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Pepperdine University
Graduate School of Education and Psychology

EVALUATION OF THE YOUTH DEVELOPMENT PROJECT: A SCHOOL AND
COMMUNITY BASED INTERVENTION PROGRAM FOR AT-RISK YOUTH

A clinical dissertation submitted in partial satisfaction
of the requirement for the degree of
Doctor of Psychology

By
Mike Sherman

May, 2011

Stephanie Woo, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Mike Sherman

under the guidance of a Faculty Committee and approved by its members, has been
submitted to and accepted by the Graduate Faculty in partial fulfillment of the
requirements for the degree of

DOCTOR OF PSYCHOLOGY

Faculty Committee:

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DEDICATION

This dissertation is dedicated to David and Galina Pupkin, my grandparents and role models. Their love, tenderness, humor, and time spent together have had a very meaningful and positive impact on me. Without them I would not be the person that I am today. I am glad I get to share this accomplishment with both of you.

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Union and always reminding me of the opportunities I had here in America. To my grandparents, thank you for loving me beyond measure and always believing in me.

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To all the individuals named above and others not listed in this short message, thank you for being an important part of my life. Thank you for being there to support me in difficult times as much as you're there to celebrate in times of joy!

Mike Sherman

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- Responsible for maintaining process notes and all associated LAC-DMH paperwork
- Incorporation of community resources into the treatment model
- Consultation and collaboration with legal, educational, medical, and psychiatric service providers

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- Responsible for maintaining process notes
- Incorporation of community resources into the treatment model
- Consultation and collaboration with client's legal, medical, and psychiatric service providers

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- Writing comprehensive psychological assessment reports and providing feedback to the treatment team, parents, and school programs

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- Coding and interpretation of data using SPSS 16.0

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Project: Effect of Assignment of Conflicting Gender Traits on Gender Identity

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ABSTRACT

Attempts to meet the mental health needs of at-risk youth have led to the development of numerous prevention, intervention, and diversion programs. This study is the first to utilize statistical analyses to assess the treatment efficacy of the Saint John's Child and Family Development Center's Youth Development Project (CFDC-YDP), a school- and community-based treatment program for at-risk youth.

The study involved analysis of data that were collected from 87 culturally diverse at-risk youth, ranging in age from 11-19 years old, who were treated by the Youth Development Project program within John Adams Middle School, Lincoln Middle School, Olympic Continuation High School, and the Pico Youth & Family Center (all located in Santa Monica, California). Participants in the original study from which data were drawn were recruited during the 2009/2010 academic year and received treatment throughout that same time period. The findings of this study are based on comparison of pre- and post-intervention measures that include the Rosenberg Self Esteem Scale (Rosenberg, 1965), Center for Epidemiologic Studies Depression Scale (Radloff, 1991), Revised Life Orientation Test (Sheier, Carver, & Bridges, 1994), the General Mattering Scale (Marcus, 1991), and The Multigroup Ethnic Identity Measure (Phinney, 1992).

Data was analyzed utilizing repeated measures multivariate analysis of covariance (MANCOVA), with participant age acting as a covariate. Significant findings include improved self-esteem scores and reduced depressive symptoms. The results, strengths and limitations of the study, and recommendations for the CFDC-YDP program are discussed.

Chapter I: Introduction

Background of the Problem

Today's youth are exposed to wide-ranging social stressors, including family and community violence, proliferation of drugs and alcohol, unplanned pregnancies, and the spread of sexually transmitted diseases. For example, with regard to family violence, nearly one-in-four women (23%) and slightly over one-in-ten men (11.5%) have experienced at least one lifetime episode of intimate partner violence (Centers for Disease Control, 2008a). Lower income populations are at an increased risk for experiencing partner violence, with 33.5% of women and 20.7% of men whose annual household income meets poverty levels reporting at least one violent incident with a partner (Centers for Disease Control, 2008b). This problem extends far beyond abuse between partners in romantic relationships. Just over 50% of the female victims of intimate violence have children under age 12 living in their households (U.S. Department of Justice, 2009), and it is estimated that children are present during 10%–20% of police reported incidences of intimate partner violence each year (Carlson, 2000). Not only are these children exposed to the traumatic effects of witnessing violence, but, children present during instances of intimate partner violence can inadvertently become direct targets of abuse (Alessi & Hearn, 2007). In fact, it is estimated that 40-60% of perpetrators who assault their partners also abuse the children in the home (O'Leary, Smith Slep, & O'Leary, 2007; Smith Slep & O'Leary, 2007). Children living in homes where domestic violence occurs are at further risk for experiencing vicarious trauma, including overhearing narrative recounts of the violent experience or viewing victim bruises, marks, swelling, or scars (Meltzer, Doos, Vostanis, Ford, & Goodman, 2009).

The strongest risk factor for trans-generational transmission of the propensity to engage in violent behavior is witnessing caretaker or parental violence (Break the Cycle, 2006). Furthermore, exposure to domestic violence affects caregiver mental and emotional health (English, Marshall, & Stewart, 2003). Parents engaged in relationships that feature domestic violence experience more than 18.5 million mental health care visits each year (Centers for Disease Control, 2003). Additionally, these caretakers report fewer resources to provide emotional and physical support to their children, compromising the parental-child attachment bond. Intimate partner violence impacts the quality of caregiver interaction with their children, consequently resulting in poor physical and emotional health of the child in many cases (English, Marshall, & Stewart, 2003).

Violence and other major behavioral problems are evident among school-aged youth. Community violence exposure and aggressive behavior in the classroom were significantly related (Bradshaw, Rodgers, Ghandour, & Garambino, 2009). These problems range from risky behaviors that lead to sexually transmitted diseases, drug use, fighting, carrying weapons, planning suicide or homicide, and even death. For example, in 2007 nearly 40% of sexually active students did not use protection during sexual intercourse (Centers for Disease Control, 2008b). Adolescents who engage in behaviors such as fighting, carrying weapons, and making suicide plans are significantly more likely to engage in homicidal and/or suicidal behaviors. In a Centers for Disease Control study conducted in 2007, 36% of high school students had engaged in fighting behaviors in the past 12 months, 18% had carried a weapon in the past 30 days, and 11% had made plans to commit suicide in the past 12 months (Centers for Disease Control, 2008b).

Violence is a major cause of nonfatal injuries among youth and homicide is the second leading cause of death among youth aged 10–24 years. In 2006, a total of well over 700,000 young people aged 10–24 years were treated in emergency rooms for nonfatal injuries sustained from assaults (Centers for Disease Control, 2009).

Concerning behaviors such as unsafe sexual activity and its sequelae (e.g., transmission of STDs, unplanned pregnancies) are other concerns facing youth today. Increasing public interest in reducing adolescent pregnancy rates is based on a concern about the escalation of non-marital pregnancies and births in recent years (U.S. Department of Health and Human Services, 1995). Births to girls ages 15 to 19 have risen from one-third of all births in 1970 to one-half of all births in the early 1980s and to two-thirds of all births in 1988 (Chilman, 1989). The rise in the adolescent pregnancy rate has occurred in the context of an overall rise in non-marital pregnancies to women of all ages and follows social trends in childbirth (Franklin et al., 1997). Teenage pregnancy usually results from an unstable relationship, is often unplanned, and results in the adolescent becoming a parent before becoming an adult (Visuvanathan & Edouard, 1985). Social disadvantage and dependency on government benefits mean that many youth in this situation are required to survive on or below the poverty line (Williams, Forbesd, McIlwaine, & Rosenberg, 1987). Failure to identify and treat social and psychiatric problems in this group can result in poor parenting skills and impaired infant development (Murray, Cooper, & Stein, 1991).

Facing such issues on a daily basis can have a significant impact on how teens perceive themselves, others, and the world around them. The result is that many young people are caught up in a dangerous lifestyle and regularly make decisions that place their

health and potentially their life, at risk. Numerous phenomena, ranging from school shootings to drug use to engagement in unsafe behaviors, have increasingly appeared among teens throughout the 21st century.

Since the turn of the millennium, positive youth development (PYD) has emerged as a promising theoretical model for providing mental health treatment and preventing risk behaviors among youth (Lerner, 2005). Engagement in PYD programs is significantly and negatively associated with the initiation hazards for tobacco use, marijuana use, and sex initiation for girls, and with hard drug use for both genders. PYD has also been positively associated with the odds of condom use across genders (Schwartz et al., 2010).

A focus on the positive development of at-risk youth has evolved because of rising interest in utilizing developmental systems to gain an understanding of the plasticity of human development. The PYD movement has also focused on the importance of relationships between individuals and their real world ecological settings as the bases of variation in the course of human development (Lerner, 2005). The PYD perspective has arisen, as well, through the development and evaluation of interventions designed and delivered within community- and school-based youth serving programs (Kurtines et al., 2008; LoSciuto, Hilbert, Fox, Porcellini, & Lanphear, 1999). Programs such as these seek to reduce the incidence of risk behaviors and psychological distress among at-risk youth.

As programs targeting positive youth development have been developed throughout the nation, numerous studies have attempted to determine the efficacy of engaging at-risk youth in their own positive development within community settings

(Gallagher, Stanley, Shearer, & Mosca, 2005; Kurtines et al., 2008; LoSciuto, Hilbert, Fox, Porcellini, & Lanphear, 1999). These studies focused on youth development programs working with populations of at-risk youth living within under-served communities in Philadelphia and Miami. Treatment components of the Woodrock, PA YDP program were constructed to develop useful life skills and to promote drug abuse resistance. These components included (a) education, including human relations and life-skills seminars in which role playing and other simulations relevant to drug-use situations are included; (b) psychosocial support, including peer mentoring, tutoring, and a program of structured, alternative, extracurricular activities; and (c) family and community support, including counseling and outreach. The Miami, FL YDP program seeks to foster the development of community-supported positive youth development by creating community supported intervention programs (at the time of this writing, primarily providing counseling services, both individual and group) for multi-problem culturally diverse youth. In this program, youth obtain services either through self or counselor referral. The types of counseling services available through the Miami YDP include psychoeducational services, individual counseling, and counseling groups (the groups include abuse, anger management, alternative lifestyles, relationships, self-esteem, substance use/abuse, teen parenting, troubled families, and so on). Both the Woodrock, PA and Miami, FL youth development projects have been found to have a significant positive impact on the participants and communities at large, including statistically significant reductions in alcohol, tobacco, and drug use, improved school attendance, and improved race relations (Kurtines et al., 2008; LoSciuto et al., 1999). Additionally, LoSciuto et al. observed a non-significant positive trend in participants' self-esteem

levels and a non-significant reduction of participants' engagement in aggressive behaviors.

Child and Family Development Center - Youth Development Project

Background and history of CFDC-YDP. Saint John's Health Center's Child and Family Development Center (CFDC), located in Santa Monica, California, is a non-profit community mental health center focused on providing a comprehensive range of culturally sensitive and linguistically responsive mental health, outreach, developmental, and educational services in response to community needs since 1962. The majority of clients are drawn from the community, which contains a wide range of socio-economic, cultural, and linguistic diversity. Services are available to community members in English, Spanish, and in American Sign Language. The main populations targeted for services are children, adolescents, and their families. The CFDC multidisciplinary team includes clinical social workers, psychologists, psychiatrists, case managers, teachers, and educational, occupational and speech therapists. Services are provided within the center, at school sites, in the home, and in the greater community (parks, Police Athletic League, teen centers, etc.).

The Saint John's Child and Family Development Center Youth Development Project (CFDC-YDP) is a culturally and linguistically sensitive community- and school-based program that was developed in 1995 in response to a community need for earlier identification of at-risk youth and more culturally and linguistically sensitive services to impact at-risk behaviors in school-aged youth. The program aims to provide at-risk youth with corrective experiences focusing on the development of life skills and problem solving skills. At the time of the program's inception, 80% of the local youth surveyed

reported high levels of exposure to community violence and 70% expressed concern about their future and pessimism about their prospects (Saint John's Child And Family Development Center - Youth Development Project, 1995). Such staggering figures clearly demonstrated the need for a community- and school-based program that would assist these youth in appropriately coping with the events and hopelessness many of them experience.

Rationale, goals, and services of the CFDC-YDP program. The philosophy of CFDC-YDP, based upon PYD principles, is to foster empowerment, growth, positive coping and pro-social behaviors that enable youth and their families to succeed at home, at school, and in the community. As such, CFDC-YDP recognizes and utilizes the individual strengths of each youth, family member, and community collaborator. The program's general goals are to: 1) Identify, through collaboration with schools, youth displaying at-risk behaviors (e.g., drug and/or alcohol use, unprotected sexual behaviors, and gang involvement); 2) assist identified youth in enhancing positive coping and problem-solving skills; 3) build resilience and positive self-esteem through increasing social support by strengthening family systems through parent support groups, workshops, and visits to at-risk youth's homes; and 4) support teachers and counselors in their efforts with at-risk youth in the classroom through consultation, training and feedback with mental health professionals.

The specific targets of treatment of the CFDC-YDP program are consistent with current best practices for community-based treatment programs working with at-risk youth from a PYD approach (Bowers et al., 2010). Based on PYD principles, the treatment provided through CFDC-YDP largely aims to foster resilience, cultivate belief

in the future, and nurture the development of a clear and positive self-identity. To achieve these goals, CFDC-YDP utilizes a systems approach that is comprehensive, multifaceted, and integrated to encompass a full continuum of services that address both prevention and intervention. Services include group therapy, individual and family therapy, teacher consultation, community crisis intervention, consultation and trainings, home visits, and providing clients and community members with information and referrals that are both culturally appropriate and provide linguistically responsive interventions.

During the 2009/2010 school year, the CFDC-YDP program provided services to a culturally and socio-economically diverse sample of 109 at-risk youth ranging in age from 10 through 21 attending school or community programs in four locations within the city of Santa Monica and its surrounding area. Youth were seen at John Adams Middle School, Lincoln Middle School, Olympic Continuation High School, and at the Pico Youth and Family Center, a non-profit organization within Santa Monica that is committed to preventing youth involvement in violent and risk-taking behavior.

Statement of the Problem

Part of the CFDC-YDP program has been the collection of measurable, self-report benchmarks to help determine the program's impact on at-risk youth within the community. Data on self-esteem, hope and optimism, mattering, positive ethnic identity, and depression were collected as part of the program. The pre-tests were completed by participating youth when they first entered the program, and the post-tests were administered at the end of the academic year. The investigator was permitted access to these data to conduct a program evaluation study for his dissertation.

Primary Evaluation Questions and Hypotheses

This clinical dissertation involves a program evaluation of the CFDC-YDP program. The evaluation focuses on specific elements of the program and is guided by the following research questions:

Question 1. Do youth report improvement in measures of positive youth development after participation in the CFDC-YDP treatment program?

