FULFILLMENT OF THE DEGREE OF DOCTOR OF SOCIAL WORK

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ACKNOWLEDGEMENTS

I would like to thank my *very* supportive and dedicated Dissertation Chair, Dr. Ray Fox and Committee Members, Drs. Kail, and Adelson. I am grateful for all the feedback and encouragement to keep this project moving forward. Thank you, Dr. Cooper for your suggestions as the 4th reader and helping to get this project off the ground.

Thank you to the CARING program, Board Members, Staff and Art Therapy Interns; Dr. Ian Canino, Dr. Clarice Kestenbaum, Helen Richards, Grant Sitt, and Robin Snow. Thank you for your endless support, time, and patience. Thank you for allowing me the opportunity to work with you and making this project possible!

I would especially like to thank Dr. Evelyn Montanez and TURN 2 US, children, families, staff, Ms. Aldebot, and Ms. Arrendondo for allowing me to work at this great school and such wonderful children.

Dr. Ronnie, Patricia, Karina Rizzi, Aunt Belquis, Madeline, Sally, Allison, and Rose-Ellen I thank you for all your time and help. Thank you to my amazing friends and family for your help, support and interest; Wurzel and Bangel families, HSES friends, and the Karp and Rothfliesh families.

I am especially grateful to Valeda Dent Goodman for all of the editing and time invested.

To my parents and sister, this degree could never have been done with out your endless support and help. From the bottom of my heart, THANK YOU!

To Jason, you are the inspiration for completing this degree and project! You are the greatest and most precious person in the entire world.

To my husband, Howard this degree is as much yours as it is mine! I can't thank you enough. Your encouragement and endless support is what got me to this point.

DEDICATION

This dissertation is dedicated to my grandparents, Leah and Herman Eisenberg. It's finally completed, and I know that you have been with me every step of the way.

To the Holub and Karp families, you are my inspiration for entering this field. This project is also dedicated to you.

ABSTRACT

This study examines the effects of the CARING at Columbia program, a school-based creative arts primary prevention program at a New York City public school. Specifically, the study evaluates whether the 15 week curriculum titled *Learning to Cope with Stress through Art: An Ethnic-Sensitive Model*, (Canino, Rojas-Flores & Korman, 1999) is effective in improving several key social and emotional functions of the participants. These functions include affect, problem solving skills, the ability to seek social support, and improved self-esteem for child participants. Along with these indicators, the study also examines whether the CARING program is effective in decreasing the negative coping skills of distancing, internalizing, and externalizing. A total of 29 children, ages 9-12, participated in the study. Participants were divided into two groups - the experimental group and usual care group, and were asked to complete two different measures: The Self-Report Coping Measure (Causey & Dubow, 1992) and the Multidimensional Self-Concept Scale (Bracken, 1992). These assessments were completed at pre- and posttest intervals to determine the impact of the program on the aforementioned indicators.

Despite non-significant findings, the study suggests that the CARING program is helpful in identifying potential risks for children who were experiencing a variety of different life stressors. Design limitations such as small sample size and the inability to fully randomize the sample may have played a role in the study's outcome, thus, it is recommended that future evaluations of this program are carried out in order to more fully assess its impact.

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CHAPTER 1

INTRODUCTION

Background

Historical Development of the No Child Left Behind Act of 2001

The road to creating a safe, stable, and nurturing environment for America's children has been a long, difficult and sometimes failed one. As early as the 1800s, it was recognized by social workers and others that suitable conditions for growing healthy children did not include the deplorable conditions found in factories, plants, and manual labor environments; and that the abandonment of children to ill-equipped orphanages, asylums, or to the streets was problematic (Lindsey, 2004). As a result, more attention began to be paid to the state of child welfare by individual citizens, teachers, social workers, philanthropists, and local governments.

Similarly, efforts to improve education in the United States came into focus in the mid nineteenth century, when Massachusetts Representative Horace Mann began a crusade to develop what would later be known as the public school system in the United States (Hayes, 2008). The history of the No Child Left Behind Act of 2001 really begins some 36 years earlier, in 1965, when President Lyndon Johnson enacted the *Elementary and Secondary Education Act* (ESEA). This act was a part of the President's "War on Poverty" (Hayes, 2008, 5) and included federal funding for local public schools that enrolled underprivileged children. The Head Start program was also born during this time, providing funding for preschool programs for children in poorer communities (Hayes, 2008). Both of these developments represented a departure from previous and strongly held belief that the "public schools should be the responsibility of state and local government" (Hayes, 2008, 10). Perhaps the most critical precursor to NCLB was a report called *A Nation at Risk*, compiled by a task force led by then Secretary of Education Terrel Bell

in 1981 (Hayes, 2008). Secretary Bell sought to address to growing concern that America's schools were failing, and this report, which likened this failing to "an act of unthinking, unilateral educational disarmament" suggested a variety of ways to address the problems of illiteracy, poor math and science standardized test scores, and school-leaving (Hayes, 2008), just to name a few. The findings of this report are important, as they provide both motivation and justification for the NCLB Act of 2001. The intervening years saw the publication of the *Goals 2000* report, a list of "educational objectives" created by the nations' governors under the leadership of President George H.W. Bush (Hayes, 2008, 9), and the passage of the Improving American Schools Act of 1994.

Some 36 years later, the ESEA of 1965 is re-authorized as the No Child Left Behind Act of 2001, itself an amalgam of each of these various reports, findings, goals, and recommendations. The act, which is due for re-authorization in the near future, (Kahlenberg, 2008) has a variety of complex, interwoven components, and is typically referenced as a three-part system made up of accountability, testing, and standards (Kahlenberg, 2008). There are ten "titles," or focus areas in the NCLB, with the collective goal of making sure that "every child in every school" is "performing at grade level in the basic subjects that are the key to all learning" (Williams, 2005, 156). In the executive summary of the NCLB, President George W. Bush outlined the following priorities:

1. Improving the academic performance of disadvantaged students
2. Boosting teacher quality
3. Moving limited English proficient students to English fluency
4. Promoting informed parental choice and innovative programs
5. Encouraging safe schools for the 21st Century

6. Increasing funding for Impact Aid
7. Encouraging freedom and accountability (Bush, 2001).

The NCLB Act of 2001 places great demand on schools to produce successful children. Simultaneously, children across the country are experiencing a wide variety of socioeconomic, psychological and other challenges. The impact of rapid growth post-industrial and technological factors has placed new stressors on the family and the child (Subrahmanyam, Greenfield, Kraut, & Gross, 2002), as have a myriad of other developments. Given this, it is not inaccurate to suggest that at some point in their lives, any numbers of school-aged children are likely to report a challenging or stressful situation that can impact their ability to succeed in school (Anderson-Butcher, Steetler, & Midle, 2006). If these situations are not resolved, the psychological well-being of a child can be threatened (Lagana-Riordan & Aguilar, 2009).

It is within the context of the NCLB and its pending re-authorization that prevention programs and social workers play an important role in supporting the academic achievement of the nation's children. It is also within this context that this particular research study takes place. The next section discusses in greater detail the connection between the NCLB Act of 2001 and prevention programs.

Prevention Programs and the No Child Left Behind Act of 2001

The expectation that the nation's educational system provide a certain level of support for students is high, and it is clear that schools must find ways to address the needs of children who are at-risk for school failure and teach them skills to be successful. The high drop out rate for many schools, especially those in urban areas, is one key issue addressed by the NCLB Act of 2001 that has immediate implications for prevention programs, even those at the middle and junior high school levels such as the CARING program. Research suggests as many as one

million students drop out of high school annually (Alliance for Excellent Education, 2006). Accordingly, Balfanz and Letgers (2008) suggest that one of the most important roles of the NCLB Act of 2001 is to identify "schools that are consistently failing to serve poor and minority students and to instigate school-based and systematic remedies so that all students are provided with access to high-quality, standards-based education" (193). The nation's drop out rates have not improved over the last decade, and the tipping point in some cases may be the ability of schools to provide "additional social services for students and their families" (Hayes, 2008, 125).

Given this, partnerships between schools and local community-based organizations are seen as one way to ameliorate barriers to healthy childhood development (Richardson, 2007) by increasing the number of available support services and programs available to children within the school (Lagana-Riordan & Aguilar, 2009; Lynch, Geller & Schmidt, 2004; Richardson, 2007). Adopting comprehensive partnerships and implementing evidence-based programs can help schools to prevent the factors that are often linked to poor academics, health, and well-being (Lagana-Riordan & Aguilar, 2009), as discussed in the NCLB of 2001 (Lagana-Riordan & Aguilar, 2009; McIntosh, Filter, Bennett, Ryan, & Sugai, 2010; Webster- Stratton & Herman, 2010).

Prevention programs in public school systems across the United States have experienced marked growth over the past 15 years (Domitrovich, Bradshaw, Greenberg, Embry, Poduska, & Ialongo, 2010). The goal of primary prevention programs in schools is to reduce the incidence of children who are thought to be at-risk for psychological disorders (Frydenberg, Lewis, Bugaliski, Cotta, McCarthy, Luscombe-Smith, & Poole, 2004; Webster- Stratton & Herman, 2010) by identifying and targeting potential challenges prior to a child showing signs of deficit or struggle (Edwards, Mumford, Shillingford, & Serra-Roldam, 2007). Problems within early childhood

often antedate psychosocial problems; therefore, they are recognized by school social workers as a major area of concern (Edwards, Mumford, Schillingford, and Serra- Roldan, 2007; Newsome, 2005). The combination of early identification of potential future problems (Tomb and Hunter, 2004; Grant, Compas, Stuhlmacher, Thrum, McMahon, & Halpert, 2003), and problem behavior reduction (Domitrovich, Bradshaw, Greenberg, Embry, Poduska, & Ialongo, 2010; Tomb & Hunter, 2004) is key. Furthermore, programs that are empirically based have a greater likelihood of success, in that they have been shown to reduce and prevent negative outcomes for children who are at risk (Borowski, Smith, & Akai, 2007; Domitrovich, Bradshaw, Greenberg, Embry, Poduska, & Ialongo, 2010; Kisiel, Blaustein, Spinazzola, Schmidt, Zucker, & van der Kolk, 2006; McIntosh, Filter, Bennett, Ryan, Sugai, Pincus, & Friedman, 2004; Webster- Stratton & Herman, 2010). These programs can provide appropriate educational curricula that foster the development of social, communication, decision-making, and problem solving skills, each of which is related to improved end results for the children (Wells, Miranda, Bruce, Alegria, & Wallerstein, 2004).

The Role of the School Social Worker

The enactment of current education policy such as the No Child Left Behind Act of 2001 means that social workers have an important role to play in the evaluation and provision of prevention services within the school (Richardson, 2007). Social workers are often able to improve the well being of children who are at risk (Stieber, Lewis, Granic, Zelazo, Segalowitz, & Pepler, 2007; Tomb & Hunter, 2004) by implementing best practices within the school settings. Researchers and clinicians have designed a variety of programs to help address the long term consequences and negative outcomes associated with childhood stress, but in order for these to work, it is necessary for schools and outside agencies to come together to design, implement,

and scientifically evaluate these programs. School social workers have been providing services within public schools over the past century, during which time a great deal of pressure to help children achieve their academic goals and maintain a healthy school environment has been placed on them (Newsome, 2005). The school setting is an ideal place for social workers to utilize evidence-based prevention programs to address symptoms, disorders, peer relationships, and development (Tomb & Hunter, 2004).

Culturally competent social workers are an integral part of the school community, and in order for the worker to fully support the child, and understand the presenting problem, the school social worker should acquire a certain degree of cultural knowledge (Teasley, Baffour, & Tyson, 2005). The scope of cultural sensitivity includes addressing stressors and developmental issues, integrating social and community supports services, and being mindful of the role of economic status. Teasley (2004) states that school social workers are advocates inside and outside of the school environment, and that they are also educators who inform and teach staff, parents, students, and community members about the differences in cultures, promote diversity, provide information, and develop community relationships.

In the CARING (Children at Risk: Intervention for a New Generation) program, social workers play multiple roles which include group facilitator, curriculum developer, program evaluator, researcher, and advocate. Social workers are able to provide corrective feedback to children regarding decision making, problem solving, coping, and self-esteem. In addition, the social worker is able to adapt materials as needed to meet the needs of children who display challenging behaviors. Generally, researchers, curriculum developers, and social workers must work closely together to bridge the gaps between research and clinical practice (Garland,

McCabe, & Yeh, 2008), and provide children with the most effective programs in the school setting.

Statement of the Problem

The lack of evaluative data on school-based prevention programs that incorporate both creative arts and culturally sensitive curricula is evident from the review of the literature and recent research. The unavailability of this type of empirical feedback can hinder reflection and positive programmatic change, and thus impact the treatment outcomes for participants.

There are countless examples of school-based prevention programs that have failed to produce the expected outcomes (Greenberg, Weissberg, O'Brien, Zins, Fredericks, Resnick & Elias, 2003), and it stands to reason that the success of future programs depends on understanding the components that make for a successful intervention. Research outcomes on more traditional prevention programs dealing with issues such as teenage pregnancy, smoking, sexual abuses, and obesity, are easily located; this is not the case with unique programs whose framework integrates a culturally-sensitive approach with the creative arts. Without this evaluative information, there is no way for programs to thoughtfully and efficiently improve.

Rationale for the Study

Rationale for this study is based on a number of factors, including corroboration from the 2005 Government Accountability Office (GAO) report to Congress on the No Child Left Behind Act of 2001 and the need for more empirical evidence on the nation's school intervention and prevention programs (GAO, 2005).

First, in many school-based environments, the ability to conduct empirical research is severely hampered by financial, time, and human resource constraints, making such research even more difficult to procure. It stands to reason that with the recent economic downturn,

school closings and cutbacks of staff and programs, research will remain an elusive endeavor for many of the nation's public schools. Beyond the economic constraints, there are numerous challenges to program evaluation, an issue not unfamiliar to other researchers who are also concerned with measuring the outcomes of school-based prevention programs for children. Apsler (2009, 1) writes that some of the primary obstacles to conducting sound evaluations include difficulties in obtaining appropriate comparison groups, and dealing with sporadic attendance and attrition. This project provides an opportunity to conduct experimentally-based empirical research, while minimizing the financial and administrative obligations of the host school. Second, empirical evidence will help to answer questions about the programs' effectiveness, which can then be used to modify and/or replicate the program in the future. This is an obvious and important point especially given the fact the funding of such programs may hinge on their ability to demonstrate effectiveness in a quantitative or "evidence-based" manner (Hallfors, Pankratz & Hartman, 2007).

Justification is also based on the lack of evaluative information specifically focused on creative arts-based programs that incorporate a multicultural approach. This dearth of information is apparent in the review of the literature. Evaluative studies on school-based prevention programs dealing with violence (Ozer, Wanis, & Bazell, 2010), teenage pregnancy (Rosenthal, Ross, Bilodeau, Richter, Palley & Bradley, 2009), obesity (Gentile, Welk, Eisenmann, Reimer, Walsh, Russell, Callahan, Walsh, Strickland & Fritz, 2009), smoking (Sherman & Primack, 2009), sexual abuse (Topping & Barron, 2009), sleep problems (Moseley & Gradisar, 2009), HIV prevention (McDermott, 1998), and a host of other serious issues that disrupt the social and emotional well-being of young adults can be found in the literature with relative ease. Many of these studies are empirically-based as well. On the other hand, Hishinuma,

Chang, Sy, Greaney, Morris, Scronce, Rehuher and Nishimura (2009) suggest that evaluative studies of culturally-based school programs that promote positive development among young people have not been widely published. Zucker, Spinazzola, Pollack, Pepe, Barry, Zhang and van der Kolk (2010) studied a theater-based school prevention program designed to address risky behaviors of students, but this program did not incorporate a multicultural approach. It is difficult to find examples of assessments that address programs with both of these components.

Finally, rationale for this study might also be viewed within the context of the opportunities created by the No Child Left Behind Act of 2001 and related legislation, including evaluation and feasibility (Eddy and Berry, 2008) of programs that intersect with and support student academic achievement. In a 2005 report to Congress (GAO Report, 2005), the Government Accountability Office emphasizes the fact that although there are any number of school-based interventions at work in the nation's schools, "few of these programs have been rigorously evaluated, and education has done little to evaluate and disseminate existing research" (GAO Report, 2005, 31). The report also states that evidence of the effectiveness of these programs, for the most part, has not been demonstrated (GAO Report, 2005, 31). The report and the research that generated it provide an interesting backdrop against which to frame this research study. The GAO found that although there are many different intervention approaches, there are three general categories of programmatic intervention that schools put into place to address the goals of the NCLB Act: school-wide re-structuring efforts; alternative forms of education for students who do not do well in traditional classroom settings; and supplemental services for at-risk students (GAO Report, 2005, 32). The CARING program falls into the last category, which, like the other categories, has mostly failed to demonstrate overall impact through empirical research.

One of the aforementioned justifications for this study is further supported by the findings in the GAO (2005) report, which states that rigorous research of intervention effectiveness is limited due to a variety of factors, and even with the most structured attempts, limitations such as data collection and design problems can mean that "the evaluation of the effectiveness of these interventions are not as strong as they need to be for the results to be conclusive" (2005, 33). There is no argument that additional, rigorous and program-specific research is needed in this area.

