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Comparing Two Support Groups' Impact on the Development of Middle School Students' Self-Esteem and Internal Locus of Control

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COMPARING TWO SUPPORT GROUPS' IMPACT ON THE DEVELOPMENT OF MIDDLE SCHOOL STUDENTS' SELF-ESTEEM AND INTERNAL LOCUS OF CONTROL

SOCIAL WORK MASTER'S THESIS
AUGSBURG COLLEGE

GARY S. JOHNSON

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CERTIFICATE OF APPROVAL

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DEDICATION

During the two years of my graduate studies at Augsburg, I experienced the death of my brother, Robert, and my mother, Pearl. This thesis is dedicated to their memory.

My brother, Robert, demonstrated a depth of resilience, wisdom, common sense and humor through out his life. He encouraged me and all of his family in many ways and served as a model of caring and strength for us all.

My mother, Pearl, had an amazing ability to tap and nurture the resilience in her seven sons and always was focused on our strengths. Because she knew I could do anything I chose to do, I knew I could do it, too.

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ABSTRACT OF THESIS

COMPARING TWO SUPPORT GROUPS' IMPACT ON DEVELOPMENT OF MIDDLE SCHOOL STUDENTS' SELF-ESTEEM AND INTERNAL LOCUS OF CONTROL

GARY S. JOHNSON

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This study compared the effectiveness of two support group models in a middle school setting. Is the introduction of Health Realization (HR) concepts in a support group more effective than a standard support group without HR concepts in increasing self-esteem (SE) and internal locus of control (ILC) of participating middle school students? Eighteen 7th grade students were randomly assigned to a support group with HR concepts or a support group without HR concepts. Pre- and post test scores from the Nowicki-Strickland Locus of Control Scale for Children (N-S) and the Piers-Harris Children's Self Concept Scale (P-H) were used to assess subjects' SE and ILC changes. Results indicated an increase in SE and ILC in the support group with HR concepts (treatment) and an increase in ILC but no change in SE in the support group without HR concepts.

TABLE OF CONTENTS

LIST OF TABLES

COMPARING TWO SUPPORT GROUPS' IMPACT ON THE DEVELOPMENT OF MIDDLE SCHOOL STUDENTS' SELF-ESTEEM AND INTERNAL LOCUS OF CONTROL

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Introduction

The study of teenage chemical use, school drop-out patterns and delinquent behavior indicates that the development of an insecure and negative belief system comes about as a result of exposure to negative beliefs and a general state of insecurity developed at an early age. A journalist commented: "Youthful America's vision of its own future has never been more dire, particularly in the cities. As one 17 year old African American put it on his way into court: 'I've been dead since I was 12, so I'm not afraid of dying. I'm just waiting to get kicked into the grave'" (Vogel, 1994, p. 56). This state of insecurity and the resulting behaviors tend to put the young person "at-risk". This view of the negative effects on children comes from a focus on *maladaption*, not adaption. (Benard, 1996, p. 1) This pessimistic view of the plight of young people can be quite overwhelming to adults in education and

the helping professions. Instead of this focus on the psychopathology of children, a new paradigm, known as resilience, has been gaining support and providing optimism to the fields of education, psychology and social work. In the past, resilience has been understood to be an individual's ability to deal with stress and adversity and the self-righting nature of humans to bounce back from difficult experiences or environments. The new understanding of resilience, as described by Benard and Marshall (1997) is "the fundamental belief in every person's capacity for successful transformation and change, no matter what their lifes' circumstance" (p. 9). Resiliency is not something that some individuals have and some don't have. Resilience is something that we all are born with. It is something that merely needs to be tapped by ourselves or by someone who sees the resilience in us (Benard & Marshall, 1997).

One of the ways schools give assistance and address concerns of students is by providing support groups for children dealing with a variety of issues, stressors or risk factors. This study compared the impact on self-esteem and internal locus of control of two different support group models that address those concerns: a

support group model that introduced Health Realization principles and a support group model that did not introduce those principles.

The potential significance of this study revolves around the apparent willingness of adolescents to involve themselves in group activities, even if they are therapeutic in nature. If effective support groups can provide support and the potential for greater mental health for students, the groups could have a positive impact on the quality of the students' lives and a positive impact on the communities they live in. If children are psychologically healthy, they will be more likely to be ready to learn when they come to school.

The desire to investigate ways to provide support to students or to improve their mental health and ability to learn led to the question that this study addressed:

Is the introduction of Health Realization concepts in a support group more effective than a support group without the introduction of Health Realization in increasing self-esteem and the internal locus of control of participating middle school students?

REVIEW OF THE LITERATURE

Overview

The literature review for this study focused on a definition and investigation of the effectiveness of support group models and the theoretical concepts of resiliency, the strengths perspective and health realization. The conceptual frameworks will be defined in a manner that is intended to give direction to the study of the effectiveness of the two support group models.

Support Groups

Toseland and Rivas (1995) offer this definition of group work: "Goal-directed activity with small groups of people aimed at meeting socio-emotional needs and accomplishing tasks. This activity is directed to individual members of a group as a whole within a system of service delivery." (p. 12)

Toseland and Rivas go on to describe the two types of groups, task groups and treatment groups. Task groups, obviously, come together to focus on solving some problem or completing a task.

Treatment groups are of five basic types: support, education, growth, therapy, and socialization. School support groups generally fall within the support group category, although they may be social skill enhancing and to some degree therapeutic. Support groups are intended to assist students to cope with stressful experiences or to build skills. Socialization groups are focused on developing communication and social skills of the students involved. Therapy groups are designed to change behavior. It is clear that the lines between the group models is not always clearly drawn, with support groups being the most common label for groups of students in schools.

School-based support groups have been used since the late 1970's to give support to students with a variety of needs. The typical justification for the use of support groups in schools relates to the power of peer culture to impact significantly on adolescents. Also, support groups can be a more efficient use of staff time, since more students can be worked with at one time.

