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**SELF-ESTEEM AND COPING
IN
ADOLESCENCE**

A thesis presented in partial fulfilment of the requirements for
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ABSTRACT

A nine-week cognitive-behavioural training programme was developed to enhance self-esteem and teach coping skills to early adolescents. Sixty-seven students (37 males) participated in the weekly 90-minute programme. Students were taught rational thinking, social skills, and problem solving. Sixty-four students (30 males), acted as controls. At pre-training, post-training, and 5-month follow-up, students completed the Self-Perception Profile for Children (SPPC; Harter, 1985a), the short-form of the Children's Depression Inventory (CDI; Kovacs, 1992), and a Programme Skills measure, developed by the researcher. Teachers and parents/guardians completed checklists adapted from Programme Skills. Two-way ANOVAs confirmed that there were no significant differences between experimental and control groups at pre-training. However, significant gender effects were obtained for the Short-Form CDI, and the Athletic Competence, Global Self-Worth, and Physical Appearance subscales of the SPPC. Repeated-measures ANOVAs were conducted for each variable, comparing the scores at post-training and at follow-up, with those at pre-training. With group and gender as factors, there were no significant differences between groups when an alpha level of $p < .01$ was adopted. There was, however, a significant gender effect for Global Self-Worth at post-training. A subgroup scoring three-quarters of a standard deviation below the mean for Global Self-Worth were selected for further analysis using a Mann-Whitney U-test. This analysis revealed a significant experimental/control group difference for Programme Skills at post-training. Some evidence of construct validity for Programme Skills was obtained with a Cronbach's Alpha of .73, and significant moderate correlations of Programme Skills with the CDI Short-Form (transformed), and the Global Self-Worth subscale of the SPPC. Possible explanations of the results were discussed with respect to programme content, instructional techniques, the design and duration of the programme, and aspects related to sample characteristics, statistical power, and measurement. In particular, the preventative nature of the intervention was considered. The skills taught to typical classes of early adolescents were for potential use in times of difficulty, thus some of the benefits may lie dormant.

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CHAPTER 1

INTRODUCTION

In western society, in particular, scholastic competence is culturally valued and seen to be linked with national prosperity. Educational achievement is thus of primary concern for many young people but, by definition, low achievers are created in normative systems which ration success. This means that some students are constantly confronted with personal academic shortcomings by comparison with their peers (Stenhouse, 1994). Arguing that school success is one of the major components of self-esteem in childhood, Stenhouse suggested that if as much emphasis was put on non-academic subjects and life-skills, as on the three Rs, many children would benefit. Recently, with the advent of the new draft curriculum for health and physical education (Ministry of Education, 1997), more emphasis has been accorded to life-skills in New Zealand education. For example, the draft acknowledges that academic achievement is affected by health and well-being, and that student attitudes and behaviour impact on others. It recommends the acquisition of skills which strengthen personal identity and enhance self-worth.

In addition to the effects of enhanced self-worth on educational achievement, other benefits of promoting self-esteem in children and adolescents have been identified by researchers. For example, high levels of self-esteem may act as a stress buffer (Harter, 1990d), whereas low self-esteem has been linked to a perceived lack of competence, pessimism with respect to the self and environment, and difficulties in interpersonal relationships (Battle, 1987). Links between body image disturbance, elevated depression, and lowered self-esteem have been documented (Thompson, 1990).

From another perspective, self-esteem is not magically the key to all problems (Mruk, 1995). Although behavioural outcomes such as crime, welfare dependency, and scholastic failure have been linked to a lack of self-esteem (Baumeister 1993a, preface), the evidence is sparse (Smelser, 1989). Among suggested reasons are that measurement tools may not tap self-esteem in a reliable or valid way or that, because self-esteem is correlated with many outcomes, the correlation with any specific behaviour may be weak.

Notwithstanding, knowledge of mental and emotional health skills is important from an early age, as recognised in the new draft statement (Ministry of Education, 1997). Many emotional dysfunctions begin in childhood and continue across the lifespan. This implies that early interventions may be critical to the reduction of distress in youth, and to the prevention of difficulties in adulthood (Kazdin, 1994). Arguably, the period of adolescence, discussed in Chapter 3, is particularly important for intervention, given the young person's growing awareness of the self, and the transitional changes which occur at this stage. For example, there is often an increased focus on the opposite sex and on physical appearance, while family tensions and peer pressures may escalate. Adolescents may be so dependent on the opinions of others, that any perceived ambiguity in response to their behaviour can emphasise self-uncertainty (Rosenberg, 1986).

Although most adolescents will experience and cope with the typical stresses of adolescence, some will face problems which are more extreme. Immature students, or those experiencing many changes, are among the group for whom the transition is likely to be difficult (Simmons & Blyth, 1987). There may be gender differences in self-concept, although the research is equivocal. For example, Wylie's (1979) review of self-concept research on pre-college-age adolescents found no gender disparity for global self-image. By contrast, a variety of research has found that adolescent females score lower than males on measures of global self-esteem (e.g., Harter, 1990d; Maskill, 1991; Simmons & Blyth, 1987). Problems may occur for students who are less competent, for example in areas such as academic achievement or physical ability. Parental or peer support may be conditional on success in these domains. This makes it difficult for these students to discount the importance of areas where they perceive a deficiency. Increasing proficiency is similarly difficult when ability or endowment is mediocre (Harter, 1993).

These problems in the areas of self-esteem and coping are the focus of the present research, in which a 9-week training programme for 10 to 13 year-old students was developed. It was recognised that self-esteem is associated with competence in daily life in that feelings of self-worth do not occur in isolation from every-day affairs (Seligman, Reivich, Jaycox, & Gillham, 1995). Thus, it was not the goal of the present programme to encourage students to feel good about themselves in an unrealistic sense. Rather, it

was to provide problem solving and coping strategies ahead of the potential difficulties common to adolescence.

To effect this aim, the cognitive-behavioural approach, discussed in detail in Chapter 4, was utilised as the training medium. This approach uses performance-based and cognitive interventions formulated to produce changes in thinking, feeling, and behaviour (Kendall & Panichelli-Mindel, 1995). Although interventions commonly use a broad-based procedure, their underlying assumption is that cognitive mediating events influence behaviour.

Cognitive-behavioural interventions have been particularly successful with children and adolescents with various problems. For example, comparing an educational-supportive treatment to a cognitive-behavioural programme for social phobia revealed that the cognitive-behavioural group students learned to engage in a positive internal dialogue which was related to improvement (Kendall, 1992). Cognitive-behavioural programmes have also been very successful in treating adolescent depression (e.g., see Wexler, 1991).

Particularly relevant to the present training programme, as it was modeled, in part, after cognitive-behavioural interventions for depression (e.g., see that of Clarke, Lewinsohn, & Hops 1990, and of Wexler, 1991), is the relationship between low self-esteem and depression in children and adolescents. This link has been established in a variety of research focusing on youth (e.g., Clarke et al., 1990; Harter & Marold, 1994a, 1994b; Kendall & Panichelli-Mindel, 1995). For example, Kendall & Panichelli-Mindel (1995) cited research revealing that depressed children have low self-esteem and low levels of perceived academic and social confidence. These children evaluate their performance stringently which, in turn, is related to distorted negative self-perceptions. Using cognitive-behavioural interventions in reducing these negative perceptions and providing an optimal balance of positive and negative cognitions is related to therapeutic improvement (Kendall, 1992). Therefore both low self-esteem and depression can be ameliorated with the reduction of negative self-evaluations.

In the present study, many of the programme skills were based on Beck's cognitive model

(1961) and the rational-emotive (RET¹) model developed by Ellis (1962). Both these theorists are of the cognitive-behavioral school. Other concepts which shaped the programme were derived from the work of Harter (e.g., 1993), as well as from results of social-psychological research, problem solving research, and studies of social skills training. All programme skills were taught within a cognitive-behavioural framework with an experimental group of students trained in these skills, compared to a control group who did not receive the training programme.

Various measurement instruments, to be discussed in later chapters, were selected with a view to obtaining information about self-esteem, depressive affect, and the specific coping skills taught in the programme. Measurement of self-esteem was complicated by the complexity of the construct. Self-esteem is linked to many other self-related factors, such as self-concept and self-efficacy, and is difficult to separate both conceptually and empirically from self-concept. As a result, the two terms are often used interchangeably in the literature (Byrne, 1996b). The interpretation of self-esteem and its operational definition are therefore integral to the thesis discussion. Whereas Chapter 2 discusses self-esteem related issues, and compares self-esteem with self-concept, Chapter 5 considers measurement issues with particular reference to self-esteem, self-concept, and the self-report scale. Prior to a consideration of the pilot study and the main study contained in Chapters 7 and 8, Chapter 6 provides the rationale for the current research which is based upon the hypothesis that appropriate skills can be taught to early adolescents to improve coping skills and self-esteem. This objective is arguably worthwhile because, as this thesis contends, high self-esteem is linked to a variety of coping strategies and to positive affect in adolescents (Harter, 1990d).

¹In 1993, Ellis changed RET's title to REBT (Rational-emotive behavior therapy) based on his inclusion of behavioural methods, and the importance of the interaction of cognition, emotion, and behaviour in his early writings (Bernard, 1995).

CHAPTER 2

SELF-ESTEEM: DEFINITIONS, CHARACTERISTICS AND RELATIONSHIPS

Self-esteem is a hypothetical construct of rather equivocal character, with a wide range of interpretations and usage. It has been a variable of interest in experimental research in such diverse areas as interpersonal attraction, conformity, cognitive dissonance, and help-seeking behaviours (Wells & Marwell, 1976). Its definitional elements are complicated by the wide range of other self-related terms with which it is connected, such as self-concept, self-description, self-efficacy, and self-identity (Murrow, 1991). In particular, self-esteem and self-concept are often used interchangeably (Hughes, 1984). Further, there are several paradoxical characteristics involved in self-esteem research. It can be studied as a dependent, independent, or mediating variable; examined as a process or product of development; measured as a situational or global experience; understood from either a buffering or motivational position; and viewed from a psychological or sociological perspective, adding to the complexity of the phenomenon (Mruk, 1995).

This complexity and the attendant research on self-esteem and related topics stipulates the need for boundaries for the literature review of the present study. In this context, the following issues with respect to the definitional considerations and characteristics of self-esteem deserve particular attention:

1. A consideration of the self, as a reference point for other self-related concepts.
2. Associations and differences between self-concept and self-esteem, to clarify each, and distinguish between the two.
3. A consideration of self-esteem definitions, to characterise commonalities and differences, and to develop an understanding of the complexity of the construct.
4. A discussion of self-efficacy, competence, and self-esteem, to address the diverse conceptual perspectives on these constructs.

5. An examination of self-esteem stability, with the presumption that potential for change, versus stability, is implicit in intervention. That is, if self-esteem is a fixed commodity, intervention is irrelevant.
6. A discussion of self-esteem levels, to define high, medium, and low levels with respect to intervention.
7. A consideration of self-esteem and anxiety, to examine the buffering effects related to self-esteem.
8. A synopsis of self-esteem and its relationship with depression, to pave the way for a discussion of the connection between cognitive-behavioural techniques utilised for depression, and the present training programme.

The self

The self is a multifaceted, complex phenomenon which can be understood in at least two different ways. First, the self can be seen as real, existing in its own right, with qualities which characterise it as a developmental phenomenon. This position can be found in both sociological and psychological theories. Most sociological interpretations are based on the Cooley-Mead tradition (Cooley, 1909; Mead, 1934, cited in Mruk, 1995). From this perspective the self emerges from an interpersonal field which is created as a response to, and as a consequence of, exchanges between the individual and the social context. Psychologically oriented interpretations of the "self-as-real" can be found in psychodynamic, humanistic, and cognitive models. For example, the self of humanistic theory has specific properties, such as consciousness, and innate potential awaiting actualisation (Mruk, 1995). By contrast, cognitive models define the self in terms of hierarchies, spaces, networks, prototypes, or schemata (Marsh & Hattie, 1996). In these information-processing models the self is "real" in the same way that software becomes real once it is installed on hardware. Consciousness is seen as mechanical in that, rather than making free choices, options are weighed by decision-making trees (Mruk, 1995).

The second way of viewing the self is as an abstract concept or hypothetical construct. In this approach the self can be utilised as a tool to explain behaviour. Thus, this approach is useful in terms of psychological research where self-related phenomena can be operationally defined and measured with standard surveys or tests, without having to

investigate the existence of the self. Both positions, however, have problems. For example, in the self-as-real position, the self is less open to direct observation, manipulation, or measurement. By contrast, when viewed as a construct assessment is facilitated, but, if the self does exist, this approach avoids rather than explores the issue (Mruk, 1995). The majority of self-related literature is of the second type where constructs such as self-concept, self-esteem, and self-efficacy are commonly operationally defined, manipulated, and measured.

Rather than comparing the self-as-real to the self as a hypothetical construct, to explain the focus in the literature, Harter (1996) referred to James' (1890) model of the self. James saw the self as both dependent on the social environment, as the *self-as-known* or the *Me*, and independent of the environment, as the *self-as-knower*, or the *I* (Oosterwegel & Oppenheimer, 1993). Thus, in this conceptualisation, the *I* is the active observer, organising and interpreting experience, while the *Me* is the object of *I*'s creation. Most research is conducted on the *Me* (Harter, 1996).

Self-concept and self-esteem

Within the self, representations of varying salience to the individual constitute an inner portrait. This is self-concept which has been defined as "a body of self-knowledge" (Rosenberg, 1986, p.109), and as a picture that one holds of the self with respect to one's social skills, intellectual abilities, and physical characteristics (Bernard & Joyce, 1984). Similarly, Harter (1990d), researching self-concept in adolescence, characterised it as portraying the inner psychological self, including depictions of personal and interpersonal traits, motives, attitudes, beliefs, emotions, and wishes.

In contrast to the descriptive or pictorial aspect accorded by some to self-concept, self-esteem is commonly viewed as the evaluative aspect of the self. For example, by comparison with their descriptive representation of self-concept in the social, intellectual, and physical areas, Bernard and Joyce (1984) defined self-esteem as the evaluation of performance in these three areas using social comparison. Current performance could be contrasted to past performance or to some socially defined ideal behaviour. Harter (e.g., 1993) likewise emphasised self-evaluation in her representation of self-esteem. She

defined it as the measure of global regard that one has for one's self as a person. This regard is dependent on domain-specific evaluations of proficiency in domains significant to the self. Similarly, for Rosenberg (1965), Hattie (1992), and others, the determining factor distinguishing self-concept from self-esteem was the degree to which the particular attribute was considered important to the self (Byrne, 1996b).

Although these definitions appear straight-forward, self-esteem is by no means clearly distinguishable from self-concept in many studies (Hughes, 1984). For example, in their 1976 review of self-concept, Shavelson, Hubner, and Stanton concluded that self-concept has *both* descriptive and evaluative facets. They noted that self-evaluation and self-description were not clearly distinguished empirically or conceptually. Thus, these terms were often used interchangeably in the literature.

The theoretical complexity surrounding the self and self-related concepts explains the lack of distinction. For example, self-concept, formerly viewed as a mere static reflector of on-going behaviour, is now commonly assumed as being a mediator and regulator of functioning, as well as being modified and calibrated as a result of on-going behaviour. Put in another way, self-perceptions are seen to influence behaviour which, in turn, influences self-perceptions in a reciprocal relationship (Marsh & Hattie, 1996). Although most contemporary views of self-concept are multidimensional, models vary greatly in their underlying organisation and hierarchical structure, and this latter aspect is discussed further in Chapter 5. However, regardless of the particular definition employed, general consensus is that self-concept is dynamic (Markus & Wurf, 1987). It is this dynamic complexity which potentiates problems in separating out descriptive from evaluative components in self-concept.

In accord with these dynamics, some researchers have argued that it is not feasible to refer to self-concept from an overall perspective. In this view, the emphasis is placed on the active, changeable range of self-knowledge available to the individual at any one time. This is referred to as the working, accessible, or on-line self-concept. The theory is compatible with research indicating that individual evaluation and behaviour is influenced by currently available cognitions and beliefs (Markus & Wurf, 1987). In their

model of the "dynamic self-concept" Markus and Wurf posited that the subset of representations currently available in the working self-concept is activated depending on two main factors. These are the individual's current motivational state which can include motives such as self-enhancement or self-consistency, and the present circumstances which may automatically activate relevant salient self-representations. These active structures determine the individual's actions and the observation and evaluation of these actions.

One criticism of this perspective is that it emphasises specific aspects of the self, rather than addressing the way in which the working self is processed and how information is incorporated into prior self-beliefs. By comparison, a more general view of self-concept promotes the notion of a sense of agency or of identity, although it is not clear whether individuals have a general self-concept which mediates information about aspects of the self, or whether lower-order self-concept dimensions are integrated in some other way. For example, there may be important information-processing competencies which bias, select, and retain affectations and information about the self, and these may vary depending on self-concept level and social and cultural sources of bias (Hattie & Marsh, 1996). Relating this criticism to the discussion of the self, given at the beginning of this chapter, it appears that Hattie and Marsh's argument that the working self does not account for a sense of agency, is comparable to the notion that it does not account for the self-as-real of Mruk (1995), or the *I*-self of (James, 1890). Hattie and Marsh concluded that the issue of how, or if, various self-conceptions are synthesised or integrated into higher-order structures of self-concept is unresolved, and is in need of future research.

Defining self-esteem

Referring to the terminology confusion over self-related concepts, Hattie and Marsh (1996) suggested that, rather than differences in underlying notions, there are differences in emphasis between them. Thus, they argued that self-esteem is linked to the salience of self-concept dimensions and interrelated with a sense of self-worth.

In definitions which do isolate self-esteem from self-concept it is the evaluative aspect,

as discussed above, which is generally central. Nevertheless, these definitions differ according to other factors, to such an extent that Smelser (1989) referred to the "definitional maze" of self-esteem. To organise this array, reviewers have devised various classification systems. Wells and Marwell (1976), for example, specified four basic ways of defining self-esteem. These also relate to measures of self-esteem and, as such, are discussed further in Chapter 5. The four are:

1. The attitudinal approach, where the self is treated as an object of attention.
2. The relationship between different sets of attitudes, such as between the actual and ideal self, where self-esteem is defined as the discrepancy between them.
3. Psychological responses, usually affective in nature, which the individual holds towards the self.
4. The personality approach, where self-esteem is viewed as that part of the self-system typically concerned with motivation or self-regulation (Mruk, 1995).

Although these approaches have been differentiated, they are not always singular in particular definitions of self-esteem. Whilst one may be emphasised, others are often included. Coopersmith's (1967) definition of self-esteem, for example, corresponds to Wells and Marwell's (1976) first example, the attitudinal approach, where the self is judged as an object in relation to worthiness (Mruk, 1995). However, Coopersmith considered that judgements of worthiness also relate to the discrepancy model, the second approach. That is, performance or attributes are compared with personal standards of worthiness to determine personal value. Further, his theory included aspects of Wells and Marwell's third and fourth examples, with the assumptions that self-attitudes carry affective loadings and associated motivational consequences.

Apart from Wells and Marwell's (1976) classification, various other systems have been used to understand self-esteem and to comprehensively define the construct. Mruk (1995), for instance, analysed major psychological and sociological work on self-esteem for regularities in order to develop a phenomenological definition. He concluded that three essential aspects should be included. One, the dynamics of self-esteem, refers to its potential for both stability and change, and this aspect is discussed in a subsequent

section in this chapter. A second aspect which Mruk incorporated is the lived or experiential quality of self-esteem. Mruk found in this regard, that existing definitions tended to emphasise either the cognitive or affective experience. The cognitive factor entails self-awareness and judgement, while the affective factor comprises an emotional reaction and is associated with motivational energy. Mruk argued that both cognitive and affective dimensions are essential to a phenomenological definition.

The third, most obvious aspect, involves the basic components of self-esteem to determine what is evaluated, either cognitively, or in terms of an affective reaction. Mruk (1995) found that the fundamental components, most commonly included in the literature which has informed self-esteem historically, were either worthiness, competence, or an interaction of both. Worthiness refers to a value judgement and, as such, pertains more to the actor than to the behaviour. By contrast, competence is comparable to success or efficacy, and can therefore be evaluated in terms of observable behaviour. Notable self-esteem theorists vary according to which component they emphasise or whether an interaction is proposed. Examples of their work are as follow:

Worthiness

Although both Coopersmith (1967) and Rosenberg (1979) discussed competence in relation to defining self-esteem, both theorists accorded most importance to the worthiness component. Focusing his research on children and adolescents, Coopersmith defined self-esteem as a subjective judgement of worth, expressed in a relatively enduring evaluative attitude to the self as an object. Analogous to Coopersmith (1967), and surveying a similar age-group, Rosenberg (1979) also viewed self-esteem as an attitude and as an expression of worthiness. However, several distinctions between the two theoretical positions are notable. For example, Coopersmith considered the self as a construct and his work was representative of the behavioural learning perspective. By contrast, Rosenberg perceived the self as a social phenomenon, with the self-values which relate to self-esteem, arising from the interaction of cultural, social, familial, and interpersonal patterns (Mruk, 1995).

Competence

An emphasis on competence can be traced back to James (1890), a seminal theorist of self-concept. James advanced several premises which have been endorsed by more contemporary researchers such as Harter (e.g., 1990d, 1993), and he is renowned for characterising self-esteem as the ratio of successes to pretensions. This is a competence-based definition which argues that self-esteem is dependent on proficiency in domains which are of particular consequence to the individual. As such, the real/ideal discrepancy model of self-esteem can be linked back to James (Harter, 1996).

White (1963), a psychoanalytic theorist of the self, similarly emphasised competence as a basic component of self-esteem. He argued that, in addition to its more familiar meaning as achieved capacity, competence should be viewed as a motivational concept. Thus, adopting a developmental perspective, White believed that, as a child learns to master progressive challenges, a sense of general competence is created. In White's terms, this gives rise to a feeling of efficacy and engenders the motivation to cope effectively throughout life (Mruk, 1995).

Worthiness and competence

Both worthiness, competence, and their interaction are arguably essential components of self-esteem, as when an accomplishment of beneficial value is effected (Mruk, 1995). The humanistic theorist, Branden (1969), was the first to define self-esteem in terms of both components. Branden viewed self-esteem as a basic need, achievable through the application of reason, choice, and responsibility. Worthiness and competence were seen as natural responses to exercising these options and thus living authentically (Mruk, 1995).

More recent definitions of self-esteem still differ in emphasis with respect to worthiness and competence. For example, Bednar, Wells, and Peterson (1989) focused on worthiness. They defined self-esteem as a subjective and enduring feeling of self-value and approval, based on realistic self-perceptions. By contrast, Bernard and Joyce (1984) focused on the evaluation of performance, thus emphasising competence. Finally, as an example of the emphasis on both components, Harter (1985a) included both worthiness

as global regard, and competence as the evaluation of proficiency in domains of significance to the self, in her interpretation of self-esteem.

Self-efficacy and self-esteem

Just as self-esteem definitions differ according to their emphasis on competence and/or worthiness, so self-related theories differ according to the interpretations given to competence, efficacy, and self-esteem. This section presents some of the relevant arguments in this respect.

In Bandura's (1986) theoretical framework, self-efficacy is concerned with individual judgements about how efficiently and effectively one will be able to cope with specific circumstances in the future (Ehrenberg, Cox, & Koopman, 1991). These judgements are based on performance accomplishments in which efficacy is developed through repeated success; vicarious experiences, where the effective performance of others, as models, is deemed possible for the self; verbal persuasion or feedback, where one is encouraged that difficulties can be overcome; and/or physical and emotional arousal, where less arousal, in terms of upset, is equated with greater likelihood of success (Bandura, 1981).

Efficacy judgements can vary in:

1. Level, for example, depending on the amount of difficulty in a task.
2. Generality, for example, in specific domains or over a range.
3. Strength of belief (Bandura, 1986).

Although Bandura wove a complex, well-structured theory around self-efficacy as a specific self-related concept, self-efficacy, competence, and self-esteem are not so clearly distinguishable in some of the self-esteem literature. For example, White (1963) argued that competence should be construed as a developmental, motivational concept, producing a feeling of efficacy as early successes are built upon. White thus viewed efficacy as the taproot of self-esteem (Mruk, 1995).

Whereas White (1963) linked efficacy, in the form of performance accomplishments, to self-esteem, Bandura (1990) clearly differentiated between the two. He argued against

Harter's (1985a) conceptualisation of self-esteem, where competence and worthiness are theorised as part-whole connections within the same phenomenon. Instead, Bandura posited that evaluations of self-worth and competence characterise completely separate phenomena. With respect to self-esteem, Bandura (1986) maintained that, in contrast to perceptions about future success, self-esteem depends on the extent to which personal attributes correspond with cultural values, and the degree to which behaviour matches personal precepts of worthiness. Bandura's position on self-esteem is therefore a variant of the discrepancy type, where it is viewed as a relationship between different sets of attitudes. Thus both self-esteem and self-efficacy are seen as distinct aspects of self-referent thought which make different contributions to the quality of life.

To add to the debate, although retaining her particular characterisation of self-esteem, Harter (1996) also argued that self-efficacy and the competence aspect of self-esteem are to be differentiated. She contended that perceptions of competence, as reflected in self-esteem measures, refer to past or present self-evaluations. By contrast, self-efficacy is a motivational construct, related to the belief that performance will be effective in the future.

Again, this argument is debatable. For example, the distinction between competence and efficacy with respect to future-tense is not so clear-cut in Coopersmith's (1967) work. Although, as discussed by Mruk (1995), a main accent of Coopersmith's theory pertains to worthiness, he also identified competence as another source of self-esteem. In line with the discrepancy concept, he argued that a rough assessment of successes and failures is made to compute an approximate ratio, which is used to estimate future prospects. Because those with high self-esteem are likely to have past experiences of achievement, social acceptance, and encouragement, they are similarly likely to have expectations of future success.

These diverse perspectives from important theorists point once more to the complexity of self-related constructs and to the challenge in separating them both conceptually and empirically.

Stability of self-esteem

One such challenge, implicit in the complexity of self-esteem, relates to its potential for both stability and change. Mruk (1995) referred to this potential as the dynamics of self-esteem, arguing that this should be an essential constituent of any definition. Characteristically, different interpretations of this aspect of self-esteem can be found in the literature. For example, Markus and Wurf (1987) allowed for the concurrence of both stability and change in their working model of self-concept. In their conceptualisation, both stable and malleable aspects can coexist when important core self-conceptions, resistant to change, are active at the same time as those which are more tentative and are linked to prevailing circumstances.

From another perspective, Mruk (1995) considered the matter of stability and change in terms of developmental product or process. In this view, self-esteem can be either global or situational, depending upon the context. As a global variable, it is the product of certain developmental tasks or stages and attains a particular stable level which in turn influences perception, motivation, experience, and behaviour. Alternatively, as a situational variable, it is a process where feelings of competence or worthiness vary according to context, with the potential to modify the global level.

Although the dynamics are similar, other theorists discuss the stability issue in terms of trait or state self-esteem, rather as product or process. Stability, in an emotional pattern, is termed a trait when it is recurrent and its reactional origins reside within the person. By comparison, state emotions are mainly contextual and quickly fade (Lazarus, 1989b). Trait self-esteem represents the baseline, while fluctuations around this level, induced by temporary factors in day to day events, depict state self-esteem (Heatherton & Ambady, 1993). Substantial correlations have been found between state and trait self-esteem. Trait self-esteem is not unalterable, however, and change is possible, particularly at certain stages in life (Baumeister, 1993b). For example, Harter (1990d) found that, in youngsters, self-esteem was most likely to be modified at times of educational progression, when both competence and social acceptance could vary with new developmental tasks or referent peer groups.

The previous example described the malleability of self-esteem relative to context. From a different slant, Kernis (1993) compared those individuals prone to fluctuating levels of self-esteem with those whose levels were stable. He found an interaction effect, where different combinations of stability or malleability with high or low levels of self-esteem, were associated with different responses. Before detailing these findings further, the categorisation of self-esteem levels is considered.

Self-esteem levels

Although high and low levels of self-esteem are those most commonly appraised, medium self-esteem, and varieties such as discrepant self-esteem, are also discussed in the literature.

High self-esteem

High self-esteem is generally held to be consistent with positive affect, effective functioning, and autonomy. It is hedonically preferred, that is, a more pleasant experience than low self-esteem, and has been described as a positive illusion involving personal qualities and abilities. On the negative side, high self-esteem can be linked to limitations in acknowledging personal weaknesses, and a lack of sensitivity or empathy towards others. An over-abundance of self-esteem may therefore create difficulties. On the one hand, some degree of positive self-illusion or of a self-serving bias is useful to function effectively and ignore minor threats to self-esteem. However, an excess may be problematic if personal limitations are unacknowledged, the needs of others unrecognised, or realistic problems over-looked (Mruk, 1995).

Medium self-esteem

It may be, then, that a medium amount of self-esteem is preferable. Again, concepts of medium self-esteem are equivocal, although one perspective does represent the best of high and low self-esteem. Here, medium self-esteem involves a modest belief in personal competence and worthiness, and allows for an openness to life without imprudence (Mruk, 1995). From a different viewpoint, Coopersmith (1967) argued that medium self-esteem entailed an ambiguous position of worth suggesting uncertain self-appraisal.

Low self-esteem and its variants

Uncertain self-appraisal has also been linked to low self-esteem, and is discussed further below. However, a commonly endorsed view of low self-esteem is that of negative affect, including loneliness, feelings of inferiority, and even depression. There is a tendency towards ineffective behaviour and low energy or motivation (Mruk, 1995). Low self-esteem may also be embodied in variants of self-esteem, such as defensive or discrepant self-esteem. Although these may sometimes resemble high self-esteem, Mruk argued that all involve problems with competence, worthiness, or both. As such, he selected narcissism and pseudo self-esteem as representatives of these variants.

Narcissism is hypothesised to develop from an unrealistic sense of worthiness, for want of confirmation of genuine competence. There is thus a need to defend self-esteem by overcompensation using strategies such as exaggeration, while self-centredness or excessive boasting are common. With pseudo self-esteem, by contrast, authentic competence is present, but a sense of unworthiness distorts perceptions. This can give rise to such difficulties as performance anxiety, or overachieving behaviour. In the extreme, pseudo self-esteem may even be linked to antisocial behaviour or delinquency if normal avenues for demonstrating competence and receiving recognition are unavailable (Mruk, 1995). The direction of the relationship between self-esteem and antisocial behaviour is not clear, however, and there has been controversy as to whether delinquency precedes or follows low self-esteem (Simmons, 1987). For example, Simmons and Blyth (1987), studied adolescents at educational transition and found support for the former process. By comparison, Kaplan, Martin, and Johnson (1986) argued that perceived social rejection and failure, as prerequisites to low self-esteem, may result in loss of motivation to conform to the normative group. Adolescents with such experiences may then seek peer acceptance through a more deviant route such as gang affiliation.

Recent social psychological research has also provided a comprehensive outline of low self-esteem which can be distinguished from its more customary semblance involving feelings of inferiority. These findings depict low self-esteem individuals to be as similarly desirous of self-worth as those with higher self-esteem, but with this need

inadequately satisfied. Where self-enhancement can be utilised by those with high self-esteem to reinforce worthiness, low self-esteem individuals have fewer self-esteem resources. They are not so well equipped to compensate for self-image threats and are thus cautious, protective, and defensive when their esteem is under threat. Rather than exhibiting positive, self-serving patterns of behaviour, most present a noncommittal, neutral self-image. In this regard their self-esteem is low, only in a relative sense. In an absolute sense, it can be viewed as medium, as the majority of those classified with low self-esteem do not regard themselves as completely worthless (Baumeister, 1993b). This perspective was taken by Coopersmith (1967). He argued that medium self-esteem entails an ambiguous position of worth suggesting uncertain self-appraisal. Because of this uncertainty, and thus lacking a stable sense of self, such individuals are likely to experience mood swings relative to current positive or negative incidents, and to lack the knowledge to set appropriate goals. By contrast, high self-esteem is associated with extensive self-knowledge and the stability to manage life effectively without being swayed by minor day-to-day fluctuations (Baumeister, 1993b).

Interaction of level and stability of self-esteem

Nevertheless, as introduced previously, high self-esteem is not always associated with stability, and an interaction effect between stability and level of esteem has been of interest in the literature. In recent research, self-esteem stability is typically measured using a self-report scale which asks for current, contextually based responses over multiple assessments. That is, participants are asked to respond according to their feelings at that particular moment in time. By contrast, level of self-esteem is assessed by asking how respondents feel about themselves in general (Kernis, 1993).

Some interesting results have emerged from these studies. For example, although depression and low self-esteem are commonly linked, Kernis (1993) found this association only in those with stable low self-esteem. These individuals were prone to overgeneralise the consequences of failure, considering themselves incompetent with additional failure probable, and were therefore unlikely to experience higher self-esteem at a future time. By comparison, those with unstable low self-esteem attempted to minimise the consequences of failure by making excuses, and so provided the basis for

eventually experiencing more positive self-feelings (Baumeister, 1993b). Similarly, just as low self-esteem was found to vary as a function of stability, important differences were obtained at the high self-esteem level. For example, those with high, stable, self-esteem were not generally vulnerable to the loss of self-esteem, while those in the unstable, high category were more reactive to both positive and negative evaluative events and had greater tendencies to experience anger and depression (Kernis, 1993).

Self-esteem levels and their links with stability are not clear-cut, and theorists may interpret the dynamics differently. For example, as discussed, Mruk (1995) linked pseudo self-esteem, as a variant of *low* self-esteem, with antisocial behaviour when the normal means of receiving recognition were blocked. In this view, manipulation or deviant behaviour was employed to obtain a sense of worthiness in the diminishment of others. By comparison, Baumeister (1993b) associated this type of manipulative behaviour with unstable, *high* self-esteem. Baumeister, using bullies as an example, hypothesised that their insecure but inflated views of the self resulted in aggression, in order to avoid the experience of low self-esteem aroused by potential threat. Both Mruk and Baumeister thus posited that dynamics related to threatened esteem were active in antisocial behaviour, but they associated these dynamics with different levels or stability of self-esteem.

Self-esteem and anxiety

Whether termed unstable high, or some variant of low self-esteem, difficulties arise when this type of esteem is under threat. That is, low self-esteem is associated with vulnerability to threat, often accompanied by anxiety and its attendant perceptions of helplessness and inadequacy (Coopersmith, 1967). By comparison, high self-esteem acts as a stress buffer, is associated with a diversity of coping strategies, and is linked to positive emotional states and enhanced motivation (Harter, 1990d).

To explain the relationship between anxiety and self-esteem, Coopersmith (1967) utilised the general paradigm characterising the psychological bases for vulnerability and resistance. In this process, anxiety is aroused by some threatening stimulus or situation. Consequently, defenses are evoked which act to reduce or eliminate anxiety from

awareness. From this perspective, the prevailing level of self-esteem is an important determinant of defensive behaviour. For example, self-enhancement can be envisaged as a defense against self-image threat, and is often utilised by those with high self-esteem. By comparison, uncertainty with respect to competence or worthiness, associated with low self-esteem, can evoke anxiety.

In a related vein, Bednar et al. (1989) argued that the way in which an individual responds to threat powerfully impacts on self-esteem level. In this paradigm, two important means of responding to threat and its attendant anxiety are avoidance and coping. As a general rule, a response style favouring one of these means is commonly adopted. Avoidance, although often a less difficult choice than coping, is likely to result in impression management to circumvent problem-solving. Continued avoidance is then likely, creating difficulties in generating genuine self-esteem. If this response style persists, low self-esteem develops with accompanying sensitivity to threat. By contrast, coping involves psychological risk-taking, but with the possibility for personal growth. From this premise, Bednar et al. argued that, when the coping versus avoidance ratio is changed in a favourable direction, low self-esteem can be improved (Mruk, 1995).

In the previous view, avoidance of threat and attendant anxiety engendered low self-esteem, which, in turn, evoked further avoidance. Similarly, Coopersmith (1967) posited a reciprocal relationship between self-esteem and anxiety. He argued that, once either state was established, a self-reinforcing cycle was probable. In this cycle, low self-esteem produced feelings of apprehension and helplessness leading back to lowered confidence and self-rejection. At a more serious level, low self-esteem and anxiety can be implicated in clinical problems such as substance abuse. In this disorder, difficulties with competence and/or worthiness are thought to be involved. For example, addictive behaviour can mask the anxiety related to fear of failure in competence issues, or feelings of worthlessness indicative of depression (Mruk, 1995).

Self-esteem and its links with depression

Just as anxiety has been associated with low self-esteem, low self-esteem and depression have been related. For example, characterising major depressive disorder in adolescents,

Disley (1992) described an extreme downgrading of the self, accompanied by feelings of complete worthlessness. This relationship is of particular importance in the current research because strategies, developed for the irrational thought processes in depression, are utilised in the present self-esteem-related programme. This section therefore begins with a discussion of the effects of depression and related data. Distinctions among depressed mood, depressive syndromes, and clinical depression are subsequently described in relation to the question of whether self-esteem functions as a symptom, or as a diathesis of depression. Finally, the relationship between self-esteem and depression with respect to Harter and Marold's (1994a, 1994b) research with adolescents is considered, particularly with reference to suicidal ideation.

Effects of depression

The negative outcomes linked with low self-esteem, including mood swings and low aspirations, were documented above. When depression develops, the results are much more serious. This disorder disrupts the developmental sequence of the young person's life (Sadler, 1991), is correlated with academic or vocational difficulties (Marton, Connolly, Kutcher, & Korenblum, 1993), and with troubled social relationships (Nada Raja, McGee, & Stanton, 1992). In the worst scenario, depressive illness is associated with suicidal ideation, attempted suicide, and death by suicide (Beautrais, Joyce, & Mulder, 1996; Harter & Marold, 1994a, 1994b; Joyce, 1992).

Depression appears to be on the rise among the younger age groups (Nightingale & Mulder, 1992; Seligman et al., 1995), and the highest risk for major depression is between ages 15 to 19, and 25 to 29 (Reinherz, Frost, & Pakiz, 1991). For example, a recent New Zealand study showed that 16.7% of a cohort of 930 Dunedin-born 18 year-olds had suffered a major depressive episode within the previous year (Feehan, McGee, Nada Raja, & Williams, 1994). Unfortunately, depression is likely to manifest in recurrent episodes throughout the life cycle (Covi, 1986). This was supported in a recent three-year longitudinal study with an adolescent group who presented initially with a bout of depression. The recurrence rate was 54% by the time of the last follow-up (McCauley et al., 1993).

Depressed mood, depressive syndromes and clinical depression

When considering the relationship between self-esteem and depression it is important that terms are clearly defined. For example, confusion has arisen from the generic use of the term depression in the literature, when it is uncertain whether depression refers to *depressed mood*, *depressive syndromes*, or *clinical depression*. *Depressed mood* is concerned with depression as a symptom and alludes to the presence of sadness, or a low mood, for an unspecified time span. No assumptions are made about the presence or absence of other symptoms, such as anxiety, in conjunction with depressed mood. In *depressive syndromes*, a combination of complaints including both anxiety and depression, has been identified. The syndrome is based on characteristics such as feelings of loneliness, the need to be perfect, tearfulness, worthlessness, fear, guilt and worry. The final category, *clinical depression*, is usually diagnosed according to a disease or disorder model of psychopathology with respect to the presence, duration, and severity of symptoms (Petersen et al., 1993). Diagnostic tools, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994) are commonly utilised. Included in the primary symptom constellation required to diagnose clinical depression, the *DSM-IV* records "feelings of worthlessness or excessive or inappropriate guilt..." (p.327). The importance of these feelings was signified by Beck (1991). He described the negativity permeating the self-evaluations, attributions, and recollections of clinically depressed clients as manifest in low self-esteem, self-criticism, negative predictions, and unpleasant memories.

The question arises, however, as to whether low self-esteem is comparable to a stable, enduring feature creating vulnerability to depression, or is simply a symptom of the depressive condition. Brown and Harris (1978) argued that low self-esteem interacts with particular stressors, which they labelled "provoking agents", to increase vulnerability to depression. By comparison, Tennen and Affleck (1993) contended that the evidence for self-esteem as a diathesis for clinical depression is scant, although low self-esteem may predict later depressed *mood*. Nonetheless, they suggested that further investigation may be warranted, acknowledging that studies which failed to support the esteem-as-vulnerability model (Brown & Harris, 1978) for depressive disorders may have resulted from the exclusion of stability of esteem as a variable. If susceptibility to fluctuations

in self-esteem characterise the depression-prone individual, the joint consideration of self-esteem level and stability, as Kernis (1993) suggested, may empirically validate the link between self-esteem and depressive disorders (Tennen & Affleck, 1993). Although this potential exists, Kernis acknowledged that his framework requires much work to assess its adequacy.

Self-esteem and depression in adolescence

The question of self-esteem as a depressive diathesis, or as a mere symptom of depression, is not germane to Harter's work. In her theoretical model of the antecedents and correlates of self-esteem, self-worth, affect, and hopelessness, are subsumed under a common label, the depression composite. The model arose from research with children and adolescents, from both clinical and non-clinical samples, where correlations between depressed affect, general hopelessness, and global self-esteem attained levels of .70 or higher (Harter & Marold, 1994a, 1994b). Theoretically, the model derived originally from the works of James (1890) and Cooley (1902). It subscribes to the discrepancy paradigm of self-esteem, after James, in which cognitive evaluations of adequacy, weighed according to aspirations in important domains, define self-esteem. It also incorporates Cooley's postulate of the social origins of self-esteem. In this premise, perceived support from significant others is internalised to influence level of self-esteem. The model's two main antecedents thus involve competence in domains of importance, comprising two clusters, and social support. The first competence cluster comprises physical appearance, peer likability, and athletic competence and is related mainly to peer support, while the second cluster consists of scholastic competence and behavioural conduct and is linked to parental support. Thus, depending on differing perceptions of these factors, they impact differentially on the depression composite.

Self-esteem, depression, and suicide

Depression is particularly critical because of its association with hopelessness and suicidal ideation (Offer, Ostrov, Howard, & Atkinson, 1988). This link is epitomised in Harter's model with a path from the depression composite extending to the potential outcome of suicidal ideation (Harter & Marold, 1994a, 1994b). This sequence was included in the model because the existing variables—lack of social support, low self-

esteem, hopelessness, and depressed affect—are among the constellation of social/psychological correlates predictive of suicidal behaviour (Harter, 1993). A recent study which examined the relationship between self-esteem deficits and suicidal tendencies in adolescent inpatients and high school students was congruent with Harter's model (Overholser, Adams, Lehnert, & Brinkman, 1995). In Overholser et al.'s study, low self-esteem was associated with hopelessness, higher levels of depression, suicidal ideation, and the increased likelihood of having attempted suicide. Self-esteem added to the understanding of suicidal ideation beyond that which could be explained by hopelessness and depression.

The importance of depression, as a suicidal risk factor, was documented in recent New Zealand research which was conducted with 129 adolescents, aged from 13 to 24, who had made serious suicide attempts, and 153 community controls. Research results supported contemporary views that suicidal behaviour is multicausal in origin. Childhood adversity, social disadvantage, and psychiatric morbidity were identified as independent contributors to suicidal risk. With respect to the latter category, data showed that 89.2% of those who had attempted suicide met clinical criteria for any mental disorder, in contrast with 31.4% of controls. When mental disorders were categorised into the four groupings of any affective disorder, any substance use disorder, any anxiety disorder, and any antisocial disorder, affective disorders far outweighed the others in terms of potential suicide risk. For example, those with any affective disorder were 27.3 times as likely to have made a serious suicide attempt as those without the disorder. In the next highest category, antisocial disorder, those so diagnosed were 4.4 times more likely to have attempted suicide than those without the disorder (Beautrais, Joyce & Mulder, 1996).

In the latter study, affective disorders were not separated out, and the figures thus included bipolar disorders in addition to major depression. However, the odds ratio of 27.3 which was documented is similar to the ratio found for major depression in a related New Zealand study with a mixed age-group. In this study, 302 subjects, ranging in age from 13 to 88 years, who had made serious suicide attempts, were compared to 1,028 randomly selected controls with respect to the prevalence and comorbidity of various mental disorders. For this mixed age-group the odds ratio for major depression was 27.2,

compared with a ratio of 17.4 for bipolar I or II disorders. Given as percentages, 61.9% and 14.6% of those making serious suicide attempts had experienced major depression and bipolar disorders, respectively, in the month prior to the attempt, compared with 5.6% and 1%, respectively, of controls (Beautrais, Joyce, Mulder et al., 1996). Thus, major depression is clearly linked with attempted suicide in this study.

Proposing one interpretation with respect to the link between depression and suicidal ideation in adolescents, Harter (1993) suggested that suicide may be considered by some as an escape from the painful cognitions and affects involving the self and reactions from others. These painful self-referent thoughts and feelings, and self-defeating behaviours, are the concerns targeted in the cognitive-behavioural approach to alleviating depression. This approach is hypothesised to be effective for the present self-esteem training programme and is described further in Chapter 4.

Summary

The self is a multifaceted, complex phenomenon which can be understood either as existing in its own right, from the self-as-real position, or as a hypothetical construct. Direct observation, manipulation, and measurement is difficult from the former position. However, when viewed as a construct, the self can be used as a tool to explain behaviour, and the majority of self-related research utilises the self in this way.

Self-esteem is a self-related construct which has been associated with a number of other self constructs including self-concept and self-efficacy. Self-esteem is often viewed in an evaluative sense, and self-concept as the descriptive background within which self-judgements are made. The two are not always conceptually or empirically distinct and are often embedded in complex, dynamic theories of self-concept, which include both descriptive and evaluative elements.

When considered in its own right, the theoretical background to self-esteem is equally complex. Different systems for classifying definitions have been documented. In particular, self-esteem may be defined as an attitude towards the self, or as the discrepancy between the actual and ideal self. Self-esteem theories and related

definitions vary according to whether they focus on worthiness, competence, or both. Both appear important. The competence aspect of self-esteem is likened, in some theories, to self-efficacy. The similarity is debatable, and Bandura viewed self-efficacy and self-esteem as distinct aspects of self-referent thought.

Characteristics associated with different levels of self-esteem were identified. Low self-esteem is commonly viewed in terms of unworthiness and loneliness. Alternatively, lack of self-knowledge, caution, and limited self-esteem resources may be reflected in mood fluctuations related to current events. While self-esteem is commonly regarded as somewhat modifiable, recent research has examined interactions between its level and stability. Stable low self-esteem has the worst prognosis for change and is linked to depression. Instability of self-esteem holds the potential for modification.