Purpose of the Study

Research Questions

This investigation aims to add to the body of evaluative data on culturally sensitive, creative arts-based prevention programs by scientifically evaluating CARING, an established school linked program that provides prevention services to children identified as being at-risk. Seven research questions guide this study:

Do children who participate in CARING report an increase in affect at posttest compared to those children in the usual care group?

Do children who participate in CARING report an improvement in problem solving skills at posttest compared to those children in the usual care group?

Do children who participate in CARING report an improvement in the ability to seek social support at posttest compared to those children in the usual care group?

Do children who participate in CARING report a decrease in distancing behavior at posttest compared to those in the usual care group?

Do children who participate in CARING report a decrease in internalizing behavior at posttest compared to those children in the usual care group?

Do children who participate in CARING report a decrease in externalizing behavior at posttest compared to those children in the usual care group?

Do children who participate in CARING report an improvement in self-esteem at posttest compared to those children in the usual care group?

The CARING Program

The CARING (Children at Risk: Intervention for a New Generation) program is a school-linked creative arts primary prevention program designed to improve coping, problem solving skills, self-esteem, and related behaviors in elementary school aged children who are at risk because of experiencing a stressor. The program was initially established at New York State Psychiatric Institute in the Washington Heights section of New York City, and was created to address a growing population of children from the Hispanic community who were in need of preventative services. This program continues to flourish in three New York City public schools.

One of the hallmarks of the CARING program, which targets select risk factors and aims to improve behaviors in and out of the school setting, is the diverse nature of its components, which includes ethnically sensitive approaches, creative arts, and psycho-education.

The elementary school that served as the site for this study implemented CARING in 2004. At this particular school, CARING is affiliated with Turn 2 Us, a comprehensive health and mental health program which provides the referrals for the program. A full description of the CARING program's structure is provided in Chapter 3.

Summary

CARING is a unique program that employs culturally sensitive creative arts-based strategies to help at-risk children. This study will generate evaluative data based on examination

of outcomes related to participants' affect, problem solving skills, support seeking skills, and self-esteem. Specific predictions are that program participants will see an improvement in each of these areas, as well as a decrease in negative coping skills such as distancing, internalizing, and externalizing.

The empirical findings from this study can be used to support the development and implementation of programs like CARING in the future, and also support the replication of the program's strongest elements for others looking to address childhood behavioral and developmental concerns in a school setting. There is a demonstrated need for this type of programmatic evaluation, a need that is recognized both by educators and researchers alike, and framed in part by the mandates set forth by the No Child Left Behind Act of 2001 (GAO Report, 2005, 32).

The next chapter will provide a detailed review of the critical literature related to theoretical foundations, practice and treatment frameworks, and relevant research.

CHAPTER 2

REVIEW OF THE LITERATURE

The theoretical framework for this paper is informed by two main concepts: prevention strategies and application, and evidence-based practice and application. Each of these fairly broad themes contributes heavily to the scholarly foundations of this dissertation, and will be discussed in this literature review with the intent of highlighting those areas which are highly relevant to this research study.

Part I Prevention Strategies and Application as Theoretical Construct

Overview and definition

This study is based on the premise that there is a dearth of empirical data regarding a certain type of prevention program and its effectiveness within certain settings. The concept of prevention has developed within the context of supporting positive human development by addressing threats to emotional, psychological, and physical well-being *before* they manifest. Mosby's Dictionary of Complementary and Alternative Medicine (2005), defines prevention as "the management of those factors that could lead to disease so as to prevent the occurrence of the disease." Durlak (1995) defines prevention as a "multidisciplinary science that draws upon basic and applied research conducted in many fields, such as public health, epidemiology, education, medicine, community development, and clinical psychology" (p. 2). There are three levels of prevention, each corresponding to areas where problems are likely to occur: primary prevention, secondary prevention, and tertiary prevention. Primary prevention involves work with "normal" populations to prevent the development of problems. Secondary intervention focuses on intervening where problems have already started to develop, and tertiary prevention involves the reduction of prevalence of disorders that are already highly evident (Durlak, 1995; Durlak,

2008). For the most part, school-based programs are primary prevention programs, and like the CARING program, seek to help at-risk children deal with and overcome challenges that may hinder their progress is school.

In addition to the three levels of prevention, there are subcategories for each level that focus on how the prevention services are implemented, and whether they focus on "the person or the environment" (Durlak, 1995, p. 3). Primary prevention may involve focus on the child, and teaching the child to deal with personal issues related to their mental health; or programs may deal with the interactions between a child and their environment (Durlak, 1995; Durlak, 2008). Selection of participating populations is also a key factor in prevention, for instance, a special population may be chosen (such as children of alcoholics) for prevention outreach; or, students in a particular environment (all first graders at an inner-city school in an area prone to youth and gang violence) may be targeted for preventative measures. Regardless of how the populations are selected or which level of prevention is used, the application of treatment should be based on empirical data about which is most effective (Greenberg, 2004).

The complexity of human nature renders prevention an inexact science at best, however, prevention strategy continues to be at the heart of many programs which target both at-risk children and adults.

The "science" of prevention

Empirically-based research provides the strongest foundation for the development of effective interventions, and related prevention programs (Greenberg, 2004). This review begins with a historical look at the "science of prevention" as a way to frame prevention strategy (Coie, Watt, West, Hawkins, Asarnow, Markman, Ramey, Shure & Markman, 1993) before addressing more recent literature. Coie et al. (1993) suggest that it is only within the last several decades or

so that the science of prevention has been taken seriously as an approach to dealing with human dysfunction. As a strategy for addressing human dysfunction, it is used in "psychopathology, criminology, psychiatric epidemiology, human development, and education " (Coie, et al., 1993, p. 1013). By definition, the goal of prevention, suggest the authors, is to:

> prevent or moderate major human dysfunctions. An important corollary of this goal is to eliminate or mitigate the causes of disorder. Preventive efforts occur, by definition, before illness is fully manifested, so prevention research is focused primarily on the systematic study of potential precursors of dysfunction or health, called *risk factors* and *protective factors,* respectively (Coie et al., 1993, p. 1013).

During the course of any prevention research, the various interventions that may "counteract" the development of these risk factors are at the heart of the study. Factors that contribute to these risk factors are also studied in great detail, and it is the study of these risk and protective factors that should "inform the design of preventive interventions" (Coie et al., 1993, p. 1013). Essentially, interventions should be grounded in the research of the risk and protective factors. However, the authors point out that characterizing risk factors can be difficult because of their changing nature. Coie et al. (1993) explicate five observations about risk factors that researchers should keep in mind. First, "risk factors have complex relations to clinical disorders" (Coie et al., 1993, p. 1013). Risk factors seldom link to only one type of dysfunction; rather, there are usually a wide variety of dysfunctions that may have the same risk factor in common. Similarly, dysfunctions can be associated with a variety of risk factors (p. 1013). Isolating risk factors and aligning them with specific dysfunctions is often not possible. Second, "the salience of risk factors may fluctuate developmentally" (Coie et al., 1993, p. 1014), meaning that risk factors may not be predictive of dysfunction evenly across the lifespan. Certain risk factors may

only become apparent during critical developmental stages. Third, "exposure to man risk factors has cumulative effects" (Coie et al., 1993, p. 1014). Specifically, the researchers suggest that "the function of the number, the duration, and the "toxicity" of the risk factors encountered" can greatly increase vulnerability, especially in children (Coie et al., 1993, p. 1014). Next, Coie et al. (1993) state that diverse disorders share fundamental risk factors, and that these risk factors often precede certain types of dysfunction. For instance, Markman and Jones-Leonard (1985) found that marital strife is often a predictor of childhood misbehavior, and of depression in women. Coie, Lochman, Terry and Hyman (1992) found that rejection by peers can be predictive of social adjustment problems in middle school, conduct problems, and internalizing behavior. The last consideration is the promotion of "protective factors against dysfunction" (Coie et al., 1993, p. 1014). Protective factors – those elements in an individual's life which may mitigate against risk – should be exploited. These factors can include the child's own temperament and skills, and the support provided by parents, teachers, special programs, prosocial approaches (Coie et al., 1993, p. 1014).

The science of prevention, if it is to appropriately address human dysfunction, must adhere to very rigorous guidelines in order to be successful. Coie et al. (1993) state that prevention science research should use the following principles as guidelines:

> Prevention research should address causal processes.
> Risk factors should be addressed before they stabilize as predictors of dysfunction.
> Prevention trials should target primarily those at high risk.
> Effective prevention requires coordinated action in each domain of functioning implicated in the risk model being tested.
> Implications of developmental research for prevention science should be considered.

There are a number of factors that impede the practice of prevention in its most efficient and effective state. Those factors are discussed in the next section.

Challenges to successful prevention: Why programs fail

Currently, practitioners still struggle with the best ways to mitigate those factors that threaten to interrupt the normal development of children. Nation, Crusto, Wandersman, Kumpfer, Seybolt, Morrisey-Kane, & Davino (2003) state that there is a gap between "the science and the practice of prevention" (p. 455).

"Challenging behavior exhibited by young children is becoming recognized as a serious impediment to social–emotional development and a harbinger of severe maladjustment in school and adult life. Consequently, professionals and advocates from many disciplines have been seeking to define, elaborate, and improve on existing knowledge related to the prevention and resolution of young children's challenging behaviors" (Dunlap, Strain, Fox, Carta, Smith, Kern, Hemmeter, Matthew, McCart, Sailor, Markey, Markey, Lardieri, & Sowell, 2006, p. 29). If the identification of certain behaviors is critical to the prevention of future dysfunction, one of the most difficult aspects of this approach for practitioners remains separating what may be normal albeit challenging childhood behavior from that which may require some type of preventative approach. "Unfortunately, there remains limited understanding across professionals, disciplines, and service systems regarding what is known about early challenging behaviors and what can be done with respect to prevention and intervention" (Dunlap et al., 2006, p. 29). Specifically, Dunlap et al. (2006) state that "part of the professional reticence pertaining to challenging behaviors is that many behavioral topographies (e.g.tantrums**,**) that are considered challenging in elementary school students are developmentally typical in early childhood. Without a clear delineation of the window during which more mature topographies are expected to emerge, it can be difficult to distinguish serious problems from typical developmental progressions" (p. 29). The researchers further state that there are also severe challenges in terms of defining what types of prevention delivery would be most effective (Dunlap et al., 2006).

Certainly, there is no simple formula for setting prevention methods in place. How do practitioners gauge levels of success within prevention programs? An examination of the research literature is one method for evaluating effectiveness and efficacy. In a meta-analysis of 177 primary prevention programs for children, Durlak and Wells (1997) found that "most categories of programs produced outcomes similar to or higher in magnitude than those obtained by many other established preventive and treatment interventions in the social sciences and medicine" (p. 115). Specifically, programs that helped children "negotiate stressful transitions" produced significant mean effects (Durlak & Wells, 1997, p. 115). Nation et al. (2003) explicate five characteristics associated with "successful prevention programs" (p. 451). Successful programs are comprehensive, include varied teaching methods, provide "sufficient doses" of intervention exposure, are theory driven, and include development of positive relationships between children and caregivers (p. 453). In addition to these five characteristics, Nation et al. (2003) describe "several characteristics related to the developmental appropriateness of the intervention" which include sociocultural relevance, and proper timing. Finally, the researchers explicate the role of the use of evaluation and properly trained staff in implementation of effective prevention programs (p. 453).

Another challenge discussed in the literature is that of integration. Greenberg states that "as effective programs and policies undergo the challenge of translation from science to widespread practice, there is a need for greater integration with schools and communities to build processes and structures that will insure high-quality implementation and promote sustainability" (2004, p. 5). Community integration can be challenging at best, however. Referencing the need for integration across the three domains of stages/grades, levels of care, and community institutions, Greenberg (2004) states "During the next decade prevention initiatives face a number of new

challenges that signal the next stage of the linkage between prevention science, policy, and practice" (p. 6). Research strategies are identified as one way to address this need for increased integration, including the study of program effectiveness by understanding how programs are adopted and adapted locally (Greenberg, 2004, p. 8). Implementation of new prevention programs can face further challenges, "It is unlikely that most attempts at implementing programs will survive unless there is long-term planning and adjustment of the program model to become integrated with other programming already ongoing in schools (p. 9)".

Designing prevention programs that are culturally relevant presents another challenge. Castro, Barrera, and Martinez (2004) suggest that there is a "tension" between programs that try to preserve the "fidelity" of implementation by adhering to manualized treatments, versus adaptation of programs to fit the needs of a specific group (p. 41). The failure of programs to be able to systematically adapt to different cultural and racial groups presents a challenge that can undermine the success of the interventions. These "culturally blind" prevention programs will most likely not solicit the participation of the broader community (Castro, Barrera, & Martinez, 2004, p. 41). To address this, researchers suggest involving the community at some level during creation and implementation of prevention programs (Minkler & Wallerstein, 2003; Castro, Barrera, & Martinez, 2004). Without community buy-in or involvement, the likelihood of "mismatch" is quite high (Castro, Barrera, & Martinez, 2004). The researchers classify the major sources of mismatch as (1.) group characteristics, (2.) program delivery staff, and (3.) administration/community factors, and state that "when present, these sources of mismatch should be addressed in an a-priori strategic plan for program adaptation that precedes program implementation" (p. 43). Cultural adaptation of any program should address the morals, values, traditions, and beliefs of the target population, when possible (p. 43).

Within the spectrum of prevention, there exists a diverse array of treatment approaches, each designed specifically to target the social, emotional, and behavioral problems that children may face (Stinson, 2009). Any number of motivating factors, such as the rising number of children ages 7 to 12 years entering the criminal justice system, drives the development of new curriculum. The programmatic approaches are very diverse in nature; many integrate multi-sensory and cultural approaches to help children develop their strengths and learn skills needed to be successful. The next section will provide some background on the approaches that are relevant for this study.

Application: Review of Approaches to Prevention

Behavioral approaches to prevention

Behavioral therapy is defined as "the use of techniques based on experimentally-tested principles of learning to overcome persistent unadaptive behaviors" (Wolpe & Lang, 2009, p. 228). Gelder (1997) states "the most useful distinction is that behavior therapy is concerned with modifying *observable behaviors* that are maintaining a disorder, whereas cognitive therapy is concerned with changing *ways of thinking* that have the same function" (p. 285). There are a number of approaches to behavior therapy, the best known are exposure, response prevention and contingency management (Gelder, 1997, p. 286). "Exposure encourages patients to enter situations that they have consistently avoided; response prevention encourages patients to cease repetitive behaviors; and contingency management rearranges the consequences of behavior to favor adaptive responses and discourage maladaptive ones" (p. 286). Self-control techniques, assertiveness training, and relaxation and stress management are also frequently used strategies to address problem behaviors (Gelder, 1997).

McKay and Storch (2009) suggest that behavior therapy represents one of the fastest

growing treatment approaches for children, and more specifically, that many of the methods used to treat an array of childhood disorders are behaviorally-based. In their seminal article on the "clinical utility" of behavior therapy with children, Hobbs, Moguin, Tyroler, and Lahey (1980) describe several areas of child treatment that can benefit from a behavioral approach: (1.) impulsivity, (2.) hyperactive and aggressive behavior, (3.) academic and classroom behavior, and (d) delay of gratification and resistance to temptation (p. 149). "Techniques such as direct instruction in problem solving, self-instruction training, and cognitive modeling have been advocated as methods for the treatment of a variety of child behaviors" (Hobbs et al., 1980, p. 149). Externalizing and internalizing behaviors have been also successfully addressed by behavior therapy (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Kazdin, 2000). Prevention programs for children that focus on obesity, smoking, violent behavior, maladaptive sexual behavior, and numerous other areas frequently use a behavioral or cognitive-behavioral approach (Daniels, Brown, Edwards, Leadbetter, Middleton, Parsons, Popova, & Warmington, 2005; Pbert, Flint, Fletcher, Young, Druker & Di Franza, 2008), and may also use certain strategies to reinforce progress. For instance, the CARING program uses a rewards system to positively reinforce behavior that has been modified or changed for the better. Rewards can include stickers, stars on progress charts, and points or other visible indicators of improvement (Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006).

Cognitive approaches to prevention

American psychologist Aaron Beck is widely credited with laying the theoretical and practical foundations for what would become cognitive therapy in the 1960s. Neenan and Dryden (2004) describe cognitive therapy as a way to "amerliorate clients' emotional distress by helping them to identify, examine and modify the distorted and maladaptive thinking underlying their

distress" (p. xi). Originally conceptualized within the framework of treating depression, cognitive approaches are now used to treat anxiety disorders, substance abuse, post-traumatic stress disorder, personality disorders, obsessive-compulsive disorder across a variety of populations (Neenan & Dryden, 2004). Within prevention settings, cognitive strategies are frequently paired with behavioral elements. Suicide prevention programs and programs targeting severe depression may use cognitive approaches to help patients deal with distress (Hollon, DeRubeis, Shelton , Amsterdam , Salomon , O'Reardon , Lovett , Young , Haman , Freeman , & Gallop , 2005; Williams, Duggan , Crane, & Fennell , 2006), as well as prevention programs geared towards people at high-risk for psychosis (Morrison, French, Wolford, Lewis, Kilcommons, Green, Parker & Bentall, 2004). Recently, the concept of "mindfulness" has been incorporated into cognitive approaches. Mindfulness-based cognitive therapy "integrates mindfulness meditation practices and cognitive therapy techniques. It teaches participants to develop moment-by-moment awareness, approaching ongoing experience with an attitude of nonjudgment and acceptance. Participants are increasingly able to see their thoughts as mental events rather than facts" (Williams, Duggan, Crane, & Fennell, 2006, p. 201).