A wide range of support groups are provided in schools. Some of the more common ones include groups for students recovering from chemical use or abuse, for students concerned about the

chemical use of a significant person in their life, or for students grieving the lose of a family member or a friend. Some groups help students learn to make new friends, to support new students moving into a school, to support students with tendencies for depression or other emotional issues. (Lockwood, 1987)

Wassef, Ingham, Collins & Mason (1995) discussed easy recognition and management of emotional distress and behavioral problems in high school students. They conclude that the numbers of students with behavioral descriptors indicating emotional distress and early forms of behavior problems is increasing in schools. They go on to argue that traditional mental health resources and the comfort level for students to make use of them is limited. Students, they believe, are more likely to confide in peers, family or trusted school personnel and since schools are needing new ways of addressing behavioral and emotional difficulties that negatively impact on the student's ability to learn, support groups could be a significant method of reaching adolescents who are in distress before their problems escalate. They suggest that these groups should not replace more intensive mental health services outside of school for the students who are identified to have more serious

emotional, mental health or behavioral problems. Support groups can, however, assist more students with milder forms of distress and serve as a source of referral and early identification of more serious problems.

Morrison reviewed suicide prevention efforts after the deaths of three young people in two school districts in a northern Minnesota community using various interventions, including school support groups. There have been no further successful suicides since that time (1987). Wassef, Mason, Collins, O'Boyle, and Ingham (1996), described a study of the effects of school support groups facilitated by non-mental health volunteers from the school and community. The study that included 250 high school subjects, indicated "improvement in school interpersonal, and internal domains" (p. 8). The authors suggest the need for further research to look at standardized instruments to measure change and a consideration of the effects of using mental health professionals as group facilitators.

The literature suggests guidelines for support groups. Congress and Lynn (1994) make the point for culturally sensitive and

ethical social work practice as it relates to group work practices focused on the children of immigrants. Malekoff (1994) suggests that doing group work with adolescents requires the facilitator to remember five essential factors:

> (1) a sense of humor and willingness to check one's ego at the door; (2) an appreciation for paradox and ability to differentiate between words and music; (3) access to one's own early memories; (4) the capacity to relate to the whole person; (5) collegial support (p. 5).

Effectiveness of support groups was found in a number or studies. Helper (1991) evaluated the effectiveness of a social skills program focused on improving social interactions and peer relationships. It was discovered that the treatment group (n=20) made significant clinical gains on sociometric ratings and role-play tests.

In addition, Franklin and Streeter (1991) conducted and evaluated two social work group treatment approaches (a modified positive peer culture mutual aid support group and a psychosocial skills training group) within an alternative school setting with middle class dropout youths. Results indicated academic improvement for students from both groups with improvement in

self-esteem and anxiety reduction in the positive peer culture group and improved depression levels and family functioning in the psychosocial skills training group.

Strengths Perspective

The strengths perspective is supported in the literature as a growing social work model in social policy development (Chapin, 1995; Saleebey, 1996) and as a departure from the focus on problems and pathology (Saleebey, 1996; Weick, Rapp, Sullivan & Kisthardt, 1989). The deinstitutionalization of individuals with mental illness has led to the question of how social workers and mental health workers can best support re-entry into community life. Sullivan (1992) suggests that a community based focus on the strengths of the individuals with mental illness is superior to placing them in segregated programs.

Saleebey (1996) acknowledges the paradigm shift to do social work from the strengths perspective. Social workers and others in helping professions have been trained to diagnose what is wrong with the client and then to proceed with a treatment plan to fix the

problem. In the new paradigm, the social worker is encouraged to join the client in learning what the client's challenges are, but to move on to what capabilities and strengths each individual or family or community brings to their unique situation.

The criticisms of the strengths approach are also indicated by Saleebey (1996). The concern is often expressed that the strengths perspective is just a form of positive thinking. It isn't easy to get someone to break out of a deficit based mind set. Only factual and specific descriptions of client strengths can be believed and acted on by clients. The strengths perspective is criticized as being a reframing exercise: some change of view of the world and the ability to see the potential and choices instead of feeling locked in to a negative existence is necessary. It is also considered pollyannaish, ignoring the negative elements of individuals and society. Finally, it is suggested that the strengths perspective ignores reality. The social worker must not ignore the needs and the realities that go with those needs, but it is possible to believe in the potential and not just the definition of need that leads to a label or diagnosis. Having the expectation of the potential for change and growth is needed: assuming the best before assuming the worst.

In an article focusing on substance abuse prevention, the suggestion is made to implement resilience enhancement programs in schools. The authors (Zunz, Turner & Norman, 1993) of the article argue that a focus on what the student can do should be given equal credibility in the assessment and implementation process to the needs of the student. This strengths perspective can also include an examination of the protective factors present in the students life.

Resilience

Resilience, as applied to social work and psychology, has been described as a growing, positive approach for working with individuals and communities (Mills, 1995; Neighbors, Forehand, & McVicar, 1992; Saleebey, 1996). Stress from experiencing difficult life experiences is recognized as a contributing factor in children who demonstrate decreased social, emotional, intellectual and behavioral skills (Luthar & Zigler, 1991). Bonnie Benard (1991), in her review of resilience research, has identified traits or outcomes for children who have tapped their resilience:

Social Competence: responsiveness, flexibility, empathy and caring, communication skills, a sense of humor;
Problem-Solving Skills: ability to plan, imagination, flexibility, insight, critical thinking, resourcefulness;
Autonomy: sense of identity, mastery, internal locus of control, self-agency, self-efficacy, resistance, detachment;
A Sense of Purpose and Belief in a Bright Future: goal directedness, achievement motivation, educational aspirations, success orientation, aspirations, hopefulness, hardiness and a sense of coherence.

