

## **A Leadership Training Group for at Risk Fifth & Seventh Graders: Results from A Brief Strength-Based Group Program**

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### **Abstract:**

An increasing number of youth are exhibiting social, emotional, and behavioral problems that hinder their ability to function at grade level. Subsequently, school mental health services have not been able to address the need for services particularly among students who are minority and poor. A mixed methodology study was conducted to determine the treatment outcomes from a brief strength-based leadership training group for primarily students who are African American and poor. Pre–post scores on three scales and focus group data revealed significant positive changes in regard to internal areas of functioning and social skills, anger management skills, and school attitude. Gender and age significantly impacted outcomes.

**Keywords:** African American | at-risk youth | brief group treatment | elementary school | poor children | school-age children | school-based mental health | vulnerable youth group work

### **Article:**

An increasing number of school-age youth today are exhibiting social, emotional, and behavioral (SEB) problems that hinder their ability to handle the demands of the classroom and perform at grade level (Adelman & Taylor, 2012; Eklund & Dowdy, 2014). Approximately 20% of these youngsters have identified mental health problems whereas only 36% of these youth are receiving treatment (Lean & Colucci, 2010; Merikangas et al., 2011). Studies have found when SEB problems are left untreated youth are at greater risk for dropping out of school, being involved in the criminal justice system, and/or developing problems with substance abuse (Kauffman, Mock, & Simpson, 2007; Lane, Carter, Pierson, & Glaeser, 2006; Wang & Fredricks, 2014).

Fortunately, prevention and early intervention programs have shown great promise for addressing SEB problems before they become more serious (Jackson, Hodge, & Vaughn, 2010; Koffman et al., 2009). Research has shown that interventions in the middle school years are particularly well timed for preventing the progression of SEB (Clark, Flower, Walton, & Oakley, 2008). In addition, school-based health centers (SBHC) have been identified as key locations for providing accessible mental health services for many youth, particularly minority

and poor, who would otherwise not receive treatment (Bains & Diallo,2016; New Freedom Commission on Mental Health,2003).

A recent systematic review of studies on the effectiveness of SBHCs found that 30% of the total SBHC visits between 1990 and 2014 were related to mental health issues (Bains & Diallo,2016). These same researchers found that adolescents exhibiting high-risk behaviors (e.g., suicide, depression) were more likely to seek services at a SBHC possibly because it has less stigma attached to it. Moreover, Stone, Whitaker, Anyon, and Shields (2013) found that students' utilization of SBHCs were associated with school assets such as experiencing a caring relationship with an adult, receiving high expectations, and engaging meaningful participation in school activities. The present study was designed to help students who were young and at risk overcome their negative self-images and to engage them more fully in therapeutic services. Overcoming these two challenges was tested by examining the effects of a brief strengths-based leadership training group intervention with primarily African American and fifth and seventh graders who are low-income. To counter the negative self-attitude of risk students, the group intervention was presented as a leadership skills development group rather than a "problem intervention" group. We believed this approach would begin changing students' negative attitudes toward themselves even before the group began. Moreover, by focusing on leadership development, the targeted students' motivation to participate in a group would increase because the focus would be on their positive qualities or strengths rather than their problems. Specifically, the present study utilized a mixed-methods design to examine the effects of a leadership skills training group intervention for youth that focused on social skill development, positive school attitude, and anger management skills.

### School-based group interventions

Seminal research studies have documented the benefits of group treatment approaches that utilize developmentally appropriate goals and programming such as the support, acceptance, and safety created among peers within a group (Garland, Jones, & Kolodny,1973; Middleman,1968; Mishna, Kaiman, Little, & Tarshis,1994). Several more recent studies have documented the benefits of school-based group treatment interventions. For example, a targeted anger management group therapy program found that children felt accepted and perceived the group as a positive experience (Nickerson & Coleman,2006). Another study that provided a manualized life skills training group (i.e., Cognitive Behavior Therapy and solutions-focused framework) to primarily mothers who were Latino and adolescent showed improvement in adolescents' attendance and grades relative to the control group (Harris & Franklin,2009). Other studies have shown that group interventions promote positive outcomes such as improving youths' feelings of acceptance and belongingness, connectedness to school, and normalization of experiences (Drumm,2006).