Cognitive approaches with children must pay attention to both developmental and socioemotional contexts, and can include five distinct elements: interpersonal/environmental context, physiology, emotional functioning, behavior and cognition (Friedberg & McClure, 2002, p. 3). Practitioners intervene within this framework to "influence thinking, acting, feelings, and bodily reaction patters" (p. 4). The ability of the child patient to interpret interaction with others, their experiences, communication, and connections with the world around them is a key focus in cognitive therapy (p. 4), and these "cognitions" are what must be recognized and interpreted by the practitioner (Friedberg & McClure, 2002, p. 6). Another key element of the

cognitive approach is the importance of active learning – children learn by doing, and "connecting coping skills to concrete actions is likely to help children attend to, recall and perform the desired behavior" (Friedberg & McClure, 2002, p. 9). The connection between learning and facilitating a change in behavior can play a major role within the prevention setting.

Many prevention programs that focus on children are based in school settings, which provide an ideal environment in which to treat the child within the context of a relevant, familiar backdrop. The school, the family, and the community are all elements within the "system" in which the child functions daily, and practitioners must be able to think broadly about treatment within these systems. Friedberg and McClure (2002) suggest that "the systems in which children function can reinforce or extinguish adaptive coping skills. Family involvement and school consultation are critical for successful initiation, maintenance, and generalization of therapeutic gains" (p. 8). Ronan (1998) also notes the importance of treating children within their "natural" environments, to be distinguished from unfamiliar settings such as a therapist's office. Prevention programs may utilize a variety of very specific strategies to address behavioral problems in child clients, including guided discovery (the child comes to understand their own thinking, and make connections to their behavior), collaboration with parents and teachers, problem-solving strategies, relaxation techniques, and pleasant event scheduling (the deliberate planning of activities that will positively reinforce improved or improving behavior) (Dummett, 2006; Friedberg & McClure, 2002). These approaches may occur within routinized prevention programs that adhere to manuals and set curricula, or be part of a more flexible treatment approach that incorporates other techniques as well.

Cognitive-behavioral approaches to prevention

Historically, cognitive and behavioral approaches to psychological treatment developed along separate tracks, with noted behaviorists Thorndike, Pavlov, Skinner and Watson leading the charge from the behavioral perspective, and Beck and Ellis working on the role and applications of cognition. During the 1960s, the "gradual coalescence of cognitive and behavioral formulations" (Wright, Ramirez-Basco, & Thase , 2006, p. 3) began, when other prominent researchers and clinicians such as Meichenbaum (1980) began to incorporate cognitive elements to their previously behavior-based treatment. These elements added "context, depth and understanding to behavioral interventions" (Wright, Ramirez-Basco, & Thase, 2006, p.3).

Presently, cognitive-behavior therapy represents a highly prominent treatment approach, one that is steadily growing in popularity. Some of this is attributed to the significant findings from the substantial number of controlled studies that have been conducted on cognitive behavioral therapy treatment outcomes, and the more than 352 published studies on cognitive-behavioral interventions (Wright, Ramirez-Basco, & Thase, 2006; Butler, Chapman, Forman & Beck, 2006). Cognitive-behavioral therapy is used to treat depression, a range of disorders on the spectrum of Autism, Tourette's Syndrome, eating disorders, substance abuse, enuresis and encopresis, and numerous other hard-to-treat disorders in children (McKay & Storch, 2009; Butler, Chapman, Forman & Beck, 2006). Cognitive-behavioral therapies are often evaluated on the basis of their effectiveness that is, whether they work in settings where they would typically be administered, and their efficacy – how they performed in experimental settings (McKay & Storch, 2009).

A variety of factors are involved in the application of cognitive behavior therapy, as well as an understanding that not all disorders are responsive to the approach, and that there are

individual differences that will impact treatment outcomes (Marder & Chorpita, 2009). As with any treatment plan, prevention-based or otherwise, the initial assessment is critical, as it allows for the informed selection of appropriate measures, tools, protocols and strategies. Treatment protocols can formally be described based on how they are selected: by way of evidence (evidence-based), informed by practice (practice-based), or conceptualized by individual case (Marder & Chorpita, 2009). It is typical of this type of treatment to be "diagnosis or problem-driven" (Marder & Chorpita, 2009, p. 13), however, it is not unusual to find practitioners that take a more holisitic or interactional approach to dealing with child patients.

In prevention settings, cognitive behavioral approaches may be used to address difficult behavior, anxiety, aggression, depression and myriad other dysfunctions in children; of which there are numerous examples: A school-based prevention program for aggressive boys used goal-setting and anger-management skills to help the boys deal with violent outbursts (Lochman, Burch, Curry & Lampron , 1984). The *Friends for Children Programme*, based in Australia, used a 12-week intervention scheme to treat anxiety symptoms in young children (Barrett &Turner, 2001), and tested the impact of three different protocols – a psychologist-led intervention, an intervention led by a teacher, and a usual care scenario with use of the standard curriculum - on treatment outcomes. The *Coping Power* program integrated preventative components for children at-risk and their parents within a school setting, and outcome studies illustrate a positive impact on the self-regulation and social competence of the child participants, and on their parents' parenting skills (Lochman & Wells, 2002).

Implementation of CBT at the school level faces several challenges. Although the literature thoroughly and empirically supports the effectiveness of this approach with child populations, "many child and adolescent mental providers have not been trained in CBT, and are not using

(and/or are resisting) the use of empirically supported strategies" (Weist, 2005, p. 737). In addition, some of the approaches currently being used, such as "eclectic" or "insight-oriented" therapies, have been shown to be ineffective (Weist, 2005, p. 737; Weisz, 2004).

Creative arts-based therapeutic approaches to prevention

"Give a child a paintbrush or a pen, and he is less likely to pick up a needle or a gun. Give a child hope through the arts, and you just might save his life" (Randall, 1997, p. 7). In 1997, the National Endowment for the Arts partnered with the Center for Substance Abuse Prevention to co-author *Art Works! Prevention Programs for Youth and Communities* (Randall, 1997). This effort marked the first time that two such agencies had formally come together to recognize and document preventative approaches with young people that used art as the central treatment approach. Increasingly, the combination of creative arts and therapy has proven a popular approach for helping children and young people deal with a variety of behavioral, emotional, and psychosocial challenges. In particular, creative arts therapy has been used to address childhood traumas (Carey, 2006), such as those documented after the crisis in Darfur, Rwanda, the Balkans, 9/11, the conflicts in the Middle East, and the tsunami disaster in the South Pacific (Rousseau, Gaither, Lacroix, Morgan, Viger, Rojas, & Alain, 2005).

Creative arts therapy entails a wide range of approaches, for instance, victims of child trauma may be exposed to sandbox therapy (Frey, 2003; Rousseau et al., 2005), play therapy (Frey, 2003), drama therapy (Rousseau et al., 2005), puppetry play (Frey, 2003), and story-crafting (Mills, 2006; Rousseau et al., 2005). Dance, drama, music, and theater have all been used to frame psychological and preventative treatment (Collie, Bottoroff, & Long, 2006; Goodill, 2005; Mazza, 2003). Each approach, though grounded in the arts, can entail a different

set of applications. For instance, art therapy has been used in work with children who are particularly aggressive (Nissimov-Nahum, 2008; Stinson, 2009).

Creative arts therapies may be combined with other modalities, such as cognitive behavioral therapy. Register and Hilliard (2008) describe cognitive behavioral music therapy, which "allows children to experience music-based decision-making, structure and problem solving in a manner that encourages emotional expression and validation. Additionally, participants discuss and practice these cognitive-behavioral changes in a socially supportive environment by engaging in action-oriented experiences and discussing behavior and thought patterns" (p. 164). Erfer and Ziv (2006) discuss dance/movement therapy and its application to children in preventative and other treatment settings. "DMT is a unique therapeutic modality for children. All children move in some way, and all movement is a form of communication. Children often learn about the world through body experiences that determine their emotional, social, physical, communicative, and cognitive development. DMT is a process that enables children to engage in meaningful exploration of the self, the environment, and others." (Erfer & Ziv, 2006, p. 240). Rousseau et al. (2005) and Stinson (2009) discuss the importance of adapting preventive creative arts therapies for use with multicultural and in particular child immigrant populations. Rousseau et al. (2005) states that "creative expression workshops" should "metaphorically represent cultural diversity to allow a give and take between mainstream and minority cultures" (p. 80).

While there is quite a bit of literature on the application of creative arts therapies, there is a noticeable lack of published research on the effectiveness of these approaches with child populations (Nissimov-Nahum, 2008). In addition to bringing research to bear in the use of creative arts therapies, there are also concerns about integrating creative arts therapies into

educational settings, working closely with parents, the role of the therapist within the school, and interpreting the output of creative arts-based sessions (for instance, interpreting a child's artwork or play) (Nissimov-Nahum, 2008). These limitations may discourage robust application of these approaches.

Psychoeducational approaches to prevention

Psychoeducation can often play a role in prevention settings, not as a form of stand-alone treatment, but as part of a comprehensive approach to educate those involved in mental healthcare (either directly or indirectly) about the various aspects of psychological and emotional disorders. Families are often involved in psychoeducational programs to help them deal with relatives who face psychological and psychiatric disorders, and learn about how best to support them. "Psychoeducation is the specialized education that comprises of educational endeavors directed toward the patients and their families with an aim to help prevent relapse of mental illnesses and restoration of health for mentally ill patients" (Atri & Sharma, 2007, p. 32). According to Hayes and Morgan (2005, p. 111) the school setting is seen as being a strategic environment in which to offer psychoeducational prevention services, "school-based psychoeducational programs have been found to be particularly successful in helping students at risk."

Prevention programs for children and young adults that target bullying, disruptive and aggressive behavior, eating disorders, suicide, ADHD, psychiatric disorders, and sexual behavior may employ a psychoeducational approach that entails work with the children, parents, and teachers. These programs may also include group and individual psychotherapy sessions. There are numerous documented examples of prevention programs that integrate a variety of strategies, including the *Helping Adolescents Cope Psychoeducation Program* (Hayes & Morgan, 2005),

which includes "psychoeducation, skills training, exposures, relapse prevention with a parent component" (p. 113). The program is administered via group, individual and team treatment sessions. The *Clinician-Based Cognitive Psychoeducational Intervention for Families* (Beardslee, Gladstone, Wright & Cooper, 2003) helps children and families deal with depression in a preventative setting. *Bully Busters* is a prevention program that uses psychoeducational interventions to help elementary and middle school children cope with and prevent bullying (Newman-Carlson & Horne, 2004). Mishna, Cook, Saini, Wu, & Muskat (2009) describe a psychoeducational prevention program aimed at addressing cyber-abuse.

Empirically, psychoeducational approaches for the treatment of schizophrenia and other severe psychiatric disorders have been shown as highly effective (Gearing, 2008). A meta-analysis of 64 eating disorder prevention programs with psychoeducational components found that 21% of the programs produced the desired prevention effects (Stice, Shaw & Marti, 2006). However, it can be difficult to locate empirical data on the effectiveness of the many individual psychoeducationally-based prevention programs that are available, especially those that are based in school settings where empirical research is difficult and challenging to conduct.

Multicultural approaches to prevention

The diversification of the nation's child population has serious implications for a number of areas, including education and mental health. As the number of children from difference backgrounds and cultures continue to increase, there is also an increasing need for services and programs to help these children adjust and thrive (Ringwalt, Ennett, Vincus & Simons-Rudolph, 2004). In school settings, culturally sensitive curricula, teachers and staff who can interact in a variety of languages, social workers and mental health workers who are sensitive to the stressors of adapting to a new culture are all important pieces of the puzzle. Funding and human resource

limitations often mean that support for diverse populations may not be implemented in an effective way, however, and this can leave those responsible for providing services feeling frustrated, and ill-equipped. “Research suggests that most teachers recognize this as a limitation in existing programs and take it upon themselves to adapt prevention curriculum to meet the needs of a diverse student body” (Hecht & Raup Kreiger, 2006, p. 302).

Research has demonstrated the children from non-majority backgrounds do not seem to take advantage of mental health services, no matter where they are provided, to the same degree that children from majority backgrounds do. “Many researchers believe that the main reason that ethnic minority clients underutilize mental health services and drop out of treatment at high rates is the inability of clinicians to provide culturally responsive treatments for their ethnic minority clients” (APA/EBPCA, 2008, p. 26). The role of the individual providing the treatment is also critical: “culturally insensitive treatments can cause therapists unwittingly to select goals or embrace values that reflect the culture of the therapist rather than that of the child/family” (APA/EBPCA, 2008, p. 26). There are ways to enhance the appropriateness of treatment with diverse child populations. Griner and Smith (2006) conducted a meta-analysis of 76 studies that examined a variety of interventions, all of which had been “culturally adapted” in some way. Their study found that (1.) “interventions targeting a specific cultural group were four times more efficacious than interventions provided for groups of clients of diverse cultural backgrounds, and (2.) interventions carried out in the clients’ native language (when it was not English) were twice as effective as interventions conducted in English“ (APA/EBPCA, 2008 p. 26). Although there is an acknowledgment amongst practitioners within the “prevention community” that the lack of culturally relevant programs may be problematic, “there are only a few examples of programs that describe the process of culturally adapting a program” (Hecht &

Raup Kreiger, 2006, p. 304).

The evaluation of cultural competency for prevention programs presents a real challenge for practitioners, as there are few guidelines for this type of assessment (Hecht & Kreiger, 2006). Theoretical constructs such as cultural grounding theory (Hecht & Raup Kreiger, 2006) and communication-behavior change theory (Orlandi, 2009) have been applied to the development of culturally competent prevention programs for substance abuse and disruptive behavior. These constructs focus on the role of culturally relevant language and communication during intervention and treatment, an example of which is the "*keepin' it REAL*" curriculum, part of a school-based drug prevention program evaluated by Hecht and Raup Kreiger (2006).

In addition to these constructs, several researchers have attempted to clarify the definition of culturally sensitive prevention and the process of adapting pre-existing curricula. Castro, Barrera, and Martinez (2004) define three areas that should be considered when adapting culturally sensitive curricula: cognitive information processing, affective-motivational characteristics, and environmental characteristics. Kreuter, Lukwago, Bucholtz, Clark, and Sanders-Thompson (2003) designed a five-tiered taxonomy to guide the development of culturally sensitive prevention programs, which include peripheral strategies, evidential strategies, linguistic strategies, constituent-involving strategies, and sociocultural strategies.

In addition to the fact that there is relatively little empirical research related to the creation, application and adaptation of culturally sensitive prevention curricula, there is also the challenge of acceptance of these programs by their intended communities. As Hecht and Kreiger (2006, p. 305) suggest, "in some cases, target audiences may perceive the exclusive focus on their group as "singling out" or "casting an unfavorable light on their community," especially when the behaviors addressed are associated with social stigma, such as substance abuse."

Group approaches to prevention

Group prevention programs that focus on children and young adults can be found in schools and community settings, and entail any number of treatment components, including psychoeducational, multicultural, cognitive-behavioral, and psychodynamic aspects (Stinson, 2009). Kymissis and Halperin (1996) discuss the theoretical constructs of group psychotherapy with children as being grounded in the works of Piaget, Bandura, Bronfenbrenner, and other notable psychologists. Developmental, ecological and sociocultural aspects serve to inform the dynamics of the group, whether it is a peer group or a treatment group (Kymissis & Halperin, 1996). To this end, researchers have studied a variety of issues related to group-based prevention with children, including the environments in which group approaches work best.

Coulson-Brown and Hill (2007) suggest that "group interventions with children and adolescents have the potential to mobilize the power of prosocial peer influences, positive peer and adult role models, and the persuasive power of a social interaction" (p. 39). Group-based prevention can take place in schools, community centers, and other setting where children gather. The school setting provides a familiar and logical place for these programs. Smallwood, Christner, and Brill (2007) acknowledge that "students often experience difficulties within the context of their peer group, making school-based group interventions an important aspect of school mental health programs" (p. 89).

Group cognitive behavioral therapy (GCBT) is an approach used in many settings, including schools. This approach is used to deal with anger, depression, aggression, and anxiety (Smallwood, Christner, & Brill, 2007, p. 95). These programs may include techniques to help instill social competence skills in children, including self and social awareness, problem solving skills, responsible decision-making, and relationship skills (p. 95). Examples of these

applications include the *I Can Problem Solve* program (Shure, 2001), the school-based *PATHS* curriculum (Promoting Alternative Thinking Strategies (Greenberg, Kusche, Cook, & Quamma, 1995) and the competencies outlined CASEL (Collaborative for Academic, Social, and Emotional Learning, 2005). Psychoeducational approaches can also be applied within the group setting, as evidenced by the sexual abuse prevention program for children described by Kenny (2009), a program that provides the language and social skills necessary to protect the participants from inappropriate sexual behavior and advances.

