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An Interpersonal and Cognitive-Behavioral Approach to Childhood Depression: A School-Based Primary Prevention Study

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AN INTERPERSONAL AND COGNITIVE-BEHAVIORAL APPROACH

TO CHILDHOOD DEPRESSION: A SCHOOL-BASED

PRIMARY PREVENTION STUDY

by

Tracy Black Cecchini

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ABSTRACT

An Interpersonal and Cognitive-Behavioral Approach

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by

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Depression represents a serious mental health problem

that affects the lives of many children. Depression is

frequently cited as the most recurrent emotional problem

facing younger populations. Left untreated, depression can

have several negative ramifications on later adjustment,

including suicide, substance use, academic and social

difficulties, low self-esteem, and an increased risk for

other mental health problems.

The search for effective treatments for depression has

extended into several arenas. Schools play an important

role in the lives of children and provide an ideal

setting for early detection and remediation of depression at every stage. Schools are increasingly being encouraged to offer preventative mental health services to deal with emotional issues that may often go unnoticed until a crisis situation. However, there remain a small number of studies that have investigated the impact of school-based preventative interventions for depression. For this reason, a school-based, primary prevention study was conducted.

The current study utilized an interpersonal and cognitive-behavioral model that was incorporated into the health education curriculum of the school. The sample included four fifth-grade classes in a rural school district. The study was conducted using a quasi-experimental design similar to a Solomon four-group design with two intervention and two control classes. The intervention was a total of eight 50-minute sessions. The subjects were assessed using a variety of self-report, sociometric, and rating-scale instruments.

The results of the study suggest that social skills were statistically significantly impacted by the intervention, and moderate standardized mean difference effect sizes (ES) of .51 and .48 were found.

Depressive symptom reduction was less pronounced.

Additional findings indicate that the children did in

fact learn the principles conveyed throughout the

intervention, including methods of alleviating depressive

symptomatology and social skills relevant for fifth-grade

children. The results are discussed in the context of

primary prevention models in other areas of mental health.

(212 pages)

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<div align="right">Tracy Black Cecchini</div>

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CHAPTER I

INTRODUCTION

Often cited as the most frequently occurring mental

health problem among children and adolescents, depression

represents a serious disorder that affects the lives of many

youth (Clark, Lewinsohn, & Hops, 1990). Previous reports

have estimated that by 18 years of age, over 20% of all

children have had at least one depressive episode

(Lewinsohn, Hops, Roberts, & Seeley, 1988). These reports

are disturbing given that depression may have critical

implications for later adjustment, such as increased risk

for suicide, substance abuse, academic and social

difficulties, and other mental health problems (Devin,

Kempton, & Forehand, 1994; Harris & Ammerman, 1986).

Depression as a syndrome or disorder is included under

the larger category of internalizing disorders (Achenbach &

Edelbrock, 1984). Problems of an internalizing nature are

typically characterized by social withdrawal, inhibited

reactions, anxiety, somatic symptoms, irritability, or

depressed mood (Merrell, 1994). Depression, being part of

this larger construct, represents a significant problem

among children and the search for etiological models,

assessment techniques, and successful interventions has prompted a growth in research over the past two decades.

Although research on childhood depression has recently increased, investigations into child and adolescent depression have lagged (and continue to) in comparison to adult studies on depression. Several etiological theories have been proposed and numerous intervention strategies are being implemented for childhood depression with only a scant body of research to support their effectiveness. Thus, the present state of knowledge makes the question regarding the efficacy of treatment for childhood depression unclear.

Additionally, of the controlled outcome studies that have been conducted, several problematic issues can be identified (Black & Crowley, 1996). First is the small number of treatment studies that have targeted children ages 7-12 years old. Although not much larger in number, adolescent studies of depression are more prevalent. Given the critical ramifications of depression, targeting depression in its earliest stages (i.e., with younger children) may prevent long-term debilitating mental health, academic, social, and physical problems. Second, many studies target children and adolescents who are already

experiencing moderate to severe levels of depression prior to treatment. Primary prevention programs are rare, but may have a pivotal impact on future development by averting some of the problems associated with depression. The third important issue identified in the treatment literature is the lack of consistent and operationally defined treatments, making it difficult to ascertain the effects of different treatment modalities. Finally, an overreliance on self-report instruments as dependent measures was observed in the preadult depression literature. Additional forms of assessment may provide a more accurate representation of depressive symptomatology that is not subject to self-report bias.

The previously noted impact of juvenile depression and its associated consequences illustrates the need for development of effective prevention and treatment programs. Most treatments are derived from etiological theories. Social skills ability is one etiological model that has been investigated and has shown a consistent negative relationship with childhood depression. The investigation of the relationship between social skills and depression developed from behavioral models asserting that depression

results from a lack of positive reinforcement. Deficits in social skills became an area of interest and were examined for their possible role in reducing the likelihood of response-contingent positive reinforcement (Clarizio, 1989). It was hypothesized that deficiencies in social skills are important antecedents to a low rate of positive reinforcement from the environment (Lewinsohn & Shaw, 1969). Subsequent research has demonstrated a negative relationship between social skill level and depression in children (Helsel & Matson, 1984; Sanchez & Lewinsohn, 1980; Wierzbicki, 1984; Wierzbicki & McCabe, 1988). Several interventions based on the social skills theory have been developed and implemented within the past decade, with only a limited amount of research having examined their efficacy. Furthermore, few of the studies conducted to date have been preventative in nature.

Children spend more time in school than in any other structured setting outside of the home (Maag & Forness, 1991). Consequently, the school becomes a prime setting for early detection and remediation of at-risk, subclinical, and clinically depressed children. However, a sparse number of investigations have examined the impact of school-based

prevention and intervention strategies. Because school-based programs can be costly in terms of time and resources, schools may be reluctant to participate given that the effectiveness of these programs has not been sufficiently demonstrated in the research literature. Highly controlled, systematic research is needed to identify those children at-risk for or currently experiencing depressive symptoms and to evaluate school-based interventions for these children.

The purpose of the current project was to contribute to the newly developing research area of childhood depression by examining the effects of a school-based intervention that had both a cognitive-behavioral and interpersonal focus and followed a primary prevention model. The ultimate goal was to increase social skills and to prevent or alleviate depressive symptomatology in a fifth-grade population. Multimethod and multisource data were collected in three phases spanning several months in an attempt to improve upon the weaknesses of previously published literature, such as underrepresentation of child samples, an overreliance of self-report data, and the lack of primary prevention programs. Specific questions addressed were:

1. Was there a statistically significant difference (postintervention) between social skill ratings for those children who participated in the intervention group, as opposed to control group children? What was the practical significance (e.g., effect size) of the differences?

2. Was there a statistically significant difference (postintervention) between depressive symptomatology ratings for those children who participated in the intervention group, as opposed to control group children? What was the practical significance (e.g., effect size) of the differences?

3. Was there an interaction between pretest measures and treatment conditions?

4. What was the magnitude and direction of the preintervention relationship between depressive symptomatology and social skill level?

5. At posttest, what was the magnitude and direction of the relationship between depression and social skill scores?

CHAPTER II

REVIEW OF LITERATURE

The current review of literature will include several areas. Specifically, an introduction to the childhood depression research will be provided. This discussion will include definitional and historical issues, assessment practices, and both theoretical and empirical literature regarding treatments for depression. The discussion of empirical literature will include a meta-analytic review of the treatment studies that have been conducted to date. Following the discussion of depression research, a similar presentation of the social skills research will ensue. The final sections of this review will include a discussion of the early intervention and prevention research literature, followed by theoretical and empirical literature on the relationship between social skills and depression.

Depression: Definitions, Assessment,

and Interventions

Childhood depression research has burgeoned within the past 10 to 15 years (Kazdin, 1990). This growth has

produced a wealth of research for a disorder or symptom pattern that was previously thought to be nonexistent in children. The current review is designed to provide a brief introduction to preadult depression, addressing diagnostic criteria and symptomatology, assessment practices, and depression-oriented intervention strategies.

<div align="center">Historical and Diagnostic Issues</div>

The evolution of childhood depressive criteria has spanned an approximate 20-year period (Kazdin, 1990). Initial formulations were based on the notion that depressive symptoms were not experienced by children at all, or if they were experienced, the symptoms would be different in children versus adults. For example, some researchers and clinicians believed that if children experienced depression, the symptoms were often "masked" or presented in the form of aggression, academic difficulties, enuresis, delinquency, hyperactivity, or somatization, as opposed to the dysphoric mood and the more commonly experienced depressive symptoms often observed in adults with depression (Kaslow & Rehm, 1991; Kazdin, 1990).

Current research reflects an acceptance that depression does occur in children and consists of a symptom presentation paralleling what is typically observed in adult populations. The current conceptualization of preadult depression was formalized in <u>Diagnostic and Statistical Manual of Mental Disorders</u> (3rd ed.; American Psychiatric Association, 1980) and in subsequent revisions, with diagnoses for both adults and children based on the same diagnostic criteria. However, there are some differences that can be observed that are a function of development and can vary over the life span. In other words, although the same diagnostic criteria are used to make a diagnosis, the specific constellation of symptoms present at one time may vary across different ages. Variations of the specific symptoms present, the associated features, and the clinical course of the symptoms may be expressed differently across different age cohorts (Maag & Forness, 1991). For example, irritability is often observed in younger children, as opposed to depressed mood predominantly observed in adolescents and adults. Additionally, the associated features such as suicide rates and gender distribution also differ between children and older populations. In

prepubertal children, depression appears to occur equally in both males and females, but in adolescence and adulthood, depression is twice as common in females as in males (American Psychiatric Association, 1994).

The most widely used system of classification for childhood depression is the <u>Diagnostic Statistical Manual for Mental Disorders</u> (DSM; Kazdin, 1990). In the most recent revision, DSM-IV (APA, 1994), both children and adults can be diagnosed on a continuum of mood states ranging from severe depressive symptoms to periods of abnormally persistent, elevated moods. Depression alone can vary in both duration and severity. Furthermore, children can experience periods of depression or depressive symptoms, yet not meet the criteria for a depressive disorder diagnosis. In fact, children obtaining extreme scores on rating scales often fail to meet DSM depression criteria (Maag & Forness, 1991). However, high scores on self-report and behavior rating scales <u>do</u> indicate the presence of depressive symptoms that, if left untreated, could result in a full-blown depressive disorder or have critical implications for later adjustment such as increased risk for suicide, academic and social difficulties, and other mental

health problems (Devin et al., 1994; Harris & Ammerman, 1986).

The present study assessed depressive symptomatology from a variety of sources and methods, including self-report assessments. The focus was on depressive symptomatology in line with a primary or secondary intervention model, rather than "diagnosing" subjects per se. Furthermore, given the base rates for clinical depression in children, it is unlikely that many children in a school-setting would be identified as clinically depressed.

Assessment of Depressive Symptomatology

Many instruments have been developed to measure clinical depression and depressive symptomatology in children and adolescents. Each of these instruments can be grouped under five general areas of assessment--interviewing techniques, direct observation, rating scales, sociometric approaches, and self-report techniques. Merrell (1994) provided a current overview of the most psychometrically sound and widely used methods of assessing preadult depression. A brief examination of each of these five general assessment areas will be presented.

Interview Procedures

Interviews range from highly structured, controlled assessments to less formal exchanges. In general, all forms of interviewing offer the advantages of flexibility and provide opportunities to observe behavior (Merrell, 1994). Potential limitations of interviewing include children lacking insight or awareness into emotional problems or they may feel embarrassed or hurt, and are less likely to report difficulties (Merrell, 1994). Interviews to assess depression can also be costly in terms of time and resources. The Bellevue Index of Depression (Petti, 1978) is an example of an interview constructed specifically to assess depression.

Direct Observation

Assessment of depression by direct observation has not been frequently employed by researchers and clinicians working with preadult populations. The internalizing nature of depression often makes depression difficult to assess by behavioral observations. However, several depressive symptoms such as anhedonia, sleep and appetite changes, and decreased motoric activity can be observed (Kazdin, 1988;

Merrell, 1994). Despite this evidence, there remain few studies that include a direct observational methodology to assess childhood depression.

Rating Scales

Behavior rating scales are designed to be completed by an adult informant who is familiar with the child's behavior (i.e., parent, teacher, or day care personnel). There are several rating scales available to assess internalizing disorders and many contain depression scales. A commonly used rating scale is the Child Behavior Checklist (Achenbach & Edelbrock, 1979), with both parent and teacher forms available. Because of their availability, and their ease in administration and scoring, rating scales are increasingly being used in depression outcome studies and in clinical practice. However, one limitation of rating scales is the low return or response rate often found in research.

Sociometric Techniques

The basis of sociometric approaches is the examination of group dynamics obtained directly from group members, not inferred from an outside observer. This allows for a more in-depth exploration of the individual that may not be

obtainable given the time constraints of behavior

observation (Worthen, Borg, & White, 1993).

In general, sociometric procedures have been criticized

by some authors because of possible negative peer reactions.

However, research has increasingly supported sociometric

procedures and demonstrated negligible negative consequences

resulting from their use. Landau and Milich (1990) examined

several high-risk longitudinal studies to specifically

review the ethical implications of sociometric techniques.

Their findings indicated minimal negative ramifications

resulted from the use of peer inventories. For assessing

depression in children, the most commonly used sociometric

tool is the Peer Nomination Inventory for Depression

(Lefkowitz & Tesiny, 1980).

Self-Report Measures

Currently, there are several measures developed to

assess depressive symptomatology from the child's

perspective. In research and clinical practice, self-report

instruments have become the primary method for assessing

depression and other internalizing symptoms (Merrell, 1994).

Due to the internal nature of depressive symptoms, some methods such as direct observation, and to some extent rating scales and sociometric procedures, can be difficult to use when assessing depressive symptoms (Merrell, 1994). This difficulty may explain why the majority of interventions targeting preadult depression have relied on self-report measures. Two frequently used self-report scales designed to specifically assess depression are the Children's Depression Inventory (Kovacs, 1993) and the Reynolds Child Depression Scale (Reynolds, 1989).

Although self-report measures are a crucial piece of information, increasingly a single self-report instrument is no longer considered appropriate to identify children as "depressed" for either research or intervention purposes. Additionally, limitations of self-report, such as children lacking insight or awareness into their emotional difficulties or their reports being biased by embarrassed or hurt feelings, further illustrate the need for utilizing multiple sources for depression ratings, such as teachers and peers. Thus, children identified as at-risk or currently experiencing depressive symptoms can be identified

on the basis of convergence among data sources and not by a single self-report instrument (Merrell, 1994).

Merrell (1994) has advocated a model of best practice for assessment that includes multiple methods of assessment (e.g., interview, self-report, sociometric, etc.), obtained from multiple sources (e.g., parents, teachers), in multiple settings (e.g., home, school, etc.). This comprehensive method may not be feasible for all research, but when possible, can provide a more aggregated picture of the study sample. The present study utilized several methods and sources in order to assess depressive symptoms. The instruments selected for the present study will be further discussed in the Data and Instrumentation section.

Interventions for Depression

Since the recognition and acknowledgment that depression occurs in juveniles, a wealth of research has accumulated in this area. The following discussion of depression interventions will include theoretical models and the treatments derived from them, followed by a comprehensive integrative review of the empirical studies conducted to date.

<u>Theoretical Models</u>

Two major classes of treatment, medication and psychotherapy, have been employed with depressed children. Treatments utilizing psychotherapy or psychological interventions will be the focus of the present review.

Many of the current theoretical models of childhood depression emphasize cognitive and/or behavioral variables as underlying or fundamental to the development of depression. As a result, a number of the current treatments for preadult depression were derived from behavioral or cognitive models, or both. Five of the most common interventions, social skills training, activity-level increase programs, attribution retraining, self-control therapy, and interpersonal problem solving will now be briefly reviewed.

<u>Social skills training</u>. As previously discussed, social skill deficits have been linked to childhood depression and have shown a consistent positive relationship with depressive symptomatology. The investigation of the relationship between social skills and depression developed from behavioral models asserting that depression results from a lack of positive reinforcement from the environment

(Clarizio, 1989; Lewinsohn & Shaw, 1969). The goal of social skills training is to increase skills and, as a result, increase the likelihood of receiving positive reinforcement from others. The specific skills taught vary depending on the age of the participants and their baseline level of social skills knowledge and application. Some examples include improving interpersonal style, increasing the level of social activity, and more specific skills such as posture, voice quality, and facial expressions (Kaslow & Rehm, 1991). Methods of instruction include role play, didactic instruction, modeling, feedback, and homework (Kaslow & Rehm, 1991).

Activity-level increase programs. Activity-level increase programs also originated from behavioral models, which assume that depressive symptoms result from lack of positive reinforcement from the environment. The goal of activity-level increase programs is to increase pleasant activities, thereby increasing the level of response-contingent reinforcement from the environment and reducing depressive symptomatology (Kaslow & Rehm, 1991).

Attribution retraining. Developed from the learned helplessness theory (Abramson, Seligman, & Teasdale, 1978),

the attribution retraining interventions model assumes that the manner in which a person interprets a negative or aversive event will influence feelings of helplessness and hopelessness, thus leading to depression. Attribution retraining seeks to change irrational attributions, modify the environment to produce more desirable outcomes, and change expectations of controllability (Kaslow & Rehm, 1991).

Self-control therapy. The self-control theory of depression includes a three-stage feedback model involving self-monitoring, self-evaluation, and self-reinforcement. According to the theory, individuals with depression are thought to have deficits in one or more of those areas (Rehm, 1977). Specific deficits include: (a) selective focusing on negative events; (b) a focus on short-term, rather than long-term, consequences of one's behavior; (c) unrealistic expectations; (d) misattributing success and failure; (e) minimal self-reinforcement; and (f) an excess of self-punishment (Kashani & Sherman, 1988). Self-control therapy involves teaching participants to monitor their thoughts, activity level, and self-statements. The goal is to increase those thoughts, feelings, and activities

associated with a more positive mood (Kaslow & Rehm, 1991).

Attribution retraining is also incorporated into the

treatment.

Interpersonal problem-solving therapy. The theory

behind interpersonal problem-solving therapy is that

depression is related to deficits in problem-solving skills

in social situations. According to the theory, people who

are depressed demonstrate deficits in means-end thinking,

generating alternative solutions to problems, and in general

decision-making skills (Kazdin, 1990). The goal of

interpersonal problem-solving therapy to increase social

problem-solving skills that can ultimately act as a buffer

during stressful life circumstances (Kazdin, 1990).

Of the treatments previously discussed, several were

extrapolated from adult theories and many of the

interventions have been implemented and researched solely

with adult populations. The limited number of child and

adolescent treatment studies will now be reviewed.

Empirical Studies

Given that the research on preadult depression has

increased over the past decade, several reviews have been

written in attempts to summarize the literature (Fleming &
Offord, 1990; Kashani & Sherman, 1988; Kaslow & Rehm, 1991;
Kazdin, 1990; Kovacs, 1989; Maag & Forness, 1991; Reynolds,
1990; Weisz, Rudolph, Granger, & Sweeney, 1992). However,
for the most part, these reviews have included broad-based
discussions of diagnostic issues, assessment practices, and
etiological theories. Previous reviewers have discussed
treatment models and provided examples of studies which have
implemented various interventions, but these reviews have
not thoroughly summarized and critiqued the treatment
studies available. For example, a recent review by Weisz et
al. (1992) utilized meta-analytic techniques to evaluate
therapy outcome studies for depressed children and
adolescents. However, their review focused only on specific
developmental implications of the treatment and included
only six outcome studies. To date, a comprehensive
integrative review of controlled outcome studies has not
been conducted.

The purpose of the current meta-analytic review is to
summarize and critique previous research on
nonpharmacological group interventions for children and/or
adolescents evidencing or at-risk for depressive

symptomatology. Inclusion criteria for this integrative review consisted of studies that selected their samples based on current depressive symptoms, or the study purpose was to prevent depression in a nonsymptomatic group, the treatment needed to involve a nonpharmacological group intervention, and the study had to include a depression outcome measure.

