Increasing the Effectiveness of a Social Emotional Learning Program Through Cultural Adaptation for African American Students’ Internalizing Symptoms

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Increasing the Effectiveness of a Social Emotional Learning Program Through Cultural Adaptation for African American Students’ Internalizing Symptoms

A Dissertation Presented

by

COURTENEY A. JOHNSON

Submitted to the Graduate School of the University of Massachusetts Amherst in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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University of Massachusetts College of Education
School Psychology Program
Increasing the Effectiveness of a Social Emotional Learning Program Through Cultural Adaptation for African American Students’ Internalizing Symptoms

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DEDICATION

To my mother who has always recognized my potential and strength even when I did not.
ACKNOWLEDGEMENTS

I must first thank my advisor, Sara Whitcomb, whose research led me to this field and continues to inspire my career. I want to thank you for your wisdom and guidance throughout the years. In addition to Dr. Whitcomb, I would also like to thank my professors, Drs. Amanda Marcotte, Sarah Fefer, and John Hintze, who have helped shape my professional practice. I extend this gratitude to the members of my committee for their suggestions and feedback throughout this process.

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I would like to thank the authors and contributors of Strong Teens for publishing an evidence-based social emotional program that remains a staple in my collection of curriculums and served as the basis for this project.

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Lastly, a huge thanks to my family and friends, especially my UMASS cohort, who have all been supportive during the last 6 years. Words cannot express my gratitude. I could not have done this without any them.
ABSTRACT

INCREASING THE EFFECTIVENESS OF A SOCIAL EMOTIONAL LEARNING PROGRAM THROUGH CULTURAL ADAPTATION FOR AFRICAN AMERICAN STUDENTS’ INTERNALIZING SYMPTOMS

MAY 2019

COURTENEY A. JOHNSON, B.A., THE JOHNS HOPKINS UNIVERSITY

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Directed by: Professor Sara Whitcomb

Cultural adaptation is a mechanism used to increase the congruency of evidence-based interventions when delivered to a specific ethnic-cultural group. While initially conceptualized in response to the lack of support of evidence-based treatments with ethnic minorities, research identifying unique risk and protective factors for minority groups, as well as poor participant engagement and a lower utilization of mental health services as compared to Caucasian youth, provide additional support for the cultural adaptation of interventions. This study compared the results of a school-based social emotional curriculum culturally adapted for African American youth to a non-adapted intervention. The study analyzed participants’ overall internalizing symptoms, social-emotional knowledge, engagement, and social acceptability of the intervention.
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CHAPTER I

STATEMENT OF THE PROBLEM

A. Overview

Internalizing problems encompass a large class of psychological issues including expressions of anxiety, depression, somatic complaints, and suicidal behaviors (Gueldner & Merrell, 2011; McIntosh, Ty, & Miller, 2014; Reynolds, 1990). Internalizing problems are characterized by their covert and over-controlled symptomology (McIntosh et al., 2014; Reynolds, 1990). The development of these symptoms is associated with significant impairments and future psychopathology. Unfortunately, since symptoms are not readily observed, detection and proper intervention can be difficult (McIntosh et al., 2014; Reynolds, 1990). Given this negative trajectory, identifying critical periods when the development of these symptoms is likely, may aid in the delivery of appropriate preventative and early intervention efforts.

The increased demands and stress during adolescence increase teenagers’ risk for developing various emotional and behavioral problems including internalizing problems (Caldwell, Assari, & Brelan-Noble, 2016; Gaylord-Harden & Cunningham, 2009). More pointedly, the appearance of internalizing symptoms is highly correlated with the increase in daily stressors and the major life events and disruptions characteristic of adolescence (Reynolds, 1990; Schmeelk-Cone & Zimmerman, 2003). For minority youth there are additional culturally specific risk factors that result in perpetual and chronic levels of stress (Algeria, Vallas, & Pumariega, 2010). This is particularly the case for African American youth who are disproportionally affected by various risk factors including: unsafe neighborhoods, impoverished conditions, discrimination, and exposure to violence.
(Alegria et al., 2010; Caldwell et al., 2016). While many African American youth manifest resiliency (Carter, Mitchell, Sbrocco, 2012), others appear to have difficulty coping in the face of these stressors. Given the noted appearance of many stressors during this time, adolescence is a period where the receipt of interventions may be crucial in thwarting long-term negative effects. The implementation of effective prevention and intervention strategies can assist teens in developing positive coping strategies to more effectively manage the developmental, environmental, and culturally unique stressors present in their environment.

One commonly implemented prevention (and early intervention) strategy used to address internalizing problems during youth is Social and Emotional Learning (SEL). SEL practices have been found to reduce problem behaviors, positively affect school performance, and provide psychosocial benefits to youth by fostering protective factors and reducing risk factors that associated with difficulties during youth (Durlak et al., 2011; Payton et al., 2008; Slaten, Rivera, Shemwell, & Elison, 2016). Unfortunately, many SEL programs adhere to a one-size fits all approach (Slaten et al., 2016) and are typically comprised of content that fails to address the unique sociocultural stressors experienced by minority students. For many psychological interventions, an inability to engage minority students may hinder the effectiveness of these programs (Slaten et al., 2016; Sweeney, Robins, Ruberu, & Jones, 2005). This direct relationship between participants’ engagement during interventions and the effectiveness of these interventions suggests a need for both researchers and practitioners to develop and utilize methods that will increase the treatment engagement of minorities, particularly African American youth. One method that can be used to increase participant engagement and overall
social acceptability is cultural adaptation (Bernal, Jimenez-Chafey, & Rodriguez, 2009; Bernal, & Rodriguez, 2012; Cardemil, 2010).

The primary goal of cultural adaptation is to increase appropriateness and acceptability by systematically integrating cultural aspects such as language, case conceptualization, and worldview into evidence-based treatments and practices (Bernal, & Rodriguez, 2012). The purpose of this study was to examine the effects of a culturally adapted evidence-based, social-emotional curriculum, Strong Teens, implemented with African American adolescents. The success of these modifications was assessed using pre- and post-test analysis of participant engagement, internalizing symptoms, social-emotional knowledge, and treatment acceptability.

B. Internalizing Disorders and Adolescents

Mental health impairments are one of the leading causes of disability worldwide and affect many youth (Merikangas, Nakamura, & Kessler, 2009). Some studies estimate that upwards of 20% of children exhibit significant emotional and behavioral difficulties (Merikangas, et al., 2010; Holm-Hansen, 2006). Social, emotional, and behavioral problems typically fall into one of two broad categories: externalizing and internalizing (Achenbach et al., 2016). For years, mental health literature has primarily focused on the presence and treatment of externalizing behaviors (Caldarella, 2009; Sanders, Merrell, & Cobb, 1999). Only recently has attention shifted to studying internalizing behaviors in school aged populations (Reynolds, 1990). This increased focused research has resulted in a more comprehensive understanding of the pervasiveness of internalizing symptoms among both children and adolescents. To date, internalizing problems represent the most prevalent emotional and behavioral disturbances among youth (Lembke, 2012).
Internalizing symptoms include those associated with depression, anxiety, social withdrawal, and somatic (physical) problems such as fatigue, negative cognitions, and physiological symptoms (Gueldner & Merrell, 2011; McIntosh et al., 2014; Reynolds, 1990). This group of behaviors is most notable for its covert symptomology (Reynolds, 1990). In comparison to the visible, often disruptive, nature of externalizing symptoms, internalizing symptoms are inner-directed and over controlled (Gueldner & Merrell, 2011; McIntosh et al., 2014; Reynolds, 1990). However, depending on the illness (and the individual) there may be some variation in the expression of symptoms (Reynolds, 1990). While some behaviors may go unnoticed, other symptoms may manifest in more externalized ways such as non-compliance or observable repetitive behaviors (Gueldner & Merrell, 2011; McIntosh et al., 2014; Reynolds, 1990). For instance, children with separation anxiety, an internalizing disorder, may become highly non-compliant and visibly distressed (Reynolds, 1990).

Internalizing behaviors, while typically non-disruptive to their environment, have long-lasting detrimental effects on the individual themselves. Even at subclinical levels, symptoms are associated with social, relational, physical, and occupational impairments (Buskirk-Cohen, 2012; Caldarella, 2009; Reynolds, 1990). Social withdrawal, peer-rejection, depressed self-esteem, and poor academic outcomes are all common effects observed in youth with emotional problems (Brody et al., 2006; Sanders, Merrell, & Cobb, 1999). Additionally, this group of individuals is more vulnerable to developing other emotional disorders including an increased risk for suicide (Buskirk-Cohen, 2012). Given the level of impairment associated with internalizing problems, it is important to
understand the etiology of these behaviors to effectively reduce the likelihood of these outcomes occurring.

While individuals may exhibit internalizing symptoms early on, for anxiety and depression, the two most prominent disorders within this category, the risk for developing these symptoms rapidly increases as individuals enter adolescence (Buskirk-Cohen, 2012; Carlson & Grant, 2008; Casey et al., 2010; Robinson, Case, Droedge, & Jason, 2015; Compas, Orosan, & Grant, 1993; Gaylord-Harden & Cunningham, 2009; Gueldner & Merrell, 2011; Hey, Bailey, & Stouffer, 2001; Merikingas et al., 2010) In addition to the various biological and genetic characteristics (e.g., inherited factors, maternal depression) that can influence individuals’ development of emotional difficulties, the etiology of internalizing symptoms is most commonly associated with exposure to environmental and ecological stressors (Reynolds, 1990; Gueldner & Merrell, 2011), which are often experienced in adolescence (Caldwell, Assari, & Breland-Noble, 2016; Compas et al., 1993).

In the 1900s G. Stanley Hall coined the phrase “storm and stress” referring to adolescence as a tumultuous developmental stage, one that is characterized by the defiant behaviors and mood disruptions often exhibited by individuals during this time (Arnett, 1999). Hall’s ideology was later reinforced by Anna Freud, a staunch proponent of his, who more pointedly inferred that tumultuous experiences during adolescence were both inevitable and biological (Arnett, 1999). This theory has been further supported by the various cognitive, environmental, and biological changes youth undergo during this period (Casey et al., 2010; Seaton et al., 2008). Puberty, increased independence, and school transitions are all linked to an increased vulnerability and onset for various
emotional and behavioral difficulties (Merikingas et al., 2010; Carlson & Grant, 2008).

However, this “inevitable trajectory” proclaimed by Hall and Freud has since come into question. In the century since Hall introduced the phrase “storm and stress,” researchers have determined that despite the overall increase in stress during adolescence, the level of stress and “storminess” is further influenced by biology and individual experiences, experiences that are often influenced by an individual’s culture (Arnett, 1990).

C. Culturally Specific Risk Factors

While all adolescents are prone to developing internalizing symptoms, this risk is elevated for racial and ethnic minorities who, in addition to the pressures (e.g., school demands) and major life events (e.g., parental divorce) experienced by many during this period (Leonard et al., 2015), face additional, significant stressors unique to their race and ethnicity (Gibbons, Roberts, Beach, Simons, Gerrard, Li, Weng, & Philbert, 2012). This is especially true for African American youth, who are disproportionately affected by poverty, poor social mobility, limited resources, and exposure to violence; all factors associated with an increased risk for internalizing problems (Alegria et al., 2010; Caldwell et al., 2016; Sanders et al., 1999; Schmeelk-Cone & Zimmerman, 2003). Additionally, many African Americans also experience culturally unique problems such as racism and discrimination (Gibbons et al., 2012; Robinson et al., 2015).

Racism is a significant stressor for all individuals of color (Gaylord-Harden & Cunningham, 2008). This is particularly true for African Americans who experience more racism than any other racial and ethnic minority group (Gaylord-Harden & Cunningham, 2008). While most of the research on this topic has focused on the experiences of adults, studies have found that African American youth are commonly
exposed to racism and discrimination (Scott Jr., 2003; Seaton, Caldwell, Sellers, & Jackson, 2008). Current research has found that black individuals have reported experiencing racial discrimination as young as 10 years old (Gibbons et al., 2012). For many African Americans, racism is a frequent, sometimes daily experience (Gaylord-Harden & Cunningham, 2008; Seaton et al., 2008; Scott Jr., 2003), and the rates of incidence increase with age (Seaton et al., 2008). Racism, for many African American youth, can manifest in a variety of ways, from institutional racism (e.g., lower educational expectations, police tactics, disproportionality in suspension rates) to interpersonal interactions that may involve overt racism and microaggressions (e.g., being followed in a store) (Gaylord-Harden & Cunningham, 2009; Hope, Hoggard, & Thomas, 2015). For African American youth the common stressors typical during adolescence occur alongside the unique stress of racism, further enhancing their risk for various emotional problems (Hope et al., 2015; Seaton et al., 2008)

D. The Prevalence of Internalizing Disorders Among African American Youth

Given that African American youth are exposed to more stressors than their Caucasian peers (Caldwell et al., 2016; Carter et al., 2012) it is often assumed that the prevalence of internalizing disorders for African American youth should also be higher. Unfortunately, the research examining prevalence rates across ethnic and racial groups is severely limited and the available literature currently remains inconclusive (McCaughlin, Hilt, & Nolen-Hoeksema, 2007; Sweeney, 2005). Due to researchers’ focus on externalizing symptoms, most studies of youth emotional and behavioral problems have centered around more overt behavioral concerns (Caldwell et al., 2016).
In analyzing studies on internalizing symptoms, low numbers of minority participants have rendered it difficult for researchers to determine if such symptoms are more prevalent among certain racial and ethnic groups (McCaughlin et al., 2007). There are some studies that have concluded a higher prevalence for internalizing symptoms and disorders among African American youth as compared to Caucasian youth (Alegria et al., 2010; Caldwell et al., 2016; Ginsberg & Drake, 2002; Merikingas et al., 2010; van Loon, van Schaik, Dekker, & Beekman, 2013; Williams et al., 2014). The National Comorbidity Study on adolescents (NCS-A) is one of the few large-scale national epidemiological studies in which data were collected for the purposes of calculating statistics on the rates of mental health in children and adolescents using both self-report and parental/guardian data for teens between the ages of 13-18 (Merikingas et al., 2010). Results of the NCS-A concluded that African American youth were found to have slightly higher rates of anxiety as compared to other ethnic minority and Caucasian youth (Merikingas et al., 2010). Similarly, a study examining ethnic and sex differences for depression concluded that African Americans have higher incidents of depression (Kitsner, David-Ferdon, Lopez, & Dunkel., 2007). Conversely, some literature has found either no significant differences or lower prevalence rates of internalizing symptoms for African American youth (Asnaani et al., 2010; Byck et al., 2013; Caldwell et al., 2016; Carter et al., 2012; Hofmann, & Hinton, 2014; McCaughlin et al., 2017). Some researchers have hypothesized that these inconsistent findings are due in large part to various methodological problems as well as differences in the expressions of symptoms and treatment seeking behaviors (Sweeney, 2005).
The assessment measures used in studies are what largely determine prevalence rates (Ramirez, Ford, Stewart, & Teresi, 2005). However, there is limited variability in the measures used, and different measures differ in their cultural sensitivity and psychometric utility with various ethnic and cultural groups. When assessment measures are not attuned to the cultural differences, such as the differences in symptom presentation common among the African American population (e.g., irritability, anger), reported rates of prevalence may not reflect true rates of incidence leading to differences in findings (Ramirez et al., 2005). Inconsistent findings in comparison literature may also be the result of selection biases, specifically the age of participants (McCaughlin, Hilt, & Nolen-Hoeksema, 2007). The expression of internalizing symptoms during adolescence varies as a function of individuals’ exposure to biological, cognitive, and environmental changes which also fluctuate (McCaughlin et al., 2007). Prevalence studies whose participants include teens from different ages groups may suffer from inaccurate comparisons due to participant demographics (McCaughlin et al., 2007).

Other researchers have explained the similar (and in some studies, lower) prevalence rates for internalizing symptoms among African Americans not as a symptom of methodological challenges, but rather the direct result of their resiliency (Brody et al., 2013; Carter et al., 2012; Gaylord-Harden et al., 2007; Miller & McIntosh 1999). Resiliency is defined as the unexpected achievement in a domain despite exposure to adversity (Brody et al., 2013; Miller & McIntosh, 1999). If resiliency is indeed the reason for the unexpectedly low prevalence rates of internalizing symptoms among African American youth, fostering resiliency should be a primary goal among school-based mental health professionals working with some of the most vulnerable youth (e.g.,
African American teenagers). Social Emotional Learning (SEL) is one mechanism that supports a cultivation of the resiliency among children and adolescents.

**E. Social Emotional Learning**

Given the covert nature of internalizing problems, intervention typically only occurs when an individual’s symptoms are so severe that they become noticeable to others (Gueldner & Merrell, 2011). This is problematic, as symptoms not addressed early on are likely to develop into internalizing disorders (e.g., clinical anxiety and depression) further impairing both behavior and development (Gueldner & Merrell, 2011). Therefore, early intervention and prevention is critical. One evidence-based practice with demonstrated effects in preventing and reducing internalizing symptoms is Social Emotional Learning (SEL) (Castro-Olivo, 2014; Durlak et al., 2011). Social Emotional Learning is the process by which individuals acquire skills necessary to regulate emotions, establish goals, and develop positive interpersonal relationships (Caldarella et al., 2009; Durlak et al., 2011; Payton et al., 2008). SEL practices have received a great deal of attention as of late, primarily due to a growing interest in preventative and systematic mental health practices that can produce positive mental health developments, reductions in behavioral problems, and the establishment of safe school climates (Gueldner & Merrell, 2011; Osher et al., 2016). While these practices have only recently made their way into school curricula (Slaten, Rivera, Shemwell, & Elison, 2016), conceptually, SEL has been in existence for over a century (Osher et al., 2016). The promotion of SEL programs for youth are the result of various historical movements (e.g., shift toward progressive education), ideologies (e.g., ecological influences on
behavior), and research highlighting the presence of effective practices for promoting positive youth development (Osher et al., 2016).

The primary purpose of SEL is to promote individual competence in skills that will aid in reduction of emotional barriers and improve functioning across various contexts (Elias et al., 2008). Through Social Emotional Learning, individuals acquire five key competencies: self-awareness, self-management, social awareness, appropriate relationship skills, and responsible decision making (Durlak et al., 2011; Payton et al., 2008). These competencies are associated with a number of positive academic and social behaviors including reductions in emotional distress, behavioral and conduct problems (Payton et al., 2008). Research has shown that youth who possess these competencies are better equipped to handle the effects of external stressors and manage difficult situations (Durlak et al., 2011; Payton et al., 2008).

Unfortunately, many children and adolescents lack these skills. While they can be taught (Osher et al., 2016), parents (and other caregivers) are often ill-equipped to teach their children effective mechanisms for handling stress (Gueldner & Merrell, 2011). Failure to attain these skills by adolescence can severely compromise one’s academic performance and social behaviors, (Durlak et al., 2011) and increase one’s risk for developing internalizing symptoms, such as depression and social withdrawal (Kramer et al., 2014; McCaughlin et al., 2007). As research has continued to highlight the importance of these social emotional competencies, the onus has been placed on schools to cultivate opportunities where students can acquire these skills in order to help foster their resiliency and proactively eliminate problems (Caldarella et al., 2009). In response, school-based SEL programs have been developed as a way for school-based practitioners
to assist youth and to emphasize those protective factors that can help them succeed, while simultaneously reducing risk factors associated with difficulties during youth (Joseph & Strain, 2003; Osher et al., 2016).

i. Social Emotional Learning and Internalizing Symptoms

The effectiveness of SEL programs has been well-established through a plethora of studies. Meta-analyses of SEL programs have found that these curricula increase social emotional skills, self-esteem, and prosocial behaviors as well as decrease emotional distress (Durlak et al., 2011; Payton et al., 2008). The benefits associated with SEL programs include decreases in students’ internalizing symptoms. Further support for this reduction in internalizing symptoms through SEL practices is also accomplished as a result of the theoretical approaches by which SEL programs are developed. SEL is heavily influenced by both social learning and cognitive behavioral theories, both of which highlight the influence of one’s cognitions on their behaviors (Elias et al, 2008). Many SEL programs utilize a cognitive-behavioral approach, a highly effective form of psychotherapy commonly used in the treatment of internalizing symptoms and disorders (Gueldner & Merrell, 2011; McIntosh et al., 2014; Oswald & Mazefensky, 2006). Cognitive-behavioral techniques often embedded in SEL curriculums include understanding emotions, linking feelings to certain physiological sensations, learning tactics for stress management, identifying thinking errors, discussing goals, engaging in empathic behaviors, weighing the pros and cons of a potential solution, and being reflective of one’s decisions (Gueldner, & Merrell, 2011; Osher et al., 2016;).

Meta-analyses have examined data of various SEL studies and have discovered that these practices yield positive effects not just for symptomatic youth, but also for
those who do not show symptoms (i.e. non-symptomatic and non-identified youth) (Durlak et al., 2011; Payton et al., 2008). These findings support the use of SEL programs as a preventative tool that can be implemented with all students. Given the negative trajectory associated with internalizing behaviors (Sanders et al., 1999), fostering skills associated with coping and positive adjustment early on, before symptoms become too severe, will be beneficial. Additionally, for youth whose symptoms may go unidentified, being afforded access to SEL content allows them the opportunity to attain skills that they may otherwise be denied. This is especially important for African American youth whose internalizing symptoms may be expressed through more disruptive manners (Kitsner et al, 2007; Robinson et al., 2015; Stein et al., 2010).

ii. **African Americans and Social Emotional Learning**

While SEL programs have produced a variety of benefits for youth including preventing psychological problems and improving academic outcomes (Slaten et al., 2016), it is not clear that these benefits extend to children and adolescents of color (Slaten et al., 2016). Few studies have examined SEL programs with non-Caucasian participants. When ethnic minorities are included, the sample sizes are small and limited in their diversity (Castro-Olivo, & Merrell, 2012; McCormick, Capellla, O’Conner, McClowry, 2015; Payton et al., 2008; Schonfeld et al., 2015) The absence of robust research on the effects of SEL with respect to race, ethnicity and other socio-demographic variables weakens the generalizability of these programs (Osher et al., 2016; Slaten et al., 2006).

Additionally, most SEL programs do not address the culturally unique stressors and situations experienced by many African American youth (Graves et al., 2017). Adopting a universal-approach with ethnic and cultural minorities may be detrimental to
ethnically and culturally diverse youth by perpetuating the very mainstream structures that play a role in the etiology of their symptoms (Lembke, 2012). A hallmark feature of effective SEL programs is the opportunity for participants to engage in instructional experiences that are relevant (Payton et al., 2008). Given that many experiences and behaviors are highly influenced by both context and individual experiences (Elias et al., 2008), programs that fail to consider the integration of the cultural and contextual stressors experienced by African American youth may lack relevance to participants, resulting in poor acceptability and engagement. This is problematic given the documented history of African Americans’ low engagement during therapeutic practices (Carter et al., 1996; Jonassaint et al., 2017; Wilson & Cottone, 2013; Williams et al., 2014). When treatment acceptability, reflective of participant engagement, is non-equivalent across cultural groups, cultural integration within the treatment process becomes increasingly pertinent (Cardemil, 2010). Efforts to increase the alignment between the culture and treatment can be achieved through a process known as cultural adaptation.

F. Culturally Adapted Treatments

A relatively new concept in the field of psychology, cultural adaptation, is a systematic and thoughtful process of incorporating culture into evidence-based treatments (Bernal & Rodriguez, 2012). Cultural adaptations involve making modifications to the content and/or treatment process in an effort to achieve a level of equivalence between the beliefs and values of the ECG and those discussed during treatment (Bernal & Rodriguez, 2012). However, cultural adaptations can also include aspects beyond the treatment’s components, including cultural sensitivity with respect to the therapeutic
approach (e.g., assessment, recruitment) and the relationship between client and therapist (i.e. therapist’s behavior) (Cardemil, 2010).

While cultural adaptations of interventions have received a great deal of recognition, some have criticized the practice stating that any change to a treatment, even those that aim to increase cultural relevance, as a dilution of the treatment and threatening to the treatment fidelity (Cardemil, 2010). Yet, the proponents of cultural adaptation maintain that that the scientific integrity of treatments is protected due to the retention of active ingredients, changes are only made to aspects of the treatment that will increase the social validity for ECGs. In the context of increasing diversity, the continued lack of diversity in efficacy studies and the push for the use of evidence-based interventions, therapists may find themselves having to use treatments with no established validity for a client’s group. This may result in a treatment that is not only ineffective but possibly even harmful (Bernal, & Rodriguez, 2009). Through cultural adaptations, practitioners work to increase the appropriateness of the treatment approach for the target population while still providing a treatment with empirical support.

Within the literature, cognitive behavioral treatments have been a very prominent medium for cultural adaptations with many studies analyzing its effectiveness with various ECGs, often for the treatment of internalizing disorders (Bernal & Rodriguez, 2012). Previous cultural adaptations have focused primarily on the restructuring of cognitive behavioral therapies. This concentration on cognitive behavioral interventions may be attributed to the practice’s individualized therapeutic approach and the fact that it is typically delivered in a scripted format increasing the feasibility for specific modifications (Kelly, 2006; Sue, Zane, Hall, & Berger, 2009).
Recent research supports the use of these adaptations as results have demonstrated that culturally adapted treatments are moderately effective when paralleled with traditional treatments, supporting the use of this approach (Kelly, 2006; Sue et al., 2009).