Benard's summary of the research on resilience also describes the protective factors that tap the resilience in children in **families**, **schools** and **communities**: a caring relationship within a supportive environment, high expectations with challenges, firm guidance and rites-of-passage, and opportunities for participation (meaningful involvement and responsibility).

In addition, resilience research documents the "self-righting tendencies" that move children toward normal development under all but the most persistent circumstances" (Werner and Smith, 1992, p. 202). Werner and Smith (1982) conducted a 30 year longitudinal study of 698 residents of the island of Kauai in Hawaii. The study revealed that initially, one third of the subjects were exposed to

risk. By age eighteen, two thirds of this group who were exposed to risk were demonstrating high risk behaviors. By age 32, two thirds of the original group of risk exposed individuals were being successful in the significant aspects of their lives (parenting, relationships, work).

Werner demonstrated that youth considered "at high risk" overcame the odds over time. The resilience research offers "a more optimistic outlook than the perspective than can be gleaned from the literature on the negative consequences of perinatal trauma, caregiving deficits, and chronic poverty" (Werner and Smith, 1992, p. 202). Barnard (1994) describes research pointing to the resilience of children of alcoholics. In this research, the conclusions indicated that children of alcoholics who have not been involved in therapy (non-clinical) were not significantly different from adults who were not children of alcoholics except for one variable. The non-clinical, children of alcoholics were more successful at developing close personal relationships then were the adults who were not children of alcoholics.

Beardslee (1989) compared three separate studies that suggest that self-understanding is an important psychological

process in subjects who have tapped their own resilience, leading to being able to master difficult situations in life.

The resilience literature appears to support using a strengths perspective in social work. There is a limited amount of literature documenting the benefits of support groups. The resilience and social work research can inform support group practice.

Health Realization

Saleebey (1996) presents the "Health Realization" model as applicable to individual and group therapy and community development. This model grew out of clinical and community work of psychologists Roger Mills and George Pransky, spanning the last 20 years. Their work led to the development of a psychology model known as Psychology of Mind (POM), which in its school and community development applications is referred to as Health Realization

Mind, Thought, Consciousness

In this model, according to Mills (1995) the three basic principles of human psychological functioning includes:

1) The most useful and important way to view the mind is as the source of thinking and consciousness. The mind projects thought as the vehicle to create our experience of "reality." it mixes thought and consciousness in the process of producing our subjective reality. In this model of psychological functioning, the human mind is capable of projecting either conditioned thinking or thinking that produces insight, common sense and wisdom.

2) Thought is the function that creates images and perceptions in the brain. There are two qualitatively distinct kinds of thoughts in the human experience, conditioned versus original or clear, insightful, common sense thinking.

3) Consciousness is the faculty that brings our thoughts to life and makes these images appear real. In other words, consciousness is the ingredient that is added to thought to make our version of things take on the appearance of reality (p. 34).

"Thought+ consciousness=experience=perception=personal reality" (Pransky, Mills, Sedgeman & Blevens, 1997, p. 409)

Two Modes of Thought

Some interpret this model as a form of cognitive psychology, which focuses on reframing our thoughts to make them more positive (seeing things in a different, more pleasant light). In psychology of mind, however, the focus is on recognition of thought. In this model, free flowing, original thought accesses innate wisdom or common sense. Remaining caught up in memories and the past with conditioned, or computer like thinking keeps us stuck in old ways of reacting to thoughts and circumstances and stops us from reaching our greatest potential. Healthy psychological functioning leads to a sense of well-being and opens options for making common sense decisions about ourselves and our interactions with those around us.

Our level of understanding of thought processes and moods is a significant influence on our ability to remain in the free-flowing mode of thought. This mode allows our resilience, common-sense, and innate intelligence to come through.

Recognizing this cycle of thought, consciousness, feeling and behavior response is suggested to be the beginnings of change within individuals. Kelley (1996) looked at the individual therapeutic application of Health Realization (Psychology of Mind) with deviant and conforming behavior of young offenders.

Mills, Dunham, & Alpert, 1988, described research and theory suggesting that the insecurity of high risk youth can be reduced by increasing the mental health and support of the learning environment, i.e. the adults in the school and community. In addition, the improvement of the student's mental health and understanding of their own thought process can lead to prevention of chemical use, school problems and delinquent behavior.

Mills (1995) developed the Health Realization/Community Empowerment model for use with individuals, schools, and communities. The results of his work with families in two low-income housing projects in Miami document such changes:

Case Study-Modelo and Homestead Gardens Housing Projects, Miami, results after three years (150 families and 650 youth served):

Risk Factors	Before	After
Households Selling or Using Drugs	65%	<20%
Overall Crime Rate	Endemic	Decreased by 70% to 80%
Teen Pregnancy	50%+	10%
School Dropout Rates	60%	10%
Child Abuse and Neglect	Endemic	Decreased 70%+
Households on Public Assistance	85%	35%
School Absenteeism/Truancy	65%	Negligible
Parent Unemployment Rate	85%	35%

(Pransky, Mills, Sedgeman, & Blevens, 1997, p. 417).

Bailey, 1990, makes the case for applying POM to the field of addiction treatment. He suggests that the downward spiral of insecure thoughts leading to insecure feelings leading to insecure and self-destructive behaviors eventually may lead to the use of chemicals as a way to temporarily relieve the insecurity and stress. He makes the argument that maintaining a state of mental health through thought recognition allows the individual to experience the

good feeling that had been sought through the use of the chemicals, along with the common sense, innate intelligence, and state of resilience that is also present.

Health realization or Psychology of Mind is one way to tap resilience in individuals, schools and communities. Psychology of Mind suggests we are all born with common sense and the POM model can be used to teach people to access that wisdom.

None of the studies looked at applying the Health Realization model to support groups in schools. School support groups which incorporate Health Realization concepts can foster resilience and operationalize a strengths perspective for school social workers. This study examines the effectiveness of using the Health Realization/Psychology of Mind model in school based support groups to address the needs of adolescents in a middle school setting.