Thirteen primary research studies that met inclusion criteria were selected via computer searches of PSYCH LIT. and ERIC. Retrospective searches of references lists also identified several studies. The search did not extend to unpublished documents, theses, or dissertations.

A comprehensive coding sheet was developed to assist in summarizing the breadth of information extracted from the studies (see Appendix A). Studies were coded for information related to subject, intervention, and outcome characteristics. Each of the studies was also rated on the overall quality of the experiment.

For each measure at posttreatment, a standardized mean difference effect size (ES) was calculated (i.e., treatment group mean minus control mean, divided by the standard deviation of the control group). When means and standard

deviations were not provided by the author(s), additional formulas that utilized t tests, F-ratios, and percent improved were used to compute the effect sizes.

To avoid giving undue weight to studies which used several depression outcome measures, the effect sizes were averaged within each treatment group. Some studies reported as many as nine depression scores on various instruments and others reported only one measurement. Thus, an average effect size estimate was used to compare across studies.

There has been some discussion in the literature with regard to using labels or conventions for interpreting effect sizes (i.e., small, moderate, large). The discussion has centered on the subjectivity of the label and has emphasized there being no inherent value in a particular effect size. In other words, the argument is that the value depends on the construct being assessed (Glass, McGaw, & Smith, 1981). Because conventions can be somewhat arbitrary, it becomes important to approach effect size interpretation cautiously when making discriminations (Shaver, 1993).

One approach to interpreting the magnitude of standardized mean difference effect sizes has been observed

in the literature. This approach uses the terms low,
medium/moderate, and large for effect sizes approximating
.2, .5, and .8, respectively (Cohen, 1988). As previously
indicated, this convention is not agreed upon by all in the
literature. However, given the current research is an
introduction to the issues and little is known about this
literature base, these parameters will be used to interpret
the magnitude of the effect sizes throughout this
dissertation.

Specific areas of interest for this integrative review
were selected based on conclusions of past reviews and on
the treatment studies of preadult depression. Variables of
interest included the overall effect of the following
variables on the study outcome: (a) age of the sample (child
versus adolescent), (b) the level of pretreatment
depression, (c) the type of intervention model utilized, (d)
the intensity and duration of the intervention, and (e) the
particular depression outcome measure utilized.

Age of subjects. All of the 13 studies provided data
on the age group included in the experiment. Subjects
ranged in age from 7 to 19 years. Nine studies included
adolescent subject pools (ages 13-18 years) and only four

included samples in the 7-12 year age group.   Table 1

illustrates the effect of age on study outcome for both the

child and adolescent group interventions.

Overall, the four studies that included child samples

produced 14 effect sizes with an average effect size of .61,

while adolescent studies provided data for the calculation

of 33 effect sizes that resulted in an average pooled effect

size of .92 .   A much greater range of effect sizes were

found in the adolescent studies.   For example, the study by

Fine, Forth, Gilbert, and Haley (1991) produced effect sizes

ranging from .23 to 3.19.   The 3.19 effect size is obviously

an outlier in the data and is likely inflated because it was

calculated from pre/post data.   This study did not include a

control group and had several threats to internal validity.

Although the adolescent studies produced a higher

average effect size, the average pooled effect size for

child samples could be considered a medium or moderate

effect (ES = .61).   It should be noted that only 3 of the

total 47 effect sizes were in the negative range, which

suggests interventions for both children and adolescents

were quite effective in reducing depressive symptoms in both

age groups.   Although these data are promising, a larger

Table 1

Average Effects Across Age Groups

Study	N ES	mES	Range of ES
Children (ages 7-12)			
Butler et al. (1980)	2	.67	.62 to .72
Stark et al. (1987)	8	.62	.06 to 1.07
Liddle & Spence (1990)	2	.58	.36 to .78
King & Kirschenbaum (1990)	2	.57	.17 to .96
total	N=14	mES= .61	
Adolescents (ages 13-18)			
Fine et al. (1991)	4	1.36	.23 to 3.19
Kahn et al. (1990)	9	1.11	.63 to 1.99
Lewinsohn et al. (1990)	6	1.02	-.15 to 1.52
Reed (1994)	1	1.15	
Mufson et al. (1994)	2	1.83	1.48 to 2.18
Clarke et al. (#1) (1993)	2	.04	-.1 to .18
Clarke et al. (#2) (1993)	2	.03	-.1 to .06
Reynolds & Coats (1986)	6	1.57	1.07 to 2.47
Brown et al. (1992)	1	.18	
total	N=33	mES= .92	

Note. mES= mean or average effect size

number of studies is needed before firm conclusions can be

drawn regarding overall effectiveness for these populations.

Only four studies targeted children ages 7 through 12

evidencing depressive symptoms. Although the prevalence of

depression is estimated to be lower in younger populations compared to adolescents and adults, depression is still a significant problem in this age group (Fleming & Offord, 1990). However, the majority of preadult depression studies utilized adolescent samples. Targeting younger age groups and averting depression at an early stage may have critical implications for future development. Furthermore, although depression can be diagnosed in children, adolescents, and adults with the same criteria, there are developmental differences in the manifestation of the disorder or symptom pattern (Kazdin, 1990). For example, the specific constellation of symptoms may vary as a function of age (Fleming & Offord, 1990; Kazdin, 1990). These developmental differences are important and should be considered in selecting the age of the subjects. Several studies in this review reported an age range for their sample and some ranges spanned as many as 5 years (Reed, 1994). When large ranges such as this are employed, it is difficult to generalize results to other populations.

Severity of pretreatment depression. Seventy-seven percent (10 studies) selected subjects evidencing moderate to severe levels of depressive symptoms prior to treatment.

The majority of these studies utilized a multiple gating procedure. The goal of this procedure is to sequentially narrow down a large population to a group of individuals exhibiting the characteristic of interest to the researcher (Merrell, 1994). For example, a large number of potential subjects are screened on a depression measure and those meeting a specified level on the instrument(s) advance to the next stage of the procedure. At the second stage, potential subjects are further assessed for depressive criteria and those meeting the study's criteria at this point advance to the third gate and are then assessed with more intensive diagnostic or assessment procedures. Those who meet the defined level of symptoms are selected as the final subject pool. The resulting samples in these 10 studies evidenced depressive symptoms meeting DSM-III-R (APA, 1987) criteria for major depression or dysthymia.

Only three studies targeted children or adolescents exhibiting mild depressive symptoms or an absence of depression. One study by King and Kirschenbaum (1990) included subjects considered "at-risk" for depression based on teachers' ratings of externalizing problem behavior and internalizing symptoms. Thus, children in this study were

referred due to inflated scores on rating scale measures,

which would not be considered a primary prevention model.

The effect size for their intervention was .96 on a

structured clinical interview for depression. The effect

was not nearly as strong for the two other studies, both by

Clarke, Hawkins, Murphy, and Sheeber (1993). These

experiments were primary prevention programs addressing

large groups of adolescents not selected because of

depressive symptoms (study #1 $\underline{N}$ = 622; study #2 $\underline{N}$ = 380).

The first study employed an educational intervention and

produced the following effect sizes for depression: ES = .18

for boys and ES = -.1 for girls. The second study by Clarke

et al. (1993) was a behavioral intervention that produced

effect sizes of .06 for boys and -.01 for girls. The effect

sizes for these two studies, although higher and positive

for boys, were still quite low. However, it is important to

note that the treatments in both studies were of fairly low

intensity (i.e., only three and five sessions of 50-minutes

duration). It may be that the sessions were too brief and

subjects were not able to comprehend the material presented

and integrate the principles outside of the treatment.

Clearly, more research needs to be conducted in this area,

as it is difficult to draw conclusions on the effectiveness of primary prevention programs for depression based only on the two studies by Clarke et al. (1993). As previously emphasized, the impact of primary prevention and early intervention on future development is important for child and adolescent populations.

Quality of study. Eleven of the 13 studies (85%) utilized control groups. Two of these 11 studies also included an "attention placebo" group to assist in determining whether the observed effects were due to the treatment or the special attention afforded to experimental groups. Of the two studies that did not include controls, one compared two different types of treatment without utilizing a true control group (Fine et al., 1991). The other by Mufson et al. (1994) provided a single treatment without a comparison or control group. For both of these studies, effect sizes were calculated from pre/post data and must be interpreted with some degree of caution.

Eighty-five percent (11 studies) were true experimental designs and used random assignment to groups. The remaining two studies utilized pre/post designs.

The studies were given a general validity rating that ranged from "1" (excellent) to "5" (unacceptable). This rating was determined based on the degree and number of threats to internal validity and the overall quality of the studies (i.e., experimental design, random sampling, and assignment). Four or 31% of the studies received a rating of "1," suggesting these were well designed, controlled studies with negligible threats to internal validity. The same percentage of studies (31%) was rated as "2." Two studies (15%) received a rating of "3," and three studies (23%) were rated as "4." There were no studies that were evaluated as "unacceptable" or were given a "5" rating. Testing and selection were the biggest threats to internal validity, followed by mortality. Table 2 displays the effect sizes according to each general validity rating. The highest average effect size was found in the three studies rated lowest in methodological quality.

Intervention characteristics. Overall, there were not large differences between the studies in regards to the intensity and duration of the treatments. On average, the intervention lasted 8 weeks and included 12 group sessions that lasted approximately 60 minutes each. The average

Table 2

Effect Sizes by Quality of Study Rating

Rating	$\underline{N}$ Studies	N ES	Range ES	mES
1 (Excellent)	4	21	-.01 to 1.99	.78
2 (Good)	4	16	-.15 to 2.47	1.05
3 (Fair)	2	3	.17 to 1.51	.88
4 (Inferior)	3	7	.18 to 3.19	1.32
5 (Unacceptable)	0			

average group size for treatment and control groups was 11 subjects. Eight of the 13 intervention groups were lead by a mental health professional (usually a master's level graduate student). Two of the treatment groups were lead by teachers, one by a trained paraprofessional, and two studies did not report these data. The above-noted variables had no apparent effect on study outcomes.

One of the most salient findings from the present review of literature was the lack of consistent and operationally defined treatments in the studies of preadult depression. In the broad literature, childhood and

adolescent depression can be conceptualized according to the predominant etiological theories. These theories have spawned several approaches to treating preadult depression. The various interventions include social skills training, cognitive therapy (addressing distorted and negative thinking), attribution retraining (formulated from learned-helplessness model), activity-level increase programs (engaging in pleasant activities), self-control therapy (includes self-monitoring, evaluation, and reinforcement), and interpersonal problem-solving strategies (Kaslow & Rehm, 1991; Kazdin, 1990; Maag & Forness, 1991). In the preadult depression literature, the prevalent etiological models, and the treatments derived from them, were mainly extrapolated from adult theories and treatment models of depression.

Upon examining the 13 studies located for this review, few of the treatments neatly fell into one of the above-noted categories.

An additional problem that was observed included the lack of consistent terminology employed. For example, when similar strategies were utilized by two studies, one author may have labeled it a "cognitive" intervention, while another author called the treatment a "cognitive-behavioral"

intervention. This inconsistency was observed throughout the 13 studies and precluded the ability to compare meaningful effect sizes across the different treatments. However, some treatments such as social skills strategies and relaxation training were more consistently defined across the studies.

Table 3 illustrates the variety of labels employed for the various treatments, along with average effect sizes for each treatment versus control comparisons. Regardless of the name given to the intervention, some authors provided a description of the treatment so that the nature of the theoretical model could be identified. However, many other authors did not provide sufficient information so that the particular treatment model could be distinguished.

Overall, these interventions are finding encouraging results in terms of reducing depressive symptomatology in experimental groups. One treatment worth mentioning is the Coping with Depression Course-Adolescent version (Clarke & Lewinsohn, 1984) that was utilized in two high quality studies in this review (Kahn, Kehle, Jenson, & Clark, 1990; Lewinsohn, Clark, Hops, & Andrews, 1990), both producing

Table 3

Effect Sizes Across Treatment Groups

Study	TX #1	TX #2
Butler et al. (1980)	Role play mES = .72	Cog. restruct. mES = .62
Stark et al. (1987)	Bhv. prob. solv. mES = .59	Self-control mES = .66
Liddle & Spence (1990)	Social competence mES = .58	
King et al. (1990)	Social skills mES = .96	Consultation mES = .17
Fine et al. (1991)	Social skills mES = .76[a]	Support mES = 1.98[a]
Kahn et al. (3 groups)	Cog-behval Relax. mES = 1.37	Modeling mES = .97 mES = .98
Lewinsohn et al. (1990)	Adol. CWD mES = .69	CWD + parent mES = 1.34
Reed (1994)	Structured learning theory--no mES	
Mufson et al. (1994)	IPT-A mES = 1.83[a]	
Clarke et al. Study #1 (1993)	Educational mES = .04	
Clarke et al. Study #2 (1993)	Behavioral skills mES = .03	
Reynolds & Coats (1986)	Cog-behval mES = 1.59	Relaxation mES = 1.55
Brown et al. (1992)	Aerobic exercise mES = .18	

Note. Tx #1 and Tx #2 represent different interventions discussed in a single study.
[a] Pre/post data--no control group available.

moderate to large effect sizes. The Lewinsohn et al. study
(1990) added parent participation to one of the adolescent
treatments, along with an adolescent-only group. The
intervention appeared to be more effective in the adolescent
plus parent condition (mES = 1.34) compared to the same
intervention for the adolescent-only treatment group (mES =
.69). Kahn et al. (1990) adapted the adolescent version of
the Coping with Depression course for a younger middle
school population. Their modification appeared to be highly
effective (mES = 1.37) for the group receiving the
intervention. The most recent edition of this course, now
called the Adolescent Coping with Depression Course (Clarke
et al., 1990), is a cognitive-behavioral psychoeducational
program that addresses the following areas: social skills,
negative thoughts, relaxation, pleasant events,
communication, and problem solving. The course is designed
for participants 14 to 18 years old, but the authors contend
that with modification of the content and pace, the course
could be applicable to younger populations. Empirical
evidence provided by Kahn et al. (1990) provides preliminary
support for this modification, as their sample included
subjects ranging from 10 to 14 years old.

Outcome measures. Across the 13 studies, depression was measured a total of 47 times with 11 different assessment instruments. Four studies (31%) used only one instrument, three studies (23%) utilized two assessment instruments, four studies (31%) used three instruments, and two studies (15%) measured depression with four different assessment instruments.

As previously indicated, assessment instruments can be grouped under five general areas--direct observation, interviewing techniques, rating scales, sociometric approaches, and self-report techniques. The general features of each of the assessment areas were reviewed in the previous section and thus will not be discussed in detail.

In the studies located for this meta-analysis, self-report instruments were used in 12 of the 13 studies, with 5 of the 12 studies using more than one self-report instrument. An average effect size of .71 was found in the studies that used self-report. The Children's Depression Inventory (Kovacs, 1993) was the most frequently used instrument, with 6 of the 13 studies including this scale.

Eight of the 13 studies assessed depression by a

structured interview at posttreatment. Of the eight studies that employed interview assessments, only four reported sufficient data for the calculation of effect sizes. The average effect size for these four studies was 1.51. There were three different structured interviews utilized: The Children's Depression Rating Scale (Poznanski, Cook, & Carroll, 1979); the Schedule for Affective Disorders and Schizophrenia for School-age Children (Puig-Antich & Chambers, 1978); and the Bellevue Index of Depression (Petti, 1978).

The Child Behavior Checklist-parent form (CBCL; Achenbach & Edelbrock, 1979) and the Hamilton Rating Scale for Depression (HRSD; Carroll, Fielding, & Blashki, 1973) were the only two rating scales used in the outcome studies reviewed. Three studies used the CBCL and one utilized the HRSD. An average effect size of .96 was found for three studies that reported sufficient data for the calculation of effect sizes.

There were no studies in this integrative review that included a direct observational assessment instrument or a sociometric procedure.

Summary of Empirical Studies

Thirteen preadult depression-oriented treatment studies were reviewed. These studies were part of an exhaustive search of the juvenile depression literature that included group, nonpharmacological interventions for children evidencing or at-risk for depressive symptomatology. An extensive amount of data was extracted from the identified studies and the current summarization is an attempt to demonstrate what can be concluded about this literature base at the current time.

To begin, investigations into preadult depression began approximately 20 years ago, but at the time of this review, only 13 studies were identified from an exhaustive search. The limited number of studies is severely deficient in a topic area with such profound ramifications on development, and further illustrates the need for more research in this area. However, there are several case studies and investigations utilizing psychotropic medications that contribute to this literature base, but were not of interest to the current endeavor. Furthermore, some articles that may have met the selection criteria might not have been located by the current reviewer.

Regarding the 13 studies that were located, the studies were found to include a large age range, from 7 to 19 years. Even within a single study, some authors included subject pools with age ranges as large as 5 years. This becomes important when developmental differences in the manifestation of depression are considered (i.e., different age groups reporting different constellations of depressive criteria, thus possibly needing different interventions). Because this literature base is gradually growing, little is known about what types of intervention components are effective with different cohorts. Future research may benefit from utilizing more age-homogeneous samples.

The majority of reviewed treatment studies were school-based interventions. Nine of the 13 preadult depression studies were conducted in the school setting, most finding moderate to large effects. Upon closer examination, it appeared that the larger effects were found in those studies with higher levels of pretreatment depressive symptomatology.

The only two primary prevention articles located for this review were two studies by Clarke et al. (1993), which found rather low effect sizes. The first study was a three-

session educational intervention that reportedly found short-term reductions in depression for boys, but not girls. The effect did not persist at the 12- week follow-up. The second study further sought to decrease depressive symptoms by increasing the intensity of the intervention and providing a skills training component. This study included a five-session behavioral intervention focusing on increasing pleasant activities. According to the authors, the second study failed to produce any differences between intervention and control groups with regards to depressive symptoms. The authors speculated that the intensity of both interventions may not have been powerful enough to effect changes in depression at the treatment's conclusion and at the 12-week follow-up assessments (Clarke et al., 1993). They offered the following suggestions for further research: increasing the intensity and duration of the intervention, expanding the assessment battery to include modalities other than the single self-report instrument utilized in the two studies, and a shift from focusing on prevention of specific disorders to more broad-based general healthy living skills (Clarke et al., 1993). The two studies by Clarke et al. (1993), being the only two prevention studies located for

this review, provide an excellent illustration of the dearth of research on childhood depression in general, and on primary prevention programs in particular.

As previously indicated, there are several interventions currently being implemented with juvenile populations that were extrapolated from adult etiological theories and models. The majority of these treatment models were represented in the empirical literature that was reviewed. Several of the studies employed more than one intervention model, either by combining two strategies or by including two treatment groups with different intervention programs. As previously discussed, the Adolescent Coping with Depression Course (Clarke et al., 1990) is an example of a standardized treatment program that incorporated various components of cognitive, behavioral, and interpersonal models. The two reviewed studies that utilized this treatment program found moderate- to large-effect sizes after modifying the standardized treatment for younger populations (Kahn et al., 1990; Lewinsohn et al., 1990).

Overall, the reviewed studies appeared to be well-controlled investigations that are producing moderate- to

large-reductions in depressive symptoms. These data are

encouraging and suggest that of the investigations conducted

to date, many have been effective in alleviating depression

in symptomatic or referred children and adolescents. The

data are less promising for nonsymptomatic preadult groups,

although only two studies were identified that approached

depression from a preventative standpoint.

Given that the foundations of the depression literature

have been discussed, the focus now shifts to the social

skills research. A similar format will be used to describe

the current state of the literature.

Social Skills: Definitions, Assessment,

and Interventions

The research on social skills has extended to a number

of disciplines. Social skills deficits have been

investigated for their role in a variety of disorders and

for their impact on future development. Despite the wealth

of research currently available, the present review is

designed to provide only a brief introduction to the

foundations of social skills, including operational

definitions, assessment practices, and social skill training approaches.