Links between self-esteem and anxiety were considered. High self-esteem acts as a stress buffer. Low self-esteem is associated with greater vulnerability to threat and resultant anxiety. Low self-esteem and anxiety may have a reciprocal relationship. The comorbidity of depression and anxiety is often indicated and both are linked to low self-esteem. It is debatable whether low self-esteem is a symptom or diathesis of depression. Conclusions may differ dependent on whether depressed mood or depressive disorder is in question, or whether level and stability of esteem are considered jointly.

Adolescent research by Harter and colleagues found self-worth, affect, and hopelessness to be highly related. As such, they are termed the depression composite, and are affected by perceptions of competence in important domains and by peer and parental support. The depression composite has the potential outcome of suicidal ideation. Recent New Zealand research supports the position that suicidal behaviour is multicausal in origin, and that major depression is an important area of potential risk.

In addition to research linking low self-esteem and depressed mood in adolescence, Harter (1987, 1990a, 1990c, 1990d, 1993) has extensively examined adolescence from a developmental perspective. The next chapter considers issues relevant to both developmental and mental health themes in adolescence.

CHAPTER 3

SELF-ESTEEM AND COPING IN ADOLESCENCE

Adolescent research in developmental and clinical psychology was virtually lacking in previous decades (Forehand, 1990). Recent work, such as that by Harter and colleagues (Harter, 1990d, 1992; Harter & Monsour, 1992), has begun to fill the gap. The importance of this area of research for New Zealand was emphasised by Maskill (1991) who warned that, as adolescents make up approximately one fifth of the population, they will represent a significant group in the future of the adult population. Furthermore, today's youth have had to contend with concerns such as noticeable environmental variations, constantly changing technologies, and threat of nuclear war. These are all important influences with the potential to affect emotional and mental well-being. However, as Offer et al. (1988) noted, concern about adolescents has not been combined with valid systematic data.

This chapter discusses adolescent mental well-being and coping. Initially, it considers adolescent development and concomitant changes in self-concept in terms of increasing inner and outer awareness. The questions of self-concept volatility and self-esteem equilibrium are subsequently addressed. Both are contentious issues within the literature and arguments from both sides are considered. With respect to domains of transition particularly relevant to adolescent self-esteem, the following are then examined: educational transition; domains of competence and social support; academic achievement; and pubertal change and physical appearance. Gender discrepancies in these areas are noted where pertinent. Coping in adolescence is subsequently discussed and normative and nonnormative stressors are considered in the context of coping and its links to self-esteem. Subsequently, the association between coping and self-esteem is examined with respect to locus of control and to different types of coping. A consideration of temperament, social support, perceived coping efficacy, and ego development, as they relate to coping, concludes the discussion.

Developmental changes in adolescence

The major developmental changes of adolescence, which occur in the biological, cognitive, and psychosocial domains, are widely recognised. Evident pubertal maturation signifies change in the biological sphere. The cognitive realm becomes more complex as the adolescent develops the increased capacity for abstract reasoning and self-reflection. Simultaneously, changes are occurring in the psychosocial domain in terms of interpersonal relationships and identity development (Petersen & Leffert, 1995).

Developmental changes in self-concept

Given that these biological, cognitive, and psychosocial domains affect the inner self-picture, it is clear that changes in self-referent thought will occur during adolescence. It is at this stage that the locus of self-knowledge reverts from without to within (Rosenberg, 1979). Rosenberg proposed that the earlier components of self-concept—physical characteristics, interests, and social identity factors—are increasingly overshadowed by inner constituents. Those which he identified as unfolding at this life-stage are: an awareness of the inner world of cognition, emotion, and experience; the characterisation of the self in terms of abstract traits; and the perception of the self as an interpersonal actor which comes to be understood from the perspective of others. The unreflective self-acceptance of earlier years disappears and the adolescent comes to understand the motives, attitudes, and characteristics of others as well as of the self. This development of "psychological mindedness" increases significantly during late childhood and adolescence (Hatcher, Hatcher, Berlin, Okla, & Richards, 1990).

Self-concept volatility

Undisputedly, major developmental changes occur during adolescence and self-awareness increases. Additional categories of self-description are added to the adolescent's repertoire, the range of trait labels and abstractions is expanded, and the number of discriminable domains for self-evaluation increases (Harter, 1990b). There is, however, disagreement in the literature as to whether this transition translates into a period of psychological upheaval, or is simply a particular developmental stage, unmarked by "storm and stress" for most adolescents (Block & Robins, 1993; Simmons, 1987).

In the last two decades mounting evidence for the latter stance has accumulated. For example, in a three-year longitudinal and cross-sectional study, Dusek and Flaherty (1981) established no evidence for self-concept upheaval in adolescence. No significant change in self-concept level occurred over the time period studied (ages 11 to 18). They concluded that, with respect to self-concept, the adolescent is basically the same person before and after the transition. Similarly, from the perspective of psychiatric disturbance, Offer et al. (1988) argued that the prevalence of psychiatric symptoms would likely be higher among adolescents than among adults if turmoil theories were tenable. However no such data has been found and prevalence rates for adolescents and adults are similar.

Regardless of its characterisation as turmoil or normal transition, Rosenberg (1986) maintained that there is substantial evidence to signify that adolescence is a difficult life stage. To clarify self-concept volatility, he distinguished between "baseline" self-concept, where baseline stability refers to self-concept change which may occur slowly over an extended time period, and "barometric" self-concept. Barometric change refers to the experience of rapid fluctuations in self-attitudes from moment to moment, and is the type most psychologically distressing. Rosenberg argued that this latter type intensifies in early adolescence as a result of a variety of influences. One, in particular, concerns teenagers' overriding concerns with what others, particularly peers, think of them. Because they depend so greatly on these opinions, any ambiguity in others' attitudes towards them, emphasises their uncertainty about the self.

At the same time as these psychosocial modifications are occurring, cognitive processes are also changing. Harter (1988a) described the adolescent developmental trajectory as the shift from concrete self-descriptions, to trait labelling, to forming abstractions about the self. However, until the ability to *control* the application of hypothetico-deductive reasoning to the self-theory is fully developed, disruptions within the self-system are likely. The developing awareness of diverse emotional reactions and the realisation that behaviours may differ according to role-related contexts are antithetical to a congruent self-theory (Harter, 1988b). For example the perception of behaving differently at school from at home (e.g., cheerful vs. depressed), exemplifies role-specific differentiation.

Middle adolescents, aged approximately 15 to 17 years, as opposed to younger and older adolescents, appear to be particularly vulnerable to tensions with respect to these contradictions within the self (Harter & Monsour, 1992). Harter and Monsour explained this finding from a neo-Piagetian framework. They argued that, at this middle juncture, there appears to be strong socialisation pressures for the adolescent to adopt multiple roles, while the cognitive mechanism still endorses integration. By contrast, younger adolescents have the ability to construct single abstractions about the self, but are unable to simultaneously compare these abstractions. This means that the younger group do not actually experience opposing attributes and resultant conflict. In later adolescence a more refined integration of self-referent characteristics becomes possible as the capacity to coordinate, normalise, and resolve apparently opposing self-attributes emerges. However, in middle adolescence, the tension created by such conflict within the self-system may be conceptualised as one type of storm and stress.

Self-esteem and issues of equilibrium

Just as there is debate over the issue of storm and stress in adolescence, there is also a lack of consensus as to whether there is a correlation between age and self-esteem. Two decades ago when Rosenberg (1979) made a case for self-concept disturbance in adolescence, he also argued that global self-esteem diminished in early adolescence. In later adolescence Rosenberg considered that, while self-concept disturbance generally persisted, global self-esteem improved. Acknowledging Rosenberg's work, Harter (1990d) agreed that self-esteem is not stable over adolescence and begins to decline at age 11. It is at its lowest between ages 12 to 13, and subsequently gradually and systematically improves. Factors associated with the decline, such as educational transition, are discussed in the subsequent section. With respect to the systematic improvement in self-esteem of later adolescence, Harter suggested that a number of factors may be important. As the adolescent gains experience, self-esteem may improve as personal autonomy develops and domains of competence are selected. The adolescent may become increasingly realistic about the ideal self, reducing the discrepancy and resultant psychological conflict between the ideal and actual self-images. Opportunity to select support groups may expand, and increased role-taking ability may provide avenues for more socially acceptable and self-esteeming behaviour.

In contrast to this view, Wylie (1979) found no clear evidence of a correlation between age and self-esteem, as measured on any well-known verbal self-regard scales, when other variables were suitably controlled. Wylie's findings can be construed as compatible with the recent conceptualisation of adolescent development which is consistent with a life-course stability perspective (Savin-Williams & Demo, 1984). In this perspective, the low self-esteem and turmoil experienced by some adolescents may be characteristic of the entire life course of those individuals, rather than an effect of puberty.

Whether the turmoil of puberty is detrimental to self-esteem remains in dispute. Block and Robins (1993), for example, conducted a longitudinal study of young people from early adolescence to early adulthood. Their research involved approximately 90 females and males who, at ages 14, 18, and 23, portrayed their perceived selves and their ideal selves using the Self-Descriptive Q-Set (Block & Block, 1980, described in Block & Robins, 1993). With respect to the sample as a whole, the average level of self-esteem did not alter appreciably over the three assessments. This provided support for longitudinal ordering consistency of self-esteem across the nine-year period. These results could be said to support the opinion that the biological, emotional, and social changes occurring during adolescence do not result in normative psychological disturbance (Block & Robins, 1993). However, although mean changes overall were negligible, the majority of participants changed in self-esteem level by over half of a standard deviation, highlighting the importance of understanding individual differences.

Hirsch and DuBois (1991), discussing this issue in detail, outlined the problems involved in analysing the developmental stability of self-esteem to achieve dependable results. For example, the most widely used longitudinal method focuses on the average change in self-esteem across all subjects, and thus disguises individual fluctuations if a balancing out effect occurs. The other commonly used method, correlating measures of developmental stability over time, such as rank ordering self-esteem at different times over a one-year period, also provides for a limited understanding of individual differences. Although rank ordered correlations are often in the order of .60 or higher, this still leaves much of the total variance unaccounted for. In addition, Hirsch and DuBois argued that there are sound theoretical reasons to conclude that subgroups of

early adolescents exhibit markedly disparate self-esteem trajectories. For example, the storm and stress model would indicate that adolescents present a long term decline in self-esteem, or striking ups and downs—the volatility described by Rosenberg. In contrast, the life-course stability perspective of development would indicate that most adolescents might show fluctuations in self-esteem while adapting to new conditions but, for most, the effect would presumably be short-term (see Nottelmann, 1987, below). Given the possibility of different trajectories which may remain obscured in the longitudinal methods discussed above, Hirsch and DuBois used cluster analysis. Their self-esteem research, discussed in more detail in a subsequent section, followed 128 adolescents over a two-year period and revealed four clearly separate self-esteem trajectories. As a consequence of these findings they argued that attention may better be directed towards understanding individual differences in self-esteem, rather than towards analysing its developmental stability or instability in early adolescence.

Self-esteem and domains of transition

Some of the important areas which have been associated with individual differences in self-esteem in the literature include the following: adjustment at times of educational transition, as for example, when progressing to American junior high school or to New Zealand secondary school; domains of competence and perceived support from significant others; academic achievement; and pubertal change and the physical self-concept. Gender differences apply to most of these areas. However, there is debate over the question of whether girls differ from boys with respect both to global self-esteem in adolescence, and in response to the transition into adolescence. For example, Wylie (1979), reviewing research on pre-college-age adolescents, reported no global self-image disparity by gender. By contrast, in longitudinal research, Simmons and Blyth (1987) found both preadolescent and adolescent females scored lower than males on self-esteem as well as in other specific areas of self-evaluation. Maskill (1991), reviewing New Zealand adolescent health surveys, found that females regularly scored lower than males on measures of self-esteem, while Harter (1993), in her American research, found that gender differences in self-esteem increased with development. These issues are discussed further in the remainder of this section.

Educational transition

Within the competing views of psychological turmoil, and constancy rather than instability during adolescence, the impact of educational transition on both self-esteem and perceived competence has gained considerable attention (Proctor & Choi, 1994). Simmons and Blyth (1987), in their five-year longitudinal study with 11 to 16 year-old Milwaukee students, found that the majority did not decrease in self-esteem. However, certain children suffered negative effects if the transition occurred when sufficient maturity was lacking. Girls appeared to be at particular risk, with negative effects on self-esteem persisting into middle adolescence, and recovery slow and often incomplete (Simmons, 1987). This finding supports the "developmental readiness" hypothesis, where environmental change will have negative consequences if it occurs too early, before the student is psychologically ready to handle the new social and academic demands (Simmons & Blyth, 1987).

In addition, Simmons and Blyth (1987) were interested in the impact of cumulative change. They proposed that adjustment should be easier if a student experienced change at different time periods rather than experiencing many changes simultaneously—the "focal" theory of change. Again, adolescent girls, as compared to boys, were more at risk for low self-esteem if entry to adolescence coincided with significant change in different life areas. In this respect, Simmons and Blyth argued that an "arena of comfort" where the student can feel relaxed in order to tolerate discomfort in other areas is protective. Nevertheless, despite negative effects for some children, particularly girls, there was evidence of a general rise in self-esteem for most students over the study.

In the same vein, a considerable body of research has found that educational transition is non-traumatic for the majority of students. For example, Nottelmann (1987) investigated perceived competence and self-esteem across a one-year period for fifth and sixth grade students aged around 11 to 12 years. Approximately half of these students, the transition group, transferred to a higher level school early in the study. The others formed the nontransition group and advanced to the next grade level within the same school. The study found positive change in perceived competence and self-esteem in both transition and nontransition groups, although there was more stability in specific

domains of competence than there was in self-esteem. Nottelmann surmised that this latter finding of relatively less stability in self-esteem, was likely to be related to adjustment and expectations about the new school, which later evened out. She therefore concluded that self-esteem in early adolescence does appear to be relatively stable, even for students who negotiate a new educational environment during this developmental period. Similarly, Proctor and Choi (1994) found self-esteem and perceived physical and social competence were either stable or increased for most children over the transition from elementary to junior high school.

The overall increase in self-esteem for most students, reported in both Nottelmann (1987) and Proctor and Choi's (1994) studies, was based on mean differences over all students. In addition to these mean results, Proctor and Choi reported the percentage of individual change on two measures of global self-esteem for the 112 students in their study. These results showed that approximately 50% of the sample did not change, 35% increased, and 16% decreased in global self-esteem over the transition. Comparably, with respect to changes in self-worth over the transition from sixth to seventh grade, Harter (1986, citing a dissertation by Riddle, 1985) identified three different groups of adolescents: 61% of the sample did not change, 20% increased, and 19% decreased in self-esteem overall.

Similarly interested in self-esteem disparities in early adolescence, Hirsch and DuBois (1991) investigated self-esteem trajectories at educational transition. As mentioned previously, they identified four groups using cluster analysis. They found that the self-esteem of 35% of their sample remained consistently high, 13% remained chronically low, 21% displayed steeply declining trajectories, and 31% showed a small increase in self-esteem over the two years of transition. Hirsch and DuBois discussed both the stability of self-esteem and individual differences within and between the different trajectories as follows:

1. The consistently high group presented a stable pattern of well-being. These students were satisfied with school, enjoyed high levels of perceived peer support, were competent, and were unshaken by the transition. Their stable high self-esteem pattern was likely to have preceded the transitional period.

2. The chronically low group similarly presented a stable pattern, albeit in the opposite direction, which was likely to have preceded the transition. This group were average in academic competence but had the lowest perceived peer support and least satisfaction with school. They presented with symptoms of depression which increased over the transitional two years, from the 85th percentile at Time 1, to the 94th percentile at Time 4, on the BSI (Brief Symptom Inventory; Derogatis & Spencer, 1982, cited in Hirsch & DuBois, 1991). This finding indicates that the transitional period may have exacerbated depressive symptomatology, resulting in a deterioration in well-being for this group.
3. The small increase group had reasonably high self-esteem which increased slightly over the transitional period. This may have been due to increased competence or support, or might reflect a regression towards the mean.
4. The steeply declining group initially showed high self-esteem and perceived peer support but each of these effects declined over the transition. In addition, depressive symptomatology in this group increased from the 60th percentile at Time 1, to the 80th percentile at Time 4, on BSI norms.

Interested in early identification of at-risk adolescents for preventative purposes, Hirsch and DuBois (1991) examined differences between the trajectories. The variable set consisting of satisfaction with school, academic competence, and peer support was the most powerful multivariate discriminator between all but the steeply declining group. Lacking evidence to predict which students would fall into this latter group, Hirsch and DuBois speculated that these adolescents may have been disillusioned by junior high school, had an unexpected decline in academic performance after the transition, or had experienced particularly stressful family circumstances which were not explored in their particular study. They therefore argued that it is not whether the stability model is correct that matters. Rather, it is important to examine the frequency of, and circumstances under which, different outcomes occur. Similarly Proctor and Choi (1994), with reference to the results of their own study, questioned why a small group of children suffered a decline in self-perceptions, what the consequences of the decline implied, and what preventive action might be appropriate for those early adolescents whose self-esteem declined at educational transition.

Domains of competence and social support

The decline in self-perceptions at educational transition may well be associated with a perceived lack in particular competencies and in social support for those adolescents concerned. As discussed in the previous chapter, Harter and colleagues (Harter, 1993; Harter & Marold, 1994a, 1994b), in extensive research with children and adolescents, found that both spheres are important mediators of global self-esteem and depression in older children and adolescents. Further discussion of their work is presented in this section.

From about eight years of age, children begin the process of social comparison. This process, which continues into adolescence, entails comparing the self with others across culturally valued domains such as physical appearance and scholastic achievement. By definition, these comparisons involve an evaluation of the self in terms of personal adequacy and desirability. They can therefore affect feelings of self-worth, as when the self is judged less adequate in comparison to others or in comparison to the ideal self. It has been suggested that individual differences in the social comparison process, such as whether the attributes chosen for comparison are more or less culturally valued, may comprise a predisposition to persistent negative self-evaluations, and may be associated with depression (Swallow & Kuiper, 1988). However, Stenhouse (1994) argued that, in children and adolescents, self-esteem is conditional upon parental warmth/care, school success, peer acceptance, and physical appearance. As previously discussed, it appears that parents are often most concerned with their teenager's scholastic and behavioural adequacy. Peers, by contrast, whose approval becomes increasingly influential in adolescence, are impressed with domains of likability, physical appearance, and athleticism (Harter, 1993). These domains include most attributes that can be chosen for comparison. Discounting the importance of these domains is thus likely to prove difficult, given that they are culturally valued and tied to parental or peer support. The alternative of improving competence in, for example, scholastic achievement or athleticism, may also be problematic, given individual limits on aptitude (Harter, 1993). Notwithstanding, changes in self-esteem levels do occur (e.g., see Hirsch & DuBois, 1991, above). Harter found that, although those with exceedingly low self-esteem present more of a challenge, there is potential for self-esteem enhancement among adolescents

with moderately low self-esteem if the competence/importance discrepancy is decreased and self-enhancing support established.

Academic achievement

The academic domain has been identified as one of the specific facets of self-concept relevant to self-esteem for many adolescents perceiving scholastic success as important (e.g., Harter, 1987, 1990b). Employing Harter's paradigm, it can be measured in the Self Perception Profile for Children (Harter, 1985a) as a single academic self-concept subscale, thus representing a unidimensional view of academic self-concept within a multidimensional model (Byrne, 1996a). Over the last 15 years, however, much support has arisen for a view of academic self-concept as multidimensionally structured in its own right. For example, in the Marsh/Shavelson model (Marsh & Shavelson, 1985) two academic self-concept facets, academic/math self-concept and academic/English self-concept, form separate higher-order academic factors with academic-specific self-concepts below each. Factor-analytic research with a revised version of this model incorporating additional first-order academic-specific self-concepts, showed that the latter could clearly be distinguished from each other. Research pertaining to self-perceptions in particular academic subject areas should therefore utilise instrumentation designed to measure that specific dimension, rather than employing a global scale (Byrne, 1996a).

Discipline-specific measures, in addition to separate measures of academic and global self-esteem were employed in longitudinal research following 11 to 13 year-olds for two years. In this study, Hoge, Smit, and Hanson (1990) investigated the impact of school experiences on self-esteem, using each of the three types. Subjects, such as mathematics and language, were the domains of interest for discipline-specific self-esteem. Academic self-esteem involved self-feelings regarding ability in school work, while the global level was defined with the Self-Esteem Scale (SES², Rosenberg, 1965, 1989). In Rosenberg's work, global self-esteem is viewed as an attitude and as an expression of worthiness.

²Different abbreviations for Rosenberg's (1965, 1979, 1989) Self-Esteem Scale are found in the literature, according to the edition referred to. For example, Wylie (1989) refers to the RSE (Rosenberg, 1965), Keith and Bracken (1996) discuss the RSES (Rosenberg, 1979), and Byrne (1996b) refers to the SES (Rosenberg, 1965, 1989). For consistency this scale is referred to as the SES in the present study.

Examining influences impacting on the three levels of self-esteem, global, academic, and discipline-specific, Hoge et al. (1990) found differences. The major difference between the global and academic versions was that physical appearance affected global, but not academic, self-esteem whereas IQ affected academic, but not global, self-esteem. The most important school experiences affecting both global and academic self-esteem were teacher evaluations and school climate. School climate was defined as students' perceptions regarding policies, motivations, and attitudes in general, as opposed to their opinions of particular staff members. Research has found that encouragement of student autonomy and an emphasis on cooperation, rather than competition, has been associated with higher self-esteem. For discipline-specific self-esteem, with the exception of physical education, the most important aspect was grade-level in the particular discipline.

Given that school experiences, among other factors, affect global and academic self-esteem and that self-esteem is linked to perceptions of competence, intrinsic motivation may also be affected. Harter (1992) found that children who had self-perceptions of competence were less anxious about school performance and opted for, or maintained, an intrinsic motivational style. Conversely students with low levels of perceived competence were more anxious and adopted an extrinsic motivational orientation. In addition, when studying motivation across grades, Harter noted a general pattern where intrinsic motivation decreased, and extrinsic motivation increased, at higher levels. The shift was particularly noticeable at the time of educational transition and was attributed to the new school environment. At higher levels the educational environment is commonly more impersonal, more competitive, and more evaluative, with a focus on outcome achievements superseding the enjoyment in learning for its own sake.

Accordingly, as children reach adolescence, the increasing focus on competition and achievement is likely to foster extrinsic motivation. Of even more concern, comparative performance, which generally amounts to competition as the significance of grading systems accelerate, is tied to feelings of self-worth. The need to maintain self-esteem because of this competitive focus promotes the demand to enhance ability status. Unfortunately, because competition also breeds the belief that ability is a fixed entity, this is likely to foster a sense of hopelessness for low achievers. Returning therefore to the

issue of perceived competence, it is the way in which students explain success or failure that tempers achievement. If competition breeds the need to enhance ability, and failure is linked to its lack, lowered expectations and poor performance are likely. Alternatively, if failure is attributed to a lack of effort which is modifiable, guilt and raised expectations can result in improved performance (Covington, 1989). Covington suggested that redefining the objectives of achievement from competitive to educative by returning to the learning-centred system of earlier years would improve self-worth for low achievers. He put forward several recommendations which included (a) reemphasising effort rather than ability as the preferred means to success; (b) promoting an incremental view of ability where intelligence is an ever-increasing process; and (c) emphasising the notion that falling short of goals is just that, and should not be generalised to the self.

Pubertal change and physical self-concept

Although the domain of academic achievement is particularly important for global self-esteem in adolescence, physical appearance is paramount (Harter, 1993). Physical self-concept can be viewed from either a unidimensional or a multidimensional perspective, as the literature to date is inconclusive. Whereas support has been found for the three factors of physical appearance, physical performance, and weight-control behaviours as comprising a multidimensional construct, other evidence supports a unidimensional model of physical self-concept. Further, physical self-concept is not synonymous with body image. The former reflects self-perceptions related to the physical domain, while the latter is linked more directly to affect-related evaluations of physical appearance (Stein, 1996). In the SPPC (Harter, 1985a) the two dimensions of athletic competence and physical appearance are measured in separate scales, with respect to the self-perceptions of children and adolescents.

Individual perceptions, rather than objective data, appear to be particularly important with respect to physical self-concept. For example, relative weight norms may classify an individual as well within the average weight range for height and gender, but personal perceptions may be of over weight (Stein, 1996). Similarly, with respect to physical competence and physical appearance, individual perceptions are often more influential than physical reality, while gender differences are also evident in each area. Reviewing

the research to date, Crain (1996) argued that the divergence between girls' and boys' perceptions of their physical ability self-concept appears to reflect the biggest difference between the sexes. She suggested that, in the school years, this is probably due to the greater emphasis placed on boys' participation in games and sports and to the greater variety of such activities available to them. Boys also tend to have higher physical appearance self-concepts than girls although individual differences in rates of maturation are important. For example, early pubertal development affects body-image evaluation negatively for girls and positively for boys (Simmons, 1987). Early-maturing girls are likely to be most dissatisfied with their appearance, especially in terms of weight. They tend to be heavier than later maturers and do not fit the cultural stereotype of attractiveness which is closely related to self-esteem (Harter, 1990d). Other research has found that late-maturing boys are also liable to be dissatisfied with their appearance because they are out of sequence with their peers in physical and sexual maturation. Both groups may thus experience social isolation, and are particularly vulnerable to feelings of low self-esteem related to body image (Sadler, 1991).

Although certain boys may be vulnerable to negative self-evaluation related to body image, many studies have found that girls appear to be more at risk. For example, in Simmons and Blyth's (1987) longitudinal study, both preadolescent and adolescent girls scored lower than boys on self-esteem, as well as on more specific areas of self-evaluation such as body image (Simmons, 1987). Simmons proposed that, at least in the seventies, girls tended to place more value on body image than did boys. This proposal was supported in the next decade when Offer et al. (1988) found that there was a particularly striking gender discrepancy with respect to body image in all ten countries they surveyed. Sixty-seven percent of boys compared to 52% of girls reported that they were proud of their bodies, while 38% of girls compared to 27% of boys reported feeling ugly and unattractive. The authors argued that, because these differences were not confined to the younger adolescents in the sample, results could not be a function of girls experiencing pubertal variations earlier than boys. In all countries studied, boys felt more in control, more self-confident, and happier than girls.

Similarly, Harter (1990d) argued that the evidence points to a gender divergence with

respect to looks, whereby females regard physical attractiveness as more important than males and are also more dissatisfied with their appearance. Her research indicated that there is a cluster of associated perceptions among girls which include a less salutary body image, feelings of unattractiveness, greater self-consciousness, and less positive attitudes towards their own gender. These affect female self-esteem in connection with the value placed on physical appearance in western society. A discrepancy between reality and the ideal physical self is created, affecting the self-esteem of many young women. Also discussing the gender discrepancy with respect to appearance, Offer and colleagues (1988) suggested that its basis is probably historical and social. It is related to traditional sex roles, where male roles provide greater power and access to resources than do those which are available to females. Crain (1996), however, advocated a cautionary note. She argued that, because the gender divergence in self-concept domains is not great, and girls and boys are clinically more similar than different in self-concept domains, it has limited clinical significance. It does not appear to warrant intervention such as educational programmes which aim to bring girls "up to par" with boys in perceptions of physical appearance. Thus, from Crain's perspective, gender as a moderator of multidimensional self-concept should be given less emphasis than the effects of pubertal change or the societal attitudes which encourage gender disparity.

Akin to its links with self-esteem, body-image has been linked with depression in adolescence. For example, Thompson (1990) documented research which found body image disturbance associated with elevated depression, lowered self-esteem, and general distress for adolescents. Similarly, research by Allgood-Merten, Lewinsohn, and Hops (1990) demonstrated the salience of body-image to self-esteem, particularly for adolescent girls. They found that problems with body image and low self-esteem functioned as a precursor, as well as a powerful correlate of depressive features, and argued that if adolescent girls felt as good about themselves as their male counterparts they would experience less depression. It is important to note, however, that a gender discrepancy with respect to negative perceptions of body image and related depression has not been obtained in every study. For example, Patton (1991), in her Australian research, found a relationship between self-image and depression for both adolescent girls and boys. No significant difference was established on mean depression scores by gender.

Coping

Depression, characterised by feelings of inadequacy, diminished activity, and discouragement about the future is antithetical to coping (Chaplin, 1985). This section addresses the definition of coping, and discusses stressors typical to adolescence, in addition to nonnormative stressors. Subsequently, the relationship between coping and self-esteem is examined with reference to locus of control and to different categories of coping. Temperament, social support, and perceived coping efficacy are then considered as factors involved in the complex association among stress, coping, and self-esteem. A consideration of ego developmental stages in adolescence, as they relate to coping, concludes the discussion.

Defining coping

Although there is controversy in the literature regarding the precise meaning of coping, the definition offered by Lazarus and Folkman (1984) is clear and relevant to adolescence. They defined coping as "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). This definition is process, rather than trait orientated, does not distinguish between coping and defensive processes, and emphasises management, rather than mastery, of stress. The process-oriented perspective recognises both stability and change. This flexibility is particularly important in adolescence where, over development, there may be significant shifts in the strategies used to cope with different stressors in specific situations (Hauser & Bowlds, 1990).

Normative and nonnormative stressors

In adolescence, normative stresses, such as those related to pubertal development and educational transitions, pressures to explore risky areas, and relationship issues, are usual. Nonnormative stressors, which increase the adolescent's risk of maladaptive outcomes such as depression, may involve the familial stressors of divorce or parental psychiatric disorder, chronic illness, or social burdens (Hauser & Bowlds, 1990). Maskill (1991), profiling the health of New Zealand adolescents, identified seven groups of young people particularly vulnerable to stress-related problems. These are as follow: minority group adolescents; those experiencing significant loss; adolescents with disabilities or chronic

illness; victims of physical, sexual, or emotional abuse; adolescents who are unemployed, homeless, or enduring poverty; and pregnant adolescents and teenage parents. Although some adolescents in these groups will become healthy, resilient adults, nonnormative stressors are often problematic. In New Zealand, for example, "stress and adjustment reactions" was cited as the leading cause of mental health first admissions for 15 to 19 year-old New Zealand females in 1992 (New Zealand Health Information Service, 1993). However, as Hauser and Bowlds emphasised, the relationship between stress and negative outcomes, such as low self-esteem and depression, is not simple. Just as stressful situations may negatively influence coping to disturb well-being, low self-esteem and depression may also be antecedent to, rather than result from, stressful conditions such as substance abuse or school problems.

Self-esteem, locus of control, and categories of coping

With respect to stress and adjustment, a coping, as opposed to an avoidant response style was discussed in relation to anxiety in the previous chapter. In this paradigm, coping is a gauge of personal adequacy, with successful coping posited to generate pleasing self-evaluations because the psychological responses, inherent in the behaviour, are of high quality. High or low self-esteem is therefore a result of the inner, affective feedback most commonly experienced in response to coping with, or avoiding, some type of conflict (Bednar et al., 1989). Similarly, and viewing high self-esteem as a protective factor, Harter (1990d) found that it acts as a stress buffer, is associated with a diversity of coping strategies, and is related to enhanced motivation and positive affect in adolescents.

Kliewer and Sandler (1992) also investigated the stress-buffering effects of self-esteem. This research included locus of control as a moderator variable and was conducted with 8 to 16 year-olds who had experienced a variety of negative stressful life events. Results showed that the stress-buffering effects of internal locus of control on psychological symptoms occurred across age and gender. However, the buffering effect of self-esteem was found only for females and was accounted for by the interaction of locus of control and self-esteem. This indicated that, for females, external locus of control and low self-esteem was associated with most vulnerability to the effects of stressful life events on

psychological symptoms. It was unclear why this effect was not found for boys. One suggestion was that the stressful events utilised in the life events measure were predominantly familial or interpersonal examples. They may thus have been more threatening to girls' self-esteem, as compared with boys'. With respect to the processes involved in the stress-buffering effects of locus of control which occurred across age and gender, Kliewer and Sandler noted that associations between children's control beliefs and coping behaviour have been equivocal in the literature. In adults, several studies have supported the relationship between internal control beliefs and the ability to appraise and cope, using strategies appropriate to the degree of controllability in the situation. If situations actually *are* controllable, then problem-focused coping efforts and challenge appraisals are likely to be adaptive. Conversely, if situations are perceived as uncontrollable, strategies such as redefining the importance of the event, are likely to promote stress reduction.

In contrast to problem-focused coping which is intended to impact on particular stressors, emotion-focused coping, such as denial or distraction, is aimed at regulating associated emotional states (Hauser & Bowlds, 1990). Although Bednar et al. (1989) argued that avoidant techniques are unlikely to benefit self-esteem, strategies such as denial of a chronic illness can sometimes facilitate emotional equilibrium. For this reason, coping techniques cannot be categorised indiscriminately as "good" or "bad". Effective coping is likely to involve flexibility, and no single strategy will be effectual for all types of stress (Compas, 1987). Yet certain processes, such as delaying gratification, depending on personal resources, and being orientated to the future, are among patterns of coping which have been found to contribute to resilient outcomes (Hauser & Bowlds, 1990).

Temperament, social support, and perceived coping efficacy

Besides locus of control, controllability of situation, and response style, temperament is involved in the complex relationship among stress, coping, and self-esteem. An easy-going disposition can buffer the impact of stress (Hauser & Bowlds, 1990), while different types of coping tasks may be beneficial to self-esteem, contingent on personality. For example, Bednar et al. (1989) pointed out that an adolescent with a dependent nature may benefit by learning to disagree.

Social support is also important. Social support, with reference to both parents and peers, was characterised above as a mediator of global self-esteem in children and adolescents (Harter, 1993). Because peer group acceptance becomes increasingly salient in adolescence, balancing family and peer group demands is potentially stressful, demanding coping skills. It appears that, as they get older, adolescents extend their social networks and differentiate within them with respect to the type of support which is required (Hill, 1993). Those who fail to maintain social support may suffer as a consequence because loneliness and disruptions in peer relationships are associated with adolescent depression (Gray, 1988; Nada Raja et al., 1992). Similarly, lower perceived attachment to parents is significantly related to lower levels of psychological well-being for New Zealand adolescents (Nada Raja et al., 1992). It may be, therefore, that the capacities necessary to develop and maintain good interpersonal relationships are the basis of psychological well-being and adaptive functioning (Ebata, Petersen, & Conger, 1990).

Sustaining positive interpersonal relationships involves confidence in one's popularity and social skills. By contrast, perceived self-inefficacy in social attachments can produce depression by reducing the development of personal relationships which provide satisfaction and buffer stress (Bandura, 1990). Here, the emphasis is on the cognitive aspect of coping. Dwelling on coping deficiencies in any competence area is distressing and inefficacious. Self-appraisals of inadequacy mediate disruptive arousal and impair performance by diverting attention from the current task to self-evaluative concerns (Bandura, 1981). Depression can thus occur from perceived inefficacy to accomplish any desired life goal which affects the evaluation of self-worth (Bandura, 1990).

Ego development

Developmental stage is the final factor to be considered with respect to stress and coping. Hauser and Bowlds (1990) defined ego development as the "qualitatively differing psychosocial stages through which an adolescent progresses" (p.399). Focusing on varying profiles in adolescence and their relationship to coping, they identified four different trajectories. These trajectories represented the base level of ego development in early adolescence and the subsequent pattern of change or stability through high school. Hauser and Bowlds characterised these as follows:

1. At the earliest stage, relatively simple cognitive constructions were apparent, there was significant dependence on parents, and relationships with others were exploitative. If this stage continued for at least two years, it was termed the "severely arrested path of ego development". In this trajectory, coping styles reflected low levels of empathy, objectivity, and intellectuality. Defense mechanisms such as displacement, detachment, and rationalisation, thought to be related to problematic adaptation, were evident.
2. A second pattern portrayed compliance with peer dictates and with social rules. Awareness of complex views and individual differences was limited. These students were at conformist stages, common during adolescence. If advancement to higher stages did not occur, this stage was termed the "steady conformist path".
3. The third trajectory was that of "accelerated ego development". This stage contrasted most markedly with the severely arrested path, and reflected the highest levels of empathy, objectivity, and intellectuality. This higher level reflected a postconformist ego stage and included an adherence to norms based on inner standards, a strong interest in paradox, and a regard for complexity of experience. There was increased autonomy from parents and concern for mutuality with others.
4. The fourth trajectory was termed the "progressive ego development path", to represent a shift from any of the earlier stages of functioning to a more advanced stage.

Ongoing research into these psychosocial stages and their relationship to coping is important. Several predictive studies have suggested that variations in the underlying dimensions of ego control and resiliency can anticipate such problems as depression or drug use. Other, more general, research has outlined how personality and developmental paths may underpin adaptation and coping in adolescence (Hauser & Bowlds, 1990).

Summary

In summary, inner changes and external influences in the biological, cognitive, and psychosocial realms, impact on the young person at adolescence. Self-concept matures and there is growing awareness of the self and of the motives and opinions of others. This awareness brings new concerns about role differentiation and impression

management, thus it may prove difficult for the adolescent to construct a stable sense of self. There is disagreement in the literature as to whether adolescence translates into a period of psychological upheaval, or is merely a particular developmental stage, unmarked by storm and stress for most adolescents.

Likewise, debate has occurred with respect to changes in self-esteem during adolescence. For example, Rosenberg (1979) argued that self-esteem declined in early adolescence and subsequently improved, while Wylie's (1979) review found no correlation between age and self-esteem. Similarly, there is disagreement as to whether, on average, adolescent girls rate lower in measures of global self-esteem than boys, or whether the gender difference occurs solely in specific dimensions of self-esteem. Therefore, rather than analysing the developmental stability or instability of self-esteem, or, for that matter, overall gender differences, understanding individual differences was considered to be more useful.

Educational transition is one important area where individual differences are present. Although research shows that, for most students, self-esteem remains stable or rises over the transition, immature students or those experiencing multiple changes, may be negatively affected. This may be particularly true for females. Different self-esteem trajectories may exist, with a low self-esteem group and a declining self-esteem group most at risk for depression and loss of perceived support.

Individual differences in areas of competence are indisputable, and important domains such as academic achievement and physical ability are commonly esteemed by either parents or peers who provide social support. It is therefore difficult for the adolescent to discount the importance of these areas, or to increase proficiency in areas where ability or endowment is mediocre. Further, the focus on competition, which accelerates during college years, promotes the notion that ability is fixed. The approach of learning-centred education, with emphasis on effort rather than achievement, was a suggested alternative to increase motivation and self-worth for low achievers. Body image is a domain of paramount importance to adolescents. Adolescent girls may be especially vulnerable to negative self-evaluations and associated depression related to body image because of the

cultural emphasis on female attractiveness.

Educational transition and emphasis on physical attractiveness may create normative stressors causing problems for some adolescents. Nonnormative stressors are likely to be even more difficult to cope with. Coping involves the way in which these stressors are appraised and managed, and particular groups of young people are likely to be most at risk for maladaptive outcomes. Coping can be categorised as problem-focused or emotion-focused, and an avoidant approach may often be detrimental to self-esteem. However, context and individual differences, including temperament and locus of control, may determine the type of strategy used, and matching relevant strategies to particular stressors is associated with adaptive coping.

Social support may affect coping and self-esteem. If the adolescent cannot balance family and peer demands, or has problems with interpersonal relationships, loneliness or depression may ensue. The cognitive domain is similarly important. Self-perceptions of efficacy or inefficacy impact on psychological well-being and competence.

The adolescent's stage of psychosocial development interrelates with these other factors. Adolescents at the simplest cognitive stage may cope less adaptively, and may utilise those defense mechanisms associated with problematic adaptation. In contrast, those at a higher level of empathy, objectivity, and intellectuality may cope best. The possibility exists that these developmental paths may be used to forecast psychological or behavioural problems.

The cognitive therapeutic approach has been used extensively in dealing with both psychological and behavioural problems. The following chapter discusses cognitive-behavioural theory and therapy and reviews pertinent studies which have used this approach.

CHAPTER 4

THE COGNITIVE-BEHAVIOURAL APPROACH: THEORY, THERAPY, AND INTERVENTIONS

In the section above which discussed coping in adolescence, coping was defined with reference to the individual's changing cognitive and behavioral endeavours to handle problems. Cognitive-behavioural approaches to therapy are congruent with training in adaptive coping. Although their theoretical foundations and methodology are highly varied, both cognitive and behavioural models presuppose that prior learning is having current maladaptive consequences (Brewin, 1996). Interventions focus on the mediating function of cognitions in maintaining or eliminating emotional distress or problematic behaviour (Lazarus & Folkman, 1984). New behaviours are practised utilising relevant cognitive strategies and a different coping structure is produced. This structure represents a template which is founded on experience. It is the basis for recognising problems, mediating dysfunctional processing, and for adaptive problem-solving (Kendall, 1992). Thus the cognitive-behavioural approach does not neglect affect and environmental influences at the expense of cognitive and behavioural strategies, but integrates cognitive, behavioural, affective, contextual, and social strategies for change (Kendall, 1993).

Cognitive-behavioural therapies encompass a variety of different approaches. There were five or six basic types of cognitive psychotherapy in 1980, and there are now more than twenty (Mahoney, 1993). These vary according to their explanation of how cognitive and behavioural factors are integrated, processed, judged to mediate change, and in the techniques they employ (Clarke, Lewinsohn, & Hops, 1990). Because many of the skills in the present training programme are based on Beck's cognitive model (1961) and the RET model proposed by Ellis (1962), each is subsequently discussed with reference to theory and therapy, scientific status, and tenets on self-esteem. Following a consideration of these models, the cognitive-behavioural approach in general is addressed. In the final sections, different types of self-esteem enhancement programmes utilised in the classroom are examined, prior to a discussion of specific cognitive-behavioural interventions which are particularly relevant to the present research.

The cognitive theory of Aaron Beck

Theory and therapy

Beck's clinical application of the cognitive perspective was initially evident in his early therapeutic work on depression (Mahoney, 1993). His theory and therapy have since been adapted to a variety of psychiatric disorders such as the emotional disorders and anxiety (Beck, 1976; Beck & Emery, 1985). This present discussion will focus mainly on depression because of its link with low self-esteem, and the primacy of the depression theory in Beck's work. Although early expositions of the cognitive theory of depression did not distinguish between endogenous and nonendogenous types, the causal elements of the theory have now been restricted to nonendogenous depression. The theory can be separated into its descriptive and causal components, both with testable hypotheses. Descriptively, depressed individuals are postulated to present with the cognitive triad of automatic negative thoughts about the self, the world, and the future. The degree of negative thought is believed to correlate with the severity of other symptoms (Haaga, Dyck, & Ernst, 1991).

The causal elements of the theory pertain to the view of human information processing where schemata, or integrated knowledge structures, are believed to influence memory and current judgements. These schemata can be adaptive, or can be more potent and negative (Hollon & Beck, 1994). If negative depressogenic schemata are present, they are considered to be latent predispositions which can lie dormant for long periods before being activated in response to certain factors. In particular, individual differences in autonomy and sociotropy are hypothesised as the two personality modes which specify the classes of stressors likely to trigger dysfunctional beliefs. For example, stress in the form of personal rejection is more likely to activate dysfunctional beliefs in a person high in sociotropy, rather than in one who is high in autonomy (Haaga et al., 1991). When activated, depressogenic schemata override more adaptive schemata to skew information processing, constituting the negative cognitive shift (Beck, 1991). This shift entails biased inferences and interpretations about the self, the world, and the future. Dysfunctional beliefs are thus postulated to constitute a predisposition for nonendogenous depression: the theory's causal diathesis-stress hypothesis (Haaga et al., 1991).

The biased interpretations which occur with the cognitive shift, are discernible in distortions such as *selective abstraction*. In the latter case there is a focus on particular negative aspects of a situation at the expense of the more positive facets. Cognitive distortions link the dysfunctional schemata with current maladaptive automatic thoughts or imagery (Robins & Hayes, 1995). In cognitive therapy, or CT, these maladaptive cognitions and attitudes are evaluated. The aim is to modify them by empirically disconfirming their validity to correct distorted concepts and thus to encourage more adaptive emotional responses and behaviour.

Beck's cognitive model holds that dysfunctional or distorted thinking is common not only to depression, but to all psychological disturbances (Beck, 1995). Particular schemata bias perceptions in terms of danger, loss, or other varieties of threats to the self (Robins & Hayes, 1995). It is hypothesised that interventions at the cognitive level modify affective and motivational symptoms, because the three systems of cognition, affection, and motivation, are interrelated. Thus changes in one system may offset changes in the others (Beck, 1991). In all forms of therapy originating from Beck's model, treatment is founded on a cognitive formulation of a particular disorder which is applied to an understanding of the individual patient (Beck, 1995).

Scientific status

From its inception for the treatment of depression in the 1960s, the cognitive model has been the subject of much research. The aspects considered important for the present discussion include the efficacy and prophylactic effects of CT for depression; its efficacy for other problems; a consideration of the mechanisms of cognitive change which are hypothesised to occur with CT; and empirical support for the descriptive aspects of the theory, and for its causal formulation.

Efficacy and prophylactic effects of CT for depression. Studies investigating the cognitive model of depression have been generally supportive of the efficacy of CT. However, it is premature to conclude that CT's efficacy has been established, or that CT is superior to pharmacotherapy or to other psychotherapies (Hollon & Beck, 1994). For example, Dobson's (1989) meta-analysis of 28 studies found cognitive therapy more

efficacious for treating unipolar depression than behaviour therapy, pharmacotherapy, or other psychotherapies, but the conclusions of this analysis have been questioned. Many of these studies lacked a placebo control group and pharmacotherapy may have been insufficient (Robins & Hayes, 1995). In addition, although later studies have supported the efficacy of CT, they have generally been conducted with populations which are not wholly clinical, or they have been conducted by the adherents of CT (Hollon & Beck, 1994).

Comparing CT, as well as interpersonal psychotherapy (IPT), to pharmacotherapy with respect to treatment and prophylactic effects for depression was of particular interest in a recent study by the *National Institute of Mental Health's Treatment of Depression Collaborative Research Program (NIMHTDCRP)* (Elkin, 1994). The study included a control condition where patients received minimal therapist encouragement and a pill placebo. Among its findings, the TDCRP study found no significant differences at the conclusion of treatment between the two psychotherapies and pharmacotherapy. An advantage for pharmacotherapy, however, was suggested by the small, but consistent numerical gains in its measures. Specifically discussing the effects of CT, Elkin reported that it did not seem to do as well for the more severely depressed patients, and was not found to be significantly superior to the placebo control condition, as has been shown in other studies. She suggested, therefore, that, because the placebo condition included therapist support and CT was not found to be significantly superior, CT's effectiveness may not be due to the more specific factors hypothesised in its approach. In response to the TDCRP findings, Hollon and Beck (1994) raised their own objections. These included questions about the way in which CT was operationalised in the research and the fact that findings were not robust across the different sites of the study. Looking at the TDCRP results, as well as those of other studies where comparisons of CT and pharmacotherapy have produced a series of tie scores, they therefore judged it reasonable to conclude that CT is approximately equal to pharmacotherapy in treating depression, regardless of severity, in nonpsychotic clients.