Additional research has shown that school-based group treatment has improved children and adolescents' emotional and behavioral health. For example, Warner, Fisher, Shrout, Rathor, and Klein (2007) found that adolescents who participated in school-based Cognitive Behavior Therapy (CBT) program displayed clinically significant improvement in social anxiety symptoms relative to the control group who received social and academic skills training. In addition, a targeted group intervention involving children with serious emotional and behavioral issues reported that children who participated in the CBT school-based intervention had fewer

aggressive school incident reports and negative behaviors toward peers than the control group (Kellner, Bry, & Salvador, 2008).

In addition to improving emotional and behavioral health, studies have demonstrated that school-based group treatment promotes children and adolescents' competence such as social skills and emotion regulation. For example, a study of primarily White elementary and middle school students who were at risk for emotional and behavioral issues experienced improved emotion regulation abilities after participating in a school-based intervention (Bidgood, Wilkie, & Katchaluba, 2010). Another study of children identified with an emotional disturbance found participants displayed improved interpersonal relations, self-esteem, and self-reliance after participating in a CBT anger therapy group program (Nickerson & Coleman, 2006). Corkum, Corbin, and Pike (2010) also found that children who participated in a targeted group intervention for children with attention-deficit/hyperactivity disorder (ADHD) symptoms displayed improved social skills using teacher and parent report; however, no differences were found using youth self-report.

### Current study and research questions

Although there is a burgeoning literature on the benefits of child and adolescent group treatment, few studies have examined the effectiveness of a strengths-based leadership training group treatment program for youth who are minority and low income. The present study describes a leadership group intervention program provided through a SBHC. Additionally, the treatment outcomes of this group program were identified based on pre- post changes found on three standardized measures and focus group results. The study addressed three research questions: (1) What are the treatment outcomes for at risk youth who participate in a brief strength based leadership training group? (2) Does age of intervention affect the treatment outcomes of a brief strengths based leadership training group? And (3) Does gender affect the treatment outcomes of a brief strengths based leadership training group?

## **Method**

### Data collection characteristics and procedures

This Institutional Review Board (IRB) approved research study was conducted through the School Health Alliance (SHA) for Forsyth County in North Carolina (NC). The primary mission of the SHA is to increase students' ability to learn by improving the health and safety of students enrolled in the Winston-Salem/Forsyth County Schools (WS/FCS).

Students enrolled in either fifth or seventh grade from three SHA service sites (two elementary schools and one middle school with a school-based health and wellness center) participated in this study. Approximately 288 students from the two targeted schools had a current need for mental health services or are at risk for needing these services. During the 3-year period of the study, the participating elementary schools averaged 88% and 96% of their students, respectively, on free or reduced lunch with the middle school average at 93%.

### Participants

A total of 225 students from Grades 5 and 7 were recruited to participate in the 8-week school-based group therapy program intervention and an additional 100 fifth and seventh grade students were enrolled in the matched comparison group (students who received only pre- and postassessments but no group therapy intervention). Thus, a total of 325 students were enrolled in either the intervention or comparison group for this 3-year study (see Table 1 for student demographic information). Of the 225 students enrolled in the group therapy intervention, nine students dropped out of the study for various reasons (moved during the program,  $n = 8$ ; did not like the group,  $n = 1$ ). Of the 100 participants enrolled in the matched comparison group, five students left the study (moved,  $n = 4$ ; hospitalization,  $n = 1$ ). Therefore, a total of 311 students participated in either the group therapy intervention ( $n = 216$ ) or the matched comparison group ( $n = 95$ ).

The racial or ethnic breakdown for students in the treatment group included 2.5% ( $n = 5$ ) White, 13.9% ( $n = 30$ ) Hispanic, and 83.8% ( $n = 181$ ) African American. The breakdown for the matched comparison group was 3.2% ( $n = 3$ ) for White, 29.5% ( $n = 28$ ) Hispanic, and 67.4% ( $n = 64$ ) African American. Gender and grade-level data on students in the treatment and comparison groups are presented in Table 1.