Hypothesis 1a. It is expected that youth will report significantly higher ratings of self-esteem, as measured by the Rosenberg Self Esteem Scale (Rosenberg, 1965), following participation in the CFDC-YDP treatment program.

Hypothesis 1b. It is expected that youth will report significantly higher ratings of hope and optimism, as measured by the Revised Life Orientation Test (Sheier, Carver, & Bridges, 1994), following participation in the CFDC-YDP treatment program.

Hypothesis 1c. It is expected that youth will report significantly higher ratings of mattering, as measured by the General Mattering Scale (Marcus, 1991), following participation in the CFDC-YDP treatment program.

Hypothesis 1d. It is expected that youth will report significantly higher ratings of positive ethnic identity, as measured by the The Multigroup Ethnic Identity Measure (Phinney, 1992), following participation in the CFDC-YDP treatment program.

Question 2. Does participation in the CFDC-YDP program lead to a reduction in clients' ratings of their depressive symptoms?

Hypothesis 2a. It is expected that youth will report significantly fewer depressive symptoms, as measured by the Center for Epidemiologic Studies Depression Scale (Radloff, 1991), following participation in the CFDC-YDP treatment program.

Definition of Key Terms

At-risk youth – It is important to understand that the term “at-risk” refers to an increased probability of poor outcomes (e.g., school failure/dropout, drug use, gang involvement, and teen pregnancy), not a certainty of them (Anderson Moore, 2006).

Anderson Moore explains that factors contributing to the at-risk label can be attributed to the individual (disability, history of abuse, low self-esteem), the family (poverty, single parenthood, low parental education levels), or the greater community context (high crime rate, low graduation rate).

At-risk behaviors – Such behaviors include, but are not limited to poor school attendance and/or grades, frequent arguments with family members, running away from home, school suspensions or expulsions, engagement in unsafe sex practices, gang involvement, and criminal activity (Anderson Moore, 2006).

Positive Youth Development (PYD) – The PYD perspective moves beyond the negative, deficit view of youth that dominated developmental science, psychology, education, sociology, public health, and other fields through the twentieth century and towards a view of the strengths of youth and the positive qualities and outcomes we wish youth to develop (Bowers et al., 2010). PYD utilizes an integrative, relational perspective of genetic and contextual influences on human development. According to Lerner (2005), the origins of the PYD perspective stem from the research of comparative psychologists (e.g., Gottlieb, 1997; Schneirla, 1957) and biologists (e.g., Novikoff, 1945a, 1945b; von Bertalanffy, 1933, 1968) who had been studying the plasticity of developmental processes that arose from the synthesis of biological and contextual influences on human development (Tobach & Greenberg, 1984). Generally, PYD covers

a variety of attempts to utilize the inherent strengths of youth through the intentional efforts of other youth, adults, communities, government agencies, and schools to provide opportunities for youth to enhance their interests, skills, and abilities so as to improve their life trajectory.

Resilience – The ability to withstand mental or physical stress, increasing the probability of school and life success despite adversities caused by early characteristics, conditions, and experiences. This is the inherent and nurtured capacity of individuals to deal with life's stresses in ways that enables them to lead healthy and fulfilled lives (Howard & Johnson, 1999).

Hope and Optimism – The constructs of Hope and Optimism describe a tendency to expect the best, or at least a favorable, outcome and having a general feeling that one's goals can be achieved (Merriam-Webster Online Dictionary, 2010).

Mattering – The degree to which one feels he/she matters to others and is worthy of the interest or notice of another person (Rosenberg & McCullough, 1981).

Positive Ethnic Identity – The ownership of positive feelings regarding one's own ethnic group and valuing being a member of that ethnic group. Ethnicity refers to a shared worldview, language, and set of behaviors that are connected to one's cultural heritage. Ethnicity is as meaningful to an individual variable to the extent that it has as its salience to that person's life. For example, many European/White Americans do not view their ethnicity as a salient or important part of their identity, while ethnicity is salient in cases where one's ethnic group membership is overt, as in the case of ethnic groups of color (Alba, 1990; Waters, 1990). In the case of Positive Ethnic Identity, ethnic identity refers to one's ethnic group membership and the feelings associated with

that membership. A youth's relationship with his or her own ethnic identity has been conceptualized as a fundamental aspect of an adolescent's identity because it includes the attitudes and feelings associated with that membership (Bernal & Knight, 1993).

However, ethnic identity is not a categorical variable, something that one does or does not have. Rather, it is a complex, multidimensional construct that varies across members of a group (Cross, 1991).

Depression – A mood state characterized by a pessimistic sense of self, the world, and future events (Beck, 1976).

Summary

Widespread concern regarding stressors and risks faced by youth today has led to the development of numerous programs to assist at-risk youth in developing healthy coping skills and improved decision making. While a number of Positive Youth Development programs exist, program evaluations should continue to be conducted in order to determine the efficacy of any specific program within the community where it functions.

The CFDC-YDP program, based in Santa Monica, California, utilizes the individual strengths of each youth, family member, and community collaborator. CFDC-YDP fosters empowerment, growth, positive coping and pro-social behaviors that enable youth and their families to succeed at home, at school, and in the general community. These goals are achieved through school- and community-based interventions seeking to identify youth displaying at-risk behaviors, helping at-risk youth enhance positive coping and problem-solving skills, building resilience and positive self-esteem through increased

social support, and providing assistance to family systems and school staff in their efforts to provide support to at-risk youth.

A significant amount of existing research has focused on investigations of the factors associated with resilience (particularly individual, family, and community factors) that contribute to positive outcomes and reduce the incidence of risk-taking behavior in youth. Researchers have recognized the relevance and applicability of these findings to prevention and intervention. In an attempt to contribute to the existing body of literature, the current study seeks to determine the potential impact of the CFDC-YDP program on variables related to youth self-identity (i.e., self esteem, mattering, positive ethnic identity), mood (i.e., depression), and coping (i.e., optimism/hope). The results and recommendations obtained from the current evaluation are intended to determine the efficacy of the CFDC-YDP program in meeting its treatment goals and to inform future program intervention strategies and procedures.

Chapter II: Review of Literature

Adolescent Development

Historically, clinical science has developed a number of theories attempting to describe the developmental process that youth undergo during the transitional period of adolescence. Adolescence spans the second decade of life (Lerner & Steinberg, 2004), and has been described as a stage of life that begins in biological processes such as puberty and culminates in social processes, specifically the historically-, culturally-, and socially-constructed transition to young adulthood and the enactment of role choices forged during adolescence (Petersen, 1988). In sum, adolescence may be defined as the life span period in which most of a person's biological, cognitive, psychological, and social characteristics are changing in an interrelated manner from that which is considered childlike to what is considered adult-like (Lerner, 2005).

Starting with the initial scientific study of adolescent development (Hall, 1904) the prevalent theoretical framework for understanding this age period has viewed adolescence through a lens of the deficit model – as an ontogenetic time of normative developmental disturbance resulting from the juxtaposition of developing adolescent genital drives, pre-existing relationships with important figures (e.g., family), and a lack of suitable psychological defenses to adaptively cope with this situation (Freud, 1969). Largely, various deficit models of adolescence were rooted in biologically reductionist models of genetic or maturational determination (e.g., Erikson, 1959, 1968), and produced views of adolescents as simply being problems (e.g., delinquency, truancy, and other forms of misbehavior) needing to be managed (Roth, Brooks-Gunn, Murray, & Foster, 1998). Another traditional view of adolescents views them as both dangerous –

engaging in activities posing a risk to others (gang involvement, criminal activities) and endangered – engaging in activities posing a risk to themselves (drug use, unsafe sex practices, risk-taking behaviors) (Anthony, 1969). Due in part to adolescents engagement in risky behaviors and difficulty adaptively managing social relationships, Benson, Scales, Hamilton, & Sesma (2006) have gone so far as to even describe youth as “broken” during adolescence. Positive youth development was largely lacking in the literature until the 1990s, unless it was discussed as an absence of negative or undesirable behaviors.

Positive Youth Development Model

The emergence of the PYD perspective has altered the landscape of the treatment and study of adolescents (Lerner, Phelps, Forman, & Bowers, 2009). Significant evidence exists supporting the key tenets of PYD. As PYD is, at its core, a strength-based model, it holds the view that young people have strengths, as established by their capacity for considerable physiological, cognitive, emotional, social, and behavioral growth that occurs throughout adolescence (Gestsdottir & Lerner, 2007). When supported by resources that encourage healthy growth within the environment (e.g., home, school, community) the positive development of youth will be enhanced (Benson, Scales, Hamilton, & Sesma, 2006). Such findings in support of the PYD perspective have assisted in counteracting the deficit model of adolescence that was prevalent in theory and practice throughout much of the 20th century.

Unlike the traditional deficit models of youth development of Hall, Erikson, and Anna Freud, which conceptualize youth behaviors as deviations from normative development, the PYD perspective focuses on the inherent developmental plasticity

within the second decade of life and ways in which individual (e.g., self-esteem, adaptive problem solving skills, and social skills) and environmental (e.g., availability of after-school programs or mentorship programs within the community) factors, as well as relationships, can be utilized to improve the life trajectory of at-risk youth (Lerner, 2005). Based on examples from research on adolescent development as well as clinical experience (Eccles & Gootman, 2002; Lerner, 2004; Roth & Brooks-Gunn, 2003b), the factors indicative of PYD were determined to be competence, confidence, connection, character, and caring – collectively the “Five Cs.” Research has shown that incorporating these five factors is linked to the positive outcomes of youth development programs (Roth & Brooks-Gunn 2003a). Additionally, King et al. (2005) have found these “Cs” to be terms that are utilized by many clinicians, adolescents involved in youth development programs, and the parents of these adolescents in describing the characteristics of a thriving youth.

A study conducted by Heck and Subramaniam (2009) recently reviewed theoretical models of PYD and has indicated that the Five Cs Model of PYD is the most empirically supported framework available within the current literature base. Heck and Subramaniam found that there is empirical support for the Five Cs model that indicates that this construct has good psychometric properties. For example, each of the Five Cs - competence, confidence, connection, character, and caring - has good internal consistency (Lerner et al. 2005). Phelps et al. (2009) provided additional validity for the Five Cs model, with results indicating that PYD is a robust construct that can be defined comparably for early adolescents (grades 5-7).

Table 1

Definitions of the Five Cs of Positive Youth Development

C	Definition
Competence	Positive view of one's actions in domain specific areas including social, academic, cognitive, and vocational. Social competence pertains to interpersonal skills (e.g., conflict resolution). Cognitive competence pertains to cognitive abilities (e.g., decision making). School grades, attendance, and test scores are part of academic competence. Vocational competence involves work habits and career choice explorations, including entrepreneurship.
Confidence	An internal sense of overall positive self-worth and self-efficacy; one's global self-regard, as opposed to domain specific beliefs.
Connection	Positive bonds with people and institutions that are reflected in bidirectional exchanges between the individual and peers, family, school, and community in which both parties contribute to the relationship.
Character	Respect for societal and cultural rules, possession of standards for correct behaviors, a sense of right and wrong (morality), and integrity.
Caring	A sense of sympathy and empathy for others.

Note. The data in this table are adapted from "The Five Cs model of Positive Youth Development: A longitudinal analysis of confirmatory factor structure and measurement invariance," by Bowers, E.P., Li, Y., Kiely, M.K., Brittian, A., Lerner, J.V., Lerner, R.M., 2010, *Journal of Youth and Adolescence*, 39(7), pp. 720-735.

While some research suggests an inverse relationship between youth possessing traits ascribed to the Five Cs and depressive symptoms (Zimmerman, Phelps, & Lerner, 2007), current literature lacks research relating the Five Cs to other constructs utilized within the Saint John's CFDC-YDP data set. In particular, the Five C construct "character" does not appear to be assessed as directly in the Saint John's CFDC-YDP data set. This issue will be discussed further in the instrumentation section.

Factors Impacting Youth Development

There are many phenomena that can potentially negatively impact the mental and physical health of youth and contribute to increased incidence of engagement in at-risk behaviors. Existing studies have shown that family, school, social, demographic, gender,

and socio-economic factors (Tyler & Lichtenstein, 1997; West, 2009), among others, contribute to delinquent and risk-taking behavior in youth. A large number of adolescents live in conditions of poverty and attempt to survive in communities that are under-served, under-represented, and face a chronic lack of resources and opportunities (Ferrer-Wreder et al., 2002; Mizell, 1999). The parents of such youth often have to focus on coping with basic hardships and survival, leaving little time, energy, and/or financial resources to invest in their children (Bowen & Chapman, 1996; Mizell, 1999). Along with socioeconomic difficulties, some families of at-risk youth face significant difficulties with parenting (Bowen & Chapman; Lee, 2000), including dealing with their own mental illness, abusing drugs and/or alcohol, or engaging in risk-taking behaviors themselves. Histories of neglect, physical abuse, and emotional cruelty are also present in many of these families of at-risk youth (Kahan-Stravitsinski, Dolev, Shemesh, & Rhav, 1998). Literature on youth development shows that a combination of factors such as poverty and family dysfunction are significant risk factors for issues such as academic and social difficulties (Flores-Fahs, Lorion, & Jakob, 1997; Reynolds, O'Koon, Papademetriou, Szczygiel, & Grant, 2001). These adjustment difficulties may be expressed through hostility and suspicion towards family members and/or authority figures, aggressive and anti-social behavior, scholastic dysfunction, risk-taking, symptoms of depression, social withdrawal, and various forms of regressive behavior (Ron, 1996).

Exploring the multiple factors that contribute to, or can serve to prevent, risk-taking behavior in youth can aid in the development and refinement of treatment programs for youth and their families. Such exploration can also help to clarify the

societal and individual factors that serve as challenges to programs promoting positive youth development.

Adolescence is a period of rapid development that is usually accompanied by an increased sense of social awareness and associated escalations in social pressures.

Individual differences, family factors, peer pressure, modeling, significant relationships, the media, and cultural norms, among other factors, influence how youth view themselves and the world around them (Polce-Lynch, Myers, Kliewer, & Kilmartin, 2001). Such influences can serve as either protective factors against engagement in risk behaviors or as variables that impinge upon the positive development of youth.

Literature shows that both internal (i.e., self-esteem and mastery) and external (i.e., social support) factors are related to social, academic, and individual functioning (Lipschitz-Elhawi & Itzhaky, 2005). Additionally, youth who possess a positive attitude toward school, a good relationship with parents, and a sense of efficacy over their environment tend to engage in fewer instances of risk-taking behavior (Young, 2003).