Operational Definitions

The concept of "social skills" can refer to a variety of abilities that increase the likelihood of successful social experiences. In a general sense, many authors have referred to social skills as a set of behaviors that increase the likelihood of obtaining pleasant social consequences for the person demonstrating them (Merrell, 1994). Young and West (1984) conceptualized social skills as being interpersonal in nature, positive and effective, involving action, and as valued by society. Additionally, they viewed social skills as being performed consistently, in a natural manner, and at the appropriate times and situations (Young & West, 1984). Despite the previously noted views, there is currently no universally agreed upon definition of social skills (McFall, 1982). Operational definitions of what constitutes social skills are usually somewhat subjective in interpretation and are nonexistent in some empirical reports found in the literature.

Gresham (1986) has assisted in operationalizing some of the subjectivity observed in the social skills literature. He defined social skills by viewing them as part of the broader construct of social competence. According to Gresham, a model of socially competent behavior that is composed of social skills, adaptive behavior, and peer acceptance, encompasses the requisites necessary to develop positive social outcomes and social relations. A description of the subcategories composing Gresham's model (adaptive behavior, social skills, & peer acceptance) will be provided in the following sections.

Adaptive Behavior

Although several definitions have been proposed, there is general agreement that definitions of adaptive behavior should emphasize personal independence and social responsibility (Grossman, 1983). Although the characteristics of adaptive behavior such as functional living skills and independent behavior have been well documented, the emphasis placed on each of its features is often disputed (Gresham & Reschly, 1987). For example, the emphasis placed on cognitive competencies is often

criticized, although it is considered a vital component in the classification of mental retardation and developmental delays (Merrell, 1994).

Social Skills

Gresham (1981) conceptualized social skills as

those behaviors that, within given situations,
maximize the probability of securing and
maintaining reinforcement and/or decreasing the
likelihood of punishment or extinction contingent
upon one's social behavior. (p. 368)

Other definitions have varied slightly, yet generally emphasize social skills as being a group of behaviors that increase the likelihood of obtaining positive reinforcement and decrease the probability of punishment (Merrell, 1994).

Peer Acceptance

According to Gresham, the last domain of social competence, peer acceptance, is considered to be a product or consequence of adaptive behavior and social skills combined. Often referred to as peer relations, this construct can be thought of as a result of socially competent behavior that is composed of adequate social skills and adaptive behavior (Gresham & Reschly, 1987). Social skills are often related to peer acceptance, while

negative peer behaviors are associated with rejection from

peers (Merrell, 1994).

To summarize, social skills definitions have varied,

yet generally refer to social skills as a set of behaviors

that increase the likelihood of positive reinforcement.

Gresham's (1986) conceptualization of social competence

assists in operationally defining social skills. He has

asserted that social competence is primarily based on two

content areas (social skills and adaptive behavior) and a

result or consequence of socially competent behavior (peer

acceptance).

<u>Assessing Social Skills</u>

A large number of assessment practices have been

developed to measure social skills. As previously described

in the section on depression assessment practices, the

majority of social skill instruments can be grouped under

five general areas: direct observation, interviewing

techniques, rating scales, sociometric approaches, and self-

report techniques. A brief examination of each of these

five general assessment strategies will be presented.

Direct Observation

Assessment by direct observation, along with behavior rating scales, has been utilized most frequently in the social skills research. This frequency is not surprising given that social skills by their behavioral nature are readily observable. A variety of structured behavioral observation techniques has been developed to assess social skills, such as the Target/Peer Interaction Code (Shinn, Ramsey, Walker, Steiber, & O'Neil, 1987) and the Behavioral Assertiveness Test (Eisler, Miller, & Herson, 1973). Despite the objectivity of these instruments, they are often too costly and difficult to conduct with large subject groups, which is often the case in school-based interventions and large-scale screenings (Merrell, 1994). Therefore, direct observation was not utilized in the present study.

Rating Scales

Along with direct observation, behavior rating scales are used most frequently to assess social skills. These instruments are designed to be completed by an adult informant who is familiar with the child's behavior. The

development of rating scales has increased over the past

decade due to the growing interest in school-based

assessment and training of social skills (Merrell, 1994).

Some examples include The Walker-McConnell Scales of Social

Competence and School Adjustment (Walker & McConnell, 1988)

and The Social Scales Rating System (Gresham & Elliott,

1990). The rating scale for the present intervention, The

School Social Behavior Scales (Scale A-Social Competence)

(Merrell, 1993), was selected because of its intended use in

school settings, well demonstrated psychometric

characteristics, large standardization samples, and general

availability (Merrell, 1994).

Self-Report Measures

Currently there have been few measures developed to

assess social skills from the standpoint of the child's

perspective (Merrell, 1994). As with interviewing, younger

children may lack insight or awareness into their social

difficulties or their reports may be tainted by embarrassed

or hurt feelings. However, one psychometrically sound

instrument, the student form of the Social Skills Rating

System (Gresham & Elliott, 1990), is widely available and

was used in the present intervention to assess social

skills.

Interview Procedures and
Sociometric Techniques

Despite the benefits that interviewing offers for

various other constructs, interviews are rarely used to

assess social skills. As previously mentioned, the

difficulty in using these instruments may be due to children

lacking insight into interpersonal problems or they may feel

embarrassed or hurt and thus are less likely to report

difficulties. Currently, there are no structured interview

procedures exclusively constructed to measure social skills

or the lack thereof (Merrell, 1994).

Sociometric techniques can be used to assess social

skills deficits or positive social status. Although there

are no specific instruments developed to assess social

skills from the peer perspective, the Peer Nomination

Inventory for Depression (Lefkowitz & Tesiny, 1980) includes

questions relevant to interpersonal skills and difficulties,

such as smiling and increasing involvement with

interpersonal activities.

Social Skills Interventions

The history of the social skills training approach dates back to the early 1970s. The central assumption of social skills training is that children with social difficulties lack the necessary behavioral skills for competent social interaction. Consequently, treatment focuses on the acquisition of essential behavioral skills, and preventive programs are less common (Beelmann, Pfingsten, & Losel, 1994).

Social skill interventions have been applied to children with difficulties ranging from social isolation to behavior problems such as aggression. Typical strategies include shaping procedures using adult reinforcement, modeling, role playing, rehearsal, feedback, self-management skills, and general problem-solving techniques (Maag & Forness, 1991).

A meta-analysis conducted by Beelmann et al. (1994) examined the effects of training social competence in children. Social skills' interventions were one of four approaches that comprised the social competence training in their study. The authors concluded their results indicated

that social competence training, in general, was moderately effective (ES = .61) in increasing social competence in children with a range of behavioral and emotional problems. However, because the sample was so broad, including a range of behavioral and emotional problems, and social skills training comprised only one fourth of the intervention approaches, it is difficult to ascertain the pure effect of social skill training with depressed individuals from this meta-analysis.

In concluding the discussion of social skill training approaches, it is important to note that the majority of studies and programs that utilize social skill training often do so with children already exhibiting deficits in social skill level. Thus, these approaches are primarily utilized on a tertiary prevention level, reacting to crises or problems, as opposed to primary preventive strategies.

Prevention and Early Intervention

Definitions

Prevention programs have a lengthy history in medical research. The main emphasis has been the search for sources that may prevent the spread of disease (Gelso & Fretz,

1992). Prevention research in mental health has received

less attention. Mental health preventive programs are

primarily based on the goal of preventing mental illness and

emotional disturbance, along with averting needless distress

and psychological dysfunction (Gelso & Fretz, 1992). Since

the 1960s, Caplan (1964) has been a primary force in the

investigation of prevention models for mental health. He

delineated levels of prevention using the terms primary,

secondary, and tertiary prevention (Brown, Thurman, & Pearl,

1993; Gelso & Fretz, 1992). Within his conceptualization,

Caplan (1964) defined primary prevention as activities

directed toward a large population in order to avert mental

health dysfunction. Secondary prevention involves early

detection and treatment of existing mental illness or

dysfunction in order to reduce severity and duration.

Finally, tertiary prevention involves working with those who

already have a mental health problem by assisting in

lessening the impact and working towards the highest

possible level of functioning (Brown et al., 1993; Caplan,

1964; Gelso & Fretz, 1992). In essence, primary prevention

seeks to avoid the problem altogether, secondary prevention

involves early identification and remediation, and tertiary

prevention seeks to reduce the impact or outcomes of mental health problems that are not subject to remediation.

In the preadult depression literature, few studies have taken a primary prevention focus. Given that depression can have serious implications for later development, such as increased risk for future depression, suicide, substance abuse, and other psychiatric problems, primary prevention merits serious consideration. Clearly, more research needs to be conducted in this area given that only two studies could be located that addressed depression from a primary prevention model (Clarke et al., 1993).

The Relationship Between Social
Skills and Depression

Given the foundations of social skills and depression research presented, the theoretical and empirical literature that has demonstrated a relationship between social skills and juvenile depression will now be discussed. As previously indicated, social skills deficits have been investigated as an etiological model for depression. Lewinsohn (1975) was one of the first to examine social skills' relationship to depression. His model proposed that

depression resulted from a lack of reinforcing social interactions due to deficits in social skills. Research examining adult depressive disorders supports Lewinsohn's theory (Kennedy, Spence, & Hensley, 1989), and since its formulation, additional empirical studies have reported strong associations between childhood depressive symptoms and social skills (Helsel & Matson, 1984; Sanchez & Lewinsohn, 1980; Wierzbicki, 1984; Wierzbicki & McCabe, 1988). Specifically, Helsel and Matson (1984) reported that childhood depression was significantly related to low levels of appropriate social skills and to increased levels of impulsiveness. An additional study found depressive symptoms to be related to difficulties in multiple areas of competence, including maladaptive social problem-solving styles, conflict-negotiation, affect-regulation deficits, and peer rejection (Rudolph, Hammen, & Burge, 1994). Prediction studies have offered further support for a relationship between social skills and childhood depression. Wierzbicki (1984), after controlling for the influence of concurrent levels of depression, demonstrated that two measures of social skills significantly increased the predictability of depressive symptomatology assessed two

months later. In a subsequent study, Wierzbicki and McCabe
(1988) concluded that measures of social skills, independent
of concurrently assessed depressive symptoms, were
significantly correlated with levels of depressive
symptomatology one month later at the conclusion of the
study (r = -.77).

The above-mentioned studies were those in which social
skills were either operationally defined by the author or
explicitly stated as a variable of interest. Although
additional research has been conducted, the authors of these
studies did not directly implicate or define social skill
deficits. Instead, broader constructs such as social
dysfunction or general competence were the focus of
investigation. Although not agreed upon by all in the
empirical literature, many authors argue that these
constructs are not social skills deficits but may be a
consequence of lacking social skills or that their presence
may increase social skills deficits (Hymel, Rubin, Rowden, &
LeMare, 1990). The studies that include these broader
constructs will now be reviewed.

In the majority of reviewed studies that appear related
to social skill deficits, a relationship was found between

childhood depression and some measure of general social interaction. Bell-Dolan, Reaven, and Peterson (1993) used multisource reports of both depression and "social functioning," and after employing factor analysis identified six factors of social functioning: negative social behavior, social withdrawal, other-rated social competence, self-rated social competence, social activity, and accuracy of self-evaluated social competence. They found that negative social behavior was the best predictor of depression in fourth- to sixth-graders. In general, higher ratings of negative social behavior were correlated with higher ratings of depressive symptoms ($\underline{R}^2$ = 19.1).

Hymel et al. (1990) examined social withdrawal and isolation and found them to be negatively related to measures of peer acceptance and self-perception of social competence. The assessment of social isolation and withdrawal remained stable across a 3-year period. These authors concluded that social skill deficits may be the result of social withdrawal and these deficits, in turn, may produce more withdrawal and negative self-perceptions (Hymel et al., 1990).

Research has also examined whether interpersonal difficulties are specific to depressive disorders exclusively, or are a broad indicator of psychopathology (Rudolph et al., 1994). Kennedy et al. (1989) examined whether deficits in social competence were unique to depression or were present in other groups such as anxious/fearful children. They concluded that interpersonal difficulties were not associated with a general maladjustment group, but were specific to depression.

The previously reviewed research appears to provide initial support for a relationship between social skills and preadult depression. However, the above-noted studies were all correlational, and none included a treatment component or were preventative in nature. Although the present study sought to understand and report on the relationship between social skill deficits and depressive symptomatology, it also involved a treatment phase, use of control group comparisons, and multiple sources and methods of data collection.

CHAPTER III

METHOD

Population and Sample

Since the purpose of the current research was to
examine the effectiveness of a school-based, primary
prevention model on social skills level and depressive
symptomatology, the sample for the present study included
approximately 110 nonreferred fifth-grade students. These
students were chosen from four Box Elder County elementary
schools. Schools were recruited through contact with the
Box Elder School District Office and teachers were
specifically contacted for their permission, so as to ensure
their cooperation. Parents of all students in participating
classrooms were notified by letter informing them of the
modification to their child's regular Healthy Lifestyles
curriculum. They were informed about the assessment
procedures and the possibility that their child may be
selected for the intervention program. Parents were
instructed to return an enclosed Waiver of Consent form if
they did not want their child to participate in the

assessment procedures or the modified curriculum. Children were also informed of the current project prior to onset.

Design

The study was conducted using quasi-experimental design similar to a Solomon four-group design with four classrooms in separate Box Elder County schools. The Solomon four-group is a special type of factorial design where two factors, pretest and treatment, are varied. Figure 1 presents an overview of this design.

The Solomon four-group design allows for a systematic investigation of not only treatment effects, but also the interaction of the treatment with the presence or absence of a pretest(s). This design is primarily used for three purposes: (a) to assess the effects of the experimental

GROUP	PRETEST	EXPERIMENTAL TX	POSTTEST
1	O	X	O
2	O		O
3		X	O
4			O

X= experimental treatment
O= observation (pretest or posttest)

Figure 1. Quasi-experimental adaptation of a Solomon four-group design.

treatment relative to the control treatment, (b) to assess the effect of a pretest relative to no pretest, and (c) to assess the interaction between pretest and treatment conditions (Borg & Gall, 1989). In the present study, subjects were not randomly assigned to treatment conditions. Therefore, the design is quasi-experimental rather than a true Solomon four-group design.

The assessments and intervention were delivered to all children within the context of the Healthy Lifestyles Curriculum (i.e., the school district's standard health class curriculum). Using identical procedures with all the children in a classroom greatly reduced or eliminated the possible stigmatization that could have resulted from singling out only children with depressive symptomatology or low social skills for the intervention. Thus, individual random assignment was not utilized. Instead, the children were nested in classrooms and the classrooms were randomly assigned to each condition.

Data and Instrumentation

The study involved a three-phase multiaxial procedure that utilized multisource and multimethod data to assess the level and severity of children's depressive symptomatology

and social skill functioning. Phase one included pretesting

two classrooms with a battery of depression, social skills,

and internalizing disorder instruments. During the second

phase, all children in the two classrooms chosen as

experimental groups participated in the intervention phase

of the study. During the posttest stage (phase 3), children

in all four classrooms were reassessed for the level and

severity of depressive symptoms and social skills

functioning. Only one child's parents refused permission to

participate in the study. This particular child was in the

posttest-only condition. The instruments included in the

assessment battery and the three phases of the study will

now be discussed in detail.

Instruments

The Reynolds Child Depression Scale (RCDS) (Reynolds,

1989) was the self-report depression measure used. The RCDS

is a 30-item instrument designed to measure depressive

symptomatology in children ages 8 to 12 or in grades three

through six. Children respond to 29 of the questions on a

4-point scale ranging from "almost never" to "all the time."

The last item consists of five faces displaying a range of

emotional expressions. Children are asked to endorse the

item that best describes the way they have felt over the past 2 weeks. Several of the questions reflect depressive symptoms such as "I feel sad," "I have trouble sleeping," and "I feel like hurting myself," while other items reflect the lack of depressive symptomatology such as "I feel loved" and "I feel like having fun."

The standardization process of the RCDS involved over 1,600 children from the western and midwestern sections of the United States. The sample consisted primarily of third-through sixth-grade children. According to information provided in the manual, the RCDS has a 2-week test-retest reliability of .82, and test-retest coefficients ranging from .81 to .92 at 4 weeks. Internal consistency of the entire sample was .90, using a Cronbach's coefficient alpha.

The self-report social skills measure included the student form of the Social Skills Rating System (SSRS) (Gresham & Elliott, 1990). The elementary version of the SSRS is a 34-item instrument designed to assess the child's perception of his/her social behavior. The instrument was designed for children in grades three through six. The items are rated on a 3-point scale that includes "never," "sometimes," and "very often." The items reflect positive social skills and attributes, such as "I smile, wave, or nod

at others," "I accept people who are different," and "I start talks with class members." The SSRS student form includes four subscales (cooperation, assertion, self-control, and empathy).

The SSRS student form standardization sample included 4,170 children from various states. The test-retest coefficients at 4-week intervals range from .52 to .68. Internal consistency coefficients were calculated for the elementary-level student form subscales and the total scale. The total scale coefficient alpha reliability was .83. The internal consistency coefficients ranged from .51 to .74 for the subscales.

The Systematic Screening for Behavior Disorders (SSBD) (Walker & Severson, 1992) and the School Social Behavior Scales (Scale A) (SSBS; Merrell, 1993) were the instruments selected for teacher ratings. The SSBD is a multigated screening system for internalizing and externalizing behavior problems. It involves a three-phase system for sequentially narrowing down a large group of children to only those exhibiting serious internalizing or externalizing symptoms. Because the present study was only interested in those children with internalizing symptoms, the focus of

this review will not include the externalizing scale of the SSBD.

The first phase of the SSBD involves the teacher identifying 10 students who exhibit internalizing behaviors and rank ordering those 10 from the least to most severe. The next phase then has the teacher rate those 10 students on a critical events index. Those students who pass the second phase or gate are then observed in the classroom or the playground in the third phase of the procedure.

The SSBD has been adopted as a "best practice" assessment strategy by the Utah State Board of Education (Merrell, 1994). However, this procedure is often costly and time intensive. Therefore, for the purposes of this study, only the first phase of the SSBD was utilized. Teachers were asked to identify 10 children exhibiting internalizing symptomatology and to rank order those children from least to most severe.

The School Social Behavior Scales (Scale A) (Merrell, 1993), developed for teachers and other school personnel for assessing social competence, were also used for teacher ratings. This instrument has two scales--Scale A (Social Competence) and Scale B (Antisocial Behavior). Scale A

measures socially competent behavior and was utilized in the present study. This scale includes 32 items assessing positive, prosocial behaviors and characteristics on which teachers rate each student using a 5-point scale. Scale A also has three subscales--subscale A1 (interpersonal skills), subscale A2 (self-management skills), and subscale A3 (academic skills). Scale A1 can be considered a measure of peer-preferred social skills, while subscale A2 assesses more teacher-preferred social skills.

Both of the two main scales (A and B) were normed on a group of 1,856 students in kindergarten through 12th grade. The students represented all regions of the United States. Internal consistency coefficient alphas for Scale A subscales ranged from .94 to .96. The total social competence coefficient alpha was .98. Test-retest coefficients for the subscales ranged from .76 to .82 at 3-week intervals, and the total social competence coefficient was .83. Interrater reliability estimates using scores from teachers and paraprofessional classroom aides ranged from .72 to .82 for the subscales, and was .83 for the total scale.

The Peer Nomination Inventory for Depression (PNID)

(Lefkowitz & Tesiny, 1980) is the only standardized peer

rating instrument for depression and was used to collect

peer-report data. The PNID consists of 19 statements that

are read out loud to a group of children and they are asked

to identify which children, from their class list, exhibit

the particular behavior or characteristic. The PNID has

three subscales--depression, happiness, and popularity. The

following are examples of statements included in each

subscale: "who often looks sad," "who often smiles," and

"who are the children you would like to have as your best

friends?"

The PNID was standardized on a group of 3,000 children

in grades three through five (Merrell, 1994). Internal

consistency coefficients for the 13 depression items have

been reported at .85. Test-retest coefficients for the

total depression score were .79 (Lefkowitz & Tesiny, 1980).