When adaptations are made, they are generally characterized as either one-dimensional (surface) or deep (core) structure modifications (Cardemil, 2010). Surface level adaptations involve minor changes made to the treatment so that its components match the observable characteristics of the population (Cardemil, 2010). This form of adaptation focuses primarily on the treatment’s face validity with respect to making it appear culturally relevant (e.g., including culturally relevant music and pictures). Alternatively, core structure adaptations require a deeper consideration of the central and salient aspects of the cultural group with respect to the contextual influences (e.g., economic, historical) on the individual’s behavior (Cardemil, 2010). Core adaptations often involve incorporation of salient cultural values through specific metaphors or changing the content to make it more relevant to the target group. Due to the relative novelty of this approach, there is no deemed “correct” way to culturally adapt a treatment. In the absence of specific guidelines, researchers and interventionists structure this process using one (or more) of the many available frameworks and models (e.g., Multidimensional Model for Understanding Culturally Responsive Psychotherapies, Ecological Validity Framework, Cultural Accommodation Model, Cultural Sensitivity Framework, Cultural Adaptation Process Model, Hybrid Prevention Program Model, etc.). One commonly used approach is the Ecological Validity Framework.
G. Ecological Validity Framework

Grounded in Bronfenbrenner’s ecological systems theory, the Ecological Validity Framework (EVF) posits that social validity and positive treatment outcomes result from an alignment between the client’s experience as it relates to their experienced cultural context and culture components present within a treatment (Bernal & Rodriguez, 2012). As part of this framework, the individual’s culture, language, and worldview are adapted into each of the following eight treatment domains: language, persons, metaphors, content, concepts, goals, methods, and context (Bernal & Rodriguez, 2012). Cultural adaptations with respect to the intervention’s language refers to modifications made to the oral and written communication. Deemed as the “carrier of the culture” (Bernal et al., 1995, p. 73) modifications to language goes beyond translating into the participant’s native language but also considers language that is culturally, demographically, or developmentally relevant. This may entail incorporating specific jargon that is relevant and comprehensible to the population, such as the use of “urban youth slang”.

Adaptations to the persons domain focuses the dynamics between client and interventionist. Modifications to this domain typically consider variables such as an ethnic and/or racial match between the client and therapist, as research indicates that such a match may improve outcomes for minority individuals (Carter et al. 1996; Castro et al., 2010), the therapeutic alliance, and the level of cultural sensitivity present in the therapist’s behavior and interactions (Bernal & Rodriguez, 2012). The metaphors domain refers to the symbols, ideas, and images that are recognized by the culture (Bernal et al., 1995). Adaptations of this type involve surface level modification by embedding culturally relevant verbal and imagery forms (e.g., folk sayings and cultural
superstitions) into the treatment and the physical environment (e.g., hanging African art on the walls).

Cultural adaptations to the content require attending to the values, customs, and traditions of the specific ECG. This is typically achieved by including case examples that are reflective of the values and traditions of the target cultural group (Bernal et al., 1995). Adaptations made to the intervention goals ensure that the purpose of the treatment is framed in a manner congruent with the values and traditions of the target cultural group (Bernal et al., 1995). The methods domain refers to culturally sensitive procedures used to accomplish the treatment goals (Bernal et al., 1995). Concepts and Context are often interrelated. Within the concepts dimension, the interventionist works to ensure that the conceptualization of the treatment considers the group’s beliefs, values, norms and the cultural context, or political and social environment and surroundings, that may influence engagement, content, and outcomes during treatment.

H. Proposed Study

Studies analyzing treatment outcomes and factors associated with engagement have demonstrated positive results for culturally adapted treatments, however, the novelty of this approach has led to limited research on the topic suggesting a need for additional research focused on assessing treatments adapted for different ECGs. Additionally, this research should also address the applicability of culturally adapted treatments in practical settings, considering the delivery of many treatments are being implemented in contexts outside of the clinical setting (e.g., in schools). This study analyzed the effects of a culturally adapted social-emotional intervention with African American youth, delivered as a small group intervention in a school.
This study observed the treatment engagement for African American participants to assess whether use of a culturally adapted treatment reduces attrition and increases both homework completion and participation (i.e. engagement behavior). Secondly, the study analyzed participants’ social acceptability of the treatment. These are critical questions, considering the primary goal of cultural adaptations is to improve engagement through improving the face validity and acceptability of a treatment for a cultural group. In fact, many researchers suggest using cultural adaptations when there is evidence to show low levels of engagement with the non-adapted treatment (Cardemil, 2010; Castro et al., 2010). Additionally, this study also assessed whether application of the treatment led to reduction in internalizing symptoms. Given the primary goal of treatment was to positively enhance individuals’ well-being, this was an important mental health question. Lastly, since this treatment was associated with increases in students’ social-emotional competency (Merrell et al., 2008), which helps prevent the occurrence of later internalizing symptoms (Gueldner & Merrell, 2011), participants’ retention of the social-emotional information was also assessed.

I. Research Questions

i. Participant Engagement

*Did the cultural adaptation of an SEL program yield higher participant engagement scores (e.g., retention, active participation) in the experimental group as compared to those obtained from participants in the control (non-adapted curriculum) group?*

ii. Internalizing Symptom Reduction

*Did the culturally adapted curriculum promote a greater reduction of internalizing symptoms in participants as compared to those who received the curriculum as written?*
iii. **Social Emotional Knowledge**

*Did the cultural adaptations made to the curriculum lead to greater acquisition of social emotional knowledge by participants in that group as compared to the control group?*

iv. **Social Acceptability**

*Did modifications that were made to the curriculum result in higher social acceptability ratings by those in the culturally adapted group?*
CHAPTER II

LITERATURE REVIEW

The purpose of this chapter is to provide an in-depth literature review that will emphasize the importance of integrating culture into prevention and intervention techniques to better meet the needs of African American youth. Furthermore, this chapter will highlight the prior studies that used of cultural adaptation to increase both the engagement and efficacy of evidence-based practices.

A. An Ethical Dilemma

Culture is defined as a collection of orientations that influence an individual through a shared set of beliefs, behaviors, knowledge, and observable characteristics that are transmitted down through generations (Barrera Jr., Castro, Strycker, & Toobert, 2013; Cardemil, 2010; Scott, 2005). A person’s culture often determines what, for that individual, is considered normal, valuable, and what are appropriate manners of self-expression (Scott, 2005). Culture also influences all aspects of an individual’s livelihood including their values, health behaviors, assumed gender roles, worldview, and styles of interpersonal communication (Barrera Jr. et al., 2013; Cardemil, Moreno, & Sanchez, 2011). In terms of psychopathology, culture also affects one’s conceptualization of mental illnesses, their risk and protective factors, perceptions regarding a disorder’s etiology, the manner in which symptoms are expressed, and perceptions of treatment approaches. (Bernal & Rodriguez, 2012; Castro-Olivo & Merrell, 2012; Osher et al., 2016; Stein et al., 2010). As a result, all facets of psychotherapeutic interventions should consider the culture of the client (Barrera Jr. et al., 2013; Bernal, Jimenez-Chafey, & Rodriguez, 2009). This idea of cultural consideration is included in APA’s definition of
evidence-based practice in that they require practices to integrate research, clinical knowledge, and contextual and cultural characteristics of the client (Helms, 2015). Unfortunately, most standard evidence-based treatments and practices are typically founded on western norms, values, and views and ignore the cultural and racial experiences of ECGs (Helms, 2015; Huey & Polo, 2010; Osher et al., 2016).

Therapeutic practices not reflective of the culture or values of ethnic and racial minority communities are often incongruent with the assumptions and worldview of diverse cultures (Bernal & Rodriguez, 2012). This results in practices that undermine and devalue the values and traditions inherent to a particular culture generating feelings of oppression and forced assimilation to the dominant culture (Bernal & Rodriguez, 2012). Furthermore, failing to address and integrate the cultural beliefs of an ethno-cultural group (ECG) may result in individuals’ feeling oppressed through the perception that these practices serve as mechanisms for forced assimilation to the dominant culture (Bernal & Rodriguez, 2012). Overall, the invisibility of ethno-cultural values within therapeutic practices is harmful and can lead to miscommunication, conflict, and discomfort of minority clients (Castro et al., 2010).

B. Movement Toward Cultural Competency

In recent years, professional organizations have acknowledged the importance of culture in the conceptualization and delivery of evidence-based practices and treatments and have noted its general absence within these therapeutic methods. In response to these observations, many organizations have voiced a need for practitioners to integrate client culture into their practices and treatments (Cardemil, 2010). In 2006, the American Psychological Association (APA) encouraged a progression toward cultural competency
by empowering practitioners to think about the ways in which culture and contextual factors could be integrated into their therapeutic practices (Bernal et al., 2009).

In their most recent publication of the professional ethical codes, both the APA and the National Association of School Psychologists (NASP) stressed increases in practitioners’ cultural consideration in assessments and interventions. Attending to a client’s cultural and linguistic background is crucial to the provision of fair, non-discriminatory practices that respects individuals’ rights and dignity (APA, 2010; NASP, 2010). These ethical policies represent a shift in the field, a field that is now highly critical of using Eurocentric approaches with diverse clients and promotes a greater focus on client diversity and cultural competency within therapeutic practices (Barnett & Bivings, 2002). This movement toward greater cultural competency has been occurring alongside an increased attention to the ethical and legal standards requiring that practitioners employ evidence-based, well-established prevention and intervention techniques with all clients (Bernal et al., 2009). The emerging prominence of these two views yields an interesting dichotomy as the movement toward greater cultural inclusivity often conflicts with the implementation of practices and treatments that are evidence-based. This is primarily because most evidence-based practices are non-inclusive, having been developed for and validated mainly with Caucasian individuals (Bernal et al., 2009; Sue et al., 2009).

For decades, studies evaluating effectiveness of various evidence-based treatments (EBTs) and evidence-based practices (EBPs) have failed to include adequate numbers of racial and ethnic minorities. In 1996, APA’s Division 12 discovered that the empirically validated studies available were devoid of cultural and ethnic minority
participants (Satterfield, 1998). This lack of heterogeneity in empirical research narrows interventions’ scope of generalizability to predominately middle-class, European-American individuals (Bernal & Rodriguez, 2012; Cardemil, 2010; Castro et al., 2010; Huey & Polo, 2008; Sue et al., 2009). While the National Institute of Health (NIH) now requires that research include representative numbers of ethnic minorities within their participant samples (Bernal & Rodriguez, 2012), progression has been slow, and evidence indicates that the underrepresentation of minority participants in efficacy studies persists (Bernal & Rodriguez, 2012). However, there have been some advancements in this area particularly the literature on outcome research for youth (Huey & Polo, 2008).

In a 2008 meta-analysis, researchers Huey and Polo compiled data from prior studies that evaluated the efficacy of evidence-based treatments for minority youth. This analysis was conducted given the apparent absence of effective treatments for minorities as well as noted mental health disparities concerning ethnic minorities (Huey & Polo, 2008). In their analysis of 25 studies, results concluded that there were (to date) no evidence-based interventions for minority youth that met criteria for the highest level of empirical support. Additionally, many of the studies used contained a number of methodological issues such as low numbers of participants in each condition and low statistical power which made it difficult to make statistical conclusions (Huey & Polo, 2008). In their discussion of future research, the authors’ questioned whether the effects of evidence-based treatments demonstrate an ethnic invariance or ethnic disparity (which would support modifications for appropriate use) between minority and Caucasian youth as results have so far remained inconclusive (Huey & Polo, 2008). Furthermore, they

As questions about the applicability and effectiveness of westernized psychotherapeutic approaches for ethnically diverse individuals have continued to emerge, practitioners have identified a need for empirically supported and culturally sensitive treatments (Hall, 2001). They have responded by integrating the characteristics of their clients into identified evidence-based treatments (Bernal & Rodriguez, 2012). This process is known as cultural adaptation. Cultural adaptation has been promoted as a way to increase the effectiveness and acceptability of therapeutic practices (Bernal & Rodriguez, 2012). Ultimately shifting the perception of these evidence-based practices from a potential vehicle for oppression to a source of empowerment for ethnic and racial minorities (Bernal & Rodriguez, 2012).

C. Review of Cultural Adaptation Research

Cultural adaptation refers to the systematic modification of evidence-based treatments and practices used to increase their compatibility with the beliefs, values, and worldviews of a culture (Barrera Jr. et al., 2013; Cardemil, 2010; Castro et al., 2010). A number of fields (e.g., education, advertising, and public health) have incorporated the practice of cultural adaptation to facilitate the dissemination of services (or information) to diverse populations (Bernal & Rodriguez, 2012). However, its presence in psychology is fairly recent. The first recorded use in psychotherapy occurred in 1982 when it was used to modify family therapy for minority clients (Bernal & Rodriguez, 2012; Bernal, 2006). Its use has increased exponentially, primarily due to that competing objective: the use of EBTs and EBPs in the midst of an increasingly diverse landscape (Castro et al.,
2010). In a sense, cultural adaptation of EBTs/EBPs represents an intermediary between developing entirely novel treatments uniquely tailored to each client and implementing a one-fits-all evidence-based treatment whose underlying ideology may conflict with the client’s culture. However, the primary question has focused on whether cultural adaptations of EBTs/EBPs produce positive outcomes for racial and ethnic minorities.

In 2006, Griner and Smith conducted a meta-analysis intent on answering that very question through assessing the outcomes of various culturally adapted interventions. Based on the authors’ inclusion and exclusion criteria, 76 studies were included in their review. These studies included EBPs and EBTs that were modified according to the client(s) culture. The authors analyzed various outcomes of these studies including changes in client symptoms and retention rates. The results showed a moderately strong effect size ($d=.45$) for culturally adapted interventions. Participant satisfaction and acceptability also produced a moderate effect size ($d=.35$) indicating that overall cultural adaptations targeted to specific cultural groups appear to be beneficial (Griner, & Smith, 2006).

In a more recent meta-analysis, Van Loon et al (2013) conducted a systematic review of nine studies that implemented culturally adapted treatments for anxiety and depression. The studies used were comparison studies in which the results from the culturally adapted treatment were compared to either a wait-list control or a non-adapted version (Van Loon et al., 2013). Overall, the effect sizes were considered clinically relevant, however larger significant pooled effect sizes were obtained for studies that compared their results against a wait-list control ($s.d.m.= 1.06$) rather than the non-adapted treatment ($s.d.m. =0.67$) (Van Loon et al., 2013).
Some of the most successful cultural adaptations have focused on cognitive behavioral treatments for internalizing disorders (e.g., depression) among African American clients (Cardemil, 2010). Cognitive behavioral based treatments are considered an ideal medium for cultural adaptation given their effectiveness in remediating a variety of concerns and their (often) manualized approach, making modifications both feasible and relevant for the treatment of many symptoms (Bernal & Rodriguez, 2012). The effectiveness of a culturally adapted, evidence-based, cognitive-behavioral treatment, Adolescent Coping with Stress Course (CWS) (Clarke & Lewinsohn, 1995) was compared to a standard control care condition (Robinson, Case, Droedge, & Jason., 2015).

CWS is a 15 session, CBT based, small-group prevention intervention for stress reduction (Robinson et al., 2015). The CWS curriculum consists of ways to help youth reduce negative cognitions, identify risks factors, enhance resiliency, and develop coping skills (Robinson et al., 2015). While the program was initially developed and validated for suburban, European youth a culturally adapted version for African American teens was created in 2003 (Robinson et al., 2015). This version, titled Adapted- Coping with Stress Course (A-CWS), included content related to the socioecological stressors faced by African American urban youth in low-resource areas (Robinson et al., 2015). Adaptations to the original curriculum included the use of proper names more recognizable to urban African youth, use of multimedia, and examples more representative of the daily stressors commonly faced by this group. Participants were randomized into two groups, one received the A-CWS prevention while the other served as a standard-care control group. All participants were administered pre-post assessments of the variables of interest:
thoughts, behaviors, feelings, and coping skills related to stress (Robinson et al., 2015). Results showed that the individuals who received the adapted curriculum reported lower symptoms of anxiety and improvement in the mediators associated with lower internalizing symptoms (e.g., coping skills, positive thinking) at post-test when compared to those in the standard-care control group (Robinson et al., 2015).

In the Ward and Brown (2015) pilot studies, a CBT based intervention, Coping with Depression, used to treat major depressive disorders, was culturally adapted for African Americans, (titled the “Oh Happy Day Class”). Adaptations included providing participants opportunities to discuss experiences specific to their identity as African Americans and the incorporation of principles stemming from the Afrocentric paradigm Nguzo Saba (Ward & Brown, 2015). While the pilot was conducted with adults and did not consist of a comparison group, participants demonstrated a statistically significant reduction in depression symptoms, high retention rates, and high ratings of acceptability among participants (Ward & Brown, 2015).

Other studies whose results support the use of cultural adaptations and integrations include a culturally sensitive school-based health center, staffed primarily with African Americans and provided culturally sensitive services, was successful reducing substance abuse for low-income inner city African American teens was examined (Robinson, Harper, & Schoeny, 2003). In the Banks et al. study (1996) a social skills training (SST) intervention delivered to African American adolescents was culturally adapted to include culturally relevant (and in one group Afrocentric) values and themes, African American facilitators from the local community, and included culturally specific content. While the Afrocentric group did not show any measurable differences,
the cultural adaptations made across all groups led to reductions in anger and increases in social skills (Banks et al., 1996). Williams and colleagues (2014) discussed cultural adaptations to assist therapists in addressing and confronting cultural mistrust of African Americans clients receiving prolonged exposure (PE), a method commonly used for the treatment of PTSD. Modifications included increasing the number of sessions for building rapport, opportunities to discuss and address race-related issues and discrimination. Additionally, the authors encouraged therapists to increase their cultural knowledge and sensitivity to avoid engaging in stereotypes and potentially damaging the client-therapist relationship. In the case studies presented, the clients who took part in culturally adapted versions of PE saw reductions in symptoms. (Williams et al., 2014). Researchers Ginsberg and Drake (2002) assessed the effectiveness of a school-based CBT intervention for African American high school students with anxiety disorders. The intervention used was modified to be both developmentally and culturally relevant. Participants were assigned to either the treatment or control group and changes in participant symptomology were assessed and compared in both groups. Overall, the study showed positive outcomes for the treatment group including a decline in symptoms for 3/4 of those who attended at least one session (as compared to 1/5 in the control group) and lower ratings of participant impairment.

D. Framework for Cultural Adaptation: The Ecological Validity Framework

While research on the topic is limited, results thus far indicate that when modifications are made to programs, there are observed increases in the effectiveness, engagement, and commitment for racial and ethnic minorities even when compared to the usual care or control groups (Barrerra et al., 2013; Bernal & Rodriguez, 2012; Carter et
al., 2012; Griner & Smith, 2006; Sue et al., 2009; Ward & Brown, 2015). However, the process is not without its critics. An argument often made is that due to the modifications made, these EBPs/EBTs many no longer be considered efficacious (Castro et al., 2010). However, when cultural adaptations are conducted, practitioners are warned against making changes to the core components of an intervention (Barrera et al., 2013). Rather than being implemented haphazardly, modifications should be employed in a careful, systematic manner that avoids making changes to the active ingredients. One way to increase the congruence between the intervention components and the group’s cultural values, while preserving the core elements and fidelity of the intervention, is to use a framework (Bernal & Rodriguez, 2012; Castro et al., 2010). One of the most popular frameworks is the Ecological Validity Framework (Bernal et al., 1995)

The Ecological Validity Framework (EVF) (Bernal et al., 1995) was conceptualized for the purposes of increasing the cultural sensitivity of interventions and subsequently augmenting both the ecological and external validity (Bernal et al., 1995). First use of the framework was conducted by the authors in their adaptations of treatments for Hispanic populations. Using the framework, the authors identified key dimensions of a practice where cultural adaptations can occur: *language, persons, metaphors, content, concepts, goals, methods and context*. In this article, Bernal et al (1995) discussed possible modifications to treatment as it pertained to Hispanic culture such as having a bilingual therapist, welcoming clients in a way that increased their level of comfort, including familiar cultural objects and symbols into treatment’s physical space, framing the goal of a treatment around decreasing hyperactivity as a way to
increase “respect”, and including other family members in the treatment process by utilizing family therapy.

EVF was used Duarte-Velez, Bernal, and Bonilla (2010) to culturally adapt a cognitive-behavioral therapy for use with a Puerto Rican adolescent suffering from major depression disorder (MDD). The article demonstrated the flexibility of EVF in considering both cultural and individual traits while maintain treatment fidelity. In addition to the inclusion of Latino values and beliefs, the researchers also attended to individual characteristics as the client also identified as being Christian, homosexual, and residing in a conservative and male-dominated, machismo, family. These individual contextual, and ecological factors played a role in the types of adaptations made to the curriculum (Duarte-Velez et al., 2010). Modifications to the original treatment included discussing the client’s thoughts about his own sexuality and spiritual beliefs, recognizing important contextual influences such as family expectations and behaviors and cultural values around homosexuality, aligning treatment goals to the client’s goals which involved personal acceptance and identity formation, and modifying the methods by allowing family members to participate in the treatment process (Duarte-Velez et al., 2010).

Matos and colleagues culturally adapted Parent-Child Interaction Therapy (PCIT) using the EVF for use with families of Puerto-Rican preschool children with ADHD and other behavioral concerns (Matos et al., 2006). Changes to the intervention included translating all materials and documents (e.g., manual and handouts) into Spanish, while considering sociocultural context given that they were families who were living in Puerto-Rico, having therapists establish personalismo, close personal contact, with
parents, providing time for families to discuss issues not directly related to the child’s process but other stressors that could influence family progress (e.g., transportation, financial difficulties), including various culturally relevant idiomatic expressions to describe the child’s behavior or parenting practice, addressing concerns around how to help other family members (who may have played a role in the child’s life) learn about the strategies provided during treatment, and ensuring that the concepts, methods, and goals were acceptable to the Puerto-Rican families (Matos et al., 2006)

While the Ecological Validity Framework was originally conceptualized as a method for adapting treatments to be used with Hispanic populations, the framework has been applied for use with other ethnic minority groups (Bernal et al., 1995). Nicolas and colleagues (2009) used EVF to culturally adapt a group treatment for Haitian American adolescents diagnosed with depression. The study used the curriculum Adolescents Coping with Depression course (Lewinsohn, Rohde, Hops, & Clarke, 1990) a small-group CBT treatment that consists of 16 sessions implemented over an 8 week-period. The core curriculum includes strategies for controlling depression and covers topics such as relaxation, pleasant events, negative thoughts, social skills, communication, and problem solving (Nicolas et al., 2009). Derived from conversations with focus groups, adaptations that were suggested included clarifying the meaning of certain words and concepts, describing the onset of depressive symptoms as it relates to supernatural forces and spirituality rather than cognitive behavioral theory, discussing treatment in the form of massages, herbal teas, and other traditional remedies, using pictures, examples, and stories that are reflective of Haitian youth in today’s society, and removing the active listening exercises from the treatment curriculum and expectations.
E. African Americans and the Importance of Cultural Adaptation

While there is no explicit professional or legal mandate pertaining to the use of cultural adaptations, specifically, in prevention and intervention models (Castro et al., 2010; Huey, & Polo, 2008), best practice supports its inception in instances where the client’s culture exhibits unique attributes relevant to diagnosis and/or treatment (e.g., risk and resiliency factors, the presentation of symptoms; Castro et al, 2010); especially if those cultural characteristics are not aligned to the underlying treatment or practice (Bernal & Rodriguez, 2012). Additionally, researchers also support its use for specific ECGs when generalizability has not been established or when low efficacy, acceptability, and/or treatment engagement are noted (Bernal, & Rodriguez, 2012; Cardemil, 2010).

As previously mentioned, most evidence-based prevention and intervention methods are rooted in western norms and ideals (Bernal, & Rodriguez, 2012). This is often the case for African American clients whose cultural values, beliefs, and norms are often differ or are in opposition with those (i.e. European-American) embedded in many therapeutic practices (Hall, 2001). African American culture is comprised of various subcultures inherent to countries in Africa, the Caribbean, and Central and South America (Scott, 2005). Due to African Americans’ historical roots (e.g., slavery), many also identify with many American experiences thus sharing many western cultures and values (Scott, 2005). Despite this relation to the dominant culture, racial and cultural differences have resulted in dramatic differences in the ways that African Americans are viewed and treated as compared to the European-White counterparts (Scott, 2005). This is highly evident within the field of psychology which often views African Americans through a negative lens, overemphasizing risks factors and deficits (Murray et al., 2004).
While African Americans, especially African American youth, are exposed to more chronic stressors and challenges such as discrimination, poverty, and community violence (Gibbons et al., 2012) many go on to achieve great success (Murray et al., 2004). Indicating that while this group is often exposed to many risks, they also possess many protective factors such as ethnic identity, familial support, and community ties (Murray et al., 2014). The incorporation of these protective factors into intervention and prevention practices may not only help promote resiliency among African American youth, but also increase the level of engagement with this specific population.

In general, minority youth have the greatest rates of unmet, untreated mental health needs (Holm-Hansen, 2006; Kataoka, Zhang, & Wells, 2002; Sweeney et al., 2005). This finding is especially pronounced within the African American community (Caldwell et al., 2016; Ward & Brown, 2015) whose youth, when compared to Caucasian youth, are less likely to receive quality, evidence-based treatment for mental health problems (Carter et al., 2012; Holm-Hansen, 2006; Kodjo & Auinger, 2004). Disparities in treatment are commonly attributed to both economic and cultural factors (Sweeney et al., 2005). Specifically, while factors such as diminished access to quality services due to poverty, issues with insurance, and under identification of symptoms all contribute to an underutilization of services, when these factors are controlled for, this mental health disparity persists (Alegria et al., 2010; Griner, & Smith, 2006; Holm-Hansen, 2006; Sue et al., 2009). Specifically, even when treatments are made readily accessible, minorities from various ECGs are still likely not to seek help or terminate prematurely (Cardemil, 2010). This suggests that these disparities stem from internal factors such as an inattention to cultural factors (e.g., neglecting to acknowledge stressors such as
discrimination) within the mental health practices which may deter individuals from seeking help from outsiders (Cardemil, 2010; Holm-Hansen, 2006; Kohn et al, 2002; Sweeney et al., 2005).

In addition to a reluctance toward seeking out treatment, lack of cultural appropriateness has also been linked to the high attrition rates evident among ethnic minorities (Holm-Hansen, 2006; Ward & Brown, 2015). When the development, content, and delivery of a practice does not hold any relevance to the cultural needs and preferences of an individual (or a group of individuals) it may be viewed negatively and result in lower engagement (Cardemil, 2010; Castro et al., 2010). Treatment engagement is defined as a collection of behaviors indicative of an individual’s level of commitment to treatment (Fraynt et al., 2014). Low engagement can manifest as a lack of awareness of treatment availability, declined entry/enrollment, low participation, and decreased retention during treatment (Castro et al., 2010; Fraynt et al., 2014). There is a considerable amount of research to support the existence of mental health disparities with respect to engagement for most minority groups, particularly African American youth (Carter et al., 1996; Sweeney et al., 2005; Wilson & Cottone, 2013).

