Promoting Emotional Resiliency Through Instruction: The Effects of a Classroom-Based Prevention Program

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Advance Organizer

1. Review of problem and statement of need (5 minutes)
2. Methodology (10 minutes)
3. Results (5 minutes)
4. Discussion (10 minutes)
5. Open forum for questions and discussion

In Our Nation’s Schools: Introduction

- Becoming more difficult to meet needs of all students
  

- Common Reactions to the Increase in Problem Frequency
  
  - “Get tough” approaches in behavior
    Lewis & Sugai, 1999; Nelson & Colvin, 1996; Sugai & Horner, 1999
  
  - “Reactive” approaches in mental health
    Simpson, 1999
Disparities in Identification

- **Number**
  - 1% currently identified for special education services
  - 6-10% need the services
    - Landrum & Tankersley, 1999; Kauffman, 1997

- **Age**
  - Children with emotional and behavioral disorders identified for services much later than other disorders.
    - Merrell, 2001

- **Cultural Bias**
  - Over-representation and under-representation of certain groups
  - Higher probability of diagnostic errors

Pitfalls of current methods of intervention

- Drop out rates of children with emotional and behavioral disorders are the highest of any other group of students.
  - Landrum & Tankersley, 1999

- Children with emotional and behavioral disorders are most often placed in restrictive (and expensive) environments.
  - Simpson, 1999
Strong Kids Curriculum

- Intensive programs are best.
- These programs are seldom used \textsuperscript{Kauffman, 1999}
- Social, emotional, and behavioral skills can be taught (with no added expensive/intensive components) & the effects are often beneficial \textsuperscript{Eisenberg, Wentzel, & Harris, 1998; Greenburg, Kusche, Cook, & Quamma, 1995}
  - Curricula have shown to be effective with social skills, social problem solving, social anxiety, depression, etc.

Promises: Strong Kids

- Easy to use
- Requires little resources
- Promotes a wide variety of skills to promote emotional resiliency
Research Purpose

Evaluate the efficacy of the Strong Kids Curriculum.

Research Questions

1. Does completion of the Strong Kids curriculum increase students’ knowledge in content areas related to the lessons?
2. Does participation in the Strong Kids program increase students’ self-reports of positive social and emotional skills and affect, and decrease students’ self-reports of negative emotions, cognitions, and maladaptive behaviors?
3. Does participation in the Strong Kids program decrease teacher reports of problem behavior?
Methodology

- **Schools**
  - 2 participating schools
  - 2 groups in each school (n=7)
- **Participants**
  - 2, 8th grade groups
  - 2, 4th grade groups
- **Group Leaders**
  - 8th grade group leader: school psychologist with teaching certification
  - 4th grade group leader: school psychologist
Primary Prevention Groups

- **General Education 8th grade**
  - Group 1 (control): 7 students
  - Group 2 (treatment): 7 students
Selected Prevention Groups

- Teacher nominated from general education (4th grade)
  - Group 1 (control)
    - 7 students
  - Group 2 (treatment)
    - 7 students

Instruments

- **Strong Kids Pretest/Posttest**
  - Measures the extent of knowledge gained via the curriculum
  - Experimental measure
- **Internalizing Symptoms Scale for Children (ISSC)** Merrell & Walters, 1998
  - Reliability and validity measures all acceptable
## Instruments continued

- **Strong Kids Symptoms Questionnaire**
  - 25 items
  - ORP experimental measure
- **The Self-Perception Profile for Children (SPPC)**
  - Harter, 1985
  - Self-report scale for children ages 8-15
  - Reliability and validity acceptable
- **Parent-Teacher Rating of Internalizing and Severe Child Behavior (RISC-B)**
  - Walker, Severson, Feil, Steiber, & Nishioka
  - This parent-teacher rating scale is a brief, one-page indicator for both externalizing and internalizing behaviors.
  - Recently developed experimental measure

## Treatment Integrity

- **Direct observations**
  - Direct observational data taken 60-75%
- **Self-report check-lists:**
  - When direct observation data was not possible, indirect integrity data was obtained via self-reports
Summary of Procedure for 8th Grade Group

1. Obtain written parental consent
2. Obtain verbal student assent
3. Assigned to groups (not random)
4. Administer pretest scales
5. Implement the curriculum (special service provider)
6. Regular fidelity checks and consultation
7. Administer posttest scales

Summary of Procedure for 4th Grade Group

1. Obtain teacher nominations for “at-risk” students
2. Obtain written parental consent
3. Obtain verbal student assent
4. Assigned to groups (random)
5. Administer pretest scales
6. Implement the curriculum (special service provider)
7. Regular fidelity checks and consultation
8. Administer posttest scales
Design

<table>
<thead>
<tr>
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<th>Pretest Measures</th>
<th>Curriculum</th>
<th>Posttest Measures</th>
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<tr>
<td>Control Groups</td>
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</tbody>
</table>

Analysis

- Several assumptions of ANCOVA were not tenable
  - Homogeneity of variance
  - Normal distribution
  - Equal means of covariate
- Nonparametric Stats (Wilcoxon Exact)
  - Provides exact p-values
  - Tests for location and scale (rank order comparisons)
  - Tests that based on simple linear rank statistics
Results

Treatment Integrity Results

- Direct observations indicated that curriculum was followed as prescribed during:
  - 70% of the observed lessons for the 8th grade group
  - 80% of the observed lessons for the 4th grade group.

- Self-report integrity data indicated that fidelity was established
  - 80% of the time in the 4th grade group
  - 80% of the time in the 8th grade group.
Primary Prevention Group

Significant Results

Compared to the control group, the treatment group Strong Kids Symptoms Questionnaire scores significantly decreased at posttest, $p<.05$. 
Compared to the control group, the treatment group **Strong Kids Content** scores significantly increased at posttest, \( p < .05 \).

Compared to the control group, the treatment group **ISSC** scores significantly decreased at posttest, \( p < .05 \).
Compared to the control group, the treatment group RISC-B A scores significantly decreased at posttest, $p<.05$.

Compared to the control group, the treatment group RISC-B total scores significantly decreased at posttest, $p<.05$. 
Compared to the control group, the treatment group SPPC-SC scores significantly increased at posttest, $p<.05$.

Compared to the control group, the treatment group scores on the SPPC-BC significantly increased at posttest, $p<.05$. 
Selected Prevention Groups

Significant Results

Compared to the control group scores, the treatment group scores on the Strong Kids Symptoms Questionnaire significantly decreased at posttest, $p<.05$. 
Compared to the control group scores, the treatment group scores on the Strong Kids Content test significantly increased at posttest, $p<.05$.

Compared to the control group scores, the treatment group scores on the ISSC test significantly decreased at posttest, $p<.05$. 
Significant Results in both groups

- Strong Kids Content Test
- Strong Kids Symptoms Questionnaire
- ISSC

*Mixed results with the RISC-B A, RISC-B T, SPPC-SC, and SPPC-BC*

*No change found in all other scales*

School 1 and School 2 comparisons

- Primary prevention group:
  - More significance found
  - Less fidelity (10% less)
  - Treatment group all girls
  - Group leader with teaching degree

- Selected prevention group:
  - Less significance found
  - Groups with males and females
  - More fidelity
Implications

- Results in context of global purpose and specific research questions
- Results in the context of previous findings

Limitations

1) Internal and external validity: attrition and method of treatment, racial, ethnic, gender, and geographic characteristics.
2) Measurement: established measures and self-report measures
3) Treatment integrity: practice assignments and shortened class time
Implications for Future Research

1) generalization
2) Maintenance
3) Capacity
4) Accountability
5) Scope
6) methodology