Phase One

The initial phase of the study involved the use of

multiple sources and methods of data collection. This phase

included self-report, teacher-report, and peer-report

measures of internalizing disorders in general, and depression and social functioning, in particular. Instruments were selected for inclusion in the study based on available information regarding psychometric characteristics, and favorable reviews by clinicians and researchers (Merrell, 1994).

The pretest assessment took place on April 3, 1995 with two randomly selected classrooms. The test battery was administered by this author and a doctoral-level psychologist. The order of administration was as follows: The RCDS (Reynolds, 1989), the SSRS-student form (Gresham, & Elliott, 1990), and the PNID (Lefkowitz & Tesiny, 1980). The teachers completed the SSBD (Walker & Severson, 1992) and the SSBS (Merrell, 1993) on their own time and returned them by mail.

Throughout the testing, children were encouraged to respond to the items in an open manner that reflected how they think, feel, and behave. It was emphasized that there were no incorrect answers to any of the items, but the responses should indicate how the individual student views him- or herself, or their fellow classmates, in the case of the peer nomination instrument. Children were also

encouraged not to share their responses outside of the classroom.

Phase Two

The second phase of the study involved group interventions conducted with all experimental group children during class time at the schools. The intervention consisted of eight sessions, 50-minutes each, that were conducted twice a week in the context of the Healthy Lifestyles Curriculum. Two classes were randomly selected for the intervention.

The treatment program that was utilized in the present study was developed based on a review of theoretical and empirical research. However, in addition to the research literature, the ecological validity and usefulness of the treatment were also thought to be very important. Therefore, both the empirical literature and the ecological validity were considered when developing the intervention for the current study and will be discussed below.

Preceding the development of the treatment program, an informal survey of elementary school teachers was conducted in a rural school district outside of Box Elder County. The

purpose of the survey was to assess the ecological validity of the intervention. In other words, the goal of the survey was to determine what social skills deficits were observed by professionals currently working with fifth-grade populations and to assess what fifth-grade teachers thought would be essential in a program of this nature. According to the teachers surveyed, respect for one another, and the lack of kindness and acceptance for those children not included in the "inner circle" or "clic," were the most deficient skills observed in fifth-grade students. Furthermore, the teachers overwhelming indicated that "adult to child" social skills (e.g., following directions, accepting feedback, listening skills) were severely lacking in this age group and, in the teachers' opinions, had decreased dramatically over the years. It is important to note that the social skills identified by this group of teachers are specific to the school and classroom environment. The results of this informal survey were used to guide the modification of the treatment program.

The core of the intervention consisted of a treatment adapted from the <u>Adolescent Coping with Depression Course</u> (CWD; Clarke et al., 1990). The adapted treatment focused

on social skills and interpersonal relationships (i.e.,

derived from behavioral models of depression), with selected

cognitive strategies considered developmentally appropriate

for fifth-grade students. The original CWD course was

designed for participants in the 14- through 18-age range.

However, the developers of this course contend that with

modification of the content and pace, the course could be

applicable to younger populations. As previously discussed,

Kahn et al. (1990) adapted the CWD program for a young

middle-school population and achieved favorable results.

The intervention used in the present study (see

Appendix B) included modified portions of the CWD course and

additional strategies that had both empirical support and

were currently being implemented in the field. The

intervention was developed by this author was designed to be

a standardized treatment that could be replicated in future

trials. Prior to implementing the treatment, each session

was assessed for its developmental appropriateness by two

doctoral-level psychologists with extensive experience in

school psychology issues and childhood depression. Table 4

includes a brief description of each intervention session.

Table 4

Intervention Sessions

Session	Specific Focus of Session
1	Introduction; social skills (interactions; eye contact, smiling)
2	Mood Monitoring (rating moods/feelings throughout different times of day--continue throughout the duration of the intervention); personality as a 3-part system (introduce the relationship between thoughts, feelings, and behavior)
3	Social skills (conversation skills, being introduced to someone new, smiling, asking appropriate questions)
4	Increasing pleasant activities (how actions can affect moods); social skills (the importance of social/interpersonal activities)
5	Awareness of thoughts (how thoughts can influence moods, how to control thinking, strategies for erasing negative thoughts)
6	Positive thoughts and statements (how to increase positive thoughts and self-statements); social skills (saying positive things about others, how to give a compliment)
7	Using social skills with adults (politeness, following instructions)
8	Adult-related social skills continued (accepting "no" for an answer); Review; Conclusions

The intervention began approximately 1 week following the pretest and was conducted by two graduate students with master's segrees in psychology and experience in group interventions with children. Group leaders were blind to each child's degree of depressive symptomatology and social skills level. Because the intervention was conducted in two separate intervention group classrooms, adherence to the treatment manual was emphasized, so as to ensure equivalence between treatment groups. Each session was delivered to both classrooms on the same day and the order of the classrooms was reversed for each session, to prevent one classroom from always being first or second.

At the end of each session, the children were given a goal to work on until the next session. A chart listing the goals was left in both intervention classrooms. At the beginning of each session, the group leaders would review the previous session and ask the children about the progress made on their goal.

Phase Three

The final phase of the study included posttest assessment and data collection. Upon completion of Phase

Two, children, peers, and teachers in all four classrooms were again asked to complete the assessment battery (RCDS, SSRS, PNID, SSBD, and SSBS). Teachers in all four classrooms were asked to completed the SSBD, SSBS, and return them by mail. They were offered a small incentive and given a postage-paid envelope. None of the four teachers replied with this request, despite repeated encouragement (e.g., telephone contacts) from this author.

In addition to the assessment battery delivered at pretest (e.g., RCDS, SSRS, and PNID), the posttest assessment for the children also included two questionnaires. Both of the questionnaires were developed specifically for this project and were designed to investigate knowledge of general mental health principles taught during the intervention and attitudes toward the intervention (see Appendix C). Both questionnaires were created for descriptive information only.

The first questionnaire was designed to assess knowledge of relevant social skills and methods of alleviating depressive feelings. This questionnaire included multiple choice, true/false, and fill-in-the-blank

questions. The first questionnaire was administered to all four groups at posttest.

The second questionnaire was designed to evaluate the intervention groups' thoughts and feelings concerning the intervention, particularly in regards to its helpfulness and utility. For example, intervention group children were asked to rate the helpfulness of the course on a Likert scale ranging from 1 (not helpful) to 7 (very helpful). Other questions included how often the children thought they might use the skills in the future and how the skills taught in the course may help other kids. The questionnaire also asked for open-ended feedback from the children regarding the strengths and weaknesses of the intervention sessions.

Following the posttest and the examination of the results, children who continued to have noteworthy depressive symptomatology after the third phase of the study were referred for further assessment and possible treatment (as indicated in the letter and consent form distributed to parents prior to the study). In collaboration with the special education director of the school district, a procedure for making referrals was established. The initial step was to give the names of students evidencing

significant symptoms to the director. The school counselor

in the child's school was to be notified and he or she would

assess the need for further services. In the event that the

school did not have a resident counselor, the mental health

staff from the district (including the school psychologist)

was to be contacted by the special education director.

However, it is important to note that the information

obtained in the present study was not sufficient for

diagnostic purposes and does not provide an adequate

evaluation for recommending a specific course of action.

Following the posttest assessment, four children were

identified from high scores on the RCDS (e.g., above the

recommended cutoff score of 72). The names of these four

students were given to the special education director of the

school district as specified in the proposed referral

protocol.

CHAPTER IV

RESULTS

The analysis of data followed the format specified by the proposed research questions. However, prior to presenting each research question and its results, a preliminary examination of the data will be provided, including descriptive data, internal consistency reliability, questionnaire data, and how missing data were addressed. This examination will include additional analyses that were not included as part of the original research questions, but were important to the overall findings of the study. Furthermore, important information regarding the procedures used to prepare the data set will be discussed.

Preliminary Analyses

Descriptive Data (Posttest)

The calculation of descriptive data was completed for the intervention and control groups. At posttest, a total sample of 100 children was obtained for the four groups. This includes all the children who completed all of the

instruments in the posttest assessment battery (N = 52 for the two intervention groups and N = 48 for the two control groups). Children who were absent from the classroom on the day of testing, those children whose parents refused participation (N = 1), or those who did not complete the full battery of tests were not included in the final posttest analyses. Table 5 displays the posttest descriptive data for the two intervention groups. The table includes the three subtests of the PNID (depression, happiness, and popularity); the four subtests of the SSRS

Table 5

Intervention Groups' Descriptive Data (Posttest)

Subtest	Mean	SD
PNID		
depression	.81	.91
happiness	3.03	.40
popularity	.55	.21
SSRS		
self-control	13.49	3.82
assertion	15.05	2.87
cooperation	16.04	2.82
empathy	17.10	2.78
RCDS	47.56	11.87

Note. N = 52.

(self-control, assertion, cooperation, and empathy); and the summary score for the RCDS.

With the RCDS, higher scores indicate a greater level of depressive symptoms. A score of 74 is the recommended cutoff that defines a level of symptom endorsement associated with clinically relevant levels of depression and should be used to identify a child for further evaluation. The standardization sample for fifth-grade students (N = 460) had a mean score on the RCDS of 56.80 with a standard deviation of 12.57. The sample for the present study had a lower overall mean score (47.56) compared to the standardization sample.

The subscales of the SSRS (self-control, assertion, cooperation, and empathy) were all within the "average" range at posttest for both elementary girls and boys when compared to the normative data.

PNID normative data are provided for only the depression subscale. A mean depression score of 4.0 is the cutoff score that is recommended for interpreting the presence of considerable symptoms of depression. The PNID depression subscale score (.81) for the current sample at

posttest was much lower than the recommended score for identifying significant depressive symptomatology.

Posttest descriptive data for the two control groups were also examined. These data are presented in Table 6.

As with the posttest data for the intervention groups, the RCDS for the control groups was much below the recommended clinical threshold for identifying depressive symptoms. The SSRS subscales were all within the "average" range for both elementary boys and girls when compared to the normative data. Similarly, the depression subscale of

Table 6

Control Groups' Descriptive Data (Posttest)

Subtest	Mean	SD
PNID		
depression	.70	.74
happiness	2.71	.60
popularity	.55	.22
SSRS		
self-control	12.05	2.97
assertion	13.87	2.30
cooperation	15.13	2.42
empathy	17.27	2.64
RCDS	48.66	10.91

Note. N = 48.

the PNID was also well below the cutoff score used for identifying significant levels of depression.

When posttest descriptive data for the intervention and control groups are compared, it appears that the children in the experimental groups had lower self-reported depression scores, as measured by the RCDS. The discrepancy indicates that children in the intervention groups reported feeling less depressed. However, the peer-rated depression mean was slightly higher in the intervention groups, which suggests that control group children rated each other as less depressed.

Regarding social skills level, the intervention groups, on average, were higher on three of the four subscales of the SSRS (self-control, assertion, and cooperation). The control groups had a higher mean on the "empathy" subscale of the SSRS.

Descriptive Data (Pretest)

The two classrooms that were randomly selected for the pretest assessment included a total of 49 children (N = 26 and N = 23). One of the pretested classrooms also received the intervention. The pretest data for the intervention

group is presented in Table 7. The pretest data for the control group classroom that was pretested is displayed in Table 8.

As was the case with the posttest data, the subscale and summary scores for the pretest data did not reach significant cutoff levels for depression when measured by the RCDS and the PNID depression subscale. Furthermore, the subscales for the SSRS were also in the "average" range when compared to normative data.

Prior to the intervention, the two groups appeared roughly equivalent on measures of depression and social skills. The largest mean difference was on the pretest "cooperation" subscale of the SSRS and this difference was still within one point.

<div align="center">Teacher Data</div>

The two teachers of the pretested classrooms and all four teachers of the posttested groups were asked to complete the SSBS-Scale A for every child in their class, along with stage one of the Systematic Screening for Behavior Disorders. The two teachers from the pretest condition returned the data.

Table 7

Pretest Descriptive Data (Intervention Group)

Subtest	Mean	SD
PNID		
depression	.69	.91
happiness	2.74	.24
popularity	.44	.13
SSRS		
self-control	12.43	3.88
assertion	13.57	3.61
cooperation	15.14	3.13
empathy	16.35	3.07
RCDS	49.49	11.11

Note. N = 26.

Table 8

Pretest Descriptive Data (Control Group)

Subtest	Mean	SD
PNID		
depression	.61	.65
happiness	2.18	.41
popularity	.47	.20
SSRS		
self-control	11.04	2.70
assertion	13.58	2.64
cooperation	14.13	3.05
empathy	16.26	2.58
RCDS	49.38	9.24

Note. N = 23.

However, none of the four teachers returned the posttest
assessment instruments, despite repeated encouragement from
the present author. As a result, there were no pre/post or
intervention versus control comparisons for the teacher
report data. However, the pretest descriptive data for the
three subscales of the SSBS-Scale A are presented in Table
9. The $\underline{N}$ size is slightly larger than the pretest data for
the children because the teachers ranked all the children in
the classroom, regardless if they were in attendance on the
day of the pretesting.

The SSBS items are rated on a 5-point scale. The
subscales are scored in the positive direction. In essence,
higher scores indicate positive, prosocial skills. For the

Table 9

School Social Behavior Scale (Scale A--Teacher Pretest)

Subtest	Mean	$\underline{SD}$	Mode
Interpersonal skills	57.35	12.44	70.0
Self-management skills	44.79	7.41	50.0
Academic skills	34.62	7.96	40.0

Note. $\underline{N}$ = 52.

group of children who were pretested, their interpersonal skills subscale summary scores ranged from 26 to 70. A score of 70 is the highest possible for this scale. On the second subscale (self-management skills), the scores ranged from 24 to 50, with 50 being the highest obtainable score. The academic skills subscale ranged from 12 to 40 for pretested children. A score of 40 is also the maximum score for the subscale. Interestingly, the modal ratings for all three subscales were the highest possible for each scale, suggesting the teachers viewed several of their students as possessing a high degree of social competence.

The SSBD-stage one was also completed by the teachers at pretest. This instrument asked the teachers to rank the top 10 children in their classroom who exhibit internalizing disorder symptoms. These data were to be compared to posttest rankings on the SSBD. However, given that posttest data were not returned by the teachers, comparative procedures were not possible.

Internal Consistency of the Measures

The internal consistency reliability of the instruments utilized in the present study was calculated using

Cronbach's coefficient alpha. Coefficient alphas for the

pretest and posttest measures are presented in Table 10.

The coefficient alphas produced on the current study's

measures approximate those found on the standardization

samples of each instrument.

Missing Data

As previously indicated, those children who missed an

entire assessment battery, either pre- or posttest, were not

included in the analyses. However, in addition to those who

missed an entire battery, there were also children who had

one or two blank items on an individual instrument. Summary

Table 10

Internal Consistency

Test/Subtest	Pretest	Posttest
PNID		
depression	.893	.892
happiness	.895	.914
popularity	.738	.877
SSRS	.998	.996
RCDS	.997	.993
SSBS (teacher)	.981	

scores for the instruments could not be completed for those children with missing data. In order to include the small percentage of children who omitted an item(s), mean substitutions were made for the missing items (i.e., for every classroom, means were calculated for each item in the assessment battery). Omitted items were given the mean score for that item in the particular child's classroom.

Questionnaire Data

In addition to the standard test battery administered at posttest, two questionnaires specifically designed for the current project were also given to the children during the posttest phase of the study. The questionnaires were designed to be descriptive measures that assessed acquisition of knowledge from the intervention, attitudes toward the program, and to further assess the ecological validity of the intervention (i.e., whether the program was considered to be valuable and worthwhile for the children themselves). One questionnaire was administered to all four groups, while the other was designed only for the two intervention classrooms (see Appendix C).

The first questionnaire was constructed to measure
general knowledge of social skills and ways of alleviating
depressive feelings. This questionnaire included 15
multiple-choice, true/false, and fill-in-the-blank
questions. All four classrooms were given this measure at
posttest. Table 11 displays the frequency and percentage of
correct responses for 15 of the items. The questionnaire
also included two open-ended questions that were not
included in this analysis--item number 16, "What do you have
to do to learn a new skill?" and number 17, "What is an
important skill to remember when dealing with parents?"

The intervention groups had a higher percentage correct
on 13 of the 15 items. Although only descriptive, for the
purpose of discussion items with a 10% difference between
intervention and control groups will be presented.
Questions that discriminated between the intervention and
control groups involved knowledge of basic social skills
such as maintaining eye contact, and methods of alleviating
depressive feelings such as erasing negative thoughts. The
difference between the percentage correct for intervention
and control groups was quite large (over 30%) on some items,
such as numbers 7 and 11, which addressed appropriate

Table 11

Questionnaire #1: General Knowledge

Item #	Intervention $\underline{N}$ = 53 freq. correct (%)	Control $\underline{N}$ = 49 freq. correct (%)
1	44 (83.0)	34 (69.4)
2	52 (98.1)	42 (85.7)
3	34 (64.2)	25 (51.0)
4	50 (94.3)	45 (91.8)
5	38 (71.7)	31 (63.3)
6	22 (41.5)	20 (40.8)
7	48 (90.6)	27 (55.1)
8	31 (58.5)	28 (57.1)
9	50 (94.3)	48 (98.0)[a]
10	43 (81.1)	44 (89.8)[a]
11	43 (81.1)	15 (30.6)
12	50 (94.3)	41 (83.7)
13	48 (90.6)	44 (89.8)
14	46 (86.8)	37 (75.5)
15	50 (94.3)	38 (77.6)

[a] Control percentage higher than intervention groups'
percentage.

conversation skills and a technique for decreasing negative

thoughts. Other items such as numbers 1, 2, 3, 12, 14, and

15 also had reasonable differences (over 10%) between the

percentage correct for intervention and control groups.

These items assessed a variety of skills, including

prosocial behavior and changing negative thoughts.

The percentage of correct responses was quite similar

between the groups on approximately five of the items.

However, on two of the questions (numbers 9 and 10), the control group had a higher percentage correct, although these differences in percentages were still less than 10%. The first of these questions addressed how increasing activity level can impact mood, while the second question assessed perceived control over thought processes.

The second questionnaire was administered only to the intervention groups in order to assess their satisfaction of the program and obtain feedback for future modifications to the intervention. Of particular interest was the interventions groups' thoughts and feelings regarding the helpfulness and utility of the program. For example, intervention group children were asked to rate the helpfulness of the course on a Likert scale ranging from 1 (not helpful) to 7 (very helpful). Other questions included how often the children thought they might use the skills in the future and how the skills taught in the course may help other kids. The questionnaire also asked for open-ended feedback from the children regarding the strengths and weaknesses of the intervention sessions. Table 12 includes each of the four questions with the corresponding ratings.

Table 12

Questionnaire #2: Feedback from Intervention Groups

	Question	Mean	SD	Modal rating
#1	Helpfulness of the intervention?	6.2	2.3	7
#2	Could it help other children?	6.0	2.3	7
#3	How often have you used the skills learned in the intervention?	5.6	2.4	7
#4	How often do you think you'll use the skills in the future?	5.4	3.1	7

Note. N = 53.

Overall, it appeared the children were highly satisfied with the program and felt it would have value for themselves and other children in the future. Although the ratings ranged from "2" to "7," the modal rating was "7" on all four of the questions, suggesting that the majority of the intervention group children felt the intervention was worthwhile and they had learned valuable skills they would use in the future.

On the open-ended responses the children listed a variety of skills they thought were the best part of the program. Many liked the negative thought stopping techniques and listing positive attributes of themselves. Several of the children listed the two group leaders as the "best part" of the intervention. The children also indicated they preferred the role plays and liked practicing the new skills with their classmates as opposed to practicing outside of the group. When asked about the least desirable part of the intervention, several children stated that the program was "too short" or "it ended too soon." Furthermore, one of the intervention groups appeared to be a more active and less disciplined group. Therefore, during some of the sessions with this group, their teacher had instructed the children to "take notes" so as to control the noise and activity level during the intervention. Not surprisingly, the children in this group indicated that "taking notes" was their least favorable part of the intervention.