Self-Esteem. Self-esteem is a construct that speaks to a person's general evaluation of his or her own worth. Self-esteem is comprised of being competent to cope with the basic challenges of life and feeling worthy of happiness beliefs (Branden, 1969). One's beliefs (e.g., "I am a smart person" or "I am stupid") and feelings such as shame, guilt, and pride also factor into one's feelings of self-worth. A person's self-esteem can apply to a particular facet of their functioning (e.g., "I feel that I am a great student, and am specifically proud of my grades this semester") or be reflective of a more global evaluation of self-worth (e.g., "I am a hard worker, and feel proud of myself for my work ethic"). Self-esteem is an underlying factor in many human interactions, emotions, and

behaviors and has been proposed as a fundamental human need that serves an important motivational role throughout the human life cycle (Maslow, 1943). Maslow argued that the need for self-respect (i.e., self-perceived strength, competence, mastery, self-confidence, independence, and freedom) is fundamental and deprivation of this need can lead to an inferiority complex, weakness and helplessness (p. 531).

The protective effect of self-esteem on both externalizing and internalizing problem behaviors has been demonstrated in at-risk youth (Gerard, 2001). A recent study of sexually abused adolescents attempted to determine the protective factors against these youth experiencing significant depressive symptoms and anger (Asgeirsdottir, Gudjonsson, Sigurdsson, & Sigfusdottir, 2010). This study's findings showed that while factors such as parental support, positive attitudes towards school, and sports participation negatively predicted depressed mood and anger, self-esteem turned out to be a stronger negative predictor of depressed mood and anger. Additionally, self-esteem mediated the effects of parental support, attitudes towards school, and sport participation on depressed mood and anger. Another study (Sharaf, Thompson, & Walsh, 2009) demonstrated that high self-esteem serves a protective function against suicide risk in adolescents, especially in youth who have low levels of family support.

Conversely, poor self-esteem has been tied to a number of problematic and/or risk-taking behaviors, including sexual risk taking (McNair, Carter, & Williams, 1998), unplanned pregnancy (Smith, Gerrard, & Gibbons, 1997), and suicide (Sharaf, Thompson, & Walsh, 2009). Given this research, the fostering of self-esteem – especially during a highly influential period of rapid development such as adolescence – is clearly pivotal in reducing adolescent risk-taking behaviors. Additionally,

interventions focused on protecting youth from engaging in high risk behaviors by increasing their self-esteem are likely to be most effective and cost-efficient if they are aimed at the family and school domains (Wild, Flisher, Bhana, and Lombard, 2004) – areas specifically addressed by the CFDC-YDP program.

Hope & Optimism. Given that many at-risk youth grow up exposed to direct or vicarious trauma in a milieu that is both underserved and under-represented, it is not difficult to imagine that such youth would have few reasons to be hopeful and optimistic. Research shows that at-risk youth often have little hope for the future due to environmental factors such as poverty, discrimination, and educational failures (Smith, 1983). Many at-risk adolescents who feel hopeless about their future believe that they have little control over what will happen to them. Such individuals can be described as having an external locus of control, believing that they have little impact on the course their future takes (Levenson, 1972; Rotter, 1966). Hopeless youth frequently hold beliefs that they will not be able to find a way to achieve their goals (Snyder, Irving, & Anderson, 1991) or that they will not be able to achieve desired outcomes through their efforts, thus demonstrating low self-efficacy (Bandura, 1977). Ultimately, adolescents who are pessimistic about their future are likely to engage in the creation of a self-fulfilling prophecy, whereby their hopelessness leads to them not putting forth the effort required to succeed. This pattern of thought and behavior often leads to failure to attain one's goals and consequently continues the cycle of hopelessness.

Literature on optimistic individuals shows that they have greater success in multiple settings, including school, the workplace, and athletic endeavors (Rettew & Reivich, 1995; Schulman, 1995). This may be because optimists are more persistent,

particularly when tasks become difficult or when they encounter obstacles (Dweck, 1975). Research also shows that optimistic individuals report significantly fewer depressive and anxious symptoms (Gladstone & Kaslow, 1995; Joiner & Wagner, 1995; Robins & Hayes, 1995; Scheier & Carver, 1992; Scheier & Carver, 1993). Similarly, in a five-year longitudinal study, Nolen-Hoeksema, Girgus, and Seligman (1992) found that children with pessimistic explanatory styles were more likely than their peers to develop high levels of depressive symptoms. Furthermore, cognitive-behavioral therapy, a gold-standard treatment for depression, assists in reducing depressive symptoms by targeting pessimistic interpretive styles and promoting more flexible and optimistic thinking (Beck, Jars, Shaw, & Emery, 1979). Numerous studies have shown that hope and optimism are related to a variety of positive outcomes. Such findings demonstrate that being hopeful and optimistic are correlates of numerous positive outcomes and that intervention programs seeking to foster hope and optimism in at-risk youth are a worthwhile endeavor.

Mattering. The research of Rosenberg and McCullough (1981) shows that mattering is comprised of four distinct, but related, facets – attention, importance, dependence, and ego-extension. The first facet, attention, highlights the positive feelings often experienced when one finds him/herself the object of a significant other’s attention and, conversely, the despondency felt when one experiences that there is no one out there who shows interest in them. Importance describes not only the need to be seen and attended to, but also the desire to be cared about. Dependence points to the desire to be needed by those around us – to serve some necessary function in the lives of people we encounter. Finally, ego-extension describes feeling that others are interested in how one

is doing – their successes and failures. Rosenberg and McCullough further state that mattering is implicit in all social relationships and represents a “powerful source of social integration” due not only to our dependence on others, but also to our desire to be depended upon.

Mattering to significant others builds upon what is known about adolescent development, with its rapidly shifting emotions and frequent questioning of the self (Kroger, 1999). Many youth struggle under the demands placed upon them by their families, teachers, friends, and society at large. Furthermore, during adolescence youth often struggle to form their individual identities while also navigating successful relationships in which they matter to their significant others. In describing the identity development occurring during adolescence, researchers have addressed adolescents' needs for feeling they matter to others and the significance of mattering in their daily relationships (Baumeister & Leary, 1995; Erikson, 1963). While mattering and belonging are both important in the life of an adolescent and appear to be similar concepts, perceptions of mattering are formulated through one's perceptions of the quality and quantity of other individuals' attending behaviors toward them (Dixon Rayle, 2005), while a sense of belonging is typically group oriented. Therefore, adolescent development is influenced by a youth's ability to navigate relationships with individuals, as well as larger groups of people.

Mattering has been associated with numerous markers of psychological well-being and mattering to significant others may be especially critical for adolescents as they strive to feel important and significant to their family, teachers, and peers (Dixon Rayle & Myers, 2004). Specifically, mattering is significantly and negatively associated with

depression and significantly and positively associated with self-esteem (Taylor & Turner, 2001). Youth who feel they matter to their parents are less likely to experience depression, anxiety, and negative affective states, independent of self-esteem (Rosenberg & McCollough, 1981). Rosenberg and McCollough also found that male adolescents who feel they matter little to their significant others are significantly more likely to engage in delinquent behavior. Furthermore, emerging literature postulates that through its impact on self-esteem and depression, mattering is associated with reduced incidence of suicidal ideation (Elliott, Colangelo, & Gelles, 2005).

Ethnic Identity. Although ethnic identity can be conceptualized in numerous ways, a general definition of ethnic identity can consist of factors including positive attitudes about one's ethnic group and a sense of belonging to it, voluntary and regular association with members of one's ethnic group, and engagement in ethnic practices such as preferred music, food, language, and attendance at ethnic festivities (Johnson, 2004). Like many developmental processes that occur throughout adolescence and early adulthood, identity development is a fluid process. Interestingly, the metacognitive abilities that develop as a result of cognitive maturation in adolescence make the development of ethnic identity particularly salient for adolescents (Dupree, Spencer, & Bell, 1997; Spencer, 1995). An especially important facet of identity development for adolescents is the integration of a sense of ethnic identity into their larger personal identity (French, Seidman, Allen, & Aber, 2006; Phinney, 1989; Phinney 1990; Phinney, Lochner, & Murphy, 1990). The developmental perspective on the formation of one's ethnic identity is largely based on Erikson's theory of identity development (Erikson, 1959). Erikson postulated that one's identity is established after a period of exploration

that occurs during adolescence (Phinney, 1989; Phinney, Cantu, & Kurtz, 1997; Roberts et al., 1999; Umaña-Taylor, Yazedjian, & Bámaca-Gómez, 2004). Ethnic identity formation also incorporates social identity theory, which emphasizes the importance of group membership as a source of self-esteem (Phinney et al., 1990; Roberts et al., 1999; Tajfel & Turner, 2004).

There is significant body of literature demonstrating the stressors that many inner city youth face on a regular basis and the poor outcomes associated with these persistent stressors. Such youth have to deal with stressors that include poverty, community violence, and discrimination, all of which are associated with low self-esteem, poor adjustment, and increased rates of anxiety, depression, and behavioral problems. A strongly developed sense of one's ethnic identity has been shown to serve a protective function against such stressors (Chatman, 2007).

Recent research has shown that ethnic identity development of youth and early college-age students has an impact on their psychological well-being (Kwan & Sadowsky, 1997; Yoo & Lee, 2005). Lower (i.e., less positive) ethnic identity has been associated with above average ratings of depressive symptoms, while higher ethnic identity appears to buffer the stress associated with poor achievement (Costigan, Koryzma, Hua, & Chance, 2010). In African-American youth, high ethnic identity has been shown to buffer against oppression and helps maintain psychological well-being (Hyers, 2001). Additionally, the use of illegal drugs has been found to be lower among those with strong ethnic identities (Brook, Balka, Brook, Win, & Gursen, 1998; Brook, Whiteman, Balka, Win, & Gursen, 1998; Resnicow, Soler, Braithwaite, Ben Selassie, & Smith, 1999). Ethnic identity is also linked to perceptions of discrimination; with

evidence showing that high ethnic identity can buffer the negative effects of perceived discrimination (Sellers, Copeland-Linder, Martin, & Lewis, 2006).

Depression. Depressive episodes commonly emerge during the secondary school years and have potentially impairing effects on learning, social relationships, and the self and world-views of youth. Approximately 21–28% of adolescents experience an episode of major depression by the age of 19 years (Hankin et al. 1998; Lewinsohn, Rohde, & Seeley, 1998), with females showing twice the risk of developing a depressive disorder than males (American Psychiatric Association, 2000). Cognitive theories of depression (Abramson, Metalsky, & Alloy, 1989; Beck, 1967) posit that some individuals typically interpret life events in a negative way that heightens the risk for developing depression. This vulnerability appears to coalesce and become fully operational during adolescence (Gibb & Alloy 2006; Hankin & Abramson 2001; Hyde, Mezulis, & Abramson, 2008), a period where one's self-esteem and world-views tend to be easily influenced.

There have been numerous studies researching the risk factors contributing to the development of depression in adolescence to date. The most commonly cited risk factors across such studies include being female (Compas et al., 1997; Koenig, Isaacs, & Schwartz, 1994; Leadbeater, Blatt, & Quinlan, 1995), minority status (Roberts, Roberts, & Chen, 1997; Swanson, Linskey, Quintero-Salinas, Pumariega, & Holzer, 1992; Vega, Zimmerman, Warheit, & Apospori, 1993), low parental support (Aseltine, Gore, & Colten, 1994; Lempers and Clark-Lempers, 1990), substance use (Henry et al., 1993; Swanson et al., 1992), family history of depression (Diego, Sanders, & Field, 2001; Hammen, Shih, Altman, & Brennan, 2003), negative life events/life stress (Ge, Lorenz, Conger, Elder, & Simons, 1994; Rudolph et al., 2000), problematic peer relationships

(Garland & Fitzgerald, 1998; Rudolph, Hammen, & Burge, 1994), negative parental rearing behavior (Lau & Kwok, 2000; Liu, 2003), low self-esteem (Marcotte, Fortin, Potvin, & Papillon, 2002; Muris, Schmidt, Lambrichs, & Meesters, 2001), negative body-image (Kovacs, Obrosky, & Sherrill, 2003; Siegel, 2002), low SES (Frigerio, Pesenti, Molteni, & Battaglia, 2001), conduct problems (Merikangas & Avenevoli, 2002), and attention regulation difficulties (Bird, Gould, & Staghezza, 1993).

Depressed youth show significantly increased chances of engaging in risk-taking behaviors. Numerous sexual partners and failing to engage in safe sex practices may reflect a depressive disorder in both genders (Kosunen, Kaltiala-Heino, Rimpelä, & Laippala, 2003). Many people with major depressive disorder experience their first depressive episode during adolescence (Kim-Cohen et al., 2003), and the highest rates of alcohol abuse and dependence (a common comorbidity of depressive disorders) are found among 18–23 year-olds (Harford, Grant, Yi, & Chen, 2005). The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide, which increases steadily through the teens, is the third leading cause of death at among adolescents (Hoyert, Arias, Smith, Murphy, & Kochanek, 1999). Furthermore, research indicates that poor interpersonal interactions with parents, absence of peer interactions, and experiencing traumatic life events can lead to depression, which in turn can lead to suicidal ideation. Indeed, depressive symptoms are some of the strongest predictors of suicidal ideation (Nissel, 1998). Among females, depression predicts drug involvement, and in turn, drug use increases suicidal ideation (Kandel, Raveis, & Davies, 1991).

Risk-taking behavior and depression during adolescence are predictors of delinquency later in life (Leas & Mellor, 2000). The multiple problem hypothesis posits

that children with externalizing problems and comorbid depression are more likely to progress toward engaging in high risk behaviors characterizing the path of persistent delinquent and criminal behavior (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Moffitt 1993; Serbin, Moskowitz, Schwartzman, & Ledingham, 1991; Verhulst & van der Ende, 1992). In a succinct summary of support for the multiple problem hypothesis, Loeber et al. (1998) asserted that “We see serious problem behavior of elementary school-age boys as involving several domains of maladaptation. First because of the presence of externalizing problems, and second because of comorbid internalizing problems” (p. 255). Youth high risk behaviors, including drug and alcohol use, truancy, stealing, and running away from home, impact not only the individuals exhibiting the behaviors but also others around them. High-risk behaviors have both immediate and long-term consequences for youth including continued involvement in antisocial activities, legal action, and development of mental health problems (Loeber et al.). Moreover, youth who engage in these behaviors place emotional and financial stress on their families, disrupt the sense of community in their neighborhoods and schools, and contribute to the creation of a culture of fear (Moffitt et al., 1996; Moore & Tonry, 1998; Thompkins, 2000).

Summary and Implications

The body of literature exploring risk-taking behavior in youth is abundant. As a direct cause for adolescent engagement in risk-taking behavior has not been determined, research has focused on the identification of the factors contributing to significant risk-taking behavior during adolescence. Often cited variables contributing to the engagement of at-risk youth in risk-taking behaviors include low self-esteem, low hope and optimism,

a sense of not mattering to peers and close ones, lacking a positive ethnic identity, and being depressed. Although any one of these factors does not in and of itself bring about risk-taking behavior and psychological distress, the interaction of these variables may increase the likelihood of youth experiencing psychological symptoms and engaging in risky behaviors. Therefore, it is imperative to consider targeting many of these variables in programs seeking to promote positive youth development, decrease the incidence of risk-taking in today's youth, and facilitate the development of appropriate coping and interpersonal skills.

Given the existing literature reviewed, it is not difficult to conclude that self-esteem, hope and optimism, mattering, positive ethnic identity, and depression are factors that significantly contribute to, or detract from, the positive development of many of today's youth. Therefore, setting out to increase self-esteem, hope and optimism, mattering, and a positive sense of youth ethnic identity is consistent with the PYD intervention approach. Furthermore, targeting depression and the externalizing (e.g., risk-taking behaviors) and internalizing symptoms frequently seen in depressed youth demonstrates a focus on promoting positive development in at-risk adolescents. Determining whether the CFDC-YDP program successfully impacts these factors can provide a partial evaluation of this programs' treatment effectiveness and insight into how treatment strategies within the CFDC-YDP program can be further focused or transformed to better meet the needs of at-risk youth.

Chapter III: Methodology and Procedures

Overview

The current study was the first to utilize statistical analyses to assess the effectiveness of the Saint John's Child and Family Development Center's Youth Development Project, a school- and community-based treatment program for at-risk youth. The Executive Director of the Saint John's Child and Family Development Center, which the Youth Development Project is a part of, granted permission to conduct this evaluation study (see Appendix A). The primary investigator was additionally granted permission to conduct this study by the Pepperdine University Institutional Review Board (see Appendix B).

The following methodology and procedures will be described in this chapter: (a) research approach and design, (b) inclusion and exclusion criteria, (c) sample, (d) instrumentation, (e) original recruitment and consent procedures, (f) treatment procedures, and (g) original data collection procedures.

Research Approach and Design

The present study is a program evaluation that focused on determining the effectiveness of the CFDC-YDP treatment program and measured changes resulting from participation in treatment. The evaluation utilized an archived data set consisting of participant self-report ratings of 5 variables, with measurements obtained at intake and at termination of treatment (length of treatment varied based on when participants were referred for treatment). Data on participant's ratings of self-esteem, hope and optimism, mattering, ethnic identity, and depression were originally gathered in the Saint John's CFDC-YDP program during the pre-intervention phase, and then again at the conclusion

of treatment. A within-subjects, pre- and post-test, or naturalistic, design was utilized in this study to examine the impact of treatment in the CFDC-YDP program. A naturalistic design was chosen for this evaluation as it best fit the existing data collected by the CFDC-YDP team.

Inclusion and Exclusion Criteria

The following inclusionary criteria were used in the Saint John's YDP program: (a) all participants had to be enrolled in Santa Monica/Malibu Unified School District schools or after-school programs in the Santa Monica area; (b) all participants must have obtained consent for participation within the CFDC-YDP program from their parents or legal guardians; (c) all participants must have been referred to the CFDC-YDP program by school or after-school program staff due to significant at-risk behaviors or problematic internalizing (i.e., anxiety, depression) or externalizing (i.e., defiance, fighting) symptoms.

The following exclusionary criteria were used in the Saint John's YDP program: (a) individuals who could not obtain consent for services from their legal guardians; (b) referred participants who exhibited symptoms significant enough to place them at need for a higher level of care were not included in the present study. Instead, such individuals received referrals for programs that could more appropriately meet their existing needs. Additionally, although participants who were younger than age 11 or older than age 19 at the time of treatment received services through the Saint John's YDP program, their data were excluded from the study as they do not fall into the age range defining "at-risk youth" discussed in the literature review of this dissertation project.

Sample

The participants for this study were a total 87 culturally diverse at-risk youths being treated by the Saint John's Child & Family Development Center's Youth Development Project program (CFDC-YDP) within John Adams Middle School, Lincoln Middle School, Olympic Continuation High School, and the Pico Youth & Family Center, which are all located in the city of Santa Monica, California. Participants for this study were originally recruited for the Saint John's YDP program during the 2009/2010 academic year and received treatment throughout that same time period. The sample consisted of 41 female and 46 male participants who ranged in age from 11 to 19 years. The ethnic composition of the sample, determined by participant self-report, included African-American, Latino/Hispanic, Caucasian, Asian-American, and Mixed-Race participants. More specific information on the sample demographics will be presented in the Results section.

Instrumentation

Data for the present study were obtained from a number of questionnaires that are routinely employed as a part of the CFDC-YDP program. These include: the Rosenberg Self Esteem Scale (Rosenberg, 1965), the Revised Life Orientation Test (Sheier, Carver, & Bridges, 1994), the General Mattering Scale (Marcus, 1991), the Multigroup Ethnic Identity Measure (Phinney, 1992), and the Center for Epidemiologic Studies Depression Scale (Radloff, 1991). See Appendices E and F for copies of the measures used as part of the CFDC-YDP program.

These questionnaires were chosen for the CFDC-YDP program for their ease of administration, brevity, and to provide objective benchmarks to show therapeutic gains

made by participants. These factors are certainly important to consider for any psychological measures utilized within a community based mental health center. However, it is also important to look at how well the instruments used within the CFDC-YDP program align with the current body of literature on positive youth development – specifically the Five Cs model.

As previously noted, the constructs comprising the Five Cs model (competence, confidence, connection, character, and caring) have an inverse relationship with depressive symptoms (Zimmerman, Phelps, & Lerner, 2007). Self-esteem, as defined by Rosenberg (1965) is one's overall sense of worth as an individual. Based on Rosenberg's definition, the construct for self-esteem aligns with the competence (positive view of one's actions in domain specific areas) and confidence (internal sense of overall positive self-worth and self-efficacy) components of the Five Cs model. Mattering – the degree to which one feels they matters to others (Rosenberg & McCullough, 1981) parallels the connection component of the Five Cs model in that both reflect positive bonds between the individual and peers, family, school, and community. The ethnic identity construct corresponds to the connection component, as this reflects positive bi-directional exchanges between the individual and their community in which both parties contribute to the relationship. Finally, while the hope and optimism construct does not specifically map onto any of the Five Cs, it is apparent how being competent, confident, connected, caring, and possessing a good moral compass would lead one to be hopeful and optimistic towards future events.

While additional research into the relationships among the constructs comprising the Five Cs and self-esteem, optimism, mattering, and ethnic-identity is needed, the

statement that the constructs assessed in the current study are related to the constructs comprising the Five Cs appears have face validity.

Rosenberg Self Esteem Scale (RSES). In his 1965 publication, Rosenberg defined self-esteem as one's overall sense of worth as an individual. The Rosenberg Self Esteem Scale (Rosenberg, 1965) was utilized to collect information regarding participating youths' self-ratings of their global self-esteem during the pre- and post-test data collection points. The RSES is a 10-item assessment comprised of 5-positively and 5-negatively worded items that take just a few minutes to complete. Participants are asked if they strongly agree, agree, disagree, or strongly disagree with each of the 10 items. In his analysis, Rosenberg found a significant association ($p < .05$) between the RSES and participants' self-reports, nurses' and peers' ratings of depression, psychophysiological indicators of anxiety, and peer group reputation. Test-retest reliability was strong at a 2-week follow up ($\alpha = .85$) and 1-year post initial administration ($\alpha = .77$).

The RSES is one of the most widely utilized measures of global self-esteem (Byrne, 1996) and its wide usage can be attributed to its simplicity of use, high face validity, and succinctness. Although the RSES has not faced intense scientific rigor, a number of studies speaking to the validity and generalizability of the scale have been conducted. Some researchers question the RSES in part due to a lack of a theoretical underpinning, its validation being conducted on a demographically limited sample, and the test items being selected based solely on their face validity (Butler & Gasson, 2006). Other studies, however, support the internal consistency, test-retest reliability, and structural and predictive validity of the RSES (Torrey, Mueser, McHugo, & Drake, 2000;

Schmitt & Allik, 2005). Schmitt and Allik (2005) also addressed the generalizability of the RSES through meta-analytic research, with their findings showing the RSES to be applicable to samples coming from 53 different nationalities. The internal consistency of the RSES across cultures was supported by a robust Cronbach's coefficient α ($M = 0.81$).

Self-esteem, as measured by the RSES, has been found to increase with age, specifically between late adolescence and young adulthood (Twenge & Campbell, 2001). However, while Rosenberg (1965) initially researched utilization of the RSES with a population consisting mostly of undergraduate college students, it has since been found to be a useful tool for assessing the self-esteem of high- and middle-school aged adolescents (Hagborg, 1993; Hagborg, 1996).

Revised Life Orientation Test (LOT-R). The Revised Life Orientation Test was developed by Scheier, Carver, & Bridges (1994) to assess individual differences in generalized optimism versus pessimism. The LOT-R was designed as a research instrument and has been utilized in a wide range of research on the affective, behavioral, and health consequences of being optimistic. The LOT-R is a 10-item scale, with 6 test items (1, 3, 4, 7, 9, 10) and 4 filler items (2, 5, 6, 8). Participants are asked to rate their responses on a 5-tier scale: A = I agree a lot, B = I agree a little, C = I neither agree nor disagree, D = I disagree a little, and E = I disagree a lot. The conciseness of the LOT-R makes it easily utilizable in research studies that make use of multiple measures.

The LOT-R has good internal consistency, as demonstrated by a Cronbach's coefficient α of .78. Test-retest reliability research shows that LOT-R scores are fairly stable over time (Scheier, Carver, & Bridges, 1994). With test-retest intervals of 4 months ($N = 96$), 12 months ($N = 96$), 24 months ($N = 52$), and 28 months ($N = 21$), the

test-retest reliability correlations were found to be .68, .60, .56, and .79, respectively.

Given the modest convergent and discriminant validity of the LOTR (Scheier, Carver, & Bridges, 1994) and lower Cronbach's coefficient α scores reported in more recent studies (Herzberg, Glaesmer, & Hoyer, 2006), it is recommended that the LOTR be used for research purposes only, and not as a clinical measure of general optimism.

General Mattering Scale (GMS). The General Mattering Scale (Marcus, 1991) is a brief 5-item scale asking participants to rate their responses on a 4-point Likert scale (1 = Not at all; 2 = A little; 3 = Somewhat; 4 = Very much). The total obtained score ranges from 5 to 20, with higher scores reflecting higher perceptions of personal mattering. Numerous studies have utilized the GMS to study the interaction of mattering with variables such as gender (Dixon Rayle, 2005), ethnic identity, and acculturation (Dixon Rayle & Myers, 2004). The reliability of the GMS was initially evaluated in the work of DeForge and Barclay (1997), who reported a Cronbach's α of .85 for the GMS using a sample of 199 homeless males. In a study of college students, Connolly and Myers (2003) reported an α of .86. In the same study, Connolly and Myers performed a confirmatory factor analysis of the GMS in order to confirm the previously established factor structures and determined the GMS to be a valid instrument for the measurement of mattering.

Multigroup Ethnic Identity Measure (MEIM). The original version of the Multigroup Ethnic Identity Measure (Phinney, 1992), a 15-item questionnaire, was utilized in this study. According to Phinney, the MEIM is comprised of two factors: 1) Ethnic identity search, which reflects a developmental and cognitive component of ethnic identity and 2) Affirmation, belonging, and commitment, which represents an affective

component of ethnic identity. The MEIM includes 12 statements to which respondents answer based on a four-point Likert scale (1 = Strongly disagree; 2 = Disagree; 3 = Agree; 4 = Strongly agree). Higher scores indicate higher levels of ethnic identity. The items fall into the two factors as follows: ethnic identity search is comprised of items 1, 2, 4, 8, and 10 while items 3, 5, 6, 7, 9, 11, and 12 fall under affirmation, belonging, and commitment. Items 13, 14, and 15 are used only for purposes of identification and categorization by ethnicity, and were omitted in the present study due to redundancy, as this information was already obtained during the initial intake process.

The MEIM was normed with 407 high school adolescents and 136 college-aged students (Phinney, 1992). Phinney reported Cronbach's α of .81 with high school students and .90 with college students. The factor structure of the MEIM was confirmed in a study with 2,184 adolescents, in which two factors were identified: Identification and Exploration (Spencer, Icard, Harachi, Catalano, & Oxford, 2000). Reliabilities for the two factors were .84 and .76 respectively.

Center for Epidemiologic Studies Depression Scale (CESD). The CESD (Radloff, 1977) is a short self-report scale designed to measure depressive symptoms in a general adult population. The scale consists of 20 items that comprise six scales reflecting major dimensions of depression: depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance. Participants are asked to report how often during the past week they have experienced each of the 20 items on a 4-item Likert scale ranging from rarely or none of the time (less than 1 time per day) to most or all of the time (5–7 days out of the past week). Although the CESD was designed and normed utilizing an

adult population, it has frequently been used in the literature to assess the prevalence of depressive symptomatology in a variety of adolescent populations (Dick, Beals, Keane, & Manson, 1994; Dumenci & Windle, 1996; Garrison, Schluchter, Schoenbach, & Kaplan, 1989). The CESD has been shown to be a reliable measure for assessing the number, types, and duration of depressive symptoms across racial, gender, and age categories (Knight, Williams, McGee & Olaman, 1997; Radloff, 1977; Roberts, Vernon, & Rhoades, 1989). High internal consistency has been reported with Cronbach's alpha coefficients ranging from .85 to .90 across studies (Radloff, 1977). Radloff established concurrent and construct validity of the CESD based on the scale's positive correlation with other measures of depression and improvement in CESD scores after treatment for depression. Although the CESD has been shown to be a useful measure of depressive symptoms, it may not be a good clinical tool for screening for major depression (Roberts, Vernon, & Rhoades, 1989).

Original Recruitment and Consent Procedures

Participants were originally recruited from John Adams Middle School, Lincoln Middle School, Olympic Continuation High School, and the Pico Youth & Family Center. Participants were recommended for treatment by school or center staff (e.g., teachers, counselors, school psychologists), their parents, or self-referral. All potential participants were given the Saint John's Child and Family Development Center Youth Development Project Assessment Tool to determine their fit with the CFDC-YDP treatment program (see Appendix C). The CFDC-YDP Assessment Tool was used to obtain information regarding participants risk and protective factors across 5 areas: 1) Individual Context, 2) Family Context, 3) Peer Context, 4) School Context, and 5)

Neighborhood and Community Context. To determine an appropriate course of action for each youth, the CFDC-YDP triage team reviewed contextual information along with specific clinical concerns reported by referring parties. The triage team consisted of licensed mental health clinicians (licensed clinical social workers and licensed psychologists).

Consent for treatment and administration of measures to be utilized for program evaluation purposes was obtained from participants' parents or legal guardians prior to initiation of services. Parental Consent, Acknowledgement of Understanding Grievance Procedures, and Acknowledgement of Receipt of Notice of Privacy Practices forms were provided in English or Spanish, depending upon the language spoken by any specific participants' legal guardians (see Appendix D). Prior to treatment and administration of measures, participants' parents' consented to having their child participate in individual and/or group counseling conducted by a social worker, psychologist, or intern on the YDP team. Additionally, consent was obtained for YDP staff to communicate with administrators, teachers, and other professionals who provide services for the youth on or off the school site. Finally, parents consented to allow youth to complete questionnaires before and after participation in counseling as part of program evaluation. Parents were informed that these questionnaires would lead to increased knowledge of the effects school- and community-based counseling has on the youth participants and to aid in program development and evaluation. Parents were encouraged to contact their child's treating therapist, group counselors, or program coordinator if they had any questions, concerns, or grievances regarding the services their child would be receiving.

Treatment Procedures

Treatment was provided to participants by either licensed mental health clinicians (licensed clinical social workers or psychologists) or trained and supervised unlicensed staff (social workers, social work interns, and psychology interns). Unlicensed staff received weekly individual and group supervision with licensed supervisors. The length of treatment was not standardized and varied for participants depending on when the participant was referred for treatment. Due to ethical considerations and the acute needs of participants, treatment groups had rolling enrollment. Specific data regarding individual participants' length of treatment was not included in the de-identified data provided to the investigator.

Original Data Collection Procedures

Staff of the CFDC-YPD program collected data from each participant at the onset of treatment and again at the end of the treatment period. Length of treatment was not standardized for all participants and varied depending on when individual participants were referred to CFDC-YDP. Data collection was conducted by CFDC-YDP therapists providing treatment to the participants or by psychology/social work interns who were assigned to the CFDC-YDP program, but not directly involved with treating the participants. Participants were provided questionnaires that they completed individually while seated in a group setting. Participants were able to ask questions regarding any items on the questionnaires by raising their hand and directing their questions to the administrators. Completed questionnaires were given to the CFDC-YDP program coordinator who then reviewed the data and entered participants' responses into a database program (Microsoft Access). Individual identifying information was removed

from the data set and each participant was randomly assigned a participant number. The participant number was utilized to match participants' pre- and post-test data and track drop out from the program.

Institutional Review Board (IRB) approval to conduct analyses on the data was obtained from Pepperdine University (see Appendix B) and the Executive Management at Saint John's Child and Family Development Center (see Appendix A). All participant data was provided to the primary investigator in a de-identified format.

Chapter IV: Results

Overview

The results of this research study are presented in this chapter in the following order: (1) data analysis, (2) preliminary analyses, (3) participant's demographic information, (4) reliability of measures, (5) correlational analyses, and (6) results of statistical analyses testing the hypotheses.

Data Analysis

All data analyses were conducted using Statistical Package for the Social Sciences (SPSS) version 16.0 for Windows. A within-group design was utilized to examine the differences within the sample of CFDC-YDP participants from pre- to post-intervention. Data corresponding to hypotheses 1a, 1b, 1c, 1d, and 2a were analyzed utilizing repeated measures MANCOVA analyses, employing participant age as a covariate, to determine whether a significant change in self-esteem (1a), optimism (1b), mattering (1c), ethnic identity (1d), and depression (2a) occurred from pre- to post-treatment for each participant. The repeated measures independent variable was time (e.g., pre-test to post-test) and the dependent variables were participants' ratings of their self-esteem, optimism, mattering, ethnic identity, and depression. Additionally, reliability analyses for individual item responses on each of the dependent variable measures were conducted to obtain internal reliability data for the measures with the specific sample of participants in this study. Finally, correlational analyses were performed to determine the strength and direction of relationships among the five dependent variables.

Preliminary Analyses

Preliminary review of the data resulted in the identification and elimination of 22 participants who either did not complete all responses on the pre- and post-treatment measures (15) or did not complete the Saint John's CFDC-YDP treatment program (7). An additional 8 participants who participated in the study and completed the treatment program were excluded from statistical analysis as their age at the time of treatment did not fall into the literature-derived definition of "at-risk youth" utilized for this dissertation project (e.g., 10, 20, and 21 year olds). This resulted in a final sample size of 87 participants.

Demographic Information. Demographic data are summarized to describe the characteristics of the 87 participants of the Saint John's CFDC-YDP program whose data were analyzed in this study (see Table 1). At-risk youth participants ranged in age from 11 to 19 years, with a mean age of 13.31 years. The sample consisted of 41 female and 46 male participants who completed the Saint John's CFDC-YDP treatment program as well as pre- and post-intervention measures. A little more than half of the sample self-identified as Latino/Hispanic (51.7%), followed by Multi-racial (18.4%), Caucasian (16.1%), African American (10.3%), Other (2.3%), and Asian American (1.1%).

Table 2
Description of Participants

Variables	<i>N</i>	%	<i>M</i>
Gender (<i>N</i> = 87)			
Male	46	52.9	
Female	41	47.1	
Ethnicity (<i>N</i> = 87)			
Latino/Hispanic	45	51.7	
African American	9	10.3	
Caucasian	14	16.1	
Asian American	1	1.1	
Multi-racial	16	18.4	
Other	2	2.3	
Age (<i>N</i> = 87)			13.31 (2.16)
11	15	17.2	
12	21	24.1	
13	29	33.3	
14	4	4.6	
15	1	1.1	
16	4	4.6	
17	7	8.0	
18	4	4.6	
19	2	2.3	

Reliability of Measures. Cronbach's alpha reliabilities were calculated for each of the measures utilized in this study. Based on responses obtained from the participants of this study, the internal consistency reliability figures for the measures were as follows: CESD ($\alpha = .877$), MEIM ($\alpha = .839$), RSES ($\alpha = .834$), GMS ($\alpha = .747$), and LOTR ($\alpha = .622$).

Correlational Analysis. Correlational analyses were performed to determine the strength and direction of relationships among the dependent variables as well as relationships between the dependent variables. Numerous relationships among the dependent variables were observed and can be seen in Table 3. Some of the strongest correlations observed in the data were among participants' scores on the CESD and the RSES (pre = $-.613$, $p < .01$; post = $-.713$, $p < .01$). These results suggest that as self-

esteem increases depressive symptoms tend to decrease and vice versa. The relationship between CESD and LOTR scores was also sizeable (pre = $-.708, p < .01$; post = $-.651, p < .01$), signifying an inverse relationship between depressive symptoms and the constructs of hope and optimism. Substantial positive correlations were found to exist between RSES and LOTR scores (pre = $.638, p < .01$; post = $.657, p < .01$) and RSES and GMS scores (pre = $.635, p < .01$; post = $.583, p < .01$), showing that as self-esteem increases so do mattering and optimism. Similarly, LOTR scores were found to have significant positive correlation with GMS scores (pre = $.527, p < .01$; post = $.593, p < .01$), demonstrating that increases in hope and optimism tend to be related to increases in feeling that one matters to others.

Table 3
Correlations

		CESD		MEIM		RSES		LOTR		GMS	
		pre	post	pre	post	pre	post	pre	post	pre	post
CESD	pre	1.000	.465 [†]	-.294 [†]	-.230 [*]	-.613 [†]	-.396 [†]	-.708 [†]	-.380 [†]	-.379 [†]	-.166
	post	.465 [†]	1.000	-.251 [*]	-.341 [†]	-.402 [†]	-.713 [†]	-.331 [†]	-.651 [†]	-.289 [†]	-.491 [†]
MEIM	pre	-.294 [†]	-.251 [*]	1.000	.613 [†]	.268 [*]	.211 [*]	.295 [†]	.170	.257 [*]	.118
	post	-.230 [*]	-.341 [†]	.613 [†]	1.000	.214 [*]	.430 [†]	.151	.344 [†]	.173	.259 [*]
RSES	pre	-.613 [†]	-.402 [†]	.268 [*]	.214 [*]	1.000	.644 [†]	.638 [†]	.362 [†]	.635 [†]	.379 [†]
	post	-.396 [†]	-.713 [†]	.211 [*]	.430 [†]	.644 [†]	1.000	.333 [†]	.657 [†]	.482 [†]	.583 [†]
LOTR	pre	-.708 [†]	-.331 [†]	.295 [†]	.151	.638 [†]	.333 [†]	1.000	.382 [†]	.527 [†]	.249 [*]
	post	-.380 [†]	-.651 [†]	.170	.344 [†]	.362 [†]	.657 [†]	.382 [†]	1.000	.358 [†]	.593 [†]
GMS	pre	-.379 [†]	-.289 [†]	.257 [*]	.173	.635 [†]	.482 [†]	.527 [†]	.358 [†]	1.000	.565 [†]
	post	-.166	-.491 [†]	.118	.259 [*]	.379 [†]	.583 [†]	.249 [*]	.593 [†]	.565 [†]	1.000

[†]. Correlation is significant at the 0.01 level (2-tailed).

^{*}. Correlation is significant at the 0.05 level (2-tailed).

Change in Self-Esteem

A repeated measures MANCOVA, with age as a covariate, was used to test hypothesis 1a. The hypothesis that following treatment in the Saint John's CFDC-YDP program participants would report significantly increased ratings of self-esteem was

confirmed. A statistically significant difference between participants' pre- and post-treatment ratings of self-esteem (Wilks' Lambda = 0.95, $F(1,85) = 4.45$, $p = .038$) was found, with mean RSES scores increasing from pre-intervention ($M = 20.069$, $SD = 4.92$) to post-intervention ($M = 20.655$, $SD = 5.45$). In addition, a significant interaction between RSES scores and age (Wilks' Lambda = 0.94, $F(1,85) = 5.48$, $p = .022$) was observed, where younger participants showed mild reductions in RSES scores between pre- and post-test, and older participants showed moderate to sizeable improvement in their average RSES scores. Figure 1 illustrates the interaction.

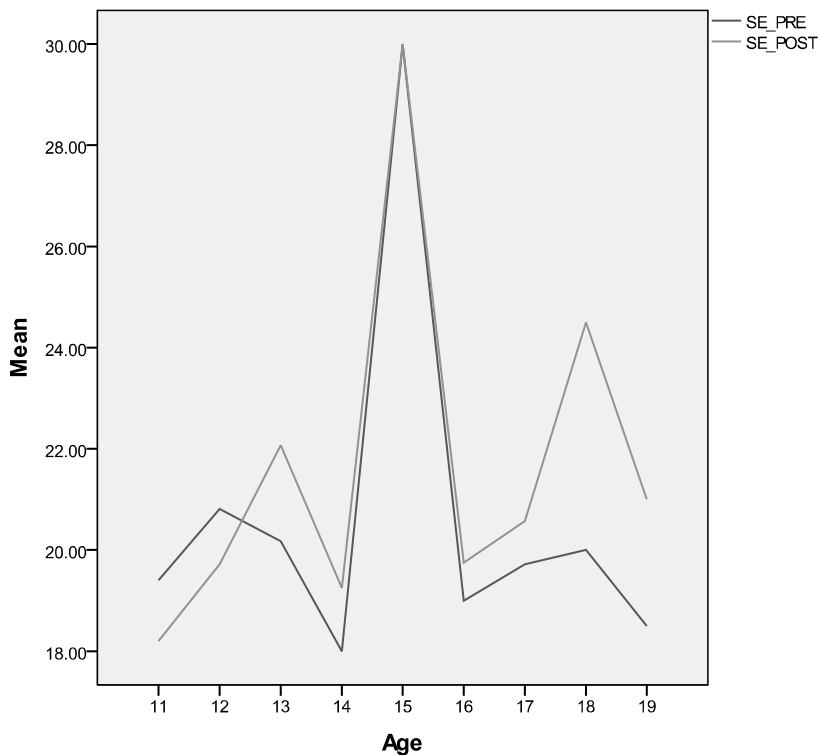


Figure 1. Interaction of RSES scores and participant age.

Change in Life Orientation

A repeated measures MANCOVA, with age as a covariate, was used to test hypothesis 1b. No significant differences were found between pre- and post-treatment measurement on the LOTR. The hypothesis that treatment in the Saint John's CFDC-

YDP program would increase participants' self-ratings of hope and optimism was not supported. No significant interaction between LOTR scores and age was observed.

Change in Mattering

A repeated measures MANCOVA, with age as a covariate, was used to test hypothesis 1c. Although a statistically significant (Wilks' Lambda = 0.91, $F(1,85) = 8.37$, $p = .005$) difference was found between the pre- and post-intervention measures, the direction of the change was in an unexpected direction. Results showed that overall, participants' self-ratings of mattering on the GMS decreased from pre-treatment ($M = 9.954$, $SD = 3.03$) to post-treatment ($M = 9.781$, $SD = 3.39$). A significant interaction between GMS scores and age was observed (Wilks' Lambda = 0.91, $F(1,85) = 8.07$, $p = .006$). The interaction between age and the pre and post treatments are illustrated in Figure 2. As shown in Figure 2, the relationships between pre and post treatments were different for different age groups. There were reductions in GMS scores for participants age 11 and 12, participants age 13 and 14 showed mild increases, participants age 15 showed sizeable reductions, participants age 17 and 18 showed moderate increases, and participants age 19 showing moderate reductions in ratings of mattering between pre- and post-treatment time assessments. Figure 2 illustrates this interaction.

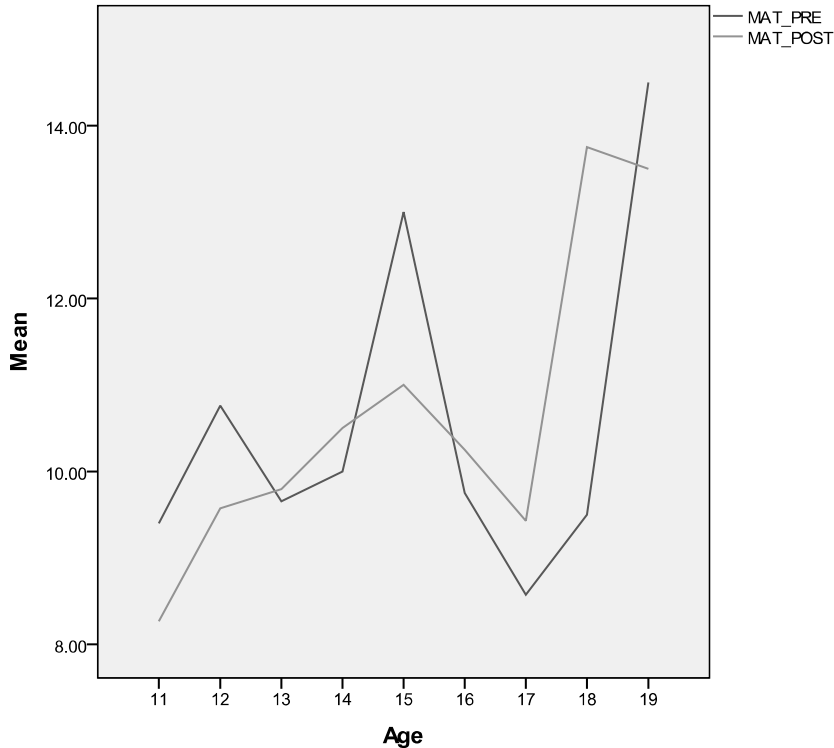


Figure 2. Interaction of GMS scores and participant age.

Change in Ethnic Identity

A repeated measures MANCOVA, with age as a covariate, was used to test hypothesis 1d. No significant differences were found from pre- to post-treatment measurement on the MEIM. The hypothesis that treatment in the Saint John's CFDC-YDP program would increase participants' self-ratings of ethnic identity was not supported. No significant interaction between MEIM scores and age was observed.

Change in Depression

A repeated measures MANCOVA, with age as a covariate, was used to test hypothesis 2a. The hypothesis that following treatment in the Saint John's CFDC-YDP program participants would report significantly decreased ratings of depression was confirmed. A statistically significant difference between participants' pre- and post-treatment ratings of depressive symptoms (Wilks' Lambda = .92, $F(1,85) = 7.65$, $p =$

.007) was found, with mean CESD scores decreasing from pre-intervention ($M = 17.93$, $SD = 10.64$) to post-intervention ($M = 15.26$, $SD = 10.53$). A significant interaction between CESD scores and age (Wilks' Lambda = 0.89, $F(1, 85) = 10.16$, $p = .002$) was observed as illustrated in Figure 3, where larger decreases in CESD scores were seen in participants age 15 and older than those ranging from 11-14 years old. This interaction is illustrated in figure 3.

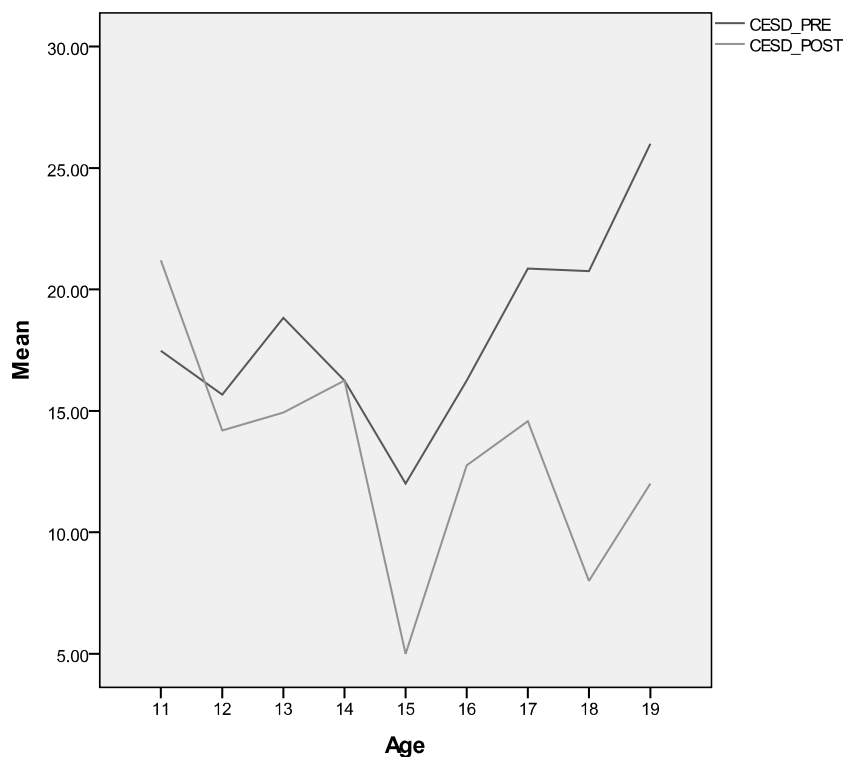


Figure 3. Interaction of CESD scores and participant age.

Chapter V: Discussion

Overview

This study was the first to utilize statistical analyses to examine the effectiveness of the Saint John's Child and Family Development Center's intervention program for at-risk youth, the Youth Development Project. The outcome evaluation focused on assessing the impact participation in the Saint John's CFDC-YDP program had on participants from pre- to post-treatment.

Participant's self-ratings across five dependent variables - self-esteem, hope & optimism, mattering, ethnic identity, and depression were examined. The findings of this study are based on comparison of pre- and post-intervention measures that include the Rosenberg Self Esteem Scale (Rosenberg, 1965), Center for Epidemiologic Studies Depression Scale (Radloff, 1991), Revised Life Orientation Test (a measure of hope and optimism; Sheier, Carver, & Bridges, 1994), the General Mattering Scale (Marcus, 1991), and The Multigroup Ethnic Identity Measure (Phinney, 1992).

The results of this study are based on an archival analysis of pre- and post-intervention measures administered to 87 at-risk youth who participated in the Saint John's CFDC-YDP treatment program. Participants received treatment during the 2009/2010 academic year and ranged between 11 and 19 years of age. The vast majority (82%) of the participants were ethnic minority individuals, with the highest percentage within this group being Hispanic (52%).

The primary goals of CFDC-YDP, based upon PYD principles, are to foster empowerment, growth, positive coping and pro-social behaviors that enable youth and their families to succeed at home, at school, and in the community. As such, CFDC-YDP

seeks to accurately assess and incorporate into treatment the individual strengths of each youth, family member, and community collaborator. The program's general goals are to:

- 1) Identify, through collaboration with schools, youth displaying at-risk behaviors (e.g., drug and/or alcohol use, unprotected sexual behaviors, and gang involvement);
- 2) assist identified youth in enhancing positive coping and problem-solving skills;
- 3) build resilience and positive self-esteem through increasing social support by strengthening family systems through parent support groups, workshops, and visits to at-risk youth's homes; and
- 4) support teachers and counselors in their efforts with at-risk youth in the classroom through consultation, training and feedback with mental health professionals.

The specific targets of treatment of the CFDC-YDP program are consistent with current best practices for community-based treatment programs working with at-risk youth from a PYD approach (Bowers et al., 2010). Individual and group treatment provided through CFDC-YDP aims to foster resilience, cultivate belief in the future, and nurture the development of a clear and positive self-identity. To achieve these goals, CFDC-YDP utilizes a systems approach that is comprehensive, multifaceted, and integrated to encompass a full continuum of services that address both prevention and intervention. Services include group therapy, individual and family therapy, teacher consultation, community crisis intervention, consultation and trainings with school and community center staff, home visits, and providing clients and community members with information and referrals that are both culturally appropriate and provide linguistically responsive interventions.

It was hypothesized that in comparison to pre-intervention ratings participants would report following participation in the CFDC-YDP program significantly: (1a)

higher ratings of self-esteem, as measured by the Rosenberg Self Esteem Scale (Rosenberg, 1965); (1b) higher ratings of hope and optimism, as measured by the Revised Life Orientation Test (Sheier, Carver, & Bridges, 1994); (1c) higher ratings of mattering, as measured by the General Mattering Scale (Marcus, 1991); (1d) higher ratings of positive ethnic identity, as measured by the The Multigroup Ethnic Identity Measure (Phinney, 1992); and (2a) fewer depressive symptoms, as measured by the Center for Epidemiologic Studies Depression Scale (Radloff, 1991).

Results support two of the five hypotheses. With respect to hypothesis 1a, a statistically significant improvement in participant's ratings of self-esteem from pre- to post-treatment was found. Second, a statistically significant decrease in participant's ratings of depressive symptoms between pre- and post-treatment was observed (hypothesis 2a). Unexpectedly, the hypothesis that treatment would lead to increased ratings of mattering (1c) had significant findings showing that participants rated themselves significantly lower on the General Mattering Scale post treatment. Hypotheses regarding ethnic identity (MEIM) and life orientation (LOTR) showed no statistically significant findings.

Interpretation of the Results

Self-Esteem. Strong self-esteem has been shown to have significant protective properties when looking at adolescents' problematic externalizing and internalizing behaviors (Gerard, 2001). Well-developed self-esteem is negatively correlated with depressive symptoms and unresolved anger in sexually abused adolescents, even more so than parental support, attitude towards school, and participation in extracurricular activities (Asgeirsdottir, Gudjonsson, Sigurdsson, & Sigfusdottir, 2010). Additionally,

high self-esteem serves a protective function against suicide risk in adolescents, especially in youth who have low levels of family support (Sharaf, Thompson, & Walsh, 2009). These findings and other significant literature (Sharaf, Thompson, & Walsh, 2009; Smith, Gerrard, & Gibbons, 1997) clearly show the importance of high self-esteem in adolescence. Data analyses showing a statistically significant improvement in participants' ratings of self-esteem in the present study is reassuring and points towards the treatment provided through the Saint John's CFDC-YDP program being associated with increases in at-risk youth's sense of self-worth and personal regard. While not all confounding variables were, or could be, controlled for in a study such as this one, it appears likely that the statistically significant improvement in participants' self-esteem can be attributed to the treatment provided through the Saint John's CFDC-YDP program.

The observed interaction between participant age and RSES scores sheds some light on what age groups the Saint John's CFDC-YDP treatment is most effective when it comes to improving self-esteem. The analyses showed that participants who fell into the early adolescent group (ages 11 and 12) actually had a mild decrease in self-reported RSES scores while those in mid- and late adolescence (ages 13 to 19) generally showed a moderate to sizeable improvement in self-esteem ratings. These findings are consistent with literature on self-esteem development showing that self-esteem tends to decline during the transition from childhood to adolescence (Eccles et al., 1989; Engel, 1959; Marsh, Parker, & Barnes, 1985; Piers & Harris, 1964; Rosenberg, 1986; Savin-Williams & Demo, 1984; Simmons, Rosenberg, & Rosenberg, 1973). Whether the decrease in self-esteem ratings in the early adolescent sample is due to developmental issues or

factors specific to the CFDC-YDP treatment program, a further look into ways to tailor treatment to better address self-esteem in younger adolescents is needed. Findings showing that intervention programs that have the strongest positive impact on the self-esteem and self-concept of children and early adolescents incorporate treatment strategies that specifically target self-esteem (Haney & Durkal, 1998) suggest that incorporating self-esteem specific treatments, especially in late childhood and early adolescent populations would be warranted.

Life Orientation. No significant results regarding the impact of treatment provided through the Saint John's CFDC-YDP program on LOTR scores were observed. The lack of a significant finding may be due in part to the instrumentation utilized to assess the adolescent participants' levels of hope and optimism. A youth format of the LOTR, the Youth Life Orientation Test (YLOT), developed by Ey et al (2005) may be preferable for use with this population, as it has psychometric properties (internal consistency, test-retest reliability) and validity that is comparable to other child self-report measures. Although the YLOT is a somewhat lengthier questionnaire – 19 items vs. the 10-item LOTR – it is preferable due to it being specifically designed for use with an early adolescent population.

Mattering. Research shows that those who feel that they matter to their families are much less likely to engage in anti-social or self-destructive behaviors and that mattering can serve as an anchor while the self-concept is developing during the tumultuous period of adolescence (Elliot, 2009). The data obtained in the current study showed a statistically significant, yet unexpected, result. In general, participants' scores on the GMS had a statistically significant decrease following treatment. Although the

exact reasons for this change are unclear, one can hypothesize that throughout treatment participants were asked, latently and expressly, to catalogue and take a closer look at their personal relationships with family members, friends, teachers, and other people who play a role in their lives and contrast these relationships with those of other participants in the group. In some cases, doing so may have penetrated some participants' basic psychological defenses (e.g., denial, distortion, idealization) and provided a clearer perspective of their true relationships with important figures in their lives.

Another possible reason for the unexpected findings may be the questionable validity of utilizing the General Mattering Scale with an adolescent population. While research has been conducted to validate the use of the GMS with college students (Connolly & Myers, 2003) and a homeless adult population (DeForge & Barclay, 1997), no current literature exists on the use of the GMS with an early-to-late adolescent population. Use of an alternate measurement of mattering that has been validated with an adolescent population is warranted. One possible alternate measure is the Mattering to Others Questionnaire (MTOQ; Marshall, 1998, 2001). The MTOQ is an 11-item measure that assesses global perceived mattering to others that was specifically developed for use with adolescent populations. The measure comes in multiple forms to directly assess adolescents' views of how much they matter to their mothers, fathers, and friends. In a study of 532 high-school aged Canadian adolescents, Marshall reported Cronbach's alpha scores of .93, .95, and .93 for the mother, father, and friend forms, respectively (2001). Although the MTOQ is a somewhat lengthier questionnaire than the 5-item GMS – it is preferable due to its higher validity with an early adolescent population.

Ethnic Identity. No significant differences were found from pre- to post-treatment on the MEIM. While research shows that ethnic identities begin to form before adolescence (Phinney & Tarver, 1988), possibly as early as 4 years old (Pnevmatikos, Geka, & Divane, 2010), the availability of assessment tools of ethnic identity in childhood and early adolescence is lagging behind this research. CFDC-YDP clinicians reported, in personal communication with the primary investigator, that the ability to concretely identify and discuss one's own ethnic identity was difficult for many adolescent participants in this study. It was further communicated that this was especially so for those in early adolescence, who were reported to ask many more questions about how to properly complete the MEIM items than any other measure utilized in this study, possibly due to the nebulous nature of the items (e.g., I think a lot about how my life will be affected by my cultural identity). Given this anecdotal information, that the MEIM was not normed with an early adolescent population, and the lack of other existing measures of ethnic identity in child and early adolescent populations, it is possible that ethnic identity will continue to be a difficult construct to assess in this population, especially as early adolescents comprise over 40% of the overall sample.

Depression. Many people with major depressive disorder experience their first depressive episode during adolescence (Kim-Cohen et al., 2003). Depressed youth show significantly increased chances of engaging in risk-taking behaviors, including sexual promiscuity (Kosunen, Kaltiala-Heino, Rimpelä, & Laippala, 2003), drug and alcohol abuse (Harford, Grant, Yi, & Chen, 2005), and attempted suicide (Hoyert, Arias, Smith, Murphy, & Kochanek, 1999). Therefore, programs seeking to reduce at-risk behaviors in

adolescents are wise to target their presenting depressive symptoms in an attempt to reduce both depression and its associated risky behaviors.

A statistically significant difference between participants' pre- and post-treatment ratings of depressive symptoms was observed, with mean CESD scores decreasing an average of 2.67 points from pre-intervention to post-intervention. Data analysis showing a statistically significant improvement in participants' ratings of depressive symptoms illustrates that treatment provided through the Saint John's CFDC-YDP program appears to be effective in decreasing depressive symptoms in at-risk youth. Significantly larger decreases in CESD scores were seen in at-risk youth age 15 and older than those ranging from 11-14 years old. Although the older adolescents had higher mean CESD scores at intake ($M = 19.89$) than the early adolescent group ($M = 17.42$), they showed larger reductions in depressive symptoms post treatment ($M = 11.89$) than the younger group did ($M = 16.15$).

These findings suggest the hypothesis that treatment provided by the Saint John's CFDC-YDP program may be more effective in helping older adolescents reduce their depressive symptoms than it is for younger adolescents. However, given that treatment type and length were not standardized across all participants and that the number of late adolescent participants ($N = 18$) was significantly smaller than the number of early adolescents ($N = 69$), it is difficult to make conclusive statements regarding treatment-related effects.

Methodological Assumptions, Study Strengths, and Limitations

Primary assumptions of this study were that participants were invested in their treatment, responded to test items in honest and open ways, and that the measures

themselves were valid and reliable assessments of the goals of the Saint John's CFDC-YDP program.

A primary strength of the current study is its high level of ecological validity. The present study reflects the administration of treatment in a real-world treatment setting that is inclusive of factors that are typically found in such settings (i.e., varying length of treatment for different participants, selection of a variety of theoretical models to inform treatment, treatment decisions based on client needs, etc.). Additionally, the feedback and recommendations from this study have significant value to the refinement and continued development of the Saint John's CFDC-YDP program. Consequently, the findings of this study will also serve to benefit the community collaborators and individual clients who receive treatment through CFDC-YDP. Another strength of the current study is the relatively large sample size allowing for sufficient statistical power to observe statistically significant changes in the data from pre- to post-test.

A number of limitations are inherent to this type of study. First, the nature of the program does not allow for the implementation of random sampling. Second, as opposed to true experiments, there is a lack of procedures to control for the impact of confounding variables. Overall, utilizing data obtained in natural settings poses a limitation to the conclusions one can make based on the data.

Several limitations of this study are associated with the data collection process. The General Mattering Scale and Multi Ethnic Identity Measure used to evaluate treatment gains were not validated with adolescent and early adolescent populations, respectively. Some participants may have had a difficult time comprehending the nature of the questions asked in these measures or were not yet cognitively developed enough to

provide accurate responses to the questions. Use of an alternate measure of mattering is suggested in the program recommendation section. The original sample size of 116 individuals had to be reduced due largely to incomplete measures or attrition.

Given the nature of the treatment setting (e.g., multiple treatment providers from diverse professional fields possessing diverse theoretical orientations and personal factors) and individual client needs, specific treatment protocols were not followed. Saint John's CFDC-YDP treatment staff used an eclectic blend of treatment modalities based on appropriateness of client to the model and the individual clinician's theoretical framework. Treatment approaches were influenced by psychodynamic theory, aspects of cognitive behavioral therapy, and structural family therapy, thus making it difficult to operationally define treatment and isolate specific treatment effects. Additionally, not all participants received treatment in the same format. Of the 109 participants initially treated through Saint John's CFDC-YDP, 61 youth received group therapy only, 47 youth received individual therapy only, and 1 youth required additional support and participated in both individual and group treatment. This posed a significant challenge as multiple treatment providers utilizing diverse treatment approaches in multiple settings likely added significant variance to the data obtained. Additionally, the inability to establish a uniform length for treatment for all participants was likely a significant confounding variable that could not be accounted for. Therefore, no conclusive statements could be made regarding the evaluation of specific treatment modalities.

Data for this program evaluation were collected from individuals who participated in the Saint John's Child and Family Development Center – Youth Development Project. Participants of this program reside in Santa Monica, CA or its surrounding cities. It is

important to note that this sample may not be representative of other communities and the results of this study would be difficult to generalize to other areas without comparing the demographics of the populations served.

Finally, it cannot be stated with certainty that the differences observed within the pretest-posttest design utilized in this study resulted exclusively from interventions provided through the Saint John's CFDC-YDP treatment program. Several other plausible hypotheses exist that could account for the differences observed between pre- and post-treatment testing. Specifically, individual differences, individual history, testing effects, maturation, and attrition may have contributed to post-treatment findings.

Directions for Future Research

The current study was conducted in order to contribute to the body of research available on intervention programs with at-risk youth, specifically in the area of positive youth development. The purpose of the evaluation was to also provide feedback and recommendations to the Saint John's Child and Family Development Center - Youth Development Project program coordinators for future program planning. The overall results of this study suggest that the Saint John's CFDC-YDP program is a promising intervention approach for assisting at-risk youth in a community-based setting. However, further research is warranted to solidify the findings of this study under more tightly controlled experimental conditions. Continued evaluation of various program components (e.g., treatment, theoretical orientation, measurement instruments) is warranted, especially as future intervention shifts towards evidence based treatment modalities.

Future research at Saint John's CFDC-YDP would warrant a shift towards a more rigorous research design that aimed to control confounding variables. The most obvious of these confounds include treatment length and what constituted the treatment itself. A uniform length of treatment would be required to control for effects related to some participants receiving treatment for a longer period of time than others. Perhaps increased recruitment efforts to build a waiting list for group treatment during summer vacation would allow for a uniform start and termination date for treatment. Treatment itself should include a more clearly defined treatment protocol. Doing so will assist in making clear decisions regarding specific treatment interventions within the program and determine assignment to either individual or group modalities. Training the clinical staff in administration of clinical protocols should be conducted and clinicians' adherence to the treatment protocols should also be evaluated at regular intervals via direct observation or assessment of video recordings of sessions to insure fidelity to the treatment model.

While there is anecdotal evidence showing that the Saint John's CFDC-YDP program is valued in the community, process oriented research geared towards obtaining feedback from participants, family members, school officials, and community contributors can provide significant data regarding the program's impact on the clients as well as the community at large. Having subjective data from various sources can also assist in obtaining feedback regarding the program and suggestions for ways it can be adjusted to better serve the community.

If possible, future research conducted on the Saint John's CFDC-YDP program should utilize a more rigorous experimental design. Adjustments such as having a uniform length of treatment, incorporating a fixed treatment protocol, utilizing an

extended post-treatment follow up, and possibly having an increased sampling of participants in late adolescence would also increase confidence in the results.

Finally, further research on the constructs used to evaluate the program and the measures utilized to obtain treatment efficacy data is recommended. It is possible that other instruments may exist that are validated with adolescents and measure program goals with a higher level of sensitivity.

Saint John's CFDC YDP Program Recommendations

Based on the findings of the current study and the primary investigator's understanding of the program, the following recommendations are made in order to support, guide, and enhance the goals of the Saint John's Child and Family Development Center Youth Development Project:

1. If possible, the use of the Mattering to Others Questionnaire (Marshall, 1998, 2001) should be considered in replacement of the General Mattering Scale (Marcus, 1991) due to better psychometric properties with the population being served.
2. If possible, the use of the Youth Life Orientation Test (Ey et al, 2005) should be considered in replacement of the Life Orientation Test – Revised (Scheier, Carver, & Bridges (1994) due to better psychometric properties with the population being served.
3. If future research into the effectiveness of the CFDC-YDP treatment program is expected to occur, adoption of a standardized treatment duration and a standardized treatment protocol will aid in making more conclusive statements about specific treatment effects.

4. It is recommended that the program utilize standardized (e.g., evidence based) treatment modalities, especially if continued research is expected to occur. This should be feasible, as the Saint John's Child and Family Development Center has already established an infrastructure valuing empirically supported treatments and provided significant training for all of their staff in various evidence based treatment models. If possible, the targets of such treatment modalities should adhere to the outcomes linked to positive development of at-risk youth within the PYD model.

5. If possible, future research should consider following participants for 6 months to 1 year following intervention to gain an understanding of how sustainable gains made during treatment are.

6. It is recommended that the program obtain subjective feedback regarding program experiences from clients, families and collateral sources from referring agencies to find out, in a more qualitative manner, what youth think about the intervention and subjective changes participants have experienced. Obtaining this input directly from the at-risk youth served by the program provides a unique perspective and will contribute to their sense of being valued by demonstrating that their opinion matters and will be utilized to guide future program development. Additionally, exit interviews with therapists should be considered to obtain subjecting feedback about treatment strategies and experiences that can inform treatment decisions in the future. Additionally, subjective feedback from all involved parties can provide a clearer understanding of the value placed on various aspects of the program by all groups involved.

Conclusion

It is clear that issues pertaining to problem behaviors in at-risk youth are multi-determined and multifaceted. As programs targeting the population of at-risk youth have evolved, so has the body of literature discussing best practices with this population. The Saint John's Child and Family Development Center – Youth Development Project is one of a number of agencies seeking to engage at-risk youth in their own positive development. While it is the investigator's hope that this study contributes to the body of work on positive youth development, the most important aspect of this study is the ability to provide objective feedback to a community agency striving to improve the life trajectory of at-risk youth. Such evaluation is integral to the refinement and continued proliferation of such intervention programs – programs that many of our communities have significant need for.

The Saint John's Child and Family Center Youth Development Project is a culturally and linguistically sensitive community- and school-based program that was developed in response to a community need for earlier identification of at-risk youth and more culturally and linguistically sensitive services to impact at-risk behaviors in school-aged youth. Results of this program evaluation indicate that participation in the CFDC-YDP treatment program is associated with significant improvements in client's self-esteem and depressive symptoms. Although results indicated a statistically significant reduction in participant's scores on the General Mattering Scale, no proven validity of this measure with an early adolescent population brings these results into question. Results did not indicate a significant change in ethnic identity or life orientation.

The results of this study and the pertinent literature and recommendations obtained through the evaluation of the Saint John's Child and Family Development Center - Youth Development Project may provide important information regarding the future development and implementation of diversion programs for at-risk youth.

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APPENDIX A

Letter Granting Permission to Conduct the Evaluation

Please note: Original copy, on formal letterhead, has been mailed directly to Pepperdine University by Saint John's Child and Family Development Center.

November 10, 2010

Stephanie Woo, Ph.D.
Dissertation Chair
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive
Los Angeles, CA 90045

Dear Dr. Woo:

This letter formalizes an oral agreement previously given to Mike Sherman, Doctoral Candidate, Pepperdine University, Psy.D., regarding permission to use data collected as part of a study to evaluate the effectiveness of the Saint John's Child and Family Development Center (CFDC), Youth Development Project Program (YDP).

As the Director of the APA-Accredited Pre-Doctoral Psychology Internship Training Program and Chief Psychologist, I have granted Mr. Sherman permission to use the data to fulfill any and all requirements with respect to his doctoral dissertation, including submitting the results to professional conferences and for publication. When any oral or written presentation of this data is made, Mr. Sherman will acknowledge the support of the Saint John's CFDC, YDP, the City of Santa Monica and the youth who participated in the program during the evaluation.

Permission to use the data is contingent upon preserving the anonymity of all participants. No names or other information that could personally identify the CFDC YDP participants or their families will be made public. All data provided to Mr. Sherman will be de-identified to preserve participant confidentiality.

We look forward to working with Mr. Sherman and Pepperdine University on this project, which we are sure will be mutually beneficial.

Sincerely,

Olga Tuller, Ph.D.
Director of Psychology Training
Chief Psychologist
Saint John's CFDC
310-829-8708
Olga.tuller@stjohns.org

APPENDIX B

Pepperdine IRB Letter Granting Permission for Research

Please note: Original copy, on formal letterhead on file at Pepperdine University

February 14, 2011

Mike Sherman


Protocol #: P0211D06

Project Title: *Evaluation of the Youth Development Project: A School and Community Based Intervention Program for At-risk Youth*

Dear Mr. Sherman:

Thank you for submitting your application, *Evaluation of the Youth Development Project: A School and Community Based Intervention Program for At-risk Youth*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Stephanie Woo, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(4) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Category (4) of 45 CFR 46.101, research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to “policy material” at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Jean Kang
Manager, GPS IRB & Dissertation Support
Pepperdine University
Graduate School of Education & Psychology
6100 Center Dr. 5th Floor
Los Angeles, CA 90045
Jean.kang@pepperdine.edu
W: 310-568-5753
F: 310-568-5755

cc: Dr. Lee Kats, Associate Provost for Research & Assistant Dean of Research, Seaver College
Ms. Alexandra Roosa, Director Research and Sponsored Programs
Dr. Yuying Tsong, Interim Chair, Graduate and Professional Schools IRB
Ms. Jean Kang, Manager, Graduate and Professional Schools IRB
Dr. Stephanie Woo
Ms. Cheryl Saunders

APPENDIX C

Saint John's CFDC-YDP Screening Assessment Tool

Saint John's Child and Family Development Center Youth Development Project Assessment Tool

Date:

Students Name:		
Age:	Birth Date:	Gender:
School:	Grade:	School Counselor:
Ethnicity/Primary language spoken at home:		
Financial (MC, Free and Reduced Lunch Program):		
Mother's/Guardian Name:		Father's/Guardian Name:
Mother's/Guardian Home Phone:		Father's/Guardian Home Phone:
Mother's/Guardian Work Phone:		Father's/Guardian Work Phone:
Mother's/Guardian Cell Phone:		Father's/Guardian Cell Phone:
Student Lives With:		
Street Address:		
City:	Zip:	
Other Street Address:		
City:	Zip:	
Referred by:		

1. Individual Context

Risk Factors:

- ☐ Low Verbal Skills
- ☐ Favorable attitudes towards antisocial behavior
- ☐ Psychiatric Symptomatology
- ☐ Cognitive bias to attribute hostile intentions to others
- ☐ Externalizing/Internalizing Behaviors
- ☐ Externalizing/Internalizing Behaviors e.g., attire, language
- ☐ Other:

Protective Factors:

- ☐ Ethnic Culture
- ☐ Intelligence
- ☐ Being first born
- ☐ Easy temperament
- ☐ Conventional attitudes
- ☐ Problem solving skills
- ☐ Other:

Explain behaviors: What is being seen at home? How often? When did they begin? Are there any medical problems? What are the individual strengths?

2. Family Context:

Risk Factors:

- ☐ Newly Immigrated
- ☐ Lack of monitoring
- ☐ Ineffective discipline
- ☐ Low warmth
- ☐ High conflict
- ☐ Parental difficulties e.g., child abuse, drug abuse, psychiatric conditions, SES, homelessness
- ☐ Criminality
- ☐ Chronic Illness
- ☐ Other:

Protective Factors:

- ☐ Culture
- ☐ Attachment to parents
- ☐ Supportive family environment
- ☐ Marital harmony
- ☐ Organized Family Constellation
- ☐ Other:

Explain behaviors and family dynamics: What are the family stressors? What is the impact on family relations? What are family strengths?

3. Peer Context

Risk Factors:

- ☐ Association with deviant peers
- ☐ Poor relational skills
- ☐ Low association with prosocial peers
- ☐ Other:

Protective Factors:

- ☐ Culture
- ☐ Bonding with prosocial peers
- ☐ Other:

Explain peer relationships: What is their peer group? What is their relational style? What are their strengths?

4. School Context

Risk Factors:

- ☐ Low achievement e.g., LD, SED
- ☐ Dropout
- ☐ Low commitment to education
- ☐ Aspects of the school, such as weak structure and chaotic environment
- ☐ Other:

Protective Factors:

- ☐ Bonding with prosocial peers
- ☐ Positive relationship with teacher/counselor
- ☐ Motivation
- ☐ Culture
- ☐ Other:

Explain school behaviors: What are the attitudes towards school from both the parents and student? What are the teacher/counselors concerns? What are their strengths?

5. Neighborhood and Community Context

Risk Factors:

- ☐ High mobility
- ☐ Low community support neighbors, religion/spirituality
- ☐ High disorganization
- ☐ Criminal subculture
- ☐ Other:

Protective Factors:

- ☐ Ongoing involvement in religious/spiritual activities
- ☐ Strong indigenous support network
- ☐ Community Supports Individuals
- ☐ Culture:
- ☐ Other:

Explain their role in the community: What is their involvement in the community and awareness of resources? Where do they go after school? Can they identify positive role models outside the home and school context?

YDP TRIAGE

Recommendations to Triage:

- 1)
- 2)

Clinical Issues: _____

- ☐ **At-Risk**
- ☐ **High-Risk**

Date presented to YDP Triage Team: _____

Final Disposition and Action Plan:

- ☐ Group
 - ☐ Specific Topic/Issue: _____
- ☐ Individual
- ☐ Family
- ☐ Referred out
 - ☐ Referred to: _____
 - ☐ Referred to: _____
- ☐ Wait-listed for _____
- ☐ Referred to Clinic
- ☐ Other types of intervention: _____

Clinician Name/Signature

Coordinator Name/Signature

APPENDIX D

Saint John's CFDC-YDP Parent Consent Forms

Please note: The same form, with changes made to underlined items for specific schools/program, was used for all schools and programs involved with CFDC-YDP.

Tim Cuneo
Interim Superintendent of Schools

Eva Mayoral
Principal

SANTA MONICA-MALIBU UNIFIED SCHOOL DISTRICT

JOHN ADAMS MIDDLE SCHOOL

2425 SIXTEENTH STREET

Santa Monica, CA 90405

Phone: (310) 452-2326 FAX (310) 452-5353

Dear Parent/Guardians:

The counseling office of John Adams Middle School along with Saint John's Child and Family Development Center's Youth Development Project will be conducting a counseling group on campus. This group will focus on positive ways to handle relationships and school pressures. The group will take place during school hours and effort will be made to have students attend group at times that are least disruptive to academic learning.

Your child has been selected for a group which will be conducted by a social worker, psychologist, or intern. In order for your child to participate, your consent is required. Please sign below to indicate your consent and return this form to the counselor's office. In order to assure your child benefits from these services, the Saint John's counselors may be in communication with administrators, teachers and other professionals who provide services for your child on or off the school site. YDP staff may review and discuss student educational records with these same professionals in order to provide comprehensive services.

If you have any questions, please call the Saint John's Child and Family Development Center and ask for the YDP Coordinator at (310) 829-8921.

Parent/Guardian consent:

As parent or legal guardian of _____, I give my permission for him/her to participate in a counseling group at John Adams Middle School.

I understand that I may terminate my child's involvement in the group at any time. I also understand that confidentiality will be maintained by staff at John Adams Middle School and Saint John's Child and Family Development Center. I understand that students may be given questionnaires before and after participation in counseling as part of program evaluation. This will lead to increased knowledge of the effects school-based counseling has on student participants. Additionally, other measures of achievement such as grades, attendance, and behavior records may be used in analysis to help aid in program development and evaluation.

If you have a concern or grievance about the services you are receiving you may contact your child's treating therapist, the group counselors or the program coordinator at (310) 829-8921.

Parent/Guardian Printed Name

Relationship to Child

Signature of Parent/Guardian

Date

Home phone number

Work/Day time phone number

City

Zip Code

***My child has (please check one):**

☐ MediCal ☐ Healthy Families

☐ HMO/PPO ☐ No Insurance

***This information will remain confidential and is only for data collection purposes.**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

APPENDIX E

Saint John's CFDC-YDP Pre-Treatment Questionnaire

Name: _____

Date: _____

YDP QUESTIONNAIRE PACKET

We are really glad that you are participating in YDP this year. It is helpful for us to learn more about everyone who is participating at the beginning of the group by asking you to complete these questionnaires. We will then ask you to fill them out again at the end of the group, so we can better understand how teenagers change over the course of the school year.

The following questions ask about your experience of yourself, your friends, your family, your school, your feelings, and your attitudes. We will keep this information confidential. Please answer each question as honestly as you can. The "right" answer is the answer that is most true for you.

NAME: _____ AGE: _____ BIRTHDATE: _____

GRADE IN SCHOOL: _____ GENDER: male _____ female _____

PLEASE CIRCLE ONE:

I am:

- (1) Asian or Asian American, including Chinese, Japanese, and others
- (2) Black or African American
- (3) Hispanic or Latino, including Mexican American, Central American, and others
- (4) White, Caucasian, Anglo, European American; not Hispanic
- (5) American Indian/Native American
- (6) Mixed; Parents are from two different groups
- (7) Other (write in): _____

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now (Please be specific – for example, auto mechanic, high school teacher, homemaker, laborer, shoe salesman, army sergeant).

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

PRE**Name:** _____

These questions are about your culture and background and how you feel about it.

How much do you agree with each of these statements? Please check Only One.

	NO, Not True At All	Not Really	Yes	Absolutely Yes, Very True
1. I try to find out more about my culture, such as its history and customs.				
2. I am involved in organizations or social groups that include members from my culture.				
3. My culture has meaning to me (ex. being African American means something to me).				
4. I think a lot about how my life will be affected by my cultural identity.				
5. I am happy that I am a member of my culture.				
6. I have a strong sense of belonging to my culture.				
7. I understand what my culture means to me.				
8. In order to learn more about my culture, I have often talked to other people about my culture.				
9. I have a lot of pride in my culture.				
10. I participate in cultural practices of my own group, such as eating special food, listening to music from my culture, or other customs.				
11. I feel very close to others in my culture.				
12. I feel good about my culture.				

PRE

Name: _____

Below is a list of statements dealing with your general feelings about yourself.

Please check the one box that applies the most.

	NO, Not True At All	Not Really	Yes	Absolutely Yes, Very True
1. Overall, I am happy with who I am.				
2. Sometimes, I think I am not good at all.				
3. I have a number of good qualities.				
4. I am able to do things as well as other people.				
5. I do not have much to be proud of.				
6. I feel useless at times.				
7. I feel that I'm equal to others.				
8. I wish I could have more respect for myself.				
9. Overall, I feel that I am a failure.				
10. I feel good about myself.				

The following five questions ask how much you think you matter to others.

Please check the one box that applies the most.

	Not at all	A little	Somewhat	Very Much
1. How important do you feel you are to other people?				
2. How much do you feel other people pay attention to you?				
3. How much do you feel others would miss you if you went away?				
4. How interested are other people in what you have to say?				
5. How much do people depend on you?				

PRE

Name: _____

Below is a list of some of the ways you may have felt or behaved.

Please check how often you have felt this way during the past week.

None of the time = Less than one full day

Sometimes = 1-2 days

A lot of the time = 3-4 days

Most of the time = 5-7 days

	None of the time	Sometimes	A lot of the time	Most of the time
1. This week things bothered me that usually don't bother me.				
2. I did not feel like eating.				
3. I felt sad even when my family or friends tried to make me feel better.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt very sad.				
7. I felt that everything I did took a lot of energy.				
8. I felt good about the future.				
9. I thought my life had been a failure.				
10. I felt scared.				
11. I couldn't sleep.				
12. I was happy.				
13. I didn't talk much.				
14. I felt lonely.				
15. People were unfriendly to me.				
16. I enjoyed life.				
17. I cried a lot.				
18. I felt sad.				
19. I felt that people didn't like me.				
20. I didn't feel like doing anything.				

PRE

Name: _____

How often have you done these things in the past year?

	Never	Once in a while	Alot
1. Done something risky or dangerous on a dare.			
2. Broken a rule that your parents set for you just for the thrill of seeing if you could get away with it.			
3. Stolen or shoplifted.			
4. Left the house at night while your parent(s) thought you were asleep.			
5. Willingly rode in a car with someone that you knew was a dangerous driver.			

How much do you agree with each of these statements?

	No not true at all	Not really	Maybe	Yes	Absolutely yes, very true
1. I usually expect the best to happen.					
2. It's easy for me to relax.					
3. If something can go wrong for me, it will.					
4. I feel positive about my future.					
5. I enjoy my friends a lot.					
6. It's important for me to keep busy.					
7. I hardly ever expect things to go my way.					
8. I don't get upset too easily.					
9. I do not think that good things will happen to me.					
10. Overall, I expect more good things to happen to me than bad.					

THANK YOU! ☺

APPENDIX F

Saint John's CFDC-YDP Post-Treatment Questionnaire

Name: _____

Date: _____

YDP QUESTIONNAIRE PACKET

We are really glad that you are participating in YDP this year. It is helpful for us to learn more about everyone who is participating at the beginning of the group by asking you to complete these questionnaires. We will then ask you to fill them out again at the end of the group, so we can better understand how teenagers change over the course of the school year.

The following questions ask about your experience of yourself, your friends, your family, your school, your feelings, and your attitudes. We will keep this information confidential. Please answer each question as honestly as you can. The "right" answer is the answer that is most true for you.

NAME: _____ AGE: _____ BIRTHDATE: _____

GRADE IN SCHOOL: _____ GENDER: male _____ female _____

PLEASE CIRCLE ONE:

I am:

- (8) Asian or Asian American, including Chinese, Japanese, and others
- (9) Black or African American
- (10) Hispanic or Latino, including Mexican American, Central American, and others
- (11) White, Caucasian, Anglo, European American; not Hispanic
- (12) American Indian/Native American
- (13) Mixed; Parents are from two different groups
- (14) Other (write in): _____

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now (Please be specific – for example, auto mechanic, high school teacher, homemaker, laborer, shoe salesman, army sergeant).

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

POST**Name:** _____

These questions are about your culture and background and how you feel about it.

How much do you agree with each of these statements? Please check Only One.

	NO, Not True At All	Not Really	Yes	Absolutely Yes, Very True
1. I try to find out more about my culture, such as its history and customs.				
2. I am involved in organizations or social groups that include members from my culture.				
3. My culture has meaning to me (ex. being African American means something to me).				
4. I think a lot about how my life will be affected by my cultural identity.				
5. I am happy that I am a member of my culture.				
6. I have a strong sense of belonging to my culture.				
7. I understand what my culture means to me.				
8. In order to learn more about my culture, I have often talked to other people about my culture.				
9. I have a lot of pride in my culture.				
10. I participate in cultural practices of my own group, such as eating special food, listening to music from my culture, or other customs.				
11. I feel very close to others in my culture.				
12. I feel good about my culture.				

POST

Name: _____

Below is a list of statements dealing with your general feelings about yourself.

Please check the one box that applies the most.

	NO, Not True At All	Not Really	Yes	Absolutely Yes, Very True
1. Overall, I am happy with who I am.				
2. Sometimes, I think I am not good at all.				
3. I have a number of good qualities.				
4. I am able to do things as well as other people.				
5. I do not have much to be proud of.				
6. I feel useless at times.				
7. I feel that I'm equal to others.				
8. I wish I could have more respect for myself.				
9. Overall, I feel that I am a failure.				
10. I feel good about myself.				

The following five questions ask how much you think you matter to others.

Please check the one box that applies the most.

	Not at all	A little	Somewhat	Very Much
1. How important do you feel you are to other people?				
2. How much do you feel other people pay attention to you?				
3. How much do you feel others would miss you if you went away?				
4. How interested are other people in what you have to say?				
5. How much do people depend on you?				

POST

Name: _____

Below is a list of some of the ways you may have felt or behaved.

Please check how often you have felt this way during the past week.

None of the time = Less than one full day

Sometimes = 1-2 days

A lot of the time = 3-4 days

Most of the time = 5-7 days

	None of the time	Sometimes	A lot of the time	Most of the time
1. This week things bothered me that usually don't bother me.				
2. I did not feel like eating.				
3. I felt sad even when my family or friends tried to make me feel better.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt very sad.				
7. I felt that everything I did took a lot of energy.				
8. I felt good about the future.				
9. I thought my life had been a failure.				
10. I felt scared.				
11. I couldn't sleep.				
12. I was happy.				
13. I didn't talk much.				
14. I felt lonely.				
15. People were unfriendly to me.				
16. I enjoyed life.				
17. I cried a lot.				
18. I felt sad.				
19. I felt that people didn't like me.				
20. I didn't feel like doing anything.				

POST

Name: _____

How often have you done these things in the past year?

	Never	Once in a while	Alot
1. Done something risky or dangerous on a dare.			
2. Broken a rule that your parents set for you just for the thrill of seeing if you could get away with it.			
3. Stolen or shoplifted.			
4. Left the house at night while your parent(s) thought you were asleep.			
5. Willingly rode in a car with someone that you knew was a dangerous driver.			

How much do you agree with each of these statements?

	No not true at all	Not really	Maybe	Yes	Absolutely yes, very true
1. I usually expect the best to happen.					
2. It's easy for me to relax.					
3. If something can go wrong for me, it will.					
4. I feel positive about my future.					
5. I enjoy my friends a lot.					
6. It's important for me to keep busy.					
7. I hardly ever expect things to go my way.					
8. I don't get upset too easily.					
9. I do not think that good things will happen to me.					
10. Overall, I expect more good things to happen to me than bad.					

THANK YOU! ☺