Gender	Grade	Treatment group	Comparison group
		Percentage	Percentage
Males	5th	35.3 $n = 76$	28.4 $n = 27$
Males	7th	15.8 $n = 34$	13.7 $n = 13$
Females	5th	34.4 $n = 74$	45.3 $n = 43$
Females	7th	14.4 $n = 31$	12.6 $n = 12$
Total		100 $n = 215$	100 $n = 95$

Table 1. Sample demographics

## Procedure

After students were referred to a group, parents or legal guardians and youth provided consent and assent, respectively, to participate in the study prior to preassessment. Students and their homeroom teachers completed the assessment measures at pre- and posttest. The clinical cut-off (scores  $> 64$ ) on the Achenbach Teacher Report Form (TRF) or Youth-Self Report (YSR) was used to determine the need for more intensive mental health care or services (i.e., individual therapy or medication management). Specifically, students in either the intervention or comparison groups with scores at or above the clinical cut-off were provided with a referral for further mental health evaluation and treatment services. All completed assessments were reviewed by SHA mental health providers and individual clinical interviews were conducted with each student endorsing items that warranted further assessment and/or referral.

## Overview of school-based group intervention

Each intervention group, involving seven to nine students per group from the same grade level (fifth or seventh graders) and gender (all groups were single gender groups), were provided eight weekly 45-minute sessions that were planned and facilitated following the Dennison Group Practice Model (DGPM) (Dennison,1998,2008). The DGPM has been developed and refined for use with a wide variety of children and adolescents who are at risk in school settings across the country for the past 30 years. The DGPM combines Yalom's(1995) work on group process and therapeutic factors with the cognitive-behavioral group work model (Rose,1990). By combining these two latter approaches, this model places an equal emphasis on planning skill development strategies during each session while addressing the process of the group. Similar to manualized group programs, the DGPM includes a very detailed template that allows for easy replication of this approach in other settings. However, unlike manual group approaches, group facilitators of this model must use their clinical skills in terms of individualizing the planning of sessions and facilitating the group meetings. In this study, social skill enhancement, anger management skills, and positive school attitude skills were the targeted areas of functioning focused on in these groups.

All groups had two licensed mental health (MH) providers as cofacilitators; all extensively trained on the DGPM. To ensure consistent application of the model across intervention groups, facilitators attended the same full day of training on the DGPM conducted by the model's developer (first author). The cofacilitating teams were trained on how to plan and facilitate sessions and were given a wide variety of session plan ideas. In addition, the first author met regularly with the individual facilitator teams to review their session plans and responses of the youth during group meetings.

The DGPM requires facilitators to follow a set format to all sessions that results in the use of interventions that address the process goals (i.e., establishing an attractive group, building relationships among members, and maintaining balanced participation) the treatment goals (social skills, anger management, and school attitude) in every session. By addressing the process goals facilitators are then able to more effectively and efficiently help group members attend to and learn social skills, anger management skills, and skills to improve their school attitude. This strengths-based group model delineates specific ways, through planning and facilitating, that facilitators are to build a group of students who are at risk into a supportive and caring group. Once a group has bonded the attainment of treatment goals flow more easily and usually with fewer occurrences of behavioral management problems in the group setting.

## Measures

A mixed-methodology design was utilized for this study which included the following three standardized scales administered pre- and postgroup intervention and a focus group conducted with each group after their eighth group session.

### *School social competence*

Adolescents' school social competence was assessed using teacher report on three subscales of the Merrell School Social Behavior Scales Second Edition (SSBS-2) (Merrell,2001). Previous studies have found that the SSBS-2 demonstrated good psychometric properties including high internal consistency, test-retest, and inter-rater reliabilities as well as discriminant and convergent validity (Crowley & Merrell,2003; Merrell,2002).

### *Internalizing and externalizing symptoms*

Adolescents' internalizing and externalizing symptoms were measured using the Youth Self-Report (YSR 11–18) and teacher report (TRF) versions (Achenbach,1991; Achenbach & Rescorla,2001) of Achenbach Child Behavior Checklist (CBCL). Previous research has reported that the YSR and TRF internalizing and externalizing measures demonstrated good psychometric properties including high internal consistency, test–retest reliability, and discriminant and construct validity (Achenbach,1991). Watson, Potts, Hardcastle, Forehand, and Compas (2012) also found comparable internal consistencies between a younger (9- to 10-year-olds) and older (11- to 15- year-olds) sample on the YSR internalizing and externalizing symptoms scales (all alphas $\geq$ .78).

### *Focus groups*

Focus groups were conducted by the first author with assistance from a graduate student after the last session of each 8-week intervention group. Group participants were asked the following questions: (1) What was this group like for you?, (2) What made this group a positive experience for you?, (3) If you were in charge of this group, what would you change about it?, and (4) what is different about you as a result of being in this group? Focus group sessions lasted approximately 45 minutes and participants' responses to these questions were recorded. Extensive notes on participants' responses were taken by graduate students at these sessions with responses transcribed and classified into major theme categories based on a content analysis.

### *Data analysis*

The statistical package SPSS (v.21.0) was used to conduct independent sample t tests to examine whether treatment and comparison group participants differed in their pretest scores on internalizing, externalizing, and social competence measures. To assess within-group pre–post change for participants in the intervention group, paired sample t tests were conducted on these same measures.

## **Results**

Initially the research design for this study was to include a comparison between the treatment group and a matched comparison group. However, prescale score data (CBCL-YSR) indicated that intervention group participants reported significantly higher internalizing symptoms than matched comparison group counterparts at pretest,  $t(309) = -3.35, p < .01$ ; no significant group differences were found using the CBCL TRF,  $t(292) = -1.10, p > .05$ . The intervention group also was significantly higher than the matched comparison group at pretest on externalizing symptoms from the CBCL-YSR,  $t(309) = -2.00, p < .05$ , and TRF,  $t(179.78) = -2.82, p < .01$ . Finally, the intervention group was significantly lower than the matched comparison group at pretest on peer relations,  $t(291) = 3.28, p < .01$ , self-management and compliance,  $t(291) = 3.70, p < .001$ , and academic behavior,  $t(291) = 2.67, p < .01$ , on the SSBS-2. Given that the intervention and matched comparison group were significantly different at pretest and groups were not randomly assigned, between-group comparisons were not tested. Data for the

comparison group are provided in Tables 1, 2, and 3 but only for purposes of general comparison because no analyses between the two groups were conducted.

### Within Group Pre-Post Changes

#### *Internalizing and externalizing behavior (CBCL Scores) comparisons*

Means, Standard Deviations, and number of cases for pre–post youth (YSR) and teacher (TRF) reports on the Internalizing and Externalizing Behavior Scales of the CBCL are presented in Table 2. The results show a significant YSR pre–post difference score on the Internalizing Behavior Scale indicating improved internalizing scores. In contrast, a significant TRF difference surfaced on the Externalizing Behavior subscale indicating an increase in problem behavior. Further analysis on the YSR internalizing score difference revealed that the difference was largely due to fifth-grade boys reporting improved internalizing behavior. In terms of the externalizing behavior results, the increased problem behavior reporting was primarily attributable to the behavior of male seventh graders. No significant differences were found on the YSR for externalizing behaviors and on the TRF for youth internalizing behaviors.

#### *School social behaviors scale comparisons*

Means, Standard Deviations, and number of cases for pre–post teacher reports on the School Social Behaviors Scale are shown in Table 3. One subscale, peer relations, was found to show a significant pre–post difference representing positive change. Additional exploration of scale results, however, revealed several notable findings. When compared by gender within grade, comparison of pre–post differences for the subscales: Peer Relations, Self-Management, and Social Competence total scale were all significantly different but only for fifth-grade girls. It is notable that on the three subscales that make up the Social Competence Total subscale, fifth-grade girls were assessed to have significant changes on two of the three subscales, but on the Antisocial Behavior Total and its three subscales, teachers rated the girls' behavior more problematic at post when compared to their preintervention ratings. For seventh-grade girls positive pre–post changes in ratings were reflected on five of the eight subscales: Peer Relations, the Antisocial Behavior Total and its subscales, Irritable/Hostile, Antisocial/Aggressive and Defiant/Disruptive. For fifth-grade boys improved postscores were reported on all but the Self-Management/Compliance subscale; for seventh-grade boys nonsignificant positive change scores were noted on all but the Self-Management/Compliance, Academic Behavior, and Social Competence Total subscales.

Table 2. Child Behavior Checklist internalizing and externalizing behavior subscale scores for total sample.

Subscale	Group	N	Prescore		Postscore		p
			M	SD	M	SD	
Internalizing Behavior Total Score (Youth self-report)	Intervention	215	15.21	9.37	13.40 <sup>a</sup>	8.98	.001
	Comparison	95	11.58	7.64	10.51	6.43	ns
Externalizing Behavior Total Score (Youth self-report)	Intervention	215	12.36	9.00	11.61	8.27	ns
	Comparison	95	10.32	7.46	9.45	6.92	ns
Internalizing Behavior Total Score (Teacher report)	Intervention	201	4.99	5.99	5.26	6.44	ns
	Comparison	87	4.21	5.33	4.08	4.45	ns
Externalizing Behavior Total Score (Teacher report)	Intervention	201	9.56	10.61	10.58	12.13	.021
	Comparison	87	6.06	9.89	7.34	9.64	.047

<sup>a</sup>Lower post scores are associated with positive improvement.

Table 3. School social behaviors-2 subscale scores for total sample.

Subscale	Group	N	Prescore		Postscore		p
			M	SD	M	SD	
Peer Relations	Intervention	201	46.46	14.29	48.15 <sup>a</sup>	15.55	.003
	Comparison	85	52.42	12.46	53.26	12.37	ns
Self-Management/Compliance	Intervention	201	35.87	9.80	36.00	10.63	ns
	Comparison	85	40.22	8.73	40.02	9.13	ns
Academic Behavior	Intervention	201	29.08	7.87	29.15	8.62	ns
	Comparison	85	31.74	7.23	31.96	7.53	ns
Social Competence Total	Intervention	201	111.41	29.90	113.30	32.99	ns
	Comparison	85	124.39	26.81	125.25	27.55	ns
Hostile/Irritable	Intervention	201	26.26	11.39	26.51	12.59	ns
	Comparison	85	21.82	10.23	21.80	10.28	ns
Antisocial/Aggressive	Intervention	201	18.97	8.39	19.13	9.23	ns
	Comparison	85	15.85	7.25	15.81	7.27	ns
Defiant/Disruptive	Intervention	201	14.72	7.09	15.02	7.81	ns
	Comparison	85	12.16	5.92	12.39	5.79	ns
Antisocial Behavior Total	Intervention	201	59.95	26.26	60.67	29.10	ns
	Comparison	85	49.84	22.90	50.00	22.81	ns

<sup>a</sup>Higher postscores are associated with positive improvement.

### *Focus group results*

Responses to the four focus group questions were categorized into major themes. The researchers decided to keep a count of how many students reported similar responses to each question. Even though qualitative data do not typically include the counting of responses to focus group questions, the research team thought it might be beneficial to have these data to compare these themes to the results on the CBCL and SSBS-2.

Table 4 contains the major themes that surfaced from the first three focus group questions, what was the group like for you, what was positive about the group, and how would you change the group. Very similar themes surfaced in response to the first two questions including the group providing a fun and attractive setting, participants acquiring friends, having a safe place to share feelings, and learning new peer skills. It was interesting that no negative



feelings about the group surfaced from the first question. For the third question, suggestions to improve the group included adding new activities, having the group meet for a longer period, allowing more students into the group, changing the time so it does not conflict with elective classes, and making sure everyone follows the rules. Some of these latter responses appeared to indicate how much the participants liked the group such that they wanted it to last longer and be available to more of their friends.

The fourth question requested members to share how they changed as a result of the group and six themes emerged (see Table 5). As can be seen on Table 5, three areas of functioning as having improved were identified by one third or more of the group participants: social skills (n= 89, 43%), school attitude (n= 85, 41%), and anger management skills (n= 69, 34%). Although reported by fewer students, three other areas of change that were reported were increased ability to express one's feelings (n= 21, 10%), improved self- esteem (n= 16, 8%), and improved home behavior (n= 9, 4%).

The largest number of students (n = 89, 43%) reported getting along better with peers and having more friends. For example, Kenyon a (seventh-grade African American) said, "I have so many more friends at this school which I never had before this group. Another student, David, (fifth-grade African American) reported, "For the first time at this school I have friends since being in this group. This makes me feel more like I belong here." James (fifth-grade African American) noted, "I am getting along better with other students and know better how to make new friends especially ones that will be good for me."

The next largest number of participants (n= 85, 41%) reported an improved school attitude that included more respect for teachers, more positive feelings about being at the school, and more hopeful about being a good student. For example, Willy (seventh-grade African American) shared, "I don't get in as much trouble in my class. My teacher even said I have a better attitude." Another student, Maria (fifth-grade Latino) shared, "I am beginning to like this school better and feel like there are more teachers I can talk to about my problems." Jerome (seventh-grade African American) said, "I feel better about school and now I am excited about going to high school."

The third largest number of participants (n= 69, 34%) reported they were not as angry and could manage their anger better. For example, Carlos (fifth- grade Latino) said, "I am not as angry now. So when I get in a fight I don't hit the other kid as many times." Another student, Michael (seventh-grade African American) noted, "Now when I get angry I stop to think before getting into a fight. I have learned how to handle my anger better so I don't get into as many fights." Tara (fifth-grade African American) reported, "I have learned how to handle my anger better and share my feelings more now which has made me less angry."

At lower numbers but still noteworthy, students also described expressing their feelings more with others (n= 21, 10%), improved self-esteem (n= 16, 8%), and improved home behavior (n= 9, 4%). For example, Molly (seventh- grade White) shared, "I talk to my friends more outside this group about my feelings. I usually feel better after sharing my feelings with others which is something I learned in this group." Bobby (fifth-grade African American) said, "I don't do what others tell me to do as much now. I think more for myself and I feel more confident." Teresa (fifth-grade Latino) shared, "My mom says I am doing better at home because I do my chores now without complaining."

## **Discussion**

In terms of the first research question, regarding what were the treatment outcomes for study participants, some very informative and contrasting findings surfaced. On the SSBS-2 the intervention group improved significantly on the Social Competence Scale, consistent with focus group results where the largest number of students reported having improved peer skills. Particularly, positive changes on the SSBS-2 were identified in regard to peer relations and self-management/compliance that indicates that teachers of these students observed these students' development of more positive social skills and also reported that these youngsters were generally able to better self-manage their behavior in the classroom and stay compliance with the rules. With regard to the Antisocial Scale on the SSBS-2, teachers reported significant improvement on hostile/irritable behavior that is further validated by the students in the focus group when they reported feeling less angry and having improved their anger management skills.

In contrast to the SSBS-2 scale results, ratings of the teachers' assessment of students' externalizing behavior showed an increase in problematic behavior from pre to post. However, based on youth self-reports (YSR), students indicated significant improvement of their internalizing problem symptoms. These latter internal change results are consistent with themes reported in the focus group where students noted improved school attitude, feeling less angry, feeling more likable, and feeling more self-confident. Based on results from the YSR and TRF, it appears that the teachers of these students did not observe the internal changes in the students that are understandable because many of these behaviors are not observable in the classroom.

These contrasting findings from the teachers' ratings (TRF) and the students' self-ratings (YSR) may partly explain why it is so difficult for students who are at risk to make positive changes in their school behaviors. Although youth may feel better about themselves and their relationships (improved internalizing behaviors), these "improvements" do not manifest into readily observable behaviors. Also, teachers may have too high expectations of students after a brief group intervention. If students are expected to be improving and are not perceived to be doing so or improvement is perceived to be too little, teachers may be inclined to continue to perceive students' behavior problematic. It is possible a negative perception loop is established—students are feeling better about themselves and their issues, but these feelings do not manifest into observable behavior changes that in turn are not reinforced by teachers which may increase the possibility of students reverting back to their negative/problematic behaviors. In addition, studies have found that underfunded schools tend to attract less qualified or new teachers who may not have the training to understand mental health issues or know how to accurately evaluate changes post brief interventions (Frauenholtz, Mendenhall, & Moon, 2017).

Another possibility is that internalizing and externalizing behaviors change independently. Internalizing behavior change may be what some current authors are calling "academic enablers" (e.g., motivation and engagement) (DiPerna & Elliott, 2002) which need to occur before youth are able to manifest externalizing behavior change. Extinguishing problematic behavior may be achievable through manipulation of punishment and reward, but to sustain change a youth's internal functioning needs to be addressed.

These findings illuminate a need to further study internal versus external changes particularly in regard to brief treatment services which are the pre-dominant type of services provided in K-12 grades. In addition, these findings point to the challenges researchers face when selecting measures with validity and reliability that can also identify outcomes from brief treatment (3 months or fewer). The difficulty in finding measures that accurately evaluate brief treatment outcomes further identifies the need to have more research designs that include quantitative and qualitative data like the current study.

