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Building Social Resilience: The Effect of a Coping Skills Training Intervention in an Educational Setting on Adolescent Victims of Bullying

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Building Social Resilience: The Effect of a Coping Skills Training Intervention in an
Educational Setting on Adolescent Victims of Bullying

by

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Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
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of the requirements for the degree of
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in Clinical Psychology

Newberg, Oregon

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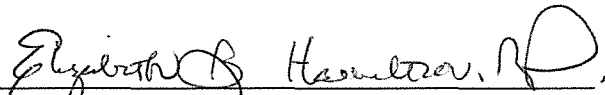
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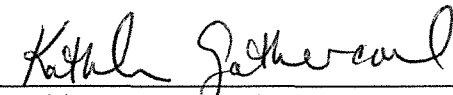


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Abstract

Despite the effectiveness of bullying prevention programs, there remains a significant portion of individuals who develop short and long-term difficulties as a result of bullying victimization. While most bullying programs are “preventative,” there is a dearth of research examining treatment effects on students who already self identify as having been victims of bullying. The most efficient way of implementing interventions to meet the needs of this population is within the educational system. This study attempted to adapt an existing evidence based intervention to the specific needs of a school setting. The adapted intervention and subsequent pilot study examined the effects of a coping skills training program on bullying victims coping skill usage and helpfulness, as well as self reported symptoms of anxiety and depression. Results showed no significant change in coping skill usage or helpfulness, and no significant overall change in anxiety and depression. Clinically significant improvement was found in 4 out of the 19

individuals; 2 in the area of anxiety, and 2 in the area of depression. Qualitative findings revealed several areas of improvement for future development.

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Chapter 1

Introduction

It is no secret that bullying is prevalent in today's society. The psychological and educational communities first came to recognize bullying as an area of concern in the 1970s and early 1980s (Olweus & Limber, 2010). Since then, numerous studies have identified bullying as a significant challenge that many children and adolescents may face throughout early life. If not properly identified and treated, victims of bullying can suffer profound effects on academic achievement as well as long term psychological health.

With the rapid state of technological advancement and the increasing ease by which individuals can connect to each other, bullying has experienced a transformation and a significant overall increase since its rise to awareness in the 1980s. One survey conducted in 2001 found that in comparison with 1983, the percentage of bullied students, and those who had been involved in the most serious forms of bullying, had increased by 50% and 65%, respectively (Olweus & Limber, 2010). In 2009, a questionnaire developed by Olweus, a pioneer of bullying research, was used in a large-scale survey of 11- 15-year-olds in 40 countries. This study showed that 26% of students self identified as having been involved in bullying, 12.6% as victims only and 3.6% both as bullies and victims, with the remaining 8% being comprised of bullies (Craig et al., 2009). In the United States, a separate national study conducted in 2012 found that approximately 28% of adolescents reported having been bullied within the past year (Robers, Zhang, Truman, & Schneider, 2012). Some researchers have recently reported a

decrease in bullying rates, presumably related to anti-bullying and bullying prevention programs (Finkelhor, Turner, Ormrod, & Hamby, 2010). One study found that bullying prevention programs reduce bullying by approximately 20% (Farrington & Ttofi, 2009). Similarly, it was reported that there was a large drop in physical bullying (21.7% to 14.8%) and a less significant drop in emotional bullying in response to anti-bullying campaigns (Finkelhor et al., 2009). When employed, prevention programs help reduce school bullying at a systems level (Rigby & Smith, 2011).

One challenge in reporting rates of bullying is the different ways that bullying has been defined and measured. The original definition developed by Olweus (1993) stated that, “a student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students” (p. 9). These negative actions could include physical contact, words, gestures, and intentional exclusion from a group (Olweus & Limber, 2010). As the research on bullying began to expand, this definition was deemed inadequate to capture the entirety of bully/victim relationship. In addition to the negative actions being repetitive, the idea of an abuse of power or a power imbalance is now frequently added in order to make the definition more specific. Relatedly, bullying involves a victim that cannot defend himself or herself easily. This could be the result of being outnumbered, being physically smaller or not as strong, or being less psychologically resilient than the bully (Smith & Brain, 2000). Though the two criterion of repetition and power imbalance are not universally accepted, they are now widely used within psychological and educational literature (Smith & Brain, 2000). Bullying can thus be described as “aggressive behavior or intentional harm doing that is carried

out repeatedly and over time in an interpersonal relationship characterized by an actual or perceived imbalance of power or strength” (Olweus & Limber, 2010, p. 125).

What might explain the increase in the reported rates of bullying over the years? One possibility is that as the definition of bullying has become more delineated, the amount of bullying being reported may have shifted as well (Rigby & Smith, 2011). Other theories regarding what could cause the variance in prevalence statistics include the increased attention on and awareness of bullying, a variety of reporting measures, and cohort differences. Specifically, numerous school shootings and highly publicized teen suicides have led to an increased attention on bullying in the past fifteen years. This increased attention could lead students and teachers to overestimate the prevalence of school bullying (Rigby & Smith, 2011). Additionally, having a variety of reporting measures, rather than one standardized measure for bullying could also lead to differences in bullying statistics. Finally, there may be differences in cohorts that lead the youth of today to act differently than youth at different times in the past.

It is also important to note the changes in definition, descriptions of presentation, and understandings of long-term consequences among bullies, victims and those who are both bullies and victims (bully/victims). Several studies have found differences in the social-emotional attitudes, skills, and behaviors that result from the different roles an individual may play in the bullying relationship (Haynie, et al., 2001; Hussein, 2013; O’Brennan, Bradshaw, & Sawyer, 2009; Yang & Salmivalli, 2013.). Noticeable differences in symptomatology and long-term consequences can be seen among bullies, victims, and bully victims. Bullies and bully victims tend to present with more aggressive and externalizing symptoms (Berry-Krazmien, 2007; Neft,

2007; Smokowski & Kopasz, 2005) and victims tend to present with more internalizing symptoms (Ozdemir & Stattin, 2011; Siebecke, 2010; Zwierzyńska, Wolke, & Lereya, 2013).

Consequences of Bullying

Though different studies show a range in the prevalence of bullying, there is no doubt that bullying is still seen as a major concern among psychologists and educators alike. Rigby and Smith (2011) suggest that even though it may appear overall that bullying is on the decline, it would be a mistake to believe that the problem of bullying does not require any further or special attention. Even if there is a decrease in the overall prevalence in bullying, there are still many individuals for whom bullying causes significant and lasting consequences. Researchers have broadly agreed that individuals who have been the victim of bullying are at a high risk for internalizing symptoms. Several studies have identified anxious and depressive symptomatology as one of the primary consequences of bullying victimization (Bond, Carlin, Thomas, Rubin, & Patton, 2001; Ivarsson, Broberg, Arvidsson, & Gillberg, 2005; Kaltiala-Heino, Rimpela, Rantanen, & Rimpela, 2000; Menesini, Modena, & Tani, 2009). Kaltiala-Heino et al. (2000) found that depressive symptoms, anxiety, and excessive psychosomatic complaints were extremely prevalent among victims and it was determined that bullying victimization could be seen as a key feature in recognizing adolescents, who are likely to develop long term diagnosable mental health disorders. Furthermore, some longitudinal studies have confirmed the link between being a bullying victim and developing specific psychological symptoms at later ages, including psychosomatic symptoms and anhedonia (Kumpulainen et al., 1998). Victims may face hyperactivity, problems with peers, and various psychosomatic complaints including sleeping problems, feeling tense, feeling tired, and dizziness (Gini, 2008).

Perhaps one of the most significant concerns of bullying victimization is that the act of bullying can put further stress on individuals who are already vulnerable to suicidal ideation, and while not directly linked, can create complicating factors for already vulnerable victims. Victims of bullying may be highly vulnerable to the effects of a parent with diagnosed psychopathology or to feeling rejected at home. These factors, coupled with emotional and behavioral difficulties, cause individuals who are being bullied to be less able to cope with the stresses of being bullied, more likely to internalize victimization experiences, and as such, more vulnerable to suicidal ideation (Herba et al., 2008).

Bullying is also related to social hopelessness, which in turn is related to suicidal ideation. In fact, social hopelessness was found to partially mediate the relationship between victimization and suicidal ideation (Bonanno & Hymel, 2010). This suggests that one way victimized students become suicidal is through social hopelessness. That is, the more a student is victimized the more socially hopeless the student becomes, and the more socially hopeless the greater an individual's suicidal ideation (Bonanno & Hymel, 2010). This is consistent with previous research showing that social hopelessness can help differentiate between individuals with high and low suicidal ideation (Heisel, Flett, & Hewitt, 2003).

Victimization and the identification of oneself as a victim have been shown to predict poor psychological adjustment, which in turn can compromise school outcomes. This can lead to a compounding pattern in which poor school outcomes can lead to further difficulty in psychological adjustment, which in turn can lead to further feelings of loneliness, low self-worth, and depression (Juvonen, Nishina, & Graham, 2000). This is of particular concern since it has also been found that some of the main predictors of bullying victimization include loneliness in

peer relationships, lower global self esteem, and negative perceptions of school climate (Brighi, Guarini, Melotti, Galli, & Genta, 2012). These behaviors are problematic as students who are bullied developed patterns that actually put them at greater risk for future bullying.

Brighi et al.'s results are consistent with other studies showing that individuals who have been victimized over time report a greater degree of suffering than victims who have been in bullying episodes only recently. Chronic victims experience a greater degree of suffering, and the relationship between depression and victimization intensifies the victims suffering (Menesini et al., 2009). One concern raised by Brighi et al. (2012) is that the negative attitudes and feelings toward school that result from bullying may expose potential victims to increasing experiences of social exclusion. Victims are already perceived by themselves, peers, and teachers as having poor social skills (Fox & Boulton, 2005), and the lack of skills such as friendliness, cooperativeness, and pro-social skills, may prevent the victimized individual from becoming a valued member of a peer group (Egan & Perry, 1998). As socialization with others is fundamental to an adolescent's process of social identity building (Marcia, 1980), being a victim of bullying is a threat to an individual's developmental process. By addressing these problems earlier rather than later, it may be possible to break negative cycles that can occur as a result of bullying victimization.

Cyber Bullying

While traditional bullying may be slightly decreasing, cyber bullying has increased in recent years (Rigby & Smith, 2011). Dilmac (2009) reported that among individuals between the ages of 13 and 17 years old, 43% had experienced cyber bullying in the previous year (Dilmac, 2009). Cyber bullying has been defined as simply as, "electronic bullying through cell phone

texting, email, instant messages, chat rooms or website postings of harmful words or photographs of an individual” (Williams & Godfrey, 2011, p. 36). A more complex definition, and one that better fits within the currently accepted definition of bullying is, “an individual or a group willfully using information and communication involving electronic technologies to facilitate deliberate and repeated harassment or threat to another individual or group by sending or posting cruel text and/or graphics using technological means” (Dilmac, 2009, p. 1308). Cyber bullying will most likely, but not always, happen outside of the school setting and, as such, is much more difficult to control. As the education system begins to react to traditional bullying by instituting bullying prevention programs, they are often at a loss as to how to combat this new form of bullying.

Cyber bullying has several characteristics that distinguish it from the traditional bullying. In cyber bullying, the perpetrator has the ability to remain anonymous and to post messages to a wide audience. The perpetrators also may not feel as responsible or accountable when they are online as they do in a face-to-face interaction (Kessel Schneider, O'Donnell, Stueve, & Coulter, 2012). But just as in traditional bullying, there are two well-defined roles: the aggressor and the victim (Ortega, Elipe, Mora-Merchán, Calmaestra, & Vega, 2009). As cyber bullying continues to increase, there is a need to develop interventions that provide victims with new skills that allow them to cope with the realities of an ever-changing bullying landscape. Further research is needed to develop interventions specifically catered to cyber bullying victims and the unique aspects of the bullying relationship.

Victims of cyber bullying have been found to experience similar consequences to victims of traditional bullying. Depression, anger, embarrassment, stress, loneliness, suicidal ideation

and decrease in school performance affect victims of cyber bullying (Ortega, et al., 2009; Völlink, Bolman, Dehue, & Jacobs, 2013; Wang, Nansel, & Iannotti, 2011). As with traditional bullying, prolonged exposure to cyber bullying increases the emotional impact on victims (Ortega et al., 2009). Because the outcomes of traditional bullying and cyber bullying are so similar, and many victims of traditional bullying are also victims of cyber bullying (Kessel-Schneider et al., 2012), it stands to reason that effective treatments for victims of traditional bullying would be effective for victims of cyber bullying as well.

Social Emotional Learning

The cause of bullying behavior and the subsequent symptom development in victims has been viewed through a number of lenses. In considering these different lenses, one of the key developmental constructs that has been identified is Social Emotional Learning. Zins and Elias define Social Emotional Learning (SEL) as “the process of acquiring and effectively applying the knowledge, attitudes, and skills necessary to recognize and manage emotions; developing caring and concern for others; making responsible decisions; establishing positive relationships; and handling challenging situations capably” (2006, p. 1). In short, SEL is the way in which we learn the basic skills that we need to work effectively with other people, manage our own emotional concerns, and to generally be effective in our lives (Merrell, 2010). In researching social emotional competencies, five core areas have been identified. They include self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. Self-awareness is the ability to accurately assess one’s own feelings, interests, values, and strengths. Self-management is the ability to regulate emotions, handle stressors, control our impulses, and overcome obstacles. Social awareness is the ability to take another person’s

perspective and to be able to empathize with them. Relationship skills are the ability to establish and maintain healthy and rewarding relationships. Responsible decision-making is the ability to make constructive and respectful choices regarding personal behavior based off of social norms (Collaborative for Academic, Social, and Emotional Learning, 2009).