METHODOLOGY

Research Question

The research question addressed by this study is, "Does the use of a support group model using Health Realization concepts bring about more of an increase in the self-esteem and internal locus of control of participating students than a support group model not using Health Realization in a middle school setting?"

Important Concept and Units of Analysis

The important concept in this study is the Health Realization/Psychology of Mind principles as they apply to working with middle school adolescents. Also, the use of support groups in schools as a form of support is central to this study.

The independent variable is the use of Health Realization in support groups and the dependent variable is the increase in the self-esteem and internal locus of control of at-risk students. The units of analysis are the participating adolescents in the middle school population. The operational definition of the effectiveness of

the Health Realization support group model is the measured change as indicated by the pre- and post-test instruments measuring self-esteem and internal locus of control of middle school student samples (see attached instrument samples: Appendix A, Piers Harris Children's Self-Concept Scale Piers, 1984, and Appendix B, Nowicki-Strickland Internal-External Control Scale for Children, Nowicki & Strickland, 1973).

Research Design Schematic

Experimental Group	Control Group
(Health Realization Infusion Group Model)	(Non-Health Realization Infusion Group Model)
Pre-tests Administered	Pre-tests Administered
Nowicki-Strickland and Piers-Harris Scales	Nowicki-Strickland and Piers-Harris Scales
Treatment Group Process	Control Group Process
Health Realization Group Model	Traditional Group Model
Post-tests Administered	Post-tests Administered
Nowicki-Strickland and Piers-Harris Scales	Nowicki-Strickland and Piers-Harris Scales

The research design is the classical experimental design of experimental and control group:

R	O_1	X	O_2
R	O_1		O_2

(R=random assignment; O_1=observation pre-tests; O_2=observation post-tests; X=treatment) (Rubin & Babbie, 1993, p. 274)

Both groups of students (control support group and the Health Realization infused model support group) were given pre-tests (Nowicki-Strickland Internal-External Locus of Control for Children and the Piers-Harris Self-Concept Scale). The control support group was facilitated by one of the middle school counselors with the school social worker as co-facilitator, using a standard support group process and curriculum. The support group with Health Realization principles was facilitated by the school social worker with the middle school counselor as co-facilitator, using a standard support group process with a Health Realization infused curriculum. The same two scales were taken by the students in the two groups at the completion of the eight group sessions.

Support Group Model

The support group model that is found in school settings has a general description. As described in the literature review, support groups do as the label suggests; they give support to the students that come together with one or two adult facilitators. The control support group described in this study was referred to as a life skills group, where students with a variety of issues came together to get and give support to and from peers. Some of the issues that students may come to group with include family change issues, chemical use concerns for themselves or significant family members, shyness and difficulties with making friends, and lack of academic or social skills. The facilitator insures that the group is a safe, comfortable and confidential environment where each student is given the opportunity to express concerns, feelings, and ideas. The facilitator determines what the students are concerned about and what they may want to focus on in the sessions, making sure that each student gets a turn to speak and can pass if they don't wish to talk about certain topics. The facilitator also focuses on the stages of the group process: beginning stage, group work stages

and ending stage.

Support Group Model with Health Realization Principles

The support group model with the introduction of Health Realization/Psychology of Mind principles used in this study included all the stages and techniques of the more standard support group model with the addition of a teaching phase. The beginning stages of the two groups are similar: the students and facilitator get acquainted with each other and the ground rules of being in a support group are introduced. Health Realization principles are introduced through a focus on listening: the facilitator listens with a non-analytical, clear mind for what the students really want to learn about-what is important in their lives. The facilitator also teaches this approach to listening to the students and asks them to listen in that manner to others in the group.

The facilitator then interjects the teaching of the core concepts of Health Realization/Psychology of Mind to the students as the opportunity arises, naturally, in the group sessions.

The focus of the teaching is on understanding the mind, thought, consciousness concepts and how the students can be aware

of their own thinking and how their thoughts lead to feelings and behaviors. The major emphasis is on realizing their own common sense and natural wisdom that is with them at all times. They are encouraged to tap their resilience through thought recognition and quieting of their minds.

Sample and Data Sources and Setting

The population being studied included 7th grade students in a middle school who were identified by teachers, school counselors, parents, or themselves as having issues or needs that may prevent them from progressing academically or socially to their greatest potential. Some of the specific reasons cited for referral to support groups in the middle school included needs for improved social skills or social connectedness to improve peer and adult relationships and a need for improved self concept and support for dealing with family issues or chemical use issues. The students in the middle school population are predominantly Caucasian boys and girls from a farming community that has a state university and a variety of small manufacturing corporations in the area. There is also a

significant number of Hmong 7th grade students (5-15 percent).

The students meeting the study criteria were randomly assigned to two support groups (treatment group and control group) of students with approximately equal numbers of males and females. The students assigned to the two support groups with nine students in each group were given pre-tests: a self-esteem scale (Piers-Harris Children's Self- Concept Scale) and an internal locus of control scale (Nowicki-Strickland Internal-External Control Scale for Children). The questions on the two scales were read to the students in the two groups and the students indicated their yes or no responses on their individual protocols.

The group sessions took place in the middle school in a private meeting area. At the completion of eight 45 minute group sessions, the subjects were given the same two scales as a post test.