Another important consideration, given that depression is generally episodic, is the difference between CT and medication in terms of relapse and recurrence. Relapse is the

return of symptoms related to prior episodes of depression, while recurrence is the onset of a new episode. Most depressive episodes run their course in between 6 to 12 months, even without treatment. Follow-up studies have suggested that CT reduces risk following treatment termination. For example, several studies found that clients who responded to CT were only half as likely to experience depression following therapy termination as were clients who responded to pharmacotherapy alone. However, in the main, instances of differential symptom return occurred within the first few months following treatment completion. This suggests that the CT advantage was most likely related to the prevention of relapse rather than recurrence. Studies are needed to ascertain whether the effect of CT can extend to the prevention of new episodes. Antidepressant medication is also effective in preventing relapse in responders. That is, it will suppress symptom reemergence while medication is continued, but there is no indication that it reduces the underlying risk of recurrence. Current pharmacological practice is therefore moving toward the indefinite maintenance of medication for patients who have a history of recurrence (Hollon & Beck, 1994). Summarising these findings, Hollon and Beck argued that CT appears to be no less effective than medication in reducing acute distress, and may be superior in reducing subsequent risk. With respect to the prophylactic effects found in the TDCRP study, Elkin (1994) reported that CT did appear to do better than pharmacotherapy in follow-up studies, but because the placebo-minimal support control group also did well, caution is required in interpreting findings.

Efficacy of CT for other problems. In addition to its service in the treatment of depression, cognitive therapy has achieved promising results with panic disorders. Recent research has shown that up to 90% of patients are panic free after 3 months of CT. Although therapy involves several components, cognitive restructuring has been shown to play a major part in treatment (Robins & Hayes, 1995). Similarly, CT has been credited with success in treating various other problems, including substance abuse and eating disorders (Beck, 1995). However, because these treatments have mainly combined cognitive and behavioural methods, empirical demonstration of the effectiveness of CT, as such, with these problems, is lacking (Robin & Hayes, 1995). Pathological conditions, although critical, are not the only focus of the cognitive model. More recently, common problems, such as relationship conflicts, have also been targeted (Beck, 1989). The

rationale for this approach is that the more serious biases of pathological conditions are theorised to be exaggerated versions of those occurring typically. For example, Beck (1991) argued that the systematic negative bias in depression, and the contrasting positive bias in mania, support the presence of comparable but less obvious biases in normal, everyday responses. This concept is discussed further in the section on self-esteem.

Mechanisms of change hypothesised to occur with CT. There has been support, then, for the efficacy of cognitive therapy, particularly with depression. With respect to the active ingredients of CT, cognitive theory assumes that change is brought about by virtue of efforts to examine the accuracy of existing beliefs, and that change in these beliefs is the mechanism of change in CT. Support has been found for this assumption in research where modification of attributional style appeared to mediate CT's relapse preventive effect (Hollon & Beck, 1994). However, although a change in the content of underlying assumptions and depressive schemata is hypothesised to occur with CT, other mechanisms which could also account for the effectiveness of cognitive-behavioural treatment for depression have been suggested. For example, treatment may deactivate depressive, and activate more adaptive schemata. Alternatively, the process of teaching compensatory skills to cope with depressogenic cognitions may mediate change (Brewin, 1996). Reviewing evidence to date, Barber and DeRubeis (1989, cited in Brewin, 1996) argued that the development of compensatory skills was the primary mode of action, but that repeated employment of these skills could result in a change in underlying schemata.

Empirical support for CT: Descriptive and causal hypotheses. Akin to support for the efficacy of CT, there has been empirical support for many of CT's hypotheses associated with the descriptive aspects of depression. For example, the *negativity hypothesis*, predicting the pervasiveness of negative thinking in all forms of depression, has been most consistently supported. Empirical support has also been established for the *content-specificity* hypothesis. This hypothesis, proposing that different disorders have specific cognitive profiles, has found support mainly in differentiating between anxiety and depressive disorders (Beck, 1991; Haaga et al., 1991). Less consensus has been reached on the validity of the cognitive theory of depression with respect to its diathesis-stress causal formulation. Haaga et al. (1991) considered four testable hypotheses related to

this formulation and found little convincing empirical support. For example the *onset hypothesis*, where initial incidents of nonendogenous unipolar depression should be anticipated from the interaction of dysfunctional beliefs, vulnerability-congruent negative events, and event valuations, is crucial to cognitive theory. Although a fully adequate test would be difficult to devise, studies examining the increase of depressive symptoms with a variety of negative elements have provided mixed but mainly negative results. However, given that these hypotheses are generally difficult to test, they remain viable (Haaga et al., 1991).

Self-esteem

In much of his writings, Beck referred to low self-esteem in relation to the negative bias inherent in depressive disorders. In this formulation, when depressive schemata are active, interpretations of experience are shaped by particular absolute beliefs such as "I can't do anything right", "I am worthless", and "I am unlovable" (Beck, 1991). These beliefs, hypothesised as forming early in life, become embedded in depressogenic schemata. They can be activated when specific life experiences and cognitions, related to areas such as self-worth or social desirability, impinge on more adaptive schemata. As maladaptive schemata become more active they can be evoked by a broad range of stimuli through the system of stimulus generalisation (Kovacs & Beck, 1978). In addition to the association with depression, Beck (1989) discussed low self-esteem within relationship problems. He argued that although negative bias is less exaggerated in every-day conflict situations than it is in depression, it can still constitute prejudice. The latter, with its underlying biased expectations and conclusions, reflects the "negative cognitive set" where all interpretations are tainted. One form of this prejudice applies to those with low self-esteem. Self-blame and assumptions of personal deficiencies predispose such individuals to interpret others' reactions towards them negatively. In this case, the object of their prejudice is themselves rather than a partner or an associate.

In the cognitive model, then, the negative cognitive set is the focus of therapy, be it in severe depression, or the low self-esteem associated with certain conflict situations. It is therefore appropriate that many of the same strategies which are utilised to combat depressogenic cognitions are used with low self-esteem. A prime example of this can

be found in the work of David Burns, a prominent cognitive psychiatrist and an associate of Aaron Beck. In 1980, Burns detailed the cognitive distortions common to depression in his bestseller on that disorder, *Feeling Good. The New Mood Therapy*. In a subsequent self-help book, *Ten Days to Self-Esteem*, Burns (1993a) described comparable cognitive distortions and very similar techniques to improve mood—this time focusing on self-esteem rather than depression.

The rational-emotive theory of Albert Ellis

Theory and therapy

Both Beck's model of cognitive therapy and Ellis' RET model focus on the individual's interpretation of events, rather than the activating situation, as mediating emotional upset. This is clearly presented in the "ABC" theory of psychopathology which is the basis of RET (Ellis, 1962, 1973). In this model, activating events (A) are not posited as direct causes of emotional and behavioural consequences (C). Rather, beliefs (B) about the events are the most important causes of emotions and actions (Haaga & Davison, 1995). RET differs from Beck's CT in that Ellis (1980, 1989) advised therapists to identify and contest underlying beliefs first, rather than targeting or emphasising automatic thoughts. In CT automatic thoughts are first challenged, and core beliefs are targeted later in therapy (DiGiuseppe & Bernard, 1990). Another difference is that CT places more emphasis on empiricism and is more likely to use behavioural components. Clients in CT are trained to experiment behaviourally to examine the accuracy of their self-beliefs, whereas RET therapists are more likely to use reason and logic, aiming for a philosophical change (Hollon & Beck, 1994). RET philosophic change is discussed further in the section on self-esteem, below.

In RET, as in CT, underlying beliefs are hypothesised to arise from both inherited and learned dispositions (Ellis, 1962, 1973, 1991). All humans, especially children and adolescents, are suggestible to both family and cultural standards. These standards entail rigid external rules and pressures, mediating self-defeating behaviour and neuroses. Although environmental pressures are important, internally repeated unconditional shoulds and demands are of even more concern. In other words, in RET theory, it is self-reindoctrination of irrationalities that largely leads to emotional distress. The RET

position is not unlike the depressive attributional style where negative outcomes are ascribed to internal, stable, and global aspects of the self. RET hypothesises that emotional and behavioural upset occurs when such negative outcomes are defined as *awful* rather than merely unpleasant. Both theories have similarities in identifying the maladaptive effects of ascribing excessive personal responsibility (Kendall et al., 1995).

RET hypothesises that an inclination towards these self-suggested imperatives derives from a biological predisposition to demands, rather than favouring more adaptive alternatives. Adaptive or rational behaviour assists, rather than sabotages the self, and develops through useful interactions, and collaboration with other members of the social group (Ellis, 1995). There are three Basic Demands which are linked by RET to emotional disturbance. These are, " 'I absolutely must perform well!' 'You always *have* to treat me nicely!' [and] 'Conditions *must* completely be as I want them to be!'" (Ellis, 1995, p.108). The thought disturbances which derive from, and accompany these absolutist demands, include the cognitive distortions described by Beck (1976) and other cognitive-behavioural therapists. In RET, clients are taught that no evidence actually exists for the verity of the Basic Demands. Therapists work with clients to forcefully argue against their unconditional character, which is hypothesised to be the source of upset, and to change demands to preferences. Accountability in creating personal upset through illogical thinking, and the converse ability to "uncreate" it, is emphasised (Ellis, 1995). By overcoming the disposition to succumb to irrational demands and thought disturbances, it is proposed that clients can ameliorate accompanying emotional upset and ineffectual behaviour (Ellis, 1962, 1973, 1991, 1995).

Among its functions, RET has been employed with many clinical disorders and has been presented to lay people as a self-help method. It has also been adapted for psychoeducational training programmes with youth, to improve self-concept, reduce test anxiety, and the like (Haaga & Davison, 1995). A variety of articles and books attest to rational-emotive educational (REE) efforts to prevent psychological disorders and promote mental health in children and adolescents (e.g., Bernard & Joyce, 1984, 1993; DiGiuseppe, 1990; Waters, 1982). REE interventions are discussed in a later section.

Scientific status

Although Ellis has not claimed a comprehensive theory of personality, rational-emotive therapy and theory have generated much interest in the literature. In particular, RET has been criticised for its lack of precision in defining both the meaning of personality, and the hypothetical constructs involved in this term (Ziegler, 1989). Compared to Beck's complex cognitive model, RET is far less clearly operationally defined (Haaga & Davison, 1989). This presents problems. It affects verifiability and comprehensiveness, since the poorly defined concepts are not amenable to empirical validation, and particulars such as the precise nature of human motivation remain largely unaddressed (Ziegler, 1989). Similarly, Lazarus (1989a) argued that the RET theory of emotion is deficient. He noted, for example, that it is overly rigid in its position on irrational beliefs and lacks details of the mediational roles of appraisal and coping in day-to-day reactions.

The assessment of RET therapeutic interventions and of irrational beliefs have also been criticised. Critics have argued that experimental data documenting RET's efficacy is not extensive (Mahoney, Lyddon, & Alford, 1989), and that outcome studies have neglected to measure treatment adherence, both in terms of therapist competence and in integrity of implementation (Kendall et al., 1995). Questionnaires, such as the *Rational Behavior Inventory (RBI)* (Shorkey & Whiteman, 1977) have been cited as lacking in discriminant validity and consequently better suited for assessing such broad-band properties as negative affectivity. Some newer measures have been developed to reduce the overlap with negative affectivity and enhance content validity by associating item content with theory. These include the *Survey of Personal Beliefs (SPB)* (Kassinove, 1986) which has provided some evidence of discriminant validity. However, much research is still required to develop and validate RET measures. For example, once the discriminant validity of irrational belief measures is demonstrated with regard to negative affectivity, it would be useful to investigate the specificity of irrational beliefs to particular categories of psychopathology (Kendall, et al., 1995).

Despite these criticisms, the RET theory of personality does rate highly in four important respects. It stimulates research; the clearly presented assumptions about human nature lead to a structure of theoretical concepts which are internally consistent; the ABC theory

is relatively straightforward; and RET has functional significance—addressing a variety of human problems, and with applied centres world-wide (Ziegler, 1989).

Self-esteem

Although self-esteem measures have been employed in REE studies, where the target is improved mental health, their use poses a philosophical problem for RET. This is because RET theory is directed more to a *lack* of self-rating. Utilising self-concept scales, where high scores reflect positive self-rating, thus appears antithetical to RET (Haaga & Davison, 1989). Self-rating is unquestionably criticised by Ellis (1973) who argued that global feelings of worthlessness derive from evaluating competencies or attributes negatively, and generalising these judgements to the entire self. In his view, it is certainly useful to rate competencies and attributes in order to improve circumstances, but it is emotionally destructive to rate the self. In RET philosophy, self-worth is a given. Low self-esteem is thus linked to the irrational Basic Demands, as when one *must* not fail at an important task or relationship. If failure occurs in the presence of such a "mustabatory" demand, it is likely to be generalised to the self. One then feels worthless or undeserving as a person, rather than less competent in a particular area (Ellis, 1995). In RET, then, self-rating is discouraged and unconditional self-acceptance is promoted. The self is viewed as an intricate combination of abilities, traits, and behaviours which cannot be rated in a global fashion (Waters, 1982). However, recognising that this philosophy is difficult for some, two levels of RET have been suggested. Thus "general" RET, synonymous with cognitive-behavioural therapy, aims to improve emotional response and adaptive behaviour (Ellis, 1980). "Preferential" RET goes further and involves attitudinal restructuring and acceptance of the RET philosophy. It endorses unconditional positive regard and strives for pervasive, rather than symptomatic change (Ellis, 1980; Mahoney et al., 1989).

The cognitive-behavioural approach

Strict adherents of CT or RET aim to follow closely to their particular model. Yet, given growing evidence that there are likely to be some effects specific to particular techniques as well as large common effects across therapies, a majority of therapists have become eclectically orientated (Lambert & Bergin, 1994). Similarly, it is common for cognitive-

behavioural interventions to utilise strategies from different models. This section discusses the cognitive-behavioural approach with reference to the following issues: assumptions common to the basis of cognitive-behavioural interventions; how treatments, specifically targeting a particular area of the personality can generalise their effects to other areas within the cognitive, emotional, motivational, and behavioural realms; the distinction between cognitive distortions and cognitive deficiencies; and the effects of developmental level on therapeutic effectiveness.

Common assumptions

Cognitive-behavioural interventions target a variety of mental-health and behavioural concerns and encompass a diversity of theorems and techniques. However, underlying this diversity are three assumptions which establish common ground and explain the use of a combination approach. It is assumed that the validity of constructs and directions for practice are empirically sound; that cognitive mediating events influence behaviour; and that individuals actively participate in their own learning (Hall & Hughes, 1989). The *Adolescent Coping with Depression Course* (Clarke et al., 1990), is one such example. It is based on the premise that successful short-term cognitive-behavioural interventions for depression include a well-planned rationale; that skills taught conform to this rationale; that skills should be meaningful to participants and generalise to real-life situations; and that participants should attribute mood improvements to their own, rather than therapist, efficacy (Clarke et al., 1990). The components in the course include relaxation training founded on Jacobsen's (1929) method; cognitive therapy sourced on the theories of Beck (1961) and Ellis (1962); and social skills training based on research demonstrating that depression and poor social functioning are highly correlated (Clarke et al., 1990). Thus, different aspects of depressive cognitions, attitudes, and behaviours are addressed through the use of the different components, and these are empirically justified according to the initial premise.

Generalisation of treatment effects

Although cognitive-behavioural therapies are designed to address many facets of a disorder, specific treatments targeting a particular area of the personality can generalise their effects to other areas. Diverse cognitive-behavioural interventions can therefore

produce similar results. For example, a study comparing cognitive therapy, a behavioural pleasant-activities treatment, and a social-skills treatment found all three methods reduced depressive levels and that effects generalised across treatments. That is, the cognitions of participants in the social skills programme changed as much as did those of the cognitive therapy group while their social skills were similarly modified; the pleasant activities of participants in the behavioural group altered as much as did those in the cognitive group, and so on (Clarke et al., 1990). This effect corresponds with the position, discussed previously, that cognition, affection, and motivation are interrelated, and changes in one system can offset changes in the others (Beck, 1991).

Cognitive distortions and deficiencies

In effecting change, cognitive-behavioural interventions are concerned with cognitive dysfunction. This construct has been separated into the two categories of cognitive distortions and cognitive deficiencies with reference to children and adolescents (Kendall, 1985, 1993). Cognitive distortions were discussed above in the context of the CT and RET models. These distortions are evidenced by dysfunctional or biased information processing. In contrast, cognitive deficiencies refer to an absence of careful information processing in contexts where thinking would be useful (Kendall, 1993). As an example of the distinction, depressed adolescents are likely to have distorted cognitions, attributing internal, stable, and global causes to negative situations. They are also likely to exhibit cognitive deficits in interpersonal problem-solving, lacking the ability to assertively solve these difficulties (Jaycox, Reivich, Gillham, & Seligman, 1994). Cognitive-behavioural interventions often target both categories. Such flexible programmes seem to have most lasting power and influence, as would be expected given the opportunity for different modalities to set corrective processes in action (Lazarus & Folkman, 1984).

Developmental level

Given that corrective processes are activated in cognitive-behavioural therapy (CBT), the question arises as to which variables mediate their effect with dysfunctional children. Durlak, Fuhrman, and Lampman (1991) conducted a meta-analysis of cognitive-behavioural studies, conducted between 1970 and 1987, in order to investigate this, and related issues. They hypothesised that developmental level would moderate treatment

effectiveness and this was supported. The effect size established for children aged between 11 and 13, presumed to be at the formal operational level of functioning, was almost twice that of younger children at lower cognitive levels. They also found that CBT produced worthwhile changes in children's adjustment, although additional improvement was both feasible and desirable. However, a significant relationship between changes in cognitive processing and behaviour was not supported. This indicates the need for further research to outline the particular mechanisms of therapeutic change (Durlak et al., 1991).

Self-esteem interventions in the classroom

Cognitive-behavioural interventions can act to enhance self-esteem directly or in conjunction with therapies for other disorders. Self-esteem enhancement with children and adolescents can also be addressed through various experimental means in the classroom, as is the case with the methods discussed in this section. These are included for comprehensiveness and are classified as curriculum assistance; special classroom procedures; and teacher training. Programmes which incorporate outdoor educational activities are not reviewed, as these are arguably in a different category to the classroom based cognitive-behavioural focus of the current research.

The first area, enhancing competence in particular curriculum areas, pertains to extra or remedial instruction, often in reading. Research has found that gains in self-esteem can occur as a by-product of the accompanying increase in assistance and teacher commitment in the area concerned, while parental involvement can contribute further (Gurney, 1987). This is in accord with Harter's (e.g., 1993) premise, described in the previous chapter, where parental support, often conditional on academic achievement, was characterised as an important mediator of global self-esteem in children and adolescents.

In addition to targeting curriculum areas, special classroom procedures, such as the use of film-making and cultural experiences, have been used in self-esteem enhancement. Research with the latter has resulted in positive changes in relationships, self-expression, and in established behaviour patterns in 11-year-old inner city children (Gurney, 1987). Another example of a specialised classroom approach is in the use of role-play. One

study, for example, reported significant changes in social behaviours and in self-concept following a psychodramatic role-play intervention. Role-play themes included accepting criticism, taking responsibility in difficult situations, and the like. The premise behind the use of psychodramatic role-play of personally relevant behaviour is that psychological processes are promoted. These processes are hypothesised to change cognitions and emotions about the enacted behaviour. This perspective has some resemblance to the theories of Beck, Ellis, and other cognitive-behaviouralists who attempt behavioural modification by first restructuring maladaptive cognitions and emotions (Jupp & Griffiths, 1990). Role-play is often utilised in cognitive-behavioural interventions, but is included in this section, rather than the cognitive-behavioural one, because of its different theoretical background.

Although remedial and specialised programmes have been successful in raising self-esteem, teacher involvement and commitment is arguably even more important. Lawrence (1996) argued that no self-esteem programme will be effective if the teacher concerned does not possess qualities of genuineness, empathy, and acceptance. He contended that teachers are in a particularly strong position to influence self-esteem because it is not failure *per se*, but reaction to failure that is of import (Lawrence, 1989). Again this is similar to Harter's position and comparable to Covington's (1989) premise that it is the way in which failure is explained that is important. Teacher training in understanding student level of functioning and in formulating realistic expectations of students is therefore crucial. In the curriculum remediation area discussed above some of the studies examined the effectiveness of the specific training packages utilised, compared to teacher-made materials. Results showed that curriculum packages were less important than teacher involvement, because teacher-made materials worked equally well. Additional research suggests that training teachers to encourage self-rewarding behaviour in students, as well as increasing self-praise is useful for both parties (Gurney, 1987).

Cognitive-behavioural interventions guiding the current research

Educating teachers to increase positive feedback, as in the example above, has a behavioural orientation. If teachers had also been trained to recognise underlying faulty cognitions which, for instance, fuelled negativity, the approach would be classified as

cognitive-behavioural. As discussed previously, one of the hall-marks of the latter orientation is that cognitive mediating events are hypothesised to influence behaviour (Hall & Hughes, 1989). In this section, research and interventions which are of specific relevance to the present study are discussed. These are self-instructional training (Gurney, 1987; Lamke, Lujan, & Showalter, 1988); self-esteem training (Burns, 1993a); the *Program for Innovative Self-Management (PRISM)* for troubled adolescents (Wexler, 1991); depression and stress interventions (Clarke et al., 1990; Gillham, Reivich, Jaycox, & Seligman, 1995; Jaycox et al., 1994; Kahn, Kehle, Jenson, & Clark, 1990; Lewinsohn, Clarke, Hops, & Andrews, 1990); REE studies (Bernard, 1996, cited in Bortolozzo & Steventon, 1997; Bernard & Joyce, 1984; Vernon, 1994); and strategic skills training (Covington, 1989). Some of the preceding interventions are primarily targeted at self-esteem enhancement, while others focus on depression, stress management, problem solving, or a combination of issues, but all have a bearing on self-esteem. Mention is made where activities or ideas were derived from particular interventions for the current training programme.

Self-instructional training

Self-instructional training is a cognitive method which has been used with students to strengthen academic skills and problem solving. It has also been employed in self-esteem enhancement studies. As an illustration, Gurney (1987) described research where increased positive self-referent verbal statements (PSRVS) correlated positively with increased self-esteem in children. In these studies students were taught to replace negative self-referent statements, likely to occur in difficult situations, with more positive statements. Gurney suggested that changing the frequency of PSRVS is useful in raising self-esteem, while there is also some support for the effect persisting over time. However, this is not always the case. For example, one cognitive-behavioural modification programme which aimed to change adolescents' self-statements and raise their self-esteem resulted in a significant increase in positive self-statements but no significant changes in self-esteem (Lamke et al., 1988). Nevertheless, the latter study was useful in that it showed that adolescents *can* modify negative self-statements and maintain this change over time, and a related activity was therefore incorporated in the present training programme. The absence of an effect on self-esteem in Lamke et al.'s

research may have been due to several factors, as they discussed. For example, positive self-statements were not linked to specific skills training so that behavioural strategies may have been lacking. In addition, the brevity of the fourteen-hour training period may have been associated with the lack of change in self-esteem.

Self-esteem training: Burns

Although the previous example of self-instructional training involved one main activity, interventions targeting more than one area are often more appropriate, given that self-esteem itself is a multi-faceted construct involving cognitive, emotional, behavioural, and social factors. The cognitive-behavioral self-esteem programme for adults and older adolescents, devised by Burns (1993a), fits this broader-based pattern. The course was first run at the Presbyterian Medical Centre of Philadelphia with inpatients, and pilot studies have been held in a variety of settings in Pittsburgh. It can be used privately in the home, or in self-help therapy groups in schools, colleges, prisons, and hospitals. Although schools are included, the level of understanding involved appears more appropriate for older adolescents and adults. Burns has written an accompanying Leader's Manual for the group procedure (Burns, 1993b). The programme itself incorporates activities and concepts from CT, RET, Burns' own clinical experience using cognitive-behavioural methods, and spirituality. It is presented in the form of a self-help work book with ten weekly steps. Prior to each step, self-report measures of depression, anxiety, and relationship satisfaction are completed, in order that users can gauge their progress. Adhering to cognitive theory, the course teaches the relationship between thoughts, feelings, and actions, and incorporates instructions and exercises such as methods to alter cognitive distortions. Burns' work book was of assistance in styling the present student work book, particularly in terms of the homework contract, homework rationale, cognitive distortions, and discussion sections at the commencement and completion of each session.

The PRISM programme: Wexler

Similarly a broad-based approach, Wexler's (1991) *PRISM* programme was designed for troubled adolescents. The basic 16-session programme is run by Wexler and colleagues in a hospital setting but can be used in schools or other suitable environments. The

intervention is based on three theoretical sources—self psychology (Kohut, 1971), CT (Beck, 1976), and hypnotherapy (Erickson, Rossi, & Rossi, 1976)—and it integrates cognitive-behavioural techniques with other approaches in a synergistic system (Wexler, 1991). Its goal is for teenagers to establish a more wholly developed sense of self. It targets self-esteem, self-control, self-management, self-efficacy, and self-soothing through practising the four central skills of self-talk, assertiveness, body control, and visualisation for self-cohesion. Wexler's programme was useful in developing the present training programme in terms of its content on attitude patterns, strategies to use when assertive communication is not effective, and the giving and receiving of positive messages.

Interventions targeting depression

The Adolescent Coping with Depression Course. Although not primarily self-esteem programmes, adolescent depression interventions are very closely related. As previously discussed, the painful self-referent thoughts, emotions, and maladaptive behaviours associated with depression and low self-esteem are targeted in such interventions. The *Adolescent Coping with Depression Course* (Clarke et al., 1990), discussed above, was particularly useful in developing the present training programme in terms of setting an agenda for each session, diagramming the three-part personality system, and the social skills content.

In its original form, the *Adolescent Coping with Depression Course* was trialed with 59 adolescents, aged between 14 and 18, who met *DSM-III-R* (American Psychiatric Association, 1987) and *Research Diagnostic Criteria (RDC)* (Spitzer, Endicott, & Robins, 1978) for a diagnosis of depression. These students were randomly assigned to an adolescent-only, adolescent-and-parent, or a wait-list condition. Both adolescent groups received 14 two-hour sessions of the depression programme over a period of seven weeks, while the parents in the adolescent-and-parent condition were enrolled in a separate parent group. Although results favoured the parent-and-adolescent condition over the adolescent-only condition, just one of the numerous comparisons was statistically significant. Compared to a waitlist condition, treated adolescents improved significantly on depression measures, and gains were maintained at the two-year post-treatment period (Lewinsohn et al., 1990). Research has found that younger depressed students are also

likely to benefit from the depression course. The course was adapted for 10 to 14 year-old depressed students, and its efficacy for the treatment of depression was investigated along with relaxation training and self-modelling interventions in a school-based programme. Compared to a waitlist-control, all active conditions showed a significant decrease in depression and a comparative increase in self-esteem (Kahn et al., 1990).

From a preventative perspective, Clarke et al. (1995) trialed an adaption of the *Adolescent Coping with Depression Course* with 150 adolescents, mean age 15.3, with respect to affective diagnostic outcome. These adolescents were considered to be at risk for future depression in terms of elevated depressive symptomatology, but they had no existing depressive disorder. Through the use of cartoons, role-plays, and discussion, students were taught to identify and challenge irrational beliefs and distortions hypothesised to contribute to future depression. Immunity to depression through raising self-esteem, developing coping strategies, and cultivating a high frequency of pleasant activities was a priority. The adolescents were randomly assigned either to the intervention, consisting of fifteen 45-minute sessions, after school, three times a week for five weeks, or to a "usual care" condition where they could continue with any pre-existing intervention, or pursue new assistance during the study period. Results showed that the adolescents who had been in the intervention group were significantly less likely to develop major depression or dysthymia over the 12-month follow-up period.

Prevention of depressive symptoms in school children. Whereas the previous study discussed affective disorder as the outcome measure with adolescents, a related intervention investigated the prevention of depressive symptoms in pre-adolescent children, aged 10 to 13. Sixty-nine students in the prevention group and 49 matched controls took part in the programme. These children were characterised as at risk for depression based on depressive symptoms and on their reports of frequency of parental conflict. Students in the prevention condition were assigned to groups of 10 to 12, and met for 90 minutes each week for a total of 12 weeks. Results were reported at six-month (Jaycox et al., 1994), and two-year follow-up periods (Gillham et al., 1995). It was hypothesised that the programme would result in the enduring relief of depressive symptoms persisting after the termination of treatment, and in the nonoccurrence of

expected symptoms in students who did not experience many initial symptoms.

The programme consists of a cognitive component, based on CT, RET, and therapies developed by Seligman (1991), and a social problem-solving component which includes direct training on coping with conflict. It targets depressive symptoms in addition to related problems such as low academic achievement, poor peer relations, and conduct problems, because of the hypothesised overlap in the expression of behavioural problems and depressive symptoms. For example, both depressed children and those with behavioural problems are inclined to demonstrate a hostile attributional bias, the former in ambiguous situations (Jaycox et al., 1994). The programme's cognitive component focuses on interpretation of problems, and aims to modify distorted depressogenic cognitions and pessimistic explanatory style. The social problem-solving and coping training focus on behaviour, and aim to counteract the deficient cognitive processing thought to be involved in acting-out behaviours. This distinction between components approximates Kendall's (1993) distinction between cognitive distortions and deficiency in cognitive processing.

Results showed that the programme produced positive long-term benefits with respect to depressive symptomatology. Although, overall, results did not support the reduction of internalising and externalising behavioural problems among prevention group students, parents of programme children reported fewer externalising behavioural problems than did those of controls at 6-month follow-up. This may indicate that the programme prevents the recurrence of externalising behavioural problems. Both depression-related prevention hypotheses were supported. The first hypothesis predicted enduring relief of depressive symptoms. Students in the prevention group who presented with initial depressive symptoms reported significantly fewer symptoms than the control group over the two-year follow-up period. Notably, prevention group children were only half as likely as controls to report moderate to severe depressive symptoms. The second hypothesis predicted the non-occurrence of expected symptoms in students who had no initial symptomatology. This hypothesis was partially supported. Children who had pre-intervention depressive symptom scores below the sample median reported significantly fewer symptoms during two-year follow-up than did controls. However, the difference

in reports of moderate to severe levels of symptoms between groups was not significant. In addition to these results, the prevention effect was shown to grow over time. Although depressive symptoms increased over two-year follow-up in both groups, as was expected given that therapy outcome effects generally wane after treatment, the prevention group had a lower increase in depressive symptoms over time than did controls. These results suggest that cognitive interventions which commence in late childhood may prevent the occurrence of depressive symptoms in early adolescence (Gillham et al., 1995). This programme was particularly useful in designing the present programme in terms of including both cognitive and behavioural components, and targeting both cognitive distortions and deficiencies.

REE studies

As discussed, these depression prevention programmes often incorporate important concepts from RET, while RET itself has also spawned specific rational-emotive educational studies designed to enhance students' socioemotional growth. Providing such experiences is aimed at reducing potential problems associated with stress, self-esteem, communication, and expression of feelings (Bernard & Joyce, 1984). RET is an appropriate medium to improve students' well-being because it emphasises critical thinking and is characteristically educative. In terms of preventative interventions, components include instruction on acceptance of strengths and weaknesses; discussion of the way in which feelings are dependent on perception; acknowledgement of both irrational and rational beliefs, where the former results in disturbing negative emotions; instruction in problem solving; and learning to tolerate frustration by challenging irrational beliefs (Vernon, 1994). Each of these concepts was included in the present training programme.

A very recent RET based programme, *Program Achieve*, developed by Dr. Michael Bernard (1996, cited in Bortolozzo & Steventon, 1997), is presently being piloted in Australia. The programme is designed to teach students how to be successful both in and out of school and, as well as rational-emotive education, incorporates research from areas such as stress-inoculation, self-efficacy, and interpersonal problem solving.

In addition to preventative work, REE has been used for remediation purposes. A review of 46 studies which utilised REE with "normals" as well as children with clinical, behavioural, and other problems found REE efficacy greatest on measures of irrationality. Although this review found moderate effects of REE in promoting behavioural and emotional change, there was no convincing evidence that these changes resulted from cognitive modification. Moderate support was found to indicate that REE influenced locus of control towards increased internality. This is consistent with the RET position that teaching emotional responsibility should bring about changes in rationality and in locus of control. Only half of the 19 studies using a self-esteem measure showed a benefit from REE, indicating that REE interventions could be modified to produce more consistent change on this dimension. Finally, personality and adjustment measures showed positive changes in 57% and 63% of the studies respectively, suggesting that REE has the potential to impact favourably on adaptive functioning in school-aged children (Bernard & Joyce, 1993; DiGiuseppe & Bernard, 1990).

Strategic skills training

Problem solving was acknowledged as an important area of instruction in REE and other cognitive-behavioural interventions such as the *Adolescent Coping with Depression Course* (Clarke et al., 1990). It is similarly important for strategic skills training. For example Covington (1989), whose work was discussed in the previous chapter, argued that, rather than competition in the classroom, effort and motivation to learn are most important and are linked to self-esteem. To this end, he researched strategic thinking skills training for over two decades. This training involved strengthening students' resource management and problem-solving skills. Results showed a number of motivational benefits. These included the increased likelihood that students would accept reasonable challenges, where success was not certain but was not improbable, and would be less likely to abandon their own judgements if these differed from peer-group opinions. The value of problem solving was recognised and included as a component in the current training programme. Concepts from the work of Berg and Calderone (1994), Elias, Branden-Muller, and Sayette (1991) and Spivack, Platt and Shure (1976) were utilised.

Summary

This chapter commenced with an overview of CT and RET, as integral to the conceptual basis of the present research. Both CT and RET posit that thoughts, feelings, and behaviour are interrelated, and, in particular, that the individual's perception of events mediates the other aspects of personality. Both have generated much empirical research and have functional significance. Theoretically however, CT is more tightly defined and complex than RET, and its efficacy, particularly for depression, has been fairly well supported. In general, studies have found that CT is comparable to pharmacotherapy for depression, and CT may be superior in reducing risk of recurrence. It is not certain which mechanisms of cognitive change occur with CT, although it is posited that change is brought about through examining the accuracy of, and changing maladaptive existing beliefs. The descriptive aspects of CT have been well supported—particularly the negativity hypothesis—but there is less consensus as to the validity of its diathesis-stress causal formulation. Overall, RET has been more strongly criticised than CT on empirical grounds. In particular, lack of precision in defining its theory of personality and associated hypothetical constructs renders problems with validation. Thus, critics have argued that experimental data documenting RET's efficacy is not extensive, while measures of irrational beliefs could be improved. However, RET is very functional. It has centres world-wide and is the basis of rational-emotive educational research.

Self-esteem was considered with respect to both CT and RET. CT posits that feelings of low self-esteem are part of the overall depressive mode, and can also be found in every-day relationship problems. Low self-esteem is evidenced in cognitive distortions within the negative cognitive set. It follows that the therapeutic methods, used to modify depressive thinking, can also be utilised and investigated in their ability to treat low self-esteem. Although, for self-concept problems, RET also attacks cognitive misconceptions which it designates as irrationalities, RET's philosophy is quite different. RET argues that the very concept of self-esteem is problematic because the self is a process. It is a conglomerate of features which cannot be rated globally, although specific competencies can be rated. Complete self-acceptance is therefore advocated. RET recognises that this perspective is inappropriate for some, and distinguishes between "preferential" RET, which aims for philosophic change, and "general" RET, which is similar to CT.

Although different theoretical perspectives denote different therapeutic strategies, cognitive-behavioural interventions commonly use techniques derived from several sources. In such broad-based programmes common underlying assumptions apply. The most important assumption is that cognitive mediating events influence behaviour, while both cognitive distortions and cognitive deficiencies are often targeted. There is empirical support that successful outcomes are moderated by cognitive developmental level where preadolescents and older students are more likely to benefit than those beneath the formal operational level. Regardless of components included in these interventions, outcomes often generalise across cognitive, emotional, behavioural, and social domains. This underscores the interrelationship between thoughts, feelings, and actions, and suggests the potential of a broad-based cognitive behavioural intervention as an effective treatment for low self-esteem.

Although cognitive-behavioural programmes are utilised to impact self-esteem, self-esteem enhancement for students can involve other types of programmes. A variety of these were briefly reviewed. These included programmes involving curriculum assistance, where self-esteem is enhanced as a by-product, particularly with strong teacher and parental involvement; special classroom procedures, such as role-play, to promote positive psychological processes; and teacher training in positive reinforcement.

Cognitive-behavioural interventions, relevant to the present self-esteem related research, were then considered. These encompassed self-instructional training, self-esteem programmes, depression interventions, rational-emotive education, and strategic skills training. Overall, these interventions were well-structured, demonstrated positive results with adolescents, and were deemed useful in designing the present training programme.

Following the next chapter, which discusses the measurement of self-esteem, the rationale for the present programme is discussed and the composition of the training programme is outlined in detail. It is argued therein that, given the capacity of cognitive-behavioural programmes to correct faulty cognitions which sustain depression and related self-esteem difficulties, a preventative broad-based programme should impact favourably on low self-esteem in adolescents.

CHAPTER 5

THE MEASUREMENT OF SELF-ESTEEM

To demonstrate their effectiveness, cognitive-behavioural programmes related to self-esteem enhancement generally use an assortment of outcome measures. Survey or test type self-report measures are typically included and are the primary focus of this chapter. However other diverse techniques can be used in self-esteem research and a variety of these are discussed. Subsequently, some general issues related to self-report measures of self-esteem are considered. Finally, the SPPC (Harter, 1985a), the self-perception scale utilised in the present research, is reviewed.

Methodological diversity

A traditional way of categorising evaluation techniques is to organise them in a hierarchical fashion. In this approach the more subjective, qualitative methods are placed lower on the scale, with the more objective, quantifiable methods located higher (Mruk, 1995). The introspective approach, the case study, the interview method, and experimental research are discussed in line with this hierarchy, and with respect to self-esteem theory and measurement.

Introspection

This is usually placed lowest on the methodological hierarchy as it is almost wholly subjective and vulnerable to the usual problems of validity and reliability associated with a single sample. Nevertheless, this method has proven particularly valuable to the literature because James (1890), generally held to be the first psychologist to create a self-concept theory, founded his work on private experience (Mruk, 1995). Four basic notions included in James' theory are the discrimination between the *I*-self, as active agent, and the *Me*-self, as content of experience; the self-concept as a hierarchical and multifaceted structure; the social aspect of the self which is concerned with external evaluations; and the operational definition of self-esteem as the ratio of successes to pretensions. These concepts have anticipated many of the succeeding developments in self-concept theory and related measurement instruments (Marsh & Hattie, 1996).

The case study method

Another researcher who contributed to the self-esteem knowledge base used the case study to generate his hypotheses. Arguing that self-esteem entailed the interrelated aspects of efficacy and personal worth (refer Chapter 2), Branden (1969) was the first theorist to explicitly include both components in a self-esteem definition. This added a crucial dimension to self-esteem understanding as the *relationship* between the two came under consideration. Nevertheless, the case study is often seen as a soft technique, low on the methodological scale, with problems of subjectivity and replication (Mruk, 1995).

The interview

This method ranks higher on the methodological scale because it is more reliable and valid than introspection or the case study. For example, results can be recorded and data can be analysed. However, sample sizes are relatively small and establishing cause and effect is difficult (Mruk, 1995). Despite these limitations and the time and financial costs involved, the interview measure has important uses. For example, it appears to be more effective than the self-esteem questionnaire in predicting the onset of depression. Discussing possible reasons for this effect, Andrews and Brown (1993) suggested that, compared to the interview, global self-esteem questionnaires are more likely to be mood dependent because they are typically restricted to generic and abstract self-descriptions. The interview, in contrast, can tap areas of dissatisfaction associated with performance in particular role-related, real-life situations. Its more specific questions may have clearer referents in memory, deeming it less likely to be vulnerable to mood-state effects than the global self-esteem scale. In addition, cognitive vulnerability to depression may be related to particular circumstances which a less comprehensive measure may miss.

Damon and Hart (1988) similarly advocated the interview method as a flexible means to gauge self-understanding in children and adolescents. They argued that self-esteem cannot be studied independently of self-understanding and that therein lies the problem with self-report scales. These scales, failing to reflect the reorganisation of self-concept which occurs over development, cannot validly assess self-esteem to produce clear empirical results. Damon and Hart thus developed an interview schedule based on their model of development from childhood to late adolescence. The model has four

developmental stages, each encompassing aspects of the *I*-self and the *Me*-self of James (1890). Among the arguments supporting their choice of the interview method, Damon and Hart maintained that its very lack of standardisation, for example in allowing question probes, acts as a validity control. Probes, and flexible restructuring of questions ensures comprehension and makes for responses relevant to these questions, rather than to alternative interpretations.

Experimental research

Whereas the interview can be criticised in terms of problems in establishing cause and effect, the experiment is considered to be the epitome of the scientific approach. In experimental research causal links can be demonstrated between constructs and other behaviours, with the manipulation of related situational factors and the control of extraneous variables (Mruk, 1995). The experimental method is used extensively in the literature brought together by Baumeister (1993a) which presents social psychological theories on the nature of low self-esteem and its emotional and behavioural effects. For example, Spencer, Josephs, and Steele (1993) discussed experimental findings related to self-affirmation and self-esteem level. They found that, although self-consistency explanations propose that low self-esteem individuals are not self-affirming, preferring realistic feedback, even if negative, to support their self-view, their own experiments have supported a different explanation³. They suggested that low self-esteem people, akin to those with high self-esteem, *do* strive for self-affirmation but use different strategies because costs are different. In situations where there is a potential threat to self-image, high self-esteem people can more readily access positive self-aspects as a counter to threat. Low self-esteem individuals, in contrast, have fewer self-esteem resources to call on. Rather than utilise self-enhancement, they may use different strategies, such as downward social comparison or caution, to maintain their self-integrity. Thus motives are similar, but the cost-benefit ratio is different for those with high or low self-esteem.

³For example, self-image threat was manipulated by giving subjects different amounts of feedback about subjective estimates of their IQs. When feedback was immediate, low self-esteem subjects lowered their IQ ratings in anticipation of humiliation if they overestimated. As hypothesised, high self-esteem subjects, with greater resources to protect against self-image threat, did not lower their ratings. When IQ estimations were ostensibly anonymous, no difference between the groups was found (Spencer et al., 1993).

Although such experimental research is extremely valuable for generating theoretical knowledge, samples utilised are usually small. Further, they are often unrepresentative of a widespread population and lack generalisability to real world situations.

Measurement with tests or surveys

The self-report test or survey is generally placed below the experiment in the methodological hierarchy, but it is the most utilised method in self-related research (Keith & Bracken, 1996). This section will discuss this measurement method with respect to issues associated with self-concept and self-esteem instruments, examining particular instruments where relevant. The issues include: the way in which self-esteem is operationalised, with respect to the generalisability of scores across measures based on different themes; variation in theoretical perspectives on the structure of self-concept and related measures; variation among measures arising from disparate psychometric strategies and response sets; and developmental changes in self-concept with consequent implications for measurement scales.

Operational definitions of self-esteem

One of the most important issues regarding self-report measures in areas appertaining to the self concerns the operational definition of the construct under consideration. In this section the definition of self-esteem is considered with respect to measurement scales, in order to address the issue of generalisability across different instruments.

The attitudinal approach, where the self is treated as an object of attention, is most commonly used in defining self-esteem (Wells & Marwell, 1976). Two well-known scales based on this approach are Coopersmith's Self-Esteem Inventory (SEI; 1967) and Rosenberg's SES (1965). From the attitudinal perspective, self-esteem is viewed in terms of approval or disapproval towards the self. For example, item two of the ten items which comprise the SES reads, "On the whole, I am satisfied with myself" (Wylie, 1989).

Another common conceptualisation of self-esteem is as the discrepancy between the real and ideal self (Wells & Marwell, 1976). Based on this approach, the SPPC (Harter, 1985a) is a well-known self-perception measure reflecting the position that cognitive

evaluations of adequacy, weighed in relationship to aspirations in important domains, operationalise self-esteem. The SPPC and its psychometric properties are discussed more fully later in this chapter.

Yet another approach to defining self-esteem concerns psychological responses, usually affective in nature, which the individual holds towards the self (Wells & Marwell, 1976). Although in many respects similar to the real/ideal discrepancy paradigm of self-esteem, it is not the discrepancy per se that is important in this approach, but rather the feeling of acceptance or dissatisfaction attached to the discrepancy. This distinction could be regarded as minor, but Wells and Marwell make it explicit with respect to Bills' Index of Adjustment and Values (Bills, Vance, & McLean, 1951, cited in Wells & Marwell, 1976). In Bills' Index, three different forms of administering a set of descriptive adjectives are given, in order to derive three different sets of scores. The first is a real self score, where the participant is asked to rate the self honestly on each adjective. In the second administration, an ideal score is obtained where each item is rated with reference to the ideal self. Finally, a self-satisfaction score is obtained with respect to the participant's feelings about the self-ratings provided for each item. Underscoring the point that even small conceptual differences can have significant effects, Wells and Marwell noted that measures based strictly on the attitudinal approach would equate with Bills' first form, rating approval or disapproval of the real self. By comparison, measures based on the discrepancy category would coincide with the difference between the real and ideal scores, that is between the first and second forms of administration in Bills' Index. Finally, measures based on the category of self-esteem as an affective response, that is the feeling attached to the discrepancy, would compare to Bills' third set of scores. The point is that these three administrations do not generally yield similar scores, yet each represents a recognised operational definition of self-esteem.

Unidimensional and multidimensional theories of self-concept

Not only do scales vary in terms of self-esteem definition, thus limiting generalisability of scores where measures are based on different definitions, the dimensional structure of self-concept is open to debate. Unidimensional models of the self, of which Coopersmith (1967) was an early proponent, have largely been superseded by multidimensional

theories (Harter, 1996). In support of the unidimensional model, Coopersmith (1967) argued that a general factor dominated the facets of self-concept to the extent that these could not be appropriately differentiated by preadolescents (Marsh & Hattie, 1996). Subsequent factor analysis of Coopersmith's original SEI (1967) did not support its unidimensionality or identify an alternative meaningful structure (Marsh & Smith, 1982).