There is a growing need to develop these core social and emotional skills in children and adolescents (Merrell & Gueldner, 2010; Zins, Bloodworth, Weissberg, & Walberg, 2004). One program that has been developed to meet this need is Strong Kids, a collection of programs developed to meet the specific social emotional of specific developmental periods, ranging from Pre-K to grades 9-12. These interventions have proven to be effective in a school based setting with limited time, training, and resources (Merrell, 2010). This “real world” approach results in programs that are feasible as well as useful for individual schools or school districts to adopt.

Primary, Secondary, and Tertiary Prevention of Bullying

When considering prevention, there are traditionally three types: primary, secondary, and tertiary prevention. Primary prevention can be defined as preventing a problem from occurring by taking a targeted action (Mason & Fogel, 2013). Primary prevention programs involve all students, not just those who are involved in the bully/victim problems. These programs attempt to alter the school climate, involve substantial training for teachers and other school staff, elicit parental involvement, and encourage generalizations across situations by involving many different people (Elinoff, Chafouleas, & Sassu, 2004). Though several programs have been identified as effective for bullying prevention, these programs merely decrease the incidence of bullying; they do not eliminate it entirely or change the effects for those involved (Livingston, 2008).

Secondary prevention techniques are focused towards individuals who are beginning to show signs of a disorder or a problem and are designed to prevent more severe problems from developing (Elinoff et al., 2004). In bullying, these interventions would be directed towards identifying individuals who show emerging problems of aggression or victimization with the goal of providing them with skills to help cope with these difficulties (Elinoff et al., 2004). Secondary prevention would then be employed with individuals who have experienced bullying, though not to the point where they have developed serious psychological difficulties as a result.

Tertiary prevention is employed when an individual has already developed disorders or significant problems. Tertiary interventions are designed to minimize the effects of the problem (Meyers & Nastasi, 1999). Once a student has been exposed to bullying for an extended period of time, at this point the interventions are aimed towards treatment. Treatment is designed towards the internalizing symptoms that are developed as a result of bullying victimization.

Coping Skills

The efforts being directed toward primary prevention of bullying are laudable. The reduction and elimination of bullying behaviors are, and should continue to be, a major goal of prevention efforts. However, research has shown that although these programs may be effective, they do not entirely eliminate bullying behavior (Farrington & Ttofi, 2009). Effort should also be focused on secondary prevention to prevent victims from developing further difficulties. If effective secondary prevention interventions can be developed, bullying victims can be provided with the necessary skills to preclude or mitigate the short- and long-term effects of bullying that lead to damaging internalizing symptoms.

Since Social Emotional Learning has been identified as a key construct in the development of the individual, programs that teach students the basic skills required for this construct should be pursued. The training and use of coping skills has been proven to not only provide a basic foundation for Social Emotional learning, but it has also been proven to prevent, alleviate, or eliminate internalizing symptoms. In fact, coping skills training can have a profound effect on short and long term mental and medical health outcomes (Chesney, Chambers, Taylor, Johnson, & Folkman, 2003; Duchinick, Letsch, & Curtiss, 2009; Kroese, Adriaanse, Vinkers, van de Schoot, & de Ridder, 2014; Srof, Velsor-Freidrich & Penckofer, 2012). But why is coping so important? Pincus and Friedman (2004) explain: “Children are continuously confronted with interpersonal problems in their daily routine. Children’s ability to deal with these common everyday stressors has been found to be significantly related to their psychological adjustment” (p. 223).

Much of the current research on coping comes from Lazarus and Folkman’s cognitive appraisal theory of stress and coping/ways of coping model. This model holds that coping is a multidimensional process, which includes aspects such as cognitive appraisals, coping responses, and coping outcomes. In this process the individual appraises the significance of a stressful event to their own well-being as well as the availability of resources and options. The individual then makes an intentional response towards the stressor. This response can be either problem focused (directly changing or mastering the source of stress) or emotion focused (managing or regulating negative emotions) (Pincus & Friedman, 2004). Breaking the response down further, some researchers have labeled certain coping styles as positive or negative, productive or unproductive, helpful or unhelpful, and so on. Roxas and Glenwick (2014) separated coping

patterns into active/engagement coping and avoidant coping and found that active/engagement coping was tied to better adjustment, and avoidant coping was tied to worse adjustment. In sum, coping patterns and styles have a significant effect on short and long term outcomes to stressful situations. Since a student's coping style is so impactful, this necessitates a focus on the design and use of interventions that teach effective, productive, and positive coping strategies.

Problem solving strategies, seeking social support, and active involvement in school are coping skills that have been identified as effective for bullying victims (Hunter & Boyle, 2004). Effective coping strategies involve students' appraisal of a situation followed by using appropriate skills to meet the demands of the situation. Because coping strategies are situation specific, training in situation specific methods of coping is necessary (Murray-Harvey, Skrzypiec, & Slee, 2012). Active coping rather than avoidant coping is related to lower internalizing symptoms. In contrast, negative thinking causes an increase in pain, depression, and anxiety symptoms (Barakat, Schwartz, Simon, & Radcliffe, 2007). Not surprisingly, coping skills training interventions reduce anxiety and depression symptoms in a number of different clinical populations (Chesney et al., 2003; Duchnick et al., 2009; Kennedy, Duff, Evans, & Beedie, 2003). Coping skills training interventions are not only effective for reducing internalizing symptoms, they have been found to be effective across a wide variety of settings for both medical and mental health issues, including diabetes management (Kroese et al., 2014), asthma management (Srof et al., 2012), and reducing the risk of substance abuse (Forman, Linney, & Brondino, 1990).

While individual studies provide an in depth look at the effectiveness of particular coping skills training programs, meta-analyses can help to provide us with an overview of the

effectiveness and breadth of interventions involving coping skills. In a 2002 meta-analysis Penley, Tomaka, and Wiebe (2002) found that problem focused coping, or learning how to solve or confront the problem, had a positive relationship with long term health outcomes whereas other more avoidant forms of coping had a negative relationship with health. Additionally, Kraag, Zeegers, and Hok, (2006) found that school programs focused on coping skills and stress management are effective in reducing stress symptoms and enhancing coping skills among children and adolescents.

These findings on coping suggest that coping skills are integral to long term health outcomes. Further, they can be learned in a school setting.

School-Based Mental Health

When faced with the task of implementing successful interventions in a school-based setting, there are a number of factors to consider. Primarily, the school environment does not lend itself particularly well to controlled studies. There are a number of unique challenges such as school operating hours, parent comfort level with mental health or parental consent to the intervention, parental compliance with homework assignments, educational demands and requirements, administrative collaboration, and so on (Weist, Youngstrom, Stephan, et al., 2013). In addition to the difficulty of creating a laboratory environment, clinicians may face challenges including lack of support from school administration or teachers, lack of family engagement, student absenteeism, and inflexibility of manuals to allow for shorter sessions and briefer interventions (Weist, et al., 2013). Thus, there is a need to properly adapt existing interventions to meet the unique needs of the school environment. Shorter sessions, focused interventions, and the development and use of existing relationships with school administrators and teachers are

necessary first steps in beginning to bridge the gap between evidenced based practices and school based mental health.

In spite of the challenges faced in school based mental health, there have been a number of interventions that have successfully bridged the gap and been successfully implemented. Programs that have been identified as successful have targeted antisocial behaviors, academic skills and competencies, aggression, internalizing behavior problems (depression and anxiety problems), and trauma. Common factors among these successful interventions include multiple targets (parents, teachers, students, etc.), multiple contexts (school and home), and complex time intensive interventions (Hoagwood et al., 2007). The difficulty apparent is that the challenges provided by school based mental health appear to be at odds with the requirements for a successful intervention. The following studies are examples of previous interventions that have been successfully implemented in a school based behavioral health format.

A 1995 study conducted in three suburban Oregon high schools targeted adolescents already experiencing depressive symptoms. The program was focused towards learning to identify and challenge negative irrational thoughts and was found to be effective across various settings, including an after school program and a clinical hospital setting. One year following treatment, depressive symptoms were found to be significantly lower for individuals in the treatment group than controls. This study was repeated in 2001 with similar findings (Coping with Stress Course, 2013).

Another example of a successful school based intervention is the Coping Power program. Coping Power is a secondary prevention program for children with aggressive behavior that puts them at risk for developing more serious problems later in adolescence. It focuses on skill

deficits, social cognitive deficiencies and distortions, difficulty with managing strong emotions, and problems with social skills. This program is time intensive as it takes place in 45-60 minute sessions, over 34 weeks, and only targets groups of 4-6 children at a time. While time intensive, the program showed effectiveness in lowering self reported covert delinquent behavior, lower levels of substance abuse as reported by parents), and greater teacher-rated behavioral improvements at school as compared to the control group (Lockman et al., 2013).

Several other school-based interventions have been proven to be effective. These programs have targeted a number of various presenting concerns or at risk populations. They include early education programs for young children at risk for developmental delays and school failure (The Abecedarian Project, n.d.), attachment based programs (Attachment-Based Family Therapy, 2011), cognitive behavioral interventions for children experiencing post-traumatic symptoms (Cognitive Behavioral Interventions for Trauma in Schools, 2013), substance abuse prevention (LifeSkills Training, 2011), promoting positive development and social responsibility (Big Brothers Big Sisters of America, 2009), and a number of other presenting concerns and populations (Promising Practices Network, n.d.).

As stated previously, the paradox that arises is that successful interventions are typically complex and time intensive, while schools are increasingly requiring interventions be focused and succinct. The solution perhaps is to limit the breadth of the study so as to spend as much time as possible focusing on a particular skill or area of growth and to keep expectations modest regarding the scientific rigor of applied school-based studies.

Coping skills based programs appear to be perfectly suited to meet both parameters. Coping skills training can be succinct and flexible enough for a school setting, yet still be

focused enough to be useful and effective. One example of a successfully implemented coping skills program was a school based cognitive intervention aimed at anger and aggression. The researchers found that the program was helpful in reducing youth delinquency, substance use and aggressive behavior in school settings at the time of follow up (Lochman et al., 2013). Another study involved a short-term school based group intervention targeting depressed students in a high school setting. It was found that the course appeared to benefit over half of the students involved in the treatment group, whereas no improvement was seen in the control group (Ralph & Nicholson, 1995).

Other brief coping skills training programs have been proven to be effective in a variety of settings, such as in university counseling centers for the treatment of anxiety disorders (Barrow, 1982), in coordination with medical treatment for high risk drinkers (Kranzler, Tennan, Penta, & Bohn, 1997), and in pain management for use with arthritic patients (Emery et al., 2006). If brief coping skills training programs can be effective in these settings, it is possible they could be adapted to meet the time, resource, and training needs of school-based mental health. In fact, several brief coping skills programs have proven to be effective in school based behavioral health. These programs include, but are not limited to, “Helping Adolescents Cope” (Hayes & Morgan, 2005), TRAVELLERS (Dickinson, Coggan, & Bennett, 2003), Bright Ideas (Cunningham, Brandon, & Frydenberg, 2002), Teaching Kids to Cope (Puskar, Lamb, & Tusaie-Mumford, 1997), and the “Best of Coping” (Frydenberg & Brandon, 2007) programs. These programs teach coping skills such as goal setting, assertiveness, social skills, relaxation, and problem solving skills; all of which are vital to succeeding within a school setting (Carter, 2010).

The “Best of Coping” Program

The present study uses an adaptation of “The Best of Coping: Developing Coping Skills for Adolescents” program, which is a skill-based program that has been evaluated using a treatment group of adolescents between 13 and 18 years of age. The program is based on the previously mentioned Lazarus and Folkman’s cognitive appraisal theory of stress and coping/ways of coping model. The original program encompasses 10 skill building sessions that are designed to run approximately an hour each. The best of coping program was chosen over other programs for several reasons. First, the best of coping program focuses on productive/positive and unproductive/negative coping patterns, allowing for discussion of why some are used over others (Carter, 2010). Victims of bullying may react to a situation in a number of ways, this program may help these students move from unproductive reactions to bullying, to more productive or positive reactions. Second, the “Best of Coping” curriculum allows for flexibility in its delivery, which as has been previously stated is crucial to success in a school based mental health intervention (Weist et al., 2013). Finally, the “Best of Coping” program was specifically developed using the Adolescent Coping Scale, and so progress can be clearly measured from pre to post testing of the curriculum (Carter, 2010).

The researchers found that the treatment group showed an increase in the use of adaptive coping strategies, and a decrease in the use of maladaptive coping strategies compared to the waitlist control group (Carter, 2010). In a separate study, “The Best of Coping” program was also implemented in concert with a program teaching cyber safety. Participants demonstrated improvements in their overall mental health as well as in making better online choices (Chi & Frydenberg, 2009). The program has also been found to be effective in promoting family self

concept and total self concept in at risk adolescent girls (Fisher, 2006) and in decreasing the reliance on non-productive coping in rural youth at risk for depression (Eacott & Frydenberg, 2009). A previous study, also aimed at rural youth at risk for depression, identified that those with the greatest needs, or those at risk for depression, were able to benefit the most from the training program (Eacott & Frydenberg, 2008).

The “Best of Coping” program has been proven to be effective across various settings with various treatment goals. Most importantly, it has been proven to be effective within a school setting for those at risk for depression. As previously stated, students who have been the victim of bullying behavior are among the most at risk for developing depressive or other internalizing symptoms. The tri-fold link between bullying victimization, internalizing symptoms, and a student’s ability to successfully cope with stressors created an opportunity to assess the effects of the “Best of Coping” program on a population for which it appeared to be uniquely suited. If by implementing the “Best of Coping” program we could increase a student’s ability to cope with stressors, we may be able to meet the specific needs of bullying victims.