Analyses of Research Questions

The following analyses were conducted on the Statistical Package for the Social Sciences (SPSSX). The

analyses followed the procedures specified in the research proposal for the current study. For all of the statistical significance testing, a Type I error rate of .05 was utilized. As is recommended and commonly done in the empirical literature, both statistical significance testing and effect sizes were computed for the first and second research questions (Cohen, 1990; Glass & Hopkins, 1984). Five research questions guided the current investigation and the findings will be discussed below.

<u>Question #1: Changes in Social Skills Level</u>

The first research question addressed whether there was a statistically significant difference (postintervention) between social skills ratings for those children who participated in the intervention group, as opposed to control group children. The question also addressed the practical significance of the findings by examining effect size estimates.

To assess whether a statistically significant difference existed between the intervention and control groups on social skills ratings, multivariate analysis of variance (MANOVA) was employed. MANOVA is a statistical

technique for determining whether several groups differ on more than one dependent variable (Borg & Gall, 1989). Each subject included in a MANOVA will have a score on two or more dependent variables. Typically, if a significant MANOVA F is obtained, an analysis of variance on each dependent variable is conducted in order to determine which of the variables are statistically significant.

For the first research question, posttest measures of social skills (i.e., the four subscales of the SSRS) were the dependent variables. Group assignment (i.e., intervention vs. control) served as the independent variable in the analysis. The data indicated a statistically significant omnibus treatment effect for the SSRS, $F(4, 95) = 2.69$, $p < .05$. Furthermore, univariate analysis of variance (ANOVA) revealed a statistically significant treatment effect for the assertion and self-control subscales of the SSRS: assertion $F(1, 98) = 5.11$, $p < .05$; self-control $F(1, 98) = 4.39$, $p < .05$. The cooperation and empathy subscales were nonsignificant, although the cooperation scale approached statistical significance, $F(1, 98) = 3.02$, $p = .08$. These data suggest that the treatment appeared to have an effect of increasing

social skills in those children who participated in the intervention groups, as opposed to control group children.

Standardized mean difference effect sizes were also computed to assess the practical significance of the findings. The assertion and self-control subscales that were statistically significant also produced moderate standardized mean difference effect sizes of .51 and .48, respectively. The cooperation subscale produced an effect size of .38, while the empathy scale's effect was -.06.

Question #2: Changes in Depressive Symptomatology

The second research question was very similar to the first in that the interest was in a statistically significant difference (postintervention) between depressive symptomatology ratings for those children who participated in the intervention group, as opposed to control group children. Also of interest was the practical significance of the findings.

To assess statistical significance, the dependent variables of interest were depression scores (i.e., the summary score of the RCDS and the depression subscale of the PNID). Group assignment (intervention vs. control) again

served as the independent variable. However, the MANOVA procedure for the depression measures indicated a nonsignificant omnibus treatment effect, $F(4, 95) = 8.36$.

Examination of the effect sizes produced from the depression related scales showed that the self-report depression measure (RCDS) produced an effect size of .10, while the depression subscale of the PNID had a -.15 effect size. Note that the happiness subscale of the PNID had a much larger finding (ES = .53).

Question #3: Interaction Between Pretest and Treatment

The third research question examined whether there was an interaction between pretest measures and treatment conditions. A multifactorial ANOVA procedure was utilized. All of the subscale scores were used as dependent variables, while group assignment and the presence or absence of a pretest were the factors that were examined (see Appendix D).

There were no significant pretest effects for any of the examined variables. Furthermore, there were also no significant interactions between the pretest and intervention conditions.

Question #4: Pretest Relationships

The fourth question to be addressed in the current research concerned the preintervention relationship between depressive symptomatology and social skills level. Pearson product-moment correlation coefficients were calculated for all the depression and social skills' subtest and scale scores collected at pretest. Table 13 includes the pretest correlation matrix.

Consistent with the findings of previous research (Helsel & Matson, 1984; Sanchez & Lewinsohn, 1980; Wierzbicki, 1984; Wierzbicki & McCabe, 1988), negative relationships were found between self-report measures of depression and social skills. A negative relationship indicates that as social skills increase, depressive symptomatology decreases, and vice versa. The correlations in the present study ranged from -.15 to -.26, with the largest of these findings accounting for approximately 7% of the variance. There were no statistically significant correlations identified from the pretest data.

Table 13

Pretest Correlation Coefficients

	RCDS	PNIDdep	PNIDhap	PNIDpop
SSRS				
assertion	-.26	-.05	.06	-.04
cooperation	-.15	.20	-.01	-.25
empathy	-.16	.17	.02	-.10
self-control	-.25	.18	.11	-.14

Note. N = 49.

Question #5: Posttest Relationships

The final research question addressed the postintervention relationship between depression and social skills scores. As in the previous analysis, Pearson product-moment correlation coefficients were calculated for all posttest measures of depressive symptomatology and social skills. Table 14 displays the posttest correlation matrix. Statistical significance testing of the correlations was also conducted.

Consistent with previous reports, a negative relationship was found between self-reported depressive symptomatology (RCDS) and all four subscales of the SSRS.

Table 14

Posttest Correlation Coefficients

	RCDS	PNIDdep	PNIDhap	PNIDpop
SSRS				
assertion	-.20*	-.11	.25*	.12
cooperation	-.22*	.01	.10	.01
empathy	-.05	.18	.003	.02
self-control	-.22*	-.03	.20*	.05

Note. N = 100.
*p < .05.

Interestingly, three of the four correlation coefficients from the RCDS and the SSRS were statistically significant at the .05 level, although the increase in statistically significant correlations is a result of the increase in sample size. These findings highlight some of the limitations of statistical significance testing. Note that again approximately 7% of the variance was accounted for and the magnitude of the correlations stayed moderately consistent from pre- to posttest.

CHAPTER V

DISCUSSION

Childhood and adolescent depression is a serious problem. The significance of depression on development and functioning in younger age groups is only beginning to be recognized. When compared to the literature base of adult depression studies, research on child and adolescent populations is insufficient. Several etiological theories have been proposed and numerous intervention strategies have been implemented on preadult populations, with minimal empirical support having been demonstrated. Several interventions based on the social skills deficits' theory have been developed and implemented within the past decade, with only a limited amount of research having examined their efficacy.

The purpose of the present study was to examine the effects of a school-based intervention that had both a cognitive-behavioral and interpersonal focus, and followed a primary prevention model. The core of the intervention consisted of a treatment adapted from the CWD (Clarke et al., 1990). The ultimate goal of the project was to increase

social skills and to prevent or alleviate depressive symptomatology in a fifth-grade population.

Review of Salient Findings

The questions that guided the present study involved statistically significant and differential changes between the intervention and control groups on measures of social skills and depressive symptomatology. The pre- and postintervention relationships between social skills level and depression were also of interest based on previous studies illustrating a negative relationship between the two.

Overall, the intervention group children had statistically significantly higher scores on social skills measures at posttest. Further inquiry found that two of the four subscales of the SSRS (student form) were statistically significant at the .05 level. Those scales were the assertion and self-control subscales. A third subscale (cooperation) approached statistical significance. These three subscales also produced standardized mean difference effect sizes of assertion = .51, self-control = .48, and cooperation = .38. From these data, one might conclude that

the intervention had a moderate effect of increasing social skills in the intervention group children. However, it is important to note that these data are self-reported perceptions of social behavior, rather than a true estimate of children's social behavior.

The intervention did not appear to have as noteworthy an impact on depressive symptomatology. There were no statistically significant differences on depression scores between groups. However, the intervention groups' mean score on the self-report depression measure was lower than the control groups' mean and a positive, albeit low, effect size of .10 was found. Peer rated measures of depression produced a low and negative effect size of -.15. Possible reasons for the negative and lower sociometric effect size may be that because the preintervention depression level was within the low to normal range, children were not able to observe small decreases of depressive symptomatology in their peers, but these small changes were more noticeable in themselves and were reflected in the lower self-report depression ratings.

Pretest scores of depression were well within the normal or low range, which suggests that few of the children

in the intervention groups had high levels of depressive symptomatology prior to the intervention. Therefore, we would not expect large changes from pre- to posttest. Pretest measures were also similar with the base rates for depression in the general population of fifth-grade students. It is important to remember that the purpose of this intervention was preventative in nature, with the goal being to increase social skills level, which could ultimately impact existing depression or prevent depressive symptomatology through education. It may be that decreases or significant changes in self- and peer-rated reports of depression may not be observed until a later time with follow-up data.

It is also important to consider the nature of the instruments that were utilized, including the sensitivity of the measures and floor effects. It is possible that the assessment instruments were not sensitive enough to detect subtle changes in depression scores, particularly those scores at the lower end of the scales. Furthermore, social skills approximate a somewhat normal distribution, while depression scores have been demonstrated to resemble more of a skewed distribution, where very few children will fall in

the depressive extreme of the distribution. Therefore, the possibility of a floor effect on depression measures is very likely.

As discussed in the review of related literature, several studies utilized a social/interpersonal intervention with juvenile samples. The current study produced effect sizes that were appreciably lower than the many of the studies identified when reviewing the literature. Several of these studies produced fairly large mean effect sizes (Fine et al., 1991, ES = .76; Kahn et al., 1990, ES = 1.37; King & Kirschenbaum, 1990; ES = .96; and Lewinsohn et al., 1990, ES = .69). Although these studies utilized approximately the same intervention model, the key difference between the current project and these studies concerns the preintervention level of depressive symptomatology. The reviewed studies targeted children with moderate to high levels of preintervention depressive symptoms while the current study was prevention-oriented and targeted a nonclinical population. We would expect more changes in children with higher levels of depressive symptomatology because they have more room to move down the depressive symptom scale.

The average child in the present research fell at the lower end of the depressive continuum. However, there were a few children who had high self-report ratings of depression (i.e., those four who were identified at the studies conclusion) and also the children ranked by the teachers in the pretest SSBD. Although not proposed as part of the original research questions, effect sizes were calculated for the top four children identified by the pretest teachers as exhibiting the greatest degree of internalizing symptoms (four children from one intervention class and four children from one control class were used). The SSBD rankings were utilized to avoid problems with statistical regression, which might have been an issue if the students with high RCDS self-report depression ratings were utilized. The comparisons of posttest effect sizes between the higher internalizing children from the SSBD ratings and the original sample are listed in Table 15.

Overall, appreciably higher effect sizes were found for the eight children rated by the teachers as exhibiting internalizing symptoms. These large effect sizes are consistent with those found in the literature, particularly

Table 15

Effect Sizes Comparisons

Measure	SSBD children $\underline{N}$ = 8	Original sample $\underline{N}$ = 100
RCDS	.51	.10
PNID depression	-.11	-.11
SSRS		
self-control	1.04	.48
assertion	1.83	.51
cooperation	.72	.38
empathy	.79	-.06

with those samples preselected for moderate to severe levels of depressive symptomatology.

The fourth and fifth research questions addressed the relationship between depressive symptomatology and social skills. Consistent with previous research reports, a negative relationship was found between self-reported depressive measures and social skills subtests at both pre- and posttest assessments. The magnitude of the relationship varied from .18 to -.22. The negative correlations indicate that as social skills scores increase, depression ratings decrease and vice versa. The magnitude of the correlations

did not change a great degree from pre- to posttest, but the total sample size at posttest increased by 51 children, which may account for the increase in the number of statistically significant correlation coefficients found at the posttest assessment.

Comparison with Previous Studies

There are not many published reports with which to compare the results of the current project. At the present time, there have been few studies conducted that have utilized both a primary prevention and school-based model to reduce the impact of current depression or future episodes of depressive symptoms in juveniles. As discussed in the review of literature for the current project, only two studies based on both a primary prevention and school-based model were identified. These two studies were conducted by the same group of researchers, who found relatively low and statistically nonsignificant effects (Clarke et al., 1993). Both experiments included large sample sizes (study #1 N = 622; study #2 N = 380). The first study employed an educational intervention and produced effect sizes of .18 for boys and -.1 for girls. The second study, also by

Clarke et al. (1993), was a behavioral intervention that produced effect sizes of .06 for boys and -.01 for girls. The current project's self-report depression measure found an overall effect size of .10, which is slightly larger than those effects of the behavioral intervention in the second study. The educational intervention in Clarke et al.'s first study found higher effects for boys. Gender differences were not considered in the current research.

One possible explanation for the relatively low effects of the two reviewed studies could be that the treatments in both of these studies were of fairly low intensity (i.e., only three and five sessions of 50-minute duration). Therefore, the issue of treatment intensity was considered when developing the intervention used in the current project. The present study included eight sessions lasting 50 minutes each. However, the effect sizes for the current study's entire sample on two depression measures did not deviate greatly from the two studies by Clarke et al. (1993). The effect size produced from the peer-rated depression measure was -.15, and the self-report depression scores produced an effect size of .10.

The depression effect sizes produced from the current study could suggest that the intervention was also not of sufficient intensity to produce a significant decrease in depression, or that perhaps treatment duration is not a variable that impacts depressive scores in a prevention model. The analyses of follow-up data from the current study may shed some light on this imperative question. If intervention intensity is not found to be a mediating variable, alternative explanations need to be explored.

The content of intervention could be an area to examine while exploring alternative explanations for the observed results. The current study utilized a social skills/interpersonal, cognitive-behavioral approach that was selected because its relationship to depression has been demonstrated throughout the literature (Helsel & Matson, 1984; Sanchez & Lewinsohn, 1980; Wierzbicki, 1984; Wierzbicki & McCabe, 1988). Perceived social skills scores did, in fact, increase as a result of the current intervention, yet depressive measures were not as greatly impacted. It may be that a social skills/interpersonal model was not as efficacious in decreasing depression as another treatment modality would have been; but, it is also

possible that because of the time frame of the study, the entire impact of the intervention could not be examined, remembering that the goal was preventative in nature, and larger results may be observed at a later time. Follow-up data and additional research could assist in clarifying this intricate issue. Additional insight regarding the delayed effects of the treatment can be gained from examining similar interventions in other prevention areas.

Prevention Programs in Other Areas

As previously emphasized, the impact of primary prevention and early intervention on future development is important for child and adolescent populations. The negative ramifications of preadult depression have been demonstrated throughout the current project, but there are also several other areas in which intervening at an early stage can be critical.

There currently are numerous programs addressing substance abuse prevention in preadult populations. Approximately 80-90% of these programs are school-based (Stein, 1994). Large-scale reviews of these prevention programs found that overall, the programs were effective in

increasing knowledge of substance use. However, the programs had little impact on changing attitudes or behavior concerning drug and alcohol use (Stein, 1994).

Similar findings are present in the current study. From the examination of questionnaire data, it is apparent that the intervention group children did have a higher level of knowledge regarding general mental health principles and of more specified areas relevant to social skills and depression. What these data suggest is that knowledge was increased throughout the course of the intervention. Children demonstrated learning of both the social skills and depression principles as evidenced by the questionnaire data. In addition to increased knowledge, the intervention groups' ratings of their social behavior on the SSRS increased throughout the program. However, it is important to note that the SSRS is a measure of the child's perception of his/her social behavior. Recent evidence suggests that the correlation between the SSRS and social behavior is rather low, further illustrating the need for an objective measure of social behavior (e.g., observational or rating scale data).

Decreases in depressive symptoms were less pronounced. What these data might indicate is that although knowledge increased, the children's feelings, attitudes, and behavior were not as greatly impacted by the intervention. Again, what is important to remember is that the increase in knowledge may be applied in future situations where the skills learned may assist in decreasing depressive symptomatology. Only future follow-up studies will reveal if the principles learned will alter future behavior.

Limitations

A limitation of the current study includes a moderate deficiency in the use of multisource data. Obtaining rating scale data from parents could have provided valuable information regarding both social skill level and depressive symptoms outside of the school setting. However, these data could not be obtained given time and financial constraints on this project.

The lack of posttest data provided by the teachers was an unexpected limitation of the current project. These data would have provided additional and useful information from the unique perspective of an adult in daily contact with the

subjects. Other forms of assessment such as observational and interview data would have nicely contributed to the results of the present study, but the scope of this project did not allow for these methods. However, it should be emphasized that the current study did utilize several forms of self-report instruments and a sociometric procedure, representing far more data than the single self-report instrument utilized in many previous studies.

The present study was also limited by the lack of follow-up data. In order to have assessed the impact of the primary prevention model, follow-up data would have contributed a great deal of information. These data were not collected for this dissertation project due to time limitations. However, follow-up data are essential to the results of the current study and will be gathered at a future time with the original sample.

Recommendations for Further Research

As previously indicated, collection of follow-up data is essential in a study of this nature and is recommended as a point of further research. Researchers interested in primary prevention and early intervention research might

want to consider longitudinal research designs that account
for the delayed effect that might be present in the study
(i.e., the knowledge was obtained, yet the opportunity to
put the knowledge to use has not yet been presented).
Research aimed at identifying the mediating variables such
as measurement issues, content of interventions, intensity
of treatment, and various issues yet to be identified would
also be important in this process.

The issue of treatment intensity is another imperative
question that is in need of further research. Because so
few studies have been conducted in the area of childhood
depression, optimal levels of intervention have yet to be
discerned. In the course of researching this issue, one
might find that the intervention should extend to the family
and community level, such as has been explored in the
substance abuse prevention literature.

Primary prevention for social and emotional issues at
the school level provides an excellent gateway for reaching
a large number of children in a cost-effective manner.
Mental health principles can be incorporated into existing
curriculums with little added cost to the educational
system. Furthermore, school-based mental health

interventions with the ultimate goal of preventing social and emotional problems in children may also provide a means for early identification of more serious issues that warrant more intensive treatments, such as psychotherapy and family-centered interventions. However, until the efficacy of school-based prevention models can be repeatedly demonstrated throughout the research, policy makers are going to be reluctant to fund such large-scale projects within the educational system. Therefore, continued research in this area may provide needed support and play a crucial role in decreasing depression in such a fragile period of the life span.

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APPENDICES

Appendix A:

Coding Instrument

Coding Sheet
Depression/Social Skills Intervention Studies

Study ID #   _____

Year of Publication   _____
Author(s)

_____
Title

_____

I. SUBJECT CHARACTERISTICS   EXP.   CONT.

N Size of Study   _____   _____

Mean Age at Beginning Intv.(years)   _____   _____

Gender: %male   _____   _____
                     %female   _____   _____

Depression Severity (pretest)   _____   _____
     1. none (prevention prog.)
     2. mild
     3. moderate
     4. severe

II. METHODOLOGICAL CHARACTERISTICS

Design . . . . ._____
  1. true experimental
  2. quasi-experimental
  3. pre-post
  4. single subject & case studies

Type of Assignment . . . . ._____
  1. random
  2. nonrandom but appropriate matching
  3. convenience
  4. single subject/case

General Validity Rating (1-5) . . . . . ._____
  1. excellent
  2. good
  3. fair
  4. inferior
  5. unacceptable

Based on the Following Threats (0-3)*:
   maturation . . . . _____
   history . . . . ._____
   testing . . . . ._____
   instrumentation . . . . ._____
   statistical regression . . . . . _____
   selection bias . . . . _____
   experimental mortality . . . . . _____
* 0= not a plausible threat
 1= minor problem
 2= a plausible alternative explanation
 3= by itself could explain most or all of the observed
results

True Control group utilized . . . . _____
 (1=yes; 2=no)

Other methodological weaknesses:

III. INDEPENDENT VARIABLE
   (Intervention Characteristics)

Nature of Intervention

    * Number of Treatment Groups . . . . . _____

    * Names of Treatment Groups

   1)   2)   3)

Adequate description of Intervention (1=yes; 2=no)

   1)   2)   3)

Setting . . . . _____
    1. school-based
    2. clinic/treatment center
    3. home-based
    4. other (describe)

Intervention delivered by . . . . _____
    1. teacher
    2. mental health professional
    3. mental health paraprofessional
    4. other (describe)

Duration of Intervention (weeks) . . . . ._____

Total # Sessions . . . . ._____

Average length of each session (mins.) _____

Average group size . . . . ._____

IV. DEPENDENT VARIABLE

Outcomes Measured . . . . _____
     1. depression only
     2. depression & other constructs . . _____
       (describe)

Assessment Type

                                    Instrument Name(s)
1. interview
2. self-report instrument
3. rating scale
   (parent or teacher informant)
4. observation
5. sociometric technique

Effect Size Calculations

Author's Conclusions

_____
_____
_____

Additional Comments

_____
_____
_____

Appendix B:

Treatment Manual

Adapted from the Adolescent Coping with Depression Course
(Clarke, Lewinsohn, & Hops, 1990)

SESSION 1

Leader: Briefly introduce yourself and ask the names of the children.