Group-based prevention and treatment with children and young adults face several challenges. Children who are at-risk and prone to behavioral problems may experience an intensification of such behaviors when surrounded by peers with similar tendencies. This is particularly true for young adults who may exhibit antisocial behavioral patterns: "during group sessions, through verbal and non- verbal communication, deviant peers may positively reinforce each others' antisocial behavior, increasing the likelihood of future delinquent acts. Youth without a history of serious antisocial behavior may be particularly vulnerable to being influenced by deviant peers in group treatment" (Weiss, Caron, Ball, Tapp, Johnson & Weisz, 2005, p. 1036). To this end, in any group with children who are prone to acting out and disruptive behavior, mixed groups may be more effective than homogenous groups, suggest Weiss et al. (2005). "Inclusion of prosocial youth who attend to more normative behavior should decrease reinforcement for deviant talk and actions" (p. 1037). In addition, groups that lack direction tend to intensify this interchange and adoption of negative behaviors among group members (Dodge, 1999). The role of the social worker, group leader, or therapist is therefore key in terms of group management, planning, and appropriate application of interventions.

School-based prevention programs

Attempts to support the emotional and psychosocial development of children within school settings began as early as the 1920s, when school-based prevention programs were initially implemented (Durlak, 1995; Durlak, 2008). Programs at that time dealt with mental health and mental "hygiene", and tended to focus on high-risk children. As well, the early 1900s saw the initial development of sex education programs, which were also framed in a preventative light (Durlak, 1995). According to Greenberg (2004), "during the last decade there have been significant developments in school-based prevention" which include "increases in the number and breadth of evidence-based programs" and "evidence-based models and the development of community-school models for effective diffusion of prevention" (p. 5).

The numbers of children with mental health issues has been steadily increasing over the past few decades. The 1999 U.S. Surgeon General's Report on Mental Health concluded that 20 percent of children experience some kind of mental health challenge. Eleven percent of these children have "significant functional impairment," and five percent suffer from "extreme impairment" (Powers, 2005, p. 3). Evidence has shown that very few of these children actually obtain help or support (U.S. Department of Health and Human Services, 1999), and furthermore, minority children are likely to receive the least attention in terms of mental health interventions (U.S. Surgeon General's Report, 2001, Mental Health: Culture, Race, and Ethnicity; Kataoka, Zhang, & Wells, 2002). There is a recognized need for school-based care and prevention for children and young adults within the "system" that Friedberg and McClure (2002) describe.

School-based prevention programs are framed by the larger construct of school-based mental health. The school-based mental health (SBMH) initiative attempts to address the shortfalls for childhood mental health care mentioned above (Weist, 2005). Based largely on the recommendations of the President's New Freedom Commission on Mental Health (Bush, 2003),

the SBMH framework includes a directive to "improve and expand school mental health programs." Weist (2005) suggests that the impetus for this directive is clear, and based on the fact that "mental health services in schools remain marginalized. A typical scenario in schools is one of limited evaluation and consultation services and, sometimes, very limited treatment services, primarily for youth in or being referred into special education" (p. 735). Sadly, schools still universally lack the resources they need to actively implement quality mental health service programs, including prevention programs. Weist (2005) states "most schools and SBMH initiatives lack resources to adequately train, supervise, and provide ongoing support to staff; to implement systematic strategies to assess and continually improve the quality of services; and to document outcomes and provide accountability data for advocacy/policy influence" (p. 737). This is especially true for urban schools and those in areas where children are especially at risk.

School-based prevention has been highlighted as an appropriate strategy for addressing risk factors, however, Greenberg, Weissberg, O'Brien, Zins, Resnick and Elias (2003) state that often, prevention programs within schools are uncoordinated, short-term, and fragmented, which leads to their eminent failure (p. 467). As a way to address this fragmented approach, social and emotional learning or "SEL" ideology was born. SEL features a conceptual framework to address both the needs of young people and the piecemeal approach that typically characterizes the response of schools to those needs (Greenberg, Weissberg, O'Brien, Zins, Resnick & Elias, 2003, p. 467). The components of SEL are easily recognizable as common-sense ingredients necessary for children and young adults to lead healthy, well-adjusted lives, and include self-management, self-awareness, social awareness, responsible decision-making, and relationship skills (Greenberg et al., 2003).

A robust meta-analysis of evaluative research on school-based prevention programs across

several domains led Greenberg, Weissberg, O'Brien, Zins, Resnick and Elias (2003) to characterize the key concepts of success: (a) teaching children to apply SEL skills and ethical values in daily life through interactive classroom instruction and providing frequent opportunities for student self-direction, participation, and school or community service; (1.) fostering respectful, supportive relationships among students, school staff, and parents; and (2.) supporting and rewarding positive social, health, and academic behavior through systematic school–family– community approaches (p. 470).

Evaluation of school-based prevention programs remains key. "The scientific community agrees on three standards for evaluating effectiveness: rigorous experimental design, evidence of significant deterrent effects, and replication of these effects at multiple sites or in clinical trials" (U.S. Department of Health and Human Services, 1999). Greenberg (2004) notes that in addition to these standards, there need to be "valid and reliable assessments of social, emotional, ethical, and health outcomes that can easily be utilized by schools as part of their accountability process" (p. 8). With specific reference to the NCLB Act of 2001, Greenberg reminds us that at the moment, "educational leaders are singularly focused on the student academic performance requirements of the No Child Left Behind Act. Following the dictum that "what gets inspected gets expected," many schools have increased the time they devote to instruction in these "inspected" areas while reducing time for "non-assessed programming." (p. 8). There remain serious implications for school-based prevention programs that cut across programmatic, financial, and outcome parameters.

School-based creative arts primary prevention programs: Examples

Two examples of school-based creative arts primary prevention programs similar to CARING's Learning to Cope with Stress through Art: An Ethnic-Sensitive Model (Canino,

Rojas-Flores, & Korman, 1999), are provided below. These programs each report that participants experienced an improvement in self-esteem, pro-social skills, cultural sensitivity, and a decrease in aggressive behavior and symptoms associated with internalizing and externalizing disorders.

The Youth Based Violence Program

The Youth Based Violence Program (YBP; Kisiel, Blaustein, Spinazzola, Schmidt, Zucker, & van der Kolk, 2006) is a theater-based arts program aimed at reducing aggressive behavior and improving pro-social behavior in a safe school-based environment. The program is facilitated by an art therapist, community worker, and teacher, and integrates music, drama, and theater into the curriculum to help children improve behaviors that are needed to be successful in school and within the community. Children have the opportunity to discuss, analyze and solve problems relating specifically to violence and crime. The theater-based program relies on role-playing, story telling, and skits to address aggressive behavior. By utilizing creative arts, children are able to explore their talents and abilities, and address anxiety and worries about coping (Kisiel, Blaustein, Spinazzola, Schmidt, Zucker, & van der Kolk, 2006).

A research study of the program included children from five inner city Boston elementary schools (n=144). A quasi-experimental pre- and post test design was implemented to see if children who participated in the program improved their self-esteem, behaviors within the classroom, and behaviors associated with internalizing and externalizing behaviors (Kisiel, Blaustein, Spinazzola, Schmidt, Zucker, & van der Kolk, 2006). Improved self-esteem, improved classroom behavior, social skills and behavior, and decreased aggressive behaviors in the school were among the outcomes reported. The findings from the study suggest that children respond

positively to creative arts interventions, and that these programs provide an opportunity to learn skills that are needed to be successful.

The National Arts Youth Dissemination Project

The National Arts Youth Dissemination Project (Wright, Lindsay, Offord, & Rowe, 2004; Stinson, 2009) is another example of a creative arts based prevention program which integrates performing, visual, and media arts to help children reduce aggressive behaviors and improve behaviors that are needed to be successful in school and within the community. Children in the program discuss, analyze and solve problems relating specifically to self-esteem, conflicts, and cooperative behavior. The program's aims are to: 1.) improve cultural sensitivity, 2). improve self-esteem, and 3.) reduce the behavior and emotional issues pertaining to internalizing and externalizing disorders at school, home and community. Creative arts provide a means of expression for the children, who learn new skills in an environment that fosters growth and awareness. The program also taught children to resolve conflicts creatively (Wright, Lindsay, Offord, & Rowe, 2004).

A three-year longitudinal study of the program was conducted in five Canadian elementary schools in 2002. A total of 183 economically disadvantaged children, aged 10-15 years, participated. A quasi-experimental pre- and post test design was implemented without randomization. Qualitative and quantitative assessments were used to measure the outcomes for the study. Information was collected from the children, parents, and teachers to monitor childrens' progress in the program over the course of three years. Anecdotes and observational data were also collected (Wright, Lindsay, Offord, & Rowe, 2004).

Results indicated that the participants improved their social skills, communication skills, and conflict resolution skills. Participants also improved relationships, attitudes about school,

social skills, and self-esteem. In addition, the researchers reported that children also improved their artistic skills (Wright, Lindsay, Offord, & Rowe, 2004; Stinson, 2009).

Although the reviews of these particular programs suggest that they are effective, there are many limitations that have been addressed by researchers (Clawson & Coolbaugh, 2001; Kisiel, Blaustein, Spinazzola, Schmidt, Zucker, & van der Kolk, 2006 ; Rosseau, Lacroix, Singh, Gauthier, & Benoit, 2005; Wright, Lindsay, Offord, & Rowe, 2004; Rapp- Paglicci, Ersing, & Rowe, 2006). The most problematic areas are in sample size, study design, randomization, data collection, and the use of measures that are not reliable and valid (Borkowski, Smith, & Akai, 2006; Rapp- Paglicci, Ersing, & Rowe, 2006). These studies also lack control groups and randomization, which are critical components and contribute to the overall reliability of the results.

Despite the limitations and tentative findings from these particular studies, these programs were able to identify children who were in need of additional support services. Results from these programs do suggest that combining creative arts and prevention programs within schools can have a positive impact on behavior, thus, these results broaden the body of literature on creative arts and primary prevention programs in schools, an area which remains understudied.

One of the most challenging aspects of implementing any prevention program is deciding which curricula or interventions to adopt. The evaluation of evidence supporting programmatic success or failure can be central to this decision-making process. Evidence-based practice is discussed in the following section as the second major construct for this research study.

Part II Evidence-based Practice (EBP) as Theoretical Construct

EBP and the School Environment

The Institute for the Advancement of Social Work Research (IASWR) states that evidence-based practices (EBP) are those "that have been established as effective through scientific research according to a set of criteria" (p. 75), with these criteria being based on the "type of research design employed" (p. 75). Experimental studies with randomly assigned control groups are "the gold standard for proving effectiveness of the intervention" (p. 75). According to the American Psychological Association, evidence-based practice "denotes the quality, robustness, and/or scientific evidence on prevention, assessment, treatment, access, engagement, and retention of targeted patient populations" and "assumes the presence of a coherent body of scientific knowledge relevant to a broad range of services that optimizes the effectiveness of interventions, treatments, or services on a particular student, client, or system" (APA Evidence-Based Practice for Children and Adolescents (APA/EBPCA) Report, 2008, p. 6). The practice of evidence-based treatment involves three components: "(a) assessment that guides diagnosis, intervention planning, and outcome evaluation; (b) intervention that includes, but is not limited to, those treatment programs for which randomized controlled trials have shown empirical support for the target populations and ecologies; and (c) ongoing monitoring, including client or participant feedback, conducted in a scientifically minded manner and informed by clinical expertise" (APA/EBPCA Report, 2008, p. 9).

Children spend upwards of seven hours per day in school, where they interact with teachers, other students, paraprofessionals, social workers, and other staff. Given this fact, the school setting provides "opportunities for prevention and treatment" for children who are experiencing difficulties (APA/EBPCA Report, 2008, p. 7; Weissberg, Kumpfer, & Seligman, 2003). The need for EBP in schools is supported by the fact that more than half a million children with behavioral disorders received special education outreach during 2001, according to

the Office of Special Education Programs (APA/EBPCA Report, 2008). These statistics are further compounded by the fact that "limited access to health and behavioral health care increases the likelihood that untreated behavioral concerns will emerge in schools" (APA/EBPCA Report, 2008, p. 7). Over the past ten years, the growing numbers of children with special needs have rendered the traditional special education system unmanageable and ineffective, and the need for using a more systematic, holistic and evidence-based approach represents a potential solution.

Huey and Polo (2008) state that EBP has been documented as having successful outcomes with childhood trauma, anxiety, ADHD, depression, behavioral and conduct problems and disorders, and substance abuse. Researchers have further demonstrated that EBP programming in schools does help to reduce undesirable behavior in children (Shepard & Carlson, 2003; Greenberg, Domitrovich, & Bumbarger, 2001; Weissberg, Kumpfer, & Seligman, 2003; Rones & Hoagwood, 2000). In addition Powers (2005) suggests that "advantages to implementing EBP in schools rather than relying solely on community social service providers include: families avoid the stigma of going to a social services agency, services are provided in a familiar setting, transportation needs are reduced, and, due to the convenience of services, commitment to therapy may be enhanced" (Committee on School Health, 2004; Powers, 2005).

Hoagwood (2005) suggests that although there is an acknowledged need for EBP in schools, EB practices are rarely implemented. A number of barriers often prevent the application of EBP for prevention or other types of programming. Walker (2004) also states that the use of empirically-based treatment approaches is rare in schools, this despite policy implications such as those framed by the NCLB Act of 2001. Why does EBP still struggle to obtain a foothold as a preferred treatment method in schools? Powers (2005) examined three potential impediments to

the implementation of EBP in schools: "impact on student outcomes, resource requirements, and the availability of information on EBPs" (p. 26). The study found that the resource or startup requirements for implementing EBP in schools was very high, and discouraged adoption at the school level. Training for staff was hard to come by, and very time consuming, which also served to discourage adoption of EBP. Data on small effect sizes and outcomes proved to further discourage implementation, and finally, the study found that the amount of research required to prepare for the implementation of EBP was intense, time-consuming, and seen as an impediment (Powers, 2005).

There are a variety of ways that EBP prevention programs in schools may manifest. The APA/EBPCA Report (2008) describes four specific categories, although there are others as well. Programs may include health promotion; focus on universal prevention where the entire school participates (Olweous, 1994); target special populations "at especially high risk of unwanted outcomes" (APA/EBPCA Report, 2008, p. 35); and "indicated prevention", where "the focus is on youngsters who already show some evidence of the target problem" (p. 36). As example of the latter category is a Montreal-based school prevention program that targeted young boys of Kindergarten age "who already showed significant disruptive behavior" (p. 36). Prevention efforts included social skills training for the boys, and parenting work with their parents (APA/EBPCA Report, 2008, p. 36). "This indicated prevention program led to better school performance and reduced delinquency over the subsequent 5 years" (APA/EBPCA Report, 2008, p. 36; Tremblay, Pagani-Kurtz, Masse, Vitaro, & Pihl, 1995).

Recent research has been promising in terms of providing evidence for positive prevention treatment outcomes across a wide variety of disorders (Eyberg, Nelson, & Boggs, 2008; Waldron & Turner, 2008; Huey & Polo, 2008; Silverman, Pina, & Viswesvaran, 2008). However,

Goodhart, Kazdin, and Sternberg (2006) state that there are major concerns with the use of EBP, especially for populations like children and the mentally challenged. Within this context, the researchers suggest, "there is a tremendous need for interventions but relatively few treatments that meet the most narrowly defined criteria of evidence because of the difficulties associated with such documentation" (p. 19).

Another limitation for the use of EBP within school settings has to do with the complex nature of childrens' presenting problems, the intricate and sometimes complicated nature of their familial backgrounds, and their cultural context (APA/EBPCA, 2008). "Most evidence-based treatments are designed for single conditions or groups of closely related conditions (e.g., a cluster of anxiety disorders with partially overlapping symptoms) and do not specify how to deal with the complex social and family circumstances that relate to the children's problems or to the cultural contexts in which the children's problems are manifested and interpreted. Comorbidity may either undermine or enhance the effects of treatment on the primary problem targeted in treatment and complexities associated with social and family circumstances and cultural contexts may hamper the effects of treatment if they are ignored" (EBPCA Report, 2008, p. 10; Amaya-Jackson & DeRosa, 2006). In order for treatment efforts to be effective, the "social ecology" of the child's world must be understood and integrated into prevention work (Bronfenbrenner, 1986).

EBP and implications for social work practice

The Institute for the Advancement of Social Work Research (IASWR) states that EBP is a "process in which the practitioner combines well-researched interventions with practice experience, ethics, client and community preferences and culture to inform the delivery of treatments and services that can be applied as the individual, family, group, or policy level"

(IASWR, 2008, p. 1). Gilgun (2005) suggests that within the field of social work, EBP is still in its infancy, and that there are "four cornerstones" that anchor EBP within the field: (1) research and theory; (2) practice wisdom, or what we and other professionals have learned from our clients, which also includes professional values; (3) the person of the practitioner, or our personal assumptions, values, biases, and world views; and (4) what clients bring to practice situations" (p. 52).

Rubin and Babbie (2008) articulate several important steps for social workers as they determine how to implement evidence based practices. Social workers should attempt to formulate a question to answer practice needs, search for evidence, critically appraise any relevant studies, determine the best evidence-based approach for the client, apply the intervention, and evaluate the outcomes (Rubin & Babbie, 2008, p. 22). However, social workers are bound by the same constraints that impede implementation and adoption of SBMH and EBP. Lack of training, lack of resources, lack of funding and lack of direction all serve to restrict the application of evidence-based best practices by school-based social workers. Moreover, since the implementation of evidence-based prevention programs must include a team approach, social workers must rely on the cooperation and interest of administrators, teachers, relevant staff, and parents. This can add yet another layer of challenges. Another pressing limitation of EBP within social work are articulations of shortcomings that have to do the patient-practitioner relationship, among others (Guyatt, Haynes, Jaeschke, Cook, Green, Naylor, Wilson & Richardson 2000; Sackett, Straus, Richardson, Rosenberg & Haynes, 2000; Straus & McAlister, 2000). Under conceptualizations of patients' values, under conceptualizations of physicians' clinical expertise, the impact of personal perspectives of the physicians on treatment, and the limitations of research practice are all challenges that impact the application of EBP for social workers and

other practitioners (Gilgun, 2005).