Lester et al (2010) investigated the retention rates of African American and Caucasian females enrolled in cognitive-behavioral treatment for PTSD. Results showed that African Americans’ retention rates differed significantly from Caucasian participants. When the researchers analyzed these results after controlling for factors such as education and income, this difference in therapeutic engagement was still present. Similarly, a study conducted by Fraynt and colleagues (2014) included data on the number of sessions attended and participant attrition for minority youth participating in a
trauma-informed treatment. Findings showed that African American youth were the least engaged, attending the fewest number of treatments compared to the two ethnic groups in the study.

More recently, a 2017 study observed the presence of racial differences in participant engagement (Jonassiant et al., 2017). Researchers compared participant behavior during treatment (i.e. engagement) and outcomes for both African American and Caucasians who participated in a computerized CBT program used to address anxiety and depression (Jonassiant et al., 2017). While the use of a computerized approach helped to eliminate some of the barriers commonly faced by African Americans, such as access to treatment (Cardemil, 2010), the results showed African Americans participated in fewer sessions (Jonassiant et al., 2017). Overall, the behavior of African Americans participants during treatment included higher attrition rates and lower content mastery. Such behaviors often suggest that participants are gaining less from treatment (Carter et al., 1996; Williams et al., 2014; Wilson & Cottone, 2013).

Results obtained from these studies further highlight the pitfalls associated when non-culturally responsive interventions are used with culturally diverse youth, particularly African American youth. When interventions, rooted in dominant perspectives, are universally-applied, negative client perceptions regarding the intervention’s usefulness is likely and lower engagement may be observed (Jonassiant et al., 2017). When treatment acceptability is non-equivalent across cultural groups, cultural adaptation of the treatment process becomes both increasingly significant and necessary (Cardemil, 2010). Through an adaptation of culture, the content and processes become more familiar and relevant to the client which increases the participant’s understanding of
the content and their motivation to continue to further engage (Castro et al., 2010). Ultimately, it has been hypothesized treatment engagement issues can be addressed by increasing the cultural responsiveness of therapeutic practices, which should result in reductions in mental health disparities and increases in the effectiveness of treatments (Alegria et al., 2010; Bernal & Rodriguez, 2012; Griner & Smith, 2006; Holm-Hansen, 2006; Huey Jr. & Jones, 2010). The results from Takeuchi, Sue, and Yeh (1995) supported the notion that cultural adaptations can lead to increased treatment engagement as their study showed that minority adults who engaged in ethnically specific program exhibited higher retention compared to those exposed to mainstream services. The negative effects on treatment outcomes often due to low treatment engagement observed amongst African American clientele (Fraynt et al., 2014; Jonassaint et al., 2017; Kazdin, Stolar, & Marciano, 1995) is further compounded by the fact that this group is in need of prevention and intervention benefits given their (often) increased exposure to numerous risk factors.

F. Empirical Research on Strong Teens

The implementation of Social Emotional Learning (SEL) programs in schools is often seen as an extension of mental health efforts by school personnel in supporting the development of emotionally and psychological healthy students (Merrell et al., 2008). Most SEL programs promote the development of various social and emotional competencies (Jagers, 2016). Typically implemented as a preventative or early intervention approach, SEL programs foster resilience and seek to eliminate school and life problems among youth (Caldarella et al., 2009; Merrell et al., 2008; Merrell, 2010). The Strong Kids series is one of the few evidence-based, social emotional curriculums
specifically targeted to address internalizing symptoms (Marchant et al, 2010; McIntosh et al., 2014). It can be implemented at the universal level as a preventive approach or as targeted intervention for identified youth (Gueldner & Merrell, 2011; Kramer et al., 2014).

*Strong Kids* focuses on skill associated with increasing resiliency, decreasing internalizing symptoms, managing stress, anger management, and cognitive restructuring (Gueldner & Merrell, 2011). The series is separated into five semi-scripted curriculums each geared toward specific developmental periods (e.g., 3-5, 9-12; Merrell et al., 2008). *Strong Teens* (Carrizales-Engelmann, Feuerborn, Gueldner, & Tran, 2016), one of the five curriculums, was developed for high school students. It utilizes cognitive-behavioral and affective education techniques to help youth acquire, practice, and generalize the competencies to help them effectively manage stressors that often occur during this development period (Carrizales-Engelman et al., 2016; Merrell et al., 2008).

Research identifying the positive effects of the *Strong Kids* curricula is extensive and results from these studies highlight a variety of positive outcomes for school-based youth including meaningful increases in pro-social behaviors, social emotional content knowledge, and coping strategies, decreases in internalizing behaviors, and high social validity for various respondents (Caldarella et al., 2009; Gunter et al., 2012; Harlacher & Merrell, 2009; Kramer et al., 2014: Marchant et al, 2010; Merrell, Juskelis, Tran, & Buchanan., 2008; Merrell, 2010; Ryan et al., 2016). The research on *Strong Teens* as an individual curriculum has been conducted on a much smaller scale. One such study was a small pilot study conducted by Merrell and colleagues (2008) who implemented the curriculum with diverse sample of high school girls. Their analysis findings included...
statically significant increases in students’ social emotional knowledge and decreases the girls’ self-reported negative social-emotional problems (Merrell et al., 2008).

**G. Cultural Adaptation of Strong Teens**

Given these positive outcomes, interest in implementing SEL programs, such as *Strong Teens*, to promote positive outcomes among youth from diverse backgrounds has increased (Jagers, 2016). However, the effects of such programs on ethnic minorities remains highly under-researched (Castro-Olivo, 2014; Osher et al., 2016). A majority of the studies analyzing the effectiveness of *Strong Kids* and *Strong Teens* have been conducted primarily with middle-class and/or Caucasian youth (Caldarella et al., 2009; Marchant et al., 2010; Merrell et al., 2008). One study that did assess the effectiveness of *Strong Kids* for a minority population (African American females) did not find statistically significant results in teacher ratings of participants’ social emotional skills and resiliencies (Ryan et al., 2016). In discussing the limitations within this particular study, the authors suggested that perhaps the curriculum would have been more successful had it been culturally adapted given the lack of research of *Strong Kids* with ethnically diverse samples (Ryan et al., 2016).

Additionally, similar to many evidence-based practices, most SEL programs exhibit a lack of consideration for cultural and contextual differences within the program content (Slaten et al, 2006). Similar to other therapeutic practices, neglecting key ecological factors, such as an absence of social privileges and institutionalized racism, SEL programs may in turn perpetuate these factors doing more harm to the minority youth (Lembke, 2012; Osher et al., 2016). Furthermore, since the acquiring of SEL content is highly dependent on participants’ ability to generalize the situations and skills

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discussed, content that is not relevant may not yield the same positive effects (CASEL, 2005; Payton et al., 2008).

Unfortunately, Strong Teens falls victim to many of these issues and, in response, some researchers have culturally adapted Strong Teens to integrate the cultural needs and experiences of targeted ethnocultural groups into the content. Castro-Olivo (2014) culturally adapted Strong Teens for Latino ELLs. An SEL curriculum was selected as an intervention considering social-emotional knowledge and resiliency are commonly considered buffers to the negative outcomes associated with sociocultural risks such as acculturative stress and perceived discrimination, two significant risk factors in the Latino ELL community. The goal of creating a culturally adapted version of Strong Teens for Latinos (Jovenes Fuertes) was to ensure that the curriculum attended to the these specific risks (e.g., acculturation process) stemming from being an ELL (Castro-Olivo, 2014). Modifications were made according to the EVF model (Bernal et al., 1995). Changes included translating the content into Spanish, using bilingual and bicultural interventionists, and including topics and skills related to ethnic pride, dealing with acculturative stress, and familial acculturative gaps. Participants included over 100 Latino adolescents enrolled in either middle school or high school English Language Development classrooms. Participants were randomly assigned to either the control or intervention condition. Pre and post data were collected on students’ social-emotional knowledge and emotional resiliency, while social validity data were obtained post-intervention. Results showed that students who received the intervention had increased levels of resiliency and social emotional knowledge compared to students in the control
condition. Participants in this group also rated the program as socially acceptable (Castro-Olivo, 2014).

In 2007, authors White and Rayle culturally adapted Strong Teens for use with African American male adolescents, a specific cultural subgroup affected substantially by the various risks and experiences associated with being an African American in this country (White & Rayle, 2007). Low academic achievement, behavioral problems, physical aggression, and racial stigmas highlighted the need for a program that would help this group improve their emotional health, self-perception, and social interactions (White & Rayle, 2007).

Adaptations made to the curriculum included an emphasis on delivering the curriculum in small groups (10-12 students) recognizing the importance of group interactions in African American culture, providing opportunities for participants to talk about their own experiences as African American males and how those experiences influenced their development. Other additions included providing participants with positive representations of themselves through discussions about prominent historical African American male figures and providing them the opportunity to hear the life experiences of other African American males. This helped to inspire participants to think critically about their current and future role in society (White & Rayle, 2007). While no assessment data was collected, the description of the adaptations identified unique cultural risk and protective factors that need to be considered when delivering SEL program such as Strong Teens to increase relevance and foster culturally specific goals. Given the limited studies available for review, this study hopes to add to the literature
pertaining SEL programs, specifically *Strong Teens*, and African American youth, as well as study the effects of a culturally adapted version of this curriculum.

**H. Making the Case: Social Emotional Learning Needs for African American Youth**

While many African American youth exhibit positive outcomes despite exposure to unfortunate situations, not all are immune to the negative psychological outcomes that precipitated from exposure to the stressors that often plague African American teens (Jagers, 2016; Miller et al., 1999). By providing preventive strategies that will increase resiliency and allow for the cultivation of positive coping mechanisms to those individuals most “at risk” (e.g., African American teens), these treatments will hopefully yield psychologically resilient individuals equipped to handle various challenges (Jagers, 2016).

Successful attainment of the coping and resiliency skills that are helpful in ameliorating internalizing symptoms is heavily dependent upon the individual’s ability to relate to the material and use it in their daily lives (Castro-Olivo, 2014; Lembke, 2012). Many SEL programs do not typically address common life situations experienced by African American youth (Graves et al., 2017; Robinson et al., 2015). The lack of alignment between SEL content and client experiences makes it difficult for students to relate to the curriculum which may affect their ability to acquire competencies related to effective coping and resiliency and their level of engagement in the program. Cultural adaptation of a SEL program should focus on increasing the relevancy of both the content and its delivery for African Americans. A summary of the considerations for cultural adaptation of an SEL, per the EVF model, are outlined below.
I. EVF Model for African American Youth

- **Language.** No translation of the intervention was required since all participants spoke English. In an effort to reduce client (or parent/guardian) hesitation toward the receipt of prevention services, clinical terms were omitted, and the program was referred to as a “stress reduction” intervention. While, the *Strong Teens* curriculum already uses developmentally appropriate language and terms (Carrizales-Engelmann et al., 2016), however, some researchers note that often many programs present cognitive “thinking traps” using abstract terms that may hinder comprehension for some children and adolescents (Joyce-Beaulieu, & Sulkowski, 2015). Given the importance of these concepts, more concrete terms were used (e.g., the phrase “Making Predictions” will replace “Fortune Telling”) facilitating participants’ understanding.

- **Persons.** With respect to the client-therapist dyad, an establishment of a positive interpersonal relationship is often dependent upon the consideration of the culture and cultural differences (Thompson, Bazile, & Akbar, 2004). The therapeutic relationship is one of the most important aspects of any therapeutic practice and indicative of positive client outcomes (Griner, & Smith, 2006). While an ethnic-cultural match between the client and the practitioner is predictive of higher retention rates (Hall, 2001; Thompson et al., 2004), high levels of cultural competence by an interventionist is just as crucial, if not more. Cultural competence entails an understanding of the target group’s culture, awareness and acknowledgement of cultural differences, important contextual variables, and an
assessment of the practitioners’ own biases and how these may affect the
treatment process (Cardemil et al., 2011; McDougall & Arthur, 2001; Williams et
al., 2014). When African Americans feel misunderstood or stereotyped by the
therapist, they are less likely to engage in treatment (Thompson et al., 2004). In
an effort to decrease cultural mistrust and promote a positive interpersonal
relationship, the interventionist examined and reflected upon readings specific to
culturally responsive practices. These readings encouraged and facilitated the
interventionist’s examination of both the their own and their clients’ worldviews
and values (Bernal & Rodriguez, 2012) within the context of the session goals.
The readings also allowed the interventionist to consider the contextual and
interpersonal influences that may affect behavior and emotions. Specifically,
culturally responsive readings highlighted the importance of not criticizing
participants’ reaction to culturally specific situations. For instance, an individual
who avoids all social situations after witnessing a violent altercation should have
their feelings validated rather than labeled distorted. In this example, rather than
focusing on the client’s perception of the situation, the interventionist should
encourage the client to identify safe spaces for appropriate social interactions
(e.g., in class, at home) and encourage them to interact within these self-identified
settings.

- **Content.** African Americans often place immense value on both their family and
the community (Larson, Richards, Simms, & Dworkin., 2001); a major aspect of
collectivist cultures (Sweeney et al., 2005). Situations and problems presented
incorporated interpersonal-interactions with family members (e.g., fighting with a
sibling, dealing with parental expectations) in settings that are familiar to African American peoples (e.g., cookouts, church, grandparents’ homes). It should also be noted that the “typical” strategies for dealing with problems that are commonly taught (e.g., problem solving, approach coping) may not be applicable to all adolescents, especially those from ethno-cultural groups who experience unique cultural stressors (Scott, 2003; Vaugh & Roesch, 2008; Ward & Brown, 2015).

Many African American youth use culturally specific coping mechanisms such as leaning on family and community members, emotional debriefing, and spirituality (Gaylord-Harden & Cunningham, 2008; Scott Jr., 2003) as these strategies are associated with better management of culturally specific stressors (e.g., discrimination) and lower psychological problems (Chapman & Woodruff-Boren, 2009; Gaylord-Harden & Cunningham, 2008; Hampton, Gullotta, & Crowel, 2010; Matsumoto & Juang, 2012; Scott Jr., 2003). Discussions about students’ social network for support, familial stressors and supports, and the use of prayer and spirituality for coping were integrated into the culturally adapted curriculum (Williams et al., 2014) through vignettes and various forms of media (e.g., video clips, song clips).

- **Metaphors.** Various forms of multimedia were used to integrate symbols, ideas, and images representative of African American cultures. The incorporation of music in with other therapeutic methods is associated with positive changes such as reducing stress, increasing motivation, and improving perceptions (Stephens, Braithwaite, & Taylor, 1998). Hip-hop is one musical genre that has critical roots in African American culture and has been used as a medium for healing and
providing a voice to a suppressed group (Stephens et al., 1998). Hip-hop is comprised of messages around social injustices, overcoming barriers, increasing self-awareness, and historical events, and cultural acceptance (Stephens et al., 1998). Music, Hip-Hop specifically, was included in the curriculum and was used to aid students’ processing and reflection on culturally relevant stressors. Other media forms included various clips from both movies and television shows (mainly those that with African American characters).

- **Goals.** The primary purpose of *Strong Teens* is to provide youth with social-emotional skills that are both relevant and applicable to their lives and promote resiliency and a positive well-being (Merrell et al., 2008). Role models play an important role in developing resiliency and positive psychological outcomes, such as lower risk for internalizing symptoms (Hurd, Zimmerman, & Xue, 2010). In line with Bandura’s Social Learning Theory, a theory underlying SEL, behaviors are often learned and reinforced by one’s environment (Elias et al., 2008). African American youth benefit from exposure to role models who display prosocial behaviors (e.g., positive coping strategies). Social Learning Theory also emphasizes the additive effects of role models who are perceived as similar to the individual (Hurd et al., 2010). For African American teenagers, role models of a similar race and/or ethnicity are more likely to influence the development of positive behavior (Zirkel, 2002). Unfortunately, minority youth are often not exposed to same-race role models (Osher et al., 2016). As part of the cultural adaptations, throughout the curriculum participants were encouraged to identify positive role models in their lives and reflect on that individual’s behavior. Stories
of famous African Americans who have successfully overcome adversity and the strategies they employed were also included to help participants further realize their own potential. Additionally, film clips with African American characters were incorporated to aid in participants’ observations of helpful techniques employed in familiar contexts.

Incorporation of role models was also used as a method of racial socialization, or the process of providing information (verbally or non-verbally) pertaining to race (and ethnicity) to youth. The purpose of racial socialization is to provide racial consciousness and promote a positive ethnic identity (Aldana & Byrd, 2015). Other aspects of racial socialization embedded in the cultural adapted curriculum included allowing for opportunities for open conversations about race and racial discrimination.

To help ensure that the skills presented were internalized, individuals were asked to reflect upon and share any short and long-term goals of theirs (e.g., become more comfortable with public speaking). This allowed the interventionist to incorporate relevant strategies to help support their goals. Additionally, when African Americans seek treatment it is often to obtain concrete and direct techniques that will help alleviate their symptoms (Thompson et al., 2004). Given this characteristic, the interventionist encouraged participants to constantly apply the skills and techniques reviewed in sessions in all aspects of their lives. During sessions participants reported back on those strategies they found helpful and were likely use in the future.
- Method. African American culture is more collectivist and communally oriented than European culture (Jackson & Sears, 1992). Treatments that utilize a group modality is preferable for many African American youth (Cater et al., 2012; Ginsberg & Drake, 2002). *Strong Teens* is typically delivered in a group setting (i.e. class-wide, small groups) so this feature was maintained in both conditions. Given this cultural preference for group learning and collaboration, the use of group activities and group discussions were incorporated into the structure and delivery of the content. Cultural values and norms also highlight the importance of peer support during interventions and are particularly important for the attainment of positive outcomes (Ginsberg & Drake, 2002, Gordon-Hollingsworth et al., 2015; Kelly, 2006). Participants were encouraged to complete activities either as a whole group or in smaller groups/pairs.

- Concepts and Context. The presence of internalizing symptoms in African American youth is often the result of various cultural and environmental stressors such as poverty, community violence, and discrimination (Cardemil, 2010). For African Americans living in the United States, experiences with marginalization, discrimination (Carter et al., 1996; Kelly, 2006; Wilson & Cattone, 2013), and socio-economic stressors are common and often contribute to the presence of anxiety and chronic stressors for individuals in this group (Carter et al., 1996; Wilson & Cottone, 2013). It is important that practitioners consider these contexts and their potential influence on shaping individuals’ negative cognitions and core beliefs. Practitioners also need to remain cautious so as not to over-emphasize race-related issues (or assume youth have had these experiences), as this can
cause unwarranted distress (Thompson et al., 2004). The collaborative nature of cognitive behavioral strategies commonly integrated into many SEL programs encourages clients to be active participants in the treatment process (Kelly, 2006).

So rather than explicitly inserting content related to race-related experience into the curriculum, the interventionist provided African American youth with opportunities to engage in open and honest discussions around race when they felt comfortable (this was in alignment to the cultural adapted goals).
CHAPTER III

METHOD

The present study assessed the effects of a culturally adapted social emotional curriculum for African Americans. The study measured participants’ a) level of engagement with respect to attendance, homework completion (when it was assigned), and interventionist’s perception of engagement, b) internalizing symptoms, c) social-emotional knowledge, and d) social acceptability. These effects were compared to data obtained from students who received the non-culturally adapted version (i.e. treatment as usual). During each session, participant engagement was documented by the interventionist. Information regarding participants’ demographic characteristics was collected during the administration of baseline measures. Self-reports of internalizing symptoms and social-emotional competency were assessed at two different time points, pre-test and post-test using psychometrically sound measures. Additionally, participants’ social validity was assessed post-intervention. Analysis included identifying both within group and between group changes.

A. Participants and Setting

This study took place in a high school located in the Southern region of the United States. According to school demographic data from 2017-2018 school year (year the study took place), the student body was comprised of 1,357 students in grades 9-12. School statistics indicated that the school consisted of 51.8% females and 48.2% males. In terms of ethnicity and racial demographics, 38.4% of the student body identified as Caucasian, 53.5% as Black/African American, 6.6% as Hispanic, 1.3% as Asian, and less than 1% as two or more races (JCampus, 2018). Demographics also indicated that 68% of the student
Body population was eligible either free and/or reduced lunch. In preparation for the University’s Institutional Review Board (IRB), the researcher obtained written support from the school district. Due to district procedures, the principal of the selected school could not be contacted until IRB approval was granted. All required documentation was submitted to the IRB and after IRB approval was granted, permission to conduct the study at the school was obtained from the principal.

B. Participant Selection

The goal of the study was to implement a preventive, social emotional learning curriculum to a group of selected participants (African American high school students). Once permission from the principal was obtained, the researcher worked with the school counselors to identify potential participants who could benefit from a preventative-based social-emotional curriculum and a majority of whom were African American given the nature of the study. Both school administrators and support staff (e.g., counselors) identified high school girls as a subgroup within the school who, given concerning interpersonal conflicts and social difficulties, would greatly benefit from strategies and supports contained within the curriculum. Once this subgroup was identified, the school counselors then focused on selecting (mostly) African American female students with the most behavioral incidents (e.g., ODRs, suspensions) as well as those who displayed internalizing symptoms (e.g., withdrawal, anxiety). Once potential participants were identified by school staff (n= 49), they were randomly assigned to either the treatment group (culturally adapted curriculum) or control group (non-culturally adapted). Based on the group the student was in, they were given either culturally adapted consent and assent forms that explicitly expressed the benefits of African American youth taking part
in a social-emotional curriculum, or non-culturally specific forms which did not contain this information. Consent and assent forms (see APPENDICES A- F) were distributed by the researcher who met with each of the potential participants (individually or in a small group) and explained the purpose of the study and answered any questions. During the scheduling of these meetings, it was discovered that some students initially identified were unable to be reached due to transfers to other schools (e.g., placement at the alternative school), or excessive absences.

Of the originally selected 49 potential participants, 36 met with the researcher and were provided assent and parent/guardian consent forms to complete and return. Both consent and assent forms included a brief description of the study, information regarding confidentiality, and a list of all foreseeable risks and benefits to participants, and a point of contact for the study. Additionally, both consent forms presented the goals of the curriculum, avoided using clinical terms, and provided an overview of the treatment process. Specifically, the forms referred to the group as a “Stress Reduction” intervention (as opposed to a curriculum used to prevent and reduce internalizing symptoms), goals included helping participants develop strategies for overcoming future barriers, and techniques used included assessment procedures, homework, group activities. While research has found this information to be specifically important to minority participants in reducing stigma and reluctance to participate, the researcher felt as if this information would be helpful for all participants (thereby keeping it in the non-adapted consent forms).

Assent and consent were obtained from 29 students and, upon receipt of these forms, participants were randomly assigned to either the non-adapted /control group
(n=14) or the culturally-adapted/intervention group (n =15). However, at the first session, two individuals in the non-adapted group and one in the culturally adapted group informed the interventionist they would no longer be able to participate due to scheduling conflicts. Total participant numbers included 12 in the control group and 14 participants in the intervention group. A diagram of the recruitment process is outlined in the diagram below.

Figure 1: Participant recruitment process
Participant \(N=26\) characteristics are displayed in Table 1. Twelve individuals were randomly assigned to the control group. The average age for this group was 15.1 \((SD=1.07)\) and they had an average grade level of 10.1 \((SD=0.90)\). Within the intervention group there were 14 total participants with an average age of 15.9 \((SD=1.07)\) and an average grade level of 10.4 \((SD=0.93)\). For both groups a majority of the participants identified as African American and all identified as female. Other races identified by participants included Caucasian, Hispanic/Latino, and other (e.g., African American and Caucasian).

<table>
<thead>
<tr>
<th>Group</th>
<th>(n)</th>
<th>Mean Age ((SD))</th>
<th>Mean Grade Level ((SD))</th>
<th><code>Race</code></th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control (Group 1)</td>
<td>12</td>
<td>15.3 (1.07)</td>
<td>10.1 (0.90)</td>
<td>75% African American</td>
<td>100% Female</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25% Non-African American*</td>
<td></td>
</tr>
<tr>
<td>Experimental (Group 2)</td>
<td>14</td>
<td>15.9 (1.07)</td>
<td>10.4 (0.93)</td>
<td>86% African American</td>
<td>100% Female</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14% Non-African American*</td>
<td></td>
</tr>
</tbody>
</table>

*Caucasian, Asian, Hispanic, etc.

C. Independent Variable

*Strong Teens* (Carrizales-Engelmann et al., 2016) is a research based, scientifically constructed, social-emotional curriculum. The program utilizes cognitive-behavioral techniques (e.g., cognitive restructuring, relaxation, behavioral change) in an effort to increase the social-emotional competence and coping skills of youth in grades 9-12 (Marchant et al., 2010; Merrell et al., 2008; Merrell, 2010). *Strong Teens* is one of five curriculums in the *Strong Kids* series. As a whole, each of the curriculums are designed to increase social and emotional knowledge and promote the positive mental health of
children at specific developmental levels (Carrizales-Englemann et al., 2016; Gueldner & Merrell, 2011).

As the last installment within the *Strong Kids* series, *Strong Teens*, is geared toward those between ages of 14-19, a time where youth are at an increased risk for various negative outcomes, including the emergence of internalizing symptoms (Merikingas et al., 2010) often stemming from environmental, biological, and social changes and challenges (Carrizales-Englemann et al., 2016). *Strong Teens* responds to this increased vulnerability by providing adolescents with coping strategies, problem solving techniques, and skills associated with resiliency (Carrizales-Englemann et al., 2016; Kramer et al., 2014; Merrell et al., 2008). The curriculum consists of 12 scripted lessons whose topics include emotional regulation, conflict resolution, displaying empathy, identifying and changing maladaptive cognitions, engaging in optimistic thinking, relaxation techniques, and goal setting (Carrizales-Engelmann et al., 2016). Concepts and skills are taught using direct instruction, group discussions, role-playing, and vignettes. Optional homework assignments are also provided at the end of each session for additional skill practice.