> In this class we're going to learn some ways to control the way we feel. You'll be learning many new skills that will help you gain control over your emotions (or the way you feel). The emphasis will be on overcoming feelings of sadness and nervousness, but the class also offers many "life skills" that may be useful to those of you who are not really feeling sad or nervous right now.

GUIDELINES FOR THE COURSE

Leader: Use the blackboard to write down the 4 simple guidelines and briefly expand on the rules & clarify/answer any questions.

<div align="center">Blackboard</div>

1. Be positive
2. Equal time
3. Keep it in the classroom
4. Be supportive

1. AVOID DEPRESSIVE OR SAD TALK. We want to focus on positive things in this class.

2. ALLOW EACH PERSON TO HAVE EQUAL TIME. We want all of you to have equal time to share ideas, ask questions, and discuss any difficulties you are having with the material. This includes raising your hand when you want to speak and not interrupting your classmates.

3. DON'T TALK TO OTHERS ABOUT THE PERSONAL THINGS THAT ARE DISCUSSED BY YOUR CLASSMATES. This is what we call "confidentiality" and it means that the personal things that are shared in this classroom should not be talked about to

other people. For example: If someone in the class were to
say that he or she had felt sad and cried when their best
friend moved. It would not be O.K. to tease that person
during recess or to tell another child who is not in this
class. Of course, there is the possibility that someone may
break our confidentiality rule; if you are concerned that
this has happened feel free to talk to me or to your teacher
about it.

4. OFFER SUPPORT AND ENCOURAGEMENT TO EACH OTHER.
Criticizing, being sarcastic, and laughing at another
student's comments are not allowed. Try to be thoughtful
and respectful and focus on the positive things others say.

LEARNING TO CONTROL YOUR LIFE

Who or what controls your life?

Leader: Ask students to volunteer some answers to this
question. Write their suggestions on the blackboard. If
the responses focus on external factors leave them alone.
If some of the responses indicate that the self is in
control, circle them. Typically, the students will focus on
external factors instead of asserting that they are in
control of their own lives to any great extent.

There are many factors controlling your life, but the
one we want to focus on is YOU. You can control many
aspects of your life, even if you don't right now. You
can learn to control how you feel and improve your
mood. Most children believe they have little or no
control over their feelings. In this course you will
learn SKILLS that will help you overcome feelings of
sadness, nervousness and fear, and you will find that
with these skills you can control your emotions.

BLACKBOARD
RULE: Learning to control your life is a skill.
You will be learning skills for controlling your life.

**What do you have to do to learn a new skill? For
example, playing the piano is a skill. What do you
have to do to learn to play the piano?** (Answer:
PRACTICE; try your best)
**PRACTICE is an important part of this class. You will
be given new skills in class, and you will need to
practice them every day. This daily practice is your
"homework".**

MAKING INTERACTIONS WITH NEW PEOPLE POSITIVE

**Today we are going to take some time and get to know
each other. I'm sure you probably know all of your
classmates by now, but we are going to pretend today
that we don't know each other. O.K.?**

How do you show people that you are a friendly person?

Leader: solicit answers from students. Give everyone a
chance to offer suggestions. Then summarize their ideas and
examples as you list the following criteria (short form on
next page) on the blackboard.

How to be a friendly person:
**1. Look at the person's eyes when you are talking or
listening.**
2. Smile at least once; the more often the better.
3. Say something positive about the other person.
4. Tell about yourself.

<u>Leader:</u> Short form to write on the blackboard.

> BLACKBOARD
> 1. Make eye contact
> 2. Smile
> 3. Say positive things
> 4. Tell about yourself

TEAM ACTIVITY:

**We're going to practice doing these things as we get to
know each other better. You are going to tell about
yourself and listen to someone tell about him- or
herself. Here are some questions you can use to learn
more about each other:**

<u>Leader:</u> Write the following questions on the blackboard.
Don't erase the "how to be a friendly person" list.

> BLACKBOARD
> Questions
> 1. Where are you from?
> 2. What are your hobbies?
> 3. What are you really good at doing?
> 4. Do you have any pets?
> 5. What is your favorite color?

<u>Leader:</u> Pair off students or form groups of 3. The goal is
for students to learn more about each other, then to
introduce one another to the rest of the class.

> **Now you and your partner are going to TAKE TURNS
> TELLING ABOUT YOURSELVES by answering these questions**
> (point to board). **Remember to use the "how to be
> friendly" skills** (point to board). **When you have
> finished you will introduce your teammate to the rest
> of the class.**

<u>Leader:</u> Briefly model for students by introducing yourself,
touching on many of the questions and using the friendly
skills, then direct students to begin. As the students
participate, make sure you reinforce and praise them for
their attempts to use the friendly skills and interview

questions. Then have the students introduce their teammate to the class.

> Now each of you will introduce your teammate to the class by telling us his or her name and one thing about them that you learned from the interview questions.

Leader: After they have finished, have them give each other constructive feedback by using the procedure outlined below.

PROVIDING CONSTRUCTIVE FEEDBACK:
> Now stay with the same partner and look at the "how to be a friendly person" list on the blackboard. Tell your partner 1 thing he or she did well and 1 thing that they could have done better to look more friendly. Just mention 1 thing, even if there were 2 or more things that needed improvement. Each person should end up with 1 thing that he or she could do better. All of us have something we need to work on. Nobody is perfect.

Leader: Model how to give feedback.

Take out the goal chart and post it on the board.

> We are going to be using this chart throughout the whole class. Every time at the end of our visit with you, we will write down the goal for the session. The chart will help you to remember the goal you need to work on until the next session. The goal for this time is to USE FRIENDLY SKILLS. So I'll write it on the first line "Session 1" and then I'll copy them on the side of the chart in case you may forget what the friendly skills are. If you would like to, you may copy the friendly skills on a sheet of your own paper and then you'll have the friendly skills with you.

> Does anyone have any questions?

> > We will be back on Friday, so you have 2 days to accomplish your goal of using the friendly skills at east once. Good Luck!!

SESSION 2

<u>Review</u>

Who remembers what our goal for our last meeting was?

How did you all do with your goal for the last session?

Tell me about some of the times you were able to use the friendly skills? Was it here at school or with your brothers and sisters, or with adults?

Were you able to use the friendly skills more than 1 time?

Well, we brought a small reward for those of you who practiced and met your goal of using the friendly skills at least one time.

Do you have any questions about what we discussed last Wednesday?

PERSONALITY IS A 3-PART SYSTEM

Today we're going to talk about how we look at personality and why we feel, think, and act the way we sometimes do.

Our point of view is that each of us has a personality that is made up of 3 parts-- actions, thoughts, and feelings/emotions.

<u>Leader:</u> draw the following diagram on the board. Point to the specific parts of the diagram as you address them. (draw arrows between each component)

BLACKBOARD

Feelings

Actions   Thoughts

Negative feelings such as sadness, anger, fear, and anxiety (nervousness) can start in any of these 3 areas: feelings, actions, and thoughts. Each area affects the other two. That's what these little arrows mean--that thoughts influence feelings, the same way that feelings influence thoughts. You see that they all are connected.

For example, if someone feels sad (point to feelings on diagram), **their face has a frown and they may walk around with their head and arms drooping** (point to actions/behavior), **and they might think thoughts like** (this is a really bad day, I bet I won't do well on my test at school).
Lets go through it one more time?

Leader: Repeat the above description because there will likely be some children who don't understand and may be reluctant to express that. Going through it again will only help to reinforce the importance of the model.

When most people are feeling sad, they try to change their emotions-- they try to feel better first, but emotions are the hardest to change. It is much easier to start with changing your thoughts and actions-- this will then change how you feel.

We are going to learn some skills to help change thoughts and actions when we feel sad, grumpy, or tense. Most of the skills we learn and practice in this course will be skills to help change negative <u>thoughts</u> and <u>actions</u>.

Leader: point to each part of the diagram as you talk about the above paragraph. This will really help to emphasize each part and avoid confusion about how each part is connected.

Likewise, remember to point to each part of the diagram as you go through the following examples. Go through each example <u>very slowly</u> emphasizing each part and eliciting feedback from the children.

Let's try some examples to further illustrate the parts
of the personality: If Brian <u>thinks</u> "I am a dumb kid"
(point to "Thoughts" on board) **then what might some of
his "Actions" or behavior be like?** (Elicit responses.
If none are given, assist by giving responses such as
"he may not do as well as he could on tests or he may
not study or work hard in school.) **These are all
actions that may result from Brian's thoughts about
being dumb.**

**What about his feelings? How might he feel if he goes
around thinking "I am a dumb kid" all of the time?**
(elicit responses. If none are given, respond with
feelings such as sadness, he probably won't feel good
about himself, and he may feel scared or fearful during
school).

<u>Leader:</u> Continue to use the same format with the following
examples (i.e., point to each part of the model as you
address it, eliciting responses from the children or
providing responses if none are given or those shared do not
reflect the desired response.)

**Let's try another example: What if Sarah has been
<u>feeling</u> really sad for the past two weeks. What might
Sarah's actions or behavior look like? If she is
always feeling sad, what may she be thinking to
herself? What would her thoughts be like?**

**What if Joey <u>thinks</u> to himself "No kids would ever want
to play with me, I'll never make any friends." If Joey
has this thought in his mind all of the time while he
is around other children, what might his actions or
behavior look like?   What might he be feeling?**

**We've used a lot of examples that showed how the parts
of this triangle are all related. The examples we used
were for negative thoughts, actions, and feelings. Do
you think the triangle works the same way for positive
thoughts, actions, and feelings?** (elicit responses).

Well let's see if we can find some ways to show how our personality triangle works the same way for the positive things.

What if Megan is in a really good mood and <u>feels</u> really happy. How might she act around her friends? How might she behave at home? What might some of her thoughts be?

What if Bobby <u>thinks</u> he is really good at basketball? Do you think this will help to influence how he plays? Do you think he may play differently if he told himself or thought he was a crumby player and no one wanted him on their team?
Do you think Bobby may actually play a better game if he goes into the game thinking positive thoughts about his abilities? (actions)

After going through these examples can you see how each part of this triangle influences the other, or how they are all related in some way?

As we mentioned earlier it is much easier to start at these parts of the triangle (point to Thoughts and Actions) than it is to try and change your feelings. However, if we work on changing our negative thoughts, then this will help to change sad or negative feelings.

Negative and sad thoughts and actions make us feel sad. Positive thoughts and actions make us feel good. Therefore the goal for this session is to "think positive thoughts". This is something we can do outside of the classroom and something we need to practice so we can use positive thoughts when we are feeling sad or really down. We are going to write this on our goal chart for session 2. Thinking Positive Thoughts will be your goal to work on until our visit on next Wednesday. You may also want to write this goal on a sheet of your own paper so you can take it

home or wherever you go to remind yourself to think positive thoughts, especially if you are not feeling good about yourself or are feeling sad.

<u>Leader:</u> Allow children enough time to write the goal if they want to, then transition to the next topic.

One of the purposes for this course is to change the way we feel when we are feeling down. Sometimes it is hard to describe how we feel in words, or to tell someone how we feel, and sometimes it can even be hard for you to determine how you feeling inside. Well today we're going to talk about a different way to determine how we are feeling or what our current mood is. We are going to do this by placing our mood on a 7-point scale. Using a scale to rate things may be something that you are already familiar with but we will go through it just in case some of you have never used a scale.

Before we talk about rating our moods, let's see how you would use a scale like this with other things. On a scale of 1 to 7, how warm are you right now? A rating of 7 is very, very hot, and 1 is very, very cold. Let's try a few more: How warm is it at the North Pole? How warm is it in the desert? How bright is the sun?

<u>Leader:</u> draw a scale with 1-7 increments on the board. As you go through the above examples, point to the scale and denote what the extremes of the scale are (i.e., how warm is the North Pole? 7= really warm/hot and 1=very cold.)

<u>Leader:</u> Try to determine whether the students know how to use a 7-point scale by the way they answer these questions. If they seem confused, go through several more examples that are based on information that is relatively objective so you can check the results. If time permits, you can ask the students for some examples to use.

We're going to pass out a chart for you to use throughout this course. It has a 7 point scale for every class period that we will be here to visit you. Each time we are here you will need to rate how you feel or what your mood is for that day on a 7-point scale. Give today's mood a number and then next Wednesday you can compare how you feel with today's rating. We will hold on to these charts for you and pass them out at the beginning of each session.

<u>Leader:</u> Pass out the "Feeling Rating List" and instruct students to rate their mood for the current day. Walk about the room to ensure that each child has grasped the 7-point scale and is recording their feelings for the correct day. Collect charts after the session.

Looks like all of you have finished the rating. We'll collect the charts and bring them back next week.

Remember to work on your goal in between now and our next meeting. Try and "think positive thoughts" throughout the next few days, especially if you're feeling sad or have a lot of negative thoughts in your head.

We'll be asking you on Wednesday if you worked on your goal.

SESSION 3

MOOD MONITORING

Before we get started today, we are going to pass out
the "Feeling Check List" and have you rate your mood
for the day. Today is Wednesday, so you'll fill in the
blank for Session 2-Wed.   Remember that the scale is
from 1 to 7 with 1 being feeling really lousy and 7
feeling on top of the world.

Leader: pass out sheets and have students rate their mood
for the day.

When you have finished look at day 1's rating. Did your
mood change from last Friday, or did you stay about the
same? (Allow children to respond or talk about their
ratings)

REVIEW

We have met twice so far and have covered a lot of
things. Let's take a minute today to go over some of
those things again. Who can tell me what the "Friendly
Skills" are. We talked about them during our first
meeting and worked on them as a goal.

Leader: Wait for students to recap the 4 friendly skills and
then point them out on the Goal Chart or write them on the
board again.
                    1. Make eye contact
                    2. Smile
                    3. Say positive things
                    4. Tell about yourself

Who remembers the goal we've been working on since last
Friday (our 2nd goal)?   Answer--Think Positive
Thoughts.

How did you all do with your goal for the last session?

Tell me about some of the times you were able to "Think
Positive". Did any of you use positive thoughts to

help yourself feel better when you were feeling sad, down, or negative?

Were you able to think positive more than once?

Well, we brought another reward for those of you who worked on your second goal of "thinking positive thoughts".

Do any of you have any questions about what we have discussed so far?

Well, today we're going to spend some time talking about and practicing what we call SOCIAL SKILLS. These are behaviors that we all use to get along with people. What are some examples of social skills?

Leader: Write suggestions on the board, adding the following if necessary: being a good listener, introducing yourself to new people, getting your point across to other people, solving problems without fighting, making friends, starting conversations, etc.

Although most of you already know how to do many of these things, we will still PRACTICE them in this class. The reason for this is that when people are feeling down, sad, or negative, they sometimes stop using their social skills and withdraw from other people.

Even if this doesn't apply to you, we still want each of you to practice social skills in this class. Everyone can benefit from a little practice and its a good way to get to know each other better in the process.

GUIDELINES FOR STARTING CONVERSATIONS

One of the hardest things for most people to do is to start a conversation or to begin to talk to someone. Sometimes children are afraid of being rejected or looking silly, although this rarely happens. The two main things we want to cover here is WHEN TO START A CONVERSATION and WHAT TO SAY. Write these on BLACKBOARD.

When to start a Conversation.
I'm going to describe a person in several different situations, and I want you to tell me whether these would be appropriate (good) or inappropriate (bad) times for you to start a conversation with this person.

Leader: Write the headings **APPROPRIATE/a good time** and **INAPPROPRIATE/a bad time** on the blackboard.

The following are some sample situations you can use for this exercise. As students identify whether a given situation is an appropriate or inappropriate time to start a conversation, list the situations under the corresponding heading on the blackboard. Once the students understand how the exercise works, ask them to suggest some examples; do this as soon as you can. Continue supplying examples until you get some contributions from students.

Sample Situations
**the person makes eye contact.
the person looks busy and is sitting at his desk writing.
the person says "Hello".
the person is waiting for a school bus.
the person looks angry.**

Leader: Continue to elicit examples from students until it appears that they have grasped the concept (evidenced by most students participating and supplying examples).

In addition to recognizing these signals from other people, you can also use them to let others know that YOU are willing to start a conversation. For example, if you look or stare at your shoes all the time or look like you're really busy, this shows others that you do not want to start a conversation or do not feel like talking to them.

Good Questions for Starting Conversations

Now let's talk about some ways to start conversations. One of the best methods is to use questions. Questions that have more than one word answers are best for starting conversations and keeping them going. An example of a one-word answer question is "Did you play ball at recess?" The answer to this question usually is a one word answer-- Yes or No. The idea is to get the other person to talk about him- or herself, like "Tell me about your baseball game last night?"

Let's think of some good and bad conversation-starter questions.

Are these good questions?
1. What time is it?
2. Do you ride a bus to school?
3. Have you seen "The Lion King"?
4. Did you know you have a rip in the seat of your
    pants?
5. What kind of music do you like?

Leader: Encourage humor!

What kinds of questions can you think of?

Leader: Write student's suggestions on the board.

The best opening lines or conversation starters are often found in the immediate situation. Carefully watch what's going on around you to find topics for conversations.

<u>Leader:</u> model using "conversation starters" with some students in the group. Base questions on things you have observed about them, then model an inappropriate conversation starter that does not reflect what's occurring in the environment. Examples: Hey Josh, I see you have a baseball glove under your desk, What do you like about baseball? -- Next example: Sarah, what do think about Dogs wearing collars? Do you think they like that?

You see this last example of a conversation starter just comes out of the blue and seems kinda weird. It seems inappropriate to just walk up to someone and talk about dog collars just out of the blue.

O.K. Does everyone understand about good and bad conversation starters? (go through more examples if children seem confused, if not move on to Goal)

The goal for session 3 is to start a conversation with someone at least once before the next session. Write "Start one conversation" on the line for session 3.

BEING INTRODUCED

We've been talking about and practicing some social skills. We are now going to focus on learning another social skill that is related to starting conversations-- it is a skill we can use to meet new people. Meeting new people can make us nervous and uncomfortable because we don't know what to expect. What we want you to remember is that meeting people is a skill you can learn.

Guidelines for Being Introduced

What does it mean to be introduced?

Leader: Allow students to answer. If no responses are given, explain that being introduced is a way of meeting new people, where you meet a new person and tell them your name.

When you are introduced to someone, you need to remember to do these five things:

> BLACKBOARD
> 1. Make eye contact
> 2. Smile
> 3. Say a greeting
> 4. Use the person's name
> 5. Tell them your name

If you do these things, the other person will have a good first impression of you, and he or she will be more inclined to think you are friendly and may like you. FIRST IMPRESSIONS are important in establishing relationships. First impressions are remembered for a long time. Is everyone clear on what a first impression is? (Wait for responses)

Sometimes we don't say anything when we meet people because we're not sure what to say, and the other person seems to do all the talking. When you are meeting someone, it's better if each person spends about the same amount of time talking (remember our rule for equal time). You will find that it's easier to get a conversation started with someone you don't know if you think of something to say AHEAD OF TIME or plan what we call a "greeting" ahead of time.

We're going to plan our greetings now. If you already have a favorite greeting, you might want to think of something better or choose another greeting to alternate with the one you are using now.

These are some of the greetings that people often use. You can choose one of these or create your own greeting or combination of greetings.

BLACKBOARD

Nice to meet you.
Glad to meet you.
I'm pleased to know you.
How's it going?
Hi. What's up?