Data Collection Instruments

Data collection instruments for this study will include a self-esteem scale, Piers-Harris Children's Self-Concept Scale, consisting of 80 yes or no responses and an internal locus of control scale,

Nowicki-Strickland Internal-External Control Scale for Children, consisting of 40 yes or no responses. The Piers-Harris Scale was designed to measure children's and adolescent's self-concepts, which Piers suggests are "a relatively stable set of self-attitudes reflecting both a description and evaluation of one's own behavior and attributes" (1984, p.1) The term self-concept used in the title of this scale is synonymous with self-esteem (Lefcourt, 1991). The Piers-Harris Children's Self-Concept Scale asks the respondent to indicate yes or no to whether or not the question is generally true of about them. Half of the questions are high self-esteem statements and half are low self-esteem statements. The higher total scores (closer to 80) indicate a higher level of self esteem. Six subscale clusters are also established: behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and happiness and satisfaction. The Nowicki-Strickland Internal-External Control Scale for Children was designed to give a measure of "the degree to which he (or she) feels the reward is controlled by forces outside of himself and may occur independently of his own actions" (Rotter, 1982, p. 171). The more the individual believes that these outside forces control their reinforcement, the more

external the locus of control. The more the individual believes that she/he has control over the reinforcement because of her/his actions or characteristics, the more it is considered a function of internal locus of control. These scales were chosen because the literature suggests that how young people feel about themselves (self-esteem) and the degree to which they feel in control of their lives and decisions (internal locus of control) has a direct influence on their sense of security.

Measurement Issues

The measurement issues in this study were addressed by the use of two scales used as pre and post test instruments. Both scales have been extensively tested and found to be valid and reliable: the Piers-Harris Children's Self-Concept Scale, (original sample of 1183 children, age 4-12, from a Pennsylvania school district: validity-convergent .4; reliability-internal consistency from .88 to .92-with caution about potential problems with response bias and socially desirable responding) (Lefcourt, 1991, p.138)and the Nowicki-Strickland Internal-External Control Scale for Children, (tested on a variety of samples, 3rd-12th grade, main sample 1017

children, mostly Caucasian in four different communities: validity-convergent .41; reliability-internal consistency above .60; adequate internal consistency and temporal consistency). (Lefcourt, 1991, p. 444-445)

Data Collection Instrument Administration

The data collection instruments (scales) were given to both groups of students involved in the two support groups (treatment and control) prior to the first group session and after the completion of the last (eighth) support group session. The questions were read to the students as a group while they read along and indicated their responses to each question on the paper protocols.

Data Analysis Procedures

The post-test means and the standard deviations of the two scales (Nowicki-Strickland Internal-External Locus of Control and Piers-Harris Children's Self-Concept Scale) were compared between the control group (standard support group model) and the treatment group (health realization support group model) to determine the evidence and degree of change for each of the two support group

models. The pre-test means were compared using a t-test to determine if the treatment and control groups had statistically significant differences. Because the pretest means of the Nowicki-Strickland approached statistical significance ($p>.08$), an analysis of covariance was used to compare the post-test means of both scales. The period of time between the pre-test and the post-test was approximately five weeks.

Protection of Human Subjects

The students who were chosen for this study were recommended by seventh grade teachers, administrators and school counselors for participation because of having issues and challenges in their lives that may limit their progress academically or socially. The students were told that they had the opportunity to be involved in the groups, but that their involvement was voluntary and they could leave the groups at any time. Their parents gave written consent for their involvement in the support groups and the study process. The students also gave their written consent for involvement in the groups and the study process. No names were attached to the scales, only an identification number and an

indication of each student's group. Every effort was made to insure their confidentiality and to insure a lack of negative consequences for missing class to be involved in the groups. The students and their parents were informed of the possible risks involved in being in a group, dealing with potentially sensitive issues, and were given information on how to access follow-up support.

Both support groups provided the students an opportunity to receive support and assistance in the school environment.

RESULTS

Study Population

The study sample included nine girls and nine boys who were recommended for the study. The 18 students and their parents gave written permission to be involved in the study. The students were randomly assigned to the control group and the treatment group by alternately drawing their names from the group of nine girls and the group of nine boys. After two group sessions, one of the boys from the control group discontinued his involvement, leaving a final sample size of eight students in the control group and nine students in the treatment group or a total of 17 students who completed the groups and the pre and post tests.

Research Question:

Results of this study follow from the research question: Does the use of a support group model using Health Realization concepts bring about more of an increase in the self-esteem and internal locus of control of at-risk students than a support group model not using Health Realization in a middle school setting?

Self-esteem

Appropriate descriptive statistics were run on the data collected (see Table 1).

Table 1

Mean Pre and Post Test Scores of Treatment and Control Groups on Nowicki-Strickland Locus of Control Scale and Piers-Harris Self-Concept Scale for Children

Support Group	N	Mean	Std. Deviation	Std. Error Mean
	Nowicki-Strickland Locus of Control[a] Pre-test			
treatment	9	16.22	4.27	1.42
control	8	20.25	4.59	1.62
	Nowicki-Strickland Locus of Control Post-test			
treatment	9	14.56	4.98	1.66
control	8	15.88	5.51	1.95
	Piers-Harris Self-Concept Scale[b] Pre-test			
treatment	9	54.11	12.32	4.11
control	8	46.75	16.62	5.88

	Piers-Harris Self-Concept Scale Pre-test			
treatment	9	56.33	15.60	5.20
control	8	46.38	21.51	7.60

Note. Lower mean scores on the Nowicki-Strickland Locus of Control scale indicate an increase in internal locus of control of subjects. Higher mean scores on the Piers-Harris Self-Concept scale indicate an increase in self-esteem of subjects.

The pre-test mean score for the 9 students in the treatment group (with Health Realization principles) in the Piers-Harris Children's Self-Concept Scale was X=54.11 (SD=12.32). It was expected that their mean score would increase because of the treatment received. Their post-test mean score was X=56.33 (SD=15.60, $p<0.30$), which does not achieve the .05 level of significance, (see Table 2) but this finding indicates a movement toward increased self-esteem, which was the desired outcome.

The pre-test mean score for the 8 students in the control group (standard support group) in the Piers-Harris Children's Self-Concept Scale was X=46.75 (SD=16.62). Their post-test mean score was X=46.38 (SD=21.51), indicating essentially no change in the self-esteem mean score of the control group (see Table 2).