*Strong Teens*, while packaged as a scripted curriculum, promotes flexibility in its delivery. The manual provides interventionists with methods for increasing feasibility including tips for shortening lessons which, unmodified, run approximately 45-55 minutes. Given the time constraints for each group, lessons were modified according to the author’s recommended stop points (“Running Short on Time?”). This, in general, involved the review of previous content, introduction to new content, 1-2 activities, and the closure activity. This modification allowed lessons to be implemented within a 30-
35-minute period. In the introductory chapter the authors make note that *Strong Teens* was not designed as a one-fits-all program. They highlight the importance of adapting the curriculum for diverse individuals noting cultural differences in emotional expression and stated that “[cultural adaptation] is essential if the curriculum is to have the most meaningful impact on the learners” (Carrizales-Engelmann et al., p. 25). As such, in the manual, the authors included recommendations for adapting materials to help increase congruency with respect to participants’ race, ethnicity, and culture. The recommendations proposed are based on their own experiences working with diverse youth and APA Guidelines for Providing Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (Carrizales-Engelmann et al., 2016). Some of the suggested cultural adaptations included: acquiring knowledge about the cultural identities represented amongst participants, modifying language and concepts to increase reliability and comprehension, examining one’s own assumptions, and seeking feedback about modifications to better ensure cultural congruence (Carrizales-Engelmann et al., 2016).

**D. Ecological Validity (Cultural Adaptation) Procedure**

Currently, there are no clear guidelines or detailed procedures for culturally adapting interventions (Cardemil, 2010). However, some cultural adaptation studies have offered some insight into the process and many researchers have provided details on the procedures and techniques they employed in their research (Cardemil, 2010; Castro, Barrera Jr., Martinez Jr., 2004; Castro et al, 2010; Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; and Lopez et al., 2002).
Given that successful cultural adaptations are heavily dependent on practitioners’ knowledge of the target group’s culture (Williams et al., 2014) in most studies, the recommended first step is to define the ethno-cultural group and gather information about that group’s culture (Barrera Jr., et al., 2013). As part of this study, this phase allowed the researcher to better establish which components of the intervention require modification (Barrera Jr., et al., 2013). It is suggested that the information collected pertain to the following: a) values, beliefs, customs, and traditions of the culture (e.g., collectivist responsibility) b) salient cultural issues (e.g., discrimination, mental health stigma, mistrust of therapists) c) unique symptomology of the disorder d) unique risk and protective factors e) cultural perceptions of the disorder, and f) cultural perceptions of mental health treatments.

The next step involved engaging in a preliminary adaptation of the curriculum. During this phase, the information collected helped inform the specific modifications that would lead to increases in the intervention’s cultural relevancy. However, changes were not made to the core curriculum (i.e. the curriculum’s active ingredients) in an effort to preserve the intervention’s efficacy (Barrera Jr., et al., 2013). To further facilitate this process, the Ecological Validity Framework (EVF) was used. EVF promotes changes to the intervention structure (e.g., modality), curriculum content, therapeutic approach, and therapist behavior (Bernal et al., 1995) and highlights eight key domains where cultural adaptations should be applied. These domains are as follows: language, persons, content, metaphors, goals, concepts, methods, and context (Bernal et al., 1995). Main adaptations to the curriculum included the following:
1) Given the collectivist, group-oriented mindset that is salient within African American culture, the curriculum was implemented in a group setting and the use of small-group activities during lessons was regularly adopted to further promote this cultural characteristic.

2) Multimedia approaches, such as the use of music and film clips from African American entertainers, were incorporated throughout the intervention activities to increase participant engagement and cultural relevance through the inclusion of African American names and visuals of African American youth.

3) To increase the saliency of positive role-models and stories of resiliency within the African American community, modifications to content included adding stories of various African American role models (e.g., Michael Jordan, Oprah Winfrey, Tyra Banks, Jay-Z) who were able to achieve success despite encountering various culturally relevant obstacles (e.g., low socioeconomic status, past trauma, discrimination, etc.).

4) Culturally specific risk factors were included within the curriculum’s scenarios, vignettes, and examples. The interventionist also provided opportunities for participants to discuss issues pertaining to racism and discrimination openly.

5) Culturally specific symptoms associated with internalizing problems (e.g., African Americans tend to exhibit more externalizing behaviors and somatic complaints as compared to Caucasian youth) were acknowledged and discussed as part of the curriculum’s psychoeducational component.

6) Support from family members, prayer, spirituality, and emotional debriefing are all coping mechanisms acknowledged within an Afrocentric worldview. These
strategies are associated with positive outcomes and were embedded into all content specific to stress management and positive behaviors.

7) Preparation for each lesson included various culturally responsive readings that encouraged the interventionist to reflect on their own cultural awareness, competence, and understanding of the cultural context in which internalizing symptoms may develop.

Once these modifications were made, additional information and suggestions for further modifications were obtained by interviewing various African American individuals. This was a pertinent step in the process as previous research has recommended that cultural adaptations utilize a “top-down/bottom-up” approach by which information about the culture’s beliefs, values, and norms is obtained both from literature reviews as well as knowledge imparted by representatives of the cultural group (e.g., community members) (Cardemil, 2010). This method better ensured that adaptations went beyond the surface level and included content that further addressed the potential sources of mismatch between the intervention and the client’s culture (Castro et al., 2004). In addition to an extensive literature review, interviews with African American educators (e.g., teachers, school psychologists) and teenagers provided additional insight into pertinent information specific to African American culture, internalizing symptoms, and therapeutic practices (e.g., cognitive behavioral therapy).

In terms of this part of the process, individuals representative of the target cultural group (African Americans) were selected to review the core, preliminary adaptations to assess the researcher’s accuracy and social acceptability. These individuals were encouraged to provide additional suggestions for increasing the cultural relevancy. The following questions were presented to each participant:
1. What are common stressors faced by African Americans?

2. What are the common stressors faced by African American students?

3. When/what contexts are these stressors typically experienced?

4. Have you ever faced discrimination or bias? If so, in what context and how did you react?

5. How do you cope with these situations? What are some specific things that you do?

6. What are some useful techniques that African American students should acquire to help them deal with daily stressors?

7. How is your family important in your life/stress? How do they help relieve/reduce stressful experiences?

8. Is there anyone else (or any other group/structure) that helps reduce stress?

9. What are some things that you like to do to relax?

10. How do African Americans feel about treatment (psychotherapy, cognitive-behavioral treatments)?

11. How are issues of anxiety and stress addressed/discussed in the African American community?

12. How culturally sensitive is the adaptation?

13. Is there anything else that can be included/modified to increase cultural appropriateness?

14. How can African American students benefit from skills such as knowing your feelings, problem solving, anger management, empathy, and relaxation techniques?

15. Are there any other skills that you feel are important for African American youth to acquire?

**i. Summary of Interview Findings**

Once the initial adaptation was completed, the researcher sought additional insight in
terms of perceived culturally unique stressors, protective factors, effective coping mechanisms, and views on therapy and therapeutic practices by interviewing African American individuals. Individuals were selected either based on their direct interactions with African American teenagers in schools (either previous or current) or their own status as an African American teenager. A total of six participants were interviewed individually by the researcher either in person or over the phone. Participants over the age of 18 received a consent form (APPENDIX I) while participants under the age of 18 were also given assent forms in addition to the consent form that their parent/guardian was asked to complete (APPENDIX G and H). Four of the interviewees were African American educators (e.g., teachers, school psychologists) who work, or have worked, with teenagers. Two of the interviewees were African American high school students. All interviews were audio-recorded and major themes from each interview were coded and compiled in a table for further analysis. Using an approach similar to that of grounded theory (Foley & Timonen, 2015), the information obtained from each interview was used to help generate common themes among each interviewee and assist with additional modifications to the curriculum. A brief description of the participant demographics is included in the table (Table 2) below:
Each participant was invited to engage in a discussion with the interviewer guided by the aforementioned questions. A collective summary of their responses is provided below.

**ii. Culturally Specific Stressors and Risk Factors**

All interviewees highlighted similar risk factors identified in the research specific to African American youth including being raised in single parent-households, transient home-life, socio-economic stressors, and interactions with the judicial system (i.e. incarceration). One common theme that emerged among all participants was the difficulty concerning peer-acceptance and belonging. Additionally, a few participants noted the added pressure that many lower income African American youth face due to their socio-economic status. Participant 3 in particular noted that [teenagers] want to have the latest items in an effort to be popular and accepted by peers and may become worried about how they are going to get these items if their parents cannot afford it. Most participants also highlighted the added concern of social media in terms of bullying and peer pressure.
The two adolescent participants noted the stress of having to balance various roles and duties as a teenager. Participant 6 specifically mentioned the difficulty of trying to manage school demands, personal expectations (i.e. doing well in school), and responsibilities at home (i.e. watching younger brother).

iii. **Experiences of Discrimination**

Regarding experiencing discrimination or racism, all adult participants noted having been in situations where they felt either judged or treated differently because of their race. Some of the experiences described involved feeling uncomfortable while shopping (e.g., being followed around in stores, being watched while shopping) and being exposed to microaggressions by others in professional settings (e.g., colleagues making off-color remarks, having their credentials questioned). While all the adult participants could recall a time(s) where they felt discriminated against, all of their experiences appeared to occur during adulthood. Participant 5 noted that she believed her awareness of discrimination did not occur until she became an adult. This latency in recognizing discriminatory experiences during adolescence was further highlighted by the fact that neither of the teenager participants could explicitly recall a time when they felt they were being discriminated against. One reason for this seemingly lack of experience for the teenagers may be due to the ways in which discrimination is typically manifested in today’s society. As adolescents get older their reasoning skills and ethnic identity are developing resulting in an increase in awareness of discrimination (Seaton, Caldwell, Sellers, & Jackson, 2008). Given these developmentally changes, youth perception may not be attuned to accurately identify situations in which more covert forms prejudice and bias of others may be taking place. For instance, some youth may not be privy to the
ways in which years of discrimination and prejudice affect their lives to this day (e.g., institutionalized racism, segregated schools, lack of education opportunities). This being said, given the frequency of the discrimination experienced by the adult participants, as well as research indicating that discrimination can be experienced, and negatively affect, individuals as young as preadolescent youth (Coker et al., 2009) it is still important that African American youth be prepared for these experiences and be provided with tools and strategies for coping.

iv. Protective Factors (Forms of Support) and Coping Mechanisms

During the discussions of discrimination with the adult participants, when asked about how they responded to these situations, most avoided internalizing these messages and maintained a positive attitude. Participant 1, who identified times when she felt she was being taken less seriously than her white colleagues, stated that in those situations she tried not to take others’ behaviors toward her personally. Participant 2 recalled early memories of racial socialization by her parents, positive messages of self-worth which she attributed to helping buffer against the negative effects of discrimination and other stressors. These precautions against internalizing other’s negative views of them in discriminatory situations is a mechanism for the development of a positive ethnic identity (Brittian, 2012; Okeke-Adeyanju et al., 2014). Other notable protective factors against stressors included ties to the religious community (Participant 3 and Participant 4) and close family relationships (Participant 1, Participant 2 and Participant 3).

An explicit discussion of positive coping strategies was prompted by the researcher in which all participants were asked to identify their own strategies for dealing with anxiety and/or manage stress. Many of the adult participants highlighted reading, socializing with
others, and exercising (e.g., taking walks) as positive ways to deal with stress. Meditation and prayer (faith) also were major techniques among all participants (teenage and adult). Regarding meditation, Participant 2 stated that meditation was a relatively new practice (for her) that she used to help focus and [that it is] a practice “for my brain, it is a practice for my thoughts”, she later added, “[it helps me remember] what is good and what is right and what is important, and not to lend a lot of thought to the negative.” When the adult participants were asked about their perceptions of teenagers and the ways in which they cope with stress, many believed that teenagers struggle with ways to effectively deal with stress. Participant 2 added that “a lot of times our teenagers don’t know how to cope with the stresses of the environment that they were raised in or what is going on with them.” Additionally, Participant 1 listed ways that she notices teens often deal with stress which included consuming drugs and/or alcohol, engaging in sexual activities, withdrawing from others, and truancy.

When the adult participants were asked about positive coping strategies that they believed would be beneficial for teenagers to engage in, all four participants expressed a desire to see teenagers discuss their issues with a trusted adult, “someone’s whose opinion they value” (Participant 3). Participant 2 stated that teenagers should “talk to an adult because they have gone down the same road.” This statement highlights the notion that adults are able provide valuable advice and insight into situations that may be more helpful than just speaking to a peer. A similar point was made by Participant 5 who felt that adults were more equipped to give teens “the right advice.” This theme of seek help from adults was also present in the interviews with both teenagers. Both teenager interviewees stated that they regularly seek adult support as a way to cope. Whether it be
family (Participant 6) or other adults in their lives. Participant 4 stated that he regularly attends therapy to help him with his problems, Participant 6 said she often turns to her guidance counselor for support during stressful periods because her counselor is “calm” and “gives good advice.”

Participant 3 highlighted the importance of helping teens cope with both chronic and momentary stressors. She stressed the value of teaching teens methods to help them cope “in the moment.” Strategies such as counting to ten, thinking positive thoughts, and taking a deep breath were all ways that she believed teens could learn to help handle every day, momentary stressful situations. When asked about what role family plays to help to relieve stress, all participants responded differently. While some participants stated that just being in the presence of family can be helpful (Participant 2 and 3), some identified a more active role of their family as individuals whom they turn to for advice (Participant 1 and 6), while others stated that family can sometimes be a source of stress (Participants 4 and 5). Overall, this question highlighted heterogeneity within the African American culture as participant responses demonstrated that the role family plays in stressful situations can vary. While turning to one’s family may be beneficial in reducing stress for some, it may not be for others, therefore it is important that other coping mechanisms are presented and discussed.

v. Cultural Perceptions of Internalizing Symptoms and Therapeutic Practices

All participants were asked about their perceptions on therapeutic practices and how issues of stress and anxiety are discussed (or not discussed) within the African American community. Participant 2 highlighted a reluctance to seek help within the African American community stating that, “the African American community is not open to
therapy,” and later adding “there is a stigma that you can’t solve your own problems when you have to seek out someone to help you understand your own thoughts and your own process.” Participant 1’s response to this question echoed this sentiment when she stated that “[in African American culture] needing somebody else’s help makes them feel inferior or weaker.” When asked about how do mental health concerns (e.g., anxiety) get addressed in the African American community, if not through therapy, many stated that these issues often go unaddressed. According to Participant 3, “[people] who have issues that lead to those types of internalization behaviors feel reluctant to even say something because their community, their culture, is not as open to dealing with it, or talking about it, or labeling it.” Participant 6 offered a similar perception regarding mental health issues among teenagers going unaddressed, noting that symptoms such as depression do not get talked about. Offering some insight as to why this might be the case, she responded, “some kids they like, they don’t want people to know their business, they would rather keep it to themselves.” Participant 6 added “I think they [mental health issues] should be discussed because a lot of kids are going through depression.”

Despite these comments many participants pointed to a noticeable shift in African American perceptions of mental health supports toward more acceptance and willingness to participate in therapeutic practices “More African Americans now are more open to it [intervention and therapeutic practices] than they used to be” (Participant 1). Participant 2 added, “I think among people who are older African Americans, there is still skepticism about anything that is therapy [sic], but I think among people who are younger, it is a lot more accepted,” Participant 5 also commented on this generational shift in which therapy has become destigmatized due to greater exposure (e.g., seeing people get help on TV).
vi. Cultural Adaptation of Curriculum

The last few questions focused on the researcher’s preliminary cultural adaptation of the curriculum. Notable adaptations, based on research, made to the curriculum were discussed with each interviewee and suggestions for additional adaptations were solicited. All participants were positive about the initial modifications. A few participants stressed the importance of having the interventionist build rapport with the students, especially in this context. Participant 4 stated that it would be helpful for the interventionist to appear more like a friend than a teacher by making attempts to relate to the teenagers in some way. All reacted positively to modifications to the curriculum in which culturally specific stressors were embedded into vignettes and examples (e.g., addressing violence in the neighborhood, single parent households)

When presented with the goals of the curriculum, Participants 3 and 5 talked about having in depth discussions with students about labeling feelings especially anger, since many other emotions can be labeled anger when there might be an underlying feeling. Participants 1, 2, and 6 added additional forms of coping that should be included. Both participants 2 and 6 discussed encouraging students to participate in sports and other extracurricular activity as a way to relieve stress. Participant 1 commented on the use of positive affirmations, “there was one I used to have like ‘I am beautiful’. ‘Good morning beautiful, this is going to be a great day’ type of thing. I think having something whether than can read and see every day to help internalize [sic] a positive feeling that they can refer back to [if] something negative comes up.” This suggestion of encouraging students to create and repeat positive statements was identified as a potential coping strategy that students can use to bolster self-esteem, which may help to alleviate negative symptoms.
When asked about other important skills they believed students should learn, African American teens in particular, Participant 1 discussed teaching students how to conduct themselves appropriate “particularly in places that are dominated by certain groups.” This idea of code-switching is an important skill for minority youth to obtain in order to reduce tensions and stressors in the environment. However, it was not just in-person mannerisms that participants felt was important to address, Participant 6 discussed talking to students about social media etiquette, particularly around “what to post and what not to post.” Below is a summary of the common themes obtained from conversation with each interviewee.

Table 3. Summary of interview responses

<table>
<thead>
<tr>
<th>Topic</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally Unique Stressors</td>
<td>Single parent families, Low Socioeconomic Status, Peer Acceptance,</td>
</tr>
<tr>
<td></td>
<td>Violence in Community, Balancing Family and School Demands, Discrimination in adulthood</td>
</tr>
<tr>
<td>Protective Factors in the African American</td>
<td>Close relationships with family, religion/church, positive self-esteem,</td>
</tr>
<tr>
<td>Community</td>
<td>positive ethnic identity</td>
</tr>
<tr>
<td>Coping Mechanisms</td>
<td>Exercise, seeking support from a trusted adult, seeking support from</td>
</tr>
<tr>
<td></td>
<td>the church, meditation, engaging in non-academic activities (e.g.,</td>
</tr>
<tr>
<td></td>
<td>sports)</td>
</tr>
<tr>
<td>Cultural Perspectives on Therapy and Therapeutic Practices</td>
<td>Heavily stigmatized, hesitant to discuss mental health with others</td>
</tr>
<tr>
<td></td>
<td>particularly mental health professionals, younger generations appear</td>
</tr>
<tr>
<td></td>
<td>less reluctant to seek therapy, more likely to engage less clinically-</td>
</tr>
<tr>
<td></td>
<td>sounding practices (e.g., counseling vs. therapy)</td>
</tr>
<tr>
<td>Ways to successfully conduct an SEL curriculum</td>
<td>Building rapport with teenagers, including culturally relevant stressors</td>
</tr>
<tr>
<td>with American Teenagers</td>
<td>in curriculum content, discussing ways to cope with stressors/anger in</td>
</tr>
<tr>
<td></td>
<td>the moment, discussions about how to accurately identify emotions</td>
</tr>
<tr>
<td></td>
<td>particularly how emotions can easily be mislabeled as anger, positive</td>
</tr>
<tr>
<td></td>
<td>affirmations, how to conduct oneself appropriately in various contexts</td>
</tr>
</tbody>
</table>
Once the interviews were completed, the information collected was used to help the researcher make additional adaptations to the curriculum. These modifications included increasing ways that the interventionist could successfully (and consistently) build rapport with the participants (e.g., starting each session spending time engaging with participants in casual conversation, seeking opportunities to learn more about them, allowing participants opportunities to get to know the interventionist), structuring the delivery of content to include more open ended discussions to increase students’ comfort in talking about more personal issues, discussing and practicing in-the-moment coping strategies, and engaging in racial socialization to facilitate the formation of a positive racial identity and discuss ways to deal with discriminatory experiences (see APPENDIX J and APPENDIX K).

E. Treatment Fidelity

To assess whether the interventionist implemented the curriculum with integrity, the number of active ingredients completed during each session was assessed using the Basic Fidelity Checklist (APPENDIX L). The Basic Fidelity Checklist is a measure developed by the curriculum’s authors. The checklist was used to assess the implementation of the components that comprised each Strong Teens lesson. For the purposes of this study, treatment integrity only focused on the interventionist’s adherence to the active ingredients of the curriculum. Since the culturally adapted curriculum did not contain the focusing activity component included in the original curriculum, a modified version of the Basic Fidelity Checklist, removing this component, was created. Due to time constraints, the interventionist had to shorten lessons based on the authors’ recommended stop and start points. Both checklists removed components of the lesson
that the authors’ suggested facilitators skip to help reduce the length of the lesson. This change was important in order to ensure that an accurate percentage and true representation of treatment integrity was obtained. For each session, using the Basic Fidelity Checklist (or the modified version), the number of delivered components was divided by the total number of activities and multiplied by a hundred to obtain a percentage of the components implemented. According to prior research specific to the measurement of treatment integrity, this value should be at least 80% (Noell, Gresham, & Gansale, 2002).

Inter-rater reliability was conducted on 30% of the total number of sessions in the study. Specifically, the 9th, 10th, 11th, and 12th sessions for each group were selected as sessions where interrater reliability was obtained. Given that the interventionist was also the researcher, inter-rater reliability was obtained by audio-recordings of the selected sessions. For each of the four sessions, scores on the completed post-session fidelity checklist (filled out by the interventionist after the session was over) were compared to scores completed (using the same checklist) by the researcher while listening of the audio-recording of the session.

Percentage of agreement was obtained by comparing fidelity ratings for each observation. If the numbers were equal to each other a score of +1.00 was assigned, if they were different a score of 0.00 was recorded. A percentage was calculated by dividing the sum of the agreement values by the number of inter-observer sessions (n=4) and multiplied by 100 (McHugh, 2012). Based on the percent agreement obtained, a Cohen kappa statistic, a correlational value ranging between -1 to +1, was obtained to further interpret the level of agreement between observers and account for the value in
relation to chance (Bryington, Palmer, & Watkins, 2002). A table for interpretation of this Cohen’s kappa statistic is included below.

Table 4: Interpreting Cohen’s kappa

<table>
<thead>
<tr>
<th>Cohen’s Kappa Statistic</th>
<th>Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 0</td>
<td>Less than change agreement</td>
</tr>
<tr>
<td>0.01-0.20</td>
<td>Slight agreement</td>
</tr>
<tr>
<td>0.21-0.40</td>
<td>Fair agreement</td>
</tr>
<tr>
<td>0.61-0.80</td>
<td>Substantial agreement</td>
</tr>
<tr>
<td>0.81-0.99</td>
<td>Almost perfect agreement</td>
</tr>
</tbody>
</table>

(Adapted from Viera, & Garrett, 2005)

F. Interventionist

For this study, the researcher took on the role as the interventionist for both the control and experimental (culturally-adapted) groups. An African American female and a 4th year doctoral candidate in a School Psychology program, the interventionist received extensive training on the delivery of evidence-based treatments to students in school settings and treatments for individuals with internalizing disorders through both graduate level coursework and clinical experiences (practica). The interventionist also had prior experience working with teenagers and implementing Strong Teens to minority adolescents with identified internalizing symptoms. At the start of the study, the interventionist had prior interactions with the school as a member of the district’s Pupil Appraisal team (the School Psychology intern) for 6 months.
G. Dependent Variables

The variables measured in this study were reminiscent of those assessed in other cultural adaptation intervention studies. These variables included participant retention rates, treatment outcomes, and social desirability (Cardemil, 2010). Specifically, this study collected data on participant engagement, internalizing symptoms, social-emotional knowledge, and social validity. Each of these variables were assessed in both the treatment (i.e. cultural adaptation) and control (i.e. curriculum as written) conditions. These data were used to compare the two groups during the analysis phase and identify any differences in the pre-posttest measures.

i. Participant Engagement

A primary goal of this study was to increase the level of engagement of the participants using a culturally adapted curriculum. This goal is aligned to the overall purpose of cultural adaptation (Bernal & Rodriguez, 2012; Cardemil, 2010), which, through the inclusion of specific cultural factors, seeks to deliver an intervention that is both more accessible to the target population and will increase participation, retention rates, and outcomes (Bernal & Rodriguez, 2012; Castro et al., 2004). For the purpose of this study, participant engagement was operationalized as student participation (e.g., contributing to discussion, participating in activities), completion of homework (when assigned), and rate of retention. The interventionist collected these data each session using the Participant Engagement sheet (APPENDIX M). Specifically, the following variables were assessed: attendance, frequency of participation, level of contribution, and homework completion (when assigned).
Attendance referred to the participant’s physical presence during the session and was evaluated dichotomously (i.e. 0 = did not attend, 1= did attend/attended partially for an excusable reason). Frequency of participation was defined as the level of engagement during group activities and was assessed on a scale from 0-2 with “0” being took part in less than half of the activities, “1” meant took part in at least half of the activities, and “2” was took part in more than half of the group activities. Contribution referred to the level in which participants added to or furthered discussions through comments or questions. If a student did not contribute any questions or comments, they received a rating of “0”, while a “1” was given to students who provided at least one comment/question, and a rating of “2” was given to students who contributed multiple comments and asked more than one question during the session. When assigned, the homework completion component was evaluated using a dichotomous measure where “0” meant the student did not do the homework and a score of “1” indicated that they did. The sum of these ratings produced a single participant engagement score for each student for each session. For each participant, their participant engagement scores for each session were averaged to yield a singular participation engagement score.

ii. Internalizing Symptoms

A secondary goal of this intervention was to decrease participants’ levels of internalizing symptoms. This variable was assessed using the self-report version of the *Strength and Difficulties Questionnaire (SDQ;* Goodman, 1997). The *SDQ* self-report is a brief measure that assesses the psychological adjustment of youth and analyzes the positive and risk attributes prevalent for children and adolescents ages 4 to 17. While often used as an initial assessment measure, the *SDQ* is also sensitive to treatment
effectiveness and can be used to evaluate outcomes of practices and interventions (Goodman, 2001). The SDQ self-report is a 25-item measure that consists of five subscales: Emotional Symptoms, Conduct Hyperactivity/Inattention, Relationship Problems, Prosocial Behavior. Each item is assessed on a 3-point Likert scale. When used as a preventative tool and/or with a general population (i.e. non-symptomatic), it is recommended that broader scales are used. Questions fall into one of five scales: Emotional problems, Conduct problems, Hyperactivity, Peer problems, and Prosocial scales. Three different scores can be obtained from the measure: Total difficulties, Externalizing, and Internalizing score. For the purposes of this study, only participants’ Total Difficulties score was obtained, which included items on all subscales except those on Prosocial scale.

The SDQ as a whole has demonstrated satisfactory reliability and validity (Goodman, 2001). Reliability was represented through a high mean internal consistency of 0.73, retest stability of 0.62, and above average interrater agreement. Validity of the measure was attributed to correlations between scale score and psychiatric risk for clinical disorders (Goodman, 2001). The SDQ has also been shown to be just as good at detecting internalizing symptoms as the Child Behavioral Checklist (CBCL) but was noted as being more adept at distinguishing between internalizing and externalizing symptoms (Goodman, 2001).

iii. Social Emotional Knowledge

Another important outcome assessed was the level of social-emotional knowledge acquired by participants. Social-emotional knowledge was defined as the attainment of social-emotional concepts and coping skills associated with resiliency. Social-emotional
knowledge refers to the social competency skills that promote emotional regulation, positive interpersonal relationships, prevention of negative behaviors, and success both academically and socially (Elias et al., 2008). This variable was assessed using the Strong Teens Knowledge Test, a 20-item measure developed by the authors of Strong Teens. This measure consists of 6 True/False statements and 14 multiple choice questions that evaluated students’ knowledge of appropriate expressions of thoughts, emotions, and behaviors as well as coping skills. Pilot studies indicate internal a consistency ratings range of $r = 0.60$ and $r = 0.70$. This measure is also considered to be sensitive to changes from interventions.

iv. Social Validity

The Children’s Intervention Rating Profile (CIRP; Witt & Elliot, 1985) is a common measure used to assess participant acceptability within intervention studies (Janney et al., 2012; Power et al., 2012; Merriman, Coddington, Tryon, & Minami, 2016). The CIRP was used to obtain participants’ opinion with respect to the “fairness” and perceived effectiveness of the intervention (Carter, 2007). The CIRP is a modified version of the Intervention Rating Profile-15 (IRP-15) adapted for use with youth participants (Carter, 2007). The measure consists of 7-items each on a 5th grade reading level and assessed using a 6-point Likert- scale ranging from 1= agree to 6 = I do not agree. With respect to reliability, internal consistency ranges between .75 and .89 (Carter, 2007). The CIRP was completed by each participant at the conclusion of the intervention to determine their acceptability of the intervention received. Ratings were compiled into an overall score which was calculated using the Social Validity Adapted CIRP Scoring Tool, an excel file for scoring made accessible by the Comprehensive Integrated Three-
Tiered Model of Prevention (http://www.ci3t.org/fabi). According to the scoring guide, a higher overall score indicates greater social validity.

**H. Experimental Design and Procedure**

This study was conducted using a non-equivalent group design, a quasi-experimental design commonly used in educational and social research and a methodology utilized in a number of *Strong Kids/Strong Teens* intervention studies (e.g., Caldarella et al., 2009; Kramer et al., 2014). This design was appropriate considering participants were selected based on recommendations of school personnel. Once selected each participant was randomized to either the control or treatment group. During the first session, each participant took the pre-test baseline assessments then participated in either the non-adapted or adapted intervention. Once the intervention concluded, all participants completed post-test measures.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Pre-test Baseline</th>
<th>Strong Teens Intervention</th>
<th>Post-test Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>O₁</td>
<td>X</td>
<td>O₃</td>
</tr>
<tr>
<td>Intervention</td>
<td>O₂</td>
<td>X</td>
<td>O₄</td>
</tr>
</tbody>
</table>

In terms of threats to internal validity due to participant selection, it was hypothesized that participants within each group were highly comparable given their demographic similarities and that this threat was minimized as a result.

**i. Phase 1: Training**

No other formal training was provided given the interventionist’s familiarity with the curriculum, skill level in conducting group counseling, and previous work with
adolescents. However, prior to each session the interventionist reviewed both the culturally adapted and non-adapted lessons prior to implementation. To further prepare for implementation of the culturally adapted lessons specifically, additional readings pertaining to culturally relevant practices were reviewed and added to the Instructor Reflection section of each lesson.

The Instructor Reflection component is part of the original curriculum designed as a pre-implementation activity. Specifically, it includes suggestions and information to help facilitate instructors’ comfort with the lesson’s content. It also provides instructors with an opportunity to reflect upon their own personal experiences with the skills covered. Additional readings were included as part of the culturally-adapted curriculum to help frame each topic in the context of African American youth (e.g., African American teenagers and their expression of anger). These readings were added to support the interventionist’s reflection on each topic through a culturally response lens, as well as to engage the interventionist in an honest self-assessment of any personal and cultural biases (APPENDIX N).

ii. Phase 2: Pre-test

After parental/guardian consent and participant assent was obtained, students in both groups completed pre-test assessments which included a demographic survey (APPENDIX O), the SDQ self-report measure (APPENDIX P), and the Strong Teens Knowledge Test (APPENDIX Q). It should be noted that because this was a prevention study, participants’ ability to participate was not dependent on their scores on the SDQ self-report measure. Strong Teens can be used for both a prevention and intervention purposes (Carrizales-Engelmann et al., 2016), so participants with non-clinical
symptomology were likely to benefit from additional social-emotional knowledge and techniques that may reduce their risk for internalizing symptoms.

iii. Phase 3: Intervention

After pre-assessments and surveys were administered, implementation of Strong Teens in both conditions began. The only difference between the two groups was that participants in the experimental group received the culturally-adapted version of the curriculum while participants in the control group received the curriculum as written. Each group was comprised of 12-14 students. Lessons were presented to participants on a weekly basis (one lesson per week). Each session lasted approximately 30 minutes, so lessons were shortened according to authors’ recommended stop points (*Running Short on Time*?). While there were only 12 lessons, breaks and changes in school schedule increased the total length of study and it took place over the course of 4 months (however there were still only 12 weeks of intervention). In delivering one lesson a week, participants had adequate time to complete homework (when assigned), internalize content taught, and practice skills introduced (Carrizales-Engelmann et al., 2016). After every session, the interventionist completed the Basic Fidelity Checklist (or Basic Fidelity Checklist-Culturally Adapted Version), a treatment fidelity measure that assesses interventionists’ level of completion of each lesson component. During each lesson the interventionist completed the Participant Engagement Form assessing individual participant engagement with respect to homework completion (when assigned), participation, and attendance during each lesson.
iv. **Phase 4: Post-test**

Once all 12 lessons in both conditions were implemented, student participants completed the *SDQ Self-Report* and the *Strong Teens Knowledge Test* again. Participants also completed the *CIRP* (APPENDIX R) which assessed their social validity of the intervention received. Students in the experimental group were debriefed and told that they were delivered a modified curriculum that was tailored to be more inclusive to African American students. They were also provided copies of the debriefing form (APPENDIX S) after the study concluded.

I. **Planned Statistical Analysis**

The data were analyzed using non-parametric statistical tests. This was facilitated by the use of the statistical software R. This form of analysis (i.e. non-parametric) was selected due to an inability to meet the assumptions of parametric tests. Specifically, the parametric assumption of normal distribution was violated due in large part to the study’s small sample size and notable outliers in each data set. In addition to obtaining descriptive statistics for each data set (e.g., mean, variance, skewness, kurtosis), methods used to further analyze the data and determine whether the hypotheses predicted are detailed below.

i. **Participant Engagement**

A comparison of participant engagement scores between groups was achieved using a between-subjects, non-parametric version of the independent t-test called the Mann-Whitney U test (Harris, Boushey, Bruemmer, & Archer, 2008)
ii. Internalizing Symptoms and Social Emotional Knowledge

To determine whether the intervention resulted in changes in participants’ internalizing symptoms and social-emotional knowledge, the Wilcoxon Signed Rank test for non-parametric analysis (within-group factors) was used to analyze these pre- and post-test data (Harris et al., 2008). Specifically, analysis included a) differences in internalizing symptoms pre-/post-test as measured by the SDQ Self-Report and b) differences in social-emotional knowledge pre-/post-test as measured by the Strong Teens Knowledge Test. Additionally, an assessment of differences between post-test scores obtained from participants in each condition (i.e. control and treatment) was conducted using a Mann-Whitney U test. Specifically, analyses included an examination of a) differences between the culturally adapted model and control condition post-test internalizing symptoms as measured by the SDQ and b) differences between the culturally adapted model and the control condition on social-emotional symptoms as measured by the Strong Teens Knowledge Test during post-test administration.

A total of three comparisons were conducted for each dependent variable (i.e. internalizing symptoms and social-emotional knowledge): pre vs. post control, pre vs. post intervention, post-intervention vs. post-control. Since multiple comparisons were conducted for each dependent variable data set, family-wise error rate was controlled using the Holm’s sequential procedure (Levin, 1996).

iii. Social Validity

Analysis of the social validity measures for the participants between both groups was accomplished using the Mann-Whitney U non-parametric test for independent groups. This analysis determined whether there were differences in the mean score for
social validity, measured by the *CIRP*, between the experimental group and the control group. Additionally, interventionist impressions and anecdotal responses from participant CIRP forms were also included as additional reflections of the success of the groups.
CHAPTER IV
RESULTS

This study was designed to answer the following research questions: 1) Did the cultural adaptation of an SEL program yield higher participant engagement scores (e.g., retention, active participation) in the experimental group as compared to those obtained from participants in the control (non-adapted curriculum) group? 2) Did participation in the intervention result in overall changes in self-reported symptomology and social-emotional knowledge? 3) Did the culturally adapted curriculum promote a greater reduction of internalizing symptoms in participants as compared to those who received the curriculum as written? 4) Did the cultural adaptations made to the curriculum lead to greater acquisition of social emotional knowledge by participants in that group as compared to the control group? 5) Did the modifications that were made to the curriculum result in higher social acceptability ratings by those in the culturally adapted group?

All questions were answered using non-parametric statistical tests analyzed using the statistical software R. For both groups (i.e. control and experimental), the data collected pertaining to the first question were analyzed using the non-parametric version of a dependent samples (within-subjects) t-test, the Wilcoxon signed-rank test. The second and fourth questions were answered using the non-parametric version of a two-
independent samples (between-subjects) t-test known as the Mann-Whitney U Test. To answer the third and fifth questions, the Mann-Whitney U test was also used to analyze participants’ post-intervention responses on the SDQ self-report measure and Social Emotional Knowledge between both groups. Parametric tests (e.g., t-tests) were considered however it was hypothesized that the assumptions of these tests would not be met due to the small sample size.

In his paper detailing deciding between parametric or non-parametric tests, Harwell (1988) specifies that that parametric tests are less robust when the sample size is very small (n < 30), as small sample sizes are highly susceptible to violating the normality assumption required to conduct parametric tests. Essentially, smaller sample sizes often yield data that is not normally distributed (e.g., flat, peaked, or strongly skewed) and reduce the power of parametric tests. (Harwell, 1988; Vickers, 2005). Using a parametric test on data that are not normally distributed leads to unreliable results and negative effects (i.e. making Type 1 and Type 2 errors; Harwell, 1988). Alternatively, when the normality assumption is violated, non-parametric tests are more robust than their parametric counterparts.

Additional support for the use of non-parametric tests was obtained from a G* power analysis that was conducted a priori. G* power analysis indicated that a sample size of at least 44 participants was required to yield enough power to conduct parametric
tests. Once the total sample size was established (N=26) the researcher decided that non-parametric tests would provide greater statistical power and would be more effective at controlling the type 1 error rate (Vickers, 2005). Given the potential lack of power that parametric tests would have on the data, it was decided that non-parametric tests would be used. For the purposes of clarity, the use of numerical subscripts will be utilized during the presentation of certain descriptive statistics where a subscript of 1 refers to the control group and a subscript of 2 refers to the experimental group. A summary table of the measures used in this study and their score ranges are provided in the table below (see Table 6).

Table 6: Study measures and their scores

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Engagement</td>
<td>0-5.08</td>
</tr>
<tr>
<td>Strong Teens Knowledge Test</td>
<td>0-20</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (Total Difficulties Score)</td>
<td>Close to Average</td>
</tr>
<tr>
<td></td>
<td>0-14</td>
</tr>
</tbody>
</table>
A. Outcomes: Participant Engagement

Participant engagement scores for each participant in both conditions (control and intervention) were compared. Based on the descriptive statistics (see Table 7), the average participant engagement score for the control group was 2.90 ($SD=0.94$). The average participant engagement score for the experimental group was 2.80 ($SD=1.34$). Regarding the distribution of the data, skewness and kurtosis values indicate that both groups were symmetric and negatively skewed ($skewness_1 = -0.54$, $skewness_2 = -0.50$), as well as platykurtic ($kurtosis_1 = 2.67$, $kurtosis_2 = 2.33$). Histograms and boxplots for each data set provide a visual representation of the distributions (See Figure 2).

Table 7: Participant engagement descriptive statistics summary table

<table>
<thead>
<tr>
<th></th>
<th>Mean $(SD)$</th>
<th>Median</th>
<th>$Q1:Q3$</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>2.90 (0.94)</td>
<td>3.05</td>
<td>2.25:3.37</td>
<td>-0.54</td>
<td>2.67</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>2.80 (1.34)</td>
<td>3.08</td>
<td>2.08:3.58</td>
<td>-0.50</td>
<td>2.33</td>
</tr>
</tbody>
</table>
Figure 2: Histograms and boxplots of participant engagement scores
B. Statistical Analysis

A one-tailed Mann-Whitney U Test was conducted (in R) to assess the research question: Did the cultural adaptation of an SEL program yield higher participant engagement scores (e.g., retention, active participation) in the experimental group as compared to those obtained from participants in the control (non-adapted curriculum) group? The analysis conducted indicated that participant engagement scores of individuals in the control group ($Mdn = 3.05$) did not differ statically from the participant engagement scores of those in the treatment group ($Mdn = 3.08$) where $z = -0.07$, $p = .47$, $\alpha = .05$ (see Table 8).

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Test Statistic (Z)</th>
<th>Sig (1-tailed)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>12</td>
<td>-0.07</td>
<td>0.47</td>
<td>-Inf 0.84</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*significant when $p < .05$
C. Outcomes: Effectiveness of Intervention

i. Social Emotional Knowledge

The average baseline measures of social-emotional knowledge for the control group was 14.3 (SD =2.53) and 13.5 (SD =4.22) for the experimental group (higher scores indicate a greater content knowledge). After the intervention, the average social emotional knowledge scores for the control group was 15.1 (SD =2.60), while the experimental group obtained a mean score of 16.0 (SD =3.82) indicating increased social emotional knowledge in both groups. Regarding the distribution of the data, pre-test measures for the control group were highly, negatively skewed and leptokurtic (skewness= -1.32, kurtosis= 4.06). Skewness and kurtosis values for the experimental group indicated a distribution that is negative, moderately skewed and platykurtic (skewness= -0.65, kurtosis= 2.80). The distribution of the post-test data for the control group indicate that it is negatively skewed, symmetric, and platykurtic (skewness= -0.19, kurtosis= 2.47). While post-test data for the experimental group indicate a distribution that is highly skewed, negative, and leptokurtic (skewness= -1.75, kurtosis= 5.35). Pre- and post-test data histograms and boxplots for each group provide a visual representation of the data distributions (see Figures 3-5).
Table 9: Social emotional knowledge descriptive statistics summary table

<table>
<thead>
<tr>
<th></th>
<th>Mean(SD)</th>
<th>Median</th>
<th>Q1:Q3</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Pre</td>
<td>14.3 (2.53)</td>
<td>15.0</td>
<td>13.5:16.0</td>
<td>-1.32</td>
<td>4.06</td>
</tr>
<tr>
<td>Control Post</td>
<td>15.1 (2.60)</td>
<td>15.0</td>
<td>14.0:16.5</td>
<td>-0.19</td>
<td>2.47</td>
</tr>
<tr>
<td>Experimental Pre</td>
<td>13.5 (4.22)</td>
<td>14.0</td>
<td>12.0:15.75</td>
<td>-0.65</td>
<td>2.80</td>
</tr>
<tr>
<td>Experimental Post</td>
<td>16.0 (3.82)</td>
<td>17.0</td>
<td>15.5:18.5</td>
<td>-1.75</td>
<td>5.35</td>
</tr>
</tbody>
</table>

Figure 3: Histograms of baseline and post-test data for control group SEL knowledge
Figure 4: Histograms of baseline and post-test data for experimental group SEL knowledge

Figure 5: Boxplots of SEL knowledge data for control and experimental groups

1 = Pre-test
2 = Post-test
ii. Statistical Analysis

To answer the first part of the research question, *did participation in the intervention result in overall changes in social emotional knowledge and self-reported symptomology?* A Wilcoxon signed rank test was used to assess any changes in participants’ baseline and post-tests scores on the *Social Emotional Knowledge* measure for both groups. Four sets of paired data, ($n_1=1$, $n_2=3$) were removed due to missing post-test scores. Analysis indicated that baseline scores ($Mdn = 15.0$) and post test scores ($Mdn = 15.0$) in the control group did not produce changes that were statistically different, $p = 0.19$, $\alpha = .05$. Baseline scores ($Mdn = 14.0$) and post-test scores ($Mdn = 17.0$) for the experimental group also did not yield results that were statistically different, $p = 0.09$, $\alpha = .05$ (See Table 10).

Table 10: Analysis of SEL knowledge- Wilcoxon Signed Rank

<table>
<thead>
<tr>
<th></th>
<th>$n$</th>
<th>Sig (1-tailed)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>11</td>
<td>0.19</td>
<td>$-0.5 \leq Mdn$</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>11</td>
<td>0.09</td>
<td>$0 \leq Mdn$</td>
</tr>
</tbody>
</table>

*significant when $p < .05$
iii. **Internalizing Symptoms**

The average baseline measures of internalizing symptomology, as measured by the *SDQ* self-report, for the control group was 13.9 (*SD* =6.05) and 15.6 (*SD* =6.65) for the experimental group (higher scores indicate the presence of more internalizing symptoms). Post-intervention, the average scores on the *SDQ* for the control group decreased to 13.5 (*SD* =5.18), while the experimental group’s average score stayed the same at 15.6 (*SD* =6.77). Regarding the distribution of the data, pre-test measures for the control group indicated a positively skewed and platykurtic distribution (skewness= 0.85, kurtosis=2.68). Skewness and kurtosis values for the experimental group *SDQ* scores indicated a baseline data that has negative, moderate skewness and a platykurtic distribution (skewness= -0.79, kurtosis= 2.28). The distribution of post-test data for the control group indicated data that it was highly and positively, skewed with a leptokurtic distribution (skewness= 1.63, kurtosis= 5.37). While post-test data for the experimental group indicated a distribution that was positive symmetric, and platykurtic (skewness=0.03, kurtosis= 2.28). Post-test data Histograms and boxplots for each data set provide a visual representation of the distributions (see Figures 6-8).
Table 11: Internalizing symptoms descriptive statistics summary table

<table>
<thead>
<tr>
<th></th>
<th>Mean(SD)</th>
<th>Median</th>
<th>Q1:Q3</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Pre</td>
<td>13.9 (6.05)</td>
<td>11.5</td>
<td>9.0:17.3</td>
<td>0.85</td>
<td>2.68</td>
</tr>
<tr>
<td>Control Post</td>
<td>13.5 (5.18)</td>
<td>13.0</td>
<td>10.0:14.5</td>
<td>1.63</td>
<td>5.37</td>
</tr>
<tr>
<td>Experimental Pre</td>
<td>15.6 (6.65)</td>
<td>18.0</td>
<td>12.0:15.8</td>
<td>-0.79</td>
<td>2.28</td>
</tr>
<tr>
<td>Experimental Post</td>
<td>15.6 (6.77)</td>
<td>16.0</td>
<td>15.5:18.5</td>
<td>0.03</td>
<td>2.28</td>
</tr>
</tbody>
</table>

Figure 6: Histograms of baseline and post-test SDQ data for control group
Figure 7: Histograms of baseline and post-test SDQ data for experimental group

Figure 8: Boxplots of SDQ data for control and experimental groups

1 = Baseline
2 = Post-test
iv. **Statistical Analysis**

The second part of the research question (*Did participation in the intervention result in overall changes in social emotional knowledge and self-reported symptomology?*) was assessed using the Wilcoxon Signed Rank test. Four pre-post paired data points, \(n_1=1, n_2=3\) were removed due to missing post-test scores. Analysis indicated that the control group baseline scores (Mdn= 13.9) and post test scores (Mdn= 13.5) did not produce changes that were statistically different, \(p= 0.45, \alpha =.05\). Baseline scores (Mdn= 15.6) and post-test scores (Mdn= 15.6) for the experimental group also did not yield results that were statistically different, \(p=0.39, \alpha =.05\).

<table>
<thead>
<tr>
<th>Table 12: SDQ- Wilcoxon Signed Rank test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
</tr>
<tr>
<td>Control Group</td>
</tr>
<tr>
<td>Experimental Group</td>
</tr>
</tbody>
</table>

*statistically significant when \( p < .05 \)

v. **Differences in Outcomes Between Control and Treatment**

Descriptive statistics for the post-test scores for both social emotional knowledge and internalizing symptomology for each group have been discussed in previous sections and are summarized in the table below (see Table 13).
Table 13: Pre-post test SEL knowledge (STK) and internalizing symptoms (SDQ)

<table>
<thead>
<tr>
<th></th>
<th>Mean$(SD)$</th>
<th>Median</th>
<th>$Q1:Q3$</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STK Control Post</strong></td>
<td>15.1(2.60)</td>
<td>15.0</td>
<td>14:0:16.5</td>
<td>-0.19</td>
<td>2.47</td>
</tr>
<tr>
<td><strong>STK Experimental Post</strong></td>
<td>16.0(3.82)</td>
<td>17.0</td>
<td>15.5:18.5</td>
<td>-1.75</td>
<td>5.35</td>
</tr>
<tr>
<td><strong>SDQ Control Post</strong></td>
<td>13.5(5.18)</td>
<td>13.0</td>
<td>10.0:14.5</td>
<td>1.63</td>
<td>5.37</td>
</tr>
<tr>
<td><strong>SDQ Experimental Post</strong></td>
<td>15.6(6.77)</td>
<td>16.0</td>
<td>15.5:18.5</td>
<td>0.03</td>
<td>2.28</td>
</tr>
</tbody>
</table>

One-tailed Mann-Whitney U test in R was conducted to answer the following questions, 

*did the culturally adapted curriculum promote a greater reduction of internalizing symptoms in participants as compared to those who received the curriculum as written?*

and *did the cultural adaptations made to the curriculum lead to greater acquisition of social emotional knowledge by participants in that group as compared to the control group?* The analysis conducted indicated that differences in the medians between the groups were not statistically significant for both social and emotional knowledge $Z = -1.22$, $p = .11$, $\alpha = .05$ and internalizing symptoms, $Z = -0.92$, $p = .82$, $\alpha = .05$. Results are summarized in the table below.
Table 14: Between group differences- Mann Whitney U

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Test Statistic (Z)</th>
<th>Sig (1-tailed)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Group Differences in Social-Emotional Knowledge</td>
<td>$n_1 = 11$</td>
<td>-1.22</td>
<td>0.11</td>
<td>-Inf</td>
</tr>
<tr>
<td></td>
<td>$n_2 = 11$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Group Differences in Internalizing Symptoms</td>
<td>$n_1 = 11$</td>
<td>-0.92</td>
<td>0.82</td>
<td>-7</td>
</tr>
<tr>
<td></td>
<td>$n_2 = 11$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*statistically significant when $p < .05$

C. Outcomes: Social Validity

To analyze the research question, *did modifications made to the curriculum result in higher social acceptability ratings by those in the culturally adapted group?* a Mann-Whitney U test was conducted. It should be noted that not all participants completed the social validity measure, CIRP ($N = 17$). The measure was distributed to students at the conclusion of the intervention, which occurred simultaneous with finals, graduation, and the end of the year activities. Due to the timing, only 7 participants in the control group and 11 participants in experimental completed the social validity measure. The descriptive statistics for this data set (see Table 3) indicated that the average CIRP score for the control group was 30.9 ($SD = 1.68$). The average CIRP score for the experimental group was 31.0 ($SD = 2.28$). Skewness values for group 1 and group 2 -0.45 and -0.42
respectively indicated data sets that are symmetric and slightly negatively skewed.

Kurtosis values of 2.27 and 1.38 for both groups respectively, indicated a distribution shape that is platykurtic, more so for the experimental group. Boxplots and histograms for each data set provide a visual representation of the distributions (See Figures 9 and 10).

Table 15: Social validity descriptive statistics summary table

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
<th>Median</th>
<th>Q1:Q3</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>30.9 (1.68)</td>
<td>31.0</td>
<td>30.0:32.0</td>
<td>-0.45</td>
<td>2.27</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>31.0 (2.28)</td>
<td>32.0</td>
<td>28.5:33.0</td>
<td>-0.42</td>
<td>1.38</td>
</tr>
</tbody>
</table>

Figure 9: Histograms for social validity data
i. Statistical Analysis

A one-tailed Mann-Whitney U test was conducted to determine whether there was a difference between the two groups in terms of social acceptability for the curriculum. The analysis conducted indicated that social validity scores provided by individuals in the control group ($Mdn = 31.0$) did not differ statically from those provided by individuals in the experimental group ($Mdn = 32.0$), $Z = -0.47$, $p = .32$, $\alpha = .05$ (see Table 16).

Figure 10: Boxplots for social validity data

1 = Control
2 = Experimental

$Mdn = \text{Median}$
An additional analysis was conducted on individual response patterns for both groups. Specifically, the percentages of participant responses were computed and compared to assess differences between groups on individual questions. Overall, participants in the experimental group, those who received the cultural adaptation, appeared to have slightly more favorable opinions than those in the control group. A summary of their responses is provided in the table below (see Table 17).

### Table 16: Social validity- Mann Whitney U

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Test Statistic (Z)</th>
<th>Sig (1-tailed)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>11</td>
<td>- 0.47</td>
<td>0.32</td>
<td>- Inf  2</td>
</tr>
</tbody>
</table>

*statistically significant when p < .05

### Table 17: Summary of participant responses on the CIRP

<table>
<thead>
<tr>
<th>Statement</th>
<th>Control</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 (Do Not Agree)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Program We Used Was Fair</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%*</td>
</tr>
<tr>
<td>I think my teacher was too harsh on me.</td>
<td>9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Control</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

101
<table>
<thead>
<tr>
<th>Statement</th>
<th>Control</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 (Do Not Agree)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being in this program caused problems with my friends</td>
<td>Experimental</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were better ways to teach me</td>
<td>Control</td>
<td>14%</td>
<td>14%</td>
<td>71%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experimental</td>
<td>27%</td>
<td>9%</td>
<td>64%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This program could help other kids</td>
<td>Control</td>
<td>86%</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experimental</td>
<td>100%*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I liked the program we used</td>
<td>Control</td>
<td>86%</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experimental</td>
<td>100%*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being in this program helped me do better in school</td>
<td>Control</td>
<td>43%</td>
<td>29%</td>
<td>14%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experimental</td>
<td>64%*</td>
<td>9%</td>
<td>9%</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

*indicates a more favorable score

Participants also had the opportunity to provide anecdotal feedback on the CIRP (this was not mandatory, but an option available). While this portion was not required, some individuals decided to write comments. One individual in the non-adapted group wrote, “It was fun, and helped a lot.” While some comments received from individuals in the culturally-adapted group included: “This is a great program for kids who has [sic] problems that they need to talk about”, “This program was very useful and fun to be in…”, and “I liked this program because it really helped me out, I wish this class would go on and on because I really enjoyed being in this class.”
As the interventionist, it appeared as if individuals in both groups enjoyed participating in the sessions. As both group sessions continued, the participants began to speak up more and participate more freely without much prompting. However, this was more evident in the culturally adapted group as the last few sessions included more frequent opportunities for open discussions. During these discussions, participants openly shared personal experiences and offered advice to one another. This conversation and increased bonding through the inclusion of discussion time appeared to facilitate an increase in the level of engagement during these sessions.

D. Fidelity of Implementation

During the study, the fidelity of implementation of the curriculum for both groups was assessed. The average implementation score for the experimental group (85%) was higher than the average percent score calculated for the control group (80%). However, both groups met the accepted fidelity percentage established by researchers (Noell, Gresham, & Gansale, 2002). To further assess implementation, inter-observer ratings were conducted for 30% of the sessions (n=4). The percent of agreement for the control group was 75% with a kappa value of 0.67 (p = .011) indicating substantial agreement. The percent of agreement for the experimental group was 100% and a kappa value of 1.00 (p = .006) indicating almost perfect agreement.
Table 18: Implementation fidelity

<table>
<thead>
<tr>
<th></th>
<th>Implementation Percentage</th>
<th>Percentage of Agreement</th>
<th>Cohen’s Kappa (K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>80%</td>
<td>75%</td>
<td>0.67</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>85%</td>
<td>100%</td>
<td>1.00</td>
</tr>
</tbody>
</table>
CHAPTER V
DISCUSSION

This chapter will include a synopsis of the results followed by a discussion of the study’s findings for practicing school psychologists and other mental health providers.

Additionally, limitations of this study will be discussed and implications for future research will also be suggested.

A. Review of Main Findings

Overall, while some changes in raw data were observed (e.g., small changes in median scores) these differences did not yield statistically significant effects for any of the analyses conducted.

According to the research on culturally-adapted research, one of the primary reasons why practitioners should consider making culturally appropriate modifications to evidence-based interventions is to increase participant engagement of minority clients (Cardemil, 2010). Historically, African Americans attend fewer sessions and are less active participants during treatment (Carter et al., 1996). It is hypothesized that by making interventions more relevant, participants are likely to be more invested. While participant engagement scores between the control and experimental group did not differ statistically, interventionist ratings for individuals in the experimental (culturally adapted) group were higher than those in the control group. One explanation for this lack of
statistical differences might have been the significant absences of a select few participants which substantially affected the group’s overall engagement score (given the small sample size). These absences, it should be noted, were not always voluntary.

Repeated consecutive absences by participants were often the result of disciplinary action (e.g., in school suspension, out of school suspension), rather than their own decision not to attend. Additionally, the study took place during the second half of the school year, a time of the year notable for Mardi-Gras break, Spring Break, state testing, finals, and field trips. Given all these events, it was difficult to ensure maximum attendance in each of the groups despite the interventionists’ best efforts (e.g., texting/emailing participants and teacher reminders).

Another explanation as to why participant engagement between groups did not differ statistically is that facilitation of the intervention in the school during the school day, likely decreased the ability for participants to voluntarily opt out of sessions. Prior research has noted that the delivery of school-based interventions helps reduce certain barriers, such as accessibility and transportation (Ginsberg, Drake, Kingery, & Nichols, 2008) and overall racial disparities (Bear, Finer, Guo, & Lau, 2014). Furthermore, given that sessions occurred during class time the day before session the interventionist sent email reminders to all participants and their teachers and called each participant out of class using the schoolwide intercom system prior to the start of each session. Use of
prompting prior to sessions has been shown to increase the session attendance of minority participants (Planos & Glenwick, 1986) so it is likely that these additional steps before every session resulted in similar retention rates across both conditions. For those participants who stopped attending sessions despite interventionist efforts, research has found that even with accommodations attrition among ethnic minorities may still occur (Cardemil, 2001).

Regarding analysis of participants’ internalizing symptoms, many of the obtained Total Difficulties scores on the SDQ self-report did not fall in the highly symptomatic, abnormal range (20-40). Given the lower scores obtained for each group at baseline, it was hypothesized that changes post-test would be minimal as it was unlikely that these scores would significantly decrease post-test thereby nullifying any potential statistically significant results (Merrell, 2010). Considering the preventative, strengths-based nature of Strong Teens (Carrizales-Englemann et al., 2016), additional measures, such as a strengths-based assessment that might have more accurately assessed participants’ resiliency or coping skills (Merrell et al., 2008) in addition to measures from various respondents, such as teacher and parent ratings, may have provided more informative data and yielded differences that were statistically significant (Banks et al., 1996; Leff, Power, Manz, Costigan, & Nabors, 2001). Along with additional measures, the use of culturally sensitive measures to assess meaningful outcomes of minority participants is
also important (Hall, 2001; Seibert, Stridh-Igo, & Zimmerman, 2001; Takeuchi et al., 1995). Previous research has highlighted the difficulty in determining accurate prevalence rates the symptoms of minority individuals due to a lack of culturally sensitive measures (Ramirez, Ford, Steward, & Teresi, 2005).

Analysis of individual participant scores demonstrated some increases in the SDQ scores at post-test, indicating more symptoms post-test. These slight increases in a few participant scores affected the overall central tendency scores, further contributed to non-effects obtained during pre- and post-test analysis. The observed increases in a participant’s post-test score have also be related to possible socially desirable responses (i.e. lower scores) patterns present during the baseline assessments. Self-reports may be subject to this phenomenon (Arnold & Feldman, 1981; Miller, 2012) and intervention research has noted that when participants engage in socially desirable response patterns, changes in scales may yield test statistics that are null or contradict the proposed hypothesis (Zemore, 2012). In some research, African Americans have been identified as a racial group likely to engage in socially desirable responses due to skepticism and hesitance to engage in self-disclosure (Dudley et al., 2005). This behavior may have been more salient pre-test (rather than post-test) given the stigmas associated with mental health treatments, particularly in the African American community, and students’ unfamiliarity with the interventionist. All of these factors increase participant hesitance
and engagement in therapeutic interventions (Thompson et al, 2004), and may have resulted in inaccurate initial reports of self-reported symptomology (i.e. lower scores pre-test). The desire to present oneself in an overly positive manner (i.e. non-symptomatic) may have also been a (conscious or unconscious) way for participants to counteract the negative stigmas and prejudices African Americans typically experience and control their image as perceived by others.

Additionally, higher symptomology scores observed post-test in some participant self-reports may be contributed to increases in participants’ development of the SEL competency of self-awareness. Self-awareness involves such skills as being able to recognize and name emotions and perceive oneself accurately and increases in self-awareness demonstrates the positive effects of a SEL curriculum (Elias et al., 2008). Initial increases in self-awareness may result in individuals enhanced ability to accurately identify the intensity of their symptoms (Gibbons et al., 1985) which may have led to higher symptomology scores post-test.

Regarding the Social Emotional Knowledge pre-test and post-test scores, average pre-test scores for both the control and experimental groups ($M=14.3$ and 13.5 respectively) indicated a relatively average baseline knowledge of social emotional concepts. Considering the maximum score one could obtain on this measure was a 20,
statistically significant increases in post-test scores were unlikely. However, it should be noted that both groups demonstrated higher average (mean) scores post-test.

Overall, participant acceptability of the program was high for both groups. Both groups strongly agreed that the program used was fair and most also gave positive reviews regarding the program being helpful. These finding supports previous research on Strong Kids programs that have supported use of these programs at the universal level for preventive purposes and positive acceptability from students (Marchant et al., 2010; Caldarella et al., 2009). While acceptability scores were not statistically different, participants in the cultural adaptation group did appear to develop close relationships. While there is a lack of quantitative data to support this finding, based on observations of the interventionist, the integration of more group discussions and whole group activities within the culturally adapted curriculum appeared to facilitate increases in social support and bonding between group participants as the study progressed. Specifically, the interventionist observed that the participants in this group appeared more comfortable and willing to interact with each other more frequently during sessions as compared to the control group. These observed increases in interpersonal relationships between group members was unintended, but beneficial, effect of the cultural adaptation model.
B. Limitations

The limitations for this study will be categorized in these domains 1) cultural adaptation process 2) instrumentation 2) research design and methodology and 4) statistical procedures.

The process of cultural adaptation requires extensive research be conducted to ensure that modifications are appropriate for the ethnocultural group (ECG). While an overview of group culture is recommended, no ECG is uniform in their beliefs and views, and this heterogeneity within the groups needs to be considered (Bernal & Rodríguez, 2012). Heterogeneity within African American culture is particularly evident between groups in different parts of the U.S. (e.g., Northeastern and Southern) as different geographic locations can display variance in cultural expressions. While efforts were made to include modifications pertinent to African American students living in the southern part of the United States (e.g., vignettes modeled from student experiences), the geographic characteristics of the individuals who participated in the interviews, conducted prior to the study, varied and interviewees were not explicitly recruited from the specific community (i.e. town) where the intervention took place due to time-constraints in conducting the study. Obtaining cultural information from more individuals, particularly
teenagers, from the location where the study was conducted may have resulted in more relevant adaptations.

In addition to ensuring that the content within the intervention was culturally relevant, assessment measures should also be culturally sensitive. Proper interventions start with assessments that are sensitive to the population enough to be able to adequately detect changes. While the researcher carefully selected measures that aligned to the cultural characteristics of the participants, relevant assessments explicitly validated with African American populations were, to the researcher’s knowledge, non-existent. While *SDQ* looks at internalizing and externalizing symptoms, it may not capture everything specific to certain ECGs. Therefore, there is a chance that these assessment measures lacked the ability to sufficiently capture participants’ symptoms and knowledge. Additionally, only the total difficulties score was obtained for each participant. This score does not take into account questions pertaining to pro-social behaviors. The inclusion of the pro-social scale in the data analysis may have provided additional information about individual’s interpersonal relationships which is a key aspect of social emotional functioning.

Adequate assessment of participant engagement was also a limitation in this study. The researcher-developed form, while it took into account a number of factors, was primarily based on interventionist observation of participant behavior (e.g., how often did the participant share out during each session). Other measures of engagement, such as a
brief assessment of participant take-aways at the end of the lesson, may have rendered a more accurate picture of engagement. Similarly, a more complete picture of participant acceptability might have been obtained if participants responded to a brief acceptability measure throughout the study (i.e. at the end of each session) rather than just at the end. Not only would have this increase in data prevented the observed participant attrition on this measure, as was observed in the study, but would have contributed to further analysis of the curriculum, specifically which components were most engaging, providing additional information for future adaptations.

As previously highlighted in the results summary (see Chapter IV), the inclusion of other measures might have been helpful in further assessing the effects of the intervention. For internalizing symptoms, given the lower mean score for participants, a measure assessing participant resiliency or coping strategies may have been beneficial. Additionally, considering that students with externalizing symptoms were included in the group, changes in externalizing behaviors (minor referrals, major referrals, in-school suspensions, etc.) should have been assessed to determine whether or not changes in their externalizing behaviors occurred. Regarding the assessment of participants’ social and emotional competency, given the high baseline scores for many, information specific to participants’ internalization and application of social emotional skills taught would have been interesting to assess, in addition to just their knowledge of social-emotional skills.
In terms of the research design and methodology, one of the first limitations to note was process of participant recruitment. The school did not have an established multi-tiered system of support for behavior (e.g., PBIS) in which students in need additional interventions and supports could be easily identified through a data-driven process. That, coupled with the fact that internalizing symptoms are notoriously difficult to detect by others, resulted in a sample group that consisted of girls with recent behavioral incidents and observable externalizing difficulties. The authors of the *Strong Kids* series have stated that level of effectiveness of the *Strong Kids* series for students who exhibit externalizing behaviors has not been established as strongly compared to the effects observed when used with individuals who demonstrate more internalizing symptoms (Caldarella et al., 2009; Carrizales-Englemann et al., 2016). While African American youth who engage in externalizing behaviors may also have underlying internalizing problems, a lack of assessment in changes in externalizing behaviors specifically is important to note as a limitation.

Regarding the research’s design, in order to effectively examine the main question of whether a culturally adapted group leads to more positive effects (lower symptomatology, increased social emotional knowledge) a large group, experimental design is ideal. However, difficulties with participant recruitment affected the researcher’s ability to implement this type of study. Additionally, no African American
males took part in the study due to administrator concerns with group dynamics that may occur if the girls’ male peers had been included. While behavior during group sessions was not an issue, the absence of African American males in the group was a significant threat to external validity.

Two other notable limitations involved the structure of the lessons. The researcher was the interventionist for both groups. While this was positive in some respects (e.g., racial match to majority of the participants, extensive knowledge of the curriculum), having a singular interventionist for both the control and experimental groups may have led to cross-contamination of information/diffusion of treatment and experimenter effects which can both affect the study’s internal validity. While the interventionist took great care to control for these effects (e.g., implement each curriculum with fidelity), they are potential threats that could have unknowingly affected the study’s outcomes.

Another threat to internal validity pertained to the lesson length. Due to time constraints during the school day lessons had to be shortened. Modifications to the length of each lesson was done according to the procedures outlined by the authors of Strong Teens. While the interventionist provided students with all the core components of the intervention (active ingredients) in the time allotted, all the content was not taught.
The provision of a booster session may have alleviated some of these difficulties and would have allowed the interventionist to cover additional material.

The last limitation, previously mentioned briefly, was in regards participant recruitment. SEL research conducted in high schools has been challenging for some researchers due to lack of flexibility and demands on teachers to deliver approved curriculum (Merrell, 2010). These were issues that were faced by the researcher in terms of selecting participants who were available, and teachers who were flexible, for participation in the curricula. Due to low sample size, non-parametric tests were used in lieu of parametric analysis. While non-parametric tests are considered more robust than parametric tests when the assumption of normality has been violated (Harwell, 1988), some of the data sets were fairly symmetric. When non-parametric tests are used in these instances there may be a slight decrease in power (Harwell, 1988).

C. Future Research

i. Additional Research in the Area of Cultural Adaptation

Cultural adaptation is a relatively new practice in the field of psychology, but one that will undoubtedly increase in utility as our population increases in diversity and as ethnically diverse individuals seek treatment that is both effective and culturally relevant. Not only does additional research in the area important, but the processes and procedures used to modify evidence-based treatments for specific groups should also be documented
and evaluated (Banks et al., 1996) to assist future researchers and increase feasibility in making effective adaptations for their clients.

ii. Conduct Study with a Larger Sample Size

In order to better evaluate the effects of the study, a true randomized, large group study needs to be implemented. Doing so would allow for a more accurate examination of differences between the two groups and would reduce the likelihood for statistical errors (i.e. the risk of making a Type II error) (Gunter, Caldarella, Korth, & Young, 2012).

iii. Include African American Male Participants

Male participants were not included in this study due to administrator concerns about student behavior and management during sessions. However, future studies should include both male and female African American participants to increase the generalizability of the study’s effects, analyze possible differences in effects between genders, and provide this subgroup with prosocial behaviors and skills that may also improve their trajectory (Ryan et al., 2016).

iv. Ensure Cultural Adaptations are Relevant to the Specific Participant Sample

While efforts to modify the curriculum based on the characteristics of the particular racial and cultural sub-group, African-American females in the southern part of the US, future research should conduct focus groups with members from the community
in which the intervention is going to be implemented (i.e. with African American individuals living in that community). It may also be beneficial to conduct brief interviews with each individual participant as well. Not all African Americans have the same cultural narrative as these differences are not uniformly experienced, there are demographic and individual differences that also need to be considered (Sweeney et al., 2005). In alignment with prior culturally adapted research methodology, once all information is obtained from focus groups, a pilot study should be conducted and further modifications should be made based on the results and feedback from the pilot study. This will facilitate implementation of a comparison study.

D. Conclusions

African Americans represent a vulnerable class of minorities commonly exposed to a number of stressors and whose mental health needs are often not met by mainstream interventions and treatments. For African American youth, exposure to these stressors increases their risk for a variety of negative outcomes, including the onset of various internalizing symptoms. Opportunities for these students to receive preventative and early intervention supports that are culturally relevant may support the effectiveness of these services, specifically by increasing their participation during sessions. By increasing engagement, it is hoped that their resiliency and acquiring of positive coping skills will also be positively affected which will enhance their overall trajectory. The purpose of
this study was to assess the effects of a culturally adapted, social-emotional curriculum (Strong Teens) on African American students’ participant engagement, internalizing symptoms, social emotional knowledge, and social validity. A total of 26 high school girls, a majority of whom were African American, took part in the study. Twelve girls received the non-adapted curriculum (control group) and fourteen girls received the culturally-adapted curriculum. Participants completed pre-test measures that included a demographic survey, a self-report measure of internalizing symptoms, and an assessment on social emotional knowledge. After the curriculum was implemented in its entirety (12 lessons shortened due to time constraints), participants completed the internalizing symptoms and social emotional knowledge assessments again for post-test evaluation. Participants also filled out a social validity survey. Participant engagement for each individual student was assessed by the interventionist during each lesson. Specifically, participants received ratings on their attendance, participation in activities and discussions, and completion of homework (when assigned).

Statistical analysis of the data did not reveal any statistically significant results, however, information from both groups indicated that social validity was high and raw scores on the social validity measure indicate a slightly higher score for those who received the culturally adapted curriculum. Additionally, interventionist observations identified closer interpersonal relationships form with participants in the cultural adapted
groups, possible due to the integrations of more open-ended discussions and participant driven components. However, given the null effects obtained, the limitations outlined in the prior section should be attended to for future research studies, taking great care to ensure cultural adaptations are relevant, assessments are culturally sensitive, and the study is implemented with a large group sample.
APPENDIX A
STUDY ASSENT FORM FOR CONTROL GROUP

Asent Form

Project Title: A Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in Teenagers
Principal Investigator: Courtney Johnson, M.S.E., M.Ed.
Faculty Sponsor: Sara Whitcomb, Ph.D., University of Massachusetts-Amherst

What is a research study?
A research project is a way to find out new information about something. You do not need to be in a research study if you don’t want to.

Why are you being asked to be part of this research study?
- You are being asked to take part in this project because we are trying to see if giving students strategies to help deal with difficult situations and decrease feelings of stress/discomfort.

If you join the study what will you be asked to do?
- You are being asked to participate in 12 lessons that focus on ways to help teenagers handle stressful situations better. During the lessons you will be asked to participate in group discussion, take part in various activities, and complete homework when assigned.
- You will also be asked to complete questionnaires during the study including a survey asking you some demographic questions (e.g., about your age, your grade), a questionnaire (the Strengths and Difficulties Questionnaire) asking about things that you find easy and things you find hard, social emotional knowledge surveys (the Strong Teens Social and Emotional Knowledge Test) asking you about strategies for dealing with difficult situations, and a questionnaire asking you about your feelings about participating in the project. They will be anonymous (your name will not be on them) and no one else will see your responses except for the principal investigator.
- Each lesson will last approximately 30 minutes and will take place either once a week for 12 weeks or twice a week for 6 weeks.

How will being in this study affect me?
- The lessons are designed to help students learn and use strategies for dealing with stress. By taking part in the project you will learn more effective ways for dealing with problems and difficult situations.
- If you are experiencing any stress (or negative emotions) currently, the lessons may also help you reduce those feelings.
- Some of the topics and conversations may be uncomfortable (e.g., discussions about racism). If you are uncomfortable in any way you do not have to participate in the discussion.
- Some of questions are sensitive and may cause feelings of discomfort or distress. However, each time a questionnaire is completed you will get information of someone (e.g., school counselor) that either your parent or you can contact if you want to speak privately about your feelings.

Do your parents know about this study?
- This study was explained to your parents and they said that we could ask you if you want to be in it. You can talk this over with them before you decide. If you want to take part in this, your parents will need to sign a form too.

Who will see the information collected about you?
- The information that you fill out on the questionnaire will remain anonymous. All forms you complete will be collected immediately and will be stored in a safe and secure place that no one, except the researcher, will have access to.
- Some lessons may be audio-recorded. This is to make sure that the instructor is teaching the lesson correctly. Any recordings will be collected and safely stored right after the lesson. Only the researcher will have access to this recording. In compliance with University regulations, all documents (e.g., assent forms, parent consent forms, and
questionnaires) and any audio-recordings will be stored in a safe, protected location for 3 years after which time they will be destroyed.

- Nobody will know you participated except for your parent/guardian, your teacher, and the researcher.
- Information about what you discuss during the lessons will not be shared with your parents or students outside of your classroom.
  - If at any point you express a desire to harm yourself or others, this will not remain confidential and all appropriate individuals (e.g., the principal) will be notified.

What do you get for being in the study?
- Snacks will be provided during some of the lessons.

Do you have to be in the study?
- You do not have to be in the study. No one will be upset if you don’t want to do this study. If you don’t want to be in this study, you just have to tell us. It’s up to you.
- You can also take more time to think about being in the study.

What if you have any questions?
- You can ask any questions that you may have about the study. If you have a question later that you didn’t think of now, you can call Courtney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb at either 413-545-6904 or swhitcomb@edu.umass.edu.
- You can also take more time to think about being in the study and also talk some more with your parents about being in the study.
- If you have any concerns about your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

Other information about the study:
- If you decide to be in the study, please check the box below your name below.
- You can change your mind and stop being part of it at any time. All you have to do is tell the person in charge. It’s okay.
- You will be given a copy of this paper to keep.
- Parent/Guardian consent is required. If they do not consent for you to be in the study you will be provided an independent task by your teacher to work on instead.

If you want to be in this study, please check the box below:

☐ I agree to being audio-recorded during discussions and take part in any assignments, questionnaires, and in-class discussions.

If you cannot agree, please contact the researcher(s) as you will not be able to participate in this study.

Participant Signature ____________________________ Date ______________

Participant Name _______________________________ Date ______________

Name of Person Obtaining Assent __________________ Date ______________
APPENDIX B
STUDY ASSENT FORM FOR EXPERIMENTAL GROUP

Assent Form

Project Title: A Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in African American Teenagers
Principal Investigator: Courtney Johnson, M.S.E., M.Ed.
Faculty Sponsor: Sara Whitcomb, Ph.D., University of Massachusetts-Amherst

What is a research study?
A research project is a way to find out new information about something. You do not need to be in a research study if you don’t want to.

Why are you being asked to be part of this research study?
• You are being asked to take part in this project because we are trying to see if giving students strategies to help deal with difficult situations and decrease feelings of stress/discomfort.

If you join the study what will you be asked to do?
• You are being asked to participate in 12 lessons that focus on ways to help teenagers handle stressful situations better. During the lessons you will be asked to participate in group discussion, take part in various activities, and complete homework when assigned
• You will also be asked to complete questionnaires during the study including a survey asking you some demographic questions (e.g., about your age, your grade), a questionnaire (the Strengths and Difficulties Questionnaire) asking about things that you find easy and things you find hard, social emotional knowledge surveys (the Strong Teens Social and Emotional Knowledge Test) asking you about strategies for dealing with difficult situations), and a questionnaire asking you about your feelings about participating in the project. They will be anonymous (your name will not be on them) and no one else will see your responses except for the principal investigator
• Each lesson will last approximately 30 minutes and will take place either once a week for 12 weeks, or twice a week for 6 weeks

How will being in this study affect me?
• The lessons are designed to help students learn and use strategies for dealing with stress. By taking part in the project you will learn more effective ways for dealing with problems and difficult situations.
• If you are experiencing any stress (or negative emotions) currently, this lessons may also help you reduce those feelings
• Some of the topics and conversations may be uncomfortable (e.g., discussions about racism). If you are uncomfortable in any way you do not have to participate in the discussion.
• Some of the questions are sensitive and may cause feelings of discomfort or distress. However, each time a questionnaire is completed you will get information of someones (e.g., school counselor) that either your parent or you can contact if you want to speak privately about your feelings

Do your parents know about this study?
• This study was explained to your parents and they said that we could ask you if you want to be in it. You can talk this over with them before you decide. If you want to take part in this, your parents will need to sign a form too

Who will see the information collected about you?
• The information that you fill out on the questionnaire will remain anonymous. All forms you complete will be collected immediately and will be stored in a safe and secure place that no one, except the researcher, will have access to.
• Some lessons may be audio-recorded. This is to make sure that the instructor is teaching the lesson correctly. Any recordings will be collected and safely stored right after the lesson. Only the researcher will have access to this recording. In compliance with University regulations, all documents (e.g., assent forms, parent consent forms, and
questionnaires) and any audio-recordings will be stored in a safe, protected location for 3 years after which time they will be destroyed.

- Nobody will know you participated except for your parent/guardian, your teacher, and the researcher.
- Information about what you discuss during the lessons will not be shared with your parents or students outside of your classroom.
  - If at any point you express a desire to harm yourself or others, this will not remain confidential and all appropriate individuals (e.g., the principal) will be notified.

What do you get for being in the study?
- Snacks will be provided during some of the lessons.

Do you have to be in the study?
- You do not have to be in the study. No one will be upset if you don’t want to do this study. If you don’t want to be in this study, you just have to tell us. It’s up to you.
- You can also take more time to think about being in the study.

What if you have any questions?
- You can ask any questions that you may have about the study. If you have a question later that you didn’t think of now, you can call Courtney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb at either 413-545-4904 or swhitcomb@edu.umass.edu.
- You can also take more time to think about being in the study and also talk some more with your parents about being in the study.
- If you have any concerns about your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

Other information about the study:
- If you decide to be in the study, please check the box below your name below.
- You can change your mind and stop being part of it at any time. All you have to do is tell the person in charge. It’s okay.
- You will be given a copy of this paper to keep.
- Parent/Guardian consent is required. If they do not consent for you to be in the study you will be provided an independent task by your teacher to work on instead.

If you want to be in this study, please check the box below:

☐ I agree to being audio-recorded during discussions and take part in any assignments, questionnaires, and in-class discussions.

If you cannot agree, please contact the researcher(s) as you will not be able to participate in this study.

Participant Signature __________________________ Date __________________

Participant Name __________________________ Date __________________

Name of Person Obtaining Assent __________________________ Date __________________
Student Consent Form

Project Title: A Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in Teenagers
Principal Investigator: Courtney Johnson, M.S.E, M.Ed.
Faculty Sponsor: Sara Whitcomb, Ph.D., University of Massachusetts-Amherst

What is a research study?
A research project is a way to find out new information about something. You do not need to be in a research study if you don’t want to

Why are you being asked to be part of this research study?
• You are being asked to take part in this project because we are trying to see if giving students strategies to help deal with difficult situations and decrease feelings of stress/discomfort

If you join the study what will you be asked to do?
• You are being asked to participate in 12 lessons that focus on ways to help teenagers handle stressful situations better. During the lessons you will be asked to participate in group discussion, take part in various activities, and complete homework when assigned
• You will also be asked to complete questionnaires during the study including a survey asking you some demographic questions (e.g., about your age, your grade), a questionnaire (the Strengths and Difficulties Questionnaire) asking about things that you find easy and things you find hard, social emotional knowledge surveys (the Strong Teens Social and Emotional Knowledge Test) asking about strategies for dealing with difficult situations, and a questionnaire asking you about your feelings about participating in the project. They will be anonymous (your name will not be on them) and no one else will see your responses except for the principal investigator
• Each lesson will last approximately 30 minutes and will take place either once a week for 12 weeks or twice a week for 6 weeks

How will being in this study affect me?
• The lessons are designed to help students learn and use strategies for dealing with stress. By taking part in the project you will learn more effective ways for dealing with problems and difficult situations.
• If you are experiencing any stress (or negative emotions) currently, the lessons may also help you reduce those feelings
• Some of the topics and conversations may be uncomfortable (e.g., discussions about racism). If you are uncomfortable in any way you do not have to participate in the discussion
• Some of the questions are sensitive and may cause feelings of discomfort or distress. However, each time a questionnaire is completed you will get information of someone (e.g., school counselor) that you can contact if you want to speak to someone privately about these feelings

Do your parents know about this study?
• Since you are not a minor (under the age of 18), parent/guardian’s permission is not required and your parent/guardian will not be contacted about your decision.

Who will see the information collected about you?
• The information that you fill out on the questionnaire will remain anonymous. All forms you complete will be collected immediately and will be stored in a safe and secure place that no one, except the researcher, will have access to.
• Some lessons may be audio-recorded. This is to make sure that the instructor is teaching the lesson correctly. Any recordings will be collected and safely stored right after the lesson. Only the researcher will have access to this recording.
• All consent forms will be kept in a secure location.
• In compliance with University regulations, all documents (e.g., consent forms, questionnaires) and any audio-recordings will be stored in a safe, protected location for 3 years after which they will be destroyed.
  Nobody will know you participated except for your teacher, the principal, and the researcher.
  Information about what you discuss during the lessons will not be shared with your parents or students outside of your classroom.
  However, if you express a desire to harm yourself or others, this will not remain confidential and all appropriate individuals (e.g., the principal) will need to be notified.

What do you get for being in the study?
• Snacks will be provided during some of the lessons.

Do you have to be in the study?
• You do not have to be in the study. No one will be upset if you don’t want to do this study. If you don’t want to be in this study, you just have to tell us. It’s up to you.
• You can also take more time to think about being in the study.

What if you have any questions?
• You can ask any questions that you may have about the study. If you have a question later that you didn’t think of now, you can call Courtney Johnson at 516-375-3005 or the Faculty Sponsor, Dr. Sara Whitcomb at either 413-545-6904 or swhitcomb@edu.ac.umass.edu.
• You can also take more time to think about being in the study and also talk some more with your parents about being in the study.
• If you have any concerns about your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

Other information about the study:
• If you decide to be in the study, please check the box below your name below.
• You can change your mind and stop being part of it at any time. All you have to do is tell the person in charge. It’s okay.
• You will be given a copy of this paper to keep.
• If you do not consent to be in the study you will be provided an independent task by your teacher to work on instead.

If you want to be in this study, please check the box below:

☐ I agree to being audio-recorded during discussions and take part in any assignments, questionnaires, and in-class discussions.

If you cannot agree, please contact the researcher(s) as you will not be able to participate in this study.

Participant Signature ___________________________________________ Date ____________

Participant Name _______________________________________________ Date ____________

Name of Person Obtaining Consent _________________________________ Date ____________
APPENDIX D
STUDENT CONSENT FORM FOR EXPERIMENTAL GROUP

Student Consent Form

Project Title: A Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in African American Teenagers
Principal Investigator: Courtney Johnson, M.S.E., M.Ed.
Faculty Sponsor: Sara Whitcomb, Ph.D., University of Massachusetts-Amherst

What is a research study?
A research project is a way to find out new information about something. You do not need to be in a research study if you don’t want to.

Why are you being asked to be part of this research study?
• You are being asked to take part in this project because we are trying to see if giving students strategies to help deal with difficult situations and decrease feelings of stress/discomfort

If you join the study what will you be asked to do?
• You are being asked to participate in 12 lessons that focus on ways to help teenagers handle stressful situations better. During the lessons you will be asked to participate in group discussion, take part in various activities, and complete homework when assigned.
• You will also be asked to complete questionnaires during the study including a survey asking you some demographic questions (e.g., about your age, your grade), a questionnaire (the Strengths and Difficulties Questionnaire) asking about things that you find easy and things you find hard, social emotional knowledge surveys (the Strong Teens Social and Emotional Knowledge Test) asking you about strategies for dealing with difficult situations, and a questionnaire asking you about your feelings about participating in the project. They will be anonymous (your name will not be on them) and no one else will see your responses except for the principal investigator.
• Each lesson will last approximately 30 minutes and will take place either once a week for 12 weeks or twice a week for 6 weeks

How will being in this study affect me?
• The lessons are designed to help students learn and use strategies for dealing with stress. By taking part in the project you will learn more effective ways for dealing with problems and difficult situations.
• If you are experiencing any stress (or negative emotions) currently, the lessons may also help you reduce those feelings.
• Some of the topics and conversations may be uncomfortable (e.g., discussions about racism). If you are uncomfortable in any way do not have to participate in the discussion.
• Some of questions are sensitive and may cause feelings of discomfort or distress. However, each time a questionnaire is completed you will get information of someone (e.g., school counselor) that you can contact if you want to speak with someone privately about those feelings.

Do your parents know about this study?
• Since you are not a minor (under the age of 18), parent/guardian’s permission is not required and your parent guardian will not be contacted about your decision.

Who will see the information collected about you?
• The information that you fill out on the questionnaire will remain anonymous. All forms you complete will be collected immediately and will be stored in a safe and secure place that no one, except the researcher, will have access to.
• Some lessons may be audio-recorded. This is to make sure that the instructor is teaching the lesson correctly. Any recordings will be collected and safely stored right after the lesson. Only the researcher will have access to this recording.
• All consent forms will be kept in a secure location.
• In compliance with University regulations, all documents (e.g., consent forms, questionnaires) and any audio-recordings will be stored in a safe, protected location for 3 years after which they will be destroyed.
• Nobody will know you participated except for your teacher, the principal, and the researcher.
• Information about what you discuss during the lessons will not be shared with your parents or students outside of your classroom.
  ○ However, if you express a desire to harm yourself or others, this will not remain confidential and all appropriate individuals (e.g., the principal) will need to be notified.

What do you get for being in the study?
• Snacks will be provided during some of the lessons.

Do you have to be in the study?
• You do not have to be in the study. No one will be upset if you don’t want to do this study. If you don’t want to be in this study, you just have to tell us. It’s up to you.
• You can also take more time to think about being in the study.

What if you have any questions?
• You can ask any questions that you may have about the study. If you have a question later that you didn’t think of now, you can call Courtney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb at either 413-545-6904 or swhitcomb@edu.umass.edu.
• You can also take more time to think about being in the study and also talk some more with your parents about being in the study.
• If you have any concerns about your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

Other information about the study:
• If you decide to be in the study, please check the box below your name below.
• You can change your mind and stop being part of it at any time. All you have to do is tell the person in charge. It’s okay.
• You will be given a copy of this paper to keep.
• If you do not consent to be in the study you will be provided an independent task by your teacher to work on instead.

If you want to be in this study, please check the box below:

☐ I agree to being audio-recorded during discussions and take part in any assignments, questionnaires, and in-class discussions.

If you cannot agree, please contact the researcher(s) as you will not be able to participate in this study.

Participant Signature ___________________________________________ Date __________

Participant Name ___________________________________________ Date __________

Name of Person Obtaining Consent ______________________________ Date __________
Parent/Guardian Consent Form for Minor Participation in a Research Study
University of Massachusetts Amherst

Researcher(s): Courtney Johnson, Doctoral Candidate of School Psychology at UMass Amherst, Dr. Sara Whitcomb, Faculty Sponsor

Study Title: Implementation of a Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in Teens

1. WHAT IS THIS FORM?
This form is called a Consent Form. It will give you information about the study so you can make an informed decision on whether to allow your child to participate in this project.

2. WHO IS ELIGIBLE TO PARTICIPATE?
All participants must be teenagers (ages 14-18) to participate in the study. All teen participants must have their parent/guardian sign a consent from and each participant must also sign an assent form in order to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY?
The teenage years are filled with a great deal of stress. From increases in school demands, greater responsibilities, to navigating social groups. Additionally, there are stressors that many African American teens are exposed to given their race and ethnicity (e.g., prejudice). The purpose of this project is to provide students with strategies to help them reduce this stress using a Social Emotional Learning Curriculum that has been modified to also include examples that will be helpful to all teenagers (includes examples unique to minority teenagers) and coping techniques that all teens will find helpful. The program will help youth become more resilient which involves increases in their problem-solving skills, positive thinking, goal-setting, empathy, and anger management. This curriculum has also been found to help reduce any current negative emotions (e.g., stress) that teenagers may currently be experiencing.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?
The curriculum will be conducted in your child’s classroom, during their regular school day (but separate from the traditional ELA, history, math, science curriculum). Each lesson of the curriculum will last approximately 30 minutes and will take place either once a week for 12 weeks, or twice a week for 6 weeks (dependent on the school schedule).

5. WHAT WILL MY CHILD BE ASKED TO DO?
If you agree to allow your child to take part in this study, they will be asked to participate in the curriculum’s in-class discussions, group activities, individual reflections, and occasional homework assignments. In order to determine the effects of this program all students will be asked to complete two questionnaires at three points during the project. One questionnaire, called the Strengths and Difficulties Questionnaire, asks students to self-report things that are going well for them and things that they are having difficulties with. The second questionnaire, the Strong Teens Social Emotional Knowledge Test, student’s knowledge of the content and strategies from the curriculum. Additionally, all participants will also be asked to fill out a brief demographic questionnaire at the start of the project, and a brief questionnaire at the end of the project asking them to rate how they felt about how they felt about the curriculum. Prior to participation, all participants’ parents/guardians will be asked to sign this consent form. Additionally, all minor participants will be asked to sign an assent form which also describes the study in
detail. Once both consent and assent have been obtained, either the researcher and/or the classroom teacher will begin the curriculum.

6. WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?
By allowing your son/daughter to take part in this curriculum they will obtain important skills that have been found to help them effectively deal with stress and conflicts which will reduce the likelihood that they will experience negative psychological problems symptoms later on. All parents/guardians will also be provided a summary sheet of strategies discussed as a way to support your child’s ability to handle stressful situations.

7. WHAT ARE THE RISKS OF BEING IN THIS STUDY?
There is minimal risk associated with participating in the discussion. However, it is possible that some of the conversation may involve content that may be uncomfortable or sensitive (e.g., discussions of discrimination or racism). Your child may choose not to participate in these parts of the conversation if they feel uncomfortable.

Additionally, some of the questionnaires include questions that may be sensitive and may produce feelings of discomfort or distress. Each time questionnaires are completed information detailing the names of individuals (e.g., school counselor) will be provided so that either you or your child can contact someone if they need to speak with someone privately.

3. Researcher is legally required to report to the proper authorities in Massachusetts any student disclosed instances of being abused, or a desire to harm themselves (or others).

8. HOW WILL MY CHILD’S PERSONAL INFORMATION BE PROTECTED?
Students will be asked to keep the conversations that occur during the lesson confidential and discuss them outside of the classroom. In terms of paperwork, all students will be assigned a specific ID number which will be placed on top of all papers (e.g., homework assignments), and questionnaires where participant information is collected. Only the principal investigator will have the master code list detailing the pairing of students’ names to numbers. All documents will be stored immediately after each lesson and held for no longer than 12 months after which the documents will be destroyed. A summary of the results of this project may be published however, specific identifying information (e.g., names of students, names of teachers, name of school, name of parish, etc.) will not be included. Depending on who is delivering the lesson (the researcher or the teachers), in order to make sure that the lessons are being taught correctly, there may be a few lessons (approximately four) where the researcher has to audio-recorded themselves. During any audio-recordings, students’ voices may be heard and therefore will be asked not to mention any student or teacher by name. However, due to the nature of group discussions and activities names may be mentioned. All audio-recordings will be collected at the end of the lesson and will be kept in a secure place that only the researcher has access to. In compliance with University regulations, all documents (e.g., consent and assent forms, questionnaires) and any audio-recordings will be stored in a safe, protected location for 3 years after which time they will be destroyed.

In the event that your child discloses they have been harmed or wish to harm themselves, the researcher is legally obligated to inform the authorities and all relevant school personnel (e.g., administrator).

9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?
Your child will not receive payment for their participation, however during students will be provided refreshments during lessons.
10. WHAT IF I HAVE QUESTIONS?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher(s), Courtney Johnson at 516-373-3003 or the Faculty Sponsor, Dr. Sara Whitcomb, at 413-545-6904 or swhitcomb@edu.umnass.edu. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

11. CAN I STOP BEING IN THE STUDY?
Your child does not have to be in this study if you do not want them to. If you agree to allow them to participate, but later change your mind, they may drop out at any time. If your child does decide to drop out, any questionnaires they responded to will be discarded (i.e. shredded) and no other information will be collected from them for the duration of the project. Rather than participant in this project, they may choose to work on an independent learning or (if the option is available) may complete work elsewhere in a separate setting while their peers continues. There are no penalties or consequences of any kind if you decide that you do not want to your child to participate.

12. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research, but the study personnel will assist you in getting treatment.

13. SUBJECT STATEMENT OF VOLUNTARY Consent
When signing this form I am agreeing to allow my child take part in this project. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw my consent at any time. A copy of this signed Informed Consent Form has been given to me.

☐ I agree to allow my child to be audio-recorded and to participate in all the activities, discussions, questionnaires and surveys that are part of the project.

If you cannot agree, please contact the researcher(s) as your child may be ineligible to participate in this study.

Parent/Guardian Signature: ____________________________ Print Name: ____________________________ Date: ____________________________

By signing below I indicate that the parent/guardian has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent: ____________________________ Print Name: ____________________________ Date: ____________________________
APPENDIX F

EXPERIMENTAL GROUP PARENT/GAURDIAN CONSENT FOR STUDY

Parent/Guardian Consent Form for Minor Participation in a Research Study
University of Massachusetts Amherst

Researcher(s): Courtnay Johnson, Doctoral Candidate of School Psychology at UMass Amherst. Dr. Sara Whitcomb, Faculty Sponsor

Study Title: Implementation of a Culturally Adapted Social Emotional Curriculum to Reduce Stress and Promote Resilience in African American Teens

1. WHAT IS THIS FORM?
This form is called a Consent Form. It will give you information about the study so you can make an informed decision on whether to allow your child to participate in this project.

2. WHO IS ELIGIBLE TO PARTICIPATE?
All participants must be African American teens (ages 14-18) to participate in the study. All teen participants must have their parent/guardian sign a consent form and each participant must also sign an assent form in order to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY?
The teenage years are filled with a great deal of stress. From increases in school demands, greater responsibilities, to navigating social groups. Additionally, there are stressors that many African American teens are exposed to given their race and ethnicity (e.g., prejudice). The purpose of this project is to provide students with strategies to help them reduce this stress using a Social Emotional Learning Curriculum that has been modified to include examples unique to African American teenagers and coping techniques that many teens find helpful. The program will help youth become more resilient which involves increases in their problem-solving skills, positive thinking, goal-setting, empathy, and anger management. This curriculum has also been found to help reduce any current negative emotions (e.g., stress) that teenagers may currently be experiencing.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?
The curriculum will be conducted in your child’s classroom, during their regular school day (but separate from the traditional ELA, history, math, science curriculum). Each lesson of the curriculum will last approximately 30 minutes and will take place either once a week for 12 weeks, or twice a week for 6 weeks (dependent on the school schedule).

5. WHAT WILL MY CHILD BE ASKED TO DO?
If you agree to allow your child to take part in this study, they will be asked to participate in the curriculum’s in-class discussions, group activities, individual reflections, and occasional homework assignments. In order to determine the effects of this program all students will be asked to complete two questionnaires at three points during the project. One questionnaire, called the Strengths and Difficulties Questionnaire, asks students to self-report things that are going well for them and things that they are having difficulties with. The second questionnaire, the Strong Teens Social Emotional Knowledge Test, student’s knowledge of the content and strategies from the curriculum. Additionally, all participants will also be asked to fill out a brief demographic questionnaire at the start of the project, and a brief questionnaire at the end of the project asking them to rate how they felt about how they felt about the curriculum.

Prior to participation, all participants’ parents/guardians will be asked to sign this consent form. Additionally, all minor participants will be asked to sign an assent form which also describes the study in
detail. Once both consent and assent has been obtained, either the researcher and/or the classroom teacher will begin the curriculum.

6. WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?
By allowing your son/daughter to take part in this curriculum they will obtain important skills that have been found to help them effectively deal with stress and conflicts which will reduce the likelihood that they will experience negative psychological problems symptoms later on. All parents/guardians will also be provided a summary sheet of strategies discussed as a way to support your child’s ability to handle stressful situations.

7. WHAT ARE THE RISKS OF BEING IN THIS STUDY?
There is minimal risk associated with participating in the discussion. However, it is possible that some of the conversation may involve content that may be uncomfortable or sensitive (e.g., discussions of discrimination or racism). Your child may choose not to participate in these parts of the conversation if you/his feel uncomfortable.

Additionally, some of the questionnaires include questions that may be sensitive and may produce feelings of discomfort or distress. Each time questionnaires are completed information detailing the names of individuals (e.g., school counselor) will be provided so that either you or your child can contact someone if they need to speak with someone privately.

3. Researcher is legally required to report to the proper authorities in Massachusetts any student disclosed instances of being abused, or a desire to harm themselves (or others).

8. HOW WILL MY CHILD’S PERSONAL INFORMATION BE PROTECTED?
Students will be asked to keep the conversations that occur during the lesson confidential and discuss them outside of the classroom. In terms of paperwork, all students will be assigned a specific ID number which will be placed on top of all papers (e.g., homework assignments), and questionnaires where participant information is collected. Only the principal investigator will have the master code list detailing the pairing of students’ names to numbers. All documents will be stored immediately after each lesson and held for no longer than 12 months after which the documents will be destroyed. A summary of the results of this project may be published however, specific identifying information (e.g., names of students, names of teachers, name of school, name of parish, etc.) will not be included. Depending on who is delivering the lesson (the researcher or the teachers), in order to make sure that the lessons are being taught correctly, there may be a few lessons (approximately four) where the researcher has to audio-recorded themselves. During any audio-recordings, students’ voices may be heard and therefore will be asked not to mention any student or teacher by name. However, due to the nature of group discussions and activities names may be mentioned. All audio-recordings will be collected at the end of the lesson and will be kept in a secure place that only the researcher has access to. In compliance with University regulations, all documents (e.g., consent and assent forms, questionnaires) and any audio-recordings will be will be stored in a safe, protected location for 3 years after which time they will be destroyed.

In the event that your child discloses they have been harmed or wish to harm themselves, the researcher is legally obligated to inform the authorities and all relevant school personnel (e.g., administrator).

9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?
Your child will not receive payment for their participation, however during students will be provided refreshments during lessons.
10. WHAT IF I HAVE QUESTIONS?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher(s), Courtney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb, at 413-545-6904 or swhitcomb@edu.umass.edu. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

11. CAN I STOP BEING IN THE STUDY?
Your child does not have to be in this study if you do not want them to. If you agree to allow them to participate, but later change your mind, they may drop out at any time. If your child does decide to drop out, any questionnaires they responded to will be discarded (i.e. shredded) and no other information will be collected from them for the duration of the project. Rather than participant in the project, they may choose to work on an independent learning or (if the option is available) may complete work elsewhere in a separate setting while their peers continues. There are no penalties or consequences of any kind if you decide that you do not want your child to participate.

12. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research, but the study personnel will assist you in getting treatment.

13. SUBJECT STATEMENT OF VOLUNTARY CONSENT
When signing this form I am agreeing to allow my child take part in this project. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw my consent at any time. A copy of this signed Informed Consent Form has been given to me.

☐ I agree to allow my child to be audio-recorded and to participate in all the activities, discussions, questionnaires and surveys that are part of the project.

If you cannot agree, please contact the researcher(s) as your child may be ineligible to participate in this study.

Parent/Guardian Signature: ___________________________ Print Name: ___________________________ Date: ____________

By signing below I indicate that the parent/guardian has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent: ___________________________ Print Name: ___________________________ Date: ____________

Page 3 of 3
APPENDIX G
INTERVIEW ASSENT FORM

Assent Form

Project Title: Interviewing African American Stakeholders to Facilitate the Cultural Adaptation of an Intervention
Principal Investigator: Courteney Johnson, M.S.E, M.Ed.
Faculty Sponsor: Sara Whitcomb, Ph.D., University of Massachusetts-Amherst

What is a research study?
A research study is a way to find out new information about something. You do not need to be in a research study if you don’t want to.

Why are you being asked to be part of this research study?
- You are being asked to take part in this research study because we are trying to learn more about how African American teens view and deal with things like stress and sadness. We are inviting you to be in the study because we feel as if you have some valuable information about this subject and can assist us in developing an intervention to be delivered to youth your age.

If you join the study what will you be asked to do?
- You are being asked to participate in a telephone conversation during which you will be asked several open-ended questions that will ask about culturally specific values, beliefs, and traditions that would be relevant to the development, prevention, and intervention of internalizing symptoms in African American youth.
- We want to tell you about some things that you will be asked to do if you are in this study.
- The conversation will last approximately 1 hour.

How will being in this study affect me?
- Some of the discussions may involve topics around discrimination or racism. If you do not want to participate in any of the questions presented you may choose not to.
- The information gathered from the discussions will help us develop an intervention to be used with African American teens in schools and to help other teens.

Do your parents know about this study?
- This study was explained to your parents and they said that we could ask you if you want to be in it. You can talk this over with them before you decide. If you want to be in the study, your parents will need to sign a form too.

Who will see the information collected about you?
- An audio-recording of the discussion will take place however, your name will not be used and only the researcher (myself) will have access to the recording.
- Nobody will know you participated except for your parent/guardian and the researcher,
- Information about what you discuss with the investigator will not be shared with your parents. The researcher will not tell your friends.

What do you get for being in the study?
- You will receive a 5- dollar gift card for your participation.

Do you have to be in the study?
- You do not have to be in the study. No one will be upset if you don’t want to do this study. If you don’t want to be in this study, you just have to tell us. It’s up to you.
- You can also take more time to think about being in the study.
What if you have any questions?
- You can ask any questions that you may have about the study. If you have a question later that you didn’t think of now, you can call Courteney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb at either 413-545-6904 or swhitcomb@educl.umass.edu
- You can also take more time to think about being in the study and also talk some more with your parents about being in the study.
- If you have any concerns about your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humanssubjects@ora.umass.edu.

Other information about the study:
- If you decide to be in the study, please check the box below your name below.
- You can change your mind and stop being part of it at any time. All you have to do is tell the person in charge.
- It’s okay.
- You will be given a copy of this paper to keep.

If you want to be in this study, please check the box below:

☐ I agree to being audio-recorded during the discussion.

If you cannot agree, please contact the researcher(s) as you will not be able to participate in this study.

Participant Signature ___________________________ Date ____________

Participant Name______________________________ Date ____________

Name of Person obtaining assent ___________________________ Date ____________
Parent/Guardian Consent Form for Minor Participation in a Research Study
University of Massachusetts Amherst

Researcher(s): Courteney Johnson, Doctoral Candidate of School Psychology at UMass Amherst, Dr. Sara Whitcomb, Faculty Sponsor
Study Title: Interviewing African American Stakeholders to Facilitate the Cultural Adaptation of an Intervention

1. WHAT IS THIS FORM?
This form is called a Consent Form. It will give you information about the study so you can make an informed decision where to allow your child to participate in this research.

2. WHO IS ELIGIBLE TO PARTICIPATE?
Subjects must be African American teens (ages 14-18) to participate in the study. All minor subjects must sign an assent form.

3. WHAT IS THE PURPOSE OF THIS STUDY?
The purpose of this research study is to obtain information relevant to the cultural adaptation of an intervention that will be used in schools.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?
The research will be conducted over the phone. Participants are asked to participate in one telephone conversation that will last approximately 1 hour. Participants will not be contacted once the study has been completed.

5. WHAT WILL I BE ASKED TO DO?
If you agree to allow your child to take part in this study, they will be asked to participate in discussions using several open-ended questions inquiring about the cultural specific values, beliefs, and traditions that would be relevant to the development, prevention, and intervention of mental health symptoms of African Americans.