Group Activity

<u>Leader:</u> Have students get together in pairs, or in groups of three.

Discuss these greetings and decide which ones you like, or think of some new ones. You'll have five minutes to do this.

<u>Leader:</u> When students are finished discussing greetings model an appropriate introduction, first to the other leader, then to one of the students.

Group Activity:

Practice introducing yourself to the person next to you. Pretend you don't know the person. Remember to follow these guidelines. (point to board)

<u>Leader:</u> Let students interact for up to the last 5 minutes of the session. If students finish early answer questions or solicit comments on the exercise.

Remember to work on your Goal for this session (start 1 conversation) and we will be checking with you in our next meeting to see how you are doing?

SESSION 4

MOOD MONITORING

> Before we get started today, we are going to pass out
> the "Feeling Check List" and have you rate your mood
> for the day. Fill in your mood rating on the line for
> Friday #3, Remember that the scale is from 1 to 7 with
> 1 being feeling really lousy and 7 feeling on top of
> the world.

<u>Leader:</u> pass out sheets and have students rate their mood
for the day.

> When you have finished look at day 1 and 2's rating.
> Did your mood change from last Wednesday, or did you
> stay about the same? (Allow children to respond or talk
> about their ratings)

REVIEW

> We have been learning a bunch of new skills and
> practicing them here in this class and in between our
> meetings. We've worked on friendly skills and positive
> thinking. Have you all been using these skills even
> though they are not the current goal you're working on?
> (Allow students to respond. Review the skills if
> necessary by listing them on the board or by referring
> to the goal chart.)

> Who remembers the goal we've been working on since last
> Wednesday (our 3rd goal)?   Answer--start one
> conversation.

> How did you all do with your goal for the last session?

> Tell me about some of the times you were able to start
> a conversation.

> Were you able to start more than one conversation?

> Well, we brought another reward for those of you who
> worked on your third goal of "starting one
> conversation".

Do any of you have any questions about what we have discussed so far?

In our first session we talked about being in control of our lives and making changes. Feeling in control and making positive changes can help us to feel better about ourselves and have a more positive mood. One of the purposes in this course is to improve the way we feel. Today, we're going to discuss how we can use information about ourselves to decide which changes will help the most, and then we'll consider some ways to follow through and make those changes.

The rule for this session is that YOU can learn how to change the way you are or learn to change your actions and behavior. Learning to change is a SKILL you can improve with practice.

There are 3 critical ingredients for learning to change:

1. RECOGNIZING THAT YOU CAN LEARN HOW TO CHANGE. Seeing a behavior that bothers you or you would like to see different.

2. BELIEVING THAT YOU CAN CHANGE. It's important to have confidence in your ability to change. Do you believe that you can change?

3. DEVELOPING A PLAN FOR CHANGE. This is what we're going to do today.

<div align="center">

BLACKBOARD
1. Recognizing
2. Believing
3. Planning

</div>

We are going to start right here today (point to #3) by developing a plan for change. We are going to talk about changing some of our ACTIONS.

Do you remember during the second session when we talked about depression influencing our thoughts, feelings and actions?

Leader: Draw the following diagram on the board and explain the each part. Answer any remaining questions about the diagram.

BLACKBOARD

Feelings

Actions   Thoughts

We talked about how when some people feel sad they try to start up here by changing their feelings, but the easiest places to start were with the THOUGHTS AND ACTIONS. About a week ago we worked on changing our thoughts. Now today we are going to develop a plan to change some of our actions/behavior.

Leader: point to the appropriate parts of the diagram as you explain. If there are questions about the diagram briefly review.

Let's start out by talking about some fun activities that have been found to be especially important in helping people deal with feelings like sadness. These are called MOOD-RELATED ACTIVITIES. There are 2 types of mood-related activities that are particularly effective in helping people to feel better when they have been feeling down. They are PLEASANT ACTIVITIES-time spent with other people that is positive, pleasurable and fun, and SUCCESS ACTIVITIES-

experiences that make us feel competent and good about ourself (the way we feel when we have done a good job on something).

<div align="center">BLACKBOARD</div>
1. PLEASANT ACTIVITIES
2. SUCCESS ACTIVITIES

What are some examples of Pleasant Activities? (allow brief responses because you'll go back to more examples below)

What are some examples of Success Activities? (allow brief responses because you'll go back to more examples below)

It's important to remember that when we do fun things we are more likely to feel better. When we feel sad or down, we are less likely to do some of these pleasant activities. Sometimes, the pleasant activities we would like to do are not in our control, such as those we have to ask our parents to do, or we need someone's help to do them (i.e., transportation).

What are some examples of activities that are within your control-- things that you can do when you are feeling sad and you don't need someone's help with?

Leader: Allow all students to respond. Encourage examples that can be done at home etc. (ride bike, play video games, talk to friend, play with brothers/sisters or friends, watch a video/T.V. etc.) Avoid activities such as going to movies, amusement parks, etc. Want to encourage activities that the child can engage in at will and not be dependent on transportation, money etc.

Increasing Pleasant Activities:

We are now going to think of some ways we can increase our activities. Probably the simplest approach would

be to try to do pleasant activities more often. But
sometimes that's not that easy. There might be a
PATTERN in your life that will make it difficult for
you to increase these activities, unless we come up
with some ideas for making it easier.

For example, if pleasant SOCIAL ACTIVITIES would make
you feel happiest, but you never do anything with
people except go to school that could be hard because
when you are in class you don't get to talk to your
friends very much. Therefore, school is not always the
best place to increase your pleasant activities. One
way to improve the situation would be for you to set a
goal to join a club. The club could be something like
scouts, sports, church clubs, or some other club that
would give you an opportunity to be with other people
in a casual situation.

If you think that SUCCESS ACTIVITIES would make you
feel happiest, but there aren't enough things that you
feel you do well, then you might need to SET A GOAL TO
LEARN HOW TO DO SOMETHING BETTER. This may involve
taking lessons, or joining a hobby group where you
could learn a new skill. What are some examples of
hobbies that you could take classes or lessons for?

Leader: elicit examples and provide additional ones if
necessary (musical instruments, karate, gymnastics, other
sports, crafts, art, etc.)

All of these things we've been talking about
[increasing our activities] are all ACTIONS. Actions
are one of the easiest things to do when you are
starting to feel sad or negative and can help to change
your mood. Therefore, the goal for this session
(Session 4) will be to increase your Pleasant
Activities, try to engage in a pleasant activity one
time or more.

Group Activity: (Leader assigns pairs)

> Right now we are going to split into partners and try to come up with a lot of different ideas for increasing our pleasant activities. I want you to think about activities that are in your control. Remember to listen to your partner's ideas so that each of you has EQUAL TIME. As you talk about all of the different activities decide which one that you want to increase over the next few days. This activity should be one activity that you enjoy and is in your control (you don't have to ask for a ride, money, etc.).

Leader: Allow students approximately 5-10 minutes to discuss depending upon the amount of time remaining in the session and the activity level of the classroom.

> Did you all come up with some fun activities to try over the next few days. Remember that our goal for this session is to take one of those activities and do it once before Friday. We will be asking you on Friday about your activity and whether you were able to meet the goal of engaging in your pleasant activity one time.

SESSION 5

Mood Monitoring

Before we get started today, we are going to pass out the "Feeling Check List" and have you rate your mood for the day. Today is the fourth session so rate your current feelings on the line that says 4-Wednesday. Remember that the scale is from 1 to 7 with 1 being feeling really lousy or negative and 7 feeling on top of the world.

Leader: pass out sheets and have students rate their mood for the day.

When you have finished look at the other ratings. Has your mood been staying the same or changing a lot. (Allow children to respond or talk about their ratings)

REVIEW

Last session we spent a lot of time talking about Activities and how they can help us to feel better when we are feeling down in the dumps. Do you remember what the 2 different kinds of activities are? (Allow students to respond, and briefly review each of the activities).

<div align="center">

BLACKBOARD
1. PLEASANT ACTIVITIES
2. SUCCESS ACTIVITIES

</div>

Pleasant activities involves things that are positive, pleasurable and fun, and Success activities- experiences that make us feel competent and good about ourself (the way we feel when we have done a good job on something).

Who remembers the goal we've been working on since last Wednesday (our 4th goal)?   Answer--engage in 1+ pleasant activity.

How did all of you do with your goal for the last session?

Tell me about some of the times you were able to do a pleasant activity.

Were you able to engage in activity when you were feeling kinda down? Did the activity help you to feel better?

Leader: allow students to discuss their activities, reinforce their participation, while pointing out the activities which were success or pleasurable activities. Also comment on those activities which are typically not in the child's control if they mention any. For example, respond by saying something to the effect of "that sounds fun, but you may not always be able to do_____ because your mom may not be able to drive you" etc.

Well, we brought another reward for those of you who worked on your 4th goal.

Do any of you have any questions about what we have discussed so far?

This triangle is something that should start to look pretty familiar to you. We've been working quite a bit with this. We've talked about how sad and negative feelings can influence our thoughts, feelings, and actions? Remember that we emphasized how the easiest parts of the triangle to change are the THOUGHTS and ACTIONS.

Leader: Draw the following diagram on the board and explain the each part. Answer any remaining questions about the diagram.

BLACKBOARD

Feelings

Actions   Thoughts

**Last time we worked on changing our ACTIONS by
increasing pleasant activities. Now we're going to go
back to Thoughts again and look at some ways we can
change our THINKING. When people are down, they tend
to have more negative thoughts and fewer positive
thoughts.**

Do you believe that you can control your thinking?

(if answer is NO: We often believe that we can't
control our thoughts, but it is possible. We'll be learning
some techniques to help us do this during this session and
the next one.)

(if answer is YES: Ask students to suggest some
specific techniques. Be brief in collecting answers.
Confirm that yes, it is possible to control our thinking.
We're going to learn several ways to do this).

Leader: Have students WORRY COVERTLY (to themselves). After
about 20 seconds, ask them to stop.

**I'd like you to close your eyes and think about
something you have recently been worried about-- maybe
a test or a bad grade you got, or someone who is mad at
you etc.** (20 sec.)

Leader: Now have them THINK POSITIVE THOUGHTS for 30 seconds

**Now I want you think about some positive things such as
your favorite place, or think positive things about
themselves.**

Leader: Provide some examples of positive thoughts.
Afterwards, briefly ask them what they experienced.

**What was that like for you? Did you notice any
differences?**

How did your mood change?

Point out that they have just controlled their thinking.

Before we can control our thoughts, we must become aware of them. In particular, we need to know which negative thoughts we have most often. Everyone has negative thoughts sometimes, and there are good reasons to have them every now and then. But NEGATIVE THOUGHTS CAN BECOME A PROBLEM IF THEY OCCUR TOO MUCH because they make us feel sad or down. The best way to work on negative thoughts is to identify the ones that you have most often.

When we become aware of our thoughts, we should notice whether we're thinking more positive thoughts or more negative thoughts. As a general rule of thumb, we should have at least TWICE AS MANY POSITIVE THOUGHTS AS NEGATIVE THOUGHTS (although this can vary somewhat from one person to the next). But if you think that you have a lot more negative thoughts, then this is something you might want to change and we are going to practice some ways to do this.

I'm going to list some examples of both positive and negative thoughts on the board and you start thinking about some additional thoughts to add to the list. These can be either negative or good thoughts that you have had yourself.

BLACKBOARD

Negative	Positive
Nobody loves me.	I'm good at math.
I am ugly.	I'm a good listener.
I'm not very smart.	I'm pretty lucky.
I will never do well at...	People Like me.

Leader: try and write as many of the student's responses on the board as is possible. Allow approximately 5 minutes discussion.

Now let's talk about some things we can do to erase negative thoughts. Here are 3 ways we might try to stop or change negative thoughts.

                        BLACKBOARD
         1. Thought stopping.
         2. The rubber band technique
         3. Set aside some "worry time."

Leader: go through each of these very slowly or twice if necessary until it appears the students have a grasp on what each of the techniques are about, enough so that they can pick one to use over the next few days.

THOUGHT STOPPING. When you're alone and catch yourself thinking negatively, yell STOP as loud as you can. Then say, "I'm not going to think about that any more." Gradually change from yelling out loud to thinking "Stop" to yourself. Then you can use the technique in front of others. This wouldn't be a technique to try in school until you've got to the point of thinking "Stop". We wouldn't want to be yelling "Stop" in a place where it may bother someone else.

THE RUBBER BAND TECHNIQUE. Wear a rubber band on your wrist and snap it every time you catch yourself thinking negatively. This will help to prevent negative thoughts.

SET ASIDE SOME WORRY TIME. If you need to think about certain negative things, then schedule a time for it once each week. Make an appointment with yourself for worrying; 15 minutes should be plenty. Only allow yourself to worry about negative things during that period of time. When you worry, don't do anything else- don't talk, eat, drink, work, or play. Save up your worries during the rest of the week, and only

worry about them during the scheduled time. This is like the exercise we tried earlier, where you sit and worry quietly to yourself.

Does anyone have any questions about these 3 techniques?

Activity: (If time permits) Have students take out a piece of their own paper and try and list one negative thought they want to work on. Once most have identified one thought, have them write down the technique they would like to use over the next few days.

Over the next week I want to pay attention to the negative thoughts you may have. When you catch yourself thinking negatively, choose one of these techniques that you would like to use to try to stop negative thinking. If you have a bunch of different negative thoughts, try and focus on the one that bothers you the most or (the one you wrote down). I know this can be very difficult, but give it a try anyway. The goal for this session will be to "erase negative thoughts" by using one of these techniques. I'll write this on your goal chart for session 5. We'll be checking next Wednesday to see how you did with your goal.   Good Luck!

SESSION 6

Mood Monitoring

> Before we get started today, we are going to pass out
> the "Feeling Check List" and have you rate your mood
> for the day. Today's rating will go in the box for 5-
> Friday, so rate your current feelings on that line.
> Remember that the scale is from 1 to 7 with 1 being
> feeling really lousy or negative and 7 feeling on top
> of the world.

Leader: pass out sheets and have students rate their mood
for the day.

> When you have finished look at the other ratings. Has
> your mood been staying the same or changing a lot.
> (Allow children to respond or talk about their ratings)

REVIEW

> In the past couple sessions we've been talking a lot
> about different kinds of ACTIONS that we can do to help
> us feel better when we've feel kinda down. Who
> remembers the 2 types of activities that we talked
> about? (Pleasant & Success Activities).

> We just talked about doing these types of activities
> when you are currently feeling sad or down and they may
> help you to feel better. But, do you think that if you
> did more enjoyable things more often, that it may keep
> you from getting sad in the first place? Do you think
> these activities will help you?

Leader: encourage discussion from students.

> In our last session we talked quite a bit about how our
> negative feelings can affect us. Do you remember what
> the three techniques or ways to help us erase negative
> thoughts were?

1) Thought stopping, 2) The rubber band technique
3) Set aside some "worry time." [briefly review each one if
necessary, i.e., if students don't respond by explaining
what they are.]

Do you think these things really work? (allow responses)

Did you all get a chance to try one of these techniques on a negative thought you were having?

Once again we brought a small treat for those of you who worked on their goals.

Last time we left off by talking about negative thoughts and how they can influence our mood. When we think negatively about ourselves, we often think negatively about others. Do you find that when you are in a bad mood and thinking negative thoughts, that you tend to think negative thoughts about others? (Allow students to respond)

It's good practice to think positively about others and about ourselves because we all know how it feels when other kids say negative things to us or treat us in a mean way.

Group Activity:

Can you all close your eyes and think back to a time when someone treated you in a negative or mean way? Like a time when someone teased or made fun of you, or excluded you from a game? Do you remember how that felt inside? (Pause for approximately 10-15 seconds and let the students experience this feeling; encourage them to keep their eyes shut).

Now I want you to keep your eyes closed and think back to a time when someone treated you in a positive way, (i.e., when a friend asked you join their team or invited you over for a party). Think about how that felt inside. (Pause for approximately 10-15 seconds and let the students experience this feeling; encourage them to keep their eyes shut).

Now open your eyes. Does anyone want to share some of
the feelings you experienced, either positive or
negative? (Do not encourage students to respond if no
one feels comfortable in doing so. This was a covert
exercise.

One of the rules for this session is to think and ACT
positive.

Group Activity:

Now I want you to take a few minutes to write one or
two POSITIVE STATEMENTS about the person sitting next
to you. Try to focus on things about their personality
or their behavior/actions. Try not to write things
about their appearance or their belongings, such as you
have a nice shirt on today. Write these statements
down on a piece of scratch paper. When everyone is
finished you will read your positive statements to your
classmate, you won't have to read them to the entire
class.

Remember to try to focus more on their personality than
on the way they look. For example, If I say "I think
you are really friendly, you always ask me to play
soccer during recess",--this is a positive statement
about his personality (friendly) and about his actions
(inviting others to play).

Leader: walk around the room and assist those students who
are having trouble by whispering some hints (friendly, nice,
outgoing, happy, smiling, fun, easy- going, etc.). Allow
approximately 5 minutes for writing.

Now take turns reading your positive statements to your
partners. When you hear the other student say
something positive about you, write in on the top of
your own scratch paper.

You can look at your own positive statement as often as you like, especially when you are feeling down and not very good about yourself. Sometimes we use negative thoughts about ourself and it is hard to feel good when we say mean things to ourself all the time.

Leader: Allow ample time for children to read statements to each other and write their positive statements on their papers.

The goal for this session will be to read your positive statement twice before Friday. If you can remember the positive statement your teammate said about you, you can change your goal to just thinking about your positive statement twice before Friday (instead of reading). We will check with you on Friday to see how you did on your goal.

Leader: Write in the goal and answer any other questions. Transition to the next topic.

Habits that Turn People Off:

O.K., we are going to talk about something different now. I want you to answer this question to yourself. Do you generally feel that other children like you? If not, then it is possible that you may do things that turn other people off.

Here is an example of someone who turns people off.

Leader: Illustrate how Gloria acts as you narrate the example.

Gloria smiles very little, and she looks at the floor or at her lap instead of at you. She usually sits slouched over, rather than looking interested and alert. She speaks slowly and softly, which makes it difficult to listen to her for long. She frequently plays with a paper clip or rubs her hand on her leg while you are talking to her. She often fails to show

interest in people and gives the impression that she would rather be left alone. All of this makes you feel as if you don't want to be around Gloria. You would rather be with someone who enjoys spending time with you.

Here are some other examples of irritating and distracting habits: ignoring others, slouching in your chair, crying often, failing to make eye contact, pulling your hair, cracking your knuckles, criticizing or being mean to others. Can you think of any other bad habits.

All of us have some bad habits, but the important thing to remember is that you can change them or learn more positive habits. Between now and our next session, think about any of the habits that you might have, that you would like to change.

Remember that the goal for this session is to read or think about the positive statement your partner said about you.

SESSION 7

Mood Monitoring

Before we get started today, we are going to pass out the "Feeling Check List" and have you rate your mood for the day. Today's rating will go in the box for 6-Wed., so rate your current feelings on that line. Remember that the scale is from 1 to 7 with 1 being feeling really lousy or negative and 7 feeling on top of the world.

Leader: pass out sheets and have students rate their mood for the day.

When you have finished look at the other ratings. Has your mood been staying the same or changing a lot. (Allow children to respond or talk about their ratings)

REVIEW

In the past couple sessions we've been talking a lot about negative thoughts and how they can affect us, but during the last session we talked about negative ACTIONS and how we feel when someone treats us in a mean way and how we feel when someone treats us in a positive way. Remember that we emphasized the positive thoughts and actions.

Who remembers the goal we been working on since the last session? (read/think about positive self-statements)

Leader: encourage discussion and responses from students

Yes, last time we asked you to write 2 positive statements about one of your classmates, to read the statements to each other, then to write down the positive statement(s) that the other person said about you. The goal was to read or think about them twice before our next meeting.

Activity:

> I want you all to close your eyes now and think about the positive things your partner said about you. (allow approximately 5 seconds)

> Right now you all just took some time to work on your goal in here. How about the during the past few days, did you read/think about your positive statements? Is it easy or hard for you to think positive things about yourself?