Table 2

Independent Samples Test (t-test for Equality of Means) of Pre and Post-tests of Treatment and Control Group Members on Nowicki-Strickland and Piers-Harris Scales.

t	df	Significance (2-tailed)	Mean Difference	Standard Error Difference	95% Confidence
	Nowicki-Strickland Locus of Control Pre-test				
-1.87	14.43	.08*	-4.03	2.16	-8.64
	Nowicki-Strickland Locus of Control Post-test				
-.52	14.26	.61	-1.32	2.56	-6.80
	Piers-Harris Self-concept Scale Pre-test				
1.03	12.83	.32	7.36	7.17	-8.15
	Piers-Harris Self-Concept Scale Post-test				
1.08	12.66	.30	9.96	9.21	-10.00

*p > .08 on the Nowicki-Strickland Locus of Control Scale pre-test approaches but does not reach statistical significance (p < .05, two tailed).

Internal Locus of Control

Appropriate descriptive statistics were run on the data collected (see Table 1). The pre-test mean score for the 9 students in the treatment group (with Health Realization principles) in the Nowicki-Strickland Internal-External Locus of Control Scale was X=16.22 (SD=4.27). It was expected that their mean score would decrease (indicating an increase of internal locus of control) because of the treatment received. Their post-test mean score was X=14.56 (SD=4.98), therefore the research hypothesis was supported. This indicates a movement toward increased internal locus of control, which was the desired outcome.

The pre-test mean score for the 8 students in the control group (standard support group) in the Nowicki-Strickland Internal-External Locus of Control Scale was X=20.25 (SD=4.59). Their post-test mean score was X=15.88 (SD=5.51), indicating a movement toward increased internal locus of control.

A comparison of the mean scores of the pre-tests of the two support group models on both the Piers-Harris Children's Self-

Concept Scale and the Nowicki-Strickland Internal-External Control Scale for Children indicate no statistically significant differences (see Table 2). However, the 2-tailed statistical significance of the pre-test mean scores on the Nowicki-Strickland Internal-External Locus of Control Scale ($p>.08$) approaches significance and therefore led to the use of the analysis of covariance (ANCOVA). The ANCOVA uses the pre-test score as a covariate (adjusting the scores of the post-test due to the effect of the pre-test measures. The resulting F score is based on a comparison of the adjusted means for the two groups). L. Lowe (personal communication, May 1, 1997).

The resulting ANCOVA (see Table 3) indicates that when comparing the mean scores of the post-test of the Nowicki-Strickland Internal-External Control Scale for Children a statistical significance level of ($p>.30$) was reached which is not statistically significant at the .05 level.

Similarly, the comparison of the mean scores of the post-test of the Piers-Harris Children's Self-Concept Scale is at a statistical significance level of ($p>.67$) which is not statistically significant at the .05 level.

Table 3

Analysis of Covariance (ANCOVA) of the Treatment and Control Group Scores on the Nowicki-Strickland Locus of Control Scale and the Piers-Harris Self-Concept Scale

	ANCOVA by support group model				
Source	Sum of Squares	df	Mean Squares	F	Signifi-cance
Nowicki-Strickland Locus of Control Scale	15.80	1	15.80	1.14	.30
Piers-Harris Self-Concept Scale	29.58	1	29.58	.19	.67

Note. The ANCOVA uses the pre-test score as a covariate with the post-test.

DISCUSSION

The findings of this study indicate that the involvement of the middle school students in the support groups has led to an increase in self-esteem and internal locus of control (see Table 1), although that increase in both groups was not statistically significant (see Table 2).

The mean score of the students in the support group model with Health Realization principles (treatment) increased in both self-esteem (X=54.11 to X=56.33) and internal locus of control (X=16.22 to X=14.56).

The mean score of the students in the support group model without Health Realization principles (control) did not change in self-esteem (X=46.75 to X=46.38) and increased in internal locus of control (X=20.25 to X=15.88).

Nunn and Parish (1992), in their study on psychosocial characteristics of so called, "at-risk" high school students, suggest that these students tend to be more externally oriented. Compared to the norms established by Nowicki and Strickland (1973) for

seventh grade students (X=13.15 males and X=13.94 females) the subjects in this study had a total mean score (X=18.12) before treatment. Since the total mean score of subjects of this study was higher than the norms established by the scale's authors for seventh grade students, it would appear that the subjects of this study were more external in their locus of control than subjects their same age in the normed group.

The Piers-Harris Self-Concept Scale mean total raw score was normed at (X=51.84) which compares favorably with the total mean score of all subjects in this study of (X=50.65) before treatment. This appears to indicate that the self-esteem of the subjects in this study as reflected in their total mean score, is similar to national norms established by the scale's authors.

The results of this study, in general, appear to support the literature indicating the efficacy of providing support groups to students in middle schools (7th graders, in this study).

The small sample size has significance in a study of this type: one of the subjects in the treatment group had a pre-test self-esteem scale score in the 50's and a post-test in the 20's. This type of outlier score can have significant statistical affects on overall

results of a study with a sample size this small. Further replications of the study may yield more significant results as the total sample size increases.

This study does not indicate statistically significant increases in self-esteem and internal locus of control in students who participate in support groups, nor does it indicate that the introduction of Health Realization principles in support groups provides statistically significant increases in these measures over support groups without Health Realization principles. It does indicate that the predicted outcome (a priori prediction) that there would be a greater increase in self-esteem did occur. The predicted outcome that there would be a greater increase in internal locus of control did not occur, there was an increase, but not greater than the group without Health Realization.

Possible reasons for this lack of significant difference in findings between the two support groups might be found in key elements of the two support groups in this study.

While support group facilitators typically focus on drawing the participants into active sharing of thoughts and feelings, the

counselor who facilitated the group with out Health Realization did more teaching of conflict resolution and anger management techniques. A more pure example of the "typical" support group may yield more significant differences in comparison to a support group where Health Realization concepts are introduced.