Prior to implementing the “Best of Coping” program, there remained the hurdle of successfully adapting the protocol for “best use” within a school setting. Due to the stated difficulties in implementing interventions in a school setting, the weekly protocols needed to be shortened to utilize the key components of each training session. This was accomplished by identifying which weekly activities best fit the aim of a given week. Additionally, time intensive group activities were shortened and eliminated in order to meet the constraints of a 30-minute session. The overall length of several interventions was also shortened by eliminating “crossover” material between sections and combining like-minded sessions (such as goal setting

and goal getting). These adaptations were guided primarily by the three styles of coping found by factor analysis in the “Best of Coping” protocol. These styles are “Solving the Problem”, “Non-Productive Coping”, and “Reference to Others” (Eacott & Frydenberg, 2008). Materials that did not focus on one of these three styles were discarded. Finally, in order to best facilitate the needs of the population, the program needed to be implemented in a school in which the researcher or clinician had already established relationships with administration, teachers, parents, and students. The preponderance of research suggested that an intervention administered within these parameters stood the greatest chance of yielding a successful result.

The authors of the “Best of Coping” program maintain that the protocol is designed to be adapted to various populations and circumstances (Frydenberg & Brandon, 2007). Several studies have made use of the protocol in various forms and situations. However, in every published study of the program, the researchers maintained a group format. The researchers have noted the program is slightly more effective for male participants, and the training of the instructor may greatly impact the effectiveness of the program (Carter, 2010). While other coping skill training programs exist, they either contain too much material to be adapted to 30-minute sessions over six to eight weeks, or they are not properly written for an education appropriate setting.

Because the main consequence of bullying victimization appears to be an increase in internalizing symptoms such as depression and anxiety, (Kaltiala-Heino et al., 2000), an intervention designed to teach positive coping skills to bullying victims should lower the risk of developing such symptoms. This study was designed to determine whether the “Best of Coping” program can be effectively adapted for use in a classroom setting, and then to pilot test the

adapted program. First, it was expected that the “Best of Coping” program could be effectively adapted for use within a classroom setting. Second, consistent with previous research, subjects were expected to exhibit a reduction in the presentation of negative coping skills and an increase in the presentation of positive coping skills. Finally, it was expected that this intervention would lead to a reduction of anxious and depressive symptoms in subjects who had already shown evidence of symptoms.

Chapter 2

Methods

Participants

Participants included 19 students in the 9th through 12th grades, recruited from two separate public schools. The ages of participants ranged from 13 to 18 (mean = 15.26, $sd = 1.41$). The students were recruited by surveying teachers and administrators as to which students could potentially benefit from the program because they were at risk for, or were currently experiencing, bullying victimization. All students were members of either a behavioral classroom outside of the general student population, or enrolled within an alternative high school. The sample group consisted of 13 male students, 5 female students, and 1 gender fluid student. Students were predominantly European American ($n = 13$) with several students of African American ($n = 2$), Latino ($n = 2$), or biracial ($n = 2$) descent. Assent and consent was obtained from all students and parents/legal guardians prior to inclusion in the study.

Instruments

Building Social Resilience. A coping skills training program (see Appendix A) was adapted from “The Best of Coping – Developing Coping Skills For Adolescents” protocol. This coping skill-training program focuses on enhancing adolescents’ ability to cope with daily stresses, develop problem solving skills, recognize and change maladaptive thinking patterns, identify and make use of social and community resources, and to learn and practice effective problem solving techniques. The curriculum provides skills necessary for individuals to cope with a myriad of different situations, but is adapted specifically for use within an educational

setting with limited time available. The protocol was adapted in consideration of the unique challenges provided by a school setting. Session lengths were shortened due to student/teacher availability and weekly topics narrowed to focus on specific skills or abilities rather than breadth of knowledge. The session topics and interventions were selected to address the three styles of coping found by factor analysis in the “Best of Coping” protocol. These styles are “Solving the Problem,” “Non-Productive Coping,” and “Reference to Others” (Eacott and Frydenberg, 2008).

Adolescent Coping Scale. The Adolescent Coping Scale (ACS) is an 80 item (60-item short form) instrument that measures the usage and helpfulness of coping strategies in general and specific situations. It assesses 20 distinct coping strategies, and includes two summary scales, “Productive Coping” and “Non-Productive Coping.” “Productive Coping” is the average of the Seek Social Support, Focus on Solving the Problem, Physical Recreation, Seek Relaxing Diversions, Invest in Close Friends, Work Hard and Achieve, Focus on the Positive, Accept One’s Best Efforts, Social Action, and Seek Professional Help scales. “Non-Productive Coping” refers to the average of the Worry, Wishful Thinking, Not Coping, Tension Reduction, Ignore the Problem, Keep to Self, Self Blame, and Act Up scales. The Humor and Seek Spiritual Support scales were not included in factor analysis. It is designed to help students to assess, reflect on, and develop their own coping skills. The overall reliability of ACS was 0.87 and the reliability of productive coping, referring to others, and non-productive styles were respectively 0.82, 0.82 and 0.81. Validation results showed that productive coping styles, as well as styles that employed reference to others (looking to others for help) had a significant positive association with mental health, while the non-productive coping style had a significant negative association with mental health (Ghazanfari, 2005, pp. 290-297). Scores are reported using

percent of usage and helpfulness, which refers to the percent of the time relative to the whole that a student uses a particular coping skill, and the percent of the time relative to the whole that a student finds that skills helpful when used. Higher scores indicate a higher percentage of usage and helpfulness.

The School Climate Bullying Survey (SCBS). The SCBS builds upon the original bullying research conducted by Olweus (see Appendix B). The purpose of the survey is to assess bullying behaviors as well as other aspects of school climate. The survey limits the timeframe to the previous month in order to identify current bullying victims. Item content has been adapted in response to feedback from users in an attempt to remain current with the bullying landscape and present research (Cornell, 2012). The original survey includes additional items pertaining to overall school climate, which are not relevant to this study. As such, it was shortened to focus on ten items specific to the research question. Exploratory factor analysis revealed three factors: Prevalence of Teasing and Bullying ($\alpha = .65$), Aggressive Attitudes ($\alpha = .80$), and Willingness to seek help ($\alpha = .80$). Scores range from 0-40, with a higher score indicating a higher prevalence of bullying victimization.

Generalized Anxiety Disorder Scale (GAD-7). The GAD-7 (See Appendix B) is a 7-item self-report anxiety questionnaire that has proven useful in primary care settings as well as in use with the general population. Optimum sensitivity for the GAD-7 was found to be at 89% and optimum specificity at 82% (Spitzer, 2006). The reliability of the GAD-7 was found to have an alpha level of 0.89 (Lowe et al., 2008) Scores range from 0-21, with higher scores indicating higher levels of anxiety. Clinical cutoffs for the GAD -7 have been identified as 10 and above for

moderate anxiety and 15 and above for severe anxiety (Lowe et al., 2008). The normative mean for the GAD-7 was 2.78, with a standard deviation of 3.49 (Lowe et al., 2008).

Personal Health Questionnaire -2 (PHQ-2). The PHQ-2 (See Appendix B) is a two-item depression screening scale. Among adolescents, the PHQ-2 was found to have a sensitivity of 74% and specificity of 75% for detecting youth who met clinical criteria for major depression. The PHQ-2 was also found to have 96% sensitivity and an 82% specificity rating among adolescents who met the criteria for major depression on the longer Patient Health Questionnaire 9-item depression screen (Richardson et al., 2010) Scores range from 0-6, with higher scores indicating higher levels of depression. The Clinical cutoff for depression on the PHQ-2 has been identified as 3 and above (Löwe, Kroenke, & Gräfe, 2005). Reliability was found to be 0.83, and the normative mean was found to be 1.4, with a standard deviation of 1.3 (Löwe et al., 2005)

Demographic Information Sheet. Students completed a demographic information sheet, which includes basic demographic data including age, grade, gender, and ethnicity (see Appendix B). The data were stored in such a way that the identity of the individuals remained confidential while also keeping the primary researcher blind to the identity of each participant.

Procedures

The George Fox Human Subjects Review Committee approved this study and all ethical guidelines established by the American Psychological Association were followed. Parents or guardians of the participants were contacted and written consent was gained from both the parent and the child (if they were a minor) before each participant was involved in the research. Parents, guardians, and participants were informed that any participation in the study was strictly voluntary and that they would be allowed to withdraw at any time during the study. Students'

personal information as well as their results were associated with a unique identification number both for the protection of the participants' confidentiality and to minimize experimenter bias.

The coping skills training curriculum was administered by graduate level psychology students within a practicum setting. Students received the proper supervision necessary, as the curriculum was administered as part of their practicum training. A mock session was held to both facilitate the training of leaders and test out the assumption of a 30-minute timeframe.

All participating students in each group were administered pre test materials which included the Patient Health Questionnaire – 2 (PHQ-2), Generalized Anxiety Disorder – 7 Item Scale (GAD-7), the Adolescent Coping Scale, a Demographic Information Sheet, and the School Climate Bullying Scale.

The treatment phase consisted of a six-week coping skills training program adapted from the “Best of Coping” protocol. The protocol was adapted to concentrate on specific skill areas in a shortened 30-minute session. The purpose for this was to meet the identified population needs in a focused, but efficient, manner. These skill areas (coping strategies, problem solving, reframing, reducing non productive strategies, identifying and utilizing social support, and goal setting) were identified by the researchers as crucial to a student's overall coping skill development.

The protocol was administered by doctoral students of psychology who had been placed in a practicum position in their respective school. This placement allowed the clinicians to build upon prior relationships and experience with the students, teachers, and administrations. At the beginning of each session following the first, the administrators reviewed the previous week's topic prior to introducing and practicing the new skill area for that week. After the completion of

each session, the facilitators completed a session feedback form identifying whether the timeframe for the curriculum was appropriate, what pieces worked well, and what suggestions for revisions or improvements they may have (see Appendix B).

At the conclusion of the six-week curriculum, post-test measures were administered to measure potential changes in coping styles, anxiety and depression symptoms, and bullying victimization, as well as a student feedback form for the full training.

Chapter 3

Results

In the present study, we utilized paired sample t-tests to investigate the differences between pre and post tests for all participants on the outcome variables. All comparisons were evaluated using an alpha level of .05 for statistical significance. No significant results were found for changes in self-reported bullying victimization, individual coping style usage and helpfulness, anxiety, and depression. Additionally, no significant changes were found between pre and post test on the summary scales for Productive and Non-Productive Coping. Results of analyses can be found in Table 1. The Jacobsen-Truax method (Jacobsen & Truax, 1991) was utilized to measure clinically significant change in self reported anxiety and depression. Of the 19 participants, 4 reported clinically significant improvement; 2 in the area of anxiety, and 2 in the area of depression.

Table 1. Paired Sample T-Tests for All Variables

Variable	T1 Mean (SD)	T2 Mean (SD)	Difference	T Value	P Value	Effect Size
Usage Social Support	49.47 (16.07)	56.30 (17.25)	6.82	-1.90	.07	.41
Helpfulness Social Support	50.88 (21.22)	54.44 (22.03)	-3.57	-.64	.53	.17
Usage Work Hard and Achieve	61.40 (18.67)	61.48 (18.80)	.08	-.02	.98	.004
Helpfulness Work Hard and Achieve	64.56 (22.67)	56.30 (20.63)	8.27	1.68	.11	.38
Usage Worry	60.70 (24.23)	60.74 (18.17)	.04	-.01	.99	.002
Helpfulness Worry	43.86 (17.96)	44.07 (20.50)	-.21	-.07	.94	.01
Usage Wishful Thinking	63.16 (23.24)	69.26 (17.80)	6.10	-1.27	.219	.30
Helpfulness Wishful Thinking	45.96 (17.05)	45.93 (19.49)	.04	.01	.99	.002
Usage Social Action	38.95 (16.52)	37.78 (15.71)	1.17	.24	.81	.07
Helpfulness Social Action	39.65 (14.48)	37.41 (19.77)	2.24	.60	.56	.13
Usage Self Blame	62.81 (26.14)	62.96 (22.36)	.16	-.03	.98	.007
Helpfulness Self Blame	40.00 (18.86)	42.59 (22.57)	-2.59	-.58	.57	.13
Usage Keep to Self	80.35 (17.70)	71.85 (22.94)	8.50	1.43	.17	.42
Helpfulness Keep to Self	57.54 (22.36)	51.48 (22.75)	6.06	1.48	.16	.27
Usage Seek Spiritual Support	40.70 (24.23)	38.15 (20.59)	2.55	.50	.63	.11
Helpfulness Seek Spiritual Support	43.86 (25.95)	43.70 (21.94)	.16	.03	.98	.007
Usage Focus on the Positive	59.30 (16.31)	56.67 (18.89)	2.63	.61	.55	.15
Helpfulness Focus on the Positive	51.93 (15.65)	52.96 (21.94)	-1.03	-.29	.78	.06

(table continued)