> Once again we brought a small treat for those of you who worked on your goals.

Throughout this course we have been learning skills and talking about ways to control our moods. Most of the skills we have focused on are those you can use when you are with your friends or alone, but you also have to be around adults such as teachers and parents. Sometimes we get in trouble with adults because of our behavior, so today we are going to practice some skills that we need to use around adults. These skills can help us get along better with adults and may help us to have more positive thoughts and moods.

The first skill is "Following Instructions". Now you may already be pretty good at this, but listening and following directions is one area that we can all use some more practice in.

Following directions is important because it helps us to learn about things (i.e., like in school when we listen to the teacher we learn more things, we can also learn a new game by following instructions). Following instructions can also help us to stay safe. For example, following our parents' instructions when we are helping out in the kitchen may prevent us from getting hurt or burned.

Can you think of any other times when following instructions would be a good thing for us to do? (other examples: helps us get along with adults; we seem helpful and cooperative etc.)

BLACKBOARD

1. <u>Look</u> at the person and <u>listen</u> to what they
   are saying.
2. Say <u>OK</u> or nod
3. <u>Do it</u> immediately (within 5 seconds)
4. <u>Check back</u>

Here are the four steps to "following instructions". (read through steps) **Step #4 "checking back" can be just looking at the person to see if you followed the direction correctly, or asking them if that was correct etc. We'll explain this better when we go through some examples. Now we are going to demonstrate how to follow instructions using these steps.**

<u>Leader:</u> Model the following steps. Group Leader-1 make a simple request (Monique will you <u>please</u> throw this in the garbage can) and Group Leader-2 follow the steps, overemphasizing each step. After leader-2 checks back, leader 1 comments by saying "thank you".

This time we will do this same direction but in a more normal way, like you might usually do it.

Repeat the same instruction in a normal fashion but still using the steps outlined on the board.

You can see that after you follow through on a direction and check back, the other person will usually respond by saying "thank you" or nodding their head, which says that your response was successful.

Now each of you can practice these steps for following instructions. Look at each of the steps and study them carefully (allow apprx. 15-30 seconds).

Activity:
Now I want each of you to pick up your pencil and write your name somewhere on a piece of scratch paper.

Leader: Go through each of the steps on the board and talk about things some students may have forgotten such as acknowledging they would comply with the request by nodding or saying "OK". Leader, also remember to acknowledge the success of the direction by saying "good, good job, or nodding approval.

Let's try another one. This time I would like you to please pass your paper to the person sitting next to you.

Leader: again assess whether students are including each of the steps.

Other examples (time permitting or if it appears that the students are not using all of the steps)
*could you please write your favorite color in the corner of your paper.
*Will you please turn to one of your classmates and ask them their favorite color.

You can see that each of these examples are pretty simple, but sometimes following instructions can be very difficult and you really need to listen carefully and follow each of these steps carefully.

Did any of you notice one word that was in each of the requests or directions we gave you? (allow students to respond-- "please"). Do you like it when people use the word "please" when they give you instructions to follow? (Allow responses) When someone asks us to do something in a nice way, we are more likely to follow through and do it. No one likes to be asked in a mean way or to be told to do something in a negative way.

It's important to say words like please and thank you when we ask people to do something. This is something you can remember to do when you give directions or make requests. Today we focused on <u>following</u> the instructions, but there will be times when you need to ask someone to do something and saying words like "please and thank you" makes that person want to do things with and for you.

Activity:

Right now we would like you to please think of a pretend request or instruction for one of your classmates to follow. Now this should be something that for now is just pretend, your partner does not have to follow directions. The purpose is for you to practice how to make a request or give instructions in a pleasant way. Remember to use the words we talked about. Turn to your partner now and take turns stating your instructions. (allow approximately 10-15 seconds)

Today we worked a lot on following instructions and this will also be our goal until the next session because following instructions is very important and helps us in a number of ways. The goal for this session will be to practice following directions. Write these steps on your paper so you can learn them and then practice at home when your parents or teacher ask you to follow an instruction.

<u>SESSION 8</u>

Mood Monitoring

> Before we get started today, we are going to pass out
> the "Feeling Check List" and have you rate your mood
> for the day. Today is our very last day to be here so
> your rating will go in the box for 7-Fri. Go ahead and
> rate your current feelings on that line. Remember that
> the scale is from 1 to 7 with 1 being feeling really
> lousy or negative and 7 feeling on top of the world.

Leader: pass out sheets and have students rate their mood
for the day.

> When you have finished look at all the other ratings.
> Did your ratings change a lot throughout the whole
> course or did they stay about the same? (Allow children
> to respond or talk about their ratings)

REVIEW

> Throughout all of our sessions we've worked on changing
> our negative thoughts, feelings, and actions. We have
> spent quite a bit of time working on goals related to
> things we can work on with our friends, peers, and
> ourselves. For example: (read through the first six
> goals while reinforcing the class for their hard work
> on each of the goals).

> During our last session we worked on a goal that we can
> use when we deal with adults such as parents and
> teachers. Who remembers the goal we been working on
> since the last session? (practice following
> directions) Tell me about some of the times you were
> able to use the 4 steps to follow a direction or
> instruction from an adult.

Leader: encourage discussion and responses from students

> Was it hard to remember each of the steps?

Did any adults notice any difference in your behavior
or say anything about your following instructions?

Once again we brought a small treat for those of you
who worked on your goals.

Today we are going to learn some more skills that we
can use when we interact with adults.

The first skill is one that we call "Accepting 'No' for
an Answer". Now you may already be pretty good at
this, but this skill is one area that we can all use
some more practice in. I'm sure we have all heard at
one time or another from our parents or teachers "you
need to learn to accept no for an answer"!! I know that
I heard this when I was your age and even now it is
sometimes hard for me to accept "no".

Activity:

I would like you to all close your eyes and try and
think of a time when you had problems accepting "no"
for an answer. You won't have to share this example
with the class.

Leader: allow approximately 15-20 seconds for children to
covertly think of an example. Do not prompt children to
share an example.

Did you all come up with time when it was hard for you
to accept no for an answer? You do not have to share
this experience, just keep it in your mind.

Sometimes learning to accept the answer "no" can be
hard to do, especially when we really want to hear
"yes". However, when we don't listen to an answer from
an adult the first time they may then not be as likely
to say "Yes" at another time or they may get angry at
us.

This can be true with our friends too. When you ask
someone to play a game and they say "no I don't want to

play". They may get angry or not want to play with you in the future if they think you don't listen to them or can not accept their answer.

Therefore, accepting no for an answer the first time is important because it helps us to get along better with others.

Well, we are now going to teach you some steps which can help you in the future to accept no and feel O.K. about it.

BLACKBOARD

1. <u>Look</u> at the person
2. Say <u>OK</u>
3. <u>No arguing</u> or complaining
4. If you don't understand why, <u>ask</u> calmly for a <u>reason</u>
5. If you disagree or have a complaint, <u>discuss it later</u>

Here are the five steps to "accepting no for an answer". (read through steps) **Now we are going to demonstrate how to follow these steps when you get an answer from another person.**

<u>Leader:</u> Model the following steps.
Child-- "Monique can I please spend the night at Joe's house?"
Monique-- sorry, not tonight.
Child-- O.K. (look disappointed), but why, it isn't a school night (ask calmly, not whining)
Monique-- Well your parents asked me to stay with you this afternoon and you'll have to ask them when they get home. I'm not allowed to give you permission to leave the yard.
Child-- Well, I guess I'll have to talk to my mom about it when she gets home.

You see how Chris followed the steps. He calmly asked
for a reason and decided to wait and discuss it later
when his mom was home. Even though he disagreed with
the answer and was pretty sad, he did not whine or
complain.

Do you think you can practice these steps for accepting
no? Look at each of the steps and study them carefully
(allow apprx. 15-30 seconds).

Activity:

Now I want you pair up with a person sitting next you.
You will each get a chance to be the adult and the
person who practices "accepting no for an answer".
* now each of you pair up
* decide who will be the adult first and who will practice
first, remember each of you will get to do both roles.
* the person who is practicing the skill will ask the adult
if he/she can do a certain activity.
* the adult says "no" and the other person practices these
steps.
* Remember that it's O.K. to feel disappointed about the
answer, but try not to whine or complain.
* when you are done then switch roles and go through the
skill again.

Leader: Allow enough time for children to briefly practice
both roles.

Was it easy for you to hear the word "no" and be O.K.
with that? (allow feedback and response) It was
probably a little easier in here, but may be more
difficult for you to do when someone tells you no about
something you really want to do or says no when you
really want them to buy you something in a store, like
a really neat game, toy, etc.

Practicing these "accepting no" steps will be your goal to work on in the next week. We won't be here next week to check on the progress you made with your goal, but you can keep track of your success on your own. We will write this goal on your goal chart, along with the steps to "accepting no". You can write these steps on your own piece of paper so that you can read and practice them long after your teacher has taken your goal chart down.

Does anyone have any questions about your goal for the next week?

CLOSING:

Each one of you has put a lot of work into practicing new skills and trying NEW WAYS OF THINKING AND BEHAVING during this time we have been coming to visit you. I hope that you can remember the things we've talked about and practiced and that you have found something that will help you gain control over your moods, thoughts, and feelings.

From time to time, you all will experience everyday problems and hassles. This is normal. It's important to build the skills and techniques you have learned over the course into your daily life, in order to prevent long lasting sad or negative feelings. It's much easier to PREVENT problems than it is to get rid of them once they get started. Trying to help you prevent sad and negative feelings is what we've been doing in this class.

You've all worked very hard so far, so keep up the practice and good work!!

Leader: say your goodbyes

Appendix C:

Questionnaires

Questionnaire 1

1. Who do you believe controls your life?

    a. you
    b. your parents
    c. other adults

2. Looking at a person's eyes when you are talking to them is a way to appear friendly.

        TRUE   FALSE

3. When people feel bad they usually try to change their _____ first, which are the hardest to change.

    a. feelings
    b. thoughts
    c. actions

4. Our feelings, actions, and thoughts are all connected and influence each other.

        TRUE   FALSE

5. It's easier to change our behavior and thoughts than it is to change our feelings.

        TRUE   FALSE

6. _____ is an example of a social skill.

    a. starting a conversation
    b. solving problems without fighting
    c. introducing yourself
    d. all of the above
    e. none of the above

7. Looking at your shoes all the time tells others that you are not interested in starting conversations.

        TRUE   FALSE

8. In talking with another person what is a good rule to remember?

    a. talk about yourself a lot
    b. equal time
    c. let the other person pick the topic

9. Pleasant or success activities often help us feel better when we feel down.

        TRUE   FALSE

10. Is it possible for people to change or control their thinking?

        YES   NO

11. The rubber-band technique can be one method for helping you_____.

    a. erase negative thoughts
    b. sort out your worries of the day
    c. hold your newspaper together

12. Do you believe that thinking or reading positive statements about yourself can help you to feel better and prevent negative thoughts?

        YES   NO

13. Following instructions can help us to get along better with _____.

    a. adults only
    b. adults and other children
    c. children only

14. Not arguing or complaining is part of accepting "no" for an answer.

        TRUE   FALSE

15. When we accept "no" for an answer, it is still OK to feel sad about it, then ask for a reason later on.

        TRUE   FALSE

16. What do you have to do to learn a new skill?

17. An important skill to remember when dealing with parents is_____.

Questionnaire 2

1. How helpful do you think this course was to you?

        1   2   3   4   5   6   7
    not helpful   very helpful

2. How much do you believe this class could help other
    kids?

        1   2   3   4   5   6   7
    not helpful   very helpful

3. Please write down the one thing you learned from these
    classes that will be most helpful to you.

4. How often have you used any of the skills taught during
    these classes?

        1   2   3   4   5   6   7
    not helpful   very helpful

    List some of the skills:

5. How often do you think you will use some of these
    skills in the future?

        1   2   3   4   5   6   7
    not helpful   very helpful

6.   What do you think was the <u>best</u> part of the class?

7.   What part didn't you like?

OTHER COMMENTS

Appendix D: Interaction Between Pretest

and Treatment Conditions

Table D-1

Interaction Between Pretest and Treatment Conditions

Source of Variation	SS	DF	MS	F	Sig of F
RCDS					
Error	12654.89	96	131.82		
Tx condition	26.08	1	26.08	.20	.657
Pretest	101.43	1	101.43	.77	.383
Tx condition by pretest	23.47	1	23.47	.18	.674
PNID (depression)					
Error	68.44	96	.71		
Tx condition	.32	1	.32	.45	.503
Pretest	.04	1	.04	.05	.819
Tx condition by pretest	.10	1	.10	.14	.713
SSRS (assertion)					
Error	664.18	96	6.92		
Tx condition	35.22	1	34.22	5.09	.026
Pretest	.82	1	.82	.12	.732
Tx condition by pretest	2.45	1	2.45	.35	.553
SSRS (cooperation)					
Error	657.80	96	6.85		
Tx condition	20.05	1	20.05	2.93	.090
Pretest	6.85	1	6.85	1.00	.320
Tx condition by pretest	14.40	1	14.40	2.10	.150
SSRS (empathy)					
Error	692.63	96	7.21		
Tx condition	.46	1	.46	.06	.801
Pretest	21.92	1	21.92	3.04	.085
Tx condition by pretest	8.49	1	8.49	1.18	.281
SSRS (self-control)					
Error	1148.38	96	11.96		
Tx condition	52.54	1	52.54	4.39	.039
Pretest	1.42	1	1.42	.12	.731
Tx condition by pretest	9.20	1	9.20	.77	.383

VITA

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ACADEMIC HISTORY

Ph.D.   Combined Clinical/Counseling/School Psychology
             (APA Approved Program)
             Utah State University, 1997

M.S.   Counseling Psychology
             Utah State University, 1996

B.S.   Psychology
             University of Utah, 1991

THESIS TITLE
Home Visiting for Children with Developmental Delays: An Empirical Evaluation

DISSERTATION TITLE
An Interpersonal and Cognitive-Behavioral Approach to Childhood Depression: A School-Based Primary Prevention Study

PROFESSIONAL AFFILIATIONS

American Psychological Association

Society of Behavioral Medicine

Western Psychological Association

PROFESSIONAL EXPERIENCE AND PRACTICA

9/96 - 8/97 Clinical Psychology Internship, VA Medical Center (APA Approved), Salt Lake City, Utah

<u>Substance Abuse Rotation</u> (both inpatient and outpatient services).
Responsibilities included assessment, individual and group psychotherapy, providing treatment for clients with dual diagnosis, teaching psychoeducational classes, and case-management. Supervisors: Warren Thorley, Ph.D., and Marie Bateman, Ph.D., Licensed Psychologists

<u>Inpatient Psychiatry Rotation</u>. Responsibilities included representing psychology on a multidisciplinary treatment team, assessment, individual therapy, co-leading daily group therapy, and teaching psychoeduational classes. Supervisor: Richard Weaver, PhD., Licensed Psychologist.

<u>Medical Psychology Consultation and Neuropsychology</u>. Assessment and treatment of a variety of psychosocial factors influencing medical conditions. Provided psychological consultations to several hospital departments. Performed cognitive, mood, neuropsychological, and personality assessments. Supervisors: Kay Koellner, PhD., and Tom Shenkenberg, Ph.D., Licensed Psychologists.

   Total Projected Supervised Hours: 2000

9/95 - 6/96 Clinical Psychology Therapist. Behavioral Health Unit, Logan Regional Hospital, Logan, Utah.

Half-time (20 hr/wk) position. Responsible for providing individual, marital, and family therapy for inpatient adolescents and adults experiencing acute and long-term behavioral, health, and/or psychological difficulties. Co-lead group therapy.

7/95 - 9/95 Inpatient Practicum. University of Utah Neuropsychiatric Institute, Salt Lake City, Utah.

Provided individual and family therapy for inpatient adolescents and adults experiencing a variety of psychological, emotional, and behavioral problems. Completed comprehensive psychological assessments and dictated reports.

Clinical Psychology Practicum. Utah State University Psychology Department Community Clinic, Logan, Utah.

Responsible for individual, couples, and family therapy for children, adolescents, and adults presenting with various psychological problems. Completed comprehensive psychological evaluations and reports. Conducted case presentations. Carried over clients during non-practicum quarters.

PROFESSIONAL EXPERIENCE (continued)

9/94 - 6/95 Counseling Psychology Practicum. Utah State University Counseling Center, Logan, Utah.
Responsibilities included providing individual, marital, and group therapy for college students presenting with a variety of behavioral and emotinal problems. Co-lead group therapy for 9 months. Completed intake interviews and reports. Crisis intervention coverage. Assisted in Date Rape Prevention program.

9/93 - 6/94 School Psychology Practicum. Clinical Services Program of the Division of Services, Center for Persons with Disabilities, Logan, Utah.
Completed comprehensive evaluations for children, adolescents, and adults with a variety of disabilities. Primarily responsible for performing comprehensive intake interviews, administering psychological and educational assessments, writing reports and recommendations based on results of evaluations, and case presentations at weekly staff meeting. Completed follow-up therapy for children, adolescents, and family when needed. Co-taught child behavior management classes for parents.

RESEARCH EXPERIENCE

9/94 - 6/95 Research Assistant, Utah State University.
Development of a depression-oriented treatment curriculum for children in a school setting. Assisted in conducting school-based interventions. Developed and revised grant and research proposals.

9/92 - 93 Research Assistant, Utah State University.
Assisted in the development of an assessment instrument to measure cruelty to animals as a correlate of future antisocial behavior in children and adolescents.

TEACHING EXPERIENCE

1993 - 1994 Teaching Assistant, Psychology 101, General Psychology, Utah State University, Logan, Utah.
Responsible for preparing and presenting lectures for 3-4 weeks each quarter, developing tests,and grading papers.

PROFESSIONAL PRESENTATIONS AND PUBLICATIONS

Ascione, F. R., Thompson, T. M., & Black, T. (in press). Childhood cruelty to animals: Assessing cruelty dimensions and motivations. Anthrozoös.

Ascione, F. R., Thompson, T. M., & Black, T. (September, 1995). Childhood cruelty to animals: Assessing cruelty dimensions and motivations. Paper presented at the 7th annual International Conference on Human-Animal Interactions, Geneva, Switzerland.

Ascione, F. R., Thompson, T. M., & Black, T. (April, 1993). Children and adolescents who are cruel to animals: An overlooked form of juvenile violence. Presentation at the Utah Children Advocacy Conference, Salt Lake City.

Black, T. L., & Crowley, S. L. (October, 1996). A meta-analytic review of child and adolescent depression interventions. Paper presented at the Second Kansas Conference on Clinical Child Psychology, Lawrence, Kansas.

Black, T., & Roberts, R. N. (March, 1995). Home visiting for children with developmental delays: An empirical evaluation. Poster presented at the 1995 WPC Annual Meeting, Los Angeles, California.

Black, T., & Roberts, R. N. (April, 1995). Home visiting: A meta-analysis of programs targeting children with developmental delays. Poster presented at the 1995 Fifth Florida Conference on Child Health Psychology, Gainesville, Florida.

Crowley, S. L., & Black, T. L. (October, 1996). Depression in school-aged children: A preliminary report of a primary prevention strategy. Paper presented at the Second Kansas Conference on Clinical Child Psychology, Lawrence, Kansas.

Ellington, L., Black, T., & Wiebe, D. (1991). Another look at unrealistic optimism: "Illusion". Presentation at the Thirteenth Annual Meeting of the Society of Behavioral Medicine.

ACADEMIC AWARDS AND HONORS

Honors at Entrance Scholarship; College of Eastern Utah

Junior College Transfer Award; University of Utah

Psychology Departmental Scholarship; University of Utah

ACADEMIC AWARDS AND HONORS (continued)

Nominated to "National Deans List"

Member of PSI CHI; psychology honor society

Member of Golden Key National Honor Society

Dean's List; University of Utah and Utah State University

REFERENCES

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