The school social worker who facilitated the group with Health Realization principles developed the curriculum based on one year of personal exposure to the core concepts of Health Realization. A greater grounding in personal understanding of the core concepts may lead to increased ability to teach those concepts within a support group setting.

Another element that may have affected both groups and limited the increase in self-esteem and locus of control was the time factor. Both group models met for 45 minute periods (which is the length of the middle school class period) for eight sessions. This short time period may have rushed the group process, which builds on trust and getting to know each other over time. The groups met twice a week for 45 minutes, for a total of 6 hours, so time to process and practice the concepts of Health Realization was limited. By contrast, core concepts training courses provided by the

Psychology of Mind Training Institute for adults typically include at least 24 hours of training. A Health Realization infused support group meeting once a week over a longer period of time, such as a semester or the entire school year, may yield more significant results.

In future research, it would be well to consider doing the study using a more traditional support group format to compare with a support group with Health Realization to more clearly isolate differences and outcomes in the two models.

Implications for Professional Practice

This study indicates that an increase in self-esteem and internal locus of control can be achieved through the use of support groups in the middle school setting. It appears that providing the opportunity for support group participation can provide needed social support for young people to reach their highest potential in school. Providing the conditions of a caring environment, high expectations and the opportunity to participate can be achieved through the use of support groups in schools. The resilience of all

students can be tapped by our own understanding, modeling and teaching of resilience. Health Realization provides promise as a model for helping us and our students to tap this resilience and the capacity to change and transform.

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APPENDIX A

Comparing the Effectiveness of Support Group Models in the Middle School Setting

Consent Form

Your child is invited to be in a research study of the effectiveness of support groups in the middle school setting. Your child was selected as a possible participant because of the recommendation of a school staff person who knows your child and believes he/she might benefit from being in a support group. We ask that you read this form and ask any questions you may have before agreeing to have your child in the study.

This study is being conducted Gary Johnson, as part of a master's thesis in social work at Augsburg College, Minneapolis, Minnesota.

Background Information

The purpose of this study is to compare the benefits of the support groups that are now being offered to students in the middle school. It is hoped that the results of this study will benefit the students involved and the school district, as a whole.

Procedures

If you agree to allow your child to be in this study, we would ask your child to do the following things: after being randomly assigned (by a flip of a coin or a similar technique) to one of the two types of support groups, your child will be asked to complete two questionnaires or scales (true or false questions) that will indicate his/her feelings of self-esteem and views about decision making. These questionnaires will be given before the first support group session and after the last support group takes place and should take from 30 to 60 minutes to complete. Whenever possible, the eight support group sessions will be held when the students have resource time or study hall and the students will always be excused from class or activities.

Risks and Benefits of Being in the Study

The study has several risks: First, the study requires the completion of the questionnaires which may cause your child to ask themselves questions about how they feel about himself/herself or how they make decisions; second, the students will be discussing issues that may be personal in nature, although all discussions in the support groups will be kept confidential.

Direct benefits of money or prizes to students will not be involved in this study.

There may be indirect benefits to all students involved since being in one of the support groups should help them cope better with difficult issues in their lives that may have a negative impact on their education.

If your child has any uncomfortable issues that come up as a result of his/her involvement in a group, he/she will have the opportunity to talk privately with his/her counselor or any other trusted adult in the school.

Confidentiality

The records of this study will be kept private. In any sort of report that is published, no information will be included that will make it possible to identify your child. Research records will be kept in a locked file; only the researcher and thesis advisor will have access to the records. Your child's name will not appear on any of the testing results: a confidential code number will be assigned, instead, along with the type of group that your child participated in.

Voluntary Nature of the Study

Your decision whether or not your child will participate will not affect your current or future relations with the School District of the Menomonie Area or Augsburg College. If you decide to allow your child to participate, she/he is free to withdraw at any time without affecting those relationships. If your child wants to participate in a support group, but does not want to do the testing involved, they will not be able to participate in the support groups in this study. Individual questions that may be too sensitive to your child may be skipped, although it is preferred that they complete all of the questions and they will be asked to do so at the time of the testing. Your child will be given the chance to be in a support group later in the school year if they choose to not be involved in the groups in this study.

Contacts and Questions:

The researcher conducting this study is Gary Johnson, Menomonie School Social Worker. You may ask any questions you have when you receive a call to follow up on this invitation to participate. If you have questions later, you may contact him at Oaklawn Elementary School, Menomonie, Wisconsin.
Phone: (715) 232-3798

Gary's Augsburg College Research Advisor:
Sharon Patten, Ph.D.
Phone: (612) 330-1723.

You will be given a copy of this form to keep for your records.

Statement of Consent to Participate in This Study

I have read the above information. I have asked questions and have received answers. I consent to allow my child to participate in the study.

Signature of Parent or Guardian_____

Date_____

Signature of Student_____

Date_____

Signature of witness for oral consent of a minor:

_____

Date_____

Signature of researcher_____

Date_____

Statement of Consent to Participate in Data-Gathering

I have read the above information. I have asked questions and have received answers. I consent to allow my child to participate in the data-collection part of the study (taking two true-false questionnaires or samples, before the first support group session and after the last support group session).

Signature of Parent or Guardian_____

Date_____

Signature of Student_____

Date_____

Signature of witness for oral consent of a minor:

_____

Date_____

Signature or Investigator_____

Date_____

APPENDIX B

Oaklawn Elementary School
500 22nd Street
Menomonie, WI 54751

February 3, 1997

Dear

Your child, , is invited to take part in a support group that will be meeting during school hours in the middle school. Students join support groups for many reasons. **Support groups are sometimes helpful to young people as they enter their teenage years or for help with friendships and relationships. In addition, support groups may help with developing good decision making skills or adjusting to the middle school, in general.**

I am involved in completing my master's thesis and as you will see on the enclosed information and consent forms, my research will be examining what is the best way to structure support groups to provide the most effective assistance to students in these groups.