Prior to the discussion, all parents/guardians will be asked to sign this consent form. Additionally, all minor participants will be asked to sign an assent form which also describes the study in detail. Once both consent and assent has been obtained the researcher will prompt the discussion of various topics associated with the perceptions and treatment of internalizing symptoms in African American youth. During discussions, your child may skip any question that you (or they) feel uncomfortable answering.

6. WHAT ARE MY BENEFITS OF BEING IN THIS STUDY?
Your son/daughter may not directly benefit from this research; however, we hope that their participation in the study may support a novel cultural adaptation of an intervention to be used with African American teens in schools.
7. WHAT ARE MY RISKS OF BEING IN THIS STUDY?
There is minimal risk associated with participating in the discussion. However, it is possible that part of the discussion may involve content that may be uncomfortable or sensitive (e.g., discussions of discrimination or racism). Your child may choose not to participate in these parts of the conversation if they feel uncomfortable.

8. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?
All telephone conversations will be audio recorded so that the researcher can review the discussion at a later date. Participants will not be referred to by name during the discussion as a confidentiality measure.

9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?
Your child will receive a 5-dollar gift card for their participation.

10. WHAT IF I HAVE QUESTIONS?
Take as long as you like before you make a decision. We will be happy to answer any questions you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher(s), Courteney Johnson at 516-375-5005 or the Faculty Sponsor, Dr. Sara Whitcomb, at 413-545-6904 or swhitcomb@edu.umass.edu. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

11. CAN I STOP BEING IN THE STUDY?
Your child does not have to be in this study if you do not want them to. If you agree to allow them to participate, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to your child to participate.

12. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research, but the study personnel will assist you in getting treatment.

13. SUBJECT STATEMENT OF VOLUNTARY CONSENT
When signing this form I am agreeing to allow my child enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw my consent at any time. A copy of this signed Informed Consent Form has been given to me.

☐ to allow my child to audio-recorded.

If you cannot agree to the above stipulation please see the researcher(s) as your child may be ineligible to participate in this study.
Participant Signature:  Print Name:  Date:

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent:  Print Name:  Date:
APPENDIX I
INTERVIEW CONSENT FORM

Consent Form for Participation in a Research Study
University of Massachusetts Amherst

Researcher(s): Courteney Johnson, Doctoral Candidate of School Psychology at UMass Amherst, Dr. Sara Whitcomb, Faculty Sponsor
Study Title: Interviewing African American Stakeholders to Facilitate the Cultural Adaptation of an Intervention

1. WHAT IS THIS FORM?
This form is called a Consent Form. It will give you information about the study so you can make an informed decision about participation in this research.

2. WHO IS ELIGIBLE TO PARTICIPATE?
Subjects must be African American to participate in the study.

3. WHAT IS THE PURPOSE OF THIS STUDY?
The purpose of this research study is to obtain information relevant to the cultural adaptation of an intervention that will be used in schools.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?
The research will be conducted over the phone in the form of a telephone conversation. Participants are asked to participate in one session that will last approximately 1 hour. Participants will not be contacted once the study has been completed.

5. WHAT WILL I BE ASKED TO DO?
If you agree to take part in this study, you will be asked to participate in discussions facilitated by several open-ended questions that focus on the cultural specific values, beliefs, and traditions that would be relevant to the development, prevention, and intervention for internalizing symptoms in African American youth.

Prior to the discussion, participants will be asked to sign this consent form. Once consent has been obtained the researcher will prompt the discussion of various topics associated with the perceptions and treatment of internalizing symptoms in African American youth. During discussions, you may skip any question you feel uncomfortable answering.

6. WHAT ARE MY BENEFITS OF BEING IN THIS STUDY?
You may not directly benefit from this research; however, we hope that your participation in the study may support a novel cultural adaptation of an intervention to be used with African American teens in schools.
7. WHAT ARE MY RISKS OF BEING IN THIS STUDY?
There is minimal risk associated with participating in the focus group. However, it is possible that some of the discussions may involve content that may be uncomfortable or sensitive (e.g., discussions of discrimination or racism). You may choose not to participate in these parts of the conversation if you feel uncomfortable.

8. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?
All telephone conversations will be audio recorded so that the researcher can review the discussions at a later date. Participants will not be referred to by name during the conversation as a confidentiality measure.

9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?
Each participant will receive a five dollar gift card as to show appreciation for your participation.

10. WHAT IF I HAVE QUESTIONS?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher(s), Courtney Johnson at 516-375-5005, or the Faculty Sponsor, Dr. Sara Whitcomb, at 413-545-6904 or swhitcomb@educ.umass.edu. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

11. CAN I STOP BEING IN THE STUDY?
You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

12. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research, but the study personnel will assist you in getting treatment.

13. SUBJECT STATEMENT OF VOLUNTARY CONSENT
When signing this form I am agreeing to voluntarily enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw at any time. A copy of this signed Informed Consent Form has been given to me.

☐ I agree to be audio-recorded.

If you cannot agree to the above stipulation please see the researcher(s) as you may be ineligible to participate in this study.
Participant Signature: ____________________________ Print Name: ____________________________ Date: ____________________________

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent: ____________________________ Print Name: ____________________________ Date: ____________________________
## APPENDIX J
### CULTURAL ADAPTATION MODIFICATIONS

<table>
<thead>
<tr>
<th>Framework Component</th>
<th>Definition</th>
<th>Adaptation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language</strong></td>
<td>Refers to the oral and written communication of the treatment (Bernal &amp; Dominguez, 2012)</td>
<td>Many African Americans are suspicious of clinical terms (Ginsberg, &amp; Drake, 2002)</td>
<td>The group was referred to as a “Stress Reduction group” and clinical terms such as “anxiety” and “internalizing” were avoided</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of theoretical terms for cognitive distortions may be difficult for children and adolescents to understand (Joyce-Beaulieu, Sulkowski, 2015).</td>
<td>Some of cognitive errors (“Thinking Traps”) were renamed to provide more concrete and developmentally appropriate terminology which facilitated comprehension of the material</td>
</tr>
<tr>
<td><strong>Persons</strong></td>
<td>Refers to the client-therapists dyad and considers both the ethnic match and interaction between both parties (Bernal &amp; Dominguez, 2012)</td>
<td>Ethnic-match leads to lower rates of premature termination (Thompson, Bazile, &amp; Akbar, 2004)</td>
<td>The intervention was delivered by an African-American female</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventionists need to be aware of the mental health stigma and mistrust of research that persists within the African American community</td>
<td>Prior to the delivery of each lesson, interventionist engaged and examined literature pertaining to cultural characteristics of African Americans and reflected upon how these characteristics influence intervention components</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is important that clients feel understood by the therapists. Therapists should also make attempts to understand the values and worldview of the client and avoid engaging in any stereotypes and colorblindness (Thompson et al., 2004).</td>
<td>Interventionist engaged in continuous rapport building with participants to increase relationship</td>
</tr>
</tbody>
</table>

143
<table>
<thead>
<tr>
<th><strong>Content</strong></th>
<th>Content presented in the intervention should be reflective of the values and views present in the cultural group (Bernal et al., 1995)</th>
<th>African American culture is considered to more collectivist than the dominant culture (Larson et al., 2001).</th>
<th>Included case examples (through vignettes and use of multimedia) that were reflective of the collectivist (whole group nature) of the ECG. Participants were encouraged to engage in open and honest discussions about their experiences (avoid making assumptions, have participants tell their own stories). Examples highlighting how family members and community groups can be assets in the treatment process was incorporated.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metaphors</strong></td>
<td>The visual and verbal forms presented should be aligned with symbols and concepts that are shared by that culture (Bernal et al., 1995; Bernal, Rodriguez, 2012).</td>
<td>Fostering identification and positive affiliation with one’s racial group is associated with racial pride and identity (Quintana, 2007), which promote resiliency in African Americans (Neblett, et al., 2009).</td>
<td>Visuals of African American teenagers were included throughout the curriculum. Examples of famous African American role models and leaders that overcome obstacles (e.g., Malcolm X, Oprah Winfrey, Jennifer Hudson, Frank Ocean, Jay-z) were integrated into the curriculum.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Goals should be consistent with the values, customs, and traditions of the group in question (Bernal et al., 1995).</td>
<td>African American community is founded on ideals of empowerment and independence (Schwartz et al., 2009). Ethnic-Racial Socialization is a process in which information regarding one’s race/ethnicity is transmitted from adults to youth (verbally or nonverbally). Often it entails African American parents promoting the development of their child’s ethnic-racial identity and preparing them from discrimination.</td>
<td>Examples of famous African American role models and leaders that overcome obstacles (e.g., Malcolm X, Oprah Winfrey, Jennifer Hudson, Frank Ocean, Jay-z) were integrated into the curriculum. Participants were encouraged to identify strengths and positive affirmations. Discussions included ways in which, as African American youth, they could respectfully and effectively advocate for themselves and establish</td>
</tr>
</tbody>
</table>
Other messages include cultural socialization, promotion of mistrust, and silence about race (Aldana & Byrd, 2015)

what they need to feel supported across various settings (e.g., home, school)

| Methods | Refers to the procedures used to achieve treatment goals (Bernal, et al., 1995) | African Americans appreciate a more problem-solving approach in which that therapy provides them with concrete and direct techniques (Thompson et al., 2004) Peer share is an important component of interventions (Ginsberg, & Drake, 2002, Gordon-Hollingsworth, et al., 2015; Kelly, 2006) African American youth typically have less well-developed coping strategies and tend to engage in less active coping strategies and more avoidant strategies (Vaughn, & Roesch, 2003; Gaylord-Harden, Gipson, Mance, & Grant, 2008) Historically, music associated with African American culture (e.g., Hip Hop) communicates struggles, accomplishments and feelings of unity which can be very therapeutic to African American individuals (Cork, 2013) | During lessons, participants were encouraged to reflect upon past/current stressors. Group discussions and activities focused on providing participants with suggestions alternative reactions to past issues/ ways to manage current stressors Interventionist attempted to normalize mental health issues and interventions through psychoeducation, having honest conversations about mental health in the African American community, sharing personal experiences, empowering students to take advantage of mental health resources and supports available (e.g., talking with school counselor) Delivery of intervention occurred in groups Collective reflection and sharing out was a key component during sessions Participants were provided with a range of coping strategies that included distractive techniques (e.g., reading, watching T.V., listening to music), active techniques, seeking social support, and acceptance. Other forms of multimedia (e.g., v |
All coping mechanisms and strategies discussed were modeled and practiced (positive feedback was provided by interventionist).

Music, and its use as both an expressive and coping strategy, was discussed. Other forms of multi-media (i.e. video clips) were also used.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Refers to the case conceptualization of treatment to ensure that is aligned in a congruent manner (Bernal et al., 1995; Graham et al., 2014)</th>
<th>Important to connect psychoeducation to individuals’ experiences (Graham et al., 2014)</th>
<th>Vignettes relevant to the lived experiences of participants were included and participants were encouraged to provide their own examples that connected to the lesson’s objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Included discussions of culturally responsive risk and protective factors.</td>
</tr>
</tbody>
</table>

| Context | African Americans are often exposed to numerous stressors including those associated with discrimination and marginalization (Kelly, 2006). Individuals experiences with discrimination (e.g., microaggressions) can affect core beliefs (Graham et al., 2014) so it is important that experiences with racism are validated (Kelly, 2006). | Discussions pertaining to cognitive restructuring avoided assuming that all “fears” were irrational (given individuals’ experiences with micro-aggressions and discrimination). Interventionist made a point to ensure that individuals feelings were validated and that the “restructuring” focuses more on the individuals own self-concept and negative feelings about the self | Integrated opportunities for discussions about race and discrimination |
# APPENDIX K
## CULTURAL ADAPTATION TO STRONG TEENS LESSONS

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Objective</th>
<th>Examples of Cultural Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>About Strong Teens Emotional Strength Training (1 lesson)</td>
<td>Overview of program, establish behavioral expectations, definition of important terms (i.e. perseverance), administer pre-assessments</td>
<td>Group activities to build rapport, explicit statement of goals, have students identify on or more goals for themselves</td>
</tr>
<tr>
<td>Understanding your emotions (2 lessons)</td>
<td>Improve emotional vocabulary and awareness, learn that thoughts and behaviors are linked to emotions, emotions can be expressed differently depending on the person and the situation</td>
<td>Emphasis on culturally specific symptoms such as somatic complaints and sleep paralysis</td>
</tr>
<tr>
<td>Understanding other people’s emotions (1 lesson)</td>
<td>Practice empathy and learn how to better understand the feelings of other people</td>
<td>Provide culturally specific examples</td>
</tr>
<tr>
<td>Dealing with Anger (1 lesson)</td>
<td>Anger management using a multi-step anger model, understand that they are active participants in their anger process</td>
<td>Discuss anger-trigging situations that are culturally and developmentally relevant (e.g., situations pertaining to discrimination, microagressions, interpersonal conflict)</td>
</tr>
<tr>
<td>Clear Thinking (2 lessons)</td>
<td>Develop an awareness of though patterns, recognize maladaptive thoughts, identify thinking traps and use strategies for reframing</td>
<td>Provide developmentally appropriate terms for Thinking Traps, ask students to share their own examples and focus on reframing their internalized beliefs of themselves (rather than the situation)</td>
</tr>
<tr>
<td>Solving People Problems (1 lesson)</td>
<td>Engage in strategies for conflict resolution</td>
<td>Include examples of how to apply newly acquired strategies when involved</td>
</tr>
<tr>
<td>Section</td>
<td>Activity</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
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<tr>
<td>Letting Go of Stress</td>
<td>Relaxation and Stress Management techniques</td>
<td>Include the use of music, family interactions, and other culturally relevant stress management techniques, have students identify specific techniques that they will use</td>
</tr>
<tr>
<td>Positive Living</td>
<td>Incorporating positive habits in to daily live, encourage positive choices in situations that they have control</td>
<td>Provide cultural specific examples of situations</td>
</tr>
<tr>
<td>Create Strong and Smart Goals</td>
<td>Learn to set attainable SMART goals, identify values that are important to them</td>
<td></td>
</tr>
<tr>
<td>Finishing Up</td>
<td>Review key points and terms, post-test assessments</td>
<td>Group share out, have a mini-celebration</td>
</tr>
</tbody>
</table>
APPENDIX L
BASIC FIDELITY CHECKLIST

Basic Fidelity Checklist

INSTRUCTIONS For each section, check the box if the lesson component was completed. If no items were implemented, check “Not” for not implemented. If some items were implemented, but not all, check “Partial” for partially implemented. If all items were implemented, check “Full” for fully implemented. In the Notes column, record the reason(s) for incomplete implementation of the component. In the Lesson Notes row, describe conditions that may have affected the fidelity for the lesson overall. Include any modifications made to the lessons.

<table>
<thead>
<tr>
<th>Lesson Component</th>
<th>Level of Implementation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesson 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
</tr>
<tr>
<td>Focusing Activity</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
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<tr>
<td>Lesson Topics</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
</tr>
<tr>
<td>Key Terms</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
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<tr>
<td>Activity A</td>
<td>☐ Not ☐ Partial ☐ Full</td>
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<tr>
<td>Activity B</td>
<td>☐ Not ☐ Partial ☐ Full</td>
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<tr>
<td>Putting it All Together</td>
<td>☐ Not ☐ Partial ☐ Full</td>
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<tr>
<td>Closure</td>
<td>☐ Not ☐ Partial ☐ Full</td>
<td></td>
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</tbody>
</table>

Lesson notes:

*from Carrizales-Engelmann, et al., 2016*
APPENDIX M
PARTICIPANT ENGAGEMENT FORM

Participant Engagement

Lesson Number:

<table>
<thead>
<tr>
<th>Student</th>
<th>Attendance (0, 1)</th>
<th>Frequency of Participation (0, 1, 2)</th>
<th>Level of Contribution (0, 1, 2)</th>
<th>HW Completion (when assigned) (0, 1)</th>
<th>Total Score</th>
<th>Comments [e.g., no homework assigned, student absent due to prior engagement]</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Engagement Rubric

<table>
<thead>
<tr>
<th>Attendance</th>
<th>0 = Did not attend the session</th>
<th>1 = attended the session (or attended part and was excused)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency of Participation</th>
<th>0 = takes part in less than half of the activities</th>
<th>1 = takes part in half of the activities</th>
<th>2 = takes part in more than 50% of the activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution</td>
<td>0 = does not contribute any questions of comments relevant to the material</td>
<td>1 = contributes at least one comment/question relevant to the material</td>
<td>2 = provides multiple insightful comments and questions relevant to the material</td>
</tr>
<tr>
<td>HW Completion</td>
<td>0 = did not do homework</td>
<td>1 = completed homework</td>
<td></td>
</tr>
</tbody>
</table>

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APPENDIX N
CULTURAL ADAPTED READING LIST FOR INTERVENTIONIST

Cultural Adapted Reading List for Interventionist


APPENDIX O
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

How old are you? ________________

Circle your gender
Female           Male           Other

What grade are you in? ________________

Circle the category that best describes you:
African American  Caucasian  Hispanic  Asian/Pacific Islander
Other
APPENDIX P
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

ID Number ____________________

**Strengths and Difficulties Questionnaire**

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try to be nice to other people. I care about their feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am restless, I cannot stay still for long</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get a lot of headaches, stomach-aches or sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I usually share with others, for example CD’s, games, food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get very angry and often lose my temper</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would rather be alone than with people of my age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I usually do as I am told</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I worry a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am helpful if someone is hurt, upset or feeling ill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am constantly fidgeting or squirming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have one good friend or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I fight a lot. I can make other people do what I want</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am often unhappy, depressed or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other people my age generally like me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am nervous in new situations. I easily lose confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am kind to younger children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am often accused of lying or cheating</td>
<td></td>
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<tr>
<td>Other children or young people pick on me or bully me</td>
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<tr>
<td>I often offer to help others (parents, teachers, children)</td>
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<tr>
<td>I think before I do things</td>
<td></td>
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<tr>
<td>I take things that are not mine from home, school or elsewhere</td>
<td></td>
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<tr>
<td>I get along better with adults than with people my own age</td>
<td></td>
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<tr>
<td>I have many fears, I am easily scared</td>
<td></td>
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<tr>
<td>I finish the work I’m doing. My attention is good</td>
<td></td>
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</tbody>
</table>

Do you have any other comments or concerns?
# Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try to be nice to other people. I care about their feelings</td>
<td></td>
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<tr>
<td>I am restless, I find it hard to sit down for long</td>
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<tr>
<td>I get a lot of headaches, stomach-aches or sickness</td>
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<tr>
<td>I usually share with others, for example food or drink</td>
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<td></td>
<td></td>
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<tr>
<td>I get very angry and often lose my temper</td>
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<tr>
<td>I would rather be alone than with other people</td>
<td></td>
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<tr>
<td>I am generally willing to do what other people want</td>
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<tr>
<td>I worry a lot</td>
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<td>I am helpful if someone is hurt, upset or feeling ill</td>
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<td>I am constantly fidgeting or squirming</td>
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<td>I have at least one good friend</td>
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<td>I fight a lot. I can make other people do what I want</td>
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<td>I am often unhappy, depressed or fearful</td>
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<td>Other people generally like me</td>
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<td>I am easily distracted, I find it difficult to concentrate</td>
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<tr>
<td>I am nervous in new situations. I easily lose confidence</td>
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<tr>
<td>I am kind to children</td>
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<tr>
<td>I am often accused of lying or cheating</td>
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<tr>
<td>I often offer to help others (family members, friends, colleagues)</td>
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<td>I think before I do things</td>
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<tr>
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<tr>
<td>I get along better with older people than with people of my own age</td>
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<td>I have many fears, I am easily scared</td>
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<tr>
<td>I finish the work I am doing. My attention is good</td>
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</tbody>
</table>

Do you have any other comments or concerns?
APPENDIX A

Strong Teens Knowledge Test for Students in Grades 9-12

Today's date ____________

For this test, you will answer questions about what you know regarding emotions, thoughts, and behaviors. Read each question carefully. Choose the best answer to each question. You may not have heard about the information in some questions, but do your best. The grade on this test does not affect your other school grades, and your answers are private. If you have any questions, please ask your instructor.

TRUE or FALSE
Read each sentence. If you think it is true or mostly true, circle the word True. If you think it is false or mostly false, circle the word False.

1. True False Clinched fists and trembling or shaking hands can be signals that tell us to stop and use problem-solving strategies.
2. True False Emotions feel the same for everyone.
3. True False Stress can be caused by comparing yourself to other people.
4. True False We can choose how we act toward other people.
5. True False Feeling uncomfortable is normal and to be expected.
6. True False There are physical feelings or sensations that often happen when we have emotions.

MULTIPLE CHOICE
Circle the letter that goes along with the best answer for each question.

7. An example of an emotion that feels uncomfortable for most people is
   a. Hopeful
   b. Frustrated
   c. Curious
   d. Excited

8. What is an emotion?
   a. A thought you have
   b. Your inner voice
   c. A memory about something that happened to you
   d. A feeling that tells you something about a situation

(continued)
9. Self-talk is a way to calm down when you are angry. Helpful self-talk might include telling yourself
   a. I don’t deserve this
   b. I should get angry when something like this happens
   c. I can work through this
   d. I hope I never see this person ever again

10. Which of the following statements best describes empathy?
    a. Feeling sorry for someone
    b. Not knowing why another person is feeling sad
    c. Understanding how another person is feeling based on your own similar experiences
    d. Wanting another person to feel better soon

11. Thinking traps happen when
    a. You see things in a way that is unhelpful or keeps you stuck
    b. You see both the good and bad of each situation
    c. You think something different from your friend
    d. You tell yourself you shouldn’t try to do something

12. Framing is a way to
    a. Make friends with someone
    b. Think about how you can forget about the situation
    c. Think differently about a situation
    d. Make it look like someone did something wrong when he or she didn’t

13. Why would you want to know how someone else is feeling?
    a. So you can leave that person alone when he or she is angry
    b. To better understand and support that person
    c. To talk about that person with other people
    d. To act the same when you are together

14. Conflict resolution is best described as
    a. Discussing a problem until there is a winner and a loser
    b. Arguing until someone sees your point and gives in
    c. Problem solving so you can reach an agreement that is respectful and responsible for all involved
    d. Talking about the problem until you change the other person’s mind

(continued)
15. Which of the following is a positive or helpful way to handle being anxious when you have to show a bad grade to someone like your parent or guardian?
   a. Tell him or her why you feel anxious and that you will work harder next time.
   b. Hide the grade.
   c. Be upset and angry with yourself.
   d. Say that other students at school distracted you.

16. Which of the following is a helpful way to deal with a problem when you are feeling stressed?
   a. Cry somewhere quietly.
   b. Talk about the problem with someone you trust, such as a friend or teacher.
   c. Throw things around.
   d. Ignore the problem.

17. Which of the following is a helpful way to handle your emotions in class when your neighbor's talking begins to annoy you?
   a. Yell and tell him or her to stop.
   b. Tell the teacher during class.
   c. Stare at the person until he or she gets the idea.
   d. Stop and breathe deeply.

18. If you're feeling tired and you're having a hard time enjoying yourself in your life, some simple things you can try are:
   a. Eating healthy meals
   b. Getting more sleep
   c. Spending time outdoors
   d. Spending time with friends
   e. Any of the above

19. An important part of achieving goals is knowing how to set them. Which of the following is not an important part of a SMART goal?
   a. Specific
   b. Measurable
   c. Approximate
   d. Relevant
   e. Timely

20. Your friend seems upset. You want to show him or her you care. The most helpful way to do this is to:
   a. Change the subject by talking about something else
   b. Listen and show that you are paying attention
   c. Act silly or make jokes so he or she smiles and laughs
   d. Look away and don’t say anything
APPENDIX R
CHILDREN’S INTERVENTION RATING PROFILE (ADAPTED VERSION)

Student ID______________ 2015-2016

POST-INTERVENTION

Date:

Adapted Version of the Children’s Intervention Rating Profile

<table>
<thead>
<tr>
<th>I agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>I do not agree</th>
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<tbody>
<tr>
<td>1. The program we used was fair.</td>
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<td>2. I think my teacher was too harsh on me.</td>
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<td>3. Being in this program caused problems with my friends.</td>
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<td>4. There were better ways to teach me.</td>
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<td>5. This program could help other kids, too.</td>
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<td>6. I liked the program we used.</td>
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<td>7. Being in this program helped me do better in school.</td>
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<td>8.</td>
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Comments: ____________________________

______________________________


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Thank you for your participation in our study! Your participation is greatly appreciated.

Purpose of the Study:

Earlier in our consent form we informed you that the purpose of the study was to see if using a curriculum that gives students strategies helps them deal with difficult situations and decreases feelings of stress and discomfort. In actuality, our study is about figuring out if by changing parts of the curriculum so that the stories, activities, and strategies are more relatable to African American teenagers does a better job at increasing participation and improving their ability to deal with difficult situations and decrease feelings of stress as compared to those in the original curriculum.

Unfortunately, in order to properly test our hypothesis, we could not provide you with all of these details prior to your participation. This ensures that your reactions in this study were spontaneous and not influenced by prior knowledge about the purpose of the study. If we had told you the actual purposes of our study, your ability to learn the strategies, participate, and complete the assignments could have been affected. We regret the deception but we hope you understand the reason for it.

Confidentiality:

Please note that although the purpose of this study has changed from the originally stated purpose, everything else on the consent form is correct. This includes the ways in which we will keep your data confidential. All information shared during the activities or on any documents will still remain confidential, your name will not be shared, and only the principal investigator will have access to these documents. Additionally, if at any point an audio-recording was used, this recording will only be reviewed by the principal investigator. All documents and audio-recordings (if used) will be kept in a locked, secure location that only the principal investigator has access to.

Now that you know the true purpose of our study and are fully informed, you may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted please contact the Principal Investigator within the next seven (7) days either in person or via email at courteneyjoh@educ.umass.edu.
Final Report:
If you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact us.

Useful Contact Information:
If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact the researcher(s), Courteney Johnson at courteneyjoh@educ.umass.edu

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance please contact the counselor or school social worker at your school.

Further Reading(s):
If you would like to learn more about Cultural Adapted Interventions please see the following references:


***Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study!***
BIBLIOGRAPHY