The SES (Rosenberg, 1965, 1989), a global self-esteem scale with excellent psychometric properties, is similarly purported by its author to be unidimensional (Hagborg, 1993). This has been a matter of controversy in the literature where factor analytic studies of the SES have found support for both a unidimensional and a bidimensional structure (Wylie, 1989). With respect to two-factor solutions, for example, research with adolescents has found that one factor was formed from positively worded items and the other from negatively worded items. Rosenberg, however, argued that both factors measure the same construct given that their pattern of correlates with many other variables is almost identical (Hagborg, 1993). Exploring this issue further with an adolescent sample, Hagborg examined the relationship between the SES and the multidimensional Self-Perception Profile for Adolescents (SPPA; Harter, 1988c) which contains nine separate domains of self-concept with global self-worth as a separate domain. Rosenberg's position on unidimensionality was supported in this research, as Hagborg found the SES to be strongly related to the global self-worth domain, beyond that found with any of the other SPPA self-concept subscales. He thus supported the use of the SES as an excellent brief measure of global self-esteem with adolescents.

Although both Rosenberg (1965, 1989) and Coopersmith (1967) posited unidimensional perspectives of self-esteem, it is important to note the important theoretical differences between their two scales. Coopersmith's SEI is based on the nomothetic model which is the oldest and most traditional view of self-concept. This model, also termed the "unidimensional general-factor model" by Marsh and Hattie (1996), posits self-concept as a unitary construct which is made up of overlapping facets of information. Scales based on this model have items which tap different content domains. Each item can be given equal weightings to yield an overall score. The assumption is that this overall score represents a reliable unidimensional reflection of self-concept as it relates to the

various domains of life. Proponents of this position (e.g., Coopersmith, 1967; Piers & Harris, 1964, cited in Byrne, 1996b) have argued for the dominance of the global factor, such that it overrides differentiation among self-concept subcomponents in preadolescents. By comparison, Rosenberg's SES attempts to measure global self-esteem with items that tap this construct directly. Rosenberg makes no attempt to tap specific self-perceptions, but measures global self-esteem directly in each item (Byrne, 1996b). He argued that, in assessing one's overall worth, different elements of the self are hierarchised, weighted, and combined according to a complex, unique process of which the individual is likely to be unaware (Harter, 1986, 1996). The general questions of the SES are thus hypothesised to allow for the relative contribution of specific self-evaluations to be uniquely amalgamated into an assessment of overall self-esteem (Wylie, 1989).

More recently, the multidimensional model and related scales have gathered support as a result of the notion that self-concept cannot be adequately understood if its multifaceted structure is ignored (Marsh & Hattie, 1996). Such models attempt to provide an assessment of specific areas within self-concept. However, the endorsement of the multidimensional model has not led to theoretical consensus. For example, Marsh and Hattie (1996) described five different multidimensional paradigms, classified as the "multidimensional independent factor model", the "multidimensional correlated factor model", the "multidimensional taxonomic multifaceted model", the "multidimensional multifaceted model" and the "multidimensional hierarchical factor model" (p.40).

It is not the intention to review these models in detail, but three main structural issues warrant discussion, to elucidate differences in theoretical background and/or to identify anomalies within models. Firstly, the multidimensional independent factor model and multidimensional correlated factor model vary according to whether their factors are independent or correlated. Marsh and Hattie (1996) pointed out that most research in the area has found that self-concept factors are correlated to at least a moderate degree. Harter's SPPC (1985a) is one important example of an instrument developed within the correlated-factor framework (Byrne, 1996b). With respect to the independent factor model, Marsh and Hattie discussed the work of Soares and Soares (1983, cited in Marsh & Hattie, 1996) which supports a weak version of the independent factor model as

opposed to the hierarchical, or general factor model. They argued that Soares and Soares analyses were flawed, in that the latter failed to complete factor analyses which would have shown correlations between scales. Marsh and Hattie thus concluded there was little evidence to support the use of the independent factor model.

A second issue with respect to differences in theoretical background, concerns whether or not particular multidimensional models are taxonomic. The taxonomic model has been interpreted as a factorial design with at least two facets, each having two or more levels. Several self-concept instruments posit this type of model, but their scores may not be congruous with the underlying design (Marsh & Hattie, 1996). For example, the Tennessee Self-Concept Instrument (TSCS; Roid & Fitts, 1988, 1994, cited in Marsh & Hattie, 1996) is based on a taxonomic model. It has three facets classified as external frame of reference, internal frame of reference, and positively/negatively worded items, in a 5 x 3 x 2 factorial design. The external facet consists of the physical, moral, personal, family, and social levels, each of which can be exhibited in relation to the internal frame of reference levels of identity, satisfaction, and behaviour. The third facet, concerning the positive or negative wording of items, acts as a control for different response biases. Several problems have been identified with the instrument. For example, although its design allows for scoring separate identity, satisfaction, and behavioural manifestations of the social self-concept, these manifestations are confounded with a single summary score. Thus, although the taxonomic model may permit researchers to combine process and structural self-concept components, further research on structure and corresponding scoring is needed (Marsh & Hattie, 1996).

The third issue concerning multidimensional models relates to hierarchical structure. Marsh and Hattie (1996) argued that the hierarchical model is compatible with the other multidimensional models previously listed, as well as with the unidimensional model of self-concept. They thus noted its strength, in presenting a broad framework within which to examine the structure of self-concept, but pointed out that this flexibility can also be interpreted as a weakness if the model is not falsifiable. It is therefore critically important that models be specified in enough detail to allow rigorous testing of the hypothesised structure.

One such model which arguably meets those requirements is that of Shavelson et al. (1976), discussed with reference to academic self-concept in Chapter 3. This model is multidimensionally and hierarchically structured. The hierarchical aspect implies that self-perceptions move from multiple, domain specific self-concepts, such as reading or mathematics, to broader areas, such as academic/nonacademic, to a higher order general self-concept (Wylie, 1989). The multidimensional aspect presupposes that self-concept facets are intercorrelated but that they can also be interpreted as separate constructs (Byrne, 1996b). The Shavelson hierarchical model and its revised editions, such as the Marsh/Shavelson model (Marsh & Shavelson, 1985), are specified in detail and have been rigorously tested. They have been subjected to extensive construct validation, particularly of the academic branch of the model, and more recently of the social and physical self-concepts. Results from validity studies have been generally supportive of Shavelson et al.'s original conceptualisation, particularly with social self-concept. Although several anomalies have arisen with respect to the proposed structure of academic self-concept, revisions have been proposed. For example, although the evidence seems clear that academic self-concept is multidimensionally structured, negligible correlations have repeatedly been found between math and English self-concepts, although both are related to the academic branch of the model. Revised models have been proposed to resolve this issue (see Byrne, 1996b).

Of the several self-concept instruments which have been developed from the Shavelson hierarchical model, the Self Description Questionnaires, such as the SDQ-1 (Marsh, 1992b, cited in Byrne, 1996b) are perhaps best known. The SDQ-1 is the most validated self-concept measure available for use with pre-adolescent children. It is designed to measure self-perceptions related to the four non-academic areas of physical ability, physical appearance, peer relations, and parent relations; the three academic areas of mathematics, reading, and school-in-general; and a global perception of the self.

Nevertheless, although the Shavelson model and its related scales are most empirically tested and validated, the model itself has received some criticism (Byrne, 1996b). For example, Hattie (1992) argued that a multidimensional self-concept structure may not be representative of all individuals, and that for some, a unidimensional model may be a

better fit. In a related vein, Harter (1996) argued that individuals differ in the weightings they give to particular areas of self-concept adding to the predictability of global self-esteem, and that the hierarchical model does not account for these differences. Harter has operationalised her perspective in measures such as the SPPC (Harter, 1985a) and the SPPA (Harter, 1988c).

The preceding sections, discussing the variety in theoretical background and structure of multidimensional models, demonstrate the problems in generalising self-esteem scores across measures, and interpreting results. Quite clearly, because different theories and structural models underlie different measures, scores may be reflecting different aspects of the self and may be weighted differentially.

Disparate psychometric strategies and response sets

Another issue affecting validity and the generalisability of results across measures, concerns the influence of varying psychometric strategies. Scales can vary in terms of the complexity of the descriptive stimuli utilised (e.g., from single adjectives to evaluative phrases), in the number of categories or points to be selected for rating (e.g., from 2 choices, to a 1 to 5 likert scale), and in the number of stimuli involved in each self-rating task. In the latter case, scales can have respondents appraise stimuli singly, respond simultaneously to two stimuli which define a bipolar dimension such as is utilised in the semantic differential method, or consider multiple descriptors of three or more. These differences can affect the equivalence of various scales. In addition to these differences, particular terminology in instructional statements can affect results. For example, self-esteem measures may direct respondents to report how they "usually feel", how they have felt over a particular time-period such as the preceding week, or how they feel "in general". Validity is thus affected if inter-individual variance relates to interpretative differences, rather than reflecting differences in levels of self-esteem (Wells & Marwell, 1976). This issue was discussed previously in relation to the interview, where it was argued that flexible questioning techniques can guard against this problem.

Different susceptibility to response sets can also result in total scores which are incomparable. Besides affecting generalisability across measures, the problem of

response sets has long been a concern within self-report instruments. Self-esteem measures are particularly susceptible to social desirability because the respondent's ego is highly involved in the assessment, and the socially desirable response is often very transparent. Respondents may thus be seen, at best, as inaccurate critics of their own behaviour or, at worst, as lying (Hughes, 1984). Social desirability can be counteracted by several methods. For example, comparing scores with the ratings of a significant other to obtain an inferred self-concept is a possible solution. However, unless the external observer is skilled, observes a variety of responses, and knows the subject very well, scores are not likely to correspond (Byrne, 1996b). One solution that is relatively straightforward is the use of a forced-choice format where two statements are matched for desirability. Harter's SPPC (1985a) and other scales which she has developed (e.g., the SPPA, 1988c) are based on a forced-choice, structured-alternative format as shown:

Really True for me	Sort of True for me				Really True for me	Sort of True for me
<input type="checkbox"/>	<input type="checkbox"/>	Some kids often <i>forget</i> what they learn	BUT	Other kids can remember things <i>easily</i>	<input type="checkbox"/>	<input type="checkbox"/>

(SPPC, 1985a, item 19)

The implication behind such a format is that it implies that half of the children in the world view themselves one way, and half view themselves in the opposite manner. Thus, the format legitimises either choice (Harter, 1985a). Wylie (1989), however, argued that Harter's inference is not totally convincing in terms of the bias towards self-favourability. That is, the majority of subscale means fluctuate around the value of 3, well above the midpoint of 2.5 for each subscale, and only 4 of the 144 means, are below 2.5 (Table 3, Harter, 1985a)

A different way of perceiving response sets, particularly with respect to adolescent self-esteem measures, pertains to evaluating false self behaviour. Adolescents may display false self behaviours for a variety of reasons. They may endeavour to present an ideal self, congruous with others' expectations, to gain acceptance from significant others or the self, or may present a false self as part of normative role experimentation. Responses to self-report measures may therefore reflect false, rather than true self responding for different reasons. Understanding the underlying processes, rather than dismissing

responses as socially desirable, may add to the knowledge base to inform us more about the self (Harter, 1986). Again, the interview may have the advantage in this respect as self-report measures are not equipped to allow in-depth analysis, with their requirements that observations are standardised, objective, and quantifiable.

Developmental changes affecting validity

The in-depth interview can also be modified to suit the maturational level of particular age groups. This issue was discussed previously with respect to Damon and Hart's (1988) four-stage developmental model and resultant interview schedule. In that discussion, Damon and Hart's argument, that self-report scales cannot validly assess self-esteem because they fail to reflect the reorganisation of self-concept which occurs over development, was noted. Discussing this issue with respect to self-report instruments, Hughes (1984) argued that a prominent characteristic in growing children is the shift in their cognitive abilities, reflected in developing verbal skills and mastery of new concepts. This shift has critical implications for test format, item selection, and method of test administration. Attention span, memory capacity, and general level of test-taking skills also differ with age and developmental level, and need to be considered in the development of an instrument.

Harter and colleagues have been particularly interested in these issues and have studied developmental changes in self-concept from childhood to late adolescence in order to develop age-appropriate instruments. Harter (e.g., 1988b) has argued that, prior to age eight, a child lacks the ability to differentiate the real from the ideal self, and cannot form a coherent self-view to evaluate. From about age eight onwards, self-attributes become integrated within domains which are increasingly differentiated. There is a growing ability to realistically observe the self and to utilise social comparison. By adolescence, the number of domains, across which the young person can meaningfully distinguish, expands, and it is during this period that children normally progress from the concrete to the formal operational stage of cognitive development. At this stage the saliency of particular domains alters and the prior focus on active and physical concerns gives way to an emphasis on psychological and social issues (Byrne, 1996b). These changes suggest that, as children mature, the overall content of scales should thus be

modified to cover additional domains of importance. Scale item structure should also vary according to cognitive-developmental level, with more concrete descriptors utilised for younger children, and more abstract, trait terminology employed for adolescents. These aspects have been reflected in scales such as the SPPA (Harter, 1988c), and the Self-Perception Profile for College Students (Neemann & Harter, 1986). Nevertheless, scales have yet to succeed in capturing the full extent of the complexity of the self's organisation and construction at different maturational stages (Harter, 1996).

Just as consensus has not been reached over the operationalisation of self-esteem, so there is debate over when, and to what extent, changes in self-concept occur over development, and Harter's model is not definitive. For example, Marsh and Hattie (1996) discussed research which was unresponsive of Harter's position that developmental differentiation of self-concept increases from preadolescence onwards. This research found that dimensions of self-concept do not appear to be increasingly differentiated after about age 11. Further, with respect to children aged five to eight, Marsh and Hattie cited research which found that multiple dimensions of self-concept are differentiated more accurately in the under-eights than was previously believed. Interestingly, this latter research used an individualised interview procedure to administer a self-report measure. This may indicate that previous failures to identify self-concept factors in young children were due to instrument difficulties or to the problem of reflecting self-concept in the conventional self-report written manner, and underscores the important implications of utilising valid measurement procedures to assess self-concept development.

Another issue related to developmental level and test construction concerns the appropriateness of instrument format and item structure. To reflect valid scores, the respondent must be able to read and understand the questions asked. A similar concern relates to attention span. If items are complicated or scales are over-long, random responding or response sets, such as endorsing a particular alternative, may occur. Scales can be read aloud to respondents or specific scale formats can be used to try to avoid this problem. For example, the SPPC (Harter 1985a) asks respondents to first choose the degree to which one alternative is true for them, rather than forcing a choice between true or false (Byrne, 1996b).

The Self-Perception Profile for Children

The previous sections have outlined many of the problems inherent in self-report measures of self-concept and self-esteem. Although not professing to solve all of these problems, the SPPC (Harter, 1985a) was developed with many of these issues in mind. For example, as explained above, it is designed to minimise social desirability and other response sets, such as random responding, and takes developmental level into account in terms of item content and dimensionality. In addition, standardised instructions are provided with respect to administering the scale and reading questions out loud for children in 3rd and 4th grades (approximately aged 8 to 10 years).

The SPPC was developed from the Perceived Competence Scale for Children (Harter, 1982, cited in Byrne, 1996b), which was revised and expanded to include the two new subscales of Physical Appearance and Behavioral Conduct. Taking account of the systematic, careful development of the original instrument, the SPPC can now be viewed as a psychometrically sound and popular measure of self-concept for pre-adolescent children (Byrne, 1996b). It is one of the only measures which was developed using factor analytic methods to select items both for specific domains and global self-worth (Wylie, 1989). Although relatively new, it has already proven its value in generating information about children's self-perceptions and their correlates (Friedman, 1992). Reviews of the SPPC, as the preceding examples show, appear to be, in the main, positive. However, criticisms with respect to the Importance Ratings scale have been mounted, and are noted in the relevant section below. In addition, Bogan (1988) argued that there are insufficient items in each subscale to adequately assess particular subdomains reliably. There are six items in each subscale, with two importance-rating items related to each domain in the Importance Ratings scale. By comparison, Bogan noted that adequate statistical reliability was demonstrated with the 10-item SES (Rosenberg, 1965), but argued that fewer than 10 items is less than acceptable. Similarly, Keith and Bracken (1996) questioned whether the content sampling of SPPC domains was adequate, given only six items in each subscale.

Format and scales

The SPPC is a multidimensional assessment scale for measuring self-concept. It is designed to tap perceptions of adequacy in five specific domains, as well as assessing global self-worth as a separate domain. It comprises 36 items in a forced-choice, structured-alternative format, yielding six subscales of six items each. These subscales are purported to measure Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Behavioral Conduct, and Global Self-Worth. Scholastic Competence taps the child's perceptions of competence within the realm of performance in school; Social Acceptance taps the extent to which the child feels popular with peers, rather than measuring social skills; Athletic Competence taps perceptions of adequacy in sports and outdoor games; Physical Appearance taps the degree to which respondents are happy with their looks; Behavioral Conduct taps perceptions of acting appropriately; and Global Self-Worth taps an overall judgement of one's worth as a person, independent of competence aspects. Items in these six subscales are keyed 1, 2, 3, or 4, where 4 represents the highest adequacy/competency. Negative items necessitate a reversal, prior to computing the average score for each subscale (Harter, 1985a).

Importance Ratings Scale

The SPPC manual includes a 10-item Importance Ratings scale, where the respondent rates how important each of the specific domains is to the self, to allow for comparison between the global self-worth subscale, and each of the domain-specific subscales. As in the other subscales, importance items are keyed from 1 to 4, where 4 is "really true (important) for me". As noted above, two items thus relate to each of the five specific domains. For example, "Some kids think it's important to be popular BUT Other kids don't think that being popular is all that important to how they feel about themselves" is one of the two items designed to measure how important Social Acceptance is to the respondent. Importance scores which exceed 3 for specific domains can then be used to calculate a competence/importance discrepancy score for that domain. For example, if a respondent scores 3 for the Social Acceptance domain, and 4 for its importance, the discrepancy score is negative 1. The higher the negative discrepancy, the lower the global self-worth score should be as a result, because the importance of the domain exceeds perceptions of competency. (Harter, 1985a).

This competence/importance discrepancy procedure is relevant with respect to operationalising Harter's (1985a) theoretical perspective, as is the development of the SPPC within the multidimensional correlated-factor model, to allow for the various dimensions to be weighted and combined. As previously discussed, Harter views self-esteem as the measure of global regard that one has for one's self as a person, dependent on domain-specific evaluations of proficiency in domains significant to the self. The section discussing domains of competence and social support, in Chapter 3, discussed Harter's perceptions of the antecedents of self-esteem in detail.

With respect to the validity of discrepancy ratings, Byrne (1996b) stated that, to the best of her knowledge, psychometric properties associated with the Importance Ratings scale have not been reported in the literature. However, she pointed out the problems involved in computing discrepancy scores. For example, because these scores result from the subtraction of one score from another, it is unlikely that they manifest the properties of an interval scale and, as a consequence, cannot be meaningfully interpreted. Posing yet another relevant problem, Robinson (1990) argued that, although Harter (1985a) affirmed the use of descriptive items in the SPPC domain-specific subscales for comparison with importance ratings, some scale items are evaluative. For example, Robinson argued that five of the six items of the Physical Appearance subscale ask about satisfaction or discontent with respect to appearance—arguably evaluative concerns. Thus, evaluative rather than descriptive scores are being compared with importance ratings, which is not the point of the process.

Teacher ratings

The SPPC Manual (Harter, 1985a) also contains a Teacher's Rating Scale containing 15 items. The teacher is asked to rate the student's actual behaviour over three items for each of the five specific domains, in a format similar to that utilised in the children's scale. Domain scores are calculated as the average of the three relevant items, and can be compared with means derived from students' scores. The teacher scale can be reworded appropriately, using the same item content, for use with other adults.

Norms

The SPPC Manual (Harter, 1985a) provides norms for four lower middle class to upper middle class samples from Colorado, comprising approximately 90% Caucasian students. Samples are described by gender and grade level. As the present research is based in New Zealand, grades have been roughly translated into age groups which are included in brackets. Sample A: 383 females and 365 males from grades 6 and 7 (12–13); Sample B: 193 females and 197 males from grades 6, 7, and 8 (12–14); Sample C : 118 females and 109 males from grades 3, 4, 5, and 6 (8–12); Sample D: 95 females and 83 males from grades 3, 4, and 5 (8–11) (Harter, 1985a). In view of the sample homogeneity in terms of location and ethnicity, the generalisability of the psychometric information based on this sample may be limited (Wylie, 1989).

Means

In general, subscale means fluctuate around a value of 3. However, variations from 2.40 (Physical Appearance and Athletic Competence for 6th grade girls in sample C) to 3.34 (Behavioral Conduct for 6th grade girls in sample C) are recorded (Table 3, Harter, 1985a). Significant differences associated with both gender and grade are described in the manual. Male average scores, across all samples, are significantly higher than those for females for Athletic Competence. By comparison, in all samples except D, where the difference is close to significance, female scores are significantly higher than males for Behavioral Conduct. In the two middle school samples (age-groups around 12–14), male scores are significantly higher than females in both Physical Appearance and Global Self-Worth. Grade effects are also only evident in the middle school samples. Scholastic Competence shows a significant decline from 6th grade to 8th grade (ages 12–14) and Global Self-Worth shows similar decreases with grade level (Harter, 1985a). However, 140 of the 144 means recorded for samples by grade and gender are 2.5 or higher (Table 3, Harter, 1985a). The score of 2.5 indicates the scale midpoint and is the score which would be obtained with chance responding. It is therefore feasible that "low self-evaluation" scores on SPPC subscales could either reflect unreliable responding due to such factors as lack of motivation or difficulty reading, or could indicate low self-evaluation. No information is presented to evaluate this possibility (Wylie, 1989).

Standard deviations

These range from .34 to .94 for different subscales, samples, and genders, although most fall between .50 and .85. This indicates considerable variation among students.

Reliability

Subscale reliabilities are acceptable, with Cronbach alphas in the .70s and .80s (Harter, 1985a). However, Keith and Bracken (1996) argued that the three subscales with estimates slightly below the criterion of .80 (i.e., .79, .78, and .74) have border-line internal consistency. No test-retest reliability coefficients are reported in the manual. Test-retest reliability coefficients for the Perceived Competence Scale on the original four subscales ranged from .70 to .87 for a subsample of children retested after 3 months, and from .69 to .80 for a subsample retested after 9 months (Friedman, 1992).

Factor analyses

Validity data reported in the manual relates to exploratory factor analytic findings (where global self-worth scores were excluded from analysis) for three of the four samples. Results exhibit a five-factor structure with most factor loadings exceeding .50, all but one exceeding .30, and no cross-loadings exceeding .18, providing strong support for the factorial validity of the SPPC (Byrne, 1996b). Similarly, Granleese and Joseph (1993) found the SPPC contained five meaningful and discriminable domains for Catholic adolescents, living in Ireland. Wylie (1989), however, queried Harter's (1985a) omission of the global self-worth scores in the factor analyses. Harter excluded these scores on the grounds that domains of importance vary across individuals and therefore bear a different relationship to self-worth. She argued that it is therefore unlikely that self-worth would systematically emerge as a distinctive factor. Wylie questioned this logic and argued that factor analyses including all SPPC items might yield inter-factor correlation patterns congruent with a multi-faceted hierarchical model of self-concept. One reason given by Wylie for this contention was that the interscale reliabilities provided in the manual follow the interfactor correlations of the SDQ measures based on Shavelson et al.'s (1976) multidimensional hierarchical model of self-concept.

Intercorrelations

Intercorrelations among subscales were found to be larger for younger, as compared to older, children. Moderate correlations were found for Behavioral Conduct and Scholastic Competence, and for Social Acceptance, Athletic Competence, and Physical Appearance. Consistent relationships were found for Physical Appearance and Self-Worth (r s from .62 to .73). The other subscales were found to be moderately related to Global Self-Worth, especially for younger children (Friedman, 1992).

Construct validity

Because the SPPC is not designed to measure children's actual competencies, but rather their perceptions of the latter, construct validity evidence must come either from correlations with other validated measures of similar constructs, or from empirical results corroborating a priori hypotheses founded on previous research. Several studies comparing SPPC scores and those from related measures, and matching SPPC scores with behaviours posited to be related to perceived self-competencies, have furnished support for the measure's construct validity (Friedman, 1992). For example, evidence of strong concurrent validity has been established between the SDQ-1 and SPPC (Byrne, 1996b).

Interpretation of scores

Although it would be expected that high self-worth scores would correlate with other indices of capability, this has not been empirically demonstrated. In addition, the meaning of high scores for specific subscales is not clear. If students do rate themselves highly in specific areas in the absence of actual competency, this may indicate at least as much of a problem as would low scores in areas where students *are* competent (Friedman, 1992). These issues are reminiscent of the variants of low self-esteem, discussed in Chapter 2, where it was argued that problems with competence, worthiness, or both could lead to diverse avenues to self-esteem (e.g., narcissism). Multiple measures and other individual data are thus critical in clinical work (Friedman, 1992).

Summary

This chapter discussed a variety of techniques used for assessing self-esteem. Qualitative methods, placed lowest on the methodological hierarchy, are generally more time-consuming and less psychometrically rigorous than are quantitative methods. Although the experiment is regarded as most scientific, samples used are often small, unrepresentative of the population, and lack generalisability. The self-report scale, although less rigorous than the experiment, is most often used in self-related research.

In discussing the self-report scale, the first issue considered was that of the operational definition. Different instruments purporting to measure self-esteem have disparate underlying theories of self-concept. Diverse structures of self-concept have been posited over time, with the unidimensional model superseded by the multidimensional paradigm. Multidimensional models, themselves, differ in their posited structures. The diversity of accompanying measurement scales signifies the problem in interpreting scores from different measures, generalising scores across measures, and selecting a scale to best tap the construct under consideration.

Other self-report related problems include the variation in psychometric strategies across measures and the issue of response sets. Social desirability is of particular concern. Maturation is similarly important and the interview, although it has its own problems, is particularly suited to modifications relevant to developmental level. Similarly, self-report instruments, such as the SPPC, aim to consider developmental level in terms of item content and the dimensionality of self-concept.

The SPPC, suitable for children aged 8 to 13, was reviewed as the self-perception scale used in the present research. It measures five specific self-concept domains and includes global self-worth as a separate subscale. Although several criticisms of the scale were noted, it is generally regarded as a psychometrically sound instrument which has generated knowledge about children's self-perceptions and their correlates. Its selection for the present research is discussed further in the next chapter which discusses the rationale for this research, and revisits the problems related to low self-esteem and the cognitive-behavioural focus introduced in earlier chapters.

CHAPTER 6

RATIONALE

Research indicates that high, as compared to low, self-esteem is hedonically preferred (e.g., Tice, 1993), but this on its own is insufficient reason to warrant intervention for improvement. Low self-esteem is important only if it can be shown to impact on people's lives (Harter, 1993). This chapter is concerned with the rationale for the present research which is aimed at improving self-esteem in pre-, or early adolescent students, in order to make just such an impact. It is hypothesised that the skills incorporated in the current programme can be taught to this age group, and will improve their coping skills and self-esteem.

Initially low self-esteem is discussed with reference to its characteristics, associated behavioural outcomes, and psychological correlates. Part of this information was presented in earlier chapters but is summarised here, because it is central to the rationale that low self-esteem is worthy of intervention. Subsequently, coping is reviewed, and the pertinence of perceptions of competence to coping is discussed. Educational transition, as a normative stressor associated with early adolescence, is revisited. It is argued that a preventative intervention, aimed at reducing future maladaptive behaviour, is particularly appropriate at this transition, given the adolescent's developing cognitive capacities. The next area addressed is that of adolescents and health education in New Zealand. The current, and recent draft, health education syllabi are discussed, and it is shown that many of the self-esteem related skills which are advocated in these documents are incorporated in the current research training programme. In addition, because the cognitive-behavioural focus of the current self-esteem programme does not appear to feature strongly in other New Zealand health programmes, it is suggested that this is a valuable method to have available.

Educational achievement is a central concern for many young people, but normative systems which ration success create low achievers by definition. Equating achievement with self-worth is discussed within this context. It is maintained that a perceived lack

of competence or attributes in important domains does not have to be generalised to the whole person. This last notion is integral to the present research where a skills-based training programme for adolescents is aimed at preventing problems associated with low self-esteem, and increasing coping skills. The development of the programme is reviewed with reference to the work of Harter and the selection of the SPPC (Harter, 1985a), as well as to cognitive-behavioural research, social psychological theories related to self-esteem, social skills training, and problem solving strategies. The chapter concludes with an outline of the components of the present programme and a synopsis of the content of sessions. This illustrates how cognitive training and performance-based exercises are integrated throughout, and how skills progress from the simple to the more complex over the course of progressive sessions.

Low self-esteem as worthy of intervention

As discussed in Chapter 2, low self-esteem is often associated with loneliness and feelings of inferiority. Even in recent research, where low self-esteem is seen as low only in a relative sense because most people classified with low self-esteem do not regard themselves as completely worthless, the state is not viewed as desirable. It is represented as an ambiguous position of worth, suggesting uncertain self-appraisal. Because of this uncertainty, people with low self-esteem are likely to experience mood swings relative to situational occurrences, and to lack appropriate goal-setting competencies. By comparison, high self-esteem is related to extensive self-knowledge and stability in daily affairs (Baumeister, 1993b).

Although a variety of issues, including crime, substance abuse, welfare dependency, and educational failure, have been linked to a lack of self-esteem (Baumeister 1993a, preface) the evidence is mixed or negligible. For example, Smelser (1989) signalled his disappointment in the low associations, which had been found at date of his writing, between self-esteem and its behavioural consequences. Discussing several reasons which could account for this, he argued that many of the behavioural consequences associated with low self-esteem, such as drug or child abuse, are either illegal or deviant. Both perpetrators and recorders of such conduct may have a vested interest in lack of its documentation, to avoid stigmatisation for example. Further, self-esteem is not often

measured in such areas as chronic welfare dependency. Another important reason may be methodological in that the measure utilised may not tap self-esteem in a reliable or valid way. In a related vein, when self-esteem is measured globally it is likely to be correlated with many potential outcomes, but the correlation for a given outcome will be weak.

Behavioural outcomes, such as those documented above, are generally intertwined with both self-esteem and other psychological factors. The latter may be particularly important. For example, as discussed previously, low self-esteem is associated with greater vulnerability to threat and resultant anxiety. Addictive behaviour can mask the anxiety associated with fear of failure in competence issues, or feelings of worthlessness, symptomatic of depression (Mruk, 1995). Further, just as low self-esteem and anxiety may have a reciprocal relationship, it is uncertain whether low self-esteem is a symptom, or diathesis, of depression. With respect to older children and adolescents, Harter and colleagues (e.g., Harter & Marold, 1994a, 1994b) were unable to separate out self-worth, affect, and hopelessness in their research into the antecedents and correlates of self-esteem. These three constructs were found to be so highly correlated that they are termed the depression composite in Harter's model. The above discussion thus indicates that low self-esteem is worthy of intervention in this age group.

Coping and its relevance to the current research

Psychological issues related to self-esteem are linked to coping styles, and it is in this area that the present research is particularly focused. Coping involves the way in which stressors are appraised and managed. High self-esteem is linked to a variety of coping strategies and to positive affect in adolescents (Harter, 1990d). Effective coping is likely to involve flexibility, and no single strategy will be effectual for all types of stress (Compas, 1987). When effective, coping is posited to generate pleasing self-evaluations because the psychological responses, inherent in the behaviour, are of high quality. High self-esteem is thus viewed as a result of the inner affective feedback most commonly experienced in response to coping with some type of conflict, rather than utilising avoidant behaviours (Bednar et al., 1989). The cognitive aspects of coping are particularly relevant to the present research. For example, perceived self-inefficacy

involving social relationships can produce depression by reducing the development of personal relationships which provide satisfaction and buffer stress (Bandura, 1990). Similarly, perceptions of competence in areas such as the physical self-concept (Stein, 1996), or in domains involving self-worth (Harter 1996) are often more important than actual skills or attributes in the area. Both practical coping skills, such as problem solving, and perception-training skills involving rational thinking, are included in the current research programme.

The adolescent transition and self-esteem intervention

Adolescence as a time of storm and stress is now equivocal. There is some evidence for a curvilinear age effect in global self-concept, where its decline in preadolescence reverses during mid-adolescence to increase during late adolescence and early adulthood (Marsh, 1991, cited in Crain, 1996). However, research indicates that at least a small group of students are affected detrimentally at the adolescent transition (e.g., Hirsch & DuBois, 1991; Proctor & Choi, 1994). Disley (1992), writing of New Zealand adolescents, noted her concern for the minority of adolescents who experience serious difficulty in finding a positive sense of identity and self-worth.

In addition, many emotional impairments begin in childhood to continue across the lifespan. This implies that early or preventative interventions may be important to reduce students' current stress and prevent or attenuate dysfunctions in adulthood (Kazdin, 1994). Even for those students experiencing a relatively normative transition, that is, experiencing normative as opposed to nonnormative stressors, a self-esteem intervention may be beneficial. Higher levels of integration, achievement, and status are traditionally associated with higher self-esteem levels (Campbell & Lavalley, 1993). Thus, improving coping and well-being in early adolescence presents a worthwhile goal, at a stage where cognitive development may be most appropriate for intervention. As noted in Chapter 4, when Durlak et al., (1991) conducted a meta-analysis of cognitive-behavioural studies encompassing a 17-year period, they found that treatment effectiveness was moderated by developmental level. The effect size for 11 to 13 year-olds, who were assumed to be at the formal operational level, was almost twice that of younger students at lower cognitive levels of development.

Adolescents and health education in New Zealand

The pressures of adolescence, discussed in detail in Chapter 3, include coping with educational transition, body image concerns, and the need to conform to the peer group. Scholastically, such issues are likely to be covered in health education or integrated into subjects such as social studies, science, or English.

At the time of writing, the current *Health Education Syllabus* (Department of Education, 1985) includes the topics, "Building Self-Esteem", "Eating for Health", "Caring for the Body", "Physical Activity for Health", "Staying Healthy", "Keeping Safe", "Relating to Others", "Finding out about Helping Agencies", and "Having a Role in Community Health Issues", in its curriculum themes (p.13). The syllabus describes the general objectives for the specific topics. It also specifies appropriate learning objectives for each topic at different age periods. For the "Building Self-Esteem" topic, the general aim is that students become aware of their personal strengths and competencies, understand their feelings, and learn to value themselves and gain confidence in so doing. At the senior primary stage, that is for the year 7 and 8 students who are targeted in the current research programme, the specific learning objectives for self-esteem are to accept individual differences and gain confidence in new situations. The domains targeted in relationship to this learning include physical growth, appearance, and pubertal changes; feelings and moods; students' developing skills; special limitations and needs; and ways in which situations affect feelings. These objectives are incorporated in the current research training programme, as documented in the programme components section, towards the end of this chapter.

Recently, a new draft curriculum for health and physical education (Ministry of Education, 1997) has been issued to schools and to other interested organisations, for consideration and comment. The concept of total well-being is the focal-point of this draft, which acknowledges that academic achievement is affected by health and well-being. It also recognises that the individual's attitudes, values, and behaviour impact on other students. In the context of the draft, total well-being encompasses physical, mental, emotional, and spiritual well-being. Key areas of learning are documented with particular objectives for each. Mental health is the first area mentioned and objectives include the

strengthening of personal identity and enhancement of self-worth; the promotion of tolerance to respect others' rights; the enhancement of relationships; and self-support and support of others in time of stress, disappointment, and loss. Communication, problem-solving, social, and cooperative skills are also among those emphasised in the draft. As shown subsequently, development of many of these skills is integral to the current research programme.

Individual schools have the responsibility of referring to the current health education syllabus and consulting with parents and caregivers in developing a health scheme appropriate to their community needs. Various resource kits are available for use in conjunction with school health schemes. For example, several schools contacted in regard to the present research had purchased the *Skills for Adolescence* (1988) programme for use as part of their health curriculum. This programme, developed in America, includes lessons aimed at fostering skills in responsibility, communication, decision-making, goal-setting, and self-confidence. Teachers are trained in the use of the programme and the intent is for parents and family members to become involved. However, anecdotal reports from two of the schools contacted suggested that teachers found some of the lessons too lecture-based, rather than participatory in design. It appeared that individual teachers were choosing from the lessons available, and therefore elements of the programme were missed. Further, cognitive-behavioural concepts, such as the relationship between cognitions, affect, and behaviours, do not appear to be covered in depth in *Skills for Adolescence*. By comparison, the current research programme focuses specifically on these aspects of the personality with respect to coping and self-esteem.

To investigate whether programmes similar to the current design were running in New Zealand schools, an advertisement seeking information was placed in *The Education Gazette* (1996), prior to the commencement of the study. The gazette is sent to both primary and secondary schools in New Zealand, and thus targets teachers of students aged approximately 5 to 18 years. Several respondents provided information about current self-esteem programmes, and others asked for information about the present research. No respondents reported using a similar cognitive-behavioural approach.

Educational achievement and self-worth

The New Zealand draft curriculum for health and physical education (Ministry of Education, 1997) acknowledges the reciprocal relationship between academic success and self-esteem. In western society, scholastic competence is culturally valued and generally respected by significant others whose positive regard is also vital to the adolescent's self-esteem. Thus, if academic competency is lacking, the self is likely to be judged less adequate in comparison to others or to the ideal self. The importance of academic success to self-esteem may be less crucial for those with the cognitive buffer of many distinct self-aspects. That is, greater self-complexity may be protective under stress, because thoughts and feelings are more likely to be constrained to immediately salient self-aspects, leaving a number of self-aspects unaffected (Linville, 1987). However, for those without this protection, other paths to self-esteem may be less socially desirable. For example, Kaplan et al. (1986) argued that perceived social rejection and failure, as prerequisite to low self-esteem, can result in loss of motivation to conform to the normative group, and to the pursuit of peer acceptance and esteem through a more unconventional route such as gang affiliation.

Another route to preserve self-esteem lies in discounting domains where attainment is low. High self-esteem college students commonly discount the salience of negative consequences and personal failures (Tennen & Affleck, 1993). Although Tennen and Affleck were concerned to look beyond subjective well-being as indicative of mental health, arguing that acceptance of limitations is healthy, some "optimal margin of illusion" may be adaptive (see Baumeister, 1989). From another perspective, the message of preferential RET argues against rating specific domains and generalising results to the self (e.g., Ellis, 1980). In this way the academic domain can be separated from the self, and lack of success does not contaminate self-worth. The student is valued as an individual and self-acceptance is therefore viable. In a related vein, Covington (1989) advocated educational policy where effort, rather than ability, is emphasised as the preferred means to success. He favoured an incremental view of ability where intelligence is an ever-increasing process, and stressed the notion that falling short of goals is just that, and should not be generalised to the self. The present research programme similarly focuses on this last notion, that a perceived lack of attributes or

ability in any domain does not have to be generalised to the self, and self-criticisms can be modified.

The development of the current research programme

Given that self-esteem is multi-faceted and that a definitive operational definition of the construct has not been achieved, the present study was not intended to test or comply with a particular theory of self-esteem. Rather, the aim was to utilise knowledge about self-esteem from a variety of sources, and to link findings from both theory and therapy to design a skills-based programme for adolescents, in order to increase coping skills and prevent problems associated with low self-esteem. This section discusses this process and explains the merging of a variety of information into the present programme, and the reasons for selecting the SPPC as the chosen self-perception measure.

Harter's research and the SPPC. Harter's (e.g., 1987, 1990a, 1990c, 1990d, 1993) work is of particular relevance to the present research. As previously noted, Harter and colleagues have researched the period of childhood and adolescence extensively, and have conceptualised links between self-worth, hopelessness, and affect in the depression composite (Harter & Marold, 1994a, 1994b). Harter's SPPC (1985a), discussed in Chapter 5, was utilised as a measurement tool in the present research because it is a developmentally constructed measure which has gained acceptance among researchers, and it has generally obtained very positive reviews (see, for example, Merrell, Cedeno & Johnson, 1993). Although two main criticisms, concern its Importance Ratings scale and its lack of generalisability of norms, these issues are not of consequence to the present usage. The Importance Ratings scale was not employed in the present study because of the psychometric problems, discussed in Chapter 5. The generalisability of norms was not a problem either, because the concern was whether the two groups differed on the SPPC, irrespective of their scores in relationship to the norms.

Cognitive-behavioural research and social learning. Cognitive-behavioural research associated with the works of Beck (e.g., Burns, 1993a) and Ellis (e.g., Bernard & Joyce, 1984; Vernon, 1994) are relevant to the present research because techniques used to combat depression can also be used to ameliorate low self-esteem (e.g., Burns, 1993a).

Burns has used many of the techniques associated with Beck's cognitive therapy, while REE studies are based on Ellis's rational-emotive theory. At the same time, the cognitive-behavioural *Adolescent Coping with Depression Course* (Clarke et al., 1990) served as an important paradigm for the current research. As in the depression course, important tenets contained in Bandura's (1977) social learning theory are recognised in the current research. In particular, emotional disorders are considered to be learned phenomena which are governed by the same rules as normal behaviours. Thus maladaptive reaction patterns, such as those found in depressive disorders, and arguably in emotional problems related to low self-esteem, can be unlearned (Clarke et al., 1990).

Further development of the current research. Clarke and colleagues (1990) examined the personal and environmental difficulties associated with depression when developing the depression course. Similarly, the current programme began by investigating low self-esteem. That is, Harter's work and cognitive-behavioural research were perused; social psychological theories related to self-esteem were examined; and other spheres associated with self-esteem, such as links with problem-solving and social skills training, were explored. Harter's work on self-concept, and cognitive-behavioural links to the present research were considered above. Social psychological research, problem solving, and social skills training, as utilised in the development of the current programme, are subsequently addressed.

Social-psychological research. Although social psychological research has reported some seemingly contradictory findings, important empirically derived deductions about the nature of low self-esteem can now be drawn. For example, the evidence indicates that low self-esteem is maintained by an inadequately satisfied desire for self-worth and, because the desire is unfulfilled, a self-protective stance is likely. Further, low self-esteem can be equated with a deficiency in self-knowledge, can lead to the rejection of praise, and to formulating inappropriately low goals. People with low self-esteem, reactive to both positive and negative environmental signals, are vulnerable to mood swings and to the emotional distress which is strongly linked to temporal changes in self-esteem (Baumeister, 1993b). Here again, the links between low self-esteem and depression are evident, because emotional distress and low mood swings are similarly

symptomatic of depression.

Although much of the social psychological research referred to above has used adult participants, the findings are arguably relevant to adolescent research. For example, there is now consensus that the central symptoms of adolescent depression correspond to those of adult affective disorders (Clarke et al., 1990), while adolescents reporting low self-esteem have consistently reported depressed affect (Renouf & Harter, 1990). The aforementioned social psychological research was therefore used as one of the building blocks for the present study. Skill instruction targeting several relevant areas was incorporated in the training programme developed for this research. For example, giving and receiving positive feedback was included to assist students with internalising and acknowledging praise. To influence the area of minimising weaknesses, exercises in discouraging self-criticism were employed. In these exercises students learned to "talk back to", and reframe, the painful cognitions which interfere with rational assessment of abilities. In addition, a goal-setting component was incorporated to encourage students to formulate appropriate goals.

Problem-solving. As well as goal-setting, Spivack et al. (1976) posited that an important determinant of adjustment in youth is their ability to solve interpersonal problems. They found that impulsive mistakes, frustration, aggression, or withdrawal are likely if children cannot think through consequences and are overly concerned with end goals. Therefore, to train students in successful problem solving, the *Interpersonal Cognitive Problem Solving* model (ICPS; described in Rhodes, Reyes & Jason, 1993) was developed. Results from research with inner-city preschool children demonstrated a relationship between teacher-rated adjustment and certain cognitive problem solving skills. Studies with older children showed that they required a more intensified programme than preschoolers, and benefited from the additional emphasis on the affective and behavioural components of problem solving (Rhodes et al., 1993). The cognitive, affective, and behavioural components are incorporated into the problem solving exercises, as presented in the student work book developed for the present programme (Appendix A). The implementation of these exercises is detailed in the sections describing the problem solving exercises in the trainer's guide (Appendix B). In addition, research by Berg and

Calderone (1994) pointed to the changing contexts of problem solving over development. For example, they found that, when asked to generate problem areas, 11 to 12 year-old students generally focused on school and hobby concerns. By comparison, younger children described family-linked concerns. School and hobby related areas were therefore targeted in the problems devised for the present study's student work book.

Social skills training. Similar to problem solving, social skills training has had positive effects on adolescents' adjustment. Strategies such as role plays and behavioural rehearsals may help adolescents to maintain eye contact, use assertive skills, and be more effective in communicating with peers and adults (Mullis, Mullis, & Normandin, 1992). Social skills training is generally incorporated into interventions for adolescent depression (e.g., Clarke et al., 1990; Jaycox et al., 1994). For example, the *Adolescent Coping with Depression Course* (Clarke et al., 1990) provides training in active listening and includes strategies for making friends. Therefore, and in the light of Harter's (e.g., 1985a) research on the relationship between perceived social acceptance and general self-worth, a social skills component was included in the present training programme. Although social acceptance can be distinguished from adeptness in social functioning, the two areas generally overlap (Berndt & Burgy, 1996). Thus, students who can communicate confidently are more likely to be popular and experience self-esteem.

Programme components

The cognitive-behavioural approach involves the development and use of performance-based and cognitive interventions designed to produce changes in thinking, feeling, and behaviour (Kendall & Panichelli-Mindel, 1995). Interventions thus focus on the way in which people respond to their cognitive interpretations of experiences and on how thoughts and behaviours are related, rather than focusing on the experiences themselves.

The present research programme likewise aimed to train students to use both cognitive and performance-based skills, and, with respect to the latter, to emphasise the influence of thoughts on behaviour. For example, in the social skills lessons where self-introduction proved difficult, students were asked to consider what they were thinking, or telling themselves, about the process. Further, in developing the programme, cognitive

distortions and cognitive deficiencies were both targeted. That is, it was recognised that, in child and adolescent research, cognitive dysfunction has been separated into the two components. The term, cognitive distortions, refers to faulty cognitions, such as black and white thinking, while cognitive deficiencies refers to an absence of careful information processing, in an area such as problem solving, where such processing would be useful (Kendall, 1985, 1993; Walen, DiGiuseppe, & Dryden, 1992). The distinction was discussed in detail in Chapter 4, and the programme outline below lists relevant exercises. For example, the twisted thinking exercise in Session 3 targets cognitive distortions, while the problem solving and social skills exercises incorporated in several sessions focus mainly on deficiencies.