Enclosed you will find a parent and student consent form and more explanation of how and when the support groups will take place. If you would like your son or daughter to be involved in a support group, please sign the consent form (green sheets) and return them in the enclosed stamped return envelope.

I will be calling in the next few days to answer any questions you may have, or you can call me at Oaklawn Elementary (232-3798) where I have my office.

In the past, students have reported that a support group has been helpful to them because they were able to share their thoughts and feelings with their peers as well as with adults. We are pleased to be able to offer this opportunity to your child at this time.

Sincerely,

Gary Johnson
School Social Worker

APPENDIX C

IRB Documentation

Comparing the Effectiveness of Support Group Models in the Middle School Setting

Student Interview Script:

Student Consent to Participate in Study and Data Collection

After receiving the signed consent to participate in the study and data collection from the student's parents, I will meet with the students to describe the study and to ask if they will be a participant in the study.

Script:

Hello. Thanks for meeting with me. I would like to invite you to be involved in a support group here in school. Someone who knows you here at school, one of your teachers, your counselor, or one of the principals thinks you could benefit from being in a support group. Parents may also ask that their children be involved in a support group.

Support groups are sometimes useful for students who are experiencing some kind of change in his or her life or they may want to get some help with friendships or relationships with important people in their life.

The support group you are invited to be in is a part of a study to help us compare 2 types of support group in order to learn more about which type of group is most helpful to students.

The groups will meet for eight one hour sessions. If you are interested in being involved in this research, you will be asked to take two short true-false questionnaires before the groups begin. Then, when all eight sessions are finished, you will be asked to take the two questionnaires or scales, again.

Your parents have given written permission for you to be a part of the support group study. If you want to be in a support group, but do not want to do the questionnaires or scales, you won't be able to be involved in these support groups offered at this time, but you will have the opportunity to be involved in a group later in the school year. You can be a part of that group if you wish.

Also, you will be free to skip any question in the questionaires you will be asked to complete and you may choose to not participate at all times in the support groups and you may end your involvement in a support group at any time.

We will attempt to schedule all groups during resource time or study hall time. If you ever miss a class, that absence will be excused.

You won't be paid or given any kind of prize for your involvement, but I believe you will benefit from your experience in our group and you should learn skills and feel support that will help you get through any hard times you may be having.

Thanks for listening to me.

Do you wish to be in our support group at this time?

If yes, I need you to sign the consent forms for your participation in the groups and for the testing I described.

If no, thanks for spending this time with me. Would you like to be notified when the next groups take place, later in the school year?

APPENDIX D

The Nowicki-Strickland Internal-External Control Scale for Children

(please circle your answer-yes or no)

1. Do you believe that most problems will solve themselves if you just don't fool with them?
(yes) (no)

2. Do you believe that you can stop yourself from catching a cold?
(yes) (no)

3. Are some kids just born lucky?
(yes) (no)

4. Most of the time do you feel that getting good grades means a great deal to you?
(yes) (no)

5. Are you often blamed for things that just aren't your fault?
(yes) (no)

6. Do you believe that if somebody studies hard enough he or she can pass any subject?
(yes) (no)

7. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?
(yes) (no)

8. Do you feel that if things start out well in the morning that it's going to be a good day no matter what you do?
(yes) (no)

9. Do you feel that most of the time parents listen to what their children have to say?
(yes) (no)

10. Do you believe that wishing can make good things happen?

(yes) (no)

11. When you get punished does it usually seem it's for no good reason at all?

(yes) (no)

12. Most of the time do you find it hard to change a friend's (mind) opinion?

(yes) (no)

13. Do you think that cheering more than luck helps a team to win?

(yes) (no)

14. Do you feel that it's nearly impossible to change your parent's mind about anything?

(yes) (no)

15. Do you believe that your parents should allow you to make most of your own decisions?

(yes) (no)

16. Do you feel that when you do something wrong there's very little you can do to make it right?

(yes) (no)

17. Do you believe that most kids are just born good at sports?

(yes) (no)

18. Are most of the other kids your age stronger that you are?

(yes) (no)

19. Do you feel that one of the best ways to handle most problems is just not to think about them?

(yes) (no)

20. Do you feel that you have a lot of choice in deciding who your friends are?

(yes) (no)

21. If you find a four leaf clover do you believe that it might bring you good luck?

(yes) (no)

22. Do you often feel that whether you do your homework has much to do with what kind of grades you get.

(yes) (no)

23. Do you feel that when a kid your age decides to hit you, there's little you can do to stop him or her?

(yes) (no)

24. Have you ever had a good luck charm?

(yes) (no)

25. Do you believe that whether or not people like you depends on how you act?

(yes) (no)

26. Will your parents usually help you if you ask them to?

(yes) (no)

27. Have you felt that when people were mean to you it was usually for no reason at all?

(yes) (no)

28. Most of the time, do you feel that you can change what might happen tomorrow by what you do today?

(yes) (no)

29. Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?

(yes) (no)

30. Do you think that kids can get their own way if they just keep trying?

(yes) (no)

31. Most of the time do you find it useless to try to get your own way at home?

(yes) (no)

32. Do you feel that when good things happen they happen because of hard work?

(yes) (no)

33. Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?

(yes) (no)

34. Do you feel that it's easy to get friends to do what you want them to?

(yes) (no)

35. Do you usually feel that you have little to say about what you get to eat at home?

(yes) (no)

36. Do you feel that when someone doesn't like you there's little you can do about it?

(yes) (no)

37. Do you usually feel that it's almost useless to try in school because most other children are just plain smarter than you are?

(yes) (no)

38. Are you the kind of person who believes that planning ahead makes things turn out better?

(yes) (no)

39. Most of the time, do you feel that you have little to say about what your family decides to do?

(yes) (no)

40. Do you think it's better to be smart than to be lucky?

(yes) (no)