EBP and policy

The relationship of policy to EBP within the social work framework can be defined in many ways. EBP can be used to guide and inform policy decisions related to prevention, intervention and assessment activities. The approach can also provide benchmarks for practitioners against which to measure progress in a number of areas. Finally, EBP provides a robust template for research and investigatory work related to prevention and treatment. There are far-reaching policy implications, the most prevalent relating to child protection and child welfare, especially for underserved populations (Lindsey & Schlonsky, 2008). Policy matters include child mental health concerns, the juvenile justice system, family preservation, foster care, adoption, institutional abuse and neglect, and poverty, just to name a few (Lindsey & Schlonsky, 2008, p. 233). A number of evidentiary studies have examined child welfare policy and practice, and the resulting data has been used to support the development of new programs and to improve existing programs. Researchers examined the effectiveness and impact of the Chicago Parent Child Center (CPC), a program designed to support economically challenged families and thus prevent the development of later maltreatment patterns (Reynolds & Mersky, 2008). Recommendations from the research study included an increase in Title 1 funding to pre-schools and pre-school intervention programs (Reynolds & Mersky, 2008). The evidence provided by the study's gathered data informed future program direction and development.

Currently, there are a number of federally-funded projects that focus on EBP and policy, such as the Center for Evidence-based Practice:Young Children with Challenging Behaviors, a national research and training center funded by the U.S. Department of Education's Office of Special Education Program. The program is designed to provide resources and guidance in

addressing prevention in early childhood (http://www.challengingbehavior.org/, 2010). The National Institutes of Mental Health support a variety of programs aimed at strengthening the nation's framework for providing prevention, including the Child Intervention, Prevention and Services (CHIPS) consortium (http://www.chipsfellows.com/, 2010). Furthermore, reports such as the "Blueprint for Change: Report of the National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment" (2001) on the mental health status of the nation's children and young adults have served to galvanize a more cohesive approach to providing preventative care at and addressing policy at national levels.

Greenberg (2004, p. 6) highlights the connection of evidence-based practices and policy decisions, stating "the growth of evidence in the field has been paralleled by a substantial change in policy legislation at both the federal and state levels. Two dramatic examples are the Safe and Drug Free Schools Act of 1999 which stated "principles of effectiveness," and the No Child Left Behind Act of 2001 that calls for school districts to implement evidence-based programming." Greenberg further articulates that ideally, policy should support the development of new programs which "simultaneously improve students' health, social–emotional, and academic outcomes", not just focus on academic performance. A more holistic approach to designing and evaluating programs is key - "researchers must collect data on academic achievement and other indices of school success to better understand the full impact of prevention activities on domains that influence program adoption decisions and sustainability (Greenberg, 2004, p. 8).

EBP also plays a role in the professional development of social workers and other practitioners. "EBP describes a process and a new professional education format (problem-based learning) designed to help practitioners to link evidentiary, ethical, and application issues"

(Gambrill, 2008, p. 52). Evidence informed practice is a slightly different take on this concept, and is also related to policy and the role of the social worker: "Evidence informed practice requires considering research findings related to important practice/policy decisions and sharing what is found with clients" (Gambrill, 2008, p. 53). It is within this spirit of sharing that the current study seeks to provide access to research data and outcomes, in the hopes that evidence from the study will inform future programmatic direction and development.

Summary

The literature on prevention treatment approaches, evaluation and policy implications covers a broad range of topics. Treatment methods within the scope of prevention are not created equal, just as evaluation approaches are not created equal. There is widespread discussion within social work and other mental health professions about the relevance and practicality of EBP. However, researchers seem to agree that school-based prevention programs, including programs like CARING, are in great need of empirical evaluation. At the same time, there are few guidelines that support school teachers, social workers, and administrators in conducting what can be very challenging and time consuming research. The current study is an effort to document empirical evidence related to the effectiveness of the CARING program.

The following chapter details these hypotheses and the methodology of the study in greater detail.

CHAPTER 3

METHODOLOGY

The CARING program focuses on helping children to improve their emotional well-being, behavior, and coping skills when dealing with stress, and this study aims to investigate the level of programmatic impact in several key behavioral and developmental areas. This chapter outlines the research methods used in the testing of the hypotheses. Details about the program and participants are discussed, including how they were recruited and selected to participate, and the nature of the usual care and experimental groups to which they were assigned. The instruments for collecting data are described. Last, the data collection plan is provided.

Hypotheses

There are seven variables examined in this study, each drawn from CARING's curriculum manual*, Learning to Cope with Stress through Art: An Ethnic-Sensitive Model*. These hypotheses also directly relate to the literature examined in Chapter 2. Specifically, the seven hypotheses of the study were formulated on CARING's belief that; (1.) stressful events cause negative consequences and (2.) Children tend to view themselves in a negative way after a stressful event (Ablea and McGirr, 2007; Lazarus and Folkman, 1984). In order to address this, the CARING curriculum aims to: (1.) teach children how to control their affective behavior and reactions by teaching both cognitive and behavioral techniques, (2.) improve problem solving skills, (3.) encourage children to seek support from positive role models within the school, home, or community, (4.) help children increase their self-esteem by helping them to recognize their strengths, (5.) teach children skills so they will not distance themselves from or avoid a stress, (6.) teach children the importance of verbalizing their emotions, compared to internalizing, and

(7.) teach children behavior consequences and the importance of controlling their behavior towards others when faced with a challenging situation (Canino, Rojas-Flores, and Korman, 1999). The focus of the study was to determine the degree of improvement in certain behaviors and skill levels of the participants across these variables, which form the basis of the seven associated hypotheses as follows.

H1. Children who participate in CARING will report an increase in affect at posttest compared to those children in the usual care group.

H2. Children who participate in CARING will report an improvement in problem solving skills at posttest compared to those children in the usual care group.

H3. Children who participate in CARING will report an improvement in the ability to seek social support at posttest compared to those children in the usual care group.

H4. Children who participate in CARING will report a decrease in distancing behavior at posttest compared to those in the usual care group.

H5. Children who participate in CARING will report a decrease in internalizing behavior at posttest compared to those children in the usual care group.

H6. Children who participate in CARING will report a decrease in externalizing behavior at posttest compared to those children in the usual care group.

H7. Children who participate in CARING will report an improvement in self-esteem at posttest compared to those children in the usual care group.

Description of the CARING program

Theoretical model

The CARING program is rooted in cognitive as well as behavioral therapies and incorporates stress theory, coping theory, and primary prevention theory (Canino, Rojas-Flores,

& Korman, 1999). Domitrovich, Bradshaw, Greenberg, Embry, Poduska, & Ialongo (2010) indicate that cognitively-based problem solving prevention treatment can help children to reduce negative and unhealthy behaviors associated with a stressful situation, and many variations of the problem solving curriculum have been applied to prevention programs. The cognitive component of the CARING program focuses on helping children become aware of negative thoughts and behaviors that place them at risk. Children are taught strategies and skills that moderate the effects of an unhealthy situation by improving problem solving skills and the ability to seek support and improve self-esteem (Causey & Dubow, 1992). For instance, children are taught to seek social support from peers, friends, and family members; to utilize resources and to speak with counselors, teachers, and professionals; and to problem solve by discussing the situation, brainstorming, and role playing (Causey & Dubow, 1992; D'Imperio, Dubow, & Ippulito, 2000; Dubow, Schmidt, McBride, Edwards, & Merk, 1993).

The behavioral component includes helping children to improve their coping skills by increasing their own self-awareness. The resulting structured lessons, use of rewards, and emphasis on change are all facets of the curriculum that serve to reduce problematic behavior.

The psychosocial needs of urban and inner city children are not the only factors guiding the effective implementation of the CARING program. Dobson & Craig (1998) suggest that the integration of culturally sensitive activities is also an important factor. To address this concern, CARING incorporated the appreciation of cultural heritage, sensitivity, and values into the curriculum based on the research of Cooper, Denner, & Lopez (1999); Dumas, Rollock, Prinz, Hops, & Belchman (1999); Gonzales & Kim (1997); and Mann, Radford, Burnett, Ford, Bond, Leung, Nakamura,Vaughn, & Yang (1998). These aforementioned researchers demonstrated that programs that are sensitized to culture were able to help children bridge cross-cultural gaps,

develop trusting relationships, and promote prosocial skills and behaviors within school and community. Children in the program also learn about the community around them by being exposed to urban community dynamics, neighborhood and community risk, and learning how to access resources. By working in groups, children are also taught cooperation and respect for others within the home, school, and community (Canino, Rojas-Flores, & Korman, 1999; Phinney, Schmidt, Edwards, & Merk, 1993).

In addition to the inclusion of multicultural elements, the integration of creative arts into the psychoeducational curriculum has also been demonstrated as being key (Stinson, 2009). This approach allows children to increase their understanding of the skills that are taught over the span of the program (Canino, Rojas-Flores, Korman, 1999; Case & Dalley, 1990; Linesch, 1990), also, the approach allows for a more gentle segue into the prevention treatment; "creative arts are thought to appeal to most children and may be less likely to raise objections from parents who may be uncomfortable with more conventional approaches of prevention programs" (Canino, Rojas-Flores, & Korman, 1999, p. x).

Relatedly, one of the developmental cornerstones for CARING was that successful prevention programs be adapted for inner city minority children as an alternative to the creation of new programs and models. The initial empirical findings of the *I Can Do* program, a successful prevention program created by Dubow in 1993, prompted the administrators at CARING to further develop the original curriculum to address the unique needs of children in inner city elementary schools. *I Can Do* is a 13 week intervention program that aims to improve coping and problem solving skills for children who are dealing with stress. The program was evaluated using a pre- and post-test design, with a control group of 84 children in fourth grade attending two Midwestern elementary schools. The Self- Report Coping Measure (Causey &

Dubow, 1992) was created for the evaluation of the program and focused on attitudes while experiencing a challenging problem (Dubow, Schmidt, McBride, Edwards, & Merk, 1993). Klein, Lakin, & Dubow (2000) reported that those who participated in the problem solving prevention program were able to generate more solutions to their stressor(s) and were able to cope with their stress, compared with those children who participated in a delayed-intervention group. CARING modified the existing *I Can Do* curriculum to meet the needs of children in inner city elementary schools and further modified it to meet the needs at the group level.

Program structure and implementation

Structurally, the CARING program includes facilitation of groups by a creative arts therapist and a trained mental health worker, such as a social worker, counselor or psychiatry resident. Groups meet for a full semester, once a week for 90 minutes during which time the children discuss disappointments and how to effectively cope with their problems. Over the fifteen week course, children are taught to apply problem-solving skills to situations in and outside of the group (Dubow, Schmidt, McBride, Edwards, & Merk, 1993; Kandall & Branwell, 1993; Weissberg, 1991). The second part of the group consists of a creative art activity where children are engaged in programming that will permit responses and behaviors learned in the first part of the group.

Program implementation consisted of two experimental groups which ran concurrently on Mondays and Wednesdays in the fall semester. The program coordinator, a board certified art therapist, co-facilitated the Monday group with an art therapy intern, and on Wednesday, co-facilitated the group with a psychiatry resident from Harlem Hospital.

The CARING curriculum manual is an important component of the program in which all lessons are outlined in detail. One shortcoming of the manual application is the inability to

address environmental factors and negative behaviors precipitated by the participants, which include acting out, disruptions, fighting, arguing amongst peers, and not following rules. Each of these behaviors potentially and negatively impact the learning of materials. In such instances, the CARING staff relies on the *Turn 2 Us* program to provide additional support.

This research project served to document the impact of some of these negative behaviors on the program implementation and outcomes. In the experimental groups, a large amount of time was taken up by group members interrupting, arguing, and not focusing on tasks. It was reported by the program coordinator that the psychoeducation lessons were difficult to complete due to the constant disruptions and outbursts of behavior. Art projects that were scheduled for one week were not completed; therefore, the program coordinator needed to spend extra time the following session to finish the task.

Non-compliance with group rules was another issue that presented a challenge during the study. Rules are published in the manual and established during the first session. Additionally, they are reviewed weekly to remind the children of the importance of respect for the other group members. The participants did not always follow the rules, which interfered with the completion of weekly lessons. This lack of a willingness to learn and self-control on the part of the participants presented a conflict for manualized prevention efforts, which relies on those elements to be successful. The drawbacks and strengths of manualized prevention is further discussed in chapter 5.

Study population

The population for the study consisted of children 9 -12 years old, attending a New York City public elementary school in Washington Heights. These children were in the third, fourth

and fifth grades. Children who participated in the study were identified as experiencing an academic, family, social, or health stressor at the time.

Study design

For the purposes of this study, a pre-test/post-test design with a usual care and experimental group was implemented. Randomization was not truly achieved, because children from the third grade were assigned to the usual care group and fifth graders were assigned to the experimental group. Children in the 4th grade were assigned to a group. The researcher was able to randomly assign these children to a group by using odd and even numbers from a list created by the CARING program.

There were a number of external and administrative factors that influenced the design structure of the study. The immediate need for services by some of the 5th grade children, as determined by the director of Turn 2 Us, provided the main impetus for the study's design. These child participants were chosen because they were in need of a program that could provide them with support for the fall semester. The decision was also made by CARING to provide services to children who did not meet eligibility criteria, but who appeared to be experiencing behavioral crises. Finally, it was decided by the CARING program that 3rd and 5th graders not be in combined groups due to differences in maturity and developmental levels. Despite the implications these decisions could have on the study, the choice was made by the researcher to move forward. The issues associated with the assignment of the children to the usual care or experimental groups are discussed further in the Limitations Section of this paper.

Recruitment of participants

In September of 2007, 3rd, 4th, and 5th grade teachers, guidance counselors, social workers, and administrators from the Turn 2 Us program met at the school site to discuss the

various school and community-based programs that were to be offered for the coming school year. CARING presented their program's curriculum and discussed eligibility and exclusion criteria. Since CARING is an external program within this school, they rely on teachers, school staff, guidance counselors, and Turn 2 Us to recruit participants.

The inclusion criteria for the CARING program is as follows; (1.) children must be in the 3rd, 4th, or 5th grade, (2.) English speaking, and (3.) experiencing a stressor. Stressors can be defined on several different levels, including academic, social, familial, and health concerns. Academic stressors may be precipitated by a child's low scores (lower than level 3 on the New York State standardized tests) and struggle with basic academics, all of which put the child at risk for academic failure. Social stressors arise when a child has difficulty with peers (including verbal and physical conflict), and difficulty making and keeping friends. Family stressors are characterized by the unrest experienced by families who are experiencing separation, divorce, financial problems, illness, and issues associated with citizenship. Children who are experiencing a death in their family or death of a friend also experience this type of stressor. Health stressors are defined by CARING as any serious health impairment, which might include asthma, allergies, or a medical issue that does not warrant hospitalization. Children might also be referred for more than one presenting problem.

Exclusion criteria includes children with the following; (1.) suicidal ideation, (2.) depression, (3.) aggression, (4.) disruptive behavior (e.g. attention deficit-hyperactivity disorder, oppositional defiant disorder, or conduct disorder), (5.) coping with a major crisis (e.g. medical illness, loss or parent or caretaker), and (6.) a history of hospitalizations or recent return from residential treatment.

Recommendation forms were distributed to the teachers at the end of the meeting. Teachers were instructed to return all forms to the Turn 2 Us office and asked to check the children's homework folders for CARING consent forms on a daily basis. Once the forms were returned to the Turn to Us office by the teachers, the guidance counselor and the director of the Turn 2 Us program met to discuss the recommendations. They created a list of children based on the recommendations and added additional names of children they thought might benefit from the program. This team then discussed whether children suggested for the program met the eligibility criteria outlined by CARING. Discussions focused on some behavioral concerns of three fifth graders, a third grader with somatic complaints, and a fourth grader whose parents were separated. Two children who were removed from the list were experiencing behaviors that were in need of immediate care from Columbia Presbyterian Hospital. Also, one child was moving and was not able to participate in the program. A total of 56 children were recommended for the study.

To facilitate the data gathering process, the researcher asked the director of Turn 2 Us and the guidance counselor to identify the type of stressor and the symptoms the child was experiencing based on the eligibility criteria defined by CARING on a form.

During the second week of October 2007, CARING staff and the researcher met individually with the 56 children who were recommended for the study in the school's small cafeteria during lunchtime. The program was described in detail to each of the children. It was explained to the children that during the program, they would participate in discussion about how to deal with stress. The art and multicultural component of the program was also discussed and the Program Director of CARING displayed examples of past projects that had been completed. Children were also informed that their completed projects would be displayed in an art show.

The children who were interested in participating in the program were asked to record their name and contact information on a form. Children were given an envelope that contained the consent and assent forms in English and Spanish. Children were informed that phone calls would be made to their homes to speak with their parents regarding the program.

To increase response rate, phone calls in English and Spanish were made that evening to the children's parents or guardians by two New York City licensed teachers hired by the researcher. They were able to answer questions and concerns regarding the study. One week prior to the study, the director of Turn 2 Us provided training for these teachers regarding confidentiality, and the role of Turn 2 US in the research study. The researcher supervised all phone calls made to the parents. Follow-up phone calls were made on a nightly basis. Parents were also informed that their child could participate in the program only, and did not have to participate in the study.

The goal for the study was to recruit 64 children. A total of fifty six recommendations were made by the director of Turn 2 Us and the school's guidance counselor. Thirty six consent forms were returned to teachers and brought to the Turn 2 Us office. Twenty nine parents consented to have their children participate in the study, three parents agreed to allow their children to participate in the CARING program and not the research, and four parents refused the study and program. Twenty forms were not returned.

Participant assignment

A total of fifteen 3rd graders were identified for the study, and five agreed to participate. These children were assigned to the control group. Twenty six 4th graders were identified for the study, and twelve agreed to participate. These children were randomly assigned to either the usual care group or experimental group by creating a list of names and assigning odd numbers to

the experimental group, even to the usual care group. Thirteen 5th graders were identified to participate in the study, and twelve agreed to participate. All 5th graders were assigned to the experimental group, and 3rd graders to the usual care group.

Description of participants

This section provides demographic information pertaining to the participants in the usual care and experimental groups. The children in this study attend a public elementary school in the Washington Heights section of the borough of Manhattan in New York City. All participants are Hispanic. Tables 1 through 5 provide a description of the participants and why they were referred to the study.

Table 1

Age of Participants in the Usual Care and Experimental Groups

Group		Age			
		9	10	11	12
Usual care (*n*=13)	*n*	6	5	2	0
	%	100	38.5	33	0
Experimental (*n*=16)	*n*	0	8	7	1
	%	0	61.5	67	100

The study consists of a total of 29 Hispanic children ranging in age from 9 to 12 years (M = 9 years, 10 months; SD = .823). The average age for children in the usual care group was 9.6 years (SD =.751), and 10.1 years (SD =.823) for the experimental group. There were a total

of 13 children (45%) aged 10 in the study, 5 (38.5%) in the usual care group, and 8 (61.5%) in the experimental group. There were a total of nine children (21%) aged 11 in the study, 2 (33%) in the usual care group and 7 (67%) in the experimental group. One 12 year old is in the study.

There are significant differences between the groups and age, χ^2 (3, N = 29) = 9.710, p = .021. Older children were assigned to the experimental group and younger children to the usual care group. This suggests non-equivalence between the groups.

Table 2

Grades of Participants in the Usual Care and Experimental Groups

Group		Grade		
		3	4	5
Usual care (n=13)	n	5	8	0
	%	100	67	0
Experimental (n=16)	n	0	4	12
	%	0	33	100

There are 5 (100%) children in the 3rd grade in the usual care group. The fourth graders make up 41% (N = 12) of the entire study, 8 children (67%) are in the usual care group, and 4 (33%) are in the experimental group. There are no 5th graders in the usual care group; these 12 children (100%) are assigned to the experimental group.

There are significant differences between the groups and grade, χ^2 (2, N =29) = 18.218, p = .000. Children in the study were placed into groups according to grade; 5th graders assigned to the experimental group and 3rd to the usual care groups. This suggests non-equivalence between the groups.

Table 3

Gender of Participants in the Usual Care and Experimental Groups

Group		Gender	
		Male	Female
Usual care (n=13)	n	10	3
	%	45.5	43
Experimental (n=16)	n	12	4
	%	54.5	57

The majority of participants was male and account for almost 76% of the entire study. There were a total of seven females, 3 were (43%) assigned to the usual care group and 4 (57%) to the experimental group.

Fisher's exact test was conducted to determine whether there were differences between the groups and gender. The results suggest that the groups are equivalent, χ^2 (1, N = 29) =.014, p = .626.

Table 4

Reason for Referral for the Usual Care and Experimental Groups

Group		Reason for Referral	
		Shyness, poor social skills, low self-esteem, withdrawal	Low self-esteem, poor social skills, anger
Usual care (n=13)	n	11	2
	%	52	25
Experimental (n=16)	n	10	6
	%	48	75

Children were referred to participate in the program by the guidance counselor for exhibiting symptoms related to stress. All of the student participants exhibited more than one symptom, and they were referred accordingly by the guidance counselor who indicated the multiple symptoms on the intake form.

Approximately 45% of the children in the study were referred because of internalizing behaviors (shyness, poor self-esteem, withdrawal, poor social skills, or sadness); 11 (37.9%) of these children were a part of the usual care group, and 10 (34.5%) were part of the experimental group. The guidance counselor and director of Turn 2 Us referred 55% of children in the study who displayed behavior that included anger; 2 (25%) of these children were part of the usual care group and 6 (75%) were part of the experimental group.

Fisher's exact test was conducted to determine whether there were differences between the groups and reasons for referral to the CARING program. The results suggest that the groups are equivalent, χ^2 (1, N = 29) = 1.756, p = .185.

Table 5

Identified Stressors

Group		Stressor	
		Academic, social	Family, academic, social
Usual Care (n=13)	n	10	3
	%	45.5	43
Experimental (n=16)	n	12	4
	%	55	57

Children were referred to participate in the CARING program if they were experiencing more than one stressor as indicated by the guidance counselors. The guidance counselor marked off multiple stressors on each form, and no children were reported as experiencing a single stressor. Although "health stressor" was indicated as one of the factors for referral, there were no participants in the study who were identified as experiencing this type of stressor.

The guidance counselor and director of Turn 2 Us referred 76% (N = 22) of the children in the total study because they were experiencing academic and social stressors, of these children 46% (N =10) were part of the usual care group and 55% (N = 12) part of the experimental group.

There was a total of 7 (24%) children who were experiencing family, academic, and social stressors; 3 (43%) were in usual care group, and 4 (57%) in the experimental group.

Fisher's exact test was conducted to see if there were differences between the groups and the stressors that the children were experiencing. The test suggests that the groups are equivalent, χ^2 (1, N = 29) = .014, p = .626.

Table 6

Identified Anger Issues at School

Group		Behavior	
		Anger Issues	No Anger
Usual Care (n=13)	n	2	11
	%	84.6	15.4
Experimental (n=16)	n	6	10
	%	37.5	62.5

Teachers, the guidance counselor, and TURN 2 US referred a total of 8 children who were displaying anger at school. Six of these children were placed in the experimental group.

Fisher's exact test was conducted to see if there were differences between the groups and displaying anger at school. The test suggests that the groups are equivalent χ^2(1, N=29) =1.76, p=.183. The externalizing measure did not pick up on the anger issues that the children were displaying the way the teachers did.

Summary

Significant differences at pretest were identified between groups and age and grade. The children in the experimental group were older, and in a higher grade than those in the usual care group. Gender, reasons for referral, stressor, and anger issues were equivalent at pretest.

Measures

Two measures were chosen for this study - the *Self Report Coping Measure (SRCM; Causey & Dubow, 1992)* and the *Multidimensional Self-Concept Scale (MSCS; Bracken, 1992).* These measures are designed to detect changes in the seven outcome variables for children in the usual care and experimental groups, and aim to assess a child's perception of the way they respond to a general problem or stressful situation. These measures were applied before and after the completion of the CARING program. The psychometric properties for each of these measures are discussed in this section. In addition to the measures used, demographic information was also collected as part of the study.

Self Report Coping Measure (SRCM; Causey & Dubow, 1992)

Coping is defined as a response to a harmful situation (Causey & Dubow, 1992). The Self-Report Coping Measure is a 34 item self-report inventory written for children in grades 4 through 6. In a factor analysis conducted by the authors, five coping strategies emerged; seeking social support, problem solving, distancing, internalizing, and externalizing. The conceptualization of the coping strategies is based on the work of Roth & Cohen (1986). Children can respond to the items when given a specific scenario or respond to problems in general, using the statement "When I have a problem." Causey & Dubow (1992) asked children to rate their coping strategies based on two stressors, poor grades and peer conflict. Examples of

statements include; “I try extra hard to let this keep from happening again” and “I go off by myself.”

Coping involves five strategies to help reduce the effects of stress. Positive coping strategies are seeking social support (questions 1, 5, 9, 13, 17, 22, 31, and 34) and problem solving (questions 2, 6, 10, 14, 18, 23, 27, and 33). Negative coping strategies are distancing (questions 3, 11, 15, 20, 24, 28, and 29), internalizing (questions 7, 8, 12, 16, 19, 25, and 32), and externalizing (questions 4, 21, 26, and 30).

Children are asked to respond to each item on a 5 point-type Likert scale, ranging from 1 = Never to 5 = Always. Subscales are scored separately, so there is no total score given for the entire scale. “Always is good for social support & problem solving; always is bad for internalizing and externalizing, and probably distancing, depending on the stressor” (Dubow, 2007). Scores should therefore improve at posttest for positive coping skills, and decrease for the negative coping skills at posttest (Dubow, 2007).

SRCM was normed on 481 children in grades 4 through 6, mostly from five local elementary schools in semi-rural, industrial communities (Ayers, Sandler, & Twohey, 1998). Internal consistency was reported at .66 to .84 for the entire scale. Internal consistency was reported at .84 for seeking social support, .84 for problem solving factor, .69 for distancing, .66 for internalizing, and .68 for externalizing. Two week test-retest was reported at .60 to .78 (Ayers, Sandler, & Twohey, 1998). Positive correlation was reported between seeking social support, problem solving, and self-esteem. A negative relationship was reported between distancing and externalizing coping strategies with positive characteristics such as self-esteem, and academic success (Ayers, Sandler, & Twohey, 1998).

In concurrent validity studies, this scale was moderately related to the self-report of the *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds and Richmond, 1985). No significant findings between grade point average and the SRCM were found (Causey & Dubow, 1992). Regarding discriminate validity, the coping subscales were found to be weakly correlated or unrelated to measures of academic achievement and perception of scholastic competence (Causey & Dubow, 1992).

Multidimensional Self-Concept Scale (MSCS; Bracken, 1992)

The Multidimensional Self-Concept Scale is a 150 item self-report measured on a 4 point Likert-type scale ranging from 1 = Strongly Disagree to 4 = Strongly Agree. Negative items (tall boxes) are scored in reverse order. Scores are summed and then converted to a standard score. Higher scores at posttest indicate an improvement in global self-esteem or the particular subscale used. There are six subscales consisting of 25 items that include affect, social, physical, competence, academic, and family. The measure is appropriate for those aged 9 to 19. The readability level was reported to be at the third grade level (Bracken &Mills, 1994).

The scale is designed to assess an individual's perception of self-esteem in general and across a variety of domains. Bracken (1992) defines self-esteem as "learned patterned behavior that reflects a child's evaluation of past behaviors and experiences, influences current behaviors and experiences, and predicts future behaviors". Children who exhibit a greater level of confidence or esteem are thought to be better in evaluating their reactions and actions in a stressful situation (Bracken, 1992). Affect is defined as reactions or responses that occur to a situation in which the child has experienced, is experiencing, or will be experiencing (Bracken, 1992).

For this study, children answered a total of 50 questions from the affect and competence subscales only. The MSCS was standardized on samples of 2,501 students from grades 5 through 12 from across the United States. Alpha coefficient for the total scale was reported at .90 (Bracken, 1992). Test-retest was reported at .79 or higher for all subscales at 4 weeks and at .90 for the total scale at 4 weeks (Merrell, 1999). Internal constancy was reported for the subscales; .90 for social, .93 for affect, .87 for competence, .91 for academic, .97 for family, and .92 for physical (Bracken and Mills, 1994).

The MSCS demonstrated content validity by comparing content with five self-esteem scales, including the *Coppersmith Self-Esteem Inventory* (SEI; Coppersmith, 1967), the *Piers-Harris Children's Self-Concept Scale* (PHCSCS; Piers & Harris, 1984), the *Self Description Questionnaire 1* (Marsh, 1998), the *Self Description Questionnaire 11* (Marsh, 1990) and the *Tennessee Self-Concept Scale* (Abarld, 1997; Roid & Fitts, 1988; Rotatori, 1994). The comparison indicated support for all six domains of the MSCS (Abarld, 1997; Rotatori, 1994). In concurrent validity studies, Rotatori (1994) reported that the MSCS correlates with the PHCSCS at .85, and has a moderate positive correlation with the *Coppersmith SEI* (1967) at .73 (Dyson, 1996). Keith and Bracken (1996) report that discriminant validity was supported by the total score on the MSCS and the *Assessment for Interpersonal Relations* (AIR; Bracken, 1993) which measures social, family, and academics.

Demographic information was also collected for each child. Children were asked the following questions on the questionnaires at pre and post test.

What grade are you in? (GRADE). This was coded 0 = 3rd grade, 1 = 4th grade, and 2 = 5th grade.

Gender (GENDER). This was coded as 0 = Female, 1 = Male

Ethnicity (RACE). This was coded as 0 = Hispanic, 1 = Other

What is your age? (AGE). This was recorded in years.

The guidance counselor identified the nature of the child's stressor by checking the boxes on a form created by the researcher (see Appendix). Children were identified by the counselor as all children having academic and family problems. The counselor indicated that there were some children who were also having social problems. This was coded and entered into SPSS as 0 = family, academic, social, 1 = academic and family problems. No children were identified by the counselor as having one stressor.

The nature of the symptoms associated with the stressor was also identified by the guidance counselor (see Appendix). The guidance counselor referred all children as experiencing poor self esteem, poor social skills, and anger. Children were also referred if they were experiencing shyness and withdrawal in addition to the symptoms listed above. This was coded and entered into SPSS as 0=shyness, poor self-esteem, withdrawal, poor social skills, anger, 1 = anger, poor self-esteem, poor social skills. No children in the study were identified as having a one symptom or behavior related to having a stressor.

Data collection

The pre and posttests were conducted in November 2007 and February 2008 for the experimental and usual care groups. Both groups completed *The Self-Report Coping Scale* (Causey & Dubow, 1992), and the *Multidimensional Self-Concept Scale* (Bracken, 1992), and were asked to record their age, grade, ethnicity, and gender. For the experimental groups, the pretest took place during the first session of the CARING program, and posttest took place 1 week after the program concluded. Testing took place during lunchtime. For the usual care groups, children were given the pre- and posttests on the same day as the experimental groups;

however, they completed the measures during their lunchtime. At pretest, all children were asked to fill out the informed consent and told the purpose of the study and the measures.

Data was collected by the researcher and two trained assistants. The researcher read the questions out loud to the group. CARING staff and the research assistants helped children who had questions regarding the instrument or trouble following along. Children in the usual care group completed the measure in approximately 20 minutes at both testing points. The experimental group completed the measures in approximately 30 minutes at pre- and posttest. If they needed assistance, their questions were answered by assistants. All questions were completed by the children.

Although all the children in the study were referred for anger issues and academic challenges, the children in the experimental group had symptoms and behaviors that appeared to be more severe. To address this, CARING assisted in redirecting children with behavioral issues by reminding them of the importance of the information and the reward for completing the measure. These children had a difficult time focusing, concentrating, or interrupting. This might explain why the questionnaire took longer to complete with this group. This is further addressed in the Limitations section.

The assistants hired by the researcher both hold Master's degrees in the human services field. One week prior to the data collection, the researcher reviewed the format for data collection, how to assign each child a unique identifier, and the protocol for children who may have a difficult time with the instrument. The director of Turn 2 Us provided HIPPA training and reviewed ethics associated with collecting data with children.

The next chapter will provide the results of the study in detail.

CHAPTER 4

STUDY RESULTS

This study examined the differences between anticipated and observed results for children participating in the CARING program across seven variables. This chapter will provide the results for the outcome tests conducted.

Independent samples *t* tests were conducted at pretest for the seven outcome variables for the usual care and experimental groups. The purpose of the analysis was to determine whether there was group equivalence. Pretest scores for the outcome variables are shown in Table 7. Independent samples *t* tests were conducted at posttest in order to determine if there were significant improvements for all of the hypotheses tested in the study. Posttest scores for these variables are shown in Table 8.

Hypotheses Testing

Table 7

Pretest Mean and t test Scores for the Usual Care and Experimental Groups

	Experimental (n=16)		Usual Care (n=13)		
Variable	*M*		*M*	*t*	*p*
Affect	101.9		99.5	-.50	.620
Problem Solving	27.6		29.4	1.12	.260
Social Support	28.9		24.8	-.124	.902
Distancing	23.8		22.3	-.773	.446
Internalizing	19.4		19.7	-.127	.900
Externalizing	10.3		7.0	-1.58	.128
Self-Esteem	95.8		100.2	.936	.358

Pretest results

H1. Affect scores for the experimental and usual care groups did not differ at pretest. The independent samples *t* test revealed that the groups were equivalent at pretest. (t=-.502, df=27, p=.620)

H2. Problem solving scores for the experimental and usual care groups did not differ at pretest. The independent samples *t* test revealed that the groups were equivalent at pretest (t=1.12, df=27, p=.260).

H3. Social support scores for both groups did not differ at pretest. An independent samples *t* test revealed no significant differences in seeking social support between the groups at pretest, suggesting group equivalency (t=-.124, df=27, p=.902).

H4. Distancing scores for the experimental and usual care groups did not differ at pretest. An independent samples *t* test revealed no significant differences in the groups at pretest, suggesting equivalency (t=-.773, df=27, p=.446).

H5. Internalizing scores for the experimental and usual care groups did not differ at pretest. An independent samples *t* test revealed that the groups were equivalent at pretest (t = -.127, df=27, p=.900).

H6. The experimental and usual care groups did not differ on externalizing scores at pretest. An independent samples *t* test revealed equivalence between the groups at pretest in regards to externalizing behavior (t=-1.58, df=27, p=.128).

H7.The experimental and usual care groups did not differ on self-esteem scores at pretest. The independent samples *t* test revealed that the groups were equivalent in self-esteem at pretest (t=.936, df=27, p=.358).

Summary

Independent samples *t* test revealed that there were no significant differences at pretest for the seven outcome variables tested. This suggests that the groups were equivalent for all the variables tested at pretest.

Post test results for all the variables are reported below. Table 8 provides a summary of the results of the analyses conducted for both groups.

Posttest results

Table 8

Posttest Mean and t test Scores for the Usual Care and Experimental Groups

	Experimental (n=16)		Usual Care (n=13)		
Variable	*M*		*M*	*t*	*p*
Affect	111.3		104.2	-1.43	.164
Problem Solving	24.8		28.7	1.56	.137
Social Support	23.7		26.9	1.26	.231
Distancing	18.5		21.1	1.18	.250
Internalizing	17.4		17.3	-.034	.973
Externalizing	9.6		7.2	-1.59	.122
Self-Esteem	108.3		100.9	-1.62	.117

In regards to the first hypotheses tested, children who participated in CARING did not report an increase in affect at posttest compared to those children in the usual care group. The testing revealed that there were no significant improvement for those in the experimental group (t=1.43, df=27, p=1.64).

The second hypotheses revealed that the children who participated in CARING did not report a significant improvement in problem solving skills at posttest compared to those children

in the usual care group. The program did not help the children in the experimental group to improve this skill (t=1.56, df=27, p=.137).

The third hypotheses tested revealed no significant improvement in the ability to seek social support at posttest compared to those children in the usual care group. Analysis revealed that the program did not help the children in the experimental group to improve this skill (t=1.26, df=27, p=.231).

The fourth hypotheses revealed that the children who participated in CARING did not report a significant decrease in distancing behavior at posttest compared to those in the usual care group (t=1.18, df=27, p=.250).

In regards to the fifth hypotheses tested, children who participated in CARING did not report a decrease in internalizing behaviors at posttest compared to those children in the usual care group. The testing revealed that there were no significant improvement for those in the experimental group (t=-.034, df=27, p=.973).

The sixth hypotheses revealed that the children who participated in CARING did not report a significant decrease in externalizing behavior at posttest compared to those children in the usual care group (t=-1.59, df=27, p=.122).

Last, children who participated in CARING did not report a significant improvement in self-esteem at posttest compared to those children in the usual care group (t= -1.62, df=27, p=.117)

Summary

Independent samples *t* tests revealed that there were no significant differences on the seven outcome variables at pretest between the usual care and experimental groups. This

suggests that there was group equivalence on affect, seeking social support, problem solving, distancing, internalizing, externalizing, and self-esteem.

Independent samples *t* tests revealed that the children who participated in the CARING program did not show significant improvement at posttest in the seven outcome variables; affect, seeking social support, problem solving, distancing, internalizing, externalizing, and self-esteem. Overall, the testing revealed that the children who participated in the CARING program did not report any significant changes for the outcome variables tested.

CHAPTER 5

DISCUSSION

This chapter reviews the findings of the study. It includes discussion of the strengths and limitations of the study design, and the impact on the study's outcome, as well as suggestions for ways to direct future practice and research in the area. This section also presents specific implications of the study that will highlight new lessons learned, and the ways that this information may be used by the CARING program to improve work with children.

Findings and discussion

Analysis of the data revealed no significant changes or improvement in any of the seven outcome areas. Specifically, the children who participated in the CARING program did not show significant improvement in affect, seeking social support, and problem solving, distancing, internalizing, externalizing, and self-esteem at posttest compared with children in the usual care groups.

These findings are not consistent with the prevention literature, which suggests that intervention programs can help at-risk children to improve certain coping skills and behaviors. In addition, the findings are not consistent with the literature on creative arts and culturally sensitive programs, which suggests that these approaches also improve behaviors and skills for at-risk children.

There is however existing literature that does support the findings of the study by suggesting that effective program components for this population of at-risk children sometimes requires strict rules, guidelines, and reinforcement in a more structured environment . For instance, Stieber, Lewis, Granic, Zelazo, Segalowitz, and Pepler (2007) found that despite interventions such as prevention programs, children who have behavior disorders or more severe

problems do not improve their behavior, and require more intensive programs to produce substantive changes in long-term outcomes (Weissberg, Caplan, & Harwood, 1991). In addition to the above, Gottfredson and Gottfredson (2002, p. 3) found in a national survey of 3,691 school-based prevention programs that "the quality of school-based prevention practices as they are implemented in the typical school is low", a finding which suggests that there may be even broader issues with fit and implementation at the school-level.

The lack of randomization in terms grade is one possible factor which influenced the outcome. The children in the experimental group were also older, and in a higher grade than those in the usual care group, and this is another factor which may have influenced the outcome of the study. The impact of these differences, and specific individual and group dynamics are discussed in detail in the limitations section. Additionally, although the hypotheses testing revealed that there were no significant differences on any of the outcome variables between the groups at pretest, the group leaders did report problematic behaviors from the onset of the study. These behaviors that were observed in the CARING group included disruptive behavior, rule breaking, acting out, and problems with peers.

Strengths of the study

This study represents the first evaluation of the CARING program, and despite the non-significant findings, this initial assessment is one of the study's most visible strengths. Prior to this study being conducted, there were no empirical data to identify weaknesses associated with the program and to provide further support for curricular and program design changes. This project also surfaced several areas for improvement in both the administrative and research realms, including the promotion of stronger collaboration with relevant agencies, school staff, family, and the program participants. CARING provides prevention programs for children at an

early age, and the program offers a developmentally appropriate curriculum that has been adapted from the I Can Do curriculum (Dubow, 1993), where at risk behaviors can be identified and addressed. We know from the literature that schools that are able to offer primary prevention programs are able to address behaviors that are compromising academic success and good emotional well-being (Pincus & Friedman, 2004; Rosseau, Lacroix, Singh, Gauthier, & Benoit; 2005; Schorr, 1997; Tashman, Weist, Acosta, Bickman, Grady, Nabors, & Waxman, 2000), thus, the identification of programmatic challenges can only serve to hopefully improve future effectiveness

The greatest strength of the study from an ethical point of view was the use of the results from the measures at pretest to accurately identify children in need of help. CARING was able to provide these children with appropriate services based on the information supplied by the researcher. Children were referred to Turn 2 Us and social services at Columbia Presbyterian Hospital, where they had access to a full array of services. The No Child Left Behind Act suggests that school-linked programs provide immediate service and attention to those who are at risk, and this is an example of how seamless, comprehensive programs provide important services for those who are in crisis or need of support.

Another strength of the study was the appropriate selection of the two measures, the Self-Report Coping Measure (Causey & Dubow, 1992) and the Multidimensional Self Concept Scale (Bracken, 1992) report, which are each reliable and valid. The measures are age appropriate, and the children are able to understand the statements from the questionnaires when read out loud by the data collectors. These measures adequately assessed behaviors and skills that are necessary to mitigate stress for the purpose of this study. In addition, the scores indicated when children were

experiencing behavioral and emotional issues, which allowed them to be targeted for additional support.

Limitations of the study

There are several key limitations of note. It is especially important to direct attention to the study's design, as this had a major impact on the results.

The inability to truly randomize the 3rd, 4th, and 5th graders into the experimental and usual care groups resulted in non equivalence between groups. These children were recruited as treatment-seeking; therefore, placed into a group by school staff based on need of service. Despite the research implications, the decision was made by the researcher to continue with the study and to allow the staff to determine the group assignments based on need. Therefore, the guidance counselor and director of the Turn 2 Us program determined that children in the fifth grade were in immediate need and were thus placed into the experimental group. Placing six children in the experimental group, or 75% of the children in the study who were exhibiting externalizing behavior, resulted in non-equivalence between groups. This may have unduly influenced the findings, especially with a small sample size.

Another concern was the selection of children for the program. Some of the children who were identified to participate in the study did not meet the eligibility criteria defined by CARING. These children participated in a program that was not designed to meet their needs. This occurred partially because there were no standardized assessments or measures administered by the researcher to make certain that the participants did not have a diagnosable psychiatric disorder. Children were recommended for the study based solely on the observations of school staff, because they were experiencing extreme behaviors (such as depression, anxiety, and gender identity issues) that were of concern.

A standardized measure used for screening would have helped CARING, Turn 2 Us, and school staff provide additional information regarding proper placement in community settings and referrals for the children with behavioral problems. A measure would detect unrecognized symptoms and disorders and provide accurate feedback as regards to eligibility criteria. In addition to using the measure, teacher and guidance feedback should be included in the screening process. Children who have been reported with behavioral concerns should be referred to Turn 2 Us for further evaluation. These children should not be considered for CARING.

Outcome data for this study was based on self-report measures. There were no measures given to the children to assess their levels of stress at pre and posttest. By limiting feedback to two measures, a great deal of information was not collected or utilized. Teachers and parents could have provided CARING and the researcher with insight as to how the child was functioning in settings beyond the group.

It is also important to report that the Self Report Coping Measure (SRCM; Causey & Dubow, 1992) did not pick up on the externalizing behaviors and anger issues of the children at pretest. Teachers observed the externalizing behaviors that the children were displaying at school.

Weissberg, Caplan and Harwood (1991) suggest that prevention programs are often too short, and it is quite possible that a program with a limited duration may not be as successful as a lengthier endeavor. Long term programs are thought to have a lasting impact on changing behaviors and gaining new knowledge, compared with programs that last a partial school year (Connell, Turner, & Mason, 1985). Throughout the weekly sessions, a large amount to time was taken up by addressing negative behaviors, and this resulted in only partial coverage of the

manual. This is problematic as manualized prevention tends to rely on the comprehensive application of treatment curriculums or plans.

This study also was limited to a sample size of 29 children. Parents were reluctant to have children participate in the program and the study, and as a result, the response rate was 52%. Hesitation to have children participate in research or mental health programs is not uncommon amongst parents of young children; researchers have reported that participation in studies can be stigmatizing, that the parents may have a fear of rejection by others, and that there is uncertainty of the program and its aims due to language barriers (Gary, 2005; Strug & Mason, 2001). The researcher was also aware of the difficulties involved in recruiting a large sample of children; therefore, the sample size was kept relatively manageable.

Disseminating the information for the study was challenging. Many contact numbers were not correct on the school emergency forms. Pre-paid cell phone numbers were used as a primary contact number and were out of service on many of the cards, making contact with a parent or guardian very difficult. Other numbers on the school emergency contact list were not accurate; therefore, the volunteers were not able to reach some families. Due to time limitations, the consent forms or information regarding the study were not mailed to the homes of children.

The director of Turn 2 Us and the guidance counselor had a challenging time recruiting children for the program based on the eligibility and exclusion criteria. They believed that if recruitment for the study had been a longer period of time, more appropriate students might have been identified for participation. Thus, recruitment for future studies will need to begin very early in the school year.

Another possible limitation was the convenience sample, which was homogeneous and consisted of only Hispanic children from one New York public city elementary school. Children

were restricted by grade, thus this sample cannot be assumed to be representative of the broader target population. Future evaluations of this program will need to have improved response rates, and perhaps utilize probability sampling methods. While a larger sample would not necessarily improve the results, a randomly selected sample would improve external validity and make any future findings more generalizable.

Last, the Self Report Coping Measure was normed on 481 Caucasian children in grades 4 through 6, from local elementary schools in semi-rural, industrial communities. The measure was not tested with children from urban populations (Ayers, Sandler, & Twohey, 1998; Causey & Dubow, 1992), and differences among cultures or ethnic groups were not studied when the SRCM was constructed (Causey& Dubow, 1992). Children in this study are not equivalent to the developmental sample of this measure, and this fact may have had an impact on the study's results. At the very least, it raises questions about the reliability of the measure for this group. Differences in language use and construction for the SRCM cannot be underestimated. To address this issue, statements from the SRCM were read out loud, and children did not appear to have any difficulty understanding the measure. Future studies of this program will need to consider whether this measure is appropriate for an urban population.

There were a number of logistical and implementation challenges associated with this study that also placed limitations on the research process and outcomes. These challenges, framed as lessons learned, and the potential impact on the study itself, are discussed below.

Implementation and logistical challenges

This study is unique in that it required the researcher to work across various agencies during the course of the project. The various touch points each required a different level of involvement and knowledge on the part of the researcher, which proved to be logistically

challenging. In hindsight, an inside contact familiar with the research guidelines and individual agencies would have served to help the researcher bridge the gap between the research efforts and the administrative aspects of the agencies. Research staff from New York State Psychiatric Institute and Columbia Presbyterian Hospital, with which CARING is affiliated, may serve as valuable contacts for future research. In addition to the complicated nature of working across multiple agencies, the IRB review process for this study was quite challenging, and included four rounds of review prior to acceptance. Approval from New York State Psychiatric Institute was required because affiliated CARING staff were to be directly involved in the study. In the event of additional research for this study, the principle researcher may meet prior to IRB application with the appropriate research staff at each of the target institutions to clarify all elements of the IRB submission and review process.

The delay of IRB approval had a negative impact on the timeline of the study on several levels. The study was slated to run for 15 weeks, which required a start date prior to November. The actual start date for recruitment was during the second week of October, a delay of two weeks. The recruitment time had to be shortened, thus making it difficult to recruit the 64 children for the study. Once the children were recruited, the shortened timeframe meant the researcher had no time to administer an eligibility measure prior to beginning the study. There was less follow-up time with the parents, and also less time to recruit additional children for the study.

The most significant barriers encountered were those associated with the various staff members, including Turn 2 Us Staff, CARING, school staff (teachers and guidance), school administration (principal), and New York State psychiatric Institute staff and IRB board. These differences in how to handle the actual implementation of the research provided serious

obstacles, some of which were insurmountable. One prime example of such a challenge was the assignment of participants into appropriate groups. The ideal study design involved true randomization of the participants into groups. However, the immediate need for support services of some of the children was determined to be of greater importance, and these children were assigned to groups regardless of their eligibility. These children, who were displaying behaviors that included acting out in the classroom, sadness, and anxiety, had been placed on a wait list for an evaluation from Columbia Presbyterian Hospital, and it was determined by the researcher that these children were not appropriate candidates for the research study, based on CARING's eligibility criteria. In the end, CARING staff and the researcher did agree that since the sample size was small and these children needed help, they should participate in the group that was to start immediately. These 5th grade children were thus put into separate groups from the 3rd graders, and the 4th graders were randomly assigned to either group. This flawed group assignment provided a less than ideal setting for the treatment to take place, and possibly influenced the study's outcomes.

This study took place amidst real-life conditions that mandated immediate care for children in need of serious help; it was unquestionably unethical to even consider turning these children away. It is hoped that the feedback provided here can facilitate a proactive approach to dealing with the many challenges that can arise during this type of research effort. Positive relationship-building and the creation of strategic alliances within the target agencies appear to be a prime key to success.

Implications

The implications for this study are concentrated around three broad areas of concern, from the most narrowly defined to the broadest: curricular development, social work practice,

and policy. It is impossible to separate these concerns, as they rely heavily on one another within the programmatic and treatment framework. Each will be discussed with this interrelatedness in mind.

This study demonstrated no significant changes across several domains for child participants in the CARING program, for a variety of reasons that have already been articulated. What do these results mean for the future direction for such programs, and what new knowledge can be extracted to demonstrate these lessons? Several questions arise: How can program administrators, teachers, and others adequately gauge a prevention program's likelihood of success? What "hidden" challenges can limit a program's ability to be successful, and how can these be discovered before implementation? For children with more serious stress-related behavioral problems, which constellation of treatment options might be a better approach? And, how can program administrators, teachers, and social workers provide these options, especially given financial and human resource restraints? Although it is not the goal of this study to provide the answers to these questions, they do represent some of the areas for further discussion given the results. In very general terms, it appears that one of the most critical considerations for programs such as CARING is the appropriate matching of the participant, the environment, and the program.

Implications for curricular development

The outcome of this study suggests that even manualized prevention programs may not work as intended. The CARING program has as one of its strengths its inclusive, creative-arts based approach to treatment for at-risk children. In some cases however, these features alone may not be enough to insure the program's success, especially in unpredictable settings or with children who have more severe behavioral problems. However, a combination of these and other

elements may work better, and should in some cases be considered. For children with severe conduct problems, Tynan (2010) recommends a multisystemic approach that may include "behavioral parent-management training, social skills training, academic support, pharmacologic treatment of ADHD or depression symptoms, and individual counseling as needed." Tynan (2010) further cautions that the group approach alone is not sufficient with children who have severe behavioral problems, stating "group treatment should be enacted with great care and consideration of group goals and possible negative adverse effects." Neither is individual therapy alone the answer, "individual psychotherapy as a single treatment has not proven effective for conduct problems. However, individual therapy sessions certainly can facilitate compliance with an overall program that emphasizes changes in the family, the school, and in social settings. Thus, individual counseling may help a child who is trying to adhere to a more comprehensive intervention program" (Tynan, 2010).

Given this, one key focal area for the CARING program must be its curriculum, an adaptation of the *Learning to Cope with Stress through Art: An Ethnic-Sensitive Model* (Canino, Rojas-Flores, & Korman, 1999). Previous studies of the *I Can Do* curriculum have been conducted (Dubow, Schmidt, McBride, Edwards, & Merk, 1993), but the ongoing success of the program is dependent on program implementation in the best of circumstances. In the case of this study, the student groupings represented an unanticipated and serious challenge to the completion of the curriculum, which is itself relatively inflexible. There is evidence from other areas of mental health research which suggests that manualized or routine treatment is not always effective due to lack of flexibility. Manualized treatment can best be described as treatment that is linked to a more formal, planned curriculum or program, with strict guidelines for adherence. While this approach does have its place, Seligman (1995), Strupp and Anderson (1997), Elkin

(1994) and many others suggest that the treatment reflects a "cookie cutter" mentality that does not always benefit patients (Strupp & Anderson, 1997, p. 80).

Strupp and Anderson (1997) further caution that "manuals can do little to counteract larger ecological influences that may be present" (p. 78). Manualized treatment cannot take into account myriad environmental factors and special cases, and, as was the case with this particular study, the impact of certain groupings of children on the teacher's ability to complete the curriculum material. What then, does this mean for programs like CARING, which rely solely on this type of treatment approach? One of the advantages of a program such as CARING is that it is portable, and the pre-developed curriculum can be used widely as needed without attention to developing further content. On the other hand, a non-manualized approach to providing preventative measures for children deemed at risk would require substantial financial and time inputs. Highly individualized treatment plans take time and research to develop, and a multisystemic approach like that described by Tynan (2010) would require far more resources than most public and urban schools have.

The CARING program might also face decreased efficacy in the face of severe behavioral problems, such as those experienced during the study. School social workers would have to play a key role in identifying children who may be especially at risk. For instance, children who exhibit more complex problems such as conduct and anxiety disorders might be inappropriate candidates for the CARING program, and school social workers would be in a position to recommend more appropriate treatment based on the latest research and practice.

For each of these considerations, the role and leadership of the social worker is critical. The relevant implications are discussed in the next section.

Implications for social work practice

The limitations of the current CARING curriculum discovered in this study shed new light on the role of the school social worker. A key objective in school-based social work practice is to strengthen the school community's capacity to solve problems. Schools serve as hubs in many neighborhoods, and provide children with programs that can help improve school success and quickly address at risk behavior (Schorr, 1997). School social workers and educators are an important part of this treatment mosaic, and remain committed to providing a supportive environment where children can grow. School social workers have the clinical and technical expertise to help schools evaluate, select and modify the appropriate treatment for children in order to help improve the effectiveness of targeted programs such as CARING (Weissberg, Caplan, & Harwood, 1991). Social workers understand that children are best served when interventions are flexible, comprehensive, individualized, and responsive to the needs of the child, and when this is not the case, it is critical that the school social worker be able to advocate for a different approach. In the case of the CARING program, school social workers may have a much better understanding of the interplay between stress and certain behavioral markers in early childhood that can predict later manifestations of more serious conditions, and how to address them. It is only through exposure to the children and knowledge of their background and personal circumstances, and the examination of this "evidence" that social workers are able to accomplish this. It thus becomes imperative that school social workers are aware of alternative treatment strategies, especially those that are evidence-based and require a more nuanced and multifaceted approach (Isaacs, 2003; Rosen, Proctor, & Staudt, 1999). School social workers are also in a position to help modify current programming to better suit the needs of the children. This is easier said than done, especially in environments where one size does not fit all, and children might require several different types of prevention strategies to help them succeed.

Cross-agency collaboration is also important. In any given community, there are various agencies that collaborate for the greater benefit of children in need of support and special services. Social workers must therefore be able to transcend agency boundaries and figure out how to address the needs of their clients most effectively. CARING is a prime example of how multiple agencies must interact on a daily basis, which can prove to be quite challenging. Milbourne, Macrae, and Maguire (2003) state that multi-agency work offers the "potential for integrated, holistic, and innovative outcomes" (p. 21), but they also suggest that financial constraints, structural differences, different agency goals and professional ideologies may be impediments (2003, p. 21). The ability of the social worker to establish positive working relationships across agencies is critical in environments where programs like CARING function. Communication, knowledge of agency roles, and an understanding of available services are all key features of a good comprehensive care model, and the social worker is charged with this stewardship.

Cross-agency contexts represent only one factor in a complex matrix of service provision in school settings. Social workers must also be able to work across cultural boundaries in order to meet the needs of at-risk children. According to Waxler-Morrison, Anderson, and Richardson (1990), providing care is a "social process in which each party – the professional and the patient – brings a set of beliefs, expectations, and practices to the encounter. "Their common task is to negotiate a common understanding of the problem, or diagnosis, and decide what to do about it" (p. 5). Social and cultural practices, norms, beliefs, and fears are elements that are not always visible, but are perhaps most important when working in diverse environments. In addition, social workers must be sensitized to their own values and norms, which have the potential to impact how they interact with children from different cultural groups. Harry (1992) identified

"five areas of potential dissonance" to be aware of when working with diverse populations: interpretations of the meaning of disability; concepts of family structure and identity; goals of education; parent-child interaction, and communication style (1992, p. 333). As Harry (1992) suggests, "awareness of one's own cultural beliefs in these areas is an essential first step in developing effective collaboration with culturally different families" (1992, p. 333). In New York City, this is especially true. There are more than 1 million students registered in public schools in the city (elementary, middle school, high school, and special education schools). Thirty-six per cent of these students are Hispanic, and close to 13 % are English Language Learners (New York City Department of Education web site, 2010). Demographic trends and changes in the population will only continue to diversify the student population, and social workers must be prepared to act accordingly.

Lastly, assessment of prevention programs is an area where school social workers have the background to provide guidance for the school community. One of the primary justifications for this study was to provide evaluative data where there was very little previously. This study of the CARING program revealed several possible areas for further investigation, and the social workers in this setting might work with other staff to follow up on these findings and suggest ways to improve the current program, or alter the prevention approach altogether.

The curriculum and the role of the social worker provide a very narrow lens through which to view the implications of this research effort. A much wider lens, that of policy is discussed in the next section.

Implications for policy

The No Child Left Behind Act (NCLB) of 2001 has reinforced the implementation of well-defined, comprehensive programs that are research-based within schools across the United

States. The NCLB Act aims to improve the achievement of students by holding schools accountable for students' success. Chapter 1 of this dissertation provided an overview of the act, but what is the relationship of the NCLB Act to the development of programs such as CARING, and to the findings of this study? Implications can be viewed in several ways.

The NCLB Act requires schools to demonstrate "success" by way of improvements in standardized test scores, high-school graduation rates, and one other indicator determined by the state (Kornhaber, 2008, p. 53). There is considerable disagreement within the educational community regarding the success of the NCLB Act so far, and most of this discourse has focused on the inadequacy of standardized test scores as a main measure of success (Kornhaber, 2008). Given this, educators and lawmakers have been trying to determine which modifications to the current NCLB Act make the most sense, and it is within this context that more emphasis on ancillary support for students (such as prevention and intervention programs) might be of value. A number of researchers have suggested that states use "multiple measures" that are more inclusive (Darling-Hammond, 2008) to assess whether or not schools are improving. These measures might include not just test scores, but attendance, school progress and continuation, course passage, and classroom performance (Darling-Hammond, 2008, p. 169). Within this range of measures, although not explicitly stated, might be outcomes generated by programs designed to support students who are at-risk. A child who is severely at-risk is far more likely not to attend school and to drop out altogether, thus, improving attendance is not possible without first addressing the reasons why a child might not be attending class. The school social worker would take the lead role in identifying these children.

It is also important to recognize that although many stressors are external to the school, there may be stressors from within as well, paradoxically, fueled by the very guidelines designed

to improve the nation's schools. The emphasis on standardized test score improvement is one illustration of this. Schools in underserved areas are at a particular disadvantage, and research has demonstrated that student discouragement based on low test achievement and the related school-exclusion policies that result from poor performance have increased the drop-out rate in a number of cities (Lilliard & DeCicca, 2001; Haney, 2002). Researchers have argued that the "punishing" and punitive nature of the NCLB Act (manifested through the withdrawal of federal funding in some cases) if schools fail to improve can cast a negative pall within the school itself, influencing students' perceptions and also, making it impossible for such schools to attract good teachers, and keep them (Darling-Hammond, 2008, p. 169). The effects of attending a failed or failing school on its children cannot be overlooked or underestimated. While the CARING schools may not be in this category, it is not unthinkable that the pressure to improve, driven in part by the NCLB Act, impacts the school environment at all levels, from the classroom to the administration to the students.

There are several ways that the CARING program is aligned with the NCLB Act's guidelines. One goal of the CARING program is to provide integrated and seamless services to children who are at-risk within a school setting, a strategy that is in keeping with NCLB standards (Franklin & Hopson, 2004). To successfully achieve this goal, communication between school personnel and the community-based program providers is critical. One of the most useful findings of this study is the importance of this idea, and the various ways that discussions related to the micro-elements (the curriculum) and the macro-elements (the policy implications) can take place.

Lastly, it bears pointing out that the main focus of educational policy reform in the United States including the NCLB Act of 2001, has traditionally been school improvement as

framed by student achievement. Generally, very little attention has been paid at the policy level to the wide range of support and services required to keep children psychologically healthy and engaged, despite the fact that children's well-being are critical to their academic success (Comer, 1984). The lack of policy guidelines and explicit accountability criteria in this area for program design, implementation, and evaluation is in and of itself an implication for the study, as it means that school social workers, teachers, and administrators must be vigilant about ensuring the quality and reach of these types of programs, on their own.

These implications are helpful in framing discussion about the future of programs such as CARING, especially in light of educational reform and the NCLB Act. In particular, new discoveries about the program structure and the limitations of the curriculum in certain situations deserve attention. School-based prevention programs are operating in an environment that is increasingly challenging – there are new standards and attached penalties, less funding, and a shrinking pool of qualified individuals to teach and provide leadership – thus, large-scale, radical change is not always feasible. However, evidence-based approaches and practice remain an important component of education policy (Nutley & Webb, 2004), and this study provides baseline evaluative data and discussion that can provide a foundation for dialogue about if, and how, the CARING program should be modified, or at least, evaluated further.

Future research

This research should be viewed as preliminary. Considerable further effort is needed to address its limitations, in particular, the sampling structure and external validity. In addition, there are several areas for additional study. The results from this study should provide information that can be applied, both clinically and in terms of program development. This preliminary study can serve the purpose of leading to more intensive and rigorous future research

studies. This experience can serve as a guide to CARING, as they consider ways to move their program towards evidence based practices.

The findings of this study suggest that the CARING program may be less effective when children's behaviors and symptoms associated with stress are severe. Peer contagion can have a negative effect on group learning and negatively impact the curriculum. CARING staff may need to further modify the current curriculum if it is to be more effective in treating children with more severe behavioral and emotional symptoms. Future program evaluation may also focus on whether the program is in fact effective for the population of children the manual was created for.

Findings from this study also suggest that when schools are able to offer primary prevention programs, they are able to address behaviors that might not be appropriate in school, and situations that compromise academic success (Pincus & Friedman, 2004; Rosseau, Lacroix, Singh, Gauthier, & Benoit; 2005; Schorr, 1997; Tashman, Weist, Acosta, Bickman, Grady, Nabors, & Waxman, 2000).

Finally, the integration of culturally sensitive creative arts into primary prevention programs and social work practice remains understudied (Borowski, Smith, & Akai, 2007); and further evaluation is required to determine the effectiveness of this type of approach versus more traditional approaches.

There are a variety of paths for additional research to pursue, each with opportunities for social workers to take an active role, and each with implications for the future growth and success of programs such as CARING.

Conclusion

Recommendations from the current research study can help CARING to further develop and implement a plan for addressing the unmet needs of children with externalizing problems. Research results and recommendations can be used to further identify priority areas for program development. More specifically, the feedback can guide development and lead to program modification.

Despite the non-significant findings for the seven outcome variables, the area of impact from this study pertains to the enhancement of service delivery. Results from the study do suggest that if CARING were to provide services to children with externalizing behaviors, then the existing program should perhaps be modified.

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APPENDICES

CARING student referral sheet- created for Turn 2 Us and Guidance

Name	Grade	Reason for referral (please list stressor and check all that apply)						
		Experiencing stress (academic, family, social, academic, other)	Poor social skills	withdrawal	shy	Focusing Problems	Poor self-esteem	Sadness

CARING and Turn 2 Us CREATIVE ARTS PROGRAM

Welcome back teachers, counselors, and staff!

CARING is a program affiliated with Columbia University College of Physicians and Surgeons. CARING provides creative and educational programs within PS 128 and other schools. **This program is affiliated with Turn 2 US.**

We are looking for students that are displaying minor deficits in social skills, worry, low self-esteem, or difficulty concentrating in the absence of learning disabilities.

PLEASE LIST CHILDREN WHO YOU FEEL MAY BENEFIT FROM THIS PROGRAM ON THE FORM BELOW. Please return the form to Room 111 (Turn 2 Us Office) as soon as possible.

_____

Teacher_____ Class_____ Room_____

ID_____

PRE _____ POST_____

ETHNICITY
0 Hispanic
1 Black
2 White
3 Asian
4 Other _____ ie (Hispanic and Black, Hispanic and White)

AGE _____ How old are you?

GRADE
0 2nd
1 3rd
2 4th
3 5th

Gender
0 Male
1 Female

Are you in extended day?
0 yes
1 no

Self-Report Coping Measure

ID #_____

Pre- test Post- test

Circle never , hardly ever; sometimes, most of the time, or always for each question.

1. When I have a problem, I tell a friend or family member what happened…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

2. When I have a problem, I try to think of different ways to solve it…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

3: When I have a problem, I make believe nothing happened…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

4. When I have a problem, I take it out on others because I feel sad or angry....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

5. When I have a problem, I talk to somebody about how it made me feel....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

6. When I have a problem, I change the story so things will work out.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

7. When I have a problem, I go off by myself....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

8. When I have a problem, I become so upset that I can't talk to anyone.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

9: When I have a problem, I get help from a friend.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

10. When I have a problem, I decide on one way to deal with it and I do it.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

11: When I have a problem, I forget the whole thing…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

12. When I have a problem, I worry too much about it.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

13. When I have a problem, I ask a friend for advice…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

14. When I have a problem, I do something to make up for it…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

15. When I have a problem, I tell myself it doesn't matter...

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

16. When I have a problem, I cry about…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

17. When I have a problem, I ask a family member for advice.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

18. When I have a problem, I know there are things I can do to make it better.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

19. When I have a problem, I just feel sorry for myself.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

20. When I have a problem, I do not want to think about it.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

21. When I have a problem, I yell to let off steam....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

22. When I have a problem, I ask someone who has had this problem what he or she would do.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

23. When I have a problem, I go over in my mind what to do or say…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

24. When I have a problem, I do something to help forget about it…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

25. When I have a problem, I worry that others will think badly of me…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

26: When I have a problem, I curse out loud…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

27. When I have a problem, I try to understand why this happened to me…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

28. When I have a problem, I say I don't care.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

29. When I have a problem, I ignore it when people say something about it…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

30. When I have a problem, I get mad and throw or hit something.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

31. When I have a problem, I get help from a family member.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

32. When I have a problem, I get mad at myself for doing something that I shouldn't have done…

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

33. When I have a problem, I try extra hard to keep this from happening again.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

34. When I have a problem, I talk to the teacher about it.....

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

35. When you have a problem, how often do you think about trying to do something to change the situation?

Never	Hardly ever	Sometimes	Most of the time	Always
(1)	(2)	(3)	(4)	(5)

MULTIDIMENSIONAL SELF-CONCEPT SCALE (Bracken, 1992)

ID_____

Pre-test Post-Test

Please rate the statements according to how well the statement applies to you. There are no rights or wrong answers. Circle the number that applies to you.

STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
(1)	(2)	(3)	(4)

1. I am honest
2. Too often I say the wrong thing
3. I am too lazy
4. I have a good sense of humor
5. I am basically a weak person
6. I feel that most people respect me
7. I am not very good at speaking my mind
8. I am assertive when I need to be
9. I am unlucky
10. I am very self confident
11. I don't seem to have control over my life
12. I frequently put off doing important things until its too late
13. I give people good reason to trust me
14. I am not as good as I should be
15. I don't keep quiet when I should

16. I am successful at most things

17. I handle my personal business responsibly

18. I lack common sense

19. I always seem to be in trouble

20. I can do most things pretty well.

21. I am not very smart

22. I am a coward in many ways

23. Others believe that I will make something of myself

24. Too often I do dumb things without thinking

25. I waste money foolishly

26. I enjoy life

27. I am afraid of many things

28. There are many things I would like to change about myself

29. I am not able to laugh at myself easily

30. I am not a happy person

31. I am proud of myself

32. I feel like a failure

33. My life is discouraging

34. I am happy with myself just the way I am

35. I am too emotional

36. I have good self control

37. I often disappoint myself

38. My life is unstable

39. I have a positive outlook on life

40. I am frequently confused about my feelings

41. Sometimes I feel worthless

42. I often feel ashamed of things I have done

43. I frequently feel helpless

44. I feel loved

45. I wish I could be someone else

46. I feel insecure

47. I am a good person

48. I am not as happy as I appear

49. I am usually very relaxed

50. There are times when I don't like myself

IRB Approvals and Informed Consent