The trainer's guide contains an agenda for each session. In addition to listing skills exercises, the agendas detail administrative exercises, such as setting ground rules and implementing the homework contract, and designate games which can be included. There is also a course synopsis at the beginning and conclusion of the student work book, summarising the skills therein.

In order to illustrate how skills are integrated and sequenced within sessions, the following framework itemises cognitive and performance-based exercises contained in programme sessions. Most sessions contain exercises in each category, although cognitive skills are emphasised in initial sessions, and performance-based skills are more central to later sessions. This is because the cognitive aspect is integral to understanding behaviour and is therefore taught first. Similarly, the more basic skills are taught first, and skills are built up in succeeding sessions. For example, social skills training begins with introducing the self, and progresses at a later session, to developing a conversation. Further, the quiz exercises, given at the start of each work book session apart from Session 1, are intended to review the main learning skills of the preceding session.

Programme Synopsis

Session	Cognitive Exercises	Performance-based exercises
1	<p>Identifying positive qualities.</p> <p>Identifying differences between opinion, fact and emotions.</p> <p>Strength of positive and negative emotions—barometer exercise for keeping things in proportion.</p> <p>Helpful and hurtful emotions.</p>	
2	<p>The three-part-personality system—the interaction of feelings, actions and thoughts.</p> <p>Disputing unhelpful thoughts.</p>	<p>Social skills—introductions.</p> <p>Welcome statements.</p> <p>Constructive criticism and positive feedback.</p>
3	<p>Twisted thinking—black and white, mind-reading, self-downing and demanding.</p> <p>Changing faulty self-talk.</p>	<p>Social skills—developing a conversation.</p>
4	<p>Attitude patterns—the resenter, despairer, self-critic, worrier and champion.</p>	<p>Social skills—understanding versus judgemental comments in dialogue.</p> <p>Off-putting behaviour.</p>
5	<p>Positive statements—internalising praise.</p>	<p>Social skills—joining and leaving a group.</p> <p>Problem solving—orientation and normalising.</p> <p>Coping strategies for problem situations.</p>
6		<p>Problem strategies and problem interpretation.</p> <p>Simple problem solving model, consequences and fall-back solution.</p>

- | | | |
|---|---|--|
| 7 | Shaping behaviour—communication steps.
Other strategies—broken record, time out,
positive feedback "if nothing works". | Problem solutions. |
| 8 | Understanding differences between over-
confidence, lack of confidence and self-
esteem.
Self-criticism exercises—who are you
comparing yourself to? Not generalising less
competent areas to the whole self.
Self-talk for coping with problems. | |
| 9 | Planning for set-backs—preconditions for
upset, self-talk to assist etc. | Goal-setting—skills, hobbies,
employment. |

Summary

This chapter discussed the rationale for the present study, the aim of which was to develop a training programme to improve self-esteem and coping skills in early adolescent students. Concerns associated with low self-esteem and the benefits of adaptive coping, relevant to the development of a preventative intervention, were considered. The benefits from the establishment of such a programme were discussed in terms of age group and current health education policy in New Zealand. The effect of a perceived lack of competency in adolescence was then addressed, with particular reference to academic achievement. It was argued that such perceptions do not have to be generalised to the self as a whole. The development of the present training programme, which incorporates this notion, was discussed. This encompassed the work of Harter and the selection of the SPPC (1985a), cognitive-behavioural research, social-psychological research, problem solving, and social skills training. In conclusion, the programme components were discussed, and a synopsis of the course was outlined, in order to illustrate its organisation, content, and sequencing.

CHAPTER 7

PILOT STUDY

The pilot study was conducted in the year prior to the main study in an urban, Auckland, New Zealand, intermediate school. The pilot was administered with the intention of trialing the student work book in terms of difficulty of content, the amount of material presented within each session, and student interest. In addition it was important to assess the suitability of the measures with respect to language, length, and participant acceptance, and to identify problems associated with organisation within the school (e.g., overhead projector availability). The value of the pilot study is reflected in the substantial changes made to the self-report measures for use in the main study.

Method

Participants

The pilot school was selected because the deputy principal was known to the researcher and expressed interest in the research. Ethical approval was obtained from the Human Ethics Committee of Massey University. Two classes of students aged 10 to 13 years, selected by the Deputy-Principal because of class teacher interest in self-esteem, together with their teachers, and parents/guardians, were involved in the pilot study. All those involved consented to complete surveys prior to the training programme and at its conclusion. One class was designated the experimental group, and the other the control group. Prior to the commencement of the training programme, the experimental class contained 34 students (18 boys and 16 girls) and the control class contained 33 students (16 boys and 17 girls). Twenty-one consent forms and parent/guardian behaviour checklists were returned by students in the experimental class (11 boys and 10 girls), and 18 of each were returned by the control class (6 boys and 12 girls). All students and their parents/guardians who returned signed consent forms were involved in the pilot. One male student in the experimental group withdrew during the training period because of commitment to other course work. Twenty students, 10 males and 10 females, thus completed the training programme in the pilot experimental group. All students completed at least 7 sessions, with six students absent from one, and one student absent

from two sessions, due to illness.

Ethnic identification (included for the main study) was not requested on the consent forms, but students in the experimental groups were asked for this information. The following data was provided: Asian, 1; European, 16; Other, 4. The student who withdrew was European. There were no students in the pilot experimental group who identified as Maori, Maori/European, or Maori Polynesian (categories which were included in the main study).

Materials

This section describes survey materials and changes resulting from their use in the pilot.

Information packs. Information sheets and consent forms were provided for all parents, students, and teachers involved in the study. The pack which was sent home with students contained two information sheets (one for parents/guardians and one for students) detailing the nature of the research, its objectives, and participants' ethical rights. Consent forms for parents/guardians and students, to allow student participation, were included. In addition the pack contained a consent form for parents/guardians to permit the researcher access to the student's achievement grades, a parent/guardian rating scale to rate student behaviour at pre-training, a question sheet asking for feedback on the clarity of the information provided in the pack, or other comments, and a return envelope. The information packs were coded to ensure confidentiality.

Work books and training manuals. A work book was provided for each student in the experimental group, and a trainer's manual, providing related instructions on activities and suggested responses, was supplied to the experimental class teacher. Work book organisation and content, and trainer's manual are described in the previous chapter.

Measures. All participating students completed the first four measures described below, while experimental group students completed an additional mood measure, and parents/guardians and teachers completed behavioural checklists.

1. *The SPPC* (Harter, 1985a). This measure and relevant technical information were discussed in detail in Chapter 5.

2. *The Social Support Scale for Children* (Harter, 1985b). This is a 24-item scale tapping support/regard from parents, classmates, teachers, and close friends, in four subscales of 6 items each. The item format and keying are similar to that of the SPPC, described in Chapter 5, and the Social Support Scale is linked to it in terms of theoretical background. That is, in Harter's conceptualisation, perceived social support is an important antecedent of self-esteem. Norms were derived from 1,134 predominantly Caucasian students from Colorado in grades 3 to 8 (ages approximately 8 to 14). Subscale internal consistency reliabilities are cited as .72 to .88, before the revision of several items which attenuated reliability. Initial validity data provided in the manual indicates that correlations between related subscales of the SPPC and the Social Support Scale are acceptable (Harter, 1985b). As explained below in the Pilot Outcomes section, both this scale and the following depression profile were not utilised in the final study.

3. *The Dimensions of Depression Profile for Children and Adolescents* (Harter & Nowakowski, 1987). This is a 30 item profile consisting of 5 subscales of 6 items each. Subscales tap mood/affect, global self-worth, energy/interest, self-blame, and suicidal ideation in an item format and keying procedure similar to the SPPC. The scale's rationale relates to Harter's conceptualisation of the antecedents and correlates of self-esteem, and this is detailed in Chapter 2. Norms are based on 1,381 predominantly Caucasian students from Colorado in grades 3 to 8 (ages approximately 8 to 14). Acceptable Cronbach's Alpha reliabilities were obtained for subscales, and factor analyses support the view that a profile of scores across factors should be considered for each student, rather than combining results into a single score.

4. *Programme Skills*. This scale was designed by the researcher to measure particular skills taught in the training course which did not appear to be specifically tapped in the previous measures. The Programme Skills scale for the pilot consisted of nine items and aimed to tap skills in communication, coping with negative emotions, and problem solving. It was formatted and keyed in the same manner as the SPPC (forced-choice,

structured-alternative format, scored 1, 2, 3, or 4, with 4 most adaptive). The modified version, used in the main study, is discussed in detail below.

5. *Mood Measure*. Students in the experimental group were asked to complete a mood measure, prior to the commencement of each session. This required them to:

Please circle 1, 2, 3, 4, or 5 to indicate how you have felt most of the time over the past week. 1 represents a very low mood over most of the previous week—where you have felt very bad or unhappy; 2 represents a low mood—where you have felt quite bad or pretty unhappy; 3 represents an average mood; 4 is where you have felt pretty good; and 5 is where you have felt extra good most of the past week.

1→→→2→→→3→→→4→→→5

Problems with this measure, as well as a description of the shortened mood measure used in the main study, are noted in the Pilot Outcomes section below.

6. *Parent/Guardian and Teacher Rating Scales*. Both parents/guardians and teachers of experimental and control groups were asked to complete rating scales, describing student behaviour, prior to and subsequent to the pilot training programme. The Teacher's Rating Scale of 15 items from the SPPC manual (Harter, 1985a), as discussed in the SPPC review in Chapter 5, was utilised for both parents/guardians and teachers, with the wording appropriately altered. For example, instead of "This child is ..." as recorded in the teacher's scale, "My child is ..." was used for parents/guardians.

Procedure

The intermediate school from which students were obtained had a roll of approximately 538 students, and was divided into nine year 7 and nine year 8 classes (previously known as Form 1 and Form 2). The two participating classes were both from year 8, with students aged from 11 to 13 years. Initially, in February 1996, the researcher met with students and teachers to explain the purpose and content of the training programme and the roles of the control and experimental groups. Information packs were distributed. When consent forms and parent/guardian rating scales were returned in their coded envelopes they were stored securely in an office at the university. In March 1996, consenting students from experimental and control groups completed the first set of measures, and teachers completed scales rating these students on behaviour. The 21

students who agreed to participate from the experimental class were split into two groups. Selection was done alphabetically by surname, to allow approximately equal numbers of males and females in each group (5 or 6 males, and 5 females per group). In term 2, towards the end of April 1996, the training programme commenced and was run weekly with each group over the duration of nine weeks. Sessions were held in double-period blocks and lasted approximately one and a half hours each. The researcher conducted sessions in allocated rooms, following the plan set out in the previously prepared trainer's guide. Each student was given a work book containing relevant notes and exercises for the course. Each training session began with the mood measure, to check on student mood over the preceding week, and this was followed by a discussion of anything that had occurred during the week, relevant to training course skills. Students then completed a short quiz related to information provided in the previous session, and the session proceeded with discussion, workbook exercises, and activities, for example role-play. At the end of each session there was time for students to express what they had enjoyed, had not found helpful, what they had learned, and time for discussion of the homework exercises. Students from the experimental class who were not involved in the study, as well as control group students, carried on normal school work. Following the programme both groups of students and teachers completed the second set of measures. Parents/guardians were sent a thank you letter and post-training rating scales to complete and return.

Pilot outcomes

Programme content

In general, session length proved to be appropriate, and session content relevant. Some exercises proved over-long for the students who were less able readers, or who had lower concentration spans than others. These exercises were modified in the work book for the final study. For example, a fairly long problem solving exercise was shortened from nine to four steps, and "twisted thinking" examples were shortened from the original eight, to four examples. In the main, students reported verbally that they enjoyed sessions and found the skills useful in areas such as playground communication, appreciating their positive qualities, and in family interactions, and stated that they would continue to practise skills. In addition, most were able to share personal experiences, and group trust

was developed. Students were provided with an evaluation sheet in the last session which showed variation in assessment of topics found to be useful. Topics mentioned as helpful included understanding feelings, self-criticism, problem-solving, and communication skills. Extra practice in group discussion, and using the "Champion" were suggested (and noted) for future sessions, while no topics were judged as "not useful".

Information packs

Feedback from parents/guardians indicated that the information sheet could be written more simply. The questions related to physical appearance on the rating scale (Harter, 1985a) were queried as to their appropriateness. For example, the question "My child is good-looking OR My child is not very good-looking" was found to be objectionable to some. Parents/guardians also criticised the repetitiveness of the rating scale, arguing that several items asked the same thing. As a result, parent information sheets were simplified for the main study, and the rating scale was changed, as discussed below.

Measures

For each measure, post-training and pre-training scores were compared by means of a two-way ANOVA, with group as a factor. At an alpha level of $p < .05$ there were no significant main effects. In view of the small n this was not unexpected. Problems with the measures, highlighted by the pilot, and consequent changes, are discussed below.

SPPC, Social Support Scale, Dimensions of Depression Profile. The forced-choice alternative format of these measures was found to be cumbersome for some students. Over the three scales, items totalled 90. In addition, the suicidal ideation items in the Depression Profile (e.g., "Some kids don't really care if they live or die BUT Other kids do care if they live or die") appeared disconcerting to some. Of the three measures, it was therefore decided to retain only the SPPC, as a measure of global self-worth, plus specific self-concept dimensions. Because of the relationship between depression and self-esteem, discussed in Chapter 2, a depression measure was deemed useful. Therefore, instead of the Depression Profile, the short form of the CDI (Kovacs, 1992) was selected for the main study. The CDI Short Form does not contain suicide-related questions, is

presented in a simple format, and contains ten items. It is discussed in the following chapter. The Social Support Scale was omitted for the main study on the grounds that the SPPC contains a Social Acceptance subscale, and social support related questions are also incorporated in the Programme Skills measure.

Programme Skills. The Programme Skills measure (refer Appendix E) aims to tap communication skills (items 1, 3, 9); coping with negative emotions (items 2, 4, 8); and problem solving (items 5, 6, 7). However, by definition, the nature of the items overlap, as the programme skills interrelate (see pp.103-106). As noted, the Pilot Programme Skills measure was formatted similarly to the SPPC. For the main study it was modified with respect to both format and wording, given that some students appeared to find the forced-choice alternative format cumbersome. Instead of the original four choices, as in the SPPC format, there are two in the revised version. These are keyed 1 or 2, with 2 most adaptive. The choices, with respect to each item, are phrased with the adaptive response first for items 3, 5, 7, and 9, and the less adaptive response first for other items to reduce response set, when items read uniformly with the same type of response first. With respect to wording, the revised Programme Skills aims to put items as simply and specifically as possible. For example, "Some kids consider what could happen when they deal with a problem and they find a good solution BUT Other kids don't consider what could happen and they have hassles", was used in the pilot Programme Skills. This item is general and wordy. A more specific example from the revised version reads:

7. When I feel bad about myself:

- I "tell myself off".
 I can use positive messages to make me feel better.

Mood measure. At each session the pilot mood measure required that students be reminded that "1" indicated low mood, and "5" represented high mood. A shortened, clearly delineated 3-point scale was therefore used in the main study.

Students were asked to rate "How you have been feeling about yourself, overall, this last week", as follows:

- * 1 you feel bad or unhappy
- * 2 you feel OK
- * 3 you feel good

Parent/Guardian and Teacher scales. As discussed, several parents/guardians were unhappy with the adaptation of the SPPC Teacher's Rating Scale. It was therefore decided to replace this with an adaptation of the Programme Skills scale for parents/guardians and teachers (refer Appendices C and D). Although the SPPC teacher scale relates directly to the SPPC student subscales, Programme Skills items relate to the coping focus of the study, are less repetitive, and do not contain items on physical appearance (contentious to some parents/guardians). Other parent measures of child functioning were examined but none were deemed suitable in terms of length (some parents indicated that their time was limited), or in terms of content. Items were chosen so as to emphasise programme-related skills.

Management Skills

Subsequent to the pilot study, guidelines for group management were drawn up as a result of minor behavioural disruption. These were as follow:

1. To enforce the ground rules more emphatically at the outset of each group meeting.
2. To remind students of these rules as necessary; to label lapses in ground rules (e.g., this behaviour is impairing other group members' feelings of safety); to give a forced choice if disruption continues to occur (e.g., "Stop teasing or leave").
3. To have the option of asking a student who has been asked to leave the group on more than two occasions to forego the right to attend.

Summary

The pilot study was a useful prerequisite to the management and organisation of the main study, particularly with respect to revising information packs, checking the relevance of work book content, trialing measures, and practising routines. Information packs were largely unaltered for the main study, although the wording on information sheets was simplified; appropriate changes were made to the student work books in terms of exercise length and clarity of information; measures were revised; and general procedures and organisation were refined.

CHAPTER 8

MAIN STUDY

The study was conducted within an urban, Auckland, New Zealand intermediate school. The school in which the pilot study had been conducted was not used because timetabling issues meant that withdrawal of groups from regular curricular activities was no longer practical. All intermediate schools within a reasonable distance of the university were therefore contacted. Only one principal volunteered his school's participation. He preferred that whole classes participate, rather than that groups be withdrawn, and so this arrangement was adopted. Minor revisions were made to the student work book and trainer's guide for use with complete classes. Although the move from group to class application of the programme may not be ideal, in that arguably this intervention utilises exercises best applied in the more personal atmosphere of a smaller group, whole-class teaching is more realistic in terms of resources usually available in state schools.

Method

Participants

Approval for the study was obtained from the Massey University Human Ethics Committee. Six classes of students aged 10 to 13 years, their teachers, and parents/guardians were involved in the study. The school was selected as discussed above. All those involved agreed to complete surveys prior to the training programme, at its conclusion, and at a follow-up period approximately five months later. Three classes formed the experimental group, and three the control group. Prior to the commencement of the training programme, the experimental and control groups each contained 83 students. Of the students in the experimental class, 15 did not participate as they were not fluent in English and were unable to complete the surveys, while one student was refused parental consent. The remaining 67 students participated in the training programme. Two students relocated shortly after the training programme and were unable to complete the follow-up survey. In the control classes, 16 students were not fluent in English and three students were refused parental consent. The remaining 64 students and their parents/guardians consented to take part in the research and to

complete the relevant surveys. No students relocated during this time. Most students completed all nine sessions with six students missing a single session, three students missing two, and one student missing three sessions. One teacher of experimental group students left after the training programme, and was thus unable to complete the follow-up Teacher Checklist for that class.

Fifty-four parents or guardians of experimental group students completed both the pre- and post-training checklists. As two families relocated, 52 parents/guardians completed the follow-up survey. In the control group, 50 parents/guardians completed the first two surveys and two of those neglected to complete the follow-up survey, leaving 48 in total.

Gender. Table 1 shows the numbers in each group who completed the surveys, and the number of their parents/guardians who did likewise. The experimental and control group students are classified by gender.

Table 1

Numbers of male and female students and parents/guardians who completed surveys

	Experimental			Control		
	Pre-train	Post-train	Follow-up	Pre-train	Post-train	Follow-up
Students						
Male	37	37	36	30	30	30
Female	30	30	29	34	34	34
Parents/Guardians						
Male	29	29	28	21	21	19
Female	25	25	24	29	29	29

Table 1 shows that, although numbers were not greatly disparate, there were more male student and corresponding parent/guardian surveys received from the experimental group, and more female student and corresponding parent/guardian surveys from the controls.

Ethnicity. The majority in each group classified themselves as European. Table 2 shows the frequency of each ethnic category for students who completed all surveys.

Table 2Ethnicities of experimental and control group students

	Experimental		Control	
	Frequency		Frequency	
Asian	6 (9.2%)		14 (21.9%)	
European	37 (56.9%)		41 (64.1%)	
Maori	2 (3.1%)		1 (1.6%)	
Maori/European	6 (9.2%)		3 (4.7%)	
Maori/Polynesian	3 (4.6%)		0 (0.0%)	
Other	11 (16.9%)		5 (7.8%)	
Total	65		64	

Academic rating. Prior to survey 1, teachers rated students on a 5-point scale where 1=low, 3=average, and 5=high in academic competence. Table 3 shows a break-down for the groups by gender.

Table 3Teacher academic ratings for males and females in experimental and control groups

Ratings	Experimental		Control	
	Male	Female	Male	Female
	Frequency	Frequency	Frequency	Frequency
1	0 (0%)	0 (0%)	0 (0%)	0 (0%)
2	6 (16.7%)	1 (3.4%)	2 (6.7%)	2 (5.9%)
3	18 (50.0%)	14 (48.3%)	20 (66.7%)	13 (38.2%)
4	8 (22.2%)	9 (31.0%)	7 (23.3%)	14 (41.2%)
5	4 (11.1%)	5 (17.2%)	1 (3.3%)	5 (14.7%)
Total	36	29	30	34

Table 3 shows that experimental and control groups were rated similarly, in terms of the numbers falling within each rating category. In addition, it appears that a greater percentage of females than males scored above the average rating of "3" on the scale in both experimental (48.2% vs. 33.3%) and control (55.9% vs. 26.6%) groups, respectively.

Materials

Information sheets and consent forms. An information sheet and consent form was provided for each teacher involved in the research, and an information pack supplied to each student in all six classes. Information packs (refer Appendices C and D) were described in the corresponding section in the previous chapter.

Work books and training manuals. A work book was provided for each student in the experimental group, and a trainer's manual was supplied to each teacher of experimental group classes. The work book organisation and content is described in Chapter 6, and modifications carried out as a result of the pilot study are described in Chapter 7.

Measures. All participating students completed three measures at pre-training, post-training, and follow-up. Two of the four measures used in the pilot study were retained. These were the SPPC (Harter, 1985a) and the Programme Skills measure. The administration of the SPPC was identical to that conducted in the pilot study, but the Programme Skills measure was modified, as detailed in Chapter 7. The Dimensions of Depression Profile for Children and Adolescents (Harter & Nowakowski, 1987), and the Social Support Scale for Children (Harter, 1985b), used in the pilot study, were omitted. The CDI (Kovacs, 1992) replaced the Depression Profile. In addition, students in the experimental group completed a mood measure and skills checklist, and parents/guardians, and teachers completed checklists based on Programme Skills. Alpha reliability coefficients for each of the survey measures were calculated for the total sample at pre-training. In addition, alpha reliability coefficients for Programme Skills, Parent/Guardian, and Teacher Checklists, were calculated at post-training and follow-up. Measures used, with alpha coefficients obtained with the present sample, are as follow:

1. *SPPC* (Harter, 1985a). This measure was reviewed in detail in Chapter 5. As discussed therein, Harter reported acceptable subscale reliabilities for the normative sample, with Cronbach Alphas in the .70s and .80s (Table 2, Harter, 1985a). For the present sample, alpha coefficients for each SPPC subscale at pre-training were as follow: Athletic Competence .85; Behavioural Competence .77; Global Self-Worth .83; Physical Appearance .84; Scholastic Competence .80; and Social Acceptance .82.

2. *CDI Short Form* (Kovacs, 1992). The 10-item Short Form of the CDI is useful when a quick screening device is required, to provide an empirical measure of the extent to which children exhibit depressive symptoms. It generally gives results comparable to the 27-item long form when the overall objective is depressive categorisation. Each item has a 3-choice response format, with higher scores reflecting more severe disturbance.

Norms: The CDI Short Form was developed with data from the normative sample used for the full scale, which employed the responses of 1,266 students aged 7 to 16 years, from Florida, USA. Most of the children were middle-class, although a range of socio-economic backgrounds was included. Approximately 20% of students were from single-parent homes, while 77% were white, and 23% were Black, American Indian, or Hispanic in ethnic origin (Finch, Saylor & Edwards, 1985, cited in Kovacs, 1992). Based on trends in the normative data and developmental differences available in the literature, separate norms for two age groups were produced for the long form. These norms are for children aged 7 to 12 ($M= 10.5, SD=7.3$) and for adolescents aged 13 to 17 ($M=9.8, SD=7.3$). The differences between these norms are not statistically significant (Kovacs, 1992). Kavan (1992), reviewing the CDI, argued that the norms provided are limited. For example, research with the CDI has obtained differences related to race, but separate norms for race or ethnicity are not available.

Factors: The full scale CDI contains the five factors of negative mood, interpersonal problems, ineffectiveness, anhedonia, and negative self-esteem. A profile of scores can thus be examined across factors. In the profiling process, raw scores are converted to T-scores with a mean of 50 and a standard deviation of 10.

Scoring: Short-Form raw scores can range from 0 to 20, and can be converted to T-scores. Table 3.1 in the manual gives interpretative guidelines for T-scores, but Kovacs (1992) cautioned that these are approximations only. Table 3.1 shows that a T-score between 45 and 55 is considered average. Using the Conversion Form in the manual (Figure 2.6), for both genders aged between 7 and 12, T-scores between 45 and 55 equate to raw scores between 2 and 4 for both groups. A T-score of 50 equates to a raw score of 3, for each group. Thus a raw score of 3 is approximately average.

Internal reliability: Alpha coefficients of reliability which have been reported for the full scale CDI range from .71 to .89, indicating good internal consistency. The internal consistency of the CDI Short Form was maximised at 10 items, since the alpha coefficient significantly decreased when other items were omitted. In addition, Kovacs excluded the suicidal ideation item from the Short Form, because asking students in this age group about suicide is controversial. The 10-item selection was accomplished using a backward stepwise internal consistency reliability analysis. That is, once the alpha reliability coefficient was calculated for the full CDI, the item which, if eliminated, would decrease the alpha coefficient least, was excluded. The remaining items were then used to recalculate the alpha coefficient and the procedure was repeated, omitting one item at a time, until 10 items remained. This method maximised the internal consistency of the items retained, which include sadness, pessimism, self-depreciation, self-hate, crying spells, irritability, negative body image, loneliness, lack of friends, and feeling unloved. These items were derived from factors 1, 3, 4, and 5. None of the items from the Interpersonal Problems factor (2), were included. The Short Form correlates $r=.89$ with the full inventory, and its alpha coefficient is .80, indicating that it approximates the content of the full CDI to an adequate degree (Kovacs 1992). For the present sample, the alpha coefficient for the Short-Form, obtained at pre-training, was .80.

External reliability: Test-retest reliability correlations in the literature, with retest intervals ranging from one week to one year, generally indicate an acceptable level of stability. For example, Finch et al. (1987, cited in Kovacs, 1992) obtained a correlation of .82 for a sample of normal youths retested after two weeks (see Table 6.4, Kovacs, 1992). In this respect, Kovacs noted that the CDI allegedly measures state, rather than trait, depression, and thus a two-week retest interval for a symptom-orientated instrument is appropriate. However, several studies have shown that repeated testing is associated with a significant drop in CDI scores from the first to second testing. This trend is common in related instruments and is akin to the statistical issue of regression to the mean. Lowered scores after several weeks must thus be interpreted with caution (Kovacs, 1992).

Validity: The CDI was developed with the adult centred Beck Depression Inventory (BDI; Beck, 1967) as its starting point (Kovacs, 1992). This was due to support in the

literature for the overlap among manifestations of depressive disorder in children, adolescents, and adults. The *DSM-III-R* (American Psychiatric Association, 1987) echoed this view, with some recognition of age-specific effects. CDI items therefore cover, fully or partially, the nine *DSM-III-R* symptom categories which are used to diagnose major depressive syndrome in children (Kavan, 1992).

Since its development, the CDI has been used in hundreds of experimental and clinical studies. As such, its validity has been well established using a variety of techniques. In general, the research evidence indicates that the inventory assesses important constructs which have strong predictive and explanatory utility in characterising depressive symptoms in children and adolescents. With respect to concurrent validity, the CDI has demonstrated strong correlations with measures of related constructs such as anxiety and self-esteem. For example, in a study of Central Pennsylvanian students, self-rated depression on the CDI correlated significantly with low self-esteem as measured with the SEI (Green, 1980, cited in Kovacs, 1992). However, the literature is less clear-cut with respect to CDI discriminant validity. For example, some research has found that the CDI can better distinguish normal from clinical samples, than it can distinguish between various diagnostic categories, and further studies are required (Kovacs, 1992).

Cut-off scores: Although the full scale CDI is not intended to be used as a diagnostic instrument, the manual does provide tentative cut-off scores for determining depression. The use of these scores has received criticism. For example Kavan (1992) argued that problems with the sensitivity and specificities of these cut-offs indicate that, with a cut-off score of 11 in a given sample, about 33% of depressive cases will be missed, while 40% will be mistakenly identified as depressed. However, in the manual, Kovacs (1992) has provided several comparison cut-off points for the CDI, in order to illustrate that a cut-off of 20 is most appropriate for use in general screening to minimise the probability of false positives. By comparison, for clinical settings where the minimisation of false negatives is critical, the cut-off can be set lower. It is important to note that a label of "depressed", made solely on the basis of high CDI scores, is inappropriate. No self-report scale should be used in isolation for diagnostic purposes (Fristad, Emery, & Beck, 1997).

Gender: Using the full CDI with the normative sample, a significant main effect for gender was obtained, indicating that boys scored higher, that is more depressed, than girls. No main effect was obtained for age, and there were no significant interactions. No main effects or interactions were obtained for the Short Form. Elsewhere in the literature, findings are inconsistent with respect to gender effects. For example, some studies using the CDI have found that boys scored higher than girls, some have found girls scored higher than boys, and some have found that scores are uncorrelated with gender (Kovacs, 1992).

3. *Programme Skills.* This measure is discussed in detail in Chapter 7. Alpha reliabilities, obtained for the present sample at pre-training, post-training, and follow-up, were .68, .74, and .78 respectively.

4. *Mood measure.* The students in the experimental group were asked to rate their mood prior to each session, as described in Chapter 7. The intention was to monitor the influence of the programme on students' general mood over the course of the sessions. However, observations of the students during the training programme indicated that students were rating the result of their immediate experiences, such as interactions with peers, that occurred just prior to sessions, rather than indicating a mood trend over the course of the previous week. For this reason the mood measure is not considered a valid indicator of any programme effects.

5. *Skills Checklist.* A skills checklist was included in the revised work books and was completed with homework each week. Its purpose was to reinforce practice of skills learned. Students were asked to copy their record of how often skills were used during the week, from the work book (e.g., see Appendix A, p. 181, for Session 1) onto a sheet which was distributed at the beginning of each session, and collected. For example, at the beginning of Session 2, having previously learned about the barometer, students were asked to record how often they had used this skill during the week. As skills were taught, they were added to the list, as in the Skills Checklist example below.

Skills Checklist Example

<input type="checkbox"/>	Using the Barometer	(Session 2 checklist)
<input type="checkbox"/>	Using the Barometer	(Session 3 checklist)
<input type="checkbox"/>	Changing hurtful thoughts to helpful thoughts	
<input type="checkbox"/>	Using the Barometer	(Session 4 checklist)
<input type="checkbox"/>	Changing hurtful thoughts to helpful thoughts	
<input type="checkbox"/>	Introducing yourself or developing a conversation	

Unfortunately, students commonly neglected to complete the weekly checklist in the work book and could not recall how many times a particular skill was used when asked for their record. For this reason, the count of skills used was not considered valid. However, the skills checklist was considered useful to reinforce skills taught.

6. *Parent/Guardian and Teacher scales.* At each period, teachers and parents/guardians were asked to complete checklists which were adapted from the Programme Skills measure, as explained in Chapter 7. Alpha coefficients obtained for parent/guardian measures at pre-training, post-training, and follow-up, were .78, .75, and .76 respectively. Those obtained for Teacher Checklists for the same survey periods were .87, .85, and .86.

Procedure

The participating school is designed in an open-plan format with three separate buildings, each containing three to four classes of mixed year 7 and year 8 (Form 1 and Form 2) students. Each class contained approximately 30 students. Two classes and teachers from each block participated in the study. The selection was semi-random in that, for each block, the health teacher and his or her class was designated the experimental group, as this fitted in with teaching schedules. One other teacher from each block was selected at random to be the control group teacher for that block. All teachers approached agreed to take part. Students were randomly sampled, in that each class contained year 7 and year 8 male and female students who were academically unstreamed.

A meeting was held with participating teachers and the researcher in February, 1997. Discussion centred around the content and background of the training programme, teacher support for the research, survey administration, and timetabling issues. The researcher

met with the classes involved and distributed information packs to students in March, 1997. In April 1997 consents had been obtained and the pre-training survey was conducted with experimental and control class students. At this same time, teachers and parents/guardians completed their first checklists. The procedure for data collection, return of information, and storage, was similar to that utilised in the pilot study.

In term 2, towards the end of April, 1997, the training programme commenced and was run weekly with each experimental class over the following nine weeks. Sessions were held in double-period blocks lasting approximately one and a half hours. The researcher conducted each session with the class teacher present, following the plan set out in the trainer's guide. Each student was given a work book containing notes and exercises for the course. The class teacher was asked to assist when students were in group discussions and completing work book exercises. Each training session began with the mood measure, followed by a discussion of anything that had occurred during the week, for which the skills taught previously were useful. The sessions proceeded as described for the pilot study. At the end of each session, students were reminded to complete a skills checklist during the subsequent week, to record which skills, if any, were utilised.

Results

Overview

Data comprised survey responses from students, parents/guardians, and teachers at pre-training, post-training, and follow-up. In order to compare results from post-training and follow-up surveys with the base-line pre-training data across experimental and control groups, a repeated-measures analysis was selected. The usual assumptions for an analysis of variance (ANOVA) are homogeneity of variance, normality for each group, and independent random samples (Sokal & Rohlf, 1969). Subsequent to screening for missing values, these assumptions were checked in an exploratory fashion with the proviso that a final check of residuals in the repeated-measures ANOVAs would be used to verify that these assumptions were met.

As a result of the initial checking, subsets of the data were transformed to more closely approximate normality. This allowed for reliable testing of differences between gender

and group in the pre-training phase using a two-way ANOVA. These differences were investigated because scores from measures such as the CDI can vary significantly according to gender, although, as discussed above, the literature in this area is equivocal (Kovacs, 1992). In the present study gender differences were found in subsets of the data, so that the subsequent repeated-measures ANOVAs were conducted for each variable using group and gender as factors. Mean values for the Programme Skills measure were then examined. Finally, correlations were obtained among the following sets of measures, transformed where relevant: Programme Skills, Teacher Checklists, and Parent/Guardian Checklists; Programme Skills, Global Self-Worth, and the Short-Form CDI; and the Physical Appearance and Global Self-Worth subscales of the SPPC.

Subsequent to the previous analyses, which were conducted with scores from the sample as a whole, a subset of scores was selected for further analyses. The subset was selected because, as mentioned later, ceiling effects seemed possible with the data obtained in the study. Further, although the programme was targeted at typical classes of students, positive increases in self-esteem may be most likely to occur in students with below-average scores (Harter, 1993). To examine this aspect, a cut-off score for Global Self-Worth was established. The overall mean obtained for this variable at pre-training was 3.13, with a standard deviation of .65. Using a conventional cut-off of one standard deviation below the mean, only 16 students' scores were included. With a cut-off of three-quarters of a standard deviation below the mean, 23 students scored below this bench mark (i.e., < 2.65). This cut-off was therefore used to obtain a subset of lower scoring students. The following sections discuss in detail: data screening, data analysis of the scores of the sample as a whole, ANOVA assumptions, correlations among various sets of measures, and data analysis of scores of the lower-scoring subset of students.

Data screening

Missing data. The numbers of students, teachers, and parents who completed measures, as well as the numbers of missing surveys due to family and teacher relocation, and parent/guardian neglect in completing checklists, were detailed in a previous section. In addition, two students in the experimental group and one in the control group filled in their forms incorrectly and so did not provide usable self-perception measures. Apart

from missing surveys, several items were missed from various measures. These items did not show a systematic pattern and were relatively few in terms of total items per measure. For example, the Programme Skills measure contains nine items, and with 67 students in the experimental group at pre-training, the possible total of items was 603. Only 5 items were missing (i.e., 0.83%). Table 4 lists all missing items.

Table 4

Numbers of missing items for each measure at each phase

	Experimental Group			Control Group		
	Pre-train	Post-train	Follow-up	Pre-train	Post-train	Follow-up
Programme Skills	5	-	1	-	12	1
CDI	-	-	-	-	-	-
Athletic Competence	1	2	4	1	1	2
Behavioral Conduct	3	1	2	2	2	2
Global Self-Worth	-	4	2	-	1	2
Physical Appearance	3	1	4	-	2	2
Scholastic Competence	-	1	4	-	2	1
Social Acceptance	1	6	5	3	1	1
Teacher Checklist	1	-	-	-	-	-
Parent Checklist	5	4	1	6	4	3

Table 4 shows that the greatest number of missing values was found in the Programme Skills measure for the control group at the post-training phase. No cause was identified for these 12 missing values. A variety of items across different report forms were involved. These items were: item 2 (3 missing), item 4 (2 missing), item 5 (1 missing), item 6 (2 missing), item 7 (2 missing), and item 9 (2 missing). Because mean values for these measures (except for the CDI for which there were no missing values) were used in subsequent data analysis, these omissions were accommodated.

Scale completion: Several respondents ticked between boxes to indicate an average choice. For any scale item, over the three surveys, this occurrence was less than 0.10%. In such cases a score representing the average value of response alternatives was used.

Homogeneity of variance. As equality of variance is an assumption when ANOVAs are employed, standard deviations for each variable at each phase of the study for both groups were examined. They are listed in Table 5.

Table 5
Standard deviations of variables at each phase

	Experimental Group			Control Group		
	Pre-train	Post-train	Follow-up	Pre-train	Post-train	Follow-up
Programme Skills	0.228	0.235	0.239	0.277	0.301	0.286
CDI	2.307	2.408	3.091	3.471	3.711	3.272
Athletic Competence	0.735	0.774	0.755	0.803	0.684	0.729
Behavioral Conduct	0.578	0.612	0.686	0.621	0.601	0.658
Global Self-Worth	0.587	0.618	0.619	0.711	0.608	0.658
Physical Appearance	0.776	0.714	0.797	0.785	0.790	0.834
Scholastic Competence	0.643	0.637	0.644	0.653	0.659	0.695
Social Acceptance	0.618	0.647	0.558	0.748	0.606	0.539
Teacher Checklist	0.325	0.283	0.308	0.316	0.294	0.295
Parent Checklist	0.284	0.269	0.244	0.297	0.270	0.283

From Table 5 it appears that the standard deviations are reasonably similar across times and groups for all variables, with the possible exception of the CDI. (CDI values are larger because they are based on sums, whereas the other values are based on means).

The Assumption of Normality. As an exploratory step, the skew values for all variables at each phase, and for both groups, were checked. Table 6 shows the varying degrees of skewness for each variable. The .001 level was selected to determine significant departures from normality as, according to Tabachnick and Fidell (1996), a conservative alpha level is appropriate. In addition, to visually represent skewness and identify outliers, each distribution was represented in a boxplot. For all but the CDI variable the distributions were comprised of means. Due to the scoring system used with the CDI, totals, rather than means, were used. All outliers were checked to ensure they were not the result of an error in data entry.

Table 6Values of skewness for each measure

	<u>Experimental Group</u>			<u>Control Group</u>		
	<u>Pre-Train</u>	<u>Post-Train</u>	<u>Follow-up</u>	<u>Pre-Train</u>	<u>Post-Train</u>	<u>Follow-up</u>
Programme Skills	-0.07	-1.01*	-0.93	-0.23	-0.61	-0.83
CDI	0.96	1.09*	1.34*	2.01*	2.18*	2.46*
Athletic Competence	-0.27	-0.11	-0.49	-0.25	-0.69	-0.79
Behavioral Conduct	-0.29	0.12	-0.33	-0.84	0.05	-0.44
Global Self-Worth	-0.46	-0.47	-0.53	-0.89	-0.64	-0.85
Physical Appearance	-0.22	-0.25	-0.21	-0.24	-0.06	-0.43
Scholastic Competence	-0.01	0.06	-0.19	-0.42	0.04	-0.70
Social Acceptance	-0.17	-0.12	-0.23	-0.77	-0.66	-0.75
Teacher Checklist	-0.43	-1.10*	-	-1.14*	-1.31*	-
Parent Checklist	-0.20	-0.95	-1.05*	-0.15	-0.46	-0.78

Note. * $p < .001$

As shown in Table 6, some of the distributions representing the Programme Skills, Parent/Guardian Checklists, and Teacher Checklists were significantly skewed in a negative direction. In the box-plot representations, these variables appeared to warrant transformation in order to reduce skewness and produce more similar standard deviations for each group. To accomplish this, these distributions were transformed to the power of three (Programme Skills), four (Parent/Guardian Checklist), and six (Teacher Checklist). In addition, as shown in Table 6, all but one of the CDI distributions was significantly skewed. In this case, the skew was in a positive direction and was obvious in the related box-plots which also highlighted several outliers. A square-root transformation was used to more closely approximate the normal distribution for the CDI.

Each of these transformations had the effect of eliminating most outliers in the respective distributions. For example, the CDI had the greatest number of outliers in the untransformed measures. The experimental group had between 1 to 5 outliers at each phase, whereas the control group had between 4 to 6 outliers at each phase. By

comparison, the transformed CDI showed no outliers for the experimental group, and two outliers at each of phases 1 and 2 for the control group. Table 7 shows the values of skewness for these transformed measures.

Table 7

Values of skewness for each transformed measure

Transformed	<u>Experimental Group</u>			<u>Control Group</u>		
	Pre-Train	Post-Train	Follow-up	Pre-Train	Post-Train	Follow-up
Programme Skills	0.51	-0.27	-0.46	0.17	-0.16	-0.42
CDI	-0.23	-0.10	0.45	0.34	0.54	0.61
Teacher Checklist	0.40	-0.20	-	-0.24	-0.56	-
Parent Checklist	0.70	-0.03	-0.18	0.56	0.10	-0.21

As shown in Table 7, skewness coefficients, in most cases, are closer to zero indicating that an assumption of normality is more reasonable. None departed from normality at the $p < .001$ level of significance.

Independent random samples assumption. This assumption was met, as described in the Procedure section above.

Differences at pre-training. Prior to conducting two-way ANOVAs to test for gender and experimental/control group differences at pre-training, ANOVA assumptions were checked when the variables, transformed where necessary, were separated by gender. Table 8 and 9 show the standard deviations and skewness coefficients, respectively, by gender, after transformation.

Table 8Standard deviations for males and females at pre-training

	<u>Experimental Group</u>		<u>Control Group</u>	
	Males	Females	Males	Females
Transformed Programme Skills	1.91	1.48	2.08	2.36
Transformed CDI	1.27	1.19	1.28	1.82
Athletic Competence	0.76	0.63	0.72	0.68
Behavioral Conduct	0.65	0.47	0.59	0.65
Global Self-Worth	0.60	0.55	0.50	0.76
Physical Appearance	0.83	0.65	0.62	0.79
Scholastic Competence	0.68	0.60	0.62	0.69
Social Acceptance	0.69	0.53	0.71	0.75
Transformed Teacher Checklist	22.78	21.09	24.08	23.90
Transformed Parent Checklist	3.96	5.07	4.65	4.93

Table 9Values of skewness for males and females at pre-training

	<u>Experimental Group</u>		<u>Control Group</u>	
	Male	Female	Male	Female
Transformed Programme Skills	0.52	0.30	0.37	0.06
Transformed CDI	0.39	0.55	1.04	0.97
Athletic Competence	-0.59	-0.25	-1.21	0.15
Behavioral Conduct	-0.19	-0.09	-0.30	-1.16
Global Self-Worth	-0.59	-0.49	-1.03	-0.55
Physical Appearance	-0.65	0.06	-0.76	0.31
Scholastic Competence	-0.17	0.29	-0.77	-0.19
Social Acceptance	-0.39	0.18	-1.15	-0.58
Transformed Teacher Checklist	0.79	0.01	-0.18	-0.31
Transformed Parent Checklist	1.03	0.33	0.04	0.66

Table 8 shows that the standard deviations by gender, after transformation, appear to be reasonably similar across variables, such that there is adequate compliance with the ANOVA assumption of homogeneity of variance. Table 9 shows that in most cases skewness coefficients are sufficiently small that the assumption of normality is reasonable. The few instances of larger skewness can be attributed to a few outliers in the small samples. At the $p < .001$ level, none of the skewness coefficients indicated a significant departure from normality.

Data analysis

Table 10 shows the means, with standard deviations in brackets, for each variable, transformed where relevant, at each survey period, for experimental and control groups.

Table 10

Means and standard deviations by group at each phase

	<u>Experimental Group means</u>			<u>Control Group means</u>		
	<u>Pre-Train</u>	<u>Post-Train</u>	<u>Follow-up</u>	<u>Pre-Train</u>	<u>Post-Train</u>	<u>Follow-up</u>
Programme Skills	4.13 (1.72)	5.10 (1.82)	5.54 (1.96)	4.78 (2.22)	4.90 (2.28)	5.37 (2.25)
CDI	1.45 (0.80)	1.32 (0.89)	1.12 (1.08)	1.43 (1.00)	1.36 (1.05)	1.13 (1.04)
Athletic Competence	2.91 (0.74)	2.89 (0.77)	2.99 (0.76)	2.89 (.80)	2.98 (0.68)	3.13 (0.73)
Behavioral Conduct	2.87 (0.58)	2.93 (0.61)	3.01 (0.69)	3.05 (0.62)	2.90 (0.60)	3.00 (0.66)
Global Self-Worth	3.07 (0.59)	3.09 (0.62)	3.18 (0.62)	3.19 (0.71)	3.13 (0.61)	3.18 (0.66)
Physical Appearance	2.68 (0.78)	2.82 (0.71)	2.86 (0.80)	2.86 (0.79)	2.81 (0.79)	2.87 (0.83)
Scholastic Competence	2.74 (0.64)	2.77 (0.64)	2.93 (0.64)	2.87 (0.65)	2.77 (0.66)	2.96 (0.70)
Social Acceptance	2.98 (0.62)	2.99 (0.65)	3.10 (0.56)	3.12 (0.75)	3.09 (0.61)	3.19 (0.54)
Teacher Checklist	27.28 (22.42)	37.40 (22.70)	- -	37.91 (23.83)	41.76 (23.38)	- -
Parent Checklist	7.13 (4.60)	8.64 (4.34)	9.69 (4.36)	7.16 (4.77)	8.79 (4.78)	9.75 (5.03)

The data used in all subsequent analyses are mean scores across items which, in the case of the Programme Skills, Parent/Guardian, and Teacher Checklists are transformed as described earlier. The exception is the CDI for which the data are totals, also transformed as described earlier.

Significance level. An alpha level of .01 was used for all statistical tests. When a number of statistical tests are conducted, the probability of making a Type I error can accumulate to an unacceptably high level. By setting an alpha level of .01 for individual tests, the accumulated error probability is controlled at a reasonable level. However, in order to provide a more complete picture of the programme outcomes, results with p -values between .01 and .025 are also recorded herein.

Group equivalence. To assess group equivalence prior to the programme, each of the pre-training measures was entered into a separate analysis of variance with gender and experimental/control group as the independent variables. A complete list of these results is contained in Appendix F, Table 19. Most importantly, the main effect of group was not significant in any of the analyses, nor were there any significant interactions between gender and group. However, significant gender effects (i.e., $p < .01$) were obtained for the following variables: CDI, $F(1, 127) = 8.03$; Athletic Competence, $F(1, 125) = 25.39$; Global Self-Worth, $F(1, 125) = 14.57$; and Physical Appearance, $F(1, 125) = 16.38$. Table 11 shows the mean values for these variables.

Table 11

Mean values for variables revealing significant gender effects at pre-training

	Experimental Group		Control Group	
	Male	Female	Male	Female
Transformed CDI	1.33	1.60	1.12	1.72
Athletic Competence	3.11	2.66	3.33	2.52
Global Self-Worth	3.18	2.94	3.51	2.92
Physical Appearance	2.86	2.45	3.21	2.56

Table 11 shows that females scored, on average, more highly (i.e., perceived themselves as more depressed) than males in both groups for the CDI, whereas males scored more highly (i.e., perceived themselves as more competent etc.) for the Athletic Competence, Global Self-Worth, and Physical Appearance subscales of the SPPC.

p-Values between .01 and .025: at pre-training, an experimental/control group difference of $F(1, 127) = 6.19, p = .014$ was obtained for the transformed Teacher Checklist. The relevant means showed that, on average, control group teachers appeared to be rating students more highly in programme related skills (37.91), than experimental group teachers (27.28).

For confirmation of these results, the pre-training phase analyses were rerun using the untransformed measures. The results were similar to those described above. That is, significant effects were obtained in the same measures on both occasions, and no significant effects were obtained in the untransformed measures where none showed in the transformed versions. Thus, results were not affected by the decision to transform variables and the findings are quite robust.

Outcomes. Each measure was subjected to a repeated-measures ANOVA, in order to compare each set of results at post-training and follow-up with the baseline pre-training results. Group and gender were entered as factors. A complete list of these results is contained in Appendix F, Table 20. A multivariate analysis of variance was not used because, unless the number of subjects is moderately large or the number of repeated measures small, MANOVA will usually have very low power compared to repeated measures split plot ANOVA analyses (M.G. Kenward, Centre for Application of Statistics and Mathematics, University of Otago, N.Z., personal communication, 1992).

No significant main effects (i.e., $p < .01$) between experimental and control groups were obtained either at post-training or at follow-up. As far as gender differences were concerned, a significant main effect was obtained for Global Self-Worth at post-training, $F(1, 122) = 7.91$. Similar to the pre-training means, the means for males at post-training (3.16 and 3.29) were higher than those for females (3.00 and 2.99), for experimental and

control groups, respectively. No main effects of gender were found at follow-up.

One significant interaction between group and gender was obtained for Athletic Competence at post-training, $F(1, 122) = 8.24$. Table 12 shows the mean values at pre- and post-training, and the change which occurred over the time period.

Table 12

Mean values and change between pre- and post-training for Athletic Competence

	Experimental Group		Control Group	
	Male	Female	Male	Female
Athletic Competence Pre-training	3.11	2.66	3.33	2.52
Athletic Competence Post-training	<u>3.12</u>	<u>2.61</u>	<u>3.26</u>	<u>2.74</u>
Change from Pre- to Post-Training	0.01	-0.05	-0.07	0.22

Table 12 shows that at post-training, compared to pre-training, the average scores of females in the experimental group dropped slightly while those of the control group females increased moderately. By contrast, control group male scores dropped slightly at post-training, whereas experimental male group scores were very similar at both times.

p-Values between .01 and .025 were obtained at post-training between the experimental and control groups $F(1, 125) = 5.99$, $p = .016$, and for the interaction between group and gender, $F(1, 125) = 5.45$, $p = .021$, for the Programme Skills measure.

For confirmation of the previous results, the repeated-measures ANOVAs were conducted with the untransformed measures. The results were similar to those described above, showing again that they were not affected by the decision to transform variables and findings are quite robust.

Programme Skills: Although no significant effects were obtained from the repeated-measures analyses, this measure was of importance because it was designed to measure skills taught in the programme. Also, as mentioned above, a *p* value of .021 was recorded for the interaction between group and gender for Programme Skills at post-

training. It was therefore of interest to examine group means at the three time periods to provide a fuller picture of programme outcomes. Table 13 shows the means by group across the three phases of the study, Table 14 separates the groups by gender, and Table 15 shows the mean change in Programme Skills, by group and gender, across the pre-training to post-training phase, and across the pre-training to follow-up phase.

Table 13Transformed Programme Skills means

	Experimental Group	Control Group
Pre-training	4.13	4.78
Post-training	5.10	4.90
Follow-Up	5.54	5.37

Table 14Transformed Programme Skills means by gender

	Experimental Group		Control Group	
	Male	Female	Male	Female
Pre-training	4.24	3.99	4.78	4.79
Post-training	4.91	5.32	4.64	5.13
Follow-Up	5.07	6.13	5.49	5.26

Table 15Mean change in transformed Programme Skills scores across two time periods(2nd period–1st period)

Mean change from:	Experimental			Control		
	Entire Group	Male	Female	Entire Group	Male	Female
Pre-training to Post-training	0.97	0.67	1.33	0.12	-0.14	0.34
Pre-training to Follow-up	1.41	0.83	2.14	0.59	0.71	0.47

Table 13 indicates that experimental group scores tended to increase more than those of the controls over the phases of the study. The increase is shown in Table 15 as the change in mean scores which occurred at each phase for each group.

Table 14 indicates that the tendency of experimental group scores to increase more than those of controls appeared to be strongest in the experimental female group from pre- to post-training, and to be maintained through to follow-up. The increase is shown in Table 15 as the change in mean scores which occurred at each phase for each group by gender. However, the variation within each group is sufficiently large to render these differences nonsignificant in a statistical sense.

CDI. Although the transformed CDI was used for data analysis, for the subsequent discussion, it is useful to record the average totals for the untransformed CDI. Short-Form CDI totals have a potential range of 0 to 20. Average totals for the experimental group were 2.7 at pre-training, 2.5 at post-training, and 2.4 at follow-up. For the control group the averages were 3.1 at pre-training, 2.9 at post-training, and 2.3 at follow-up.

ANOVA assumptions

As a final check that the assumptions for ANOVA were satisfied for the preceding repeated-measures analyses, normal plots of residuals showing the expected normal by observed values, and plots of observed by predicted residuals were examined for each variable (transformed where relevant) at each time period. The plots showed the residuals were close to the positive diagonal, with the expected exception of a few outliers for some variables, satisfying the assumption of normality. Plots of observed by predicted values showed approximately equal scatter for each predicted value, indicating that homogeneity of variance assumption was also satisfied.

Correlations between measures

In order to examine the construct validity of Programme Skills several correlations were undertaken. Table 16 records the correlations among the transformed Programme Skills, Teacher, and Parent/Guardian Checklists, at each survey period. As would be expected, each of the measures was correlated significantly with itself across each period. In addition, Programme Skills correlated significantly with the Teacher and the Parent/

Guardian Checklists at all time periods. However, only two of the six possible correlations were significant between the Teacher and Parent/Guardian Checklists. According to Cohen's (1992) set of effect size conventions for significant product-moment correlations, where an effect size of .10 is considered small, .30 medium, and .50 large, the strength of the correlations between Programme Skills and Parent Checklists was generally medium. Between Programme Skills and Teacher Checklists, and between Teacher and Parent Checklists, the strength of correlations was small.

Correlations among the transformed Programme Skills, Global Self-Worth, and the transformed CDI are shown in Table 17. All the measures were correlated significantly with each other, within and across every phase of the study. Overall, correlations for Programme Skills with the other two were in the medium to large effect size. Correlations were positive between Programme Skills and Global Self-Worth, and negative between the CDI and the others, as would be expected.

It was also of interest to examine the correlations between Physical Appearance and Global Self-Worth, because Harter's research (e.g., 1993), has found physical appearance to be strongly correlated with global self-worth in adolescents. Correlations between these variables were examined both for the sample as a whole, and when separated by gender across time periods. All correlations were highly significant ($p < .001$), both for the sample as a whole, and when separated by gender. The correlations for the sample as a whole ranged from .56, between Physical Appearance at pre-training and Global Self-Worth at post-training, to .79, between Physical Appearance and Global Self-Worth at pre-training. The outcome was very similar when the sample was separated by gender although correlations were slightly lower for males than for females. For example, the lowest correlation obtained for males was .46, by comparison with .57 for females.

Table 16 Correlations among Programme Skills, Teacher Checklists, and Parent Checklists, at each phase

	<u>Programme Skills</u>		<u>Teacher Checklist</u>		<u>Parent Checklist</u>		
	Post-Training	Follow-Up	Pre-Training	Post-Training	Pre-Training	Post-Training	Follow-Up
Programme Skills Pre-Training	.569***	.485***	.151*	.177*	.419***	.438***	.383***
Programme Skills Post-Training		.653***	.211**	.226**	.169*	.376***	.348***
Programme Skills Follow-Up			.191*	.224**	.345***	.379***	.412***
Teacher Checklist Pre-Training				.605***	.176*	.155	.108
Teacher Checklist Post-Training					.139	.106	.198*
Parent Checklist Pre-Training						.565***	.604***
Parent Checklist Post-Training							.696***

Table 17 Correlations among Programme Skills, Global Self-Worth, and CDI at each phase

	<u>Programme Skills</u>		<u>Global Self-Worth</u>			<u>CDI</u>		
	Post-Train	Follow-Up	Pre-Train	Post-Train	Follow-up	Pre-Train	Post-Train	Follow-Up
Programme Skills Pre-Training	.569***	.485***	.408***	.302**	.327***	-.572***	-.399***	-.398***
Programme Skills Post-Training		.653***	.271**	.496***	.416***	-.457***	-.530***	-.429***
Programme Skills Follow-Up			.371***	.517***	.493***	-.480***	-.536***	-.568***
Global Self-Worth Pre-Training				.643***	.657***	-.692***	-.481***	-.529***
Global Self-Worth Post-Training					.777***	-.557***	-.613***	-.590***
Global Self-Worth Follow-up						-.582***	-.569***	-.704***
CDI Pre-Training							.577***	.639***
CDI Post-Training								.612***

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Subgroup composition and analysis

As mentioned previously, a subgroup of 23 students scored below 2.65 on the Global Self-Worth subscale at pre-training. This subscale was selected because it is a respected index of global self-esteem, the construct targeted specifically in the training programme. Of the subgroup, 12 (5 males), and 11 (1 male), were members of the experimental and control groups respectively. All of these students completed each measure at each phase of the study, and their teachers likewise completed all related checklists. Nine parents/guardians completed checklists for the experimental subgroup at pre- and post-training, and 8 parents/guardians completed checklists at follow-up. Seven parents/guardians completed checklists for the control subgroup at pre- and post-training, and 6 completed checklists at follow-up.

Because of the small sample size of the subgroup it was not possible to test the relevant ANOVA assumptions. Similarly, given that there was only one male in the control subgroup, it was not appropriate that subsequent analyses should include gender as a factor. For this reason subgroup scores were analysed with the nonparametric Mann-Whitney U-test, using group as a factor.

Table 18 shows the means, with standard deviations in brackets, for each variable, transformed where relevant, at each time period for the experimental and control subgroups. This is by comparison with Table 10 which shows the means and standard deviations for the sample as a whole. When reporting significant Mann-Whitney U-test results, relevant medians are recorded.

Subgroup equivalence. The results of the Mann-Whitney U-test revealed a significant difference between experimental and control subgroups for Athletic Competence, $U=19$, ($p = .003$, two-tailed) at pre-training. Medians were 3.00 and 2.83, for the experimental subgroup and the control subgroup respectively.

Table 18Means and standard deviations by subgroup at each phase

	<u>Experimental Subgroup means</u>			<u>Control Subgroup means</u>		
	Pre-Train	Post-Train	Follow-up	Pre-Train	Post-Train	Follow-up
Programme Skills	3.28 (1.48)	5.16 (2.00)	4.93 (2.66)	2.86 (1.88)	2.89 (1.88)	3.37 (1.55)
CDI	2.15 (0.55)	1.97 (0.87)	1.75 (0.92)	2.76 (0.80)	2.39 (1.41)	2.41 (0.95)
Athletic Competence	3.26 (0.62)	2.97 (0.78)	3.26 (0.89)	2.26 (0.68)	2.61 (0.76)	2.80 (0.88)
Behavioral Conduct	2.38 (0.48)	2.37 (0.49)	2.53 (0.65)	2.61 (0.80)	2.46 (0.70)	2.72 (0.80)
Global Self-Worth	2.21 (0.39)	2.46 (0.57)	2.63 (0.69)	2.00 (0.47)	2.35 (0.62)	2.34 (0.69)
Physical Appearance	1.83 (0.60)	2.36 (0.67)	2.35 (0.79)	1.83 (0.35)	1.94 (0.46)	1.90 (0.61)
Scholastic Competence	2.60 (0.67)	2.49 (0.47)	2.71 (0.61)	2.20 (0.69)	2.21 (0.66)	2.96 (0.70)
Social Acceptance	2.97 (0.69)	2.88 (0.71)	3.12 (0.56)	2.30 (0.88)	2.53 (0.82)	2.88 (0.76)
Teacher Checklist	26.95 (21.82)	35.69 (26.64)	- -	25.53 (24.01)	18.94 (21.96)	- -
Parent Checklist	6.15 (4.21)	7.54 (3.95)	9.77 (4.13)	6.91 (6.94)	4.60 (3.78)	5.27 (5.76)

Outcomes. Difference scores between pre-training and post-training, and between pre-training and follow-up, were obtained for each measure. A separate Mann-Whitney U-test was conducted on each of these difference scores. That is, each measure was tested separately for the pre-training to post-training change, and for the pre-training to follow-up change, using experimental/control group as a factor. Only one significant effect was obtained, that being for Programme Skills between the pre-training to post-training phases, $U=21$, ($p = .006$, two-tailed). The relevant medians were 0.866 and 0.000, for the experimental subgroup and the control subgroup respectively.

CHAPTER 9

DISCUSSION

The programme designed for this research was intended as a preventative intervention to provide early adolescent students with coping skills, ahead of potential life difficulties. As such, the intent was not to target particular groups of at-risk or problem students, but rather to train a typical group of early adolescents. The aim was to increase their coping skills and consequently improve self-esteem. However, because there may be little scope for self-esteem improvement in students who already score highly on this measure, a subgroup of scores less than three-quarters of a standard deviation below the mean for Global Self-Worth, was examined separately.

When the measures used to assess depression, self-perception, and the acquisition of programme skills were analysed statistically for the whole sample, neither they, nor teacher nor parent ratings, revealed a significant difference between the students who participated in the programme and those who did not. When these same measures were analysed for the subgroup of lower-scoring students, a significant difference was found in Programme Skills between pre- and post-training for the experimental, by comparison with the control subgroup.

Results obtained with Programme Skills were seen as particularly important because this scale was designed to measure the specific skills targeted in the programme. In the light of the pre-training/post-training difference in the lower-scoring subgroup, patterns in the mean values of the whole group were re-examined informally, despite being nonsignificant in a statistical sense. The pattern of means indicated that experimental group scores appeared to increase more than those of the controls over the phases of the study. The increase appeared to be strongest in the experimental female group from pre- to post-training, and to be maintained through to follow-up.

Although Programme Skills is not a recognised scale and was developed specifically to measure skills taught in the research programme, a reasonable level of internal reliability

was demonstrated for the measure over the three survey periods, with an average alpha coefficient of .73. It also provided some initial evidence of construct-validity with the present sample, in that it correlated significantly and positively with the Global Self-Worth subscale of the SPPC, and significantly and negatively with the CID Short-Form (transformed), over the three survey periods. All correlations were in the medium to high range. Programme Skills therefore appeared to be measuring skills related to improving self-esteem and relieving depression, and these skills were increased by the programme, at least for the lower scoring subgroup at post-training.

Because no significant differences between groups or subgroups were obtained with any other measures, it is possible that the training programme or instructional techniques were not effective in influencing the variables measured. Nevertheless, the design and duration of the training programme, as well as aspects related to sample characteristics, power, and measurement, deserve further consideration, and are discussed below. In addition, because significant gender differences were found at pre-training in several measures, and in the Global Self-Worth subscale of the SPPC at post-training, these are discussed with reference to the literature. The discussion concludes with a summary of the main points.

Design

The programme was originally designed for small group implementation because the skills targeted require a degree of trust and cooperation to have full impact. As explained previously, although the move from group to class application, which occurred for the main study, was more realistic in terms of the resources usually available in state schools, it involved a trade-off in terms of an ideal environment. That is, because the main study was conducted with classes of 20 to 30 female and male students, a supportive environment was difficult to achieve. By comparison, in the pilot study, which was conducted with groups of about ten, students appeared to display less embarrassment, were more forthcoming, and showed more acceptance of individual and gender differences.

Further, managing class, rather than small group numbers, required teacher support, to ensure that students were at ease, respected course content, and completed homework.

Due to other pressures, teacher participation in the present training programme was limited. This may have affected outcomes. For example, noting that school based competence-promotion programmes are important primary preventative measures, Weissberg, Caplan, and Harwood (1991) suggested that teacher involvement may be crucial for successful interventions. Notwithstanding teacher support, Maskill (1991) noted that many adolescents perceive their life experiences as significantly different from those of their parents, and do not accept health-related advice uncritically from authority figures. It may thus be difficult for teachers both to regulate their classes, and to teach rational thinking and social skills which require a fairly relaxed approach. For this reason other adults, admired by students as role models, could be more effective in implementing or assisting with such programmes. This possibility received support in the present study, when a relieving teacher, regarded by students as a national sports hero, was in charge of one class during a scheduled programme session. Assisting the trainer, the relieving teacher reinforced skills and gave personal examples of rational thinking. It appeared that students particularly enjoyed that session, participated in activities more freely than usual, and were more receptive to the skills taught.

As well as incorporating teacher support, programmes which coordinate multiple socialising influences, including parents, may be most successful in producing long-term benefits (Weissberg et al., 1991). In the present study, parents were kept informed and were asked to complete checklists. However, there was little evidence that parents discussed programme skills, or reinforced work book homework with students. Homework which, although minimal, was important to enhance skill proficiency, is an important component of the cognitive-behavioural approach (Burns, 1993a). Training parents and/or running small groups after school was considered in the research design stage, because this was not possible during school time. It was decided that this approach would be too complex because of student commitments after school, students catching buses, parents working, and similar restrictions. In addition, students or parents attending such groups would constitute non-random volunteer samples, with the attendant concern that results would not generalise to the school community at large. Nonetheless, a meeting with parents/ guardians, prior to the commencement of the intervention, may have facilitated more home-based involvement, and produced more benefit.

Duration

In addition to group size and available support, the duration of the present training programme may have been too short to effect a significant difference between groups in the self-perception and depression variables, and in programme skills through to follow-up. While it is not certain just how many hours of instruction are required to produce robust improvements in students' health-related knowledge, attitudes, and behaviours, a substantial number may be required. Although knowledge acquisition can occur in relatively few hours, as many as 40 to 50 hours may be required in order to establish stable effects in attitudes and behaviour in addition to influencing the knowledge base (Weissberg et al., 1991). The effects of programme length on outcome were considered by Lamke et al. (1988) in relation to their 14-hour training programme. That intervention was designed to change adolescents' self-statements and increase levels of self-esteem. As compared to a control group, the programme resulted in a significant increase in positive self-statements, but no significant change in self-esteem level for the experimental group. Lamke et al. suggested that one possible reason for the lack of impact on self-esteem was that the programme length did not allow for sufficient practice of positive self-statements in real-life situations, although the experimental adolescents were able to modify their self-statements in a relatively short time-span. Similarly, the skills taught in the present programme need to be reinforced in an ongoing way through their incorporation in normal classroom instruction, while a longer training-period may have been of benefit, to consolidate skills over time.

Sample characteristics and statistical power

As shown in the results section, the sample contained a mix of ethnicities and a range of academic levels. However, the sample size was smaller than originally intended. With six classes in total, it was anticipated that the experimental and control groups would each comprise at least 90 students. Due to smaller than expected class sizes, and the presence of students for whom English was a second language and who were thus unable to complete the checklists, the sample size was reduced to about 65 in each group. With the additional separation of these groups by gender, sample sizes were relatively small. Similarly, parent/guardian numbers were low for the Parent/Guardian Checklist, due to non-return of forms, despite follow-up letters and telephone communication.

Given these sample sizes, statistical power was low. However, even with 90 students in each group the power associated with many of the comparisons would still have been low. Unfortunately, due to practical constraints (e.g., available resources), no more than six classes could be recruited. The issue of statistical power is discussed next, taking into consideration the effect size estimated for the programme and the tests utilised.

A large effect size was not predicted for the present programme, given its focus on prevention. As already discussed, the intent was not to target at-risk students. Rather, working with typical classes of early adolescents, skills taught were for potential use in times of difficulty. For this reason, it is likely that many of the students would not be required to utilise these skills on a frequent basis, over the period of the study. Thus, a significant improvement in self-esteem and related domains would not be expected for those experimental students, arguably the majority, currently coping well. Once problems are confronted by these students and dealt with by applying skills learnt, it is possible that coping successfully will increase self-esteem, or maintain medium to high levels of self-esteem, relative to students who have not acquired coping skills.

Previous research also indicates that a small effect for an educational self-esteem intervention is likely. In terms of Cohen's (1992) set of conventions for tests involving two independent means, an effect size of .20 is considered small, .50 medium, and .80 large. Hattie (1987, 1990, cited in Hattie & Marsh, 1996) synthesised over 130 meta-analyses to investigate the effect of schooling on student outcomes. In total, 22,155 effect-sizes from 7,827 studies were obtained covering many different interventions. The typical effect size for achievement was .40 (SE = .02). By comparison, the typical effect for self-esteem, across 1,399 effect sizes, was .19 (SE = .04). These figures can be used to provide a criterion from which to judge effect sizes in evaluating new programmes (Hattie & Marsh, 1996).

In order to estimate the power of statistical testing in the present research, the GPower program (Faul & Erdfelder, 1992) was utilised. For simplicity, an independent-sample *t*-test was assumed when considering the differences between the experimental and control groups. The actual sample sizes of 67 and 64, an alpha level of .05, and a small

effect size ($d = .20$) were used with most measures. From these figures, power was estimated at .21, which is low. A level closer to .80 would be preferable (Cohen, 1992). Two methods for raising power are increasing sample size, and utilising measures which are as sensitive as possible. Given the drop in the original sample number, and the limited resources of the present study, increasing sample size to raise power was not viable. For example, to obtain the power of .80 for a small effect size, a sample of approximately 400 in each group would be required. Therefore, utilising a sensitive measurement scale was given particular emphasis. As explained previously, because the SPPC (Harter, 1985a) and CDI (Kovacs, 1992) did not specifically measure the skills taught in the programme, the Programme Skills measure was developed in order to tap these skills as directly as possible. Thus, given the present sample size and an alpha level of .05, if a medium effect ($d = .50$) was anticipated, power would be approximately .81. However, the preventative nature of the programme must again be considered. It may be that the majority of experimental group students will not utilise skills taught until later in their development. In summary, the power of the statistical comparisons in the study is low, possibly obscuring real differences between groups. Longitudinal research is required to explore whether any future differences between groups would be obtained.

Measurement issues

Various problems affecting the validity of self-report scales were discussed in detail in Chapter 5. These included social desirability and random responding due to circumstances such as reading difficulties or inattention. In the present research these concerns were controlled as much as possible by endeavouring to make sure that students understood the scales (e.g., SPPC items were read aloud), and by stressing the importance of honest responding. Issues related to specific scales are considered below.

The SPPC

Although it was hypothesised that the experimental, by comparison with the control students, would show a significant difference in the Global Self-Worth subscale of the SPPC, no statistical group difference was obtained. In addition to deficits in programme content or inadequate instructional techniques, as discussed earlier, another reason for a lack of difference may be that global self-esteem is relatively insensitive to modification

by focused intervention techniques (Bracken, 1996). The present programme focused on a variety of specific areas including physical appearance and social skills.

Nevertheless, domain-related SPPC subscales showed no significant group differences either. Apart from issues relating to programme content or instructional concerns, time allocated to topics may have been too short to impact on particular self-concept domains. For example, time allocated to the discussion of physical appearance within the programme was minimal. A second explanation is that the subscales did not accurately measure the skills taught. For instance, one item from the Scholastic Competence subscale (SPPC; Harter, 1985a) asks students to decide between "Some kids feel like they are *just as smart* as other kids their age" BUT "Other kids aren't so sure and *wonder* if they are as smart". The skills taught in the programme, rather than aiming to improve perceptions of smartness, focused on improving students' acceptance of their ability in the particular domain. They were taught to consider to whom they were comparing themselves, which personal strengths they had, and how to change negative thinking. These skills do not imply that scholastic achievement will necessarily improve, although improved motivation can increase performance. Similarly, although the programme focused on changing self-critical thoughts about appearance, responses to the Physical Appearance subscale may not have changed as a result of the skills taught. As an example, one item on the subscale asks students to choose between "Some kids wish their physical appearance (how they look) was *different*" BUT "Other kids *like* their physical appearance the way it is". Even with a positive physical self-concept, a student may still wish that some part of his or her physical appearance was different. Also, as discussed in Chapter 5, the interpretation of high scores for specific subscales is not clear-cut. If students rate themselves more highly than is realistic, this can signify as much of a problem as rating themselves too low in domains of actual competence (Friedman, 1992)

The CDI

The CDI was included in the present research because self-esteem and depression are closely related in adolescence (Harter, 1993). There was thus the possibility that the programme would impact on depressive affect for some students, but no significant group effect was found. However, as discussed above, it is likely that the majority of

adolescents were currently coping, and were not depressed.

On examination of CDI scores, as recorded in the results section, this supposition is supported. At pre-training, the average raw total score was 2.7 for the experimental group and 3.1 for the control group. These scores decreased slightly for both groups over the period of the research, to 2.4 for the experimental group and 2.3 for the control group at follow-up. As discussed in Chapter 8, raw scores for the Short-Form CDI have a range of 0 to 20, with higher scores related to more depression. A raw score of approximately 3 represents the average with respect to CDI norms derived from 1,266 American school students, aged approximately 7 to 16 years. Although these norms are limited (Kavan, 1992), and are not directly representative of New Zealand children, they give some indication of the relationship between raw scores and depressive levels. The pre-training mean total of 2.7 indicates that, on average, experimental students were not depressed prior to the programme, thus it would arguably be difficult for skills taught to impact greatly on already low levels of depression.

Programme Skills

The significant effect obtained for Programme Skills for the subgroup of lower scoring students was discussed at the beginning of this chapter. However, as only one significant effect was obtained, several possibilities exist. As mentioned previously, the programme or instructional techniques may have been wanting. There may have been a lack of statistical power, or the preventative nature of the intervention, where skills taught are not necessarily utilised until later in development, may have rendered group differences insignificant. This lends justification to the development and use of the Programme Skills measure which should bear upon perceived ability to cope with future problems, such as perceived rejection or failure.

Parent/Guardian and Teacher Checklists

These checklists, as previously described, were adapted from Programme Skills with the same item content but changed wording to suit the different respondents. Over the course of the study, the average alpha coefficients for the Programme Skills, Parent/Guardian, and Teacher Checklists, were .73, .76, and .86 respectively, showing moderate

to high internal consistency. Both Parent/Guardian and Teacher Checklists were significantly correlated with the Programme Skills measure across all comparisons (refer Table 16). However, correlations between student and parent measures (most in the vicinity of .35 to .40), were higher than student and teacher correlations (most in the vicinity of .15 to .20). Correlations between Teacher and Parent/Guardian measures obtained significance only twice out of a possible six comparisons, and correlations were also low (ranging from .11 to .20). It therefore appears that teachers and parents were rating students differently in programme skills at times, over the course of the study. Previous findings of low correlations in behavioural ratings by parents and teachers has been attributed to the situational specificity of children's behaviour (Jaycox et al., 1994).

As with the Programme Skills measure, it was disappointing that a significant difference between groups was not obtained using either the Parent/Guardian, or Teacher Checklists. Because these checklists were derived from the Programme Skills measure, the above discussion with respect to techniques, and the preventative nature of the intervention is also applicable here. In addition, as reported in Chapter 8, return rates for the Parent/Guardian Checklists were lower than desired, with only 52 returns in the experimental group, and 48 in the control group, at follow-up. The implication of the low rate of return in terms of statistical power was discussed earlier. The analysis of the Teacher Checklists also presented some concern. Although not statistically significant, the pre-training analysis indicated that control teachers may have been rating students more highly in the programme skills than experimental teachers. Also, a follow-up analysis was inappropriate because one teacher left before completing her checklist.

Theoretical issues

The difficulties associated with defining self-esteem and its relationship to other self-related constructs may also have contributed to the lack of significant findings. Self-esteem was defined in the present study as incorporating worthiness, competence, and their interaction. Although the programme aimed to impact on worthiness, competence may have been more central to training. The Programme Skills measure arguably taps competence, rather than worthiness. However, competence may develop into self-efficacy (the belief that one will be able to cope adequately in the future). With on-going

practice of programme skills self-efficacy might increase, in turn decreasing negative arousal and negative self-evaluation to increase self-esteem (see Bandura, 1981, 1990). Interestingly, Gillham et al. (1995) found that the preventative effect of their cognitive-behavioural programme for depression grew over time. In the present study, the five-month follow-up period was dictated by the end of the school year, and subsequent relocation of many of the students to various secondary schools. This follow-up period may have been too short to reveal subsequent differences between experimental and control students with respect to self-esteem and/or depression.

Gender differences

At pre-training, significant gender differences were found in the transformed CDI (Kovacs, 1992), and the Physical Appearance, Athletic Competence, and Global Self-Worth subscales of the SPPC (Harter, 1985a). At post-training a significant gender difference was obtained for Global Self-Worth. Harter obtained similar differences in each of the latter three subscales in the normative sample of the SPPC. That is, a significant difference was obtained in Athletic Competence across all groups in the normative sample, and in the middle school groups (students of a similar age to those in the present study) for Physical Appearance and Global Self-Worth. For each of these domains, boys rated themselves more highly than girls. Similarly, with respect to the present study, boys, on average, rated themselves better looking, more athletically competent, and more worthy than girls, and, in relation to the CDI, less depressed (refer Table 11). It is of interest that similar patterns were evident in the New Zealand sample and in the American sample from which the test norms were derived. In addition, Harter (e.g., 1993) has found that the physical appearance domain is most closely linked with self-worth, and that the evidence points to a gender discrepancy with respect to physical appearance. These findings were also largely supported in the present research. In this study, Physical Appearance and Global Self-Worth were significantly correlated, both for the sample as a whole, as well as when separated by gender, at all time periods. Although some correlations appeared to be slightly lower for males than for females, results were very similar, and most correlations were over .50. As noted, a significant gender difference in Physical Appearance was obtained at pre-training, although significance was not obtained at post-training, or at follow-up.

As discussed in Chapter 3, the relationship between self-esteem and physical appearance in adolescence has been extended to depression. Studies have found that problems with body image and low self-esteem can function both as a precursor to, and as a strong correlate of, depressive characteristics in adolescents, particularly females (Allgood-Merten et al., 1990). Because these characteristics are often hidden, depression can be likened to a "quiet disturbance" in young women, who, although at greater risk for depression than males, may lack support because of their less aggressive and more sociable image (Offer et al., 1988). Thus, given the reported gender discrepancy, it would be of interest to work with females, using the present training programme, to discuss body image concerns in a single-sex group. The value of such assistance is supported in some of the literature. For example, Allgood-Merten et al. (1990) argued that if adolescent females felt as attractive and competent as males, they would experience less depression, and Offer et al. (1988) suggested that reaching females with depressive symptoms is important in terms of contacting large numbers of emotionally troubled adolescents. Crain (1996), however, argued that gender, as a self-concept moderator, has limited clinical significance and does not warrant educational programmes to redress female self-perceptions, to bring them in line with males. In her opinion, it is more important that the effects of pubertal change are understood and societal attitudes which encourage gender differences are addressed. Because attitudinal change across gender was considered important in the present study, all students were targeted. However, in light of the gender differences obtained it would be interesting to assess programme effectiveness if run with single-sex groups.

Summary

In summary, Programme Skills was the only variable for which a statistical difference was revealed between students who participated in the programme and those who did not. These differences were found between pre and post-training in a lower-scoring subgroup. As reasonable internal reliability and initial construct validation of Programme Skills was observed, it appeared that the subgroup of experimental students gained in the skills targeted in the programme, by comparison with controls, over the training period. Because significant differences between groups were not found for the other variables, it is possible that the lack of difference may have been due to programme quality or

instructional techniques. However, several other explanations are plausible. The design of the study, with respect to class versus group training and available support, was not ideal. Small group training was preferred, but was not feasible. Programme duration, in terms of modifying student attitudes and behaviours, may have been too brief. It is probable that increasing programme duration would have helped students to establish the skills more thoroughly in behaviour and attitudes. Further, if self-esteem in the experimental group remained stable in times of stress, rather than declining, it is possible that a longer follow-up period might have revealed a prevention effect in this group.

The programme was anticipated to have a small effect, based on its preventative nature and on previous research. Given the relatively small sample size, Programme Skills was developed in order to tap coping skills as directly as possible with the objective of raising power. Even so, the statistical power of many of the comparisons was low.

Several measurement issues are important to the discussion, and are as follow: global self-esteem may be insensitive to focused intervention strategies; time allocated to skill acquisition within specific domains may have been too brief to impact on the subdomain scales; subdomain scale items may not have assessed programme skills validly; using a typical sample it is difficult to improve on already average scores for depression, self-worth, and related domains; and the preventative nature of the intervention, where skills taught are not necessarily utilised until later in development, may have rendered group differences insignificant.

Significant gender differences were found at pre-training in the transformed CDI (Kovacs, 1992), and in the Physical Appearance, Athletic Competence, and Global Self-Worth subscales of the SPPC (Harter, 1985a). A significant gender difference at post-training was also observed in Global Self-Worth. Physical Appearance and Global Self-Worth were significantly correlated at all times for the sample as a whole, and when separated by gender. Although some correlations appeared to be slightly lower for males, observed patterns were similar and most correlations exceeded .50. Given the arguments for and against interventions aimed at redressing female self-perceptions to bring them in line with males, using the current programme with single-sex groups is a potential answer.

CHAPTER 10

CONCLUSION

Self-esteem and coping efficacy are central themes in the present study. High self-esteem acts as a stress buffer, while low self-esteem is associated with greater vulnerability to threat, an avoidant approach, and resultant anxiety. The comorbidity of depression and anxiety is linked to low self-esteem. Adolescent research by Harter and colleagues (e.g., Harter, 1990d; Harter & Marold, 1994a, 1994b) found self-worth, affect, and hopelessness to be so highly related that they were termed the depression composite in Harter's model of the antecedents and correlates of self-esteem. In turn, the cognitive aspects of coping are particularly relevant to self-esteem and depression. Perceived self-inefficacy, for example in social situations, can produce depression if withdrawal eventuates, thus reducing the development of personal interactions which afford satisfaction and buffer stress (Bandura, 1990). Similarly, perceptions of competence in important domains are often more important than actual skills in the area (Stein, 1996).

Self-esteem is particularly important in early adolescence, where self-concept matures and an increasing awareness of the self, and of the motives and opinions of others, brings concerns about role differentiation and impression management. There are increasing pressures related to educational transition, scholastic achievement, and physical appearance, while social support may be contingent on related competencies in these areas. This support, in turn, can affect self-perceptions of efficacy or inefficacy, which impact on psychological well-being and competence. From this perspective self-esteem involves evaluations of both worthiness and of competence in areas which are deemed personally important, usually through cultural demarcation. This interpretation is akin to Harter's (e.g., 1993) definition of self-esteem, as the measure of global regard that one has for one's self as a person, dependent on domain-specific evaluations of proficiency in domains significant to the self.

Although most students cope successfully with adolescence, there are particular groups at risk for emotional or behavioural difficulties. Low self-esteem has been linked to

many of these negative outcomes (see for example Battle, 1987; Thompson, 1990). Conversely, high self-esteem is among the list of mechanisms reported in the literature as protective of mental health. Other buffers include a supportive community, family cohesion, good school performance, a positive social orientation, and adaptive coping skills (Weissberg et al., 1991). Knowledge of mental and emotional health skills, and their consolidation into attitudes and behaviour, is important from an early age. Many emotional dysfunctions begin in childhood and continue across the lifespan (Kazdin, 1994). Research now suggests that 15%–22% of American children and adolescents have mental health problems which require treatment. In addition, growing numbers of American adolescents are engaging in conduct which puts them at risk for negative behavioural and psychosocial health outcomes, such as delinquency and drug abuse (Weissberg et al., 1991). The challenge is therefore for community and educational services to teach health skills effectively. However, in such preventative interventions, skills taught may not necessarily be utilised until later in development.

The objective of the present research was to improve self-esteem and coping skills in a preventative capacity in a group of typical early adolescent students. A 9-week cognitive-behavioural training programme, aimed at modifying faulty cognitions and improving social and problem solving skills, was implemented. The cognitive-behavioural approach was deemed appropriate for students in the present study because research indicates that successful outcomes are moderated by cognitive developmental level and adolescents at the formal operational stage are more likely to benefit than younger children (Durlak et al., 1991). In addition, the approach has been successful with adolescents in depression relief and prevention (e.g., Clarke et al., 1990; Jaycox et al., 1994), and links between self-esteem and depression in adolescence have been established in the self-esteem literature (e.g., Harter, 1993).

Cognitive therapy similarly posits links between depression and self-esteem, where feelings of low self-esteem are viewed as part of the overall depressive mode, and can also be found in everyday relationship problems (Beck, 1989). Although cognitive-behavioural interventions use a diversity of strategies, common underlying assumptions apply. The main premise is that cognitive mediating events influence behaviour.

Further, regardless of the components included in these interventions, outcomes have been shown to generalise across cognitive, emotional, behavioural, and social domains (Clarke et al., 1990).

In the present study self-esteem and coping skills were operationalised by the Programme Skills and related Parent/Guardian and Teacher scales, and the SPPC. The Short-Form CDI was used to measure depressive level because of the relationship between self-esteem and depression. Subsequent to training, the only significant differences between those who participated in the programme and those who did not was obtained with the Programme Skills scale. This difference was found between the pre- and post-training phases for a subgroups of students who ranked less than three-quarters of a standard deviation below the mean for Global Self-Worth at pre-training. However, from an informal examination of the mean values, it appeared that there may have been some gain in the skills targeted in the programme for the experimental group, and in particular, for females at post-training. However, the gain was not statistically significant.

Although Programme Skills is not a recognised scale, and was developed to measure the specific skills targeted in the programme, it obtained a reasonable level of internal reliability over the three survey periods. It also provided some initial evidence of construct-validity in that it was significantly and moderately correlated with the global self-esteem and depression measures, used in the study, in the appropriate direction. It thus appeared that some gain in the skills targeted by the programme occurred, at least for the lower-scoring subgroup, over the course of the programme, and that these skills were related to improved self-esteem.

No significant differences in any of the other measures were obtained and it is possible that this was a consequence of programme content. However, the programme was based on sound conceptual research such as the work of Harter (1985a, 1993), together with the cognitive-behavioural focus which has proved successful in related interventions (e.g., Clarke et al., 1990). Alternatively, programme implementation may have been at fault. For example, participation of teachers and parents could have been greater, and students may have benefited if the value of the skills had been reinforced by an esteemed role-

model. Implementation is particularly important because well-designed programmes which are run poorly can appear ineffective when they are, in reality, quite beneficial. In addition, longer programmes may be more productive, allowing incorporation of knowledge-based skills into on-going attitudes and behaviour. As previously noted, 40 to 50 hours of instruction may be required in order to establish stable effects in attitudes and behaviour, in addition to moderating the knowledge base (Weissberg et al., 1991).

In the present study, programme design was compromised when small group training was replaced with class instruction, because this was more realistic in terms of resources available. A relaxed atmosphere of trust and cooperation maximises benefits and the small group environment is ideal. In a related vein, single-sex groups may be appropriate if students can discuss personal issues more freely. The gender differences in self-perception and depression, revealed in the present study and documented in the literature, make it likely that girls, in particular, could benefit from discussing such issues.

As shown in this study, measuring the effects of preventative interventions to increase coping and self-esteem is complicated by several factors. Utilising a typical, as opposed to an at-risk, adolescent sample means that average ratings in self-esteem or depression are difficult to modify, at least in the short-term. The possibility remains that the skills learned will be utilised later in time of difficulty. In addition, measuring self-esteem is complicated by its interpretation. For example, accepting limitations and developing a balanced outlook are skills which may not be directly tapped in self-esteem scales. Yet, accepting strengths and limitations is indicative of well-being (Tennen & Affleck, 1993).

Strengthening personal identity, enhancing self-worth, encouraging tolerance, and supporting others in times of stress, are seen as important goals for student health education (Ministry of Education, N.Z., 1997). Meeting these goals and building improved psychological climates can be achieved with better understanding of self-esteem and its evaluation (Gilberts, 1983). Therefore, as Weissberg et al. (1991) stated, the critical question for researchers and educators alike, is not whether prevention programmes work, for evidence suggests that they do, but rather how they can be implemented most productively.

REFERENCES

- Allgood-Merten, B., Lewinsohn, P.M., & Hops, H. (1990). Sex differences and adolescent depression. *Journal of Abnormal Psychology, 99* (1), 55-63.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th. ed.). Washington, DC: Author.
- Andrews, B., & Brown, G.W. (1993). Self-esteem and vulnerability to depression: The concurrent validity of interview and questionnaire measures. *Journal of Abnormal Psychology, 102* (4), 565-572.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1981). Self-referent thought: A developmental analysis of self-efficacy. In J.H. Flavell & L. Ross (Eds.), *Social cognitive development. Frontiers and possible futures* (pp.200-239). New York: Cambridge University Press.
- Bandura, A. (1986). *Social foundations of thought and action: A social-cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1990). Conclusion: Reflections on nonability determinants of competence. In R.J. Sternberg & J. Kolligian, Jr. (Eds.), *Competence considered* (pp.315-362). New Haven, CT: Yale University Press.
- Battle, J. (1987). 9—19. *Crucial years for self-esteem in children & youth*. Seattle, WA: Special Child Publications.
- Baumeister, R.F. (1989). The optimal margin of illusion. *Journal of Social and Clinical Psychology, 8*, 176-189.
- Baumeister, R.F. (1993a). *Self-esteem. The puzzle of low self-regard*. New York: Plenum Press.
- Baumeister, R.F. (1993b). Understanding the inner nature of low self-esteem: Uncertain, fragile, protective, and conflicted. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.201-218). New York: Plenum Press.
- Beautrais, A.L., Joyce, P.R., & Mulder, R.T. (1996). Risk factors for serious suicide attempts among youths aged 13 through 24 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 35* (9), 1174-1182.

- Beautrais, A.L., Joyce, P.R., Mulder, R.T., Fergusson, D.M., Deavoll, B.J., & Nightingale, S.K. (1996). Prevalence and comorbidity of mental disorders in serious suicide attempts: A case control study. *American Journal of Psychiatry*, *153*, 1009-1114.
- Beck, A.T. (1961). A systematic investigation of depression. *Comprehensive Psychiatry*, *2*, 163-170.
- Beck, A.T. (1967). *Depression: Clinical, experimental and theoretical aspects*. New York: Harper & Row.
- Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A.T. (1989). *Love is never enough. How couples can overcome misunderstandings, resolve conflicts and solve relationship problems through cognitive therapy*. London: Penguin.
- Beck, A.T. (1991). Cognitive therapy. A 30-year retrospective. *American Psychologist*, *46* (4), 368-375.
- Beck, A.T., & Emery, G. (with Greenberg, R.L.). (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.
- Beck, J.S. (1995). *Cognitive therapy. Basics and beyond*. New York: The Guilford Press.
- Bednar, R.L., Wells, M.G., & Peterson, S.R. (1989). *Self-esteem. Paradoxes and innovations in clinical theory and practice*. Washington, DC: American Psychological Association.
- Berg, C.A., & Calderone, K.S. (1994). The role of problem interpretations in understanding the development of everyday problem solving. In R.J. Sternberg & R.K. Wagner (Eds.), *Mind in context. Interactionist perspectives on human intelligence* (pp.105-132). New York: Cambridge University Press.
- Bernard, M.E. (1992). *Rational-emotive therapy with children and adolescents: Live video therapy sessions*. [Video]. (Available from Television and Optical Disc Development Unit, Centre for the Study of Higher Education, University of Melbourne, Australia).
- Bernard, M.E. (1995). It's prime time for rational emotive behavior therapy: Current theory and practice, research recommendations, and predictions. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *13* (1), 9-27.
- Bernard, M.E., & Joyce, M.R. (1984). *Rational-emotive therapy with children and adolescents. Theory, treatment strategies, preventative methods*. New York: Wiley.

- Bernard, M.E., & Joyce, M.R. (1993). Rational-emotive therapy with children and adolescents. In T.R. Kratochwill & R.J. Morris (Eds.), *Handbook of psychotherapy with children and adolescents* (pp.221-246). Boston: Allyn & Bacon.
- Berndt, T.J., & Burgy, L. (1996). Social self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.171-209). New York: Wiley.
- Block, J., & Robins, R.W. (1993). A longitudinal study of consistency and change in self-esteem from early adolescence to early adulthood. *Child Development*, 64, 909-923.
- Bogan, J. (1988). The assessment of self-esteem: A cautionary note. *Australian Psychologist*, 23 (3), 383-389.
- Bortolozzo, G., & Steventon, R. (1997). *Developing a culture of achievement and success*. Paper presented at the 3rd National Health Promoting Schools Conference, Australian National University, Canberra.
- Bracken, B.A. (1996). Clinical applications of a context-dependent, multidimensional model of self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.463-504). New York: Wiley.
- Branden, N. (1969). *The psychology of self-esteem*. New York: Bantam.
- Brewin, C.R. (1996). Theoretical foundations of cognitive-behavior therapy for anxiety and depression. *Annual Review of Psychology*, 47, 33-57.
- Brown, G.W., & Harris, T. (1978). *The social origins of depression: A study of psychiatric disorder in women*. London: Tavistock.
- Burns, D.D. (1980). *Feeling good. The new mood therapy*. New York: Signet.
- Burns, D.D. (1993a). *Ten days to self-esteem*. New York: William Morrow.
- Burns, D.D. (1993b). *Ten days to self-esteem: The leader's manual*. New York: William Morrow.
- Byrne, B.M. (1996a). Academic self-concept: Its structure, measurement, and relation to academic achievement. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.287-316). New York: Wiley.
- Byrne, B.M. (1996b). *Measuring self-concept across the life span. Issues and instrumentation*. Washington, DC: American Psychological Association.

- Campbell, J.D., & Lavalley, L.F. (1993). Who am I? The role of self-concept confusion in understanding the behavior of people with low self-esteem. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.3-20). New York: Plenum.
- Chaplin, J.P. (1985). *Dictionary of psychology* (2nd rev. ed.). New York: Dell.
- Clarke, G.N., Hawkins, W., Murphy, M., Sheeber, L.B., Lewinsohn, P.M., & Seeley, J.R. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: A randomized trial of a group cognitive intervention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34 (3), 312-321.
- Clarke, G.N., Lewinsohn, P.M., & Hops, H. (1990). *Leader's manual for adolescent groups. Adolescent coping with depression course*. Eugene, OR: Castalia Publishing.
- Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112 (1), 155-159.
- Compas, B.E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin*, 101 (3), 393-403.
- Cooley, C.H. (1902). *Human nature and the social order*. New York: Charles Scribner's Sons.
- Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: Freeman and Company.
- Covi, L. (1986). The depressive syndrome: An overview. In A. Freeman, N. Epstein, & K. Simpson (Eds.), *Depression in the family* (pp.41-78). New York: Haworth Press.
- Covington, M.V. (1989). Self-esteem and failure in school: Analysis and policy implications. In A.M. Mecca, N.J. Smelser, & J. Vasconcellos (Eds.), *The social importance of self-esteem* (pp.72-124). Los Angeles: University of California Press.
- Crain, R.M. (1996). The influence of age, race, and gender on child and adolescent multidimensional self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.395-421). New York: Wiley.
- Damon, W., & Hart, D. (1988). *Self-understanding in childhood and adolescence*. New York: Cambridge University Press.
- Department of Education. (1985). *Syllabus for schools. Health education in primary and secondary schools*. Wellington, New Zealand: Government Printer.
- DiGiuseppe, R. (1990). Rational-emotive assessment of school aged children. *School Psychology Review*, 19 (3), 287-293.

- DiGiuseppe, R., & Bernard, M.E. (1990). The application of rational-emotive theory and therapy to school-aged children. *School Psychology Review, 19* (3), 268-286.
- Disley, B. (1992, August). Depression and suicide in adolescents. *Parent & School, 22* (4), 26.
- Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 57* (3), 414-419.
- Durlak, J.A., Fuhrman, T., & Lampman, C. (1991). Effectiveness of cognitive-behavior therapy for maladapting children: A meta-analysis. *Psychological Bulletin, 110* (2), 204-214.
- Dusek, J.B., & Flaherty, J.F. (1981). The development of the self-concept during adolescent years. *Monographs of the Society for Research in Child Development, 46* (4, Serial No.191).
- Ebata, A.T., Petersen, A.C., & Conger, J.J. (1990). The development of psychopathology in adolescence. In J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp.308-333). New York: Cambridge University Press.
- Ehrenberg, M.F., Cox, D.N., & Koopman, R.F. (1991). The relationship between self-efficacy and depression in adolescents. *Adolescence, 26* (102), 361-374.
- Elias, M.J., Branden-Muller, L.R., & Sayette, M.A. (1991). Teaching the foundations of social decision making and problem solving in the elementary school. In J. Baron & R.V. Brown (Eds.), *Teaching decision making to adolescents* (pp.161-184). Hillsdale, NJ: Erlbaum.
- Elkin, I. (1994). The NIHM treatment of depression collaborative research program: Where we began and where we are. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp.114-139). New York: Wiley.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: Lyle Stuart.
- Ellis, A. (1973). *Humanistic psychotherapy. The rational-emotive approach*. New York: The Julian Press, Inc.
- Ellis, A. (1980). Rational-emotive therapy and cognitive-behavior therapy: Similarities and differences. *Cognitive Therapy and Research, 4*, 325-340.
- Ellis, A. (1989). Comments on my critics. In M.E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy. A critical appraisal of the theory and therapy of Albert Ellis* (pp.199-233). San Diego, CA: Academic Press.

- Ellis, A. (1991). Suggestibility, irrational beliefs, and emotional disturbance. In J.F. Schumaker (Ed.), *Human suggestibility. Advances in theory, research, and application* (pp.309-325). New York: Routledge.
- Ellis, A. (1995). Thinking processes involved in irrational beliefs and their disturbed consequences. *Journal of Cognitive Psychotherapy: An International Quarterly*, 9 (2), 105-116.
- Erickson, M.H., Rossi, E., & Rossi, S. (1976). *Hypnotic realities: The induction of clinical hypnosis and forms of indirect suggestion*. New York: Wiley.
- Faul, F., & Erdfelder, E. (1992). GPower software (Version 2.0) [Computer program]. Bonn, Germany: Bonn University.
- Feehan, M., McGee, R., Nada Raja, S., & Williams, S.M. (1994). DSM-111-R disorders in New Zealand 18-year-olds. *Australian and New Zealand Journal of Psychiatry*, 28, 87-99.
- Forehand, R. (1990). Early adolescence: Behavioural problems, stressors, and the role of family factors. In Robert J. McMahon & Ray DeV. Peters (Eds.), *Behaviour disorders of adolescence: Research, intervention, and policy in clinical and school settings* (pp.1-11). New York: Plenum Press.
- Friedman, A.G. (1992). Self-Perception Profile for Children. In D.J. Keyser & R.C. Sweetland (Eds.), *Test critiques* (Vol.9, pp.472-479). Austin, TX: Pro-Ed.
- Fristad, M.A., Emery, B.L., & Beck, S.J. (1997). Use and abuse of the Children's Depression Inventory. *Journal of Consulting and Clinical Psychology*, 65 (4), 699-702.
- Gilberts, R. (1983). The evaluation of self-esteem. *Family and Community Health*, 6 (2), 29-49.
- Gillham, J.E., Reivich, K.J., Jaycox, L.H., & Seligman, M.E. (1995). Prevention of depressive symptoms in school children: Two year follow-up. *Psychological Science: A Journal of the American Psychological Society*, 6 (6), 343-351.
- Granleese, J., & Joseph, S. (1993). Further validation of the Self-Perception Profile for Children. *Personality and Individual Differences*, 16 (4), 649-651.
- Gray, A. (1988). *Teenangels. Being a New Zealand teenager*. Sydney, Australia: Allen & Unwin.
- Gurney, P. (1987). Self-esteem enhancement in children: A review of research findings. *Educational Research*, 29 (2), 130-136.

- Haaga, D.A., & Davison, G.C. (1989). Outcome studies of rational-emotive therapy. In M.E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy. A critical appraisal of the theory and therapy of Albert Ellis* (pp.155-197). San Diego, CA: Academic Press.
- Haaga, D.A., & Davison, G.C. (1995). An appraisal of rational-emotive therapy. In M.J. Mahoney (Ed.), *Cognitive and constructive psychotherapies. Theory, research and practice* (pp.74-85). New York: Springer.
- Haaga, D.A., Dyck, M.J., & Ernst, D. (1991). Empirical status of cognitive theory of depression. *Psychological Bulletin*, 110 (2), 215-236.
- Hagborg, W.J. (1993). The Rosenberg Self-Esteem Scale and Harter's Self-Perception Profile for Adolescents: A concurrent validity study. *Psychology in the Schools*, 30 (2), 132-136.
- Hall, R.J., & Hughes, J.N. (1989). Cognitive-behavioral approaches in the schools: An overview. In J.N. Hughes & R.J. Hall (Eds.), *Cognitive-behavioral psychology in the schools. A comprehensive handbook* (pp.1-14). New York: The Guilford Press.
- Harter, S. (1985a). *The Self-Perception Profile for Children* (manual). Denver, CO: University of Denver.
- Harter, S. (1985b). *The Social Support Scale for Children* (manual). Denver, CO: University of Denver.
- Harter, S. (1986). Processes underlying the construction, maintenance, and enhancement of the self-concept in children. In J. Suls & A.G. Greenwald (Eds.), *Psychological perspectives on the self* (Vol.3, pp.137-181). Hillsdale, NJ: Erlbaum.
- Harter, S. (1987). The determinants and mediational role of global self-worth in children. In N. Eisenberg (Ed.), *Contemporary topics in developmental psychology* (pp.219-242). New York: Wiley.
- Harter, S. (1988a). Developmental and dynamic changes in the nature of the self-concept. Implications for child psychotherapy. In S.R. Shirk (Ed.), *Cognitive development and child psychotherapy* (pp.119-160). New York: Plenum Press.
- Harter, S. (1988b). Developmental processes in the construction of the self. In T.D. Yawkey & J.E. Johnson (Eds.), *Integrative processes and socialization: Early to middle childhood* (pp.45-78). Hillsdale, NJ: Erlbaum.
- Harter, S. (1988c). *The Self-Perception Profile for Adolescents* (manual). Denver, CO: University of Denver.

- Harter, S. (1990a). Causes, correlates, and the functional role of global self-worth: A life-span perspective. In R.J. Sternberg & J. Kolligian, Jr. (Eds.), *Competence considered* (pp.315-362). New Haven, CT: Yale University Press.
- Harter, S. (1990b). Developmental differences in the nature of self-representations: Implications for the understanding and treatment of maladaptive behavior. *Cognitive Therapy and Research*, 14 (2), 113-142.
- Harter, S. (1990c). Issues in the assessment of the self-concept of children and adolescents. In A. La Greca (Ed.), *Through the eyes of the child: Obtaining self-reports from children and adolescents* (pp.292-325). Boston: Allyn & Bacon.
- Harter, S. (1990d). Self and identity development. In S.S. Feldman & G.R. Elliott (Eds.), *At the threshold. The developing adolescent* (pp.352-387). Cambridge, MA: Harvard University Press.
- Harter, S. (1992). The relationship between perceived competence, affect, and motivational orientation within the classroom: Processes and patterns of change. In A.K. Boggiano & T.S. Pittman (Eds.), *Achievement and motivation. A social-developmental perspective* (pp.77-114). New York: Cambridge University Press.
- Harter, S. (1993). Causes and consequences of low self-esteem in children and adolescents. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.87-116). New York: Plenum Press.
- Harter, S. (1996). Historical roots of contemporary issues involving self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.1-37). New York: Wiley.
- Harter, S., & Marold, D.B. (1994a). Psychosocial risk factors contributing to adolescent suicidal ideation. In G. Noam & S. Borst (Eds.), *Children, youth and suicide: Developmental perspectives. New directions for child development*. (No. 64, pp.71-91). San Francisco: Jossey-Bass Inc.
- Harter, S., & Marold, D.B. (1994b). The directionality of the link between self-esteem and affect: Beyond causal modeling. In D. Cicchetti & S.L. Toth (Eds.), *Disorders and dysfunctions of the self: Rochester symposium on developmental psychopathology* (Vol. 5, pp.333-369). Rochester, NY: Dante Press.
- Harter, S., & Monsour, A. (1992). Developmental analysis of conflict caused by opposing attributes in the adolescent self-portrait. *Developmental Psychology*, 28 (2), 251-260.
- Harter, S., & Nowakowski, M. (1987). *The Dimensions of Depression Profile for Children and Adolescents* (manual). Denver, CO: University of Denver.

- Hatcher, R., Hatcher, S., Berlin, M., Okla, K., & Richards, J. (1990). Psychological mindedness and abstract reasoning in late childhood and adolescence: An exploration using new instruments. *Journal of Youth and Adolescence*, 19 (4), 307-326.
- Hattie, J. (1992). *Self-concept*. Hillsdale, NJ: Erlbaum.
- Hattie, J., & Marsh, H.W. (1996). Future directions in self-concept research. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.421-462). New York: Wiley.
- Hauser, S.T., & Bowlds, M.K. (1990). Stress, coping and adaptation. In S.S. Feldman & G.R. Elliott (Eds.), *At the threshold. The developing adolescent* (pp.388-413). Cambridge, MA: Harvard University Press.
- Heatherton, T.F., & Ambady, N. (1993). Self-esteem, self-prediction, and living up to commitments. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.131-145). New York: Plenum Press.
- Hill, P. (1993). Recent advances in selected aspects of adolescent development. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 34 (1), 69-99.
- Hirsch, B.J., & DuBois, D.L. (1991). Self-esteem in early adolescence: The identification and prediction of contrasting longitudinal trajectories. *Journal of Youth and Adolescence*, 20 (1), 53-72.
- Hoge, D.R., Smit, E.K., & Hanson, S.L. (1990). School experiences predicting changes in self-esteem of sixth and seventh-grade students. *Journal of Educational Psychology*, 82 (1), 117-127.
- Hollon, S.D., & Beck, A.T. (1994). Cognitive and cognitive-behavioral therapies. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp.428-466). New York: Wiley.
- Hughes, H.M. (1984). Measures of self-concept and self-esteem for children ages 3–12 years: A review and recommendations. *Clinical Psychology Review*, 4, 657-692.
- Jacobsen, E. (1929). *Progressive relaxation*. Chicago: University of Chicago Press.
- James, W. (1890). *The principles of psychology* (Vol. 1). London: McMillan & Co.
- Jaycox, L.H., Reivich, K.J., Gillham, J., & Seligman, M.E.P. (1994). Prevention of depressive symptoms in school children. *Behavior Research and Therapy*, 32 (8), 801-816.
- Joyce, P. (1992, August). Myths about youth depression. *Canterbury Suicide Project*, 2, 3.

- Jupp, J.J., & Griffiths, M.D. (1990). Self-concept changes in shy, socially isolated adolescents following social skills training emphasising role plays. *Australian Psychologist*, 25 (2), 165-177.
- Kahn, J.S., Kehle, T.J., Jenson, W.R., & Clark, E. (1990). Comparison of cognitive-behavioral, relaxation, and self-modeling interventions for depression among middle-school students. *School Psychology Review*, 19 (2), 196-211.
- Kaplan, H., Martin, S., & Johnson, R. (1986). Self-rejection and the explanation of deviance: Specification of the structure among latent constructs. *American Journal of Sociology*, 92, 384-411.
- Kassinove, H. (1986). Self reported affect and core irrational thinking: A preliminary analysis. *Journal of Rational-Emotive Therapy*, 4, 119-130.
- Kavan, M.G. (1992). (Review of the *Children's Depression Inventory*). In J.J. Kramer & J.C. Conoley (Eds.), *The eleventh mental measurements year book* (pp.174-175). Lincoln, NE: University of Nebraska Press.
- Kazdin, A.E. (1994). Psychotherapy for children and adolescents. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp.543-594). New York: Wiley.
- Keith, L.K., & Bracken, B.A. (1996). Self-concept instrumentation: A historical and evaluative review. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.91-170). New York: Wiley.
- Kendall, P.C. (1985). Towards a cognitive-behavioral model of child psychopathology and a critique of related interventions. *Journal of Abnormal Child Psychology*, 13, 357-372.
- Kendall, P.C. (1992). Healthy thinking. *Behavior Therapy*, 23, 1-11.
- Kendall, P.C. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology*, 61 (2), 235-247.
- Kendall, P.C., Haaga, D.A., Ellis, A., Bernard, M., DiGiuseppe, R., & Kassinove, H. (1995). Rational-emotive therapy in the 1990s and beyond: Current status, recent revisions, and research questions. *Clinical Psychology Review*, 15 (3), 169-185.
- Kendall, P.C., & Panichelli-Mindel, S.M. (1995). Cognitive-behavioral treatments. *Journal of Abnormal Child Psychology*, 23, 107-124.
- Kernis, M.H. (1993). The roles of stability and level of self-esteem in psychological functioning. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.167-182). New York: Plenum Press.

- Kliewer, W., & Sandler, I.N. (1992). Locus of control and self-esteem as moderators of stressor-symptom relations in children and adolescents. *Journal of Abnormal Child Psychology*, 20 (4) 393-413.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kovacs, M. (1992). *Children's Depression Inventory* (manual). New York: Multi-Health Systems Inc.
- Kovacs, M., & Beck, A.T. (1978). Maladaptive cognitive structures in depression. *The American Journal of Psychiatry*, 135 (5), 525-533.
- Lambert, M.J., & Bergin, A.E. (1994). The effectiveness of psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp.143-189). New York: Wiley.
- Lamke, L.K., Lujan, B.M., & Showalter, J.M. (1988). The case for modifying adolescents' cognitive self-statements. *Adolescence*, 23 (92), 967-974.
- Lawrence, D. (1989). *Enhancing self-esteem in the classroom*. London: Paul Chapman.
- Lawrence, D. (1996). *Enhancing self-esteem in the classroom* (2nd ed.). London: Paul Chapman.
- Lazarus, R.S. (1989a). Cognition and emotion from the RET viewpoint. In M.E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy. A critical appraisal of the theory and therapy of Albert Ellis* (pp.47-68). San Diego, CA: Academic Press.
- Lazarus, R.S. (1989b). Constructs of the mind in mental health and psychotherapy. In A. Freeman, K.M. Simon, L.E. Beutler, & H. Arkowitz (Eds.), *Comprehensive handbook of cognitive therapy* (pp.99-121). New York: Plenum Press.
- Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Lewinsohn, P.M., Clarke, G.N., Hops, H., & Andrews, J. (1990). Cognitive-behavioral treatment for depressed adolescents. *Behavior Therapy*, 21, 385-401.
- Linville, P.W. (1987). Self-complexity as a cognitive buffer against stress-related illness and depression. *Journal of Personality and Social Psychology*, 52 (4), 663-676.
- Mahoney, M.J. (1993). Introduction to special section: Theoretical developments in the cognitive psychotherapies. *Journal of Consulting and Clinical Psychology*, 61 (2), 187-193.

- Mahoney, M.J., Lyddon, W.J., & Alford, D.J. (1989). An evaluation of the rational-emotive theory of psychotherapy. In M.E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy. A critical appraisal of the theory and therapy of Albert Ellis* (pp.69-94). San Diego, CA: Academic Press.
- Markus, H., & Wurf, E. (1987). The dynamic self-concept: A social psychological perspective. *Annual Review of Psychology*, 38, 299-337.
- Marsh, H.W., & Hattie, J. (1996). Theoretical perspectives on the structure of self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.38-90). New York: Wiley.
- Marsh, H.W., & Shavelson, R.J. (1985). Self-concept: Its multifaceted, hierarchical structure. *Educational Psychologist*, 20, 107-125.
- Marsh, H.W., & Smith, I.D. (1982). Multitrait-multimethod analyses of two self-concept instruments. *Journal of Educational Psychology*, 74, 430-440.
- Marton, P., Connolly, J., Kutcher, S., & Korenblum, M. (1993). Cognitive social skills and social self-appraisal in depressed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (4), 739-744.
- Maskill, C. (1991). *A health profile of New Zealand adolescents*. Wellington, New Zealand: Department of Health.
- McCauley, E., Myers, K., Mitchell, J., Calderon, R., Schloredt, K., & Treder, R. (1993). Depression in young people: Initial presentation and clinical course. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (4), 714-722.
- Merrell, K.W., Cedeno, C.J., & Johnson, E.R. (1993). The relationship between social behavior and self-concept in school settings. *Psychology in the Schools*, 30 (4), 293-298.
- Ministry of Education. (1997). *Health and physical education in the New Zealand curriculum* (draft). Wellington, New Zealand: Learning Media Ltd.
- Mruk, C. (1995). *Self-esteem. Research, theory, and practice*. New York: Springer.
- Mullis, A.K., Mullis, R.L., & Normandin, D. (1992). Cross-sectional and longitudinal comparisons of adolescent self-esteem. *Adolescence*, 27 (105), 51-61.
- Murrow, K. (1991). The relationship between self-esteem and achievement. *Bulletin, Research and Statistics, Ministry of Education, Wellington, New Zealand*, 3, 7-25.
- Nada Raja, S., McGee, R., & Stanton, W.R. (1992). Perceived attachments to parents and peers and psychological well-being in adolescence. *Journal of Youth and Adolescence*, 21, 471-485.

- Neemann, J., & Harter, S. (1986). *The Self-Perception Profile for College Students* (manual). Denver, CO: University of Denver.
- New Zealand Health Information Service. (1993). *Mental health data*. Wellington, New Zealand: Ministry of Health.
- Nightingale, S., & Mulder, R. (1992, August). Youth depression. *Canterbury Suicide Project*, 2, 3.
- Nottelmann, E.D. (1987). Competence and self-esteem during transition from childhood to adolescence. *Developmental Psychology*, 23 (3), 441-450.
- Offer, D., Ostrov, E., Howard, K.I., & Atkinson, R. (1988). *The teenage world: Adolescents' self-image in ten countries*. New York: Plenum Medical Book Co.
- Oosterwegel, A., & Oppenheimer, L. (1993). *The self-system. Developmental changes between and within self-concepts*. Hillsdale, NJ: Erlbaum.
- Overholser, J.C., Adams, D.M., Lehnert, K.L., & Brinkman, D.C. (1995). Self-esteem deficits and suicidal tendencies among adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34 (7), 919-928.
- Patton, W. (1991). Relationship between self-image and depression in adolescents. *Psychological Reports*, 68, 867-870.
- Petersen, A.C., Compas, B.E., Brooks-Gunn, J., Stemmler, M., Ey, S., & Grant, K.E. (1993). Depression in adolescence. *American Psychologist*, 48 (2), 155-168.
- Petersen, A.C., & Leffert, N. (1995). What is special about adolescence? In M. Rutter (Ed.), *Psychosocial disturbances in young people. Challenges for prevention* (pp.3-36). New York: Cambridge University Press.
- Pope, A.W., McHale, S.M., & Craighead, W.E. (1987). *Self-esteem enhancement with children and adolescents*. New York: Pergamon.
- Proctor, T.B., & Choi, H.S. (1994). Effects of transition from elementary school to junior high school on early adolescents' self-esteem and perceived competence. *Psychology in the Schools*, 31 (4), 319-327.
- Pruzinsky, T., & Cash, T.F. (1990). Medical interventions for the enhancement of adolescents' physical appearance: Implications for social competence. In T.P. Gullotta, G.R. Adams & R. Montemayor (Eds.), *Developing social competency in adolescence* (pp.220-244). Newbury Park, CA: Sage.
- Reinherz, H.Z., Frost, A.K., & Pakiz, B. (1991). Changing faces: Correlates of depressive symptoms in late adolescence. *Community Health*, 14 (3), 52-63.

- Renouf, A.G., & Harter, S. (1990). Low self-worth and anger as components of the depressive experience in young adolescents. *Development and Psychopathology*, 2, 293-310.
- Rhodes, J.E., Reyes, O., & Jason, L.A. (1993). Prevention of childhood psychopathology. In T.R. Kratochwill & R.J. Morris (Eds.), *Handbook of psychotherapy with children and adolescents* (pp.566-581). Boston: Allyn & Bacon.
- Robins, C.J., & Hayes, A.M. (1995). An appraisal of cognitive therapy. In M.J. Mahoney (Ed.), *Cognitive and constructive psychotherapies. Theory, research and practice* (pp.41-65). New York: Springer.
- Robinson, W.P. (1990). Academic achievement and self-esteem in secondary school: Muddles, myths and reality. *Education Research and Perspectives*, 17 (1), 3-21.
- Rohnke, K., & Butler, S. (1995). *QuickSilver. Adventure games, initiative problems, trust activities and a guide to effective leadership*. Iowa: Kendall/Hunt, for Project Adventure, Inc., Wellington, New Zealand.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Rosenberg, M. (1979). *Conceiving the self*. New York: Basic Books.
- Rosenberg, M. (1986). Self-concept from middle childhood through adolescence. In J. Suls & A.G. Greenwald (Eds.), *Psychological perspectives on the self* (Vol.3, pp.107-136). Hillsdale, NJ: Erlbaum.
- Rosenberg, M. (1989). *Society and the adolescent self-image* (rev. ed.). Middletown, CT: Wesleyan University Press.
- Sadler, L.S. (1991). Depression in adolescents. Context, manifestations, and clinical management. *The Nursing Clinics of North America*, 26 (3), 559-572.
- Savin-Williams, R.C., & Demo, D.H. (1984). Developmental change and stability in adolescent self-concept. *Developmental Psychology*, 20 (6), 1100-1110.
- Seligman, M.E.P. (1991). *Learned optimism*. New York: Knopf.
- Seligman, M.E.P., Reivich, K., Jaycox, L., & Gillham, J. (1995). *The optimistic child*. Adelaide, Australia: Random House.
- Shavelson, R.J., Hubner, J.J., & Stanton, G.C. (1976). Self-concept: Validation of construct interpretations. *Review of Educational Research*, 46, 407-441.

- Shorkey, C.T., & Whiteman, V.L. (1977). Development of the Rational Behavior Inventory: Initial validity and reliability. *Educational and Psychological Measurement*, 37, 527-534.
- Simmons, R.G. (1987). Self-esteem in adolescence. In T. Honess & K. Yardley (Eds.), *Self and identity. Perspectives across the lifespan* (pp.172-192). London: Routledge & Kegan Paul Ltd.
- Simmons, R.G., & Blyth, D.A. (1987). *Moving into adolescence: The impact of pubertal change and school context*. New York: Aldine de Gruyter.
- Skills for adolescence*. (1988). Granville, OH: Quest.
- Smelser, N.J. (1989). Self-esteem and social problems: An introduction. In A.M. Mecca, N.J. Smelser, & J. Vasconcellos (Eds.), *The social importance of self-esteem* (pp.294-326). Los Angeles: University of California Press.
- Sokal, R.R., & Rohlf, F.J. (1969). *Biometry. The principles and practice of statistics in biological research*. San Francisco, CA: W.H. Freeman and Company.
- Spencer, S.J., Josephs, R.A., & Steele, C.M. (1993). Low self-esteem. The uphill struggle for self-integrity. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.21-36). New York: Plenum Press.
- Spitzer, R.L., Endicott, J., & Robins, E. (1978). Research Diagnostic Criteria: Rationale and reliability. *Archives of General Psychiatry*, 35, 773-782.
- Spivack, G., Platt, J., & Shure, M. (1976). *The problem-solving approach to adjustment*. San Francisco, CA: Jossey-Bass.
- Stein, R.J. (1996). Physical self-concept. In B.A. Bracken (Ed.), *Handbook of self-concept. Developmental, social, and clinical considerations* (pp.374-394). New York: Wiley.
- Stenhouse, G. (1994). *Confident children. Developing your child's self-esteem*. Auckland, New Zealand: Oxford University Press.
- Swallow, S.R., & Kuiper, N.A. (1988). Social comparison and negative self-evaluations: An application to depression. *Clinical Psychology Review*, 8, 55-76.
- Tabachnick, B.G., & Fidell, L.S. (1996). *Using multivariate statistics* (3rd ed.). New York: HarperCollins College Publishers.
- Tennen, H., & Affleck, G. (1993). The puzzles of self-esteem. A clinical perspective. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.241-262). New York: Plenum Press.

- The Education Gazette* (September, 1996). Wellington, New Zealand: Government Printer.
- Thompson, J.K. (1990). *Body image disturbance. Assessment and treatment*. New York: Pergamon.
- Tice, D.M. (1993). The social motivations of people with low self-esteem. In R.F. Baumeister (Ed.), *Self-esteem. The puzzle of low self-regard* (pp.37-53). New York: Plenum Press.
- Vernon, A. (1994). Rational-emotive consultation: A model for implementing rational-emotive education. In M.E. Bernard & R. DiGiuseppe (Eds.), *Rational-emotive consultation in applied settings* (pp.129-148). Hillsdale, NJ: Erlbaum.
- Walen, S.R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational-emotive therapy*. New York: Oxford University Press.
- Waters, V. (1982). Other therapies for children—some brief looks. Therapy 1: Rational Emotive therapy. In C.R. Reynolds & T.B. Gutkin (Eds.), *The handbook of school psychology* (pp.570-579). New York: Wiley.
- Weissberg, R.P., Caplan, M., & Harwood, R.L. (1991). Promoting competent young people in competence-enhancing environments: A systems-based perspective on primary prevention. *Journal of Consulting and Clinical Psychology*, 59 (6), 830-841.
- Wells, L.E., & Marwell, G. (1976). *Self-esteem. Its conceptualization and measurement*. Beverly Hills, CA: Sage.
- Wexler, D.B. (1991). *The adolescent self. Strategies for self-management, self-soothing, and self-esteem in adolescents*. New York: W.W. Norton & Co.
- White, R. (1963). Ego and reality in psychoanalytic theory: A proposal regarding independent ego energies. *Psychological Issues*, 3 (3), 125-150.
- Wylie, R.C. (1979). *The self-concept: Vol. 2. Theory and research on selected topics* (rev. ed.). Lincoln, NE: University of Nebraska Press.
- Wylie, R.C. (1989). *Measures of self-concept*. Lincoln, NE: University of Nebraska Press.
- Ziegler, D.J. (1989). A critique of rational-emotive theory of personality. In M.E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy. A critical appraisal of the theory and therapy of Albert Ellis* (pp.27-45). San Diego, CA: Academic Press.

APPENDICES

Appendix A

STUDENT WORK BOOK

STUDENT WORK BOOK

*People who
expect the best
usually get what
they expect.*



Acknowledgements.

Illustrations and quotations reprinted with permission from the books:

"Mood Maker"

"Doom Destroyer"

"Why Wasn't I Told?"

"I'm a Walking Talking Miracle"

by Lisa McInnes-Smith

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regarding these books

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Student Work Book

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SESSION 1

1A. COURSE OUTLINE

Summary

This course is designed to help you develop good feelings about your capabilities and self-worth by teaching you skills to change unhelpful thoughts and to develop positive behaviours.

Changing thoughts

- * Examining beliefs and emotions.
- * Disputing hurtful thoughts.
- * Looking at twisted thinking.
- * Examining attitudes.
- * Weakening the Self-Critic.
- * Planning for set-backs.



Working on actions

- * Social Skills.
- * Problem-solving.
- * Goal-setting.

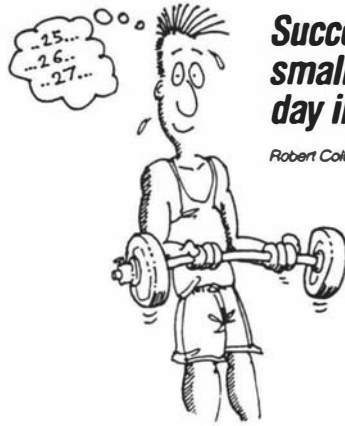
1B. WHAT I WOULD LIKE TO ACHIEVE:

Please tick the reasons which are important to you and add any others.

- * Enjoyment as I learn.
- * Power over my emotions and reactions—self management.
- * Improvement in my social skills.
- * Improvement in my problem solving ability.
- * Self-protection.
- *
- *
- *

2. GROUND RULES:

- * Confidentiality.
- * Mutual respect and support.
- * Participation.
- * Regular attendance.
- *
- *
- *



Success is the sum of small efforts repeated day in and day out.

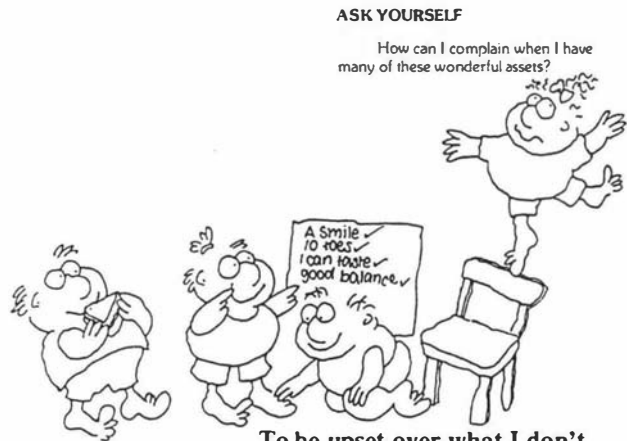
Robert Collier

I _____ pledge to abide by these rules. These rules will safe-guard my privacy and will protect the confidentiality of everyone else in the group, so that I can benefit as much as possible from participating in this course.

3. POSITIVE QUALITIES TO ENCOURAGE GOOD FEELINGS

Write down as many good things about yourself as you can think of. You can add more at any time.

POSITIVE IMAGE



To be upset over what I don't have is to waste what I do have.

YOUR CATCH PHRASE

4. HOMEWORK CONTRACT

Reasons I may not like homework. Tick what applies and add your own.

- * Boring.
- * Too hard.
- * Not in the mood.
- * Don't need it.
- * _____
- * _____
- * _____

***The rules
of success
won't work
unless you do.***



Just as the Silver Ferns and the All Blacks need to practise in order to excel, so I, _____, agree to do the small amount of homework practice required each week to give myself and the course a fair go.

Signed _____

5. OPINION, FACT AND EMOTION

The following are simple definitions of opinion, fact and emotion to help you distinguish between them:

Opinion : Your own, or another's view-point which may or may not be factual

Fact : Can be checked or is generally considered to be true

Emotion : Response such as fear or excitement; this may be accompanied by a physical feeling such as tightness or sweating

A. Decide whether each of the following responses describes an opinion, a fact or an emotion and write **O**, **F** or **E** beside each.

- * What do you think? I'm happy about that.
- * Christmas Day is on the 25th of December.
- * I'm sure I'm right about that.
- * What do you think is wrong? I'm scared.
- * What's your opinion? I'm happy about it.
- * Chocolate cake and banana cake have different ingredients.

B. Common emotions (choose about 6 and copy them here):



***If you don't believe
it's a great day, just
try missing one!***

Zig Ziglar.

C. Barometer

Illustration:

Personal Example:

10 - my parents died

10 -

8 - the house caught fire

8 -

6 - I got a C for the assignment

6 -

4 - I couldn't go to the movie

4 -

2 - It rained and sport was cancelled

2 -

0 - No problem

0 -

D. Helpful and hurtful emotions

Which of these feelings are usually helpful or protective, and which might be hurtful and cause us grief? Clue—usually the very strong ones muddle our thinking and stop us from problem-solving while the milder ones remind us to have a look at things to see what is wrong. Write in "helpful" or "hurtful" beside each. Write down one more hurtful and one more helpful feeling.

* Furious

* Relaxed

* Irritated

* Terrified

* Fairly anxious

* Slightly suspicious

* Very worried

* Sad

* Panicky

* Depressed

*

*

Draw a face or picture to illustrate one helpful and one unhelpful use of emotion.

SESSION 2

1. QUIZ



- A. Name two things that you hope this course will help you with.

- B. Name two ground rules.

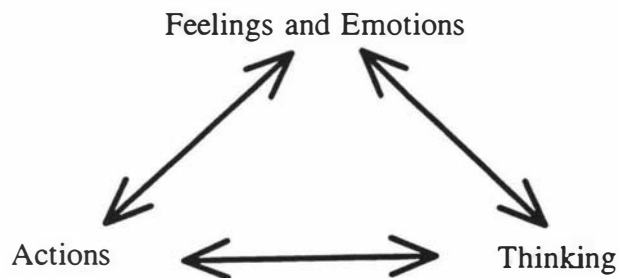
- C. Write your positive message from last session (e.g., I'm a somebody).

- D. Write down one good reason for doing homework.

- E. When is an emotion helpful?

- F. When is an emotion hurtful?

2. THE THREE-PART PERSONALITY SYSTEM



I have most control over my _____ and my _____.

3. RATIONAL OR HELPFUL THINKING

A. The ABC Model

Sue and Fred were both teased but had different b_____, e_____, and b_____

This shows us that it is not always the situation that makes us feel bad or act in an unhelpful way; our self-talk and actions can also affect our feelings.

When I don't like the situation, I can change my s_____ -t_____ or a _____ to help change uncomfortable feelings.

B. Disputing

Use the questions below to argue against hurtful self-talk.

- * Is it true (fact or opinion?)
- * Is it helpful (if not, can I change it?)
- * If it is true, do I always have to get what I want?
- * How can this one thing make me no good?



No-one can make you feel inferior without your consent.

Eleanor Roosevelt.

C. Sentences with different kinds of self-talk, emotions and behaviour

Complete the following sentence. First use an unhelpful thought, emotion and behaviour, then complete the same sentence, this time with a helpful thought, emotion and behaviour.

Example:

- * When my parents growl at me I think *You're stupid*; I feel *angry* and I *slam the door*.
- * When my parents growl at me I think *I just made a mistake*; I feel *OK about myself* and I go and *watch TV*
- * If I make a mistake I think _____ and I feel _____ and I go and _____
- * If I make a mistake I think _____ and I feel _____ and I go and _____

4. SOCIAL SKILLS: INTRODUCTIONS

A. Steps:

- * Make eye contact * Make a welcome statement
- * Smile * Use the person's name

B. Welcome statements: List four and tick the one you'd use with a person of your own age whom you have just met

- * _____ * _____
- * _____ * _____

C. When your partner is making an introduction write down one thing your partner could improve on and one thing she or he did well:

When you are making an introduction write down one thing your partner said you could improve on and one thing your partner said you did well:



Don't ever judge a day by the weather.

5. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

6. HOMEWORK



- A. Complete the following sentences to show helpful and unhelpful thoughts, emotions and behaviours, just as you did on p.7. The examples show you what to do. Also, please don't forget to fill in the checklist during this coming week. It is on the following page.

Examples:

- * When my parents growl at me I think *You're stupid*; I feel *angry* and I *slam the door*.
- * When my parents growl at me I think *I just made a mistake*; I feel *O.K.* about *myself* and I go and *watch TV*

Now you complete the following:

- * If I say something silly I think _____ and I feel _____ and I _____
- * If I say something silly I think _____ and I feel _____ and I _____
- * If I'm teased I think _____ and I feel _____ and I _____
- * If I'm teased I think _____ and I feel _____ and I _____

SESSION 3

1. QUIZ



- A. Name two things which can be affected by your thoughts.
- B. What two parts of your personality are easiest to change?
- C. Name one method of changing your beliefs (B).
- D. What are the four steps to follow when introducing yourself?
- E. If you feel uncomfortable in some way when introducing yourself what would it be good to look at?

2. TWISTED THINKING (The highlighted names are the abbreviations we'll use).

- A. **Black and white**, or all-or-nothing thinking—when it seems like there are no in between shades (e.g., I always lose; you never help).
- B. **Mind-reading** or **Fortune-telling**—assuming something without checking it out (e.g., she doesn't like me because she said _____).

**I am no bigger
than what it
takes to upset
me!**



- C. **Self-downing** or **Blaming**—putting yourself down for one mistake (e.g., I'm dumb because _____), or unfairly blaming someone else.
- D. **Demanding** that others, the world and ourselves should act in certain ways (e.g., I should always get what I want; adults should be perfect etc.)

Don't worry if you can't remember all of these. The idea is to be aware of the twists to give yourself more control over your feelings. Sometimes more than one of these might fit your beliefs.



Don't be a porcupine! There's no use having a lot of good points if no-one can get close.

3. DEVELOPING A CONVERSATION

A. Steps

- * Make eye contact.
- * Smile.
- * Make a welcome statement.
- * Use the person's name.
- * Make a statement about yourself and keep this positive.
- * Ask about the other person; don't interrupt.
- * Think about what the other person is saying.
- * Sometimes nod your head.

B. Write down two positive statements about yourself which you could use:

C. Write down four questions which you could ask your acquaintance:

D. When your partner is developing a conversation write down one thing your partner could improve on and one thing she or he did well:

When you are developing a conversation write down one thing your partner said you could improve on and one thing your partner said you did well:

4. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

SESSION 4

1. QUIZ



- A. Name three kinds of twisted thinking such as "black and white".
- B. Why is it useful to notice twists in thinking?
- C. What are the eight steps to follow when developing a conversation?
- D. If you feel uncomfortable in some way when introducing yourself it would be good to look at self-talk, because the ABC model shows that it is not always the s_____ that makes us feel bad or act in an unhelpful way; our s_____ and a_____ can also affect our feelings.
- E. What is the difference between a fact and an opinion?



**Your attitude
determines your
actions!**

2. ATTITUDE PATTERNS

- * **The Resenter** ("It's not fair" or "She always beats me in tests" or "I'm mad at myself, I can't win") → anger and frustration at self or others (the demanding twist).

Your sentence:

- * **The Despairer** ("What's the point?" or "It's hopeless") → sadness or depression (black and white thinking).

Your sentence:

- * **The Self-Critic** ("I always blow it") → low motivation and low self-esteem (the self-downing twist).

Your sentence:

- * **The Worrier** ("How am I going to cope with the test" or "They may not include me") → block to action (when we think we won't cope); or low self-worth (when we fear others won't include us) (often fortune-telling or self-downing).

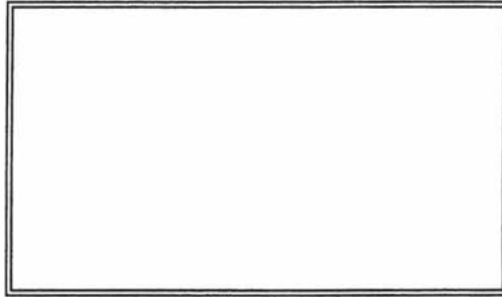
Your sentence:

Illustrate these attitudes with new names if you choose.

- * **The Champion** → confidence, protection, encouragement, and comfort.

Your sentence:

Illustrate this attitude with a new name if you choose.



3. SOCIAL SKILLS. OFF-PUTTING BEHAVIOUR

Add two to the list and tick the ones you don't like happening to you.

- * Slumping and looking depressed or bored when someone is talking.
- * Looking away, or obviously not listening, when someone is talking.
- * Interrupting.
- * Asking questions when someone is talking or reading, etc.
- * Making negative or discounting comments.
- * Making judgemental comments (e.g., "That was stupid!"—rather than understanding the other person, e.g., "That sounds like it was tricky").

* _____

* _____



Don't be a porcupine! There's no use having a lot of good points if no-one can get close.

4. UNDERSTANDING VERSUS JUDGING OR BOASTING



A friend is one who puts his finger on a fault without rubbing it in.

Friend's comment	Judging/Boasting	Understanding
The test was hard. I may not do well.	It was easy for me. You should _____	Yes it was tricky. You usually do OK.
I haven't got a good topic yet.		
Mum won't let me get a new _____		
I didn't get into the team (You did).		
I don't fit into my old jeans.		
I'd like a new CD player but I've no \$.		
These kids don't seem to like me.		

5. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

6. HOMEWORK



- A. Find an example of each of the negative attitudes below from your own self-talk, or from what you have heard someone say, or from television or you can make them up. Fill in the table and write in a positive, encouraging, but realistic comment from the Champion. Remember to turn the page and to complete the checklist.

Self-talk/feeling	Attitude	Champion talk/feeling
Example: I won't pass this test. I feel anxious, up-tight, stressed	Worrier	You passed last time. You have learned a lot. Just do your best. I now feel less stressed, more calm.
	Resenter	
	Despairer	
	Self-Critic	
	Worrier	

SESSION 5

1. QUIZ



- A. Name the four negative attitude patterns from last week (e.g., Resenter).
- B. How does using the Champion help us?
- C. What are four habits that could put your friends "off" you in conversation?
- D. If you feel uncomfortable in some way when introducing yourself what would be good to look at?
- E. If a friend is telling you about their problem you can say:
- x. "That's not hard, I could do that" or
 - y. "Yes, that can be pretty difficult".

Put x. or y. on the line to fill in the sentences below

- * The judgemental, boastful reply is _____.
- * The reply most likely to help, and keep the friendship going well is _____.

- F. What parts of the personality are easiest to change?

2. JOINING AND LEAVING A GROUP



Fill in the gaps.

Don't be a porcupine! There's no use having a lot of good points if no-one can get close.

A. To join a group:

- * Stand quietly near a group and you are likely to be included.
- * Say something about what's going on, e.g., _____
- * If you are not included in the group within five to ten minutes it is best to leave gracefully saying _____ or similar.
- * Use Champion self-talk if this occurs, e.g., _____

B. To leave a group of a few people:

- * Decide if the time is appropriate, e.g., you won't look like sore loser.
- * Make an appropriate comment such as "excuse me", or give a reason such as _____
- * Smile and leave, making a comment such as _____

C. Use the above steps to role play trying to join, or leave a group. Each person in the pair is to act out only one of these roles. If you are trying to join a group pretend that you are not included, so practise what you would say to leave and what your self-talk would be. The person leaving a group that they have been part of (as in example B) can use the steps in example B, but can use her or his own words. Remember eye contact and facial expression.

When your partner is joining/leaving a group write down one thing your partner could improve on and one thing she or he did well:

When you are joining/leaving a group write down one thing your partner said you could improve on and one thing your partner said you did well:

3. POSITIVE STATEMENTS ABOUT ME

A. Write in your positive feedback from the other group members:

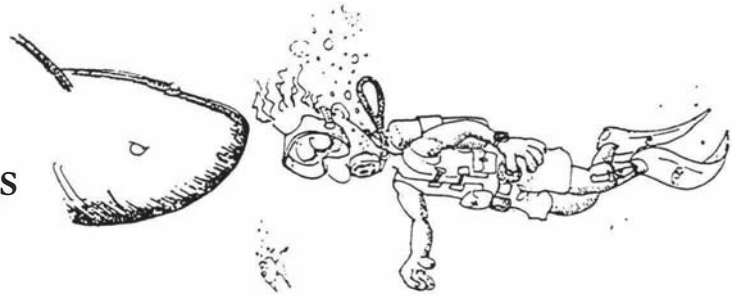


Determine who you are and what you want to become before you decide what you want to do and have.

B. Fill in your characteristics and skills. Remember to put in lots of positive ones. Also include those that you don't like. Remember you can work to change these or accept them. You never "junk" yourself.

A large, horizontally-oriented oval shape that serves as a container for writing. Inside this large oval, there are seven smaller, horizontally-oriented ovals arranged in a grid. The arrangement consists of one oval at the top center, a row of three ovals in the middle, and one oval at the bottom center. These smaller ovals are intended for students to write their characteristics and skills.

4. PROBLEM STRATEGIES



A. Problem-solving orientation. Remember that:

- * Problems are normal.
- * You can often solve problems without the help of adults.
- * Feelings are cues—most times when you feel uncomfortable, you can think of it as a signal to change self-talk and/or deal with a problem.
- * When you see a problem, STOP and THINK about coping strategies.

B. Examples of coping strategies or courses of action that can be taken to deal with a problem situation containing a conflict:

- * **Plan** to take some action at some stage in the future.
- * **Seek** extra information to find out more about the problem.
- * **Redefine** elements of the problem so you see it differently.
- * **Adapt** so your behaviour fits better to the problem's demands.
- * **Shape** the environment to change aspects to fit your goals better.
- * **Select** another environment to **avoid** the conflict in the problem.

Problem:

You have a school project due on Monday. If it is late your teacher will be cross and grade you down as you have already had an extension. It is Sunday night and it is still unfinished but a favourite television show is on and your parents are strict about your bed time on nights before school next day. Your video machine is broken. Here are some choices you could make. Write what kind of strategy each solution is (e.g., plan or seek, etc.) on the line provided. The first one is done for you and they are all different. It doesn't matter if your guesses are incorrect, you can change any that are wrong when we go over them:

- * Call your neighbour, ask to stay there the night, watch the programme and finish your homework (select to avoid).
- * Try to change your parents' minds about bed time _____
- * Plan for another way to watch the programme at a later date _____
- * Decide that the programme isn't worth the hassle _____
- * Look up the television guide to see if there is information about the programme being rescheduled _____
- * Wait to see the programme when and if it is repeated _____

5. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

6. HOMEWORK



- A. Look for examples of positive thinkers this week. These can include yourself, a friend, teacher, parent, someone in the supermarket, a television character or similar, who is in a problem situation (not necessarily major). Write down at least one positive adjective for the person (two or more if appropriate); the positive or coping thoughts you think they have; and the positive behaviour this leads to. Also, remember your checklist on the next page.

Positive thinker and situation	Positive adjective(s)	Coping thoughts	Positive behaviour
Teacher: class was noisy and a visitor came in.	Calm, good-humoured.	The class is usually quiet. I'll soon settle them down.	She spoke quietly and calmed everyone down.

SESSION 6

1. QUIZ



A. Fill in the gaps about problem strategies (look back to p.24 if you wish):

- * **Plan** to take some _____ at some stage in the _____.
- * _____ extra information to find out more about the problem.
- * _____ elements of the problem so you see it differently.
- * **Adapt** so your _____ fits better to the problem's _____.
- * _____ the environment to change aspects to fit your goals better.
- * **Select** another _____ to **avoid** the conflict in the problem.

B. Name four types of twisted thinking.

C. Problems are _____.

You can often solve problems without the help of _____.

F_____ are cues.

When you realise there is a problem _____ and _____ about coping strategies.

D. The ABC model tells us that it is not always the _____ which affects our feelings.

Our _____ and _____ can also affect our feelings.

E. Write down your positive self-statement.

2. PROBLEM STRATEGIES

A. Examples of coping strategies or courses of action that can be taken to deal with a problem situation containing a conflict:

- * **Plan** to take some action at some stage in the future.
- * **Seek** extra information to find out more about the problem.
- * **Redefine** elements of the problem so you see it differently.
- * **Adapt** so your behaviour fits better to the problem's demands.
- * **Shape** the environment to change aspects to fit your goals better.
- * **Select** another environment to **avoid** the conflict in the problem.

**I always view
problems as
opportunities
in
workclothes.**



Henry Kaiser

B. Problem Example

Your mother wants you to look after your small sister while she goes shopping. You want to fix your bike tyre because your friend is coming round in an hour for a bike ride. You can't fix your bike and look after your sister as she is very active. What do you do? Fill in the name of the coping strategy (e.g., plan) beside each solution. One of these solutions is an example of two strategies.

- * Persuade your mother to go shopping later that day after your bike ride

- * Take your bike down to your friend's house and fix it there _____
- * Plan with your friend to go for a ride later in the day _____
- * Tell yourself the bike ride doesn't matter and that you will look after your sister and do something else with your friend _____
- * Ask your mother what important shopping she needs _____



3. PROBLEM SOLVING

There are those who can live with problems and those who cannot live without them! Which one are you?

Problem

Your friend has promised to go to a movie with you on Friday night and you are really disappointed when she/he rings to cancel and says "Sorry, but I can't go now. My parents won't let me". You wonder if your friend is going out with someone else and you don't really want to ask anyone else to the movies.

Write down as many solutions as you can in the box below. Now think about the consequences to yourself and others and write these down.

Solutions	Consequences

Now select your best solution. The solution I would choose is:

A fall-back solution would be:

4. SIMPLE PROBLEM-SOLVING MODEL



**Don't fix the blame,
fix the problem!**

1. What is the problem?
2. What are some solutions?
3. What would happen if I tried these solutions (the consequences)?
- 4a. Which is the best solution, b. which could be a fall-back solution?

Problem

Your friend and yourself have done a lot of work on a school project together. Your friend gets a much higher grade than you, and you think you have done as good a job as your friend (if not better).

Now, follow the simple problem-solving model and choose a solution.

1. The problem is: I

2. Solutions	3. Consequences

- 4a. The best solution is likely to be:

- 4b. A fall-back solution is

5. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

6. HOMEWORK



- A. Use the simple problem-solving model below. Also, don't forget the checklist overleaf.

Problem:

Your friend is staying with you overnight. She wants to watch a movie on Channel 2 and you desperately want to watch your favourite programme which is on Channel 3 at the same time. You haven't got a video or another television set. What do you do?

- 1. The problem is: I

2. Solutions	3. Consequences

4a. The best solution is likely to be:

4b. A fall-back solution is

SESSION 7

1. QUIZ



- A. How do you recognise a problem?
- B. Fill in the gap. In a problem you could focus on the task or the p_____ problem.
- C. Why is it useful to think of lots of alternative solutions before choosing one?
- D. Fill in the gap. Before choosing a solution it is best to look at the _____ of all the alternative solutions.
- E. What is a fall-back solution for?
- F. What is the difference between fact and opinion?
- G. There are four steps in the simple problem-solving model. Write as many of them as you can remember.

2. SHAPING

You're either part
of the problem or
part of the
solution!



People who fight fire with fire
usually end up with ashes.

Fill in the missing part of each story (A and B) with as many solutions as you can think of to obtain the "happy ending".

- A. Your brother borrowed your calculator without asking and you need it. You find it on his desk.

Your brother says he didn't realise you needed it and will ask in future. You are both happy.

- B. Your mother often interrupts you, asking questions or making comments, when you are on the telephone. You usually snap, but it doesn't help.

Your mother stops interrupting so often, and you both have a better relationship.

3. PROBLEM STEPS FOR SHAPING

- * **Emotions:** Recognise how you feel (e.g., angry or embarrassed).
- * **Goals:** Look at what's important—getting what you want or the interpersonal relationship or both.
- * **Self-talk:** Look out for faulty self-talk that will hinder what's important (She's a selfish brat, etc.) and correct this so that you can act forcefully but are not out of control. If you need to, take time out; do deep breathing or distract yourself until you have calmed down.

- * **Communication:** Tell the person clearly, paying attention to your tone of voice and attitude:
- A. What's wrong—"You took my calculator but didn't ask me".
 - B. How you feel—"and I'm fed up about it, because I needed it myself". A possible addition is to make reference to the other person's intentions e.g., "I know you didn't mean to upset me but I needed it myself".
 - C. What you want—"I wish you would ask me first".
 - D. What that will mean (in terms of well-being) for both of you—"It will mean I won't get upset and we'll stay friends".

4. SHAPING PRACTICE

For this exercise choose your own problem, or use Problem X. Complete the steps below.

Problem X:

Your friend borrowed your encyclopedia. When he returned it there were dirty fingerprints on it and some pages had corners turned down. Fill in the problem steps:

Your problem (if different from Problem X):

Communication:

Tell your partner clearly, paying attention to your tone of voice and attitude:

- A. What's wrong:
- B. How you feel:
- C. What you want:
- D. What this will mean:

For iveness does not change the past, but it does enlarge the future.



5. OTHER STRATEGIES

- * The broken record technique: don't let other issues side-track you—go back to your point (e.g., "I need to make an important call now").
- * State the importance (e.g., "It's really important to me because I need to get the information before Joy goes to bed").
- * Admit past errors—don't get sidetracked. Agree that you may have made the same or similar mistakes but now you are trying to handle situations in a better manner.
- * Be a Detective—ask what the other person's complaints are and work on solving the problem (e.g., the other person may think you take too long in the shower).
- * Ask for time out—discuss the situation a bit later when tempers have cooled down.

6. IF NOTHING WORKS

Problem example:

You have asked your brother to stop teasing you in front of friends. Neither communicating your feelings nor any of the above alternative strategies work.

Write down a helpful statement that you could give yourself:

Draw a picture of your Champion:

The mind is
not a rubbish
tin, so don't
feed it garbage.



7. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

8. HOMEWORK



- A. To practice communication as a problem-solving method use the following problem example, or choose your own; remember the checklist overleaf.

Problem Example:

Your sister or brother borrows your clothes (or _____) without asking.

Your problem (if different from the Problem Example):

Communication:

Tell the person clearly, paying attention to your tone of voice and attitude:

- A. What's wrong:
- B. How you feel:
- C. What you want:
- D. What this will mean:

If this doesn't work I will try _____ (see p.36) and if that fails my helpful, Champion self-talk will be _____

SESSION 8

1. QUIZ



- A. Before you state the problem it is useful to think about underlying f_____ ; your g_____ ; and s_____ -_____.
- B. Last week we learned that there are four steps to problem communication. Fill in the gaps in the sequence:

Tell the person clearly, paying attention to your tone of voice and attitude:

- * What's _____ (e.g., "You took my calculator but didn't ask me first").
- * How you _____ (e.g., "and I'm fed up about it, because I needed it myself").
- * What you _____ (e.g., "I wish you would ask me first").
- * What this will _____ (in terms of well-being) for both of you (e.g., "It will mean I won't get upset and we'll stay friends").

- C. If you think the problem still exists after you have tried problem communication there are alternative strategies you can try. Write down as many of these as you can remember.

- D. If none of these strategies work it is important that you:



**Keep trying! It's only from
the valley that the mountain
seems high.**

2. OVER-CONFIDENCE, LACK OF CONFIDENCE AND SELF-ESTEEM

To describe the difference between over-confidence, lack of confidence and self-esteem, complete the sentences below. Think about ways to describe the person, and also, words to describe the way the person might act with others.

Words to describe someone who is too confident are:

How they would act with others:

Words to describe someone who is lacking in confidence are:

How they would act with others:

Words to describe someone with high self-esteem are:

How they would act with others:



**One nice thing
about egotists:
They don't talk
about other people.**

3. SELF CRITICISM

A. To weaken the Self-Critic we can:

- * **Check out what can be done.**



If there was any real power in criticism, the skunk would have been extinct years ago.

For example, see a health professional for advice (for acne medication); eat healthy foods; exercise more; get tutoring for maths, etc.

- * **Check if you are expecting too much.**

Look at self-talk, are you forgetting the Champion and using the Worrier.

- * **Who are you comparing yourself to?**

Rachel Hunter, Einstein or an average person? The Champion could say, "I may not be the prettiest or a maths whiz, but I'm OK compared to lots of kids. Why should I be perfect?"

- * **Try distraction.**

For example, if you find yourself brooding about your appearance try playing a CD, watching a movie, going for a walk, etc.

- * **Aim for a middle ground or buffer zone as a protection.** Therefore you are not aiming too high or too low and it's OK to be yourself.

B. Look at the worry below. Write down some things you could do, or tell yourself, if you had this problem.

- * You are unhappy about something you don't do as well at as you would like to (e.g., "I'm no good at maths and it's very important"), or you don't like something about your looks.

Strategies: I could:

4. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

5. HOMEWORK



- A. Find a self-critical problem this week (such as "I don't feel good about the shape of my legs" or "I'm not doing well at maths"). Fill in the steps below; don't forget the checklist.

Name the Problem or Worry:

Strategies: Choose a few from the list below that will help your problem and write in what you would do. You don't have to choose them all.

- * **Check out what can be done.** For example, see a health professional for advice (for acne medication); eat healthy foods; exercise more etc.

I could:

- * **Check if you are expecting too much.** Look at self-talk--are you forgetting your Champion and using the Worrier.

New self-talk:

- * **Who are you comparing yourself to?** Rachel Hunter, Einstein or an average person?

I don't need to compare myself to:

- * **Try distraction.** Try playing a CD, watching a movie, going for a walk.

I could:

SESSION 9

1. QUIZ



A. Write down one word to describe each of the following:

- * an over confident person
- * a person low in confidence
- * a person with high self-esteem.

B. How do each of these types act with other people?

- * the over-confident person
- * the person low in confidence
- * the person with high self-esteem

C. The Self-Critic is one type of (usually) unhelpful attitude. What are three others?

D. How does the mental filter twist operate?

E. What is a coping statement and what is it for?

2. GOALS

A. Steps to consider:

- * Be specific.
- * Be realistic—don't set impossibly high or unrealistically low goals.
- * Set small steps.
- * Examine self-talk that might be a hindrance (e.g., "I could never do that" and argue against negative self-talk—"I can give it a go. Lots of people took years to be successful").

* _____

* _____

- B.** Fill in as many of these areas as you can—remember these can be changed. If you are not sure, put in your ideas anyway. This exercise is to give you practice in looking at what you can do **now** to meet long-term goals and also to make your life as interesting and enjoyable as possible. Start with after-college goals in employment (where you see the "x") and work backwards to see what skills or hobbies you could work on now to meet these long-term goals. Remember to choose fun activities too.

Goals	Form 2	College	Long-term
Academic Employment			x
Social Activities			
Personal Relationships			
Sports or Hobbies			
Other Life Areas			

3. SET-BACKS



**It's a tough road
to the top but the
view is worth it!**

A. If things have been going really well and then you start to feel depressed or bad about yourself you could:

- * Look for what's been happening (tiredness, arguments, put-down).
- * Examine self-talk (which twists or negative attitudes do you have?)
- * Argue against negative self-talk; look at the evidence; use your Champion; write out coping messages.
- * Find some pleasant activities (talk to a friend; get some exercise; see a movie; etc.).
- * Reread this work book.

* _____

* _____

B. David used to be very self-conscious about his height (as he was the shortest boy in his class). He practised hard at a self-esteem course like this one and felt really good for about a month. Then a new boy joined his class. This boy was soon popular and was mean to David, calling him "Shorty". David started feeling upset again about his height and didn't do as well at his school work. He argued more with his parents and brother and he didn't enjoy life so much. What could David do?

Look at the set-back strategies above and write down some ideas. Also look back to page 41 to help you.

4. COURSE SUMMARY

To change feelings or mood it is often easiest to work on thoughts and actions. Here is a summary of the topics we have discussed.

Changing thoughts.

- * **Beliefs**—are they fact or opinion? How do I know?
- * **Emotions**—how bad is it really? Cut down the strong emotions, e.g., rage to irritation.
- * **The ABC model** and arguing against hurtful thoughts. Sometimes it is my thoughts, not just the situation, that is the problem.
- * **Twisted thinking** (Black and white, fortune telling, self-downing, demanding).
- * **Attitudes** (Resenter, Despairer, Self-Critic, Worrier).
- * **Weakening the Self-Critic** (What can you do? Look at your expectations; who you are comparing yourself to; try distraction; aim for the middle—it's OK to be yourself).
- * **Planning for set-backs** (look at what's been happening; look at self-talk; argue against negative self-talk; find pleasant activities).

Working on actions.

- * **Problem-solving:**
 - strategies (plan, seek extra information, redefine, adapt, shape, select).
 - communication (what's wrong? how you feel? what you want? what this will mean?)
 - other strategies (broken-record, state the importance, etc.)
- * **Goal-setting.**
- * **Social Skills** (introductions, developing a conversation, joining and leaving a group, understanding versus judgement).

5. WHAT I LEARNED



Write a few words about main points that could be useful to you now or in the future.

TRAINER'S GUIDE

TRAINER'S GUIDE

To accompany Student Work Book

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GENERAL INFORMATION

Materials:

- * Work Books (1st session)
- * "Feelings about myself" forms and skills checklists
- * Balls or other game equipment

Sessions:

Nine sessions are scheduled for approximately 80 minutes each. The trainer will put up the agenda for each session before commencement (after Clarke, Lewinsohn & Hops, 1990). Each session will begin with a simple mood measure ("Feelings about myself") and a checklist for students to note which relevant skills, taught in the course, have been used during the previous week. These forms are seen only by the researcher and the student concerned. Following this a discussion of "What's been happening for me" with reference to feelings about the self and skills practised, will be held with the whole class or in a Buzz group format, and homework will be reviewed. (This will not be implemented in the initial session).

A short quiz, to reinforce students' knowledge of skills taught during the previous session, will begin each Work Book session (except, the first)—answers can be filled in when the group go over the quiz—it is not a test. The class will then review the homework from the previous week. It is necessary to check the homework right from the start as this is integral to reinforcing skills. It is also important that students are constantly reinforced and reinforce themselves at each step of learning. To remind the trainer of this a ☺ is inserted at regular intervals in these instructions. Games are included during sessions but may be omitted if time is limited. Games are described but any appropriate games may be used, or favourite ones repeated, except where games are directly related to course work—e.g., "Opinion game" or "Find the twist".

Towards the end of each session students will be asked to note the chief skills/knowledge acquired (to reinforce learning). Each session will conclude with a discussion where students can express, "One thing I didn't like, one thing I liked, and one thing I learned in today's session" (with the trainer modelling this process) either as a class or in small groups as appropriate.

Rules:

Ground rules are established in the first session while management of disruptive or inappropriate behaviour will be discussed with the class teacher and the necessary rules explained to students and implemented.

Homework:

This is minimal but important to reinforce concepts. The class teacher will be asked to remind students of their homework during the week.

Session 1

Agenda:

- * Feelings about yourself.
- * Name game.
- * Course benefits/outline.
- * Ground rules.
- * Positive qualities.
- * Homework contract.
- * Opinion, fact and emotion.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Welcome the group.

Explain that, before proceedings begin, a simple mood measure will be completed each week. This is a simple 3 statement scale for students to indicate feelings of self-worth (how you feel about yourself overall at this time in your life). The trainer gives each student a rating sheet and collects this in when completed ☺.

2. Rapport building.

Warm-up name game in a circle. Name is given—I'm Sue and I got _____ for Christmas; next person in the circle repeats Sue's statement—Sue got _____ ; I'm Fred and I got _____ for Christmas. The next person cites Fred (not Sue as too long in a class group) and so on round the circle.

3. The forth-coming course.

This is summarised at the beginning of students' Work Books, and is presented on transparency 1, as follows:

Summary

This course is designed to help you develop good feelings about your capabilities and self-worth by teaching you skills to change thoughts which are unhelpful, and to develop positive behaviours.

Changing unhelpful thoughts

- * Examining beliefs and emotions
- * Disputing hurtful thoughts.
- * Looking at twisted thinking.
- * Examining attitudes.
- * Weakening the Self-Critic.
- * Planning for set-backs.

Working on actions

- * Social Skills.
- * Problem-solving.
- * Goal-setting.

This summary is less in depth than that at the conclusion of the course and is purely to give students a simple, non-threatening outline—it is not necessary to discuss this in detail (this focus on competence and self-worth is also implemented in Mruk, 1995). Rather, discuss the following benefits from the course and write these on the board:

- * fun and learning.
- * skills to develop power over emotions and reactions and increase options (self-management and empowerment).
- * self-protection (armour).
- * problem-solving to develop competence.
- * maintaining or building feelings of self-esteem—feeling good about the self, appreciating abilities and learning skills for getting on with other people—which are important for the transition to college to cope with change and self-doubts (adapted from Wexler, 1991).

Ask students if there are any questions at this stage. Students then look at the course outline in their Work Books and fill in the first Work Book section, *p.1*, on "What I would like to achieve", ticking the reasons which are important to them and adding any others from the board or from discussion 😊.

4. Ground Rules.

Before students turn to *p.2* of workbooks, discuss ground rules. Ask students what these would be and list on board:

- * confidentiality—things said in the class are not to be discussed outside (students can talk about the exercises and their own responses to parents and friends but cannot discuss what anyone else said).
- * mutual respect and support—allowing each other a fair hearing (listening without interruption) and accepting differences.
- * the need to participate to gain most from the course but the right to keep information private or to pass, if an issue is highly personal.
- * the need for regular attendance.

Students add any other rules, apart from the above, to the list in their Work Books on p.2, (get students to write in "**listening without interruption**", "**no teasing or put downs**" and "**respect for my Work Book**" to emphasise these practices) and to sign the confidentiality pledge detailed there ☺. (Some of the ground rules have been adapted from Mruk, 1995, and *Skills for Adolescence*, 1988).

5. **Identifying positive qualities to evoke good feelings** (to be incorporated in later exercises).

(Here, feelings is used as a general term to incorporate both emotional reactions, such as anger, and bodily feelings, such as tension).

Suggestions of positive qualities are asked for and noted on the board e.g., kind, good at tennis, loyal, sporty, fun, good humoured, interesting, hard worker etc. Students are to think of as many positive things about themselves (attributes or skills) as possible, discuss these quickly in pairs, and note these in Work Books (p.2). The students are then shown the closed fist exercise, (which comes from a video recording by Bernard, 1992), where positive attributes are symbolically placed in one's hand, the fist is closed and the hand is held to the chest with a positive self-statement such as "I'm a somebody" or "No matter if I make a mistake I'm still me". Students are asked to picture a positive image of themselves in their mind's eye and to record a positive message and sketch the positive image in their Work Books on p.2. (Note: none of the sketching suggested in this, or future, sessions is compulsory). Also, it is useful to come back to this exercise, if appropriate, at later sessions, when students may have a more useful catch phrase to add ☺.

6. **Homework contract.**

Explain that the homework will rarely take more than a few minutes to complete, two or three times over the week. Ask what may hinder completion of homework (too boring; too hard; not in the mood; don't need to practise) and write these on the board.

Explain about Silver Fern and All Black skills—how do they develop? How do you get good at something? (Practice). Similarly, to achieve success, practice is needed to change habits in thinking. Students are then asked to tick the reasons why they may not like homework, listed in their Work Books on p.3, to add other reasons they may think of, and to sign a simple contract stating that, nevertheless, they will complete their homework (adapted from Burns, 1993a). ☺

7. **Opinion, Fact and Emotion.**

A. Discuss the differences. Thoughts are often opinions and may or may not be true; factual knowledge can be checked through a reliable source and, as far as we know, is true; and emotional reactions are feelings such as fear, happiness or excitement. This knowledge is important so that students understand that only facts are stable (transparency 1b).

- Opinion:** Your own, or another's view-point which may or may not be factual.
- Fact:** Can be verified or is generally considered to be true.
- Emotion:** Response such as fear or excitement; this may be accompanied by a physical feeling such as tightness or sweating

Students are asked to complete the Work Book exercise on *p.3*, to distinguish these. Initially, discuss the fifth example, where the emotion and thought are mixed and ask students for the correct response ("What's your opinion? I'm happy about that" is a question about a thought, or opinion, with an emotional reply, and shows how we can mix facts, opinions and emotions). Ask, "Is an opinion necessarily true? How do we know? When could it be risky to accept an opinion as true? For example, your friend says you're a wimp if you don't do something, or I say this is the best type of watch, is it?" etc., (adapted from Walen et al., 1992) ☺. Give the class a few minutes to have a try, then go over responses so that students can write in Fact, E (emotion) or O (opinion) as the discussion proceeds.

Correct Responses:

1. E. The response is emotional but the question asked for a thought response. This is an example of how thoughts and emotions can be mixed as in the fifth example already discussed;
 2. Fact;
 3. O;
 4. E, again an emotional response is given when an opinion was asked for;
 5. E—as discussed;
 6. Fact;
 7. E.
- B.** Show the list of some common emotional words on the bottom of transparency 1b, as detailed below, and ask students to choose about six to enter in their Work Books on *p.4*.

Common Terms to Describe Emotions.

afraid, bored, cheerful, content, disgusted, displeased, disappointed, worried, joyous, jealous, irritated, lonely, happy, angry, impatient, furious, discouraged, hopeful, cross, gloomy, enthusiastic.

- C.** Strength of positive and negative emotions. Put up the Barometer with anchors (as shown below) on the board. Ask for examples of the different levels and write these in. (Examples have been put in here, but use students' own examples). Show the students the arm gauge to illustrate—wide apart for the worst scenario at level 10, hands close together for no problem at level 0. This is to teach students the value of keeping things in proportion and comes from Bernard's (1992) video.

Barometer

- 10 - my parents died
- 8 - the house caught fire
- 6 - I got a C for the assignment
- 4 - I couldn't go to the movie
- 2 - It rained and sport was cancelled
- 0 - No problem

Students fill in a personal scale in their Work Books on *p.4* (from Bernard & Joyce, 1984) and add cartoons if they wish ☺.

- D.** Helpful and hurtful emotions (also known as appropriate and inappropriate emotions). Ask students how they can distinguish helpful from hurtful emotions and why it could be useful to do so. Students are then asked to cite situations where the emotions were helpful or harmful. Generally the idea is that when over arousal occurs, problem solving is difficult. When the emotion is milder, rational thought and action is easier. Look at Work Books, *p.4, D, .* and distinguish which emotions could be helpful and which hurtful from the list. Go through them as a group with students writing in a + (plus) or - (minus) beside each (furious would usually be a -, as problem-solving would be hindered, while irritated would be a +, as this is a warning to take action, or change thinking). Students then draw a face or picture to illustrate one helpful and one hurtful use of emotion (e.g., a furious man punching someone, an irritated teacher discussing a problem with a student) (from Bernard, 1992).

8. Game.

Clothes basket—chairs are in a circle with one person standing. The person calls out a category, e.g., everyone who has a cat for a pet change places. The caller then takes one of the seats and the last person is now "it". If clothes basket is called, every one changes places. Other games can be used.

9. What I Learned.

Explain to students that at each session students will find some things most useful and, to reinforce these, it is useful to make a note of them. This will be done each week and written in Work Books under What I learned (*p.5* for this session). Ask students for ideas for this section as it is the first session (look at the Agenda) and then ask students to fill in their selection.

10. Evaluation.

Students discuss "One thing I didn't like, one thing I liked, and one thing I learned in today's session" (Trainer begins and students contribute).

11. Homework.

- A. Tell students to "look for uncomfortable emotions you notice in yourself or another person or on television during this week. What situation occurred and what was the emotion and behaviour or reaction that followed?" Go over the following examples which are set out in students' Work Books on p. 5 (they are asked to complete one further example).

Sue's Situation - the kids teased me;

Emotion - very sad and depressed;

Behaviour/reaction - cried and went and sat alone;

Behaviour rating - hurtful—I felt worse on my own.

Fred's Situation - the kids teased me;

Emotion - quite sad;

Behaviour/reaction - went and played softball to release energy;

Behaviour rating - helpful (I had fun and forgot the teasing).

- B. Explain to students that we are interested in whether they use any skills taught in the course during the week. Therefore each week they will be asked to complete a checklist to show which particular skills are used. Each week other skills will be added to this list as they are taught. At the start of the next session students will fill in a master checklist for research purposes and this Work Book exercise is like a kind of diary to help. This week they are to tick the boxes under Barometer each time they use the skill.

Session 2

Agenda:

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * The three part personality system.
- * Rational or helpful thinking—the ABC model and Disputing
- * Game—Positive qualities.
- * Homework and ABC model.
- * Social skills—Introductions.
- * Opinion game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.

2. Discussion/review.

Students discuss anything that happened during the week relevant to the previous session (e.g., skills learned being put into practice; uncomfortable feelings etc.) either as a class group or in small groups if this appears to be more appropriate ☺.

3. Quiz.

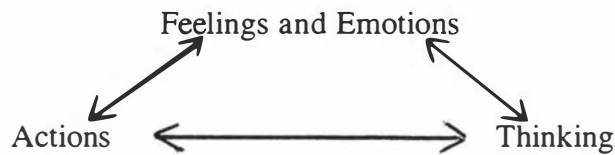
The quiz is in the Work Book on p.6 ☺. (It does not matter if students have previously looked at the questions as the objective is that they remember the answers).

Answers:

A–D are self-explanatory from last session;
E. and F.—helpful when you can take further action or similar, hurtful when you are immobilised or out of control etc.

At this stage reinforce Ground Rules—especially listening without interruption and no teasing (for group safety). (Review of homework will be carried out after explaining the ABC model).

4. The Three-Part Personality System (from Clarke et al., 1990, p.76).



The diagram is detailed on transparency 2 (cover the bottom part showing the table). Ask what the diagram means, then give an example of how the double headed arrows work—e.g., how thinking can affect action and how action can affect thinking. Use a situation where there is some kind of upset so that three variations of the same incident can be imagined—the example of **feeling** angry, thinking angry thoughts and behaving inappropriately; then of **thinking** in a less angry way—how would this affect feeling and behaviour? then of initially **acting** differently—affecting thoughts and feelings.

Thoughts and actions are usually easier to change than feelings. Explain that we are going to learn the ABC model which is concerned with changing unhelpful thinking; and the social skills exercises which we will do soon, work on changing our actions, so students can develop POWER and CHOICE. The diagram is printed in students' Work Books on p.6 and they are now asked to fill in the sentence about control (most control over thinking and actions).

5. Rational or Helpful Thinking. The ABC Model and Disputing.

The following exercise is aimed at teaching the ABC model and links between situation, emotions and reactions (where the theory is that "it is not [always the] situation, A, which creates the disturbing, emotional consequence, C, but one's beliefs, B, about A, which create the upset at C", Waters, 1982, p.570).

A. Show students the following table on transparency 2.

	Situation A	Beliefs B	Emotions C	Behaviour C
Sue	teased		depressed	cried
Fred	teased		sad	softball

Ask the students what differences and similarities are apparent between Sue and Fred's positions? (Emotions and behaviour are different but the situation is the same). What beliefs would therefore be likely to occur at B for each?

Explain to students that everyone talks to themselves inside their heads and, usually, nobody else knows what kind of messages are given. These messages happen really quickly and we don't always notice **them**, just the emotions and bodily feelings that they produce. Bad feelings can be a clue to look for negative self-talk or "silly sentences". It's good to be able to "argue away" some thoughts that make us feel bad (adapted from Pope, McHale, & Craighead, 1987). Also, these private messages are often unrealistic because, being private, they are not checked out (Beck, 1976).

Students now fill in the exercises on the ABC model (*p.7*, 3A. Answers: beliefs, emotions and behaviour; self-talk, actions).

B. Explain that one way to change unhelpful self-talk is to argue against the thoughts (just like most students can argue if they think something is unfair. Ask for examples of this from students). To practise disputing, an adapted version of Waters' (1982, *p. 576*) challenges are put up on a transparency 2b (also on *p.7* of the work book)—discuss these using the thoughts "They don't like me"; "The test will be very difficult"; "My friend got a better bike (or whatever) than I did"—or ask students for thoughts that upset them.

- * Is it true (fact or opinion?)
- * Is it helpful (if not can I change it?)
- * If it is true do I always have to get what I want?
- * How can this one thing (that I'm worried about) make me no good?

Make sure students are clear that the idea is to replace disturbed inappropriate negative emotions with appropriate, albeit, negative emotions (e.g., replace anger with irritation), as the cognitions that are necessary to maintain neutral emotions in response to negative events "are inconsistent with reality and will be impossible to maintain" (DiGiuseppe, 1990, *p.289*). Once these irrational or unhelpful beliefs are disputed, it can be useful to give the self positive messages such as using the clenched fist and statement such as "I'm still me" (with all my other positive qualities). At this stage ask students to review their catch phrase on *p.2* and amend this if they wish ☺.

6. Game.

Pass the ball among the group giving one of your positive qualities, e.g., "I'm Tom and I'm trustworthy". The person receiving the ball says "You're Tom and you are trustworthy. I am Ann and I'm humorous" etc. (This game can be slotted in whenever appropriate in future sessions).

7. Last week's homework.

To consolidate understanding of how self-talk (thoughts) can affect emotions and behaviours, students are now asked to look at their last week's homework example on *p.5*. Ask for someone's example of a situation where there was a helpful rating and one where there was a hurtful rating and put these on the board. Discuss differences. Now students are asked to share their homework example with a partner and to explain why the behaviour rating they gave was helpful or hurtful. **(The trainer quickly checks who has completed homework and takes time to reinforce its importance).**

Students are now asked to fill in the sentences on *p.7* of their work books—each example is to be competed in a hurtful and a helpful way (If I make a mistake etc.) ☺.

8. Social Skills. Introductions (adapted from Clarke et al., 1990).

A. Students are told that steps for this skill are:

- * Making eye contact.
- * Smiling.
- * Making a welcome statement.
- * Using the person's name.

(These are listed in Work Books on *p.8*). The trainer can then model this skill.

- B. A list of welcome statements are generated and written on the board. Students copy four of these into their Work Books on *p.8* (e.g., hi; g'day; nice to meet you), and choose the one they will use in the following practice ☺.
- C. Students practice in pairs with the instruction that they are to give constructive criticism to their partner on one thing from the list that the partner could improve on (e.g., smiling), and positive feedback on at least one thing that was done very well. These are written into Work Books on *p.8*.
- D. When the exercise is completed discuss how students felt during the exercise and their related self-talk (e.g., relaxed—"This is easy"; or awkward—"This is too embarrassing") and if irrational or unhelpful beliefs are evident, use the adapted version of Waters' check-list which is documented on *p.7* of Work Books, to argue against these (e.g., "I may feel a little awkward at first, but I'll soon get used to it). It is important that students start to notice their self-talk at this stage. For example if someone is giggly it may be appropriate to ask that student what thought is occurring (it could be something like "They'll laugh at me") and to ask the student for a rebuttal ☺. The trainer then models the coping statement aloud and goes ahead with the introduction. Subsequently the student with the embarrassment (or a volunteer) repeats this. Explain to the students that this coping statement might be more effective if the student pictures him or herself as coping or relaxed etc. ☺.

9. Opinion game.

Review differences among opinions, facts and emotions. Game: A circle is formed and the trainer begins by giving a sentence containing an opinion, fact or emotion. This trainer then tosses the bean bag to someone else, who has to tell the group what type of message was given. It is then that student's turn to give a sentence. Encourage fun ☺.

10. What I learned.

11. Evaluation ☺.

12. Homework and Checklist reminder.

Session 3

Agenda:

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Twisted thinking.
- * Team game. Find the twist.
- * Social skills. Developing a conversation.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.

2. Discussion/review ☺.

Ask students to share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance.

3. Quiz.

Answers:

- A. feelings/emotions and actions;
- B. thoughts and actions;
- C. disputing;
- D. making eye contact; smiling; making a welcome statement; using the person's name;
- E. self-talk or thoughts.

Remind students of the ABC model—that it is not always the situation which makes us feel bad or act in an unhelpful way, and that often you can feel better if you change self-talk and/or actions (ask for an example and why this is useful to know—to control emotions and feel good).

Also it may be useful to go over ground rules once more at this stage (*p.2* work books).

4. Twists.

This session continues from the previous one and looks at self-talk—this time at common twists we can make in our thinking.

A. Ask the students why it can be useful to think about self-talk (or private sentences). The emphasis is on students becoming aware of their thinking in order that they have more personal power to change their feelings (remember that sometimes feelings are noticed first). Explain that the disputing or arguing, practised last session, is one way of changing thoughts, and we are going to learn another similar way. Emphasise students' choices and the control this gives. Students review the list (which is also documented in their Work Books on pp. 11-12) from transparency 3 as follows:

- * **Black and white**, or all-or-nothing thinking—when it seems like there are no in between shades (e.g., I always lose; you never help).
- * **Mind-reading** or **Fortune-telling**—assuming something without checking it out (e.g., she doesn't like me because she said _____).
- * **Self-downing** or **Blaming**—putting yourself down for one mistake (e.g., I'm dumb, because I _____), or unfairly blaming someone else. (The above distortions are adapted from Wexler, 1991).
- * **Demanding** that others, the world and ourselves should act in certain ways (e.g., I should always get what I want; adults should be perfect etc.). (Adapted from Waters, 1982).

Students are told that we all use faulty self-talk at times but when we use it too often, or it makes us feel bad, it may be useful to become more aware of it and to argue against it and/or to check out the belief if appropriate.

B. Students are asked to give examples of the above categories from their experience (or the trainer may recall some that students have come up with in previous sessions) ☺. These are noted on the board as follows:

Faulty self-talk	The twist	New self-talk

(adapted from Burns, 1980)

An example of faulty self-talk, the twist and new (rational or helpful) self-talk is: I only got a C- for that assignment after all my work so I must be stupid; twist—self-downing; new self-talk—I only got a C- so I can think about what I could do to improve this grade next time as I know I worked hard, (maybe I overlooked something important) then I'll probably do better next time.

If no student examples are forthcoming choose from:

- * It's not fair—I should have got a B (not a C) (demanding).
- * It's hopeless I'll never get this done (fortune telling). This can be checked out by taking things one step at a time, modifying standards etc.
- * Mum didn't wake me so I was late (blaming).
- * I can't do this homework so I'm stupid (self-downing). This can be checked out by

- asking "What does stupid mean?"
- * My brother always gets his way (black and white thinking). This can be checked out by asking "Does he always get his way?"
- C. Following this if time permits, for practice, students play a team game (Wexler, 1991) where they try to guess which twists are being presented and then give an example of rational, more helpful self-talk, called positive rebuttals, to replace the twisted thinking. Teams can win 1 point for guessing the correct category and 1 for replacing the twist. The other team can step in if a team gets it wrong. Teams take turn about and the emphasis is on having fun ☺.

Examples to use:

- * I must be stupid—I got four spelling errors today (self-downing).
- * Mum forgot to pack my lunch—it's her fault I'm starving (blaming).
- * This is terrible—it's pouring and we can't have sport (demanding).
- * I'm useless. How could I get that wrong? (self-downing).
- * Sue always comes top (black and white thinking).
- * The teacher will tell me off if I ask (mind-reading).
- * I should get as much pocket money as my friend (demanding).
- * It's not fair—why can't I get a better grade (demanding).
- * Ben distracted me so I couldn't hear—now I don't know what to do (blaming).
- * It's wet so I can't do anything fun (black and white thinking).

5. Social skills training. Making an introduction is expanded into developing a conversation (adapted from Clarke et al, 1990, and Pope et al., 1987).

- A. Students are asked to recall the four steps for making an introduction -
- * Make eye contact.
 - * Smile.
 - * Make a welcome statement.
 - * Use the person's name.

These are recalled and the following four are added and shown on transparency 3b -

- * Make a statement about yourself and keep this positive
- * Ask about the other person; don't interrupt
- * Think about what the other person is saying
- * Sometimes nod your head

The trainer models this with a group member and asks for feedback.

- B. Students are asked to generate some appropriate statements about the self for use when meeting a new person—(e.g., "I enjoy these club meetings; I love running; This is my first time at this club; etc."). These are noted into Work Books on p.12.

- C. Students then develop a list of questions they could ask a new acquaintance—(e.g., "What are your hobbies? What school do you go to? What's your favourite television programme; sport; sport's team; movie?") Again students copy these into their Work Books on p.13 ☺. Stress that the last two steps are important listening skills to show your interest in the other person (as are eye contact and expression).
- D. Students then practise the six steps in pairs with each person having a chance to be the person initiating conversation (pretend to be meeting someone new at a social or wedding etc.). Again constructive feedback is to be given about one thing the partner could improve on and positive feedback on at least one thing that was done very well and this is also noted in Work Books (p.13) ☺.
- E. Emotions and feelings during the conversation and relevant self-talk are discussed (it is important for students to really look for the automatic thoughts that are occurring as in the last session) and to generate new coping statements for irrational thinking ☺.
6. **Game** (Who are you?). Questions from the Who are You? game are displayed on transparency G1 (adapted from Rohnke & Butler, 1995, p.81). Students have a few minutes to think about these questions and to choose one to answer. Students get into Buzz groups and do a round of responses.
7. **What I learned** (p.13) ☺.
8. **Evaluation** ☺.
9. **Homework.**

Students are asked to note three examples of twisted thinking in the coming week (either in their own thoughts or speech, or in a statement they hear); to identify the twist; and then to create a helpful, rational response (p.14). It is important that students understand that irrational or unhelpful thinking is common and that 100% success in correcting this kind of thinking is, in itself, irrational. Students are also reminded to complete the checklist ☺.

Session 4

Agenda:

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Attitude patterns.
- * Social skills.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.

2. Discussion/review ☺.

Ask students to share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance.

3. Quiz (p.15) ☺.

Answers:

- A. mind reading or fortune telling, self-downing or blaming, demanding;
- B. to understand where your unhelpful feelings or behaviour may be coming from for possible correction;
- C. see last session (p.12 Work Book);
- D. situation, self-talk, actions;
- E. a fact is generally considered to be a true statement that usually can be proven, an opinion can differ between people depending on one's perspective.

4. Attitude Patterns.

The following lesson and role-play aims to develop more understanding about self-talk (and is adapted from Wexler, 1991, with information from Walen et al., 1992). Ask students what part of the personality system are we working on when trying to change self-talk? (Our thinking). Ask what the ABC model tells us (it is not always the situation that makes us feel bad or act in an unhelpful way; often you can feel better if you change self-talk and/or actions).

A. Display transparency 4 as below (cover the Champion section), discuss the attitudes, and ask students for examples which would fit the different examples.

- * The Resenter ("It's not fair" or "She always beats me in tests" or "I'm mad at myself, I can't win") → anger and frustration at self or others (the demanding twist).

(It is important that students realise that, just as being mad at themselves doesn't feel good and leads to negative outcomes, so, also, can anger towards others—other people don't like being criticised either. Ask students what can happen if they are critical or blaming to others—difficulty in relationships etc.).

- * The Despairer ("What's the point?" or "It's hopeless") → sadness or depression (black and white thinking).
- * The Self-Critic ("I always blow it") → low motivation and low self-esteem (the self-downing twist).
- * The Worrier ("How am I going to cope with the test" or "They may not include me") → block to action (when we think we won't cope); or low self-worth (when we fear others won't include us) (often fortune-telling or self-downing).

Often students will notice the emotions and feelings accompanying each attitude pattern first (go back and review these as given after the → for each). Encourage students to picture each of the patterns in their minds. Discuss personal examples and make sure that students understand that the goal is to increase their own power. Students write their own example of each attitude (their own sentence which is familiar to them) and illustrate the attitudes in Work Books with a new name.

B. Next, the idea of an encouraging voice inside us is introduced. This can be thought of as our Champion, Ally or Mate, or students are free to choose their own terminology if they prefer. The Champion's purpose is to dispute unhelpful self-talk by reminding us to check out our assumptions and to substitute comforting, supportive messages to ourselves. Ask what the Champion might say ("You're doing O.K.; that was hard but you tried; even if so-and-so was unfair I can still cope and they are just human too; etc.) and what the Champion leads to (ask for personal examples). Also students may find it helpful to picture their Champion as a guardian angel, a movie star whom they look up to etc. Point out that the Champion has to be rational or realistic, however, as our inner selves won't believe gross exaggerations. Display information about the Champion (covered until this point, at the bottom of transparency 4).

- * The Champion → confidence, protection, encouragement, comfort.

Students then write one example of a sentence from the Champion into their Work Books (p.17) and can do a small illustration if they wish.

At this stage remind students of the closed fist exercise in session 1 and positive qualities noted on p.2 of their Work Books. Students are now asked to do the closed fist exercise with their partner where they tell their partner at least three good qualities about the

other, the partner "puts these in her or his fist" and repeats them silently ☺.

- C. Practice with attitude patterns. The following situations are presented one at a time and pairs of students may be asked to role play e.g., "What would your Despairer say in that situation?" with a response from the other person as the Champion voice. The idea is for students to be aware of negative attitudes and of how to substitute the Champion voice.

Situation examples:

- * Giving a speech to the class.
- * Problems in phys. ed.—especially with swimming.
- * Parental restrictions on going to the movies at night.

5. Social skills.

- A. Discuss students' progress with social skills to date. Has any success been achieved etc? Go on to social habits that could "put off" possible friends (adapted from Clarke et al., 1990). Students read the Work Book list on p.17. They tick the ones they particularly dislike and add two more examples to the list if they can. Discuss any extra examples, and emphasise the reason to be aware of these habits.
- B. Discuss understanding versus judgemental comments further—e.g., how students feel when they are misunderstood. How would they like the other person to respond? It is often useful to clarify that the message has been understood—as in the above example, "That sounds as if it was tricky?" posed as a question. The other person can then say, "Yes, it was tricky" and feel understood, or can disagree and say "No, I just didn't have the right equipment to fix the tyre". Role play examples of replying in a judgemental or boastful type of way as opposed to an understanding manner using the example "I haven't got a good topic yet". Students now work on the table on p.18 Work Books. Discuss ☺.
- C. Discuss faulty self-talk if students do find themselves e.g., interrupting. (What they might say to themselves—"I shouldn't have done that"; and a helpful or rational response—"It's O.K., I sometimes make mistakes."

6. What I learned (p.18) ☺.

7. Evaluation ☺.

8. Homework.

Students are asked to write down one example of each different negative attitude this coming week (Work Books p.19) from themselves, TV etc., to identify the negative attitude and substitute the Champion voice.

Session 5**Agenda:**

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Social Skills. Joining and leaving a group.
- * Positive statements.
- * Problem-solving.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.**2. Discussion/review ☺.**

Ask students to share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance. Trainer will collect Work Books after the session to check homework.

3. Quiz (p.21) ☺..

Answers:

- A. Worrier, Resenter, Despairer, Self-Critic;
- B. confidence, protection, encouragement and comfort (or words to this effect);
- C. Any 4 (see p.17 Work Book for examples such as slumping, interrupting, making negative comments, making judgemental comments);
- D. self-talk;
- E. the judgemental, boastful reply is x, the reply most likely to help is y;
- F. actions and thinking.

In addition, discuss why it is useful to be aware of the Despairer, Resenter etc.—so we can change to the Champion if we choose, and ask what affects our feelings apart from an unpleasant situation? (Self-talk and behaviour—remind students of the Three Part Personality System on p.6).

4. Social skills.

Ask students what part of the personality is being changed by working on social skills? (Behaviour or Action). This time social skills will focus on joining and leaving a group (Clarke et al., 1990 and Pope et al., 1987) ☺. Discuss when this is an appropriate or a useful skill (e.g., at a party).

- A. Discuss a useful way to join a group as below (transparency 5).
- * Stand quietly near a group and you are likely to be included.
 - * Say something about what's going on, e.g., "That sounds like fun"; (pushing in is likely to be unsuccessful).
 - * If you are not included in the group within a few minutes it is best to leave gracefully saying, "See you later" or similar.
 - * Use Champion self-talk if this occurs, e.g., "I gave it a good try. Better luck next time".
- B. Discuss leaving a group of a few people (bottom of transparency 5, covered until this point) as below.
- * Decide if the time is appropriate, e.g., you won't look like sore loser.
 - * Make an appropriate comment such as "excuse me", or give a reason such as "I have to be home by 5 p.m."
 - * Smile and leave, making a comment about seeing them later.
- C. Students then review these skