

Jason C. Cone, THE EFFECTIVENESS OF A GROUP INTERVENTION TO IMPROVE COPING SKILLS FOR EMOTION REGULATION IN PREADOLESCENT AND ADOLESCENT MALES WITH ATTACHMENT DIFFICULTIES (Under the direction of Dr. Jeannie Golden) Department of Psychology, November 2008.

This study was designed to assess the effectiveness of a six session cognitive-behavioral group intervention to improve coping skills for emotional regulation in male preadolescents and adolescents with attachment difficulties. There is a lack of research in the area of group interventions with male adolescents as well as interventions for adolescents with attachment difficulties. A multiple probe across groups and a multiple baseline across groups design were used in this study. The measures assessed difficulties in emotion regulation, coping strategies, adolescent adjustment, anger control, negative behaviors, and level of distress. Although there were no substantial findings and no hypotheses were supported, the current study did find that the participants enjoyed the group interaction and some wished to continue the group.

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SKILLS FOR EMOTION REGULATION IN PREADOLESCENT AND
ADOLESCENT MALES WITH ATTACHMENT DIFFICULTIES

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Jason C. Cone
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by
Jason C. Cone

APPROVED BY:

DIRECTOR OF THESIS

Jeannie Golden, Ph.D.

COMMITTEE MEMBER

Cathy W. Hall, Ph.D.

COMMITTEE MEMBER

Marina Bornovalova, Ph.D.

COMMITTEE MEMBER

Christy Walcott, Ph.D.

CHAIR, DEPARTMENT OF PSYCHOLOGY

Kathleen A. Row, Ph.D.

DEAN OF THE GRADUATE SCHOOL

Paul Gemperline, Ph.D.

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CHAPTER I: INTRODUCTION

The period of adolescence is a time full of changes from physical transitions to psychological and cognitive changes. Adolescence can be an extremely stressful time because of all the different changes including school transition, pubertal changes, dating, and peer group affiliation (Hetherington, Parke, Gauvain, & Locke, 2006). This is when the physical transition to adulthood begins through puberty which brings on physical growth, hormonal changes, and maturation of sexual characteristics. Puberty is a time of stress for adolescents as they take on new roles and new responsibilities. During puberty the increasing concentration of hormones, in both male and female adolescents, stimulates the development of the primary and secondary sex characteristics (Hetherington et al., 2006). The timing of pubertal onset has been receiving increasing attention in research, which has produced many inconsistent results. However, it has been repeatedly documented in research findings that early maturing male and female adolescents report more substance use such as cigarettes, drugs, and alcohol, than their average or late-maturing peers (Tschann et al., 1994; van Jaarsveld, Fidler, Simon, & Wardle, 2007; Harrell, Bangdiwala, Deng, Webb, & Bradley, 1998; Patton et al., 2004). Studies have also repeatedly shown that low self-esteem in late-maturing boys predicts depression in late adolescence (Brooks-Gunn & Warren, 1989; Harter & Whitesell, 1996; Petersen, 1988; Ge, Conger, & Elder, 2001). In general, research has found that early-maturing boys have a more positive body image than do late-maturing boys (Tobin-Richards, Boxer, & Peterson, 1984). It has also been observed that this time of pubertal maturation has an influence on the parent-child relationship such that there is an

increased emotional distance between the parents and their adolescents (Steinberg, 1987; 1988). Many studies have shown that puberty is related to a rise in parent-child conflict and both the adolescent and the parent report feeling less close to the other (Laursen, Coy, & Collins, 1998; Steinberg & Morris, 2001).

Peer relations can have major impacts on adolescent adjustment. Early behavior problems appear to set the stage for later peer rejection and low magnitude of friends. This in turn may cause internalizing difficulties including loneliness and depressed mood (Pederson, Vitaro, & Barker, 2007). Pederson et al. (2007) also found that early peer rejection prohibits the development of close relationships during this critical period of friendship development. Peer victimization is a concern in adolescence as well since victims tend to feel more depressed and anxious and have a lower self-esteem than those peers that are not victimized (Juvonen & Graham, 2001). Adolescence is a time when there is an increase in peer pressure and the need for peer group affiliation. It is a time period when reliance on the parents begins to decline. Brown, Mounts, Lamborn, and Steinberg (1993) suggests that parents foster certain traits in their children which essentially direct the child toward a specific peer group, meaning that parents have more influence than they may think on their child's peer group affiliation.

Attachment

John Bowlby's ethological theory (Ainsworth & Bowlby, 1991) is one of the most widely known theories of attachment. Previous theories, such as the theory of Secondary Drive by Sigmund Freud (1926) (as cited in Bowlby, 1969), were based on the premise that attachment was created by the mother satisfying the baby's primary need for food.

Bowlby's theory, however, states that it is not the primary need for food, but the proximity to, and close bodily contact with the mother figure that facilitated attachment (Ainsworth & Bowlby, 1991). Ainsworth, with her research in Uganda, found that attachment had clearly been developed when there were indications of distress when separating from the mother and some form of greeting upon her return (Ainsworth & Bowlby, 1991). Later in her research, Ainsworth developed a stranger research paradigm that observed infants encountering three different stressors: brief separation from the mother, a strange room, and the presence of a stranger (Ainsworth & Bell, 1970). This has helped in the classification of attachment from secure to insecure attachment and corresponding subtypes of ambivalent/resistant, disorganized, and avoidant. When infants are classified as the insecure ambivalent/resistant type they become distressed when the mother leaves, are not calmed, and may become angry when she returns. When classified as insecure disorganized type, infants play in the corner without toys and may also show levels of psychopathology. The insecure avoidant type infants are inconsistent in their responsiveness and reactivity. Research has shown that secure attachment results in high self-esteem for children as well as healthy family and peer relationships (Bowlby, 1988).

Clinical evidence suggests that children with disorganized type have histories of abuse and neglect and that a high percentage of foster care children demonstrate some form of insecure attachment (Williams, Fanolis, & Schames, 2001). O'Connor and Zeanah (2003) found that teens with attachment problems, upon reaching adolescence, begin to experience various social problems like trouble forming friendships and peer

rejection. These adolescents may not understand social situations or how they are supposed to act and may have trouble explaining and regulating their behavior.

Baumrind (1966) defines three types of parenting styles as permissive, authoritarian, and authoritative. The goal of the permissive style parent is to behave in a non-punitive, acceptant, and affirmative manner toward the child. The parent makes few demands and allows the child to regulate their own activities. The authoritarian parent, on the other hand, favors punitive, forceful measures and attempts to shape and control the behavior of the child. There is a low level of warmth with this style. This parent expects the child to accept whatever they say without question. The authoritative parent is warm, responsive, and involved but does not intrude. This parent sets reasonable limits for their child and expects appropriate mature behavior. There is a balance between control and recognizing the child as an individual (Baumrind, 1966).

Neal and Frick-Horbury (2001) have suggested that Baumrind's (1966) parenting styles correlated with attachment styles. They found a consistency between authoritative parenting and secure attachment style, authoritarian parenting and insecure-avoidant attachment style, and permissive parenting and insecure-ambivalent attachment style. It would appear that parenting style is a strong predictor of attachment security.

Emotion Regulation

A child's attachment style also has implications for his emotional development and his ability to regulate those emotions. Emotional regulation refers to an individual's efforts to modulate, manage, inhibit, and enhance emotions (Kopp, 1982). This is the ability to use such strategies as self-comforting, help seeking, and distraction to assist the

child in managing frustration and fear responses. Without the ability to recognize simple emotions like fear, anger, and happiness there is great difficulty in the development of emotion regulation and the ability to cope with emotions and situations. There is research that emotional regulation also affects behavioral control later in life. Studies have indicated that adolescents experience more intense and frequent emotions than younger or older individuals (Larson, Csikszentmihalyi, & Graef, 1980; Larson & Lampman-Petratis, 1989). Also, many of the cognitive, hormonal, and neural systems that are thought to be the cause of the development of emotion regulation appear to mature during the adolescent period (Spear, 2000).

In adolescents, regulatory capacities become increasingly sophisticated and predict children's competence in a number of important domains, including behavioral regulation and social competence (Lewis & Haviland, 1993). Silk, Steinberg, and Morris (2003) examined adolescents' emotion regulation and its link to depressive symptoms and problem behavior. They found that adolescents with a greater intensity of sadness and anger also report significantly more depressive symptoms and problem behavior. They also found that adolescents with a greater emotional lability reported significantly more depressive symptomatology and problem behavior than those who did not display emotional lability. Silk et al. (2003) therefore concluded that adolescents with a lower ability to regulate emotions are at a much higher risk for depressive symptoms as well as problem behavior. Studies have found that children and adolescents with poor emotion regulation skills are more likely to have externalizing problems like hyperactivity, fighting behavior, and defiance as well as poor interpersonal skills (Dunn & Brown,

1994; Rydell, Berlin, & Bohlin, 2003). It is therefore reasonable to assume that emotion regulation skills have a major influence in many developmental aspects and are vital in determining the degree of adolescent adjustment.

Mikulincer and Shaver (2004) described three stages in which attachment security promotes affect regulation. When there is a stressor or an unmet need, the first stage of the appraisal system triggers the attachment system to search for the attachment figure. Stage two occurs when the presence of the primary attachment figure calms the infant, which allows for better coping with the stressor or unmet need. The third stage happens only when the infant has been able to manage the stress. If stress management occurs, the other system of exploration and affiliation can be activated. Adolescents who are insecurely attached have many problems with stress tolerance, anger control, and drug abuse (Caspers, Cadoret, & Langbehn, 2005). This is a weakness that has developed in their affect regulation as well as problem solving ability.

Coping

Coping is a vital aspect of emotion regulation. The most widely accepted definition of coping is from Lazarus and Folkman (1984) which states coping is “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.” (p.141). They then classified two different coping strategies: problem-focused coping and emotion-focused coping. Problem-focused coping is simply trying to improve the troubled person’s environment or relationship by changing events and circumstances. Emotion-focused coping refers to the thoughts or actions used to relieve the emotional

impact of the stress (Lazarus & Folkman, 1984). Longitudinal research has shown that it is much more effective to reduce stress in most situations if a combination of problem-focused and emotion-focused techniques are used (Zakowski, Hall, & Cousino Klein, 2001). Ineffective coping, however, is usually largely emotion-focused and is either for the goal of escaping or simply due to impulsivity (Lazarus, 1991). It is important to form adaptive coping responses so that the stress does not become exacerbated and contribute to negative outcomes.

Matheny, Aycock, and McCarthy (1993) reviewed the literature on the effects of stress on school-aged children and youth. They found that inadequate responses to stress can cause, or contribute to, many psychosocial problems including poor academic performance, anxiety, depression, eating disorders, suicide, conduct problems, and violence. Compas, Orosan, and Grant (1993) suggested that men commonly use a “prototypic” response of an avoidant form of coping, called emotional distraction, which may explain why men have a higher prevalence of aggressive disorders and substance abuse. Adolescence is a time when the use of both functional and dysfunctional coping styles significantly increases (Seiffge-Krenke, 2000). The ability to cope with different types of stressors is greatly needed during the developmental period of adolescence. Social support is seen by many as the cornerstone of the coping process (Frydenberg & Lewis, 2004) and as a result group therapy could be extremely beneficial to adolescents.

Adoption and Foster Care

Adopted children and adolescents are at a greater risk of experiencing many different problems, including attachment difficulties and poor coping skills. Fullerton,

Goodrich, and Berman (1986) found that adopted children often exhibit poor impulse control, running away, anti-social behavior, sexual acting out, rejection of discipline, difficulty with adult authorities, and rejection of parental figures. They also found that an earlier age of adoption allowed for a better adjustment in many cases. Some adopted children go through months or even years of severe abuse and neglect. They may also have multiple placements and caregivers through this time period which in turn impedes their abilities to form attachments with the adoptive families (Hughes, 1999). Hughes describes these children as extremely friendly but being totally unaware of what constitutes a parent-child relationship or that the parent may be acting upon the child's best interests. Children with significant attachment problems can appear as a typically behaving child, but, instead of developing that parent-child bond, they often try to manipulate and intimidate adults. Often these children have survived abuse and neglect by becoming overly self-reliant. "Entering into a reciprocal parent-child relationship would require them to give up the control and self-reliance that have enabled them to survive years of neglect and emotional isolation" (Hughes, 1999, p. 544).

Group Therapy

Researchers agree that group therapy is beneficial to adolescents, especially those with social skills deficits or low self-esteem (Mishna, Kaiman, & Little, 1994), and is even more effective than individual therapy (Tillitski, 1990). These are common problems faced by children who have been adopted or who are in foster care. Other authors have listed many reasons why group therapy should be the treatment of choice for adolescents including: adolescents will more readily accept comments from their peers

than from adults, groups allow people to listen without demanding immediate active participation, and peer relationships are essential to adolescent development and the process of separation-individuation (Chaffin, Bonner, Worley, & Lawson, 1996). Mishna et al. (1994) also suggested that group therapy helps adolescents because it provides them with peers through whom they can evaluate their ideas about themselves, opportunities to help one another, and social interaction to support their self esteem and reduce the feeling of being alone.

Another important aspect of group therapy is the group composition. Mishna and Muskat (1998) found that it was much more beneficial to have a homogenous group composition than to have different diagnoses in the same group. This allows the group to better relate to one another and to share common issues. Even though the benefits of group therapy with adolescents are evident it is difficult to find research about the effectiveness of male adolescent groups. Ogrodniczuk, Piper, and Joyce (2004) found that women generally have better outcomes in group therapy settings than do men and that the men were usually less committed and had a perception of incompatibility. However, this research has not extended to adolescents.

Glodich and Allen (1998) suggested that when working with traumatized adolescents, group therapy provides a safe, focused place to learn new coping strategies for dealing with stressful and overwhelming situations. Since many adopted children experience trauma on multiple levels, group therapy should be the therapy of choice for this sample of people as well, especially in adolescence. Williams, Fanolis, and Schames (2001) proposed that foster children who have experienced trauma may act out,

withdraw, or have difficulty concentrating. Each of these symptoms is addressed in any form of group therapy.

When writing about adolescents in therapy, Wexler (1991) proposes that the most important goal of therapy when working with adolescents is to help them to understand their feelings and use them as a form of self-signaling instead of a trigger for an impulsive action. Cantor (2000) also discussed the importance of emotional experience in group therapy and believes that therapy can become much more powerful if the adolescents observe the therapist handling an emotion in an interpersonal, or in vivo, situation rather than just talking or lecturing on how to handle certain situations.

Using a token economy system is a popular behavioral technique that is used frequently with children and adolescents. A token economy system is “an exchange system that provides individuals whose behavior is being changed with near-immediate feedback cues on the appropriateness of their behavior” (Bauer & Shea, 1999, p. 225). The token system approach has been well documented with children and has even been used with adults. Franco, Galanter, and Castañeda, (1995) implemented a token economy with an intensive dual-diagnosis treatment ward. The idea was to assist in the process of fostering active and voluntary patient participation. Once implemented, they found that it significantly decreased the amount of violence on the ward.

Stedman, Peterson, and Cardarelle (1971) implemented a token system with a group of pre-adolescent males. The group consisted of a mixture of overtly aggressive and withdrawn types. The researchers set up the system by using a schedule sheet that listed the ways the pre-adolescent males could receive tokens (i.e. coming to group,

listening to others, raise hand). They found that the token system significantly reduced the inappropriate behavior of the subjects. Although hardly ever used by itself, the token economy system is beneficial when paired with other therapeutic styles.

There is very little research currently available on group interventions to teach coping skills for emotional regulation for preadolescents or adolescents with attachment difficulties. The participants in this study were preadolescents and adolescents who have a history of trauma and/or attachment difficulties. One of their main difficulties is the ability to regulate emotions, especially in the area of distress tolerance. In adolescence, group therapy tends to turn a great deal of attention toward violent behavior (Miller, 1995). Although there is not research specific to this study, there is an abundance of evidence that group therapy is efficacious for both preadolescents and adolescents in that it provides a safe and structured environment for them to try new behaviors.

Research can be found on emotion regulation in a group therapy setting for other samples like eating disorders, borderline personality disorders, bipolar disorders, suicidal ideation, and even metastatic breast cancer patients while there is also a growing body of research on the positive aspects of group therapy for adolescents with anxiety, depression, and other psychological problems (Edelman & Remond, 2005), but research on benefits of group therapy with preadolescents and adolescents with attachment difficulties is lacking.

An important component of treating children and adolescents with attachment problems is providing support and training for the parents (O'Connor & Zeanah, 2003). Having a child or adolescent with attachment difficulties, who in turn has trouble with

regulating emotions and coping with stress, can cause discouragement for the parents. A support group can provide a setting for release and help the parents realize that they are not alone in their parenting endeavors. The group can be beneficial to the parent-child relationship.

The purpose of the current study is to determine the effectiveness of a six session cognitive-behavioral group intervention and a support group for their parents in improving coping skills for emotional regulation in male preadolescents and adolescents with attachment difficulties.

Hypotheses

1) Self-ratings of distress intolerance, measured using the BASC-2 and the RASSI, will decrease as a function of participating in a group intervention to improve coping skills for emotional regulation in preadolescent and adolescent males with attachment difficulties.

2) Self ratings of coping skills, measured using the CISS, will transition from avoidance of stressors to a combination of problem and emotion focused strategies as a function of participating in a group intervention to improve coping skills for emotional regulation in male preadolescents and adolescents with attachment difficulties.

3) Parent observations of problem behaviors directly observed by the parents, measured using the behavior monitoring sheets, will decrease as a function of participating in a group intervention to improve coping skills for emotional regulation in male preadolescents and adolescents with attachment difficulties.

4) Self-ratings of emotion regulation, measured using the DERS, will improve as a function of participation in a group intervention focusing on emotion regulation and coping skills for emotional regulation in male preadolescents and adolescents with attachment difficulties.

Chapter II: METHOD

Participants

The participants consisted of nine male preadolescents and adolescents ages 12 to 17, who have a history of trauma and/or attachment difficulties as well as difficulty regulating emotions and coping skills. All of the participants have been receiving family therapy from a licensed social worker who specializes in attachment disorders. All of the participants have been diagnosed as having attachment difficulties which cause them to have difficulty with coping skills and the ability to regulate their emotions. Participant F10 is the only participant that has been diagnosed with Reactive Attachment Disorder.

TABLE 1: PARTICIPANT INFORMATION

Participant #	Age	Living Situation	Participant #	Age	Living Situation
T2	13	Adopted	T10	13	Group Home
T3	16	Adopted	F7	12	Adopted
T4	17	Adopted	F8	12	Foster Care
T6	14	Adopted	F10	15	Group Home
T7	13	Adopted			

All of the participants were asked by their therapist to participate in a voluntary research study. There was no formal screening for participants other than the social worker having previously identified those with attachment difficulties. One participant did not return after the pretest but everyone that started the intervention, completed the program.

Setting

The study took place in a private practice office of a licensed social worker in eastern North Carolina. This office is familiar to all participants and has a room that was

specifically used for the boys group. The group was led by a Licensed Psychological Associate and a Masters student in Clinical Psychology.

Instruments

Reynolds Adolescent Adjustment Screening Inventory, (RAASI). The RAASI was developed by William Reynolds in 1998 and is a 32-item self-report measure. The RAASI uses a three response frequency scale (never or almost never, sometimes, nearly all the time) to rate thoughts, feelings, attitudes, and behaviors over the past six months. The total adjustment score is derived from four separate subscales: Antisocial Behavior (AB), Anger Control Problems (AC), Emotional Distress (ED), and Positive Self (PS). All of the items in the report are written at a third-grade reading level. Administration of the RAASI should take between 5-10 minutes.

The RAASI was standardized on a sample of 1,827 adolescents that matched the 1990 U.S. Census proportions. The total adjustment score has a high internal consistency and has a coefficient alpha of .91. The subscale alpha scores range from .81 to .88. Test-retest procedures executed showed internal consistency of .89. Concurrent validity was revealed by reporting significant correlations between the RAASI items and the total scores, the Adolescent Psychopathology Scale, and the MMPI-A.

Coping Inventory for Stressful Situations, Second Edition, (CISS). The CISS is a 48-item self-report measure designed by Norman Endler and James Parker. This measure contains 45 items that are broken down into the categories of task-oriented coping, emotion-oriented coping and avoidance-oriented coping with subscales of distraction and

social diversion. For each item on the measure the examinee responds using a 5-point frequency scale from 1 (Not at all) to 5 (Very much).

Cronbach's alpha is given in the manual and is as follows: Task = .90, Emotion = .86, Avoidance = .82, with subscales Distraction = .75 and Social Diversion = .79. The manual also provides test-retest reliability which is as follows: Task = .73 (men), .72 (women); Emotion = .68 (men), .71 (women); Avoidance = .55 (men), .60 (women); with subscales Distraction = .51 (men), .59 (women); and Social Diversion = .54 (men), .60 (women).

Behavior Assessment System for Children, Second Edition, (BASC-2). The BASC-2 is used to measure observable behavior and self perception of individuals ranging in age from 2 to 25 years old. There are five components of the BASC-2: a Teacher Rating Scale, a Parent Rating Scale, a student Self-Report of Personality, a Structured Developmental History, and a Student Observation System. For the purposes of the current study only the Self-Report—Adolescent level rating form (SRP-A), for ages 12-21 was used. From this form, the items from the Anger Control content scales were used because it corresponds with similar items on the Parent Rating Scale which was taken by the parents of the male preadolescents and adolescents in the current study. The SRP-A composite scores yield most alpha coefficients in the mid to high .80s and test-retest reliabilities in the upper .70s to low .80s. Validity for the SRP was shown by correlating it to the ASEBA Youth Self-Report, the Conners-Wells' Adolescent Self-Report Scale, and the Children's Depression Inventory.

Difficulties in Emotion Regulation, (DERS). The DERS was developed by Kim Gratz and Lizabeth Roemer in 2004 to assess multiple dimensions of emotion regulation. It is a 36-item, self-report measure that looks at awareness and understanding of emotions; acceptance of emotions; the ability to engage in goal-directed behavior and refrain from impulsive behavior, when experiencing negative emotions; and access to emotion regulation strategies perceived as effective (Gratz, & Roemer, 2004). For each item on the measure the examinee responds using a 5-point scale from 1 (almost never) to 5 (almost always). There is no available psychometric data for the DERS.

The DERS has high internal consistency, with a Cronbach's alpha of .93. All six subscales report Cronbach's alphas higher than .80. Evidence of construct validity was provided by correlating the DERS with the Negative Mood Regulation Scale, another measure of emotion regulation (Gratz & Roemer, 2004).

Subjective Units of Distress, (SUDS). The SUDS was developed by Joseph Wolpe in 1969 to measure an individual's level of anxiety or emotional experience. The common rating scale for this measure is from 1 to 100 but for our research purposes we used 1 (mild) to 10 (extremely) to make it easier for the adolescents and preadolescents to rate. In order to get a SUDS rating, the subjects must accurately and vividly recall and imagine a distressing event from the past week. The participant then gives a rating of the amount of distress. The SUDS has face validity, is easy to understand, and is brief to administer. There is no available psychometric data for the SUDS.

Behavioral Monitoring Sheet, (BMS). The BMS was developed for the social work therapist who is treating the adolescents involved in this study and is a form that the

parents of the preadolescents and adolescents fill out weekly in order to measure the behavior changes that the parents perceive. The sheet contains common behaviors that children and adolescents with attachment problems experience, many of which were derived using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (1994) and the criteria that are used to diagnose Reactive Attachment Disorder. Since this measure was developed specifically for this research project, there is no reliability or validity to report. The form is broken into four categories: verbal behavior (talking back/challenging words, sarcasm, and cursing/inappropriate language), physical behavior (hitting/kicking/pushing, banging objects/slamming doors, throwing objects, breaking objects, and fire starting), covert behavior (lying, manipulating, borrowing items, stealing), and noncompliance (eye rolling/challenging look, refusing to comply, defiance, fail to complete homework/classwork, fail to do chores, fail to practice instrument/sport, and refusing to respond). This form was completed by the parents on a daily basis to assess the frequency of these behaviors.

Procedure

Before any measures were administered, the parents and adolescents were given consent and assent forms, respectively, that explained the study. It was strictly up to the parents/guardians and adolescents to decide if they wished to participate. Decisions to participate or not to participate in no way impacted services any family received from the private practice. The written measures were administered by trained graduate and undergraduate students. The RAASI, CISS, DERS and BASC were filled out by the adolescents on the testing dates (see Appendix A). The licensed therapist chose to collect

the behavioral measures as part of her therapy and requested that the parents begin filling out the behavioral monitoring sheet a month before the intervention began. The data was collected by the parents at home without the children's knowledge. The SUDS ratings were also completed by the male preadolescents and adolescents, with three scores being recorded per participant throughout each session. There were a few instances when participants could not make it for a particular session. When this happened they were asked to come earlier the following week to do an individual make-up session.

Research Design and Intervention

There were two research designs in the study, a multiple-probe across groups and a multiple-baseline across groups design. The written measures were used to probe the changes in the preadolescents and adolescents self-reporting of their own behavior from before the intervention, halfway through the intervention, and at the end of the intervention. These measures were not assessing behaviors but were assessing skill and ability. The multiple-probe across groups design was used for measures without continuous data collection. The multiple-probe technique is recommended when the person cannot perform the behavior and limited exposure to unsuccessful trials is necessary (Alberto & Troutman, 1999). It would be difficult to show weekly change in the measures used in the multiple-probe design and therefore would not be conducive for use with the multiple-baseline design, which requires continuous data collection.

The multiple-baseline across groups design was used with the BMS, which was filled out by the parents throughout the week between sessions and the SUDS to assess and monitor how the adolescents view their ability to tolerate distress as they participated

in the sessions. A multiple-baseline across groups design is advantageous when looking at the same behaviors of more than one participant at a time (Alberto & Troutman, 1999). Since a behavioral research design was used, the hypotheses would be supported if the changes on each participants testing corresponded with the specific hypothesis consistently after the intervention was implemented.

Attached in Appendix A is a schedule, with dates, of when all pre-, mid-, and post-testing and probes occurred, along with each intervention session. There were two groups of adolescent boys and the groups were run by one Master's student, Jason Cone, and a Licensed Psychological Associate, Adam Spencer. Each group of males participated in six group therapy sessions that each lasted 90 minutes. One group started their intervention first on July 24th and the second group started after the first group had received three intervention sessions on August 15th.

The intervention was developed using a manual entitled *Skills for Improving Distress Intolerance* that was written by Bornovalova, Trotman, Daughters, Gratz, and Lejuez (2006) for an inpatient addictions treatment program. The manual was originally created for adults with addiction problems and therefore some of the language and examples had to be modified for adolescents. Also, the manual was developed for individual therapy and adjustments have been made to accommodate for group therapy. The parents were informed each week about what their adolescents would be discussing and the homework assignments that they would be given. The main purpose of this was so that the parents could assist their adolescents in practicing what they had learned in the session throughout the week.

Starting with the first session there was a practice worksheet (homework) given at the end of each session which was explained by the therapists. At the beginning of the next session, the practice worksheet was reviewed and discussed by the group. After the worksheet was reviewed, the new topic of the day was introduced. Starting with session 2, four SUDS ratings were taken each session: one in the beginning that served as a baseline, one after going over the homework while each participant was attempting to re-experience a distressful moment from the past week, one after the lesson of that session had been discussed, and one at the very end of the session after performing progressive muscle relaxation. Progressive muscle relaxation was performed at the end of each session and was done according to a script that was a part of the manual.

Session 1 began with a welcome, orientation, and a brief summary of what the adolescents would be doing over the next five weeks as well as an overview of the token economy system. Group rules and confidentiality were also explained at the beginning of the session. The main topic of this session was identifying upsetting emotions. The upsetting emotions model was explained, which involved identifying triggers, unpleasant/upsetting feelings, behaviors, and consequences. The final part of the session involved explaining the practice worksheet and how to apply the upsetting emotions model throughout the week.

Session 2 began with a brief review and a look at the practice worksheet from the previous session. The theme of this session involved controlling emotions and using willingness and acceptance to experience emotions when they cannot be controlled. Session 3 involved discussing the differences between distraction and avoidance as well

as finding healthy ways to use distraction to take one's mind off of upsetting emotions for a brief period of time. Session 4 dealt with assertiveness skills and accomplishing goals effectively. In this session the adolescents learned the "DEAR MAN" acronym that helped them remember the assertiveness skills for use later.

Session 5 began with reviewing the skills that were taught in the previous sessions and trying to put them together in realistic situations from examples that were given by the group. The final session consisted of reviewing again the skills previously taught and practicing the idea of "layering." All of the worksheets were reviewed so that the participants could look back at the situations they went through so that they could use one or more of the skills that they had been taught. At the end of the session there was time set aside to discuss future situations that the adolescents might encounter in the future.

Throughout each session, a token economy system of reinforcement was utilized. The participants earned tokens for completing worksheets, sharing in the group, and following group rules. If they met the criterion number of tokens by the end of the session they then picked a small reward such as candy or other treats. At the end of the final session, the tokens were added up and if they had enough tokens then they were allowed to choose a larger reward such as a restaurant gift card. This system was explained to the parent support group to make sure that each parent approved. On a number of occasions a participants were absent from sessions, these participants attended individual make-up sessions.

Chapter III: RESULTS

The sample for this study consisted of nine preadolescent and adolescent males, six in the first group and three in the second group. The participants in the first group have a “T” before their participant number because the intervention took place on Thursday nights and the participants in the second group have an “F” before their participant number because the intervention took place on Friday nights.

Results of the RAASI

For the results of each participant on the RAASI, refer to Figure 1. A decrease in any of the five subscales (Antisocial Behavior, Anger Control, Emotional Distress, Positive Self, and overall Adjustment) indicates better adjustment in that specific domain and would support the first hypothesis of this study. Overall, no consistent patterns could be determined because of the lack of baseline data and missing data. Participant T2 initially scored in the severe disturbance range and scored in the average range on the Emotional Distress scale as well as the Adjustment Total scale during the post test. Participant T2 gradually dropped on all scales from the pre-test to the post-test. Seven of the participants’ highest scores on the pretest were on the Emotional Distress scale. The other two participants’ highest scores on the pretest were on the Anger Control scale. Although most of the subscales varied widely between individuals, the Adjustment Total scale decreased in seven of the nine participants.

Participant T7 initially scored in the mild disturbance range, then the severe range, and then fell in the average range on the Anger Control Problems scale. On the

Emotional Distress scale participant T7 scored in the severe range on the pre-test and scored in the average range on the post-test. He also scored in the mild disturbance range during the pre-test and in the average range on the post-test on the Antisocial Behavior scale. Participant F7 initially scored in the mild disturbance range on the Anger Control Problems scale and scored in the average range on the post-test.

Participant F8 initially scored in the severe disturbance range on the Emotional Distress scale but scored in the moderate disturbance range on the post-test. On the Antisocial Behavior scale participant F8 scored in the moderate range on the pre-test and in the average range on the post-test.

Participant F10's scores varied greatly between the pre-test, mid-test, and post-test. His Emotional Distress scale score went from severe disturbance to mild disturbance to moderate disturbance. The Antisocial Behavior scale score went from severe disturbance to average range to mild disturbance range. Participant F10's scores on the Anger Control Problems scale went from average range to mild disturbance range. His Positive Self scale score went from mild disturbance range to moderate disturbance range to severe disturbance range. Overall, seven of the participants' scores on *Adjustment Total* decreased from the pre-test to the post-test.

Results of the CISS

The CISS measures a person's preferred style of coping in stressful situations and an increase on any of the five subscales (Task, Emotion, Avoidance, Distraction or Social Diversion) indicated an increase in the degree of coping for that specific dimension. For

this study, an improvement in coping would be indicated by an increase in Task- and Emotion-Oriented coping and a decrease in Avoidance-Oriented coping in order to support the second hypothesis. Any score above 50 is considered to be above average for that specific dimension. For the results of each participant on the CISS, refer to Figure 2.

Overall, there were no consistent patterns across participants on this measure. Six of the participants' scores on the *Avoidance* scale as well as the *Task-Oriented* scale increased from pre-test to post-test. All nine of the participants' scores had at least a slight decrease on the *Emotion-Focused* scale. Participant T2 increased in all coping strategies except emotion-focused coping. This participant's task-oriented scale score was very much above average and therefore is his predominant coping strategy. Participant F7 initially scored highest on the emotion-focused scale and on the post-test scored highest on the avoidance scale. Participant F8 initially scored highest on the emotion-focused scale and on the post-test scored highest on the task-oriented scale.

Results of the BASC-2

For the results of each participant on the Anger Control subscale of the BASC-2, refer to Figure 3. A decrease in score suggests an improved response to hardship. This would support the first hypothesis of this study. This scale measures the level of self-control when faced with adversity. Scores between 60 and 69 are in the at-risk classification range and 70 and above falls in the clinically significant range. No consistent results were found across all participants, two participants' scores decreased, three participants' scores increased, and four participants' scores stayed the same from

the pre-test to the post-test. Participant T2 did consistently decrease on this scale; however, each time he was tested his score fell within the average range. Participant T3 initially scored in the at risk range and on the post-test scored in the average range. Participants T7 and F10 initially scored in the average range and scored in the at risk range on the post-test. F7 and F8 both consistently scored in the at risk range.

Results of the DERS

For the results of each participant on the DERS, refer to Figure 4. The DERS measures emotion regulation and the higher the score the greater the difficulty in emotion regulation. There are no norms for this measure with the adolescent population so for the purpose of this study the goal was a decrease in the overall score. Although there are no ranges in this measure, it has been reported that an individual suffering from PTSD typically obtains a score around 105, while an average college student typically obtains a score of 75-80. Overall, there were no consistent patterns across participants on this measure. Five participants' (T2, T4, T7, T10, and F8) scores decreased by the end of the intervention. This trend began with the onset of the intervention.

Results of the BMS

The purpose of the BMS was for the parents to record data on a number of specific behaviors. For this measure a decrease in the frequency of any of the four behavior categories (verbal, physical, noncompliant, and covert) would indicate an improvement in that area and would provide support for the third hypothesis of this study. For the results of each participant on the BMS, refer to Figure 5. There were only

two participants who had complete data on this measure. Two participants (T6 and T7) only had one weekly data sheet and therefore the data could not be used. Although there is a lot of missing data on this measure for many of the participants, participants' T2, T3, and F10's data showed a decrease in problem behaviors.

Noncompliance was consistently the highest or equal to the highest category on the measure for participants T2, T4, T10, F8, and F10. Physical behavior was the lowest frequency across all participants with data.

Results of the SUDS

For the results of each participant on the SUDS, refer to Figure 6. For the weekly SUDS ratings it was expected that the highest rating of distress would be the post-mood induction and after the progressive muscle relaxation the rating would back down to the baseline rating or lower. It was also expected that the post-mood induction would gradually decrease over the course of the intervention as the participants began utilizing the coping skills that were taught. All participants' post-mood induction scores across all sessions were greater or equal to their ratings after the progressive muscle relaxation. Participants F7 and F8 were the only two who's post-mood induction ratings gradually decreased over the course of the intervention.

Evaluation Form

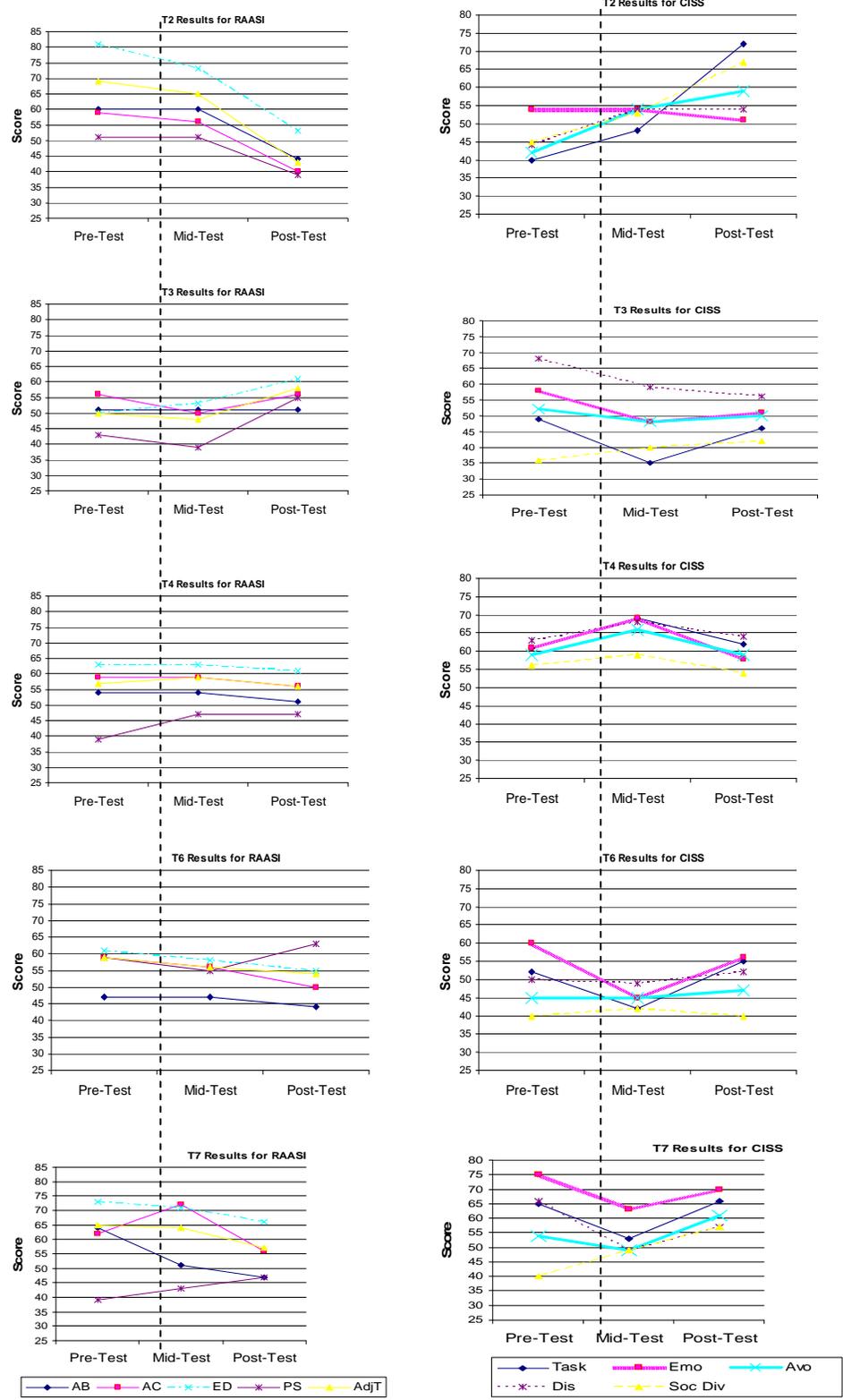
Each participant was given an evaluation form immediately following the post-test. Six of the participants completed the form. Three of the participants rated their

experience of participating in the group as very positive and three rated their experience as somewhat positive. Two of the participants rated the group as very helpful in dealing with their problems, three rated it somewhat helpful, and one rated it neutral. Two of the participants circled that they would be very likely to recommend the group to friends who have similar problems, three circled somewhat likely and one circled slightly likely.

Treatment Integrity

Data on treatment integrity were obtained in two of the Friday sessions. Raters marked on a checklist whether or not the session leader completed each step on the checklist. Treatment integrity was rated as 100% in both sessions. There were two raters the first time and inter-rater reliability was 100%. The second time there was only one rater so reliability data could not be obtained.

FIGURE 1: RESULTS FOR RAASI **FIGURE 2: RESULTS FOR CISS**



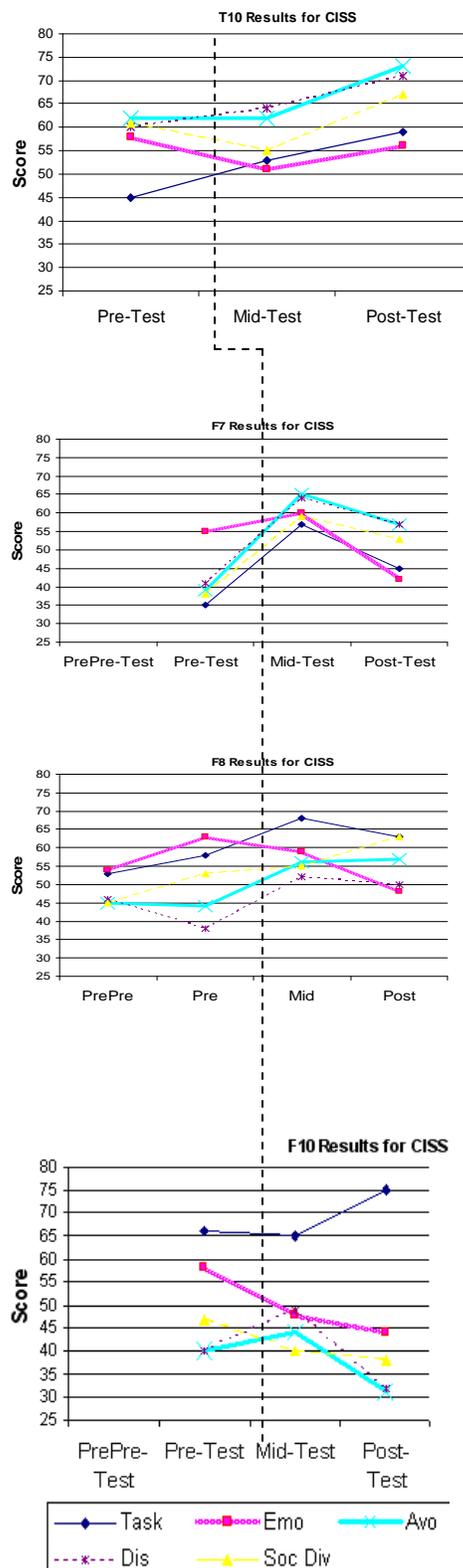
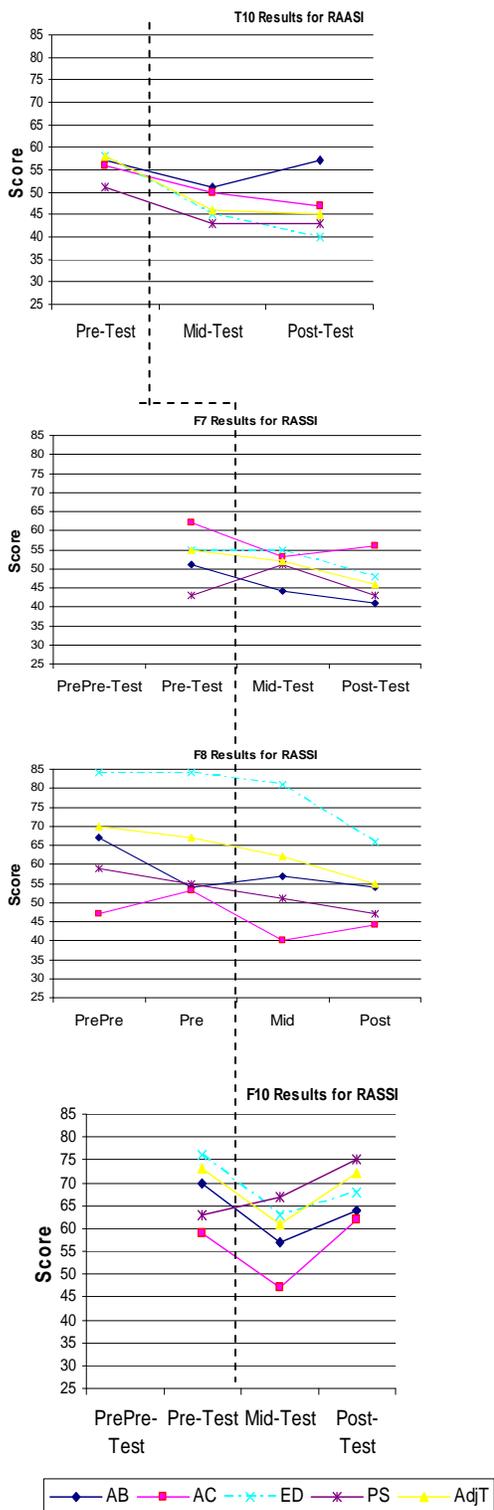


FIGURE 3: RESULTS FOR BASC

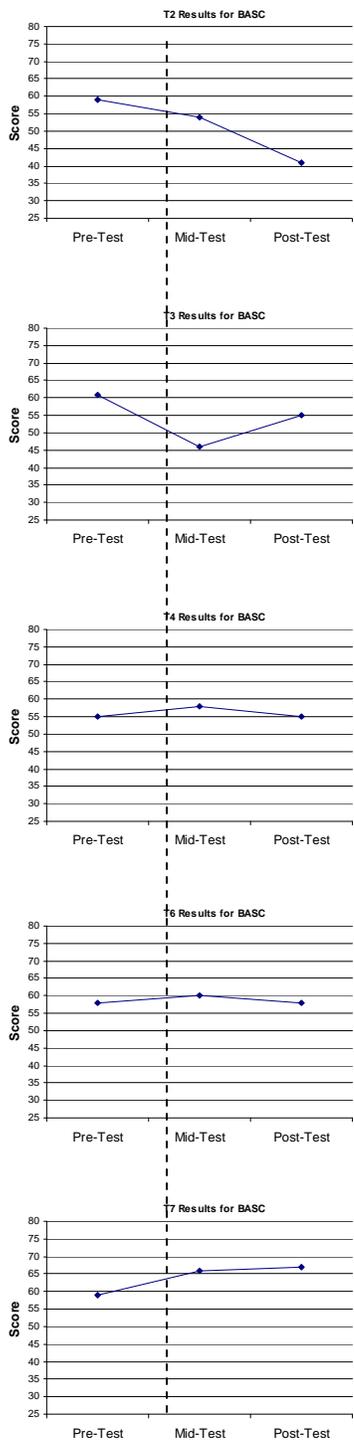
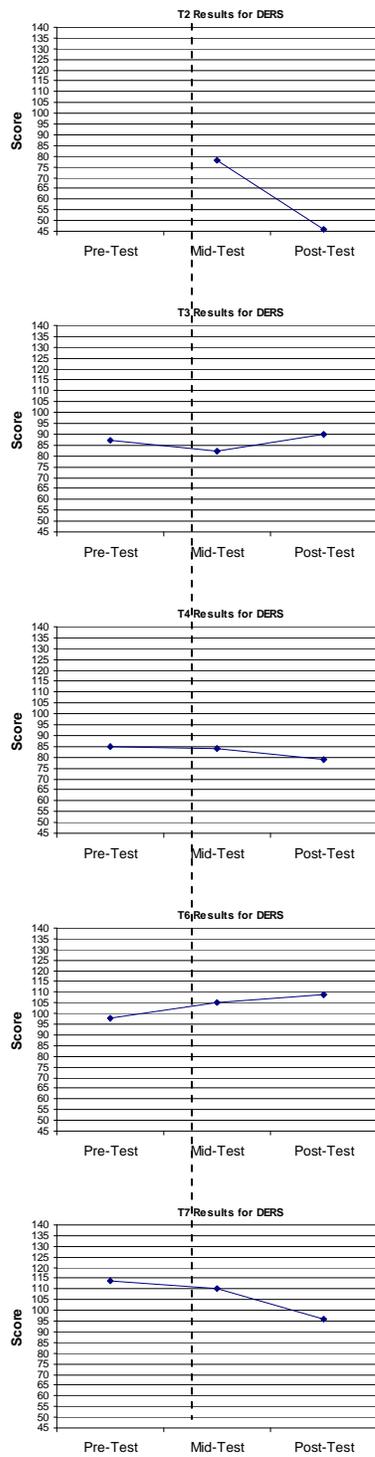


FIGURE 4: RESULTS FOR DERS



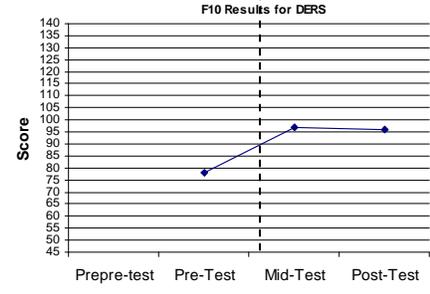
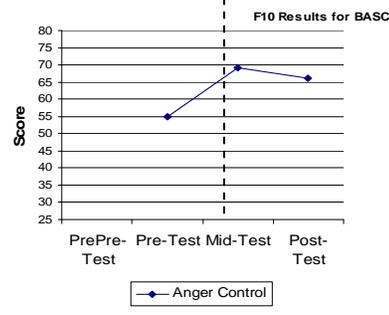
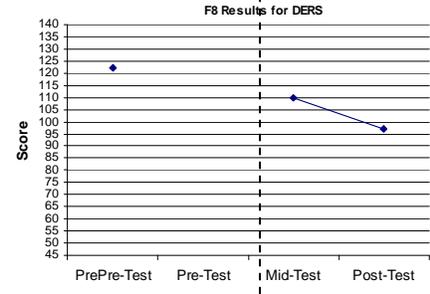
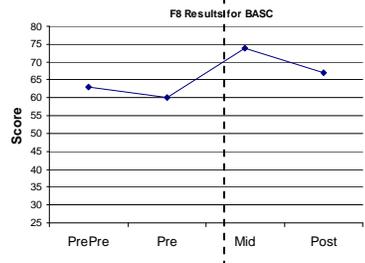
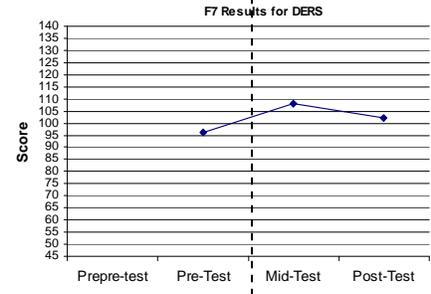
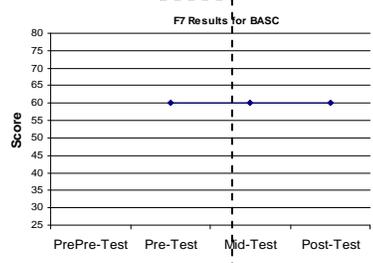
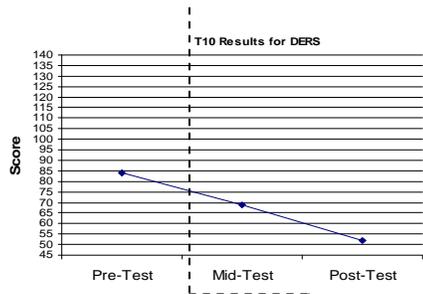
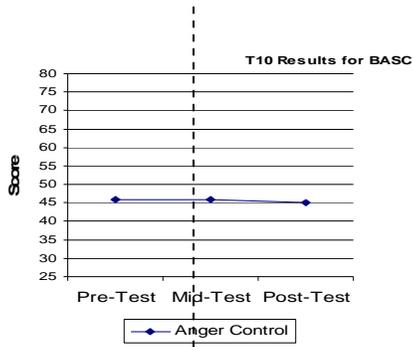
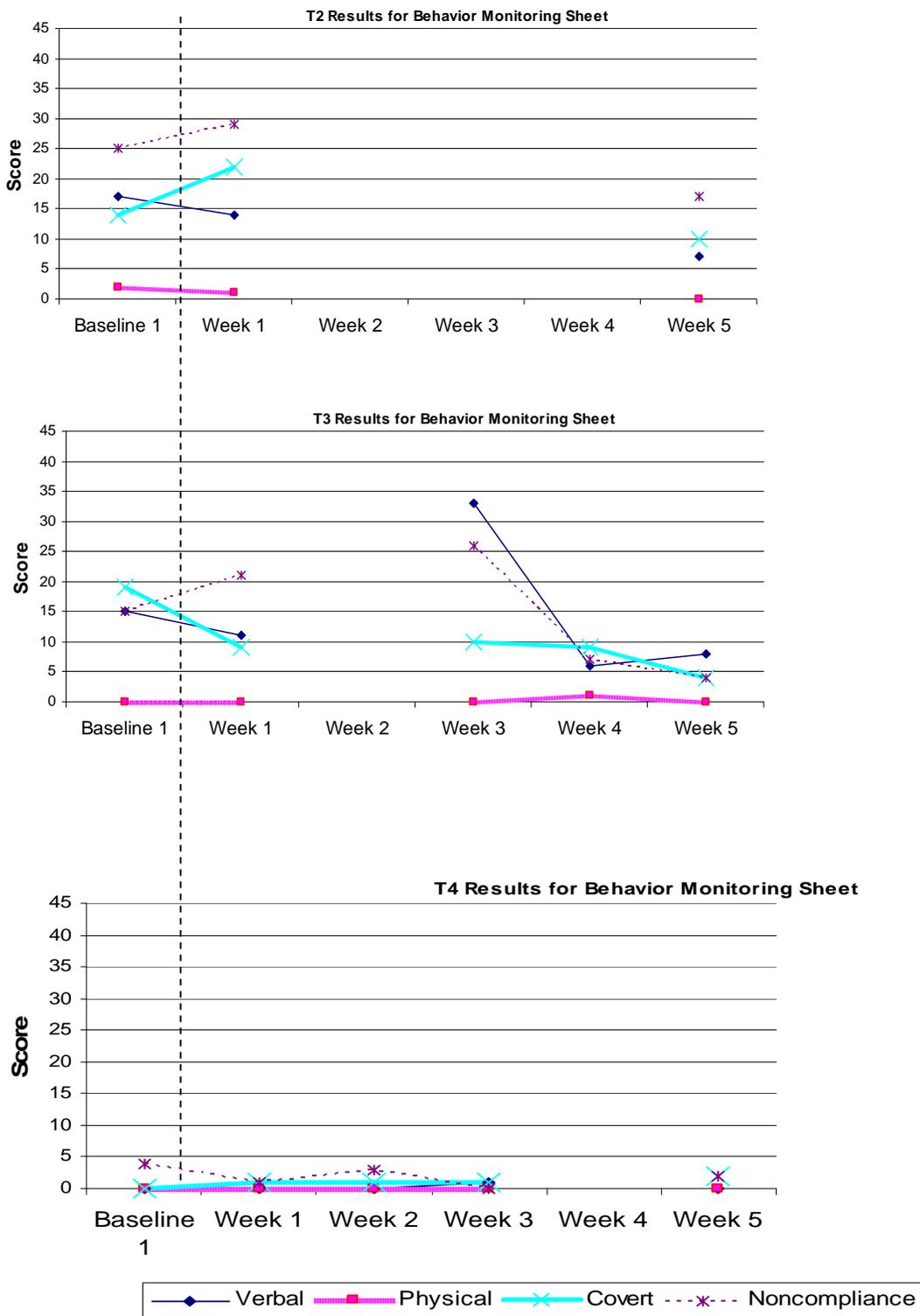


FIGURE 5: RESULTS FOR BEHAVIOR MONITORING SHEET



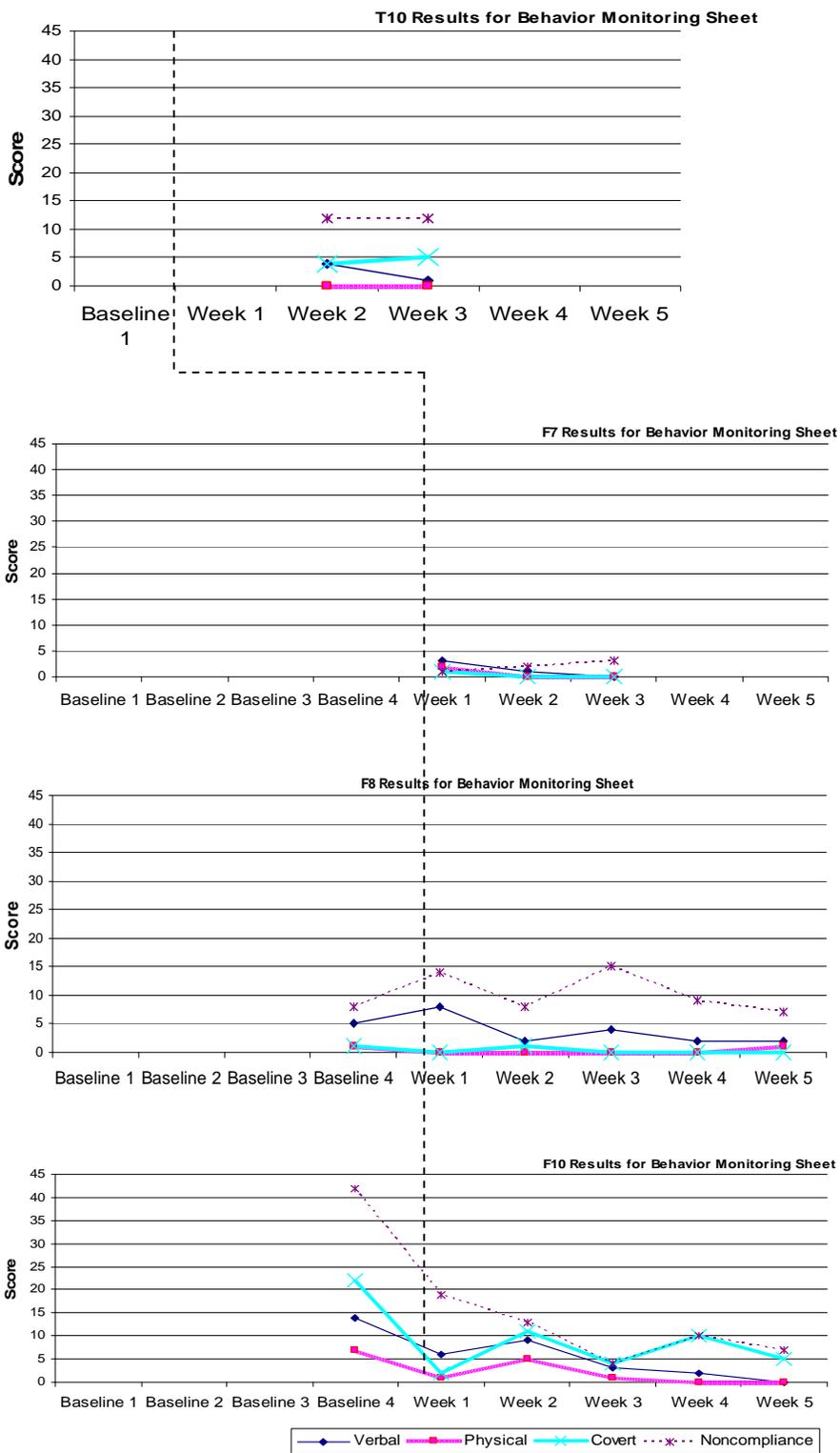
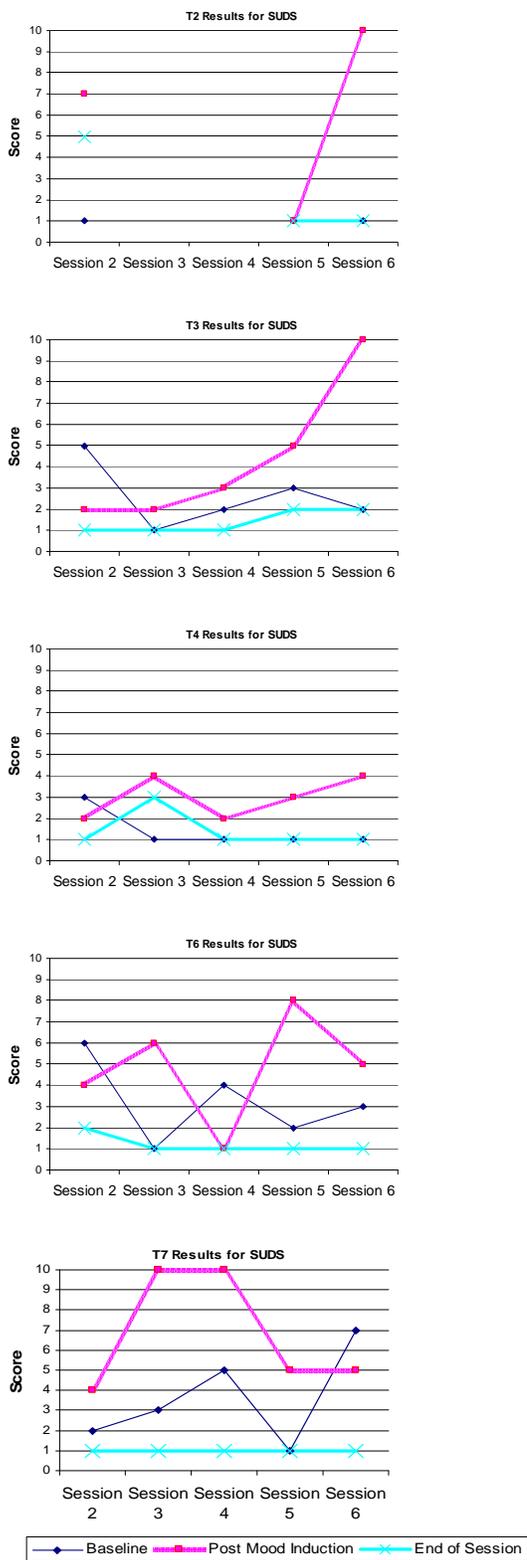
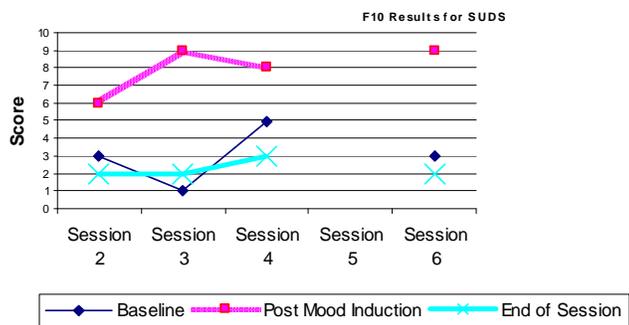
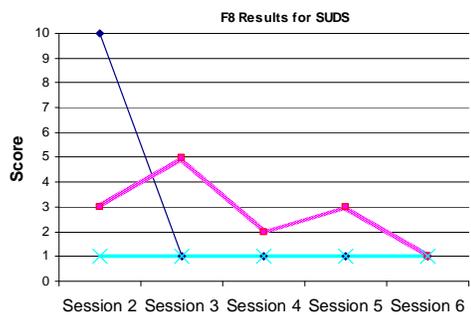
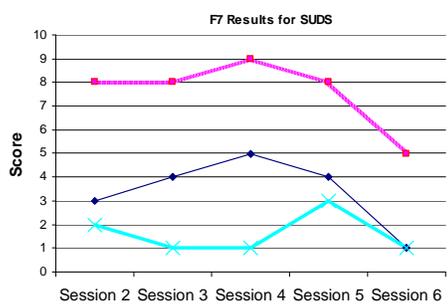
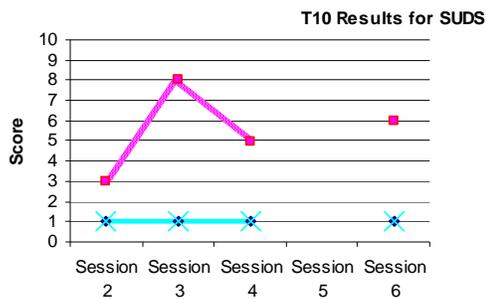


FIGURE 6: RESULTS FOR SUDS





◆ Baseline
 ■ Post Mood Induction
 × End of Session

Chapter IV: DISCUSSION

The present study investigated the effectiveness of a coping skills group intervention in preadolescent and adolescent males with attachment difficulties. Visual interpretation of the results did show some changes but there was no overall consistency to support any of the hypotheses. The hypotheses would have been supported had changes in all the members of the group on one or more of the measures occurred consistently following the intervention. Participant T2 was the oldest adolescent in the first group and also showed improvement across all measures. This could suggest that this type of intervention may be more successful with older adolescents or that the measures may have been more effective with older adolescents. Participant T2 may have better understood the measures as well and could have given answers to support the research findings.

Each individual participant evolved in different ways throughout the intervention. Some developed better coping strategies, some developed better anger control, while others may have regressed in certain areas. These measures were chosen because they deal with some of the common problems that adolescents with attachment difficulties go through. However, this study did not assess the degree of attachment difficulties in the sample. The data suggests that the participants are dealing with different degrees of attachment difficulties and the intervention may work better for some more than others. Further research is needed to determine if there is truth in this conclusion.

The purpose of the token system was to encourage and increase group participation, as well as completing of homework. For this purpose the system appeared successful. There were a couple of participants who did not do their homework and therefore did not get a reward for that week. Both seemed upset that they did not receive a reward and each week after that came to the sessions with their homework completed. Some of the parents voiced concerns that we were using “bribery” and that their adolescents would now expect to get gifts whenever they were asked to do something. The reasons for using the token economy were explained to them but a few parents were still upset that this technique was used with the intervention.

Limitations of the Current Study

There were numerous limitations to this study and most have to do with the participants. Since the two groups were split by the availability of the participants and their parents, they were not randomly assigned. Three individuals dropped out before the intervention began causing uneven group sizes and missing participants in the multiple baseline and multiple probe designs. There was also great heterogeneity between individuals and no formal screenings to determine the extent of that heterogeneity. Many of the families were unavailable some weeks which forced us to do individual make-up sessions which meant that some participants lacked much of the group experience. Additionally, the intervention was implemented over a time spanning from July to September and therefore many of the participants went from summer vacation to starting school during the intervention. This may have caused an increased level of distress and negative emotions and therefore made it difficult to determine the specific impact of the

intervention. The design of the study did not work out well because only one of the Friday participants had joined in enough time to do pre-pre testing, therefore making it difficult to determine if any change was due to the intervention or to the timing of the testing. There was not a consistent pattern of baseline prior to implementing the intervention.

As was previously stated, the participants have been going to family therapy and continued to do so throughout the intervention. Many of the adolescents may have already discussed coping skills at length in their previous sessions or sessions that went on during the intervention. This could have affected their test results as well as their group participation.

In addition, the intervention was only six weeks long and the published measures used were not ideal measures to show short-term change. After looking at the research on many different measures, the researchers decided that the RAASI, BASC-2, and CISS were the best available for the purpose of this study. The development of measures for specific use during short-term interventions could be very beneficial for this type of group. The BASC-2 has been used as more of a diagnostic tool and therefore may not be expected to show much change. This measure could, however, be a tool to guide treatment in certain directions for specific individuals. These measures may be good for adolescents with attachment difficulties, just not for showing change during interventions.

Another limitation to the current study involved the DERS. This is a fairly new scale and currently has no published results with adolescent populations. Unfortunately

there are not many options of measures that assess problems associated with attachment difficulties such as deficits in emotional regulation. There were some promising results and with further assessment this could be a positive measure for use with adolescent populations.

There were a number of limitations with the BMS. Because this form had previously been created for the therapist's use with her adolescent clients, no changes were made on the form. There was no training for the parents on how to fill out the form which caused different interpretations by the parents on how to fill it out. Some did a frequency daily for specific behaviors while others checked if that behavior had occurred today whether it had happened once or multiple times that day. Also the behaviors were not operationally defined and therefore could have been interpreted in different ways by the parents.

The SUDS measure is difficult to interpret because it appeared that the participants learned the "correct" way to fill out the measure. Thus, overall the participants circled an extremely high number post mood induction and an extremely low number after the Progressive Muscle Relaxation. Another limitation is that the participants could see each other fill out the ratings, which may have introduced bias into the measure.

All but one of the measures used were self-report and therefore it is likely that some under-reporting and over-reporting occurred. Although participants were told that their answers were confidential, they may have been worried about the impressions that their scores would make on the researchers. Many of the participants sought approval and

attention from the researchers. A behavioral measure (similar to the BMS), if used correctly, might have been a more objective way to measure change in these preadolescent and adolescent males.

Conclusion and Future Directions

The current study was a six-session group intervention with preadolescents and adolescents with attachment difficulties and although none of this study's hypotheses could be confirmed, many aspects of the study showed promise for future directions. The group therapy modality is promising for this population. Most of the participants, as well as their parents, wanted to continue the groups and thought they were helpful. This is a positive finding given that there is a stigma among adolescents, especially males, related to disclosing in groups with peers (Black & Rosenthal, 2005). One of the reasons the adolescents may have enjoyed the groups is that they were around others going through the same things that they were going through. In their everyday lives most of the adolescents probably do not come in to contact with other adolescents that have been neglected or abused. Every participant contributed to the group through interaction as well as doing the homework throughout the intervention.

Although differences between groups were not analyzed, having three people in the Friday group (the smaller group) helped cultivate more positive participation as well as more opportunities for interaction. Future research should look at group size with this population because the Thursday group was more difficult to keep on track and focused. There was also a wider range of ages in the Thursday group, which may have made it difficult for the participants to relate to each other.

Current measures made it difficult to get sound data from this study. A future direction should be the development of better tools to assess the problems dealing with attachment difficulties. The Behavior Monitoring Sheet showed promise as a positive measure to show change across the intervention, and if the steps were taken that were discussed in the limitations it could be a useful tool for other studies and interventions for a population with attachment difficulties.

The current study is a part of a growing body of research on the positive aspects of group therapy with adolescents. Research in this area needs to continue in order to better understand the problems encountered by individuals with attachment difficulties. Better assessment tools could help professionals to differentiate attachment difficulties from other diagnoses and could contribute to the development of effective treatment plans for this population. Although the current study did not find evidence to substantiate the hypotheses, it is promising that there was much positive feedback from the male preadolescents and adolescents, as well as the parents.

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APPENDIX A: INFORMED CONSENT

CONSENT DOCUMENT

Title of Research Study: Effectiveness of Group Intervention to Improve Coping Skills for Emotional Regulation in Preadolescents & Adolescents with Attachment Difficulties
Principal Investigator: Jeannie Golden, Ph.D., Psychology Department, Harriot College of Arts and Sciences

Subinvestigators: Cathy W. Hall, Ph.D.; Elizabeth Bryant, Graduate Student; Jason Cone, Graduate Student; Jillian Fitch, Graduate Student

Institution: East Carolina University

Address: Department of Psychology

Telephone #: 252-328-6206

INTRODUCTION

You are being asked to participate in a research study being conducted by Jeannie Golden Ph.D.; Cathy Hall, Ph.D.; Elizabeth Bryant, Graduate Student; Jason Cone, Graduate Student; and Jillian Fitch, Graduate Student. This goal of this research study is to evaluate the effectiveness of a group intervention to improve emotional regulation in preadolescents and adolescents with attachment difficulties.

PLAN AND PROCEDURES

As part of the study, you as parents are being asked to do the following:

1. to give consent for your preadolescent or adolescent to participate in a gender specific- group intervention led by two graduate students (or one graduate student and a psychological associate) that will consist of six one-and-one-half-hour sessions with three or four additional sessions for testing. The intervention is based on a protocol entitled Skills for Improving Distress Tolerance originally developed by Bornovalova, Trotman, Daughters, Gratz and Lejuez in the Basic Process in Addictive Behaviors laboratory at the University of Maryland- College Park for use in individual therapy with adult alcoholics in an inpatient setting. The protocol was adapted with permission by Golden and the other researchers in order for it to be applicable for use as a group intervention with adolescents experiencing attachment difficulties. The intervention consists of six sessions, is based on the cognitive-behavioral approach and involves teaching skills for improving distress tolerance through psychoeducation, mood induction, and progressive muscle relaxation.
2. to participate in a parent support group led by a therapist (licensed social worker) that will consist of nine one-and-one-half-hour sessions;
3. to fill out specific subtests of the Behavior Assessment Scale (BASC) during three or four testing sessions and the Ratings of Stressful Situations & Coping Form throughout each of the sessions;

4. to give consent for your preadolescent/ adolescent to fill out the following assessment instruments during three or four testing sessions: Reynolds Adolescent Adjustment Screening Inventory (RAASI), Coping Inventory for Stressful Situations, Second Edition (CISS), Difficulties in Emotional Regulation Scale (DERS) and the Behavior Assessment System for Children, Second Edition (BASC-2) and to fill out the Subjective Units of Distress Form (SUDS) throughout each of the session; and
5. to provide the researchers with data from the Behavioral Monitoring Sheet (BMS) from your preadolescents'/adolescents' records.
6. to give consent to have two faculty members and/or students to attend one third (two out of six) of the sessions in order to observe what is being done by the group leaders to ensure that the intervention is being conducted as it was written and intended to be conducted

Your decision to participate or not participate in this study will in no way impact any service you or your preadolescent or adolescent are currently receiving or will receive in the future from your preadolescent's or adolescent's therapist.

POTENTIAL RISKS AND DISCOMFORTS

There is the potential for possible discomfort to you or your preadolescent or adolescent associated with answering questions or discussing issues that might seem personal or intrusive in group sessions. There is also the possibility of relaxation induced anxiety. The group facilitator can help the preadolescent/adolescent experiencing this by providing individual attention to the preadolescent/adolescent and gently encouraging him/her through the relaxation process. If either you or your preadolescent or adolescent show any signs of discomfort, the researchers will remind you or your preadolescent or adolescent that you have a right to not answer the question and/or to discontinue the assessment or intervention procedures without any penalty or loss of services.

POTENTIAL BENEFITS

- We are hopeful that our research will contribute to intervention regarding emotional regulation and attachment difficulties that could potentially help preadolescents and adolescents and their families in the future. Your preadolescent/adolescent may potentially benefit by learning and practicing skills in handling emotions. As a parent, you may benefit from the support group.
- It is also possible that no direct benefit may be obtained.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS

After all of the information is collected, each preadolescent or adolescent will be assigned a participant number, and names and other identifying information will be separated from

the research data. Only the researchers will see the information before individual identities are removed. All of the information collected for this research project will be handled securely. The data will be stored in a locked file cabinet in the office of the principal investigator. No individually identifiable information will be presented with regard to you or your preadolescent or adolescent.

Research Participant Authorization to Use and Disclose Information

The purpose of the information to be gathered for this research is to evaluate the effectiveness of a group intervention to improve emotional regulation in preadolescents and adolescents with attachment difficulties. In order to determine if this intervention does alter your preadolescent's or adolescent's ability to cope with negative emotions we will need to access the following information: any of your preadolescent's or adolescent's current psychiatric diagnoses, therapy, current or past medical problems and medications that your preadolescent or adolescent takes. The individuals who will receive or access your preadolescent or adolescent's identifiable health information from your preadolescent's or adolescent's therapist, Dianna Aideius, for research purposes include Jeannie Golden, Ph.D.; Cathy W. Hall, Ph.D.; Elizabeth Bryant, Graduate Student; Jason Cone, Graduate Student; and Jillian Fitch, Graduate Student. This information will be used and released in such a way as to protect your identity as much as possible; however, confidentiality cannot be absolutely guaranteed. Someone receiving information collected under this authorization could potentially re-disclose it, and therefore it would no longer be protected under HIPAA privacy rules (federal rules that govern the use and disclosure of your health information).

You may not participate in this study if you do not sign this Authorization form. You can limit the amount and type of information that is shared or revoke the authorization by submitting a request in writing to Dr. Jeannie Golden, Department of Psychology, East Carolina University, Greenville, NC 27858. The research team will be able to use any and all the information collected prior to the request not to disclose information.

COSTS OF PARTICIPATION

There is no cost to you for participating in this research. However, you will need to provide your own transportation and this will cost you money for gas.

COMPENSATION

You will not receive any compensation for participating in this research. You will be attending a support group and your preadolescent or adolescent will be attending a group intervention. However, your preadolescent or adolescent will

receive small rewards from the token system that will be paid for by the researchers.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. If you or your preadolescent or adolescent decides not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive, and all information that has been collected will be destroyed. You may stop at any time you choose without penalty.

PERSONS TO CONTACT WITH QUESTIONS

The investigators will be available to answer any questions concerning this research, now or in the future. You may contact the principal investigator, Dr. Jeannie Golden, at phone numbers 252-328-6206 (days) or 252-946-9500 (nights and weekends). If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days) and/or the ECU Risk Management Office at 252-328-6858.

CONSENT TO PARTICIPATE

Title of research study: Effectiveness of Group Intervention to Improve Coping Skills for Emotional Regulation in Preadolescents & Adolescents with Attachment Difficulties

I have read all of the above information, asked questions and have received satisfactory answers in areas I did not understand. (A copy of this signed and dated consent form will be given to the person signing this form as the participant or as the participant authorized representative.)

Participant's Name (PRINT)	Signature	Date	Time
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If applicable:

Guardian's Name (PRINT)	Signature	Date	Time
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Advocate's Name (PRINT)	Signature	Date	Time
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PERSON ADMINISTERING CONSENT: I have conducted the consent process and orally reviewed the contents of the consent document. I believe the participant understands the research.

Person Obtaining consent (PRINT)	Signature	Date
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Principal Investigator's (PRINT)	Signature	Date
---	------------------	-------------

APPENDIX B: MINOR ASSENT

Minor Assent Document

Research Study: Effectiveness of Group Intervention to Improve Coping Skills for Emotional Regulation in Preadolescents & Adolescents with Attachment Difficulties
Principal Investigator: Jeannie Golden Ph.D.
Contact Information: 252-328-6206

The following will be read to each preadolescent/adolescent asked to participate in this research study:

We are asking you to take part in our research study. Tonight is our introductory session when we give you information about the dates, times and purpose of our group sessions. We are here to give you the information you need to decide if you would like to participate and to allow you to have any questions answered. If you do agree to participate, we will then be giving you various rating scales to fill out about yourself, your family, your feelings and your behavior. You will be filling out these same rating scales later in the study three or four more times. Most of the nights, however, the sessions will involve participating in a group with other preadolescents/adolescents around your same age. One group will be only for girls and the other group will only be for boys. The boys group will have two male visitors for two of the sessions and the girls group will have two female visitors who will be observing to make sure that the group leaders are conducting the groups correctly. You will have activities to do in the group and at home. Each group session will involve learning and practicing skills, and rating their feelings about the topics discussed. You will get tokens (points) for participating in these groups and doing the activities. You can trade in these tokens (points) for small rewards that you might like to earn. Later we will have the group make a list of some rewards you might like to earn. We hope our study will help us learn things that will be able to help other preadolescents/adolescents and their families. Participating in our research is your choice, and you can stop at any time. No one will be upset with you if you decide not to participate. Do you have any questions about our research? Will you agree to help us by taking part in our study?

Preadolescent/adolescent gave assent: Yes or No

Your therapist has asked if she can look at your rating scales and other things you will be doing with us throughout the sessions because she thinks that it might help her when she meets with you in therapy. However, she will not be upset with you if you do not want her to look at your rating scales or the other things you will be doing with us. Is it okay if we share your rating scales and the things you do during these sessions with your therapist?

Preadolescent/adolescent gave assent: Yes or No

Preadolescent/adolescent's Name:

Signature of Researcher obtaining assent:

Date:

APPENDIX C: CONFIDENTIALITY/LIABILITY

CONFIDENTIALITY - LIABILITY

.0119 Liability of Persons with Access to Client Information

- (a) Failure to comply with the provision of the confidentiality rules in Sections .0100, .0200, .0300 and .0400 of this Subchapter may constitute a misdemeanor and be punishable by fine or imprisonment.
- (b) Individuals employed in agencies listed in Rule .0117 (b) of this Subchapter and employees governed by the State Personnel Act are subject to suspension, dismissal or disciplinary action for failure to comply with these rules.
- (c) Individuals employed in agencies listed in Rule .0227 (b) and employees governed by the State Personnel Act who provide data for research, study or program planning are protected from criminal or civil liability provided that the provisions of Rule .0320 and Section .0400 are followed.
- (d) Individuals, other than employees but including volunteers, who are agents of the Department of Human Resources and who have access to client information for the purposes of data collection, processing or dissemination shall be liable in the same manner as employees.

ASSURANCE OF CONFIDENTIALITY

As an observer for the research study UMCIRB#04-0465, I understand that I must follow the Confidentiality Regulations stated above. I have read and understand the Confidentiality Regulations as developed by the Division of Mental Health, Mental Retardation, and Substance Abuse Services to ensure the privileged and confidential nature of client information. I further understand the liability of persons with access to client information and hereby agree to protect and preserve the confidential nature of all client information to which I may have access. I understand that the videotapes and data that I am collecting from the videotapes are privileged and confidential client information. Verbal or written disclosure of any information regarding children or their families observed in the videotapes or recorded on data sheets is a breach of confidentiality regulations.

Signature: _____

Title: _____

Agency: _____

Date: _____

APPENDIX D: SCHEDULE OF GROUP SESSIONS

Group Therapy Schedule

Group 1B (Boys) & 1G (Girls)- Meets on Thursday nights

July 17- Introduction, Consent Forms, Pre-Testing
July 24- Intervention
July 31- Intervention
Aug. 7- Intervention
Aug. 14- Mid-Testing, Intervention
Aug. 21- Intervention
Aug. 28- Intervention
Sept. 4- Post-Testing

Group 2B (Boys) & 2G (Girls)- Meets on Friday nights

July 18- Introduction, Consent Forms, Pre-Pre-Testing
Aug 15- Pre-Testing, Intervention
Aug 22- Intervention
Aug 29- Intervention
Sep 5- Rescheduled due to Hurricane
Sept. 12- Mid-Testing, Intervention
Sept. 19- Intervention
Sept. 26- Intervention
Oct. 3- Intervention
Oct. 10- Post-Testing

APPENDIX E: SUBJECTIVE UNITS OF DISTRESS SCALE

SUBJECTIVE UNITS OF DISTRESS SCALE

Subject # _____

Date _____

Session # _____

Time	SUDS Rating	Comments
<i>Baseline</i>		
<i>Post-Mood Induction</i>		
<i>After lesson is completed</i>		
<i>After PMR</i>		

APPENDIX F: BEHAVIOR MONITORING SHEET

Behavior Monitoring Sheet

Family # _____

Week of _____ to _____

Behavior	Sat.	Sun.	Mon.	Tues.	Weds.	Thurs.	Fri
Eye Rolling/ Challenging Look							
Refusing to Comply							
Defiance							
Fail to complete HW/CW							
Fail to Do Chores							
Fail to Practice Instrument/Sport							
Talk Back/Challenging Words							
Sarcasm							
Refusing to Respond							
Cursing/Inapp. Lang.							
Lying							
Manipulating							
Borrowing Items							
Stealing							
Hitting/Kicking/ Pushing							
Banging Objects/ Slamming Doors							
Throwing Objects							
Breaking Objects							
Fire Starting							
Other:							
Other:							
Other:							
Other:							

APPENDIX G: IRB DOCUMENTATION



University and Medical Center Institutional Review Board
 East Carolina University
 Ed Warren Life Sciences Building • 600 Moye Boulevard • LSB 104 • Greenville, NC 27834
 Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb
 Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
 Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Jeannie Golden, PhD, Dept of Psychology, ECU—226 Rawl Building
 FROM: UMCIRB *kk*
 DATE: July 17, 2008
 RE: Full Committee Approval of a Study
 TITLE: "Effectiveness of Group Intervention to Improve Coping Skills for Emotional Regulation in Preadolescents & Adolescents with Attachment Difficulties"

UMCIRB # 08-0422

The above referenced research study was initially reviewed by the convened University and Medical Center Institutional Review Board (UMCIRB) on 7.14.08. The research study underwent a review and approval of requested modifications on 7.17.08 by S. McCammon. The UMCIRB deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of 7.14.08 to 7.13.09. The approval includes the following items:

- Internal Processing Form (dated 6.24.08)
- Informed Consent (received 7.17.08)
- Minor Assent (received 7.17.08)
- Adolescent Questionnaire
- Questionnaire—CISS
- Behavior Monitoring Sheet
- Parent Weekly Rating Form
- Subjective Units of Distress Scale
- Mood Induction Script
- Task Persistence Observation Sheet
- BASC-2 TRS/PRS
- Letter of Support (7.16.08)
- Item Factor Loadings in the Amos Analysis
- Emotional Regulation Project Research Protocol
- Difficulties in Emotion Regulation Scale (DERS)
- Page 14 of protocol