Variable	T1 Mean (SD)	T2 Mean (SD)	Difference	T Value	P Value	Effect Size
Usage Seek Professional Help	45.97 (16.46)	45.19 (21.26)	.78	.20	.85	.04
Helpfulness Seek Professional Help	44.91 (16.15)	46.30 (23.14)	-1.38	-.29	.77	.07
Usage Seek Relaxing Diversions	69.12 (22.58)	73.33 (22.44)	4.21	-1.20	.25	.19
Helpfulness Seek Relaxing Diversions	64.56 (22.45)	62.22 (24.65)	2.34	.49	.63	.10
Usage Physical Recreation	53.68 (22.39)	55.93 (21.90)	2.24	-.42	.68	.10
Helpfulness Physical Recreation	55.09 (21.98)	57.04 (22.90)	-1.95	-.27	.79	.09
Usage Act Up	47.01 (19.69)	47.04 (17.56)	.02	-.00	.99	.001
Helpfulness Act Up	48.42 (16.31)	43.33 (19.02)	5.09	1.90	.07	.29
Usage Humor	58.60 (24.70)	57.04 (22.02)	1.56	.48	.64	.07
Helpfulness Humor	53.68 (22.05)	57.41 (21.90)	-3.72	-1.08	.30	.17
Usage Not Coping	54.39 (17.68)	55.56 (20.85)	1.17	-.33	.75	.06
Helpfulness Not Coping	37.44 (14.86)	38.89 (15.75)	-1.45	.327	.75	.10
Usage Accepting Ones Best Efforts	57.54 (14.27)	55.93 (17.66)	1.62	.54	.60	.10
Helpfulness Accepting Ones Best Efforts	55.44 (15.40)	52.59 (21.53)	2.85	.93	.37	.15
Usage Ignore the Problem	65.96 (18.84)	64.07 (20.26)	1.90	.49	.63	.10
Helpfulness Ignore the Problem	46.32 (16.85)	42.22 (19.25)	4.09	.82	.42	.23
Usage Invest in Close Friends	52.28 (24.57)	52.59 (22.43)	.31	-.08	.94	.01
Helpfulness Invest in Close Friends	51.23 (21.55)	57.41 (21.33)	-6.18	-1.26	.22	.29
Usage Focus on Solving the Problem	56.14 (14.79)	52.22 (20.03)	3.92	.85	.41	.23
Helpfulness Focus on Solving the Problem	51.23 (14.92)	47.04 (18.79)	4.19	1.10	.29	.25

(table continued)

Variable	T1 Mean (SD)	T2 Mean (SD)	Difference	T Value	P Value	Effect Size
Usage Tension Reduction	45.26 (22.94)	45.49 (20.43)	.08	.02	.99	.004
Helpfulness Tension Reduction	41.75 (19.73)	44.46 (16.92)	-2.70	-5.7	.58	.15
Anxiety	10.47 (6.70)	11.00 (6.64)	-.53	-.34	.74	.08
Depression	2.16 (1.71)	1.84 (1.80)	.32	.90	.38	.18
Bullying Victimization	2.73 (3.90)	4.42 (5.52)	-1.68	1.75	.10	.36
Productive Coping Usage	54.38 (10.82)	54.74 (11.39)	-.35	-.13	.90	.03
Productive Coping Helpfulness	52.95 (12.08)	52.37 (16.82)	.58	.17	.86	.04
Non-Productive Coping Usage	59.96 (14.52)	59.58 (11.59)	.37	.14	.89	.03
Non-Productive Coping Helpfulness	45.16 (10.51)	44.12 (14.26)	1.04	.39	.70	.08

Note : For all variables T1 signifies pre test values and T2 signifies post test values, difference refers to the difference between the means for T1(pre test) and T2 (post test), SD refers to the standard deviation from the given mean, the degrees of freedom is 18 for all tests, Usage and Helpfulness mean scores are reported in percent of usage and helpfulness for each given variable, Anxiety refers to self reported GAD-7 scores, Depression refers to self reported PHQ-2 scores, Bullying Victimization refers to self reported School Climate Bullying Survey scored. In addition to statistical analyses, qualitative data were collected from group participants regarding the interventions effectiveness, usefulness, materials covered, and potential improvements.

In response to the question “What was your favorite part of the training?” responses included answers such as engaging with and receiving support from peers, having a place to discuss difficult topics, and the food that was provided each session. In response to the question “What was your least favorite part of the training?” students’ responses included completing written activities, being put in a position to respond verbally when they did not want to, having to discuss difficult topics, difficulties with other peers within the group, and remaining seated for long periods of time. In response to the question “What could be done better in the future?” responses included answers such as providing more interactive activities, requiring less written materials, creating a more receptive environment for students to feel heard, and better education for administrators and students. In response to the question “What skills did you learn?” students responded with answers such as learning how to leave a volatile situation, how to manage difficult problems, how to seek out social support, and how helpful social support can be when it is utilized. Finally, in response to the question “What skills will you use in the future?” responses included answers such as making use of social support, trusting others, and utilizing coping skills.

Two group facilitators were also provided with weekly evaluations in order to examine whether the time frame was appropriate for the material provided, the effectiveness of the material, potential revisions, and additional comments. In general, facilitators reported that the time frame was appropriate for most weeks though in some instances, the time frame was reported to be in excess of what was needed for the given week, which may have led to restlessness among group participants. In other instances where the time frame was reported to not be enough, reasons given included needing more time in group discussion to process the

material, having too much material for the facilitator to present in a timely fashion, needing additional time for pretests before the first session, and needing additional time for group process in the final session.

In response to a question about what went well in a given week, facilitators provided responses such as getting students engaged in the discussion, having students provide and discuss their own examples when discussing coping skills, discussing assertiveness versus aggressiveness, discussing social support, providing and going through the steps of problem solving, and having students recap and process at the end of the group. Suggestions for potential revision made by the facilitators included having more time for group process relative to psychoeducation, eliminating unsuccessful portions of the training, combining similar sections, and expanding upon group feedback and review at the end of the training.

Additional comments provided by the facilitators included the need to be more interactive due to the difficult population included in the study, and the attention span of the group running thin towards the end of the 30-minute sessions. Facilitators also commented on the lack of consistent attendance for several participants as being a factor due to being in an educational environment. Finally, facilitators commented on the difficulty in getting accurate pre and post tests results, as students did not appear to be engaged or invested in completing the measures. Evidence provided for these statements included students rushing through the measures, or on some occasions, providing the same response to every item.

Chapter 4

Discussion

The purpose of this study was to determine the feasibility and effectiveness of adapting the 10-session “Best of Coping” program to a shorter, and more directed, 6-session coping skills training protocol. This study was undertaken with the desire to create a program that took into consideration the feedback provided by educators and administrators regarding the applicability of such programs to the current educational environment. Additionally, in order to expand on previous research with the “Best of Coping” program, I desired to measure not only the change in coping skill usage and effectiveness over time, but also the effect on participants’ anxious and depressive symptoms.

In response to the primary research questions, the adapted protocol was not successful in reproducing the results of previous research using the “Best of Coping” protocol, in that there were no significant changes in coping skill usage and effectiveness over time (Carter, 2010; Chi & Frydenberg, 2009; Eacott & Frydenberg, 2008; Eacott & Frydenberg, 2009; Fisher, 2006). Additionally, there were no significant changes between pre- and post-test in anxious and depressive symptoms. The Jacobsen-Truax method revealed that clinically significant change was found in 4 out of 19 participants; 2 in the area of anxiety, and 2 in the area of depression. While statistical analysis did not produce desirable results, qualitative information gathered from the study reveal that certain aspects of the training show promise. With the right adjustments, and a more controlled research environment, it may be possible to effectively adapt the coping

skills training protocol, and obtain more positive results. A number of reasons may explain the lack of positive results in the adapted program. The current study utilized a sample population that was drawn from schools and classrooms that were identified with higher needs due to specific behavioral issues, rather than from the general student population. It is possible these students may be more resistant to treatment, and less willing to engage in the group process, though further research is needed to make this conclusion. One example of this in the current study is the qualitative responses given by facilitators stating the difficulties in maintaining student focus during sessions. These difficulties can also be seen in facilitator feedback that assessment results may not accurately reflect participants experience due to a perceived lack of effort or engagement on pre- and post-test measures of coping skills, anxiety, and depression. Furthermore, pre-test results reveal that the sample population is not a “normative” sample, in that a majority of participants (11 out of 19) endorsed clinically significant anxiety, and nearly half of participants (9 out of 19) endorsed clinically significant depression prior to beginning treatment. This was to be expected given the nature of the study, but it is possible it may have also affected the results.

It is also important to examine the clinical cutoffs for anxiety and depression in relation to the change in participant’s self-reported symptoms. While 9 of 19 participants endorsed clinically significant depression prior to participation in the group, only 5 met the clinical cutoff criteria at post-test. Though there was not a significant change in overall levels of self-reported depression, the number of students who met clinical criteria decreased from pre to post test, which is encouraging. Self-reported scores for anxiety however revealed that the number of participants who met the clinical cutoff for anxiety increased from 11 (8 moderate, 3 severe) at

pretest to 13 (7 moderate, 6 severe) at post-test. It is possible this may reflect a change in the way students cope throughout the term, moving from more depressive symptoms, to more anxious symptoms, however, more research is needed to make this conclusion. It is also possible that these results reflect the stress related to the end of the term and taking final tests, as post-tests were administered in the last few weeks of the semester. This would be consistent with previous research findings that students exhibit higher levels of stress and anxiety prior to and while engaging in high stakes test taking (Fraas, 2015).

Additional factors that may have affected the results of the study include a smaller sample size than previous studies, differences in the administration of the materials (Carter, 2010; Chi & Frydenberg, 2009; Eacott & Frydenberg, 2008; Eacott & Frydenberg, 2009; Fisher, 2006), and inconsistent attendance for some participants. These differences will be further examined in the discussion of goals for future development.

Goals for Future Development

A number of areas can be identified for future development and improvement. As stated previously, there were a number of differences between the current study and previous research using the “Best of Coping” protocol. These differences, as well as facilitator and group feedback on the protocol, can help shed light on ways to improve this program for future use.

As discussed earlier, common factors among successful interventions include multiple targets (parents, teachers, students, etc.), multiple contexts (school and home), and complex time intensive interventions (Hoagwood et al., 2007). In an effort to meet the concerns identified by the educational community regarding time and resources, the current study sought to create a protocol that was both shorter and more direct in its approach. This approach may have limited

the effect of the coping skills training program on the participants. The natural conclusion would be to move back towards more time intensive and comprehensive interventions, however facilitator and group feedback from this study would suggest that this may not be the right course of action for this particular population. Both participants and facilitators alike reported difficulties with maintaining focused attention through even 30-minute sessions. If the goal of this study is to create a program to serve at risk students, asking these students to engage in a longer, more time intensive intervention may not serve their needs. Instead, group and facilitator feedback suggest that a better option may be to change the structure of the group and intervention itself, particularly, focusing more on areas that were seen as useful and helpful.

Participant and facilitator feedback reveal a number of areas that may be improved. In particular, one identified area of improvement is to focus time and energy on areas that were deemed helpful and useful. These areas included discussing ways to gain support from peers, having an opportunity to discuss difficult topics, engaging in social interaction with others, learning the difference between assertiveness and aggressiveness, discussing the steps to problem solving, and spending time processing and recapping at the end of the intervention. By focusing on areas that were deemed useful and helpful, the researchers can increase student interest and interaction in the group. In theory, increased interaction and interest should lead to increased effectiveness.

Another way to improve the intervention involves eliminating unhelpful sections. Specifically, facilitators suggested eliminating goal setting and goal achievement, as these topics seemed to be partially out of place with the previous material. Additionally, it was suggested that this time could be better used for group process and review of the previous weeks. By

eliminating unhelpful and irrelevant material, there will be more time for group interaction and discussion, which was an identified area for improvement by facilitators and participants alike. Qualitatively, there appeared to be an inverse relationship between the amount of material provided, and the level of helpful and effective discussion in the group. Factors that appeared to increase the effectiveness of the group were interactive activities, discussion as opposed to written expression, and having students provide their own examples.

In addition to the changes to the intervention itself, other changes were identified that may increase effectiveness. One such area was providing better education for teachers and facilitators. Facilitators were presenting this material for the first time, and it is likely that given more training and experience, their effectiveness in presenting materials and leading groups would improve.

Finally, this particular population appeared to struggle with the amount of assessment materials provided for the study. The length of the assessments was a strain on the students, and likely affected the validity of the study due to the perceived lack of effort exhibited by several students. Future development of this intervention should take into account the length of assessment materials, and attempt to more accurately assess student's coping styles and anxious and depressive symptoms. It may be beneficial to not measure students immediately prior to finals week, as this may represent an irregular increase in self-reported anxiety. Furthermore, integrating a parent or teacher report may provide a more comprehensive and accurate measure of anxious and depressive symptoms.

Future Research

Future research regarding the “Building Social Resilience” protocol should include a comparison group from the general student population in order to measure whether the findings are a result of the sample population, or a result of the methods and intervention. A larger sample size would also provide a more accurate measure of within group change. Additionally, future research must include a more effective way of assessing bullying victimization. Self-report may not be an effective way of measuring bullying victimization due to the stigma involved, and parent or teacher report may be required to get an accurate measurement. Additional research is also needed to determine whether students are more likely to exhibit anxious symptoms at the end of the term versus depressive symptoms. Finally, it is possible that the current intervention is but one of many therapeutic interactions that take place in students’ lives. Longitudinal research is needed to determine the effectiveness of multiple points of therapeutic contact over time.

Implications

The current study built upon previous research findings regarding the difficulties of providing effective and efficient services within an educational environment. The demands of this environment, coupled with the difficulties in building an effective curriculum for working with at risk students, creates a significant challenge for researchers. One implication of the current research is that there is a subset of students with higher needs than the rest of the population, and that these students are in need of support. The anxiety and depression reported by participants in the current study revealed that there is a need for coping skill based training programs such as the one used in the current study. Without intervention, many of these students will be unable to cope with the significant anxiety and depression they are currently

experiencing. The eventual implication of this is that if left untreated, it is possible that the levels of symptoms they are experiencing could lead to undesirable long-term health outcomes (Kaltiala-Heino et al., 2000).

While statistical analysis did not show significant improvement between pre- and post-test, qualitative findings reveal that students did find some benefit in the “Building Social Resilience” program. The implication of this is that by focusing on the areas that students did find some benefit, future research may be able to see more substantial results. If the current protocol can be improved, students may in turn exhibit more improvement themselves. While only a small portion of students saw therapeutic benefit from the current study, this provides encouragement that coping skills training programs can indeed be helpful for some students in terms of managing their anxious and depressive symptoms.

Finally, the qualitative results, as well as prior research, reveal that the current protocol and subsequent revisions are applicable to high need populations. In returning to the original research questions, it appears that yes, the curriculum can be applied in the school system, and even with high needs populations.

Limitations

The current study has a number of limitations. As mentioned previously, the small sample size and lack of a controlled environment in the experiment could have potentially affected the outcome of the study. Working within the confines of an educational environment meant that researchers were at times affected by class schedules, student attendance, or the ebb and flow of the normal academic year. The lack of a control group also limited the researchers’ ability to do a true experiment, and to measure whether the protocol was effective for a more

normative population. Additionally, the use of self-report measures of anxiety, depression, coping style usage and helpfulness, and bullying victimization may not have provided a comprehensive view of participants' experience. Furthermore, student feedback suggests that the limited amount of facilitator training may have reduced the effectiveness of the material being delivered. Finally, as the facilitators noted, the amount of assessment materials participants were required to complete may have led to a perceived lack of effort on behalf of the participants. This in turn may have affected individual and group scores on self-report measures.

Conclusion

The current study built upon previous research on the effectiveness of using coping skills training programs with at-risk adolescent students. While statistical analysis did not produce significant improvements in overall group changes in coping skill usage or helpfulness, anxiety, or depression, clinical improvements in anxiety and depression were found in 4 students (2 anxiety, 2 depression). Qualitative results also revealed that a number of improvements can be made to increase the effectiveness of the intervention used in the current study such as making the group more interactive, eliminating non-relevant sections, and focusing on areas that students saw the most benefit.

The current study was hindered by a number of difficulties that were present in previous research within an academic setting. This realization could easily be frustrating to future researchers as they endeavor to create new interventions or improve upon previously existing interventions. However, educators, clinicians, and researchers may hope that over the long course of education, contact with healthy adults will reinforce necessary changes. This bottom up

approach to systemic change relies upon the different individuals that each student will encounter, and the hope that each positive contact will contribute to healthy human development.

References

- Attachment-Based Family Therapy. (2011, July 1). Retrieved from
<http://www.promisingpractices.net/program.asp?programid=274>
- Barakat, L. P., Schwartz, L. A., Simon, K., & Radcliffe, J. (2007). Negative thinking as a coping strategy mediator of pain and internalizing symptoms in adolescents with sickle cell disease. *Journal of Behavioral Medicine*, 30(3), 199-208.
doi:10.1007/s10865-007-9103-x
- Barrow, J. C. (1982). Coping skills training: A brief therapy approach for students with evaluative anxiety. *Journal of American College Health*, 30(6), 269-274.
doi:10.1080/07448481.1982.9938906
- Berry-Krazmien, C. A. (2007). Bullying behavior and victimization among adolescents in a residential placement. *Dissertation Abstracts International Section A*, 67.
- Big Brothers Big Sisters of America. (2009, November 1). Retrieved from
<http://www.promisingpractices.net/program.asp?programid=125>
- Bonanno, R. A., & Hymel, S. (2010). Beyond hurt feelings: Investigating why some victims of bullying are at greater risk for suicidal ideation. *Merrill-Palmer Quarterly*, 56(3), 420-440. doi:10.1353/mpq.0.0051
- Bond, L., Carlin, J. B., Thomas, L., Rubin, K., & Patton, G. (2001). Does bullying cause emotional problems? A prospective study of young teenagers. *BMJ: British Medical Journal*, 323(7311), 480-484. doi:10.1136/bmj.323.7311.48

- Brighi, A., Guarini, A., Melotti, G., Galli, S., & Genta, M. L. (2012). Predictors of victimisation across direct bullying, indirect bullying and cyberbullying. *Emotional and Behavioural Difficulties*, 17(3-4), 375-388.
- Carter, A. E. (2010). Evaluating the best of coping program: Enhancing coping skills in adolescents. *Dissertation Abstracts International*, 72, 3089.
- Chesney, M. A., Chambers, D. B., Taylor, J. M., Johnson, L. M., & Folkman, S. (2003). Coping effectiveness training for men living with HIV: Results from a randomized clinical trial testing a group-based intervention. *Psychosomatic Medicine*, 65(6), 1038-1046.
doi:10.1097/01.PSY.0000097344.78697.ED
- Chi, C. W., & Frydenberg, E. (2009). Coping in the cyberworld: Program implementation and evaluation—A pilot project. *Australian Journal of Guidance and Counselling*, 19(2), 196-215. doi:10.1375/ajgc.19.2.196
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS). (2013, June 1). Retrieved from <http://www.promisingpractices.net/program.asp?programid=145>
- Collaborative for Academic, Social, and Emotional Learning. (2009). What is SEL? Skills and competencies. Retrieved from <http://www.casel.org/basics/skills.php>
- Coping with Stress Course. (2013, February 1). Retrieved from <http://www.promisingpractices.net/program.asp?programid=151#programin>
- Cornell, D. (2012, May 22). The School Climate Bullying Survey: Description and Research summary. Retrieved from http://curry.virginia.edu/uploads/resourceLibrary/School_Climate_Bullying_Survey_Description_for_Distribution_5-22-12.pdf

Craig, W., Harel-Fisch, Y., Fogel-Grinvald, H., Dastaler, S., Hetland, J., & Simons-Morten, B.

(2009). A cross-national profile of bullying and victimization among adolescents in 40 countries. *International Journal of Public Health*, 54, S216-S224. Journal Citation, Database: PsycINFO References

Cunningham, E. G., Brandon, C. M., & Frydenberg, E. (2002). Enhancing coping resources in early adolescence through a school-based program teaching optimistic thinking skills. *Anxiety, Stress and Coping*, 15, 369-381.

Dickinson, P., Coggan, C., & Bennett, S. (2003). TRAVELLERS: A school-based early intervention programme helping young people manage and process change, loss and transition. Pilot phase findings. *Australian and New Zealand Journal of Psychiatry*, 37, 299-306.

Dilmaç, B. (2009). Psychological needs as a predictor of cyber bullying: A preliminary report on college students. *Kuram Ve Uygulamada Eğitim Bilimleri*, 9(3), 1307-1325.

Duchnick, J. J., Letsch, E. A., & Curtiss, G. (2009). Coping effectiveness training during acute rehabilitation of spinal cord injury/dysfunction: A randomized clinical trial. *Rehabilitation Psychology*, 54(2), 123-132. doi:10.1037/a0015571

Eacott, C., & Frydenberg, E. (2008). At-risk students in a rural context: Benefits and gains from a coping skills program. *Australian Journal of Guidance and Counselling*, 18(2), 160-181. doi:10.1375/ajgc.18.2.160

Eacott, C., & Frydenberg, E. (2009). Promoting positive coping skills for rural youth: Benefits for at-risk young people. *The Australian Journal of Rural Health*, 17(6), 338-345. doi:10.1111/j.1440-1584.2009.01109.x

- Egan, S. K., & Perry, D. G. (1998). Does low self-regard invite victimization? *Developmental Psychology*, 34(2), 299-309. doi:10.1037/0012-1649.34.2.299
- Elinoff, M. J., Chafouleas, S. M., & Sassu, K. A. (2004). Bullying: Considering for defining and intervening in school settings. *Psychology in the Schools*, 41(8), 887-897.
doi:10.1002/pits.20045
- Emery, C. F., Keefe, F. J., France, C. R., Affleck, G., Waters, S., Fondow, M. M., ... Stainbrook, D. (2006). Effects of a brief coping skills training intervention on nociceptive flexion reflex threshold in patients having osteoarthritic knee pain: A preliminary laboratory study of sex differences. *Journal of Pain and Symptom Management*, 31(3), 262-269.
doi:10.1016/j.jpainsymman.2
- Farrington, D. P., & Ttofi, M. M. (2009) Reducing school bullying: Evidence-based implications for policy. *Crime and Justice*, 38, 281-345. 10.1086/599198. 10.1086/599198. Journal Citation, Database: PsycINFO References
- Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2010). Trends in childhood violence and abuse exposure. *Archives of Pediatrics & Adolescent Medicine*, 164(3), 238.
- Fisher, R. (2006). Evaluating the effects of the best of coping (BOC) curriculum on enhancing coping skills in at-risk adolescent girls. *Dissertation Abstracts International*, 67, 2223.
- Forman, S. G., Linney, J. A., & Brondino, M. J. (1990). Effects of coping skills training on adolescents at risk for substance use. *Psychology of Addictive Behaviors*, 4(2), 67-76.
doi:10.1037/h0080585
- Fox, C. L., & Boulton, M. J. (2005). The social skills problems of victims of bullying: Self, peer and teacher perceptions. *British Journal of Educational Psychology*, 75(2), 313-328.

doi:10.1348/000709905X25517

Fraas, J. J. (2015). School counselors' perspective on high-stakes testing: Exploring the impact of high-stakes testing on students and counselors. *Dissertation Abstracts International Section A*, 76.

Frydenberg, E., & Brandon, C. (2007). The best of coping: Developing coping skills for adolescents. ACER Press, Australia.

Ghazanfari, A. (2005). Validation of Adolescents Coping Scale. *Iranian Journal of Psychiatry and Clinical Psychology*, 290-297.

Gini, G. (2008). Associations between bullying behaviour, psychosomatic complaints, emotional and behavioural problems. *Journal of Paediatrics and Child Health*, 44(9), 492-497.

doi:10.1111/j.1440-1754.2007.01155.x

Hayes, C., & Morgan, M. (2005). Evaluation of a psychoeducational program to help adolescents cope. *Journal of Youth and Adolescence*, 34, 111-121.

Haynie, D. L., Nansel, T., Eitel, P., Crump, A., Saylor, K., Yu, K., & Simons-Morton, B. (2001). Bullies, victims, and bully/victims: Distinct groups of at-risk youth. *The Journal of Early Adolescence*, 21(1), 29-49. doi:10.1177/0272431601021001002

Herba, C. M., Ferdinand, R. F., Stijnen, T., Veenstra, R., Oldehinkel, A. J., Ormel, J., & Verhulst, F. C. (2008). Victimization and suicide ideation in the TRAILS study: Specific vulnerabilities of victims. *Journal of Child Psychology and Psychiatry*, 49(8), 867-876.

Heisel, M. J., Flett, G. L., & Hewitt, P. L. (2003). Social hopelessness and college student suicide ideation. *Archives of Suicide Research*, 7(3), 221-235.

doi:10.1080/13811110301557

Hoagwood, K. E., Olin, S. S., Kerker, B. D., Kratochwill, T. R., Crowe, M., & Saka, N. (2007).

Empirically based school interventions targeted at academic and mental health functioning. *Journal of Emotional and Behavioral Disorders*, 15(2), 66-92.

doi:10.1177/10634266070150020301

Hunter, S. C., & Boyle, J. E. (2004). Appraisal and coping strategy use in victims of school bullying. *British Journal of Educational Psychology*, 74(1), 83-107.

doi:10.1348/000709904322848833

Hussein, M. (2013). The social and emotional skills of bullies, victims, and bully-victims of Egyptian primary school children. *International Journal of Psychology*, 48(5), 910-921.

doi:10.1080/00207594.2012.702908

Ivarsson, T., Broberg, A. G., Arvidsson, T., & Gillberg, C. (2005). Bullying in adolescence: Psychiatric problems in victims and bullies as measured by the youth self report (YSR) and the depression self-rating scale (DSRS). *Nordic Journal of Psychiatry*, 59(5), 365-373. doi:10.1080/08039480500227816

Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12-19.

Juvonen, J., Nishina, A., & Graham, S. (2000). Peer harassment, psychological adjustment, and school functioning in early adolescence. *Journal of Educational Psychology*, 92(2), 349-359. doi:10.1037/0022-0663.92.2.349

- Kaltiala-Heino, R., Rimpelä, M., Rantanen, P., & Rimpelä, A. (2000). Bullying at school—an indicator of adolescents at risk for mental disorders. *Journal of Adolescence*, 23(6), 661-674. doi:10.1006/jado.2000.0351
- Kennedy, P. P., Duff, J. J., Evans, M. M., & Beedie, A. A. (2003). Coping effectiveness training reduces depression and anxiety following traumatic spinal cord injuries. *British Journal of Clinical Psychology*, 42(1), 41-52. doi:10.1348/014466503762842002
- Kessel Schneider, S., O'Donnell, L., Stueve, A., & Coulter, R. S. (2012). Cyberbullying, school bullying, and psychological distress: A regional census of high school students. *American Journal of Public Health*, 102(1), 171-177. doi:10.2105/AJPH.2011.300308
- Kraag, G., Zeegers, M. P., Kok, G., Hosman, C., & Abu-Saad, H. H. (2006). School programs targeting stress management in children and adolescents: A meta-analysis. *Journal of School Psychology*, 44(6), 449-472. doi:10.1016/j.jsp.2006.07.001
- Kranzler, H. R., Tennen, H., Penta, C., & Bohn, M. J. (1997). Targeted naltrexone treatment of early problem drinkers. *Addictive Behaviors*, 22(3), 431-436. doi:10.1016/S0306-4603(96)00064-0
- Kroese, F. M., Adriaanse, M. A., Vinkers, C. W., van de Schoot, R., & de Ridder, D. D. (2014). The effectiveness of a proactive coping intervention targeting self-management in diabetes patients. *Psychology & Health*, 29(1), 110-125. doi:10.1080/08870446.2013.841911
- Kumpulainen, K., Räsänen, E., Henttonen, I., Almqvist, F., Kresanov, K., Linna, S., ... Tamminen, T. (1998). Bullying and psychiatric symptoms among elementary school-age children. *Child Abuse & Neglect*, 22(7), 705-717. doi:10.1016/S0145-2134(98)00049-0

LifeSkills Training. (2011, December 1). Retrieved from

<http://www.promisingpractices.net/program.asp?programid=48>

Livingston, P. (2008). A meta-analysis of the effectiveness of anti-bullying programs on students. *Dissertation Abstracts International Section A*, 69.

Lochman, J. E., Powell, N. P., Boxmeyer, C. L., Kelly, M., Dillon, C., & Bradshaw, C. (2013). Anger management in schools: The Coping Power program for children and early adolescents. In E. Fernandez & E. Fernandez (Eds.), *Treatments for anger in specific populations: Theory, application, and outcome* (pp. 176-196). New York, NY: Oxford University Press

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the generalized anxiety disorder screener (GAD-7). *General Population. Medical Care*, 46(3), 266-274.

Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of Psychosomatic Research*, 58(2), 163-171.

Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 159-197). New York, NY: Wiley.

Mason, S. E., & Fogel, S. J. (2013). Prevention, community engagement, and social work. *Families in Society*, 94(3), 139-140. doi:10.1606/1044-3894.4320

Menesini, E., Modena, M., & Tani, F. (2009). Bullying and victimization in adolescence: Concurrent and stable roles and psychological health symptoms. *The Journal of Genetic Psychology: Research and Theory on Human Development*, 170(2), 115-133. doi:10.3200/GNTP.170.2.115-134

- Merrell, K. W. (2010). Linking prevention science and social-emotional learning: The Oregon Resiliency Project. *Psychology in the Schools, 47*(1), 55-70.
- Merrell, K. W., & Gueldner, B. A. (2010). *Social and emotional learning in the classroom: Promoting mental health and academic success*. New York, NY: Guilford Press.
- Meyers, J., & Nastasi, B. K. (1999). Primary prevention in school settings. In C. R. Reynolds & T. B. Gutkin (Eds.), *The handbook of school psychology* (3rd ed., pp. 764-799). New York, NY: Wiley. Citation, Database: PsycINFO References
- Murray-Harvey, R., Skrzypiec, G., & Slee, P. T. (2012). Effective and ineffective coping with bullying strategies as assessed by informed professionals and their use by victimised students. *Australian Journal of Guidance and Counselling, 22*(1), 122-138.
- Neft, D. I. (2007). Social and emotional profiles of bullies and victims: Implications for school-based prevention programs. *Dissertation Abstracts International, 67*.
- O'Brennan, L. M., Bradshaw, C. P., & Sawyer, A. L. (2009). Examining development differences in the social-emotional problems among frequent bullies, victims, and bully/victims. *Psychology in the Schools, 46*(2), 100-115. doi:10.1002/pits.20357
- Olweus, D. (1993). *Bullying at school: What we know and what we can do*. Malden: Blackwell Publishing, Malden MA.
- Olweus, D., & Limber, S. P. (2010). Bullying in school: Evaluation and dissemination of the Olweus Bullying Prevention Program. *American Journal of Orthopsychiatry, 80*(1), 124-134. doi:10.1111/j.1939-0025.2010.01015.x
- Ortega, R., Elipe, P., Mora-Merchán, J. A., Calmaestra, J., & Vega, E. (2009). The emotional impact on victims of traditional bullying and cyberbullying: A study of Spanish

- adolescents. *Zeitschrift Für Psychologie/Journal of Psychology*, 217(4), 197-204.
doi:10.1027/0044-3409.217.4.197
- Özdemir, M., & Stattin, H. (2011). Bullies, victims, and bully-victims: A longitudinal examination of the effects of bullying-victimization experiences on youth well-being. *Journal of Aggression, Conflict and Peace Research*, 3(2), 97-102.
- Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: A meta-analytic review. *Journal of Behavioral Medicine*, 25(6), 551-603. doi:10.1023/A:1020641400589
- Pincus, D. B., & Friedman, A. G. (2004). Improving children's coping with everyday stress: Transporting treatment interventions to the school settings. *Clinical Child and Family Psychology Review*, 7(4), 223-240. doi:10.1007/s10567-004-6087-8
- Promising Practices Network | Programs that Work. (n.d.). Retrieved from <http://www.promisingpractices.net/programs.asp>
- Puskar, K. R., Lamb, J., & Tusaie-Mumford, K. (1997). Teaching kids to cope: A preventive mental health nursing strategy for adolescents. *Journal of Child and Adolescent Psychiatric Nursing*, 10, 18-28.
- Ralph, A., & Nicholson, L. (1995). Teaching coping skills to depressed adolescents in high school settings. *Behaviour Change*, 12(4), 175-190.
- Richardson, L., Rockhill, C., Russo, J., Grossman, D., Richards, J., Mccarty, C., ... Katon, W. (2010). Evaluation of the PHQ-2 as a brief screen for detecting major depression among adolescents. *Pediatrics*, E1097-E1103.

- Rigby, K., & Smith, P. K. (2011). Is school bullying really on the rise? *Social Psychology of Education, 14*(4), 441-455. doi:10.1007/s11218-011-9158-y
- Robers, S., Zhang, J., Truman, J., & Snyder, T. (2012). Indicators of school crime and safety: 2011 (NCES 2012-002 NCJ 236021). Washington, DC: National Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Book Citation, Database: PsycINFO References
- Roxas, A. S., & Glenwick, D. S. (2014). The relationship of psychological mindedness and general coping to psychological adjustment and distress in high-school adolescents. *Individual Differences Research, 12*(2), 38-49.
- Siebecker, A. B. (2010). Victimization and internalizing problems: Examining the experience of repeated bullying, anxiety, and depression. *Dissertation Abstracts International Section A, 70*.
- Smith, P. K., & Brain, P. (2000). Bullying in schools: Lessons from two decades of research. *Aggressive Behavior, 26*(1), 1-9. doi:10.1002/(SICI)1098-2337(2000)26:1<1::AID-AB1>3.0.CO;2-7
- Smokowski, P. R., & Kopasz, K. (2005). Bullying in school: An overview of types, effects, family characteristics, and intervention strategies. *Children & Schools, 27*(2), 101-110.
- Spitzer, R. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 1092*-1097.

Srof, B. J., Velsor-Friedrich, B., & Penckofer, S. (2012). The effects of coping skills training among teens with asthma. *Western Journal of Nursing Research*, 34(8), 1043-1061.

doi:10.1177/0193945911406290

The Abecedarian Project. (n.d.). Retrieved from

<http://www.promisingpractices.net/program.asp?programid=132>

Völlink, T., Bolman, C. W., Dehue, F., & Jacobs, N. L. (2013). Coping with cyberbullying:

Differences between victims, bully-victims and children not involved in bullying. *Journal of Community & Applied Social Psychology*, 23(1), 7-24. doi:10.1002/casp.2142

Wang, J., Nansel, T. R., & Iannotti, R. J. (2011). Cyber and traditional bullying: Differential association with depression. *Journal of Adolescent Health*, 48(4), 415-417.

doi:10.1016/j.jadohealth.2010.07.012

Weist, M., Youngstrom, E., Stephan, S., Lever, N., Fowler, J., Taylor, L., ... Hoagwood, K.

(2013). Challenges and ideas from a research program on high-quality, evidence-based practice in school mental health. *Journal of Clinical Child & Adolescent Psychology*, 1-12.

Williams, S. G., & Godfrey, A. J. (2011). What is cyberbullying & how can psychiatric-mental health nurses recognize it? *Journal of Psychosocial Nursing and Mental Health*

Services, 49(10), 36-41. doi:10.3928/02793695-20110831-03

Yang, A., & Salmivalli, C. (2013). Different forms of bullying and victimization: Bully-victims versus bullies and victims. *European Journal of Developmental Psychology*, 10(6), 723-

738. doi:10.1080/17405629.2013.793596

- Zins, J. E., Bloodworth, M. R., Weissberg, R. P., & Walberg, H. J. (2004). The scientific base linking social and emotional learning to school success. In J. E. Zins, R. P. Weissberg, M. C. Wang, & H. J. Walberg (Eds.), *Building academic success on social and emotional learning: What does the research say?* (pp. 3-22). New York, NY: Teachers College Press.
- Zins, J. E., & Elias, M. J. (2006). Social and emotional learning. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III* (pp. 1-13). Bethesda, MD: National Association of School Psychologists.
- Zwierzynska, K., Wolke, D., & Lereya, T. S. (2013). Peer victimization in childhood and internalizing problems in adolescence: A prospective longitudinal study. *Journal of Abnormal Child Psychology*, 41(2), 309-323. doi:10.1007/s10802-012-9678-8

Appendix A

Building Social Resilience

A Guide to Developing Positive Coping Skills in Adolescents

Based on “The Best of Coping – Developing Coping Skills for Adolescence”

Introduction

This protocol is adapted from a ten-session group model for adolescent coping and is designed to be flexible in order for use across various treatment settings. The adapted protocol is designed for use by therapists who are working with adolescents aged 13-18. The protocol can be particularly helpful with those who have identified themselves, or who have been identified by parents, teachers, therapists, or other professionals as having been victims of bullying behavior. Bullying can be defined as “aggressive behavior or intentional harm doing that is carried out repeatedly and over time in an interpersonal relationship characterized by an actual or perceived imbalance of power or strength” (Olweus & Limber, 2010, p. 125).

This protocol is based off of research using the Adolescent Coping Scale, developed by Lazarus. The scale is used to help determine different ways in which an adolescent positively or negatively copes with stressful, harmful, or loss inducing events. The focus of this intervention is to increase the frequency of positive coping behaviors, and decrease the frequency of negative coping behaviors. By increasing positive coping behaviors and decreasing negative coping behaviors, it is believed that it is possible to prevent, or mitigate, the effects of negative social

interactions, such as bullying behavior, which lead to anxiety, depression, and psychosomatic complaints.

Each Session is designed around a specific goal or task for that week labeled as the “AIM”. The adapted protocol is structured in a way that presents the “AIM” first, followed the interventions designed to meet that “AIM.” The interventions have been adapted for use with all students, but some may be particularly useful for victims of bullying. Handouts will be made available for therapists to use in session with students. Upon completing the protocol, therapists should use clinical judgment in determining whether there is a need for a referral for additional services for students.

Before Beginning Treatment (Required)

Intake/Pre-Session

Prior to beginning treatment, **Informed Consent** must be obtained from students, as well as parents, for treatment as well as for participation in this study. After consent has been obtained, the administrator should administer the following pre test instruments and materials:

-Demographic Information Sheet

-Adolescent Coping Scale

-Social Climate Bullying Survey

-PHQ-2

-GAD-7

These measures will be completed prior to the first session taking place.

Week 1/ Sessions1 – Psychoeducation**AIM:**

To introduce the concept of coping, explore individual styles and facilitate an understanding of the various coping strategies.

Interventions, Activities, and Topics for Discussion:***What is coping?*** (suggested 10 min)

A brief psycho-educational discussion on “coping” as a way of dealing with the world and the problems life dishes out.

-What is Coping?

-Why do we need to cope?

Coping Strategies and Styles (suggested 10 min)

An interactive group discussion regarding various coping strategies and styles. Look through the various coping strategies and styles on the handout and ask the students to identify several strategies or styles they may have used at some point in their own lives. Once they have identified several strategies or styles, ask for specific examples in the student’s life.

Worksheet

Applying Coping strategies (suggested 10 min)

Work together with the students to come up with three situations, real or make-believe, that might cause a person to need to cope. Have the students choose a strategy for each scenario and discuss the possible outcomes, as well as whether that strategy was appropriate given the circumstance.

Week 2/Session 2 – Cognitive Restructuring**AIM:**

To help students gain a basic awareness of the differences between thoughts and feelings, as well as to learn the basics of evaluating and reframing thoughts.

Interventions, Activities, and Topics for Discussion:

Review (suggested 5 minutes)

Thoughts and Feelings (suggested 10 minutes)

Discuss how our feelings are controlled by our self-talk, or our thoughts, and NOT by things that happen. Identify an event in the past week that students had a negative experience with. After they have described the event, have them divide a piece of paper into two halves in order to separate their thoughts from their feelings. Help the students to identify what are thoughts, and what are feelings as he/she discusses the event.

Worksheet if necessary

Thinking optimistically and thought evaluation (suggested 15 minutes)

Discuss how negative thoughts lead to experiencing negative feelings, and alternatively how positive thoughts can lead to positive feelings. Discuss with the students ways in which negative self-talk might be affecting their feelings. Things like putting themselves down, blaming themselves regularly, putting a negative slant on events, imagining the worst, looking for ulterior motives, etc. Have the students identify ways in which they may practice negative self talk, then help them to “be a detective” to determine how likely they are to be true. Discuss how it is easier to justify out negative thoughts because we are used to thinking in a negative way.

Week 3/Session 3 – Negative Coping Strategies**AIM:**

To raise awareness of the ineffective coping strategies that people use and to explore some productive alternatives. This is one of the most important sessions, reducing non-productive strategies (particularly self-blame) has a huge effect on outcome.

Interventions, Activities, and Topics for Discussion:

Review (suggested 5 minutes)

Non productive coping strategies (suggested 20 minutes)

Introduce non productive coping strategies as bad habits, sometimes useless, and even at times harmful.

- Not Coping – What does not coping look like? Ask the students to respond.
Possible answers include giving up, emotional breakdowns, physical illnesses, suicide, homicide, etc.
- Worry – Worry is different than thinking about something and mulling it over.
Ask the students what are the results of worry? Possible answers include anxiety, confusion, stress, lack of focus, breakdowns, etc. The focus of this should in the end be that worry is useless in helping us to fix our problems
 - Positive ways to distract from worry: physical exercise, enjoyable activities, relaxing, etc.
- Tension Reduction – Smoking, drugs, alcohol, risk taking or thrill seeking, breaking the law, depression. These strategies are destructive to a persons health and/or mind.

- Self Blame – This strategy is the most likely to reduce your well being. Blaming yourself for events that are outside of your control or events that have already happened. Instead, we attempt to focus on moving forward, learning from our mistakes, and how to do things differently the next time. Ask students when they have been hard on themselves and said that it was their own fault?
- Ignoring the Problem – When we worry so much that we decide to ignore the problem all together. While this may help us to feel better, and sometimes function better, there can at times be severe consequences to ignoring the problem. While sometimes there may be a more appropriate strategy, sometimes ignoring the problem can be the best way to deal with a situation. Ask students if they can think of an example. Examples include ignoring a challenge to a fight, ignoring things that can't be changed, etc.
- Keep to Self – Problems that we hold to ourselves end to grow bigger and do harm to our physical and mental health.

Finding alternatives for negative coping strategies (suggested 5 minutes)

Work with the students to come up with a situation (real or make-believe) where someone uses a negative coping strategy. After discussing the negative strategy, ask for or suggest a more positive coping strategy that would work well in that situation. Next week we will talk about getting along with others and asking for help.

Week 4/Session 4 – Getting Along with Others and Asking for Help**AIM:**

To explore and practice aspects of communicating and listening as well as to raise awareness in the importance of reaching out to others and of the networks of support available to each person

Interventions, Activities, and Topics for Discussion:

Review (suggested 5 minutes)

Assertive communication (suggested 10 minutes)

Discuss the difference between assertive behavior, where you stand up for your rights and express how you feel in a way that does not put down others or violate their rights, and aggressive behavior where a person stands up for their rights in a way that violates the rights of others or puts them down. Aggressive behavior is an attack on another person. Non-assertive behavior may be either doing nothing, feeling sorry for yourself, being the martyr, or trying to manipulate others. This topic is particularly poignant for bullying victims, as they may have attempted any or all of these options and still found himself or herself as a victim.

Identifying which coping strategies involve reaching out or utilizing others (suggested 10 minutes)

The answers include social support, invest in close friends, belonging, social action, spiritual support, and professional help. Identify situations in which you or someone else might use these strategies.

Identifying networks of support (suggested 5 minutes)

Help the students to identify people they can reach out to for help, advice, or friendship.

Week 5/Session 5 – Problem Solving**AIM:**

To learn basic problem solving skills and be able to implement them in various situations.

Interventions, Activities, and Topics for Discussion:

Review (suggested 5 minutes)

Steps to problem solving (suggested 10 minutes)

We have been talking with the students about how to cope with problems over the last few sessions. While coping is necessary, one of the best ways to cope with a problem sometimes is to solve it. Discuss how if a problem is within your locus of control, it may be worth going through the process of problem solving.

- Define the problem – What is the real problem? Is it being clouded by emotions, opinions, etc.? Make the definition of the problem based on facts.
- Think of possible solutions – Think of as many as you can and write them down. Get others to suggest ideas. Don't evaluate these solutions at this point, just accept all the possibilities
- Evaluate the solutions – This is where we evaluate all of those ideas we just came up with. Weigh them like on a scale and consider how they may or may not work. Remove any solutions that are not acceptable to you.
- Decide which solution is best – Choose the solution that appears to be the best.
- Work out how the decision will be put into action – This step is very important! Sometimes it is easy for us to figure out what we need to do, but harder to actually do it! In order to do this, make a plan of action:

- What has to be done?
- Who is to do it?
- When will it be done?
- Assess how well it worked and retry if necessary – Did the problem go away?

Was it a good decision? Did it work in part, in whole, or not at all? If the answer is yes, great! Take the time to validate that and to celebrate the success. If the answer is no, validate the feelings of frustration or disappointment that may occur and help to determine why it didn't work. Possible reasons include maybe it wasn't the right decision, maybe it didn't get implemented correctly, or maybe it was due to factors outside of your control.

Worksheet

Practice the problem solving process (suggested 15 minutes)

Work with students to practice the six steps on the provided problem, or if they are able, to practice with a problem of their own. If possible, ask students how to incorporate their own personal values into the decision making process.

Worksheet

Week 6/Session6 – Goal Achievement and Program Review**AIM:**

To help the client build awareness about the relationship between goals and achievement and to encourage exploration of individual goals.

Interventions, Activities, and Topics for Discussion:

Review (suggested 5 minutes)

Effective Goal Setting (suggested 15 minutes)

How do you make dreams a reality? Take some time to explore the goals that the students discuss and determine with them whether they are realistic and achievable. Things to consider in this discussion include the overall picture of your life, your time and commitments, your motivation, and your values. Discuss how thought and careful planning will not guarantee success, but they will give you the best chance. The following are elements of achievable goals:

- Realistic – Large goals may become more realistic by breaking them down into smaller goals. Say the goal is to become a rockstar. You may achieve this goal, but even if you do not if you set smaller more realistic goals along the way you will develop a lot of skills and meet a lot of people to allow you to be successful in a career in the music industry. If this is the case, the effort towards the goal is not wasted.
- Achievable – Goals need to be specific and defined, so that you know when you have accomplished them.
- Effort – Are you willing to put a lot of time and effort into achieving this goal?

- Balance – Does this goal fit in with other important things in your life?
- Visualize positive goals – this will help you keep on track and motivated for success. Frame your goals positively instead of negatively. Its easier to work towards something then to fight against it. Ex. If you want to stop eating junk food you could say ‘I want to eat fruit when I want to snack.’

Overview and reflection on past 8 weeks (suggested 10 minutes)

Take time to reflect and discuss what was learned over the previous 8 weeks/sessions.

Discuss with students what they found helpful and how they feel they can and will implement these skills in their day-to-day lives.

Post Intervention – Post Test (Required)

Post Test Measures:

- a. **Adolescent Coping Scale**
- b. **School Climate Bullying Survey**
- c. **PHQ-2**
- d. **GAD-7**
- e. **Survey regarding protocol/intervention for students and teachers**

Appendix B

Scales and Instruments

School Climate Bullying Survey

School Climate Bullying Survey©

(Grades 6-12)

Do not write your name on this survey, so that your answers remain private and confidential. Your teachers will turn in the surveys without reading them. The results of this survey will be used to improve how students get along with one another at our school. *Please answer these questions honestly.*

Definition of Bullying: Bullying is defined as the use of one's strength or popularity to injure, threaten, or embarrass another person on purpose. Bullying can be physical, verbal, or social. It is not bullying when two students who are about the same in strength or power have a fight or argument.	Never	Once or twice	About once per week	Several times per week
1. By this definition, I have <i>been bullied</i> at school in the past month.	A	B	C	D
2. By this definition, I have <i>bullied others</i> at school in the past month.	A	B	C	D
Physical Bullying involves repeatedly hitting, kicking, or shoving someone weaker on purpose. During the past month (30 days) at school:				
3. I have been physically bullied or threatened with physical bullying.	A	B	C	D
4. I have physically bullied or threatened to physically bully another student.	A	B	C	D
Verbal bullying involves repeatedly teasing, putting down, or insulting someone on purpose. During the past month (30 days) at school:				
5. I have been verbally bullied.	A	B	C	D
6. I have verbally bullied another student.	A	B	C	D
Social bullying involves getting others repeatedly to ignore or leave someone out on purpose. During the past month (30 days) at school:				
7. I have been socially bullied.	A	B	C	D
8. I have socially bullied another student.	A	B	C	D
Cyber bullying involves using technology (cell phone, email, internet chat and posting, etc.) to tease or put down someone. During the past month (30 days) at school or home:				
9. I have been cyber bullied.	A	B	C	D
10. I have cyber bullied another student.	A	B	C	D

PHQ-2**Patient Health Questionnaire-2: Screening Instrument for Depression**

<i>OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?</i>	<i>NOT AT ALL</i>	<i>SEVERAL DAYS</i>	<i>MORE THAN ONE- HALF THE DAYS</i>	<i>NEARLY EVERY DAY</i>
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GAD-7**Generalized Anxiety Disorder 7-item (GAD-7) scale**

been	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Demographic Questionnaire

Date of Birth:

Grade:

Gender:

Ethnicity:

Facilitator Session Feedback Form

Facilitator name: _____

Group Name: _____

Session number: _____

Session name/topic: _____

Review Questions

Was the time frame for the curriculum this week appropriate? If not, what revisions would you suggest?

What parts of this weeks intervention worked well?

What parts of this weeks intervention would you suggest revisions too

Additional Comments?

Student Post-Program Feedback Form

What was your favorite part of the training?

What was your least favorite part of the training?

What do you think could be done better for other students in the future?

What skills do you think you learned during this training?

What skills do you think you will use in the future?

Appendix C**Curriculum Vitae****Daniel Moshofsky**

University Address
422 N. Meridian Street #V301
Newberg, Oregon 97132
Doctorate of Psychology
George Fox University

Home Address
11720 SW Bowmont Lane
Portland, Oregon 97225
971-506-1406
Daniel.Moshofsky@gmail.com

EDUCATION

- 08.2012-Present **Doctoral Student, Doctor of Psychology, Clinical Psychology**
George Fox University
Graduate Department of Clinical Psychology: *APA Accredited*
Newberg, Oregon Advisor: Mark R. McMinn, PhD, ABPP/CL
Current GPA: 3.97
Anticipated Graduation Date: May, 2017
- 08.2012-05.2014 **Masters of Arts, Clinical Psychology**
George Fox University
Graduate Department of Clinical Psychology: *APA Accredited*
Newberg, Oregon
- 09.2010-05.2012 **Student of Masters of Counseling**
George Fox University
Graduate Department of Counseling: *CACREP Accredited*
Portland, Oregon
- 08.2005-05.2009 **Bachelor of Arts, Biblical Studies**
Minors: Counseling
Life Pacific College
San Dimas, California

SUPERVISED CLINICAL EXPERIENCE

- 08.2015-Present **George Fox University Health and Counseling Center**
Newberg, Oregon

Treatment Setting: University Health and Counseling Center

Populations Served: Diverse populations of college aged undergraduate students attending a private university.

Supervisors: Bill Buhrow, Psy.D., Luann Foster, Psy.D.

Clinical Duties:

- Two-day, 16 hour per week practicum, therapeutic interventions and assessments within an integrated college health clinic.
- Utilizes Cognitive Behavioral and Solution Focused interventions in a primarily brief therapeutic model to serve a diverse clinical population.
- Conduct individual therapy with students presenting with a broad range of psychopathological symptoms.
- Administer and interpret integrated cognitive, academic, and psychodiagnostic assessments.
- Consult with medical staff to create collaborative treatment plans.
- One hour weekly individual supervision
- Two hours weekly of group training focusing on various clinical issues.

Intervention Hours: 73 (300 Anticipated)

Assessment Hours: 4 (15 Anticipated)

08.2015-Present

George Fox University PsyD Program Clinical Mentor/Peer Supervisor
Newberg, Oregon

Treatment Setting: Doctoral Program of Clinical Psychology

Populations Served: 2nd year PsyD practicum student.

Supervisor: Roger Bufford Ph.D.

Clinical Duties:

- Provide weekly supervision for a second year PsyD practicum student working within a university counseling center.

- Discuss diagnosis, case conceptualization, treatment planning, presentation skills, theoretical orientation, and professional development.

Intervention Hours: 6 (30 Anticipated)

06.2015-08.2015

Metropolitan Pediatrics Supplemental Assessment Practicum

Beaverton, Oregon

Treatment Setting: Pediatric Primary Care

Populations Served: Diverse populations of children and parents in an outpatient pediatric medical setting.

Supervisor: Catherine McClellan, Ph.D.

Clinical duties:

- Collaboratively worked in an integrated pediatric medical setting to conduct psychological intakes, administer cognitive and neuropsychological assessments, and provide feedback to patients and parents.
- Observed and consulted with professional psychologists experienced in the administration and interpretation of cognitive and neuropsychological assessments.

Intervention Hours: 6

Assessment hours: 23

03.2015-05.2015

Doctoral Dissertation Coping Skills Training Group

North Clackamas School District

Clackamas, Oregon

Treatment Setting: Public Alternative Middle and High School

Populations Served: Diverse populations of adolescents in an alternative middle and high school.

Supervisors: Fiorella Kassab, Ph.D., Leslie Franklin, Ph.D.

Clinical Duties:

- 8-week coping skills training group interaction with at risk adolescent boys in an alternative high school setting.
- Small group facilitation, psychoeducation, pre and post test administration.

Intervention Hours: 8

08.2014-06.2014

Linfield College Health, Wellness, and Counseling Center

McMinnville, Oregon

Treatment Setting: Integrated University Health and Counseling Center

Populations Served: Diverse populations of college aged undergraduate students attending a private liberal arts college.

Supervisors: Joel Gregor, Psy.D., Patricia Haddeland, C.P.N.P., Sally Goddard, M.D.

Clinical Duties:

- Two-day, 16 hour per week practicum, therapeutic counseling interventions and assessments within an integrated college health clinic.
- Combined Cognitive Behavioral, Third Wave Behavioral, and Motivational Interviewing interventions to serve a diverse clinical population.
- Worked in collaboration with medical and mental health staff to serve students' needs.
- Developed and implemented previously nonexistent assessment procedure and referral system for the university health center and academic support center.
- Administered and interpreted integrated psycho-diagnostic, psycho-educational, and neuropsychological assessments.
- Collaborated with wellness team for programming and outreach events to the student population.

- Worked with various levels of acuity and referral questions including: anxiety, depression, trauma and PTSD, sexual and physical abuse, risk assessment, university mandated counseling, crisis intervention, panic disorder/panic attacks, social anxiety, social skills, grief, academic stress, substance abuse, conflict resolution, gender issues, management of life as a student athlete, etc.
- Two hours weekly individual supervision.

Intervention hours: 216

Assessment Hours: 60

09.2013-06.2014

North Clackamas School District

Milwaukie, Oregon

Rex Putnam High School (Primary Location)

Treatment Setting: Public K-12 school district, primarily based in high school

Populations Served: Diverse populations of students and staff in a public K-12 school district. Majority of population served was high school students.

Supervisor: Fiorella Kassab, Ph.D

Clinical Duties:

- Two-day, 16 hour per week practicum, short and long-term Cognitive Behavioral Therapy and attachment oriented interventions with teenagers.
- Helped in facilitation of psycho-educational groups.
- Coordinated with Special Education teams and parents to develop Individualized Education Plans.
- Administered cognitive, achievement, adaptive functioning, and behavior tests and writing reports.

- Primarily worked within a low socioeconomic status population and gained experience in working with developmental disabilities, behavioral disorders, and other clients with special needs.
- One-hour weekly individual supervision, one-hour weekly group supervision.

Intervention Hours: 213

Assessment Hours: 55

01.2013-05.2013

George Fox University Pre-Practicum B

Newberg, Oregon

Treatment Setting: University volunteer students

Populations Served: George Fox University undergraduate students.

Supervisors: Carlos Taloyo, Ph.D and Tyler Gerdin, M.A.

Clinical Duties:

- Providing weekly therapy for two undergraduate students.
- Conducted intake interviews, developed treatment plans, wrote formal intake reports, and completed termination summaries.
- Received intensive supervision from two supervisors, reviewing videos of each session, formulating treatment plans, and measuring therapeutic relationship and outcomes.

Intervention Hours: 20

09.2012-12.2012

George Fox University Pre-Practicum A

Newberg, Oregon

Treatment Setting: PsyD Department Student Volunteers

Populations Served: George Fox University PsyD students.

Supervisors: Carlos Taloyo, Ph.D and Tyler Gerdin, M.A.

Clinical Duties:

- Practiced basic counseling skills under the supervision of a fourth year clinical mentor within a Rogerian therapy framework.
- Learned how to conduct psychological intakes, individual therapy, and termination sessions.
- 1-hour weekly group supervision that included video review of therapeutic skill development.

Intervention Hours: 5

01.2011-05.2011

George Fox Masters in Counseling Practicum – Transferred

Newberg, Oregon

Treatment Setting: Graduate department of counseling, George Fox University

Populations Served: Masters in Counseling students.

Supervisor: Michelle Cox, Ph.D.

Clinical Duties:

Provided weekly therapy for two other practicum students for 10 sessions each. Conducted intake interviews, developed treatment plans, wrote case notes and completed a case formulation.

Intervention Hours: 20

ASSESSMENT TRAINING AND EXPERIENCE

16 Personality Factor Questionnaire, Fifth Edition (16PF Fifth Edition)

21-item Test

Achenbach Child Behavior Checklists

Adaptive Behavior Assessment System-Second Edition (ABAS-II)-Parent

Adaptive Behavior Assessment System-Second Edition (ABAS-II)-Teacher

Adult ADHD Self-Report Scale (ASRS)

Behavior Assessment System for Children and Adolescents, Second Edition (BASC-2)

Benton Line Orientation Test

Booklet Categories Test

Boston Naming Test
 Brief Rating Scale of Executive Function (BRIEF)
 California Verbal Learning Test –II
 Clock Test
 Comprehensive Test of Phonological Processing, Second Edition (CTOPP-2)
 Conners 3 ADHD Index
 Continuous Performance Test-2(Conners)
 Controlled Oral Word Association
 Diagnostic Interview for ADHD in Adults (DIVA)
 Delis Kaplan Executive Function System (DKEFS)
 Doors and People Memory Test
 Finger Tapping Test
 Finer Tip Number Writing
 Gray Oral Reading Test, Fifth Edition (GORT-V)
 Grip Strength Test
 Grooved Pegboard
 Hopkins Verbal Learning Test - Revised
 Hooper Visual Organization Test
 Iowa Gambling Test
 Kinetic Family Drawing
 Medical Symptoms Validity Test
 Millon Adolescent Clinical Inventory (MACI)
 Millon Clinical Multiaxial Inventory, Third Edition (MCMI-III)
 Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)
 Minnesota Multiphasic Personality Inventory- Adolescent (MMPI-A)
 Minnesota Multiphasic Personality Inventory, Restructured Form (MMPI-2-RF)
 NEPSY-II (Developmental Neuropsychological Assessment)
 Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4)
 Personality Assessment Inventory (PAI)
 Purdue Pegboard
 Reitan-Indiana Aphasia Screening
 Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R)
 Rey-Osterrieth Complex Figure Test
 Seashore Rhythm Test
 Social Communication Questionnaire (SCQ)-Previously Autism Screening Questionnaire (ASQ)
 Speech Sounds Perception Test
 Strong Interest Inventory
 Tactile Finger Recognition
 Tactual Performance Test
 Test of Memory Malingering (TOMM)
 Test of Variables of Attention (TOVA)
 Trail-Making A & B
 Vineland Adaptive Behavior Scales, Second Edition
 Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
 Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)
 Wechsler Intelligence Scale for Children, Fifth Edition (WISC-IV) – Q-Interactive trained

Wechsler Individual Achievement Test, Third Edition (WIAT-III)
Wechsler Memory Scale-IV
Wide Range Achievement Test (WRAT-4)
Wide Range Intelligence Test (WRIT)
Wide Range Assessment of Memory and Learning, Second Edition (WRAML-2)
Wisconsin Card Sorting Test
Woodcock-Johnson Test of Achievement, Third Edition (WJ-III ACH)
Woodcock-Johnson Test of Achievement, Fourth Edition (WJ-IV ACH)
Woodcock-Johnson Test of Cognitive Abilities, Third Edition (WJ-III COG)
Woodcock-Johnson Test of Cognitive Abilities, Fourth Edition (WJ-IV COG)

Total Clinical Hours - Doctoral

Intervention Hours: 556

Assessment Hours: 142

Supervision Hours: 261

Support Hours: 565

Total Practicum Hours: 1,524

ACADEMIC RELATED EXPERIENCE

09.2015-Present	<p>Clinical Mentor/Peer Supervisor George Fox University</p> <p>Provide one-hour weekly individual supervision for a 2nd year doctoral psychology student. Areas covered include case conceptualization, treatment planning, presentation skills, theoretical orientation, and professional development.</p>
02.2014, 02.2015	<p>PsyD Program Applicant Interviewer and Student Panel Member George Fox University</p> <p>Co-interviewed prospective Psy.D. students alongside a current faculty member. Participated in student panels for prospective students.</p>

01.2015-05.2015	<p>Personality Assessment Teaching Assistant George Fox University</p> <p>Provided assistance to and consulted with students regarding personality assessment. Additional duties included occasional teaching experiences and grading coursework.</p>
09.2013-06.2014	<p>Peer Mentor George Fox University</p> <p>Assisted first year PsyD student in their transition to graduate school by providing academic and professional guidance.</p>

PROFESSIONAL AND EDUCATIONAL TRAINING EXPERIENCES

2013-Present	<p>Psy.D. Department Clinical Team George Fox University, Newberg, Oregon Consultants: Joel Gregor, PsyD, Mark McMinn, PhD, ABPP/CL, Paul Stoltzfus, PsyD</p> <ul style="list-style-type: none"> • Consultation group that meets weekly to present and discuss cases from various clinical perspectives.
10.21.15	<p>“Let’s Talk About Sex: Sex and Sexuality Applications for Clinical Work” George Fox University, Newberg, Oregon, Grand Rounds Dr. Joy Mauldin, Psy.D.</p>
09.30.15	<p>“Relational Psychoanalysis and Christian Faith: A Heuristic Dialogue” George Fox University, Newberg, Oregon, Grand Rounds Dr. Marie Hoffman, Ph.D.</p>
08.2015	<p>“Motivational Interviewing Training” Health Education and Training Institute Online Motivational Interviewing Training Keith Young, LCPC</p>
03.2015	<p>Spiritual Formation and Psychotherapy George Fox University, Newberg, Oregon Barrett McRay, PsyD</p>
02.2015	<p>Credentialing, Banking, the Internship Crisis, and Other Challenges George Fox University, Newberg, Oregon, Grand Rounds Morgan Sammons, PhD</p>

- 11.2014 "Face Time in the Age of Technological Attachment"
George Fox University, Newberg Oregon, Colloquium
Doreen Dodgen-Magee, Psy.D.
- 11.2014 Disaster Mental Health Training
Linfield College, McMinnville, Oregon
Carol Gross, LMHC, Red Cross Cascades Region Disaster Mental Health
Advisor
- 10.2014 ADHD: Evidenced-Based Practice for Children & Adolescents
George Fox University, Newberg Oregon, Grand Rounds,
Erika Doty, Psy.D. & Tabitha Becker, Psy.D.
- 10.2014 Learning Disabilities: A Neuropsychological Perspective
George Fox University, Newberg, Oregon, Didactic Training
Tabitha Becker, PsyD
- 07.2014 The Ultimate Transition Workshop (Adults with Down Syndrome)
Indianapolis, Indiana, 2014 National Down Syndrome Convention
Jo Ann Simons, MSW
- 07.2014 Adult Brothers and Sisters Who Have Siblings with Down Syndrome
Indianapolis, Indiana, 2014 National Down Syndrome Convention
Brian Skotko, MD, MPP, Sue Levine, MA, CSW
- 07.2014 Grief and Loss in Adults with Down Syndrome
Indianapolis, Indiana, 2014 National Down Syndrome Convention
Shannon Lee, MA
- 06.2014 ISC-V: Overview and Demonstration
George Fox University, Newberg, Oregon, 2014 Annual Northwest
Psychological Assessment Conference
Patrick J. Moran, PhD.
- 06.2014 Woodcock-Johnson-IV: A New Era of Assessment and Interpretation
George Fox University, Newberg, Oregon, 2014 Annual Northwest
Psychological Assessment Conference
Stephanie Rodriguez
- 05.2014 Evaluating Brain Functioning: From Prenatal Exposure to Spiritual
Disciplines
George Fox University, Newberg, Oregon, Didactic Training
Dr. Glena Andrews, Ph.D

- 03.2014 Evidence-based Treatments for PTSD in Veteran Populations: Clinical and Integrative Perspectives
George Fox University, Newberg, Oregon, Colloquium
Dr. David Beil-Adaskin, Ph.D
- 02.2014 Neuropsychological Evaluation and Consultation: Clinical and Forensic Applications
George Fox University, Newberg, Oregon, An Integrative Training
- 01.2014 Dr. Paul Kaufman J.D., Ph.D., ABPP-CN
Action and Commitment in Psychotherapy: A Mindful Approach to Rapid Clinical Change
George Fox University, Newberg, Oregon, Colloquium
Brian Sandoval, PsyD & Juliette Cutts, PsyD
- 01.2014 DSM-V Training
George Fox University, Newberg, Oregon, Colloquium
Dr. Jeri Turgesen PsyD and Dr. Mary Peterson PhD, ABPP
- 09.2013 Integrated Primary Care
George Fox University, Newberg, Oregon, Grand Rounds
Brian Sandoval, PsyD, and Juliette Cutts, PsyD
- 05.2013 Using Tests of Effort in a Psychological Assessment
George Fox University, Newberg, Oregon, 2013 Annual Northwest Psychological Assessment Conference
Paul Green, PhD
- 03.2013 The Person of the Therapist: How Spiritual Practice Weaves with Therapeutic Encounter.
George Fox University, Newberg, Oregon, Grand Rounds
Dr. Brooke Kuhnhausen, PhD
- 01.2013 Afrocentric Approaches to Clinical Practice
George Fox University, Newberg, Oregon, Grand Rounds
OHSU Avel Gordly Center for Healing, Danette C. Haynes, LCSW, Clinical Director Marcus Sharpe PsyD

PROFESSIONAL AFFILIATIONS

2013-Present **American Psychological Association**, Student Affiliate

- 2015-Present **Division 12, Society of Clinical Psychology**, Student Affiliate
 Section 10, Graduate Students and Early Career Psychologists, Student Affiliate
- 2015-Present **Division 17, Society of Counseling Psychology**, Student Affiliate
 Section 10, University Counseling Centers, Student Affiliate
- 2015-Present **Oregon Psychological Association**, Student Affiliate

RESEARCH EXPERIENCE

- 2014-Present **Dissertation Research:** *Collecting Data*
- A study examining the feasibility and usefulness of adapting a coping skills training protocol to an educational setting, with the purpose of measuring the effects on students overall, and a bullying victim subgroup.
- Advisor: Mark McMinn, PhD, ABPP/CL
- Committee Members: Elizabeth Hamilton, PhD,
 Kathleen Gathercoal, PhD
- Proposal Approved: March 30, 2015
- 2012-Present **Research Vertical Team Member**
- Bi-monthly meetings to discuss and evaluate progress, methodology, and design of group and individual research projects. Assist team members in research design, data collection, and analysis. Areas of team focus: Integration of psychology and spirituality; positive psychology of food; technology in professional psychology; and barriers to psychotherapy.
- George Fox University, Newberg, OR.
- Chair: Mark R. McMinn, PhD, ABPP/CL

RELEVANT WORK AND VOLUNTEER EXPERIENCE

- 05.2009-07.2012 Medical Office Clerk – Metropolitan Pediatrics, Beaverton, OR
 Supported doctors, nurses and other medical staff with patient communication, organization, and electronic medical records.

- 08.2008-05.2009 Resident Life Sponsor – Life Pacific College, San Dimas CA
Responsible for leading small group discussions and planning activities
within the Resident Life system at Life Pacific College.
- 08.2008-05.2009 ASB Cabinet member – Life Pacific College, San Dimas, CA
Collaborated with other ASB cabinet members to plan and direct
activities and events for undergraduate students at life pacific college

REFERENCES

Fiorella Kassab, Ph.D.
North Clackamas School District
Coordinator, Special Education
Clinical & School Psychologist
Milwaukie, Oregon
kassabf@nclack.k12.or.us
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George Fox Behavioral Health Center
Clinical Director, Clinical Psychologist
Licensed Psychologist
Newberg, Oregon
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George Fox University Health and
Counseling Center
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Licensed Psychologist
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Linfield College Health, Wellness, and
Counseling Center
Clinical Psychiatrist
Newberg, Oregon
sallygodard@earthlink.net
503-883-2535