In regard to the second and third research questions, how do age and gender affect the positive treatment outcomes of this brief treatment group, findings from the YSR, TRF, and SBSS-2 indicate that both variables had a significant impact on results. After further analysis by gender and age, on the YSR only fifth-grade boys significantly improved for the internalizing subscale and only fifth-grade girls improved on the SSBS-2 for the Social Competence subscale. Interestingly, it was primarily the seventh-grade boys who accounted for the significant differences in the negative direction for the TRF externalizing sub- scale. These findings support the benefits of early intervention with boys and girls as further evidenced by studies that have found treatment interventions in the middle school years are particularly critical to achieving positive outcomes (Clark et al.,2008; Moilanen, Shaw, & Maxwell,2010) Moreover, Burlingame, McClendon, and Alonso (2011) found that the creation of group cohesion is a stronger predictor of treatment outcome among groups of younger students. In addition, these results point out the need to further study the ideal ages/grade levels to provide early intervention to students who are at risk to maximize the positive impact of treatment services. Keeping in mind that a much larger number of K–12 boys typically are referred for services and the seventh-grade boys in this study accounted for the significant negative changes on the TRF, there is a particular need to study the ideal age of intervention for boys.

In addition to the findings relating directly to the research questions, the authors found some unexpected and noteworthy responses from the students who are at risk when they were initially asked to become members of a leadership training group versus a problem-focused group. Initially, youth had the expectation that the leadership groups were intended for the good students and not students with problems. During the first set of 8-week groups conducted for this study, many of the students responded to members of the research team that some teachers must have confused him or her with another student since they believed no one would ever select them for a leadership training group. However, they were assured there was no mistake but rather their teacher obviously had seen some potential in him or her to be a leader. Most of these students appeared perplexed by this response, but later responses during the focus group indicated that this experience of positive support had a remarkably positive impact. For example, several students reported (and this was repeated over the 3 years of focus groups) that once they were identified for a leadership training group they realized they had to begin making some positive changes and live up to this new image of themselves.

One unexpected outcome was that several students in the groups wanted to refer friends to the group program because they found the experience to be so positive. In fact, after the initial groups were conducted for this study, many of the earlier challenges the research team encountered regarding obtaining parental permission for participation were no longer a problem. In addition, teachers reported hearing parents say that they were much more open and eager to have their children participate in a leadership group rather than a group that focuses on their child's problems.

Another unexpected finding was that the students in the treatment groups did not initially like being in a single gender group. In fact, during many of the initial group meetings the participants asked repeatedly why groups could not be mixed with boys and girls. However, during the focus group sessions these same youth were asked why they did not suggest making this composition change for future groups in response to the third focus group question. In all the groups these youngsters responded that they found the single gender group to be a much safer and supportive place to share and open up about their feelings. Interestingly, several related

studies have found more significant positive outcomes have been attained in single-gender groups when compared to mixed-gender groups (Baskin et al.,2010).

## **Limitations**

This study was initially designed to include a matched comparison group however students in this group were found to be significantly different from students in the treatment group on a number of variables on the prescales of the SSBS-2, TRF, and the YSR. Therefore, the research team focused their analysis in this report on the results of this mixed-methodology study as a pre–post investigation. One of the limitations of this study was the lack of comparison group data when analyzing the results. This is a common problem encountered when conducting research in K–12 settings and needs to be further examined.

## **Conclusion**

Findings from this study identify the value of introducing brief group treatment from the very beginning as building on the strengths of students who are at risk rather than addressing their problems. Similar to the call by the American Psychological Association (2008) Task Force on Resilience and Strength in Black Children and Adolescents, we need to make a paradigm shift from describing K-12 students as “at risk” to “at promise.” In addition, by using a group approach that pays equal attention to group process (i.e., establishing an attractive group, building relationships, and maintaining balanced participation) and skill building, results from this study showed that fifth and seventh grade students were able to make significant positive changes over 8 weeks in regard to their peer skills, anger management, and school attitude. Furthermore, these findings point out the value of conducting early intervention programs in SBHC where services often have less stigma attached to them and they can be delivered to a larger number of students, particularly minority and poor. It is imperative that group interventions like this leadership training group be replicated and further studied in order to contribute to our knowledge base in terms of evidence-based treatment for our K–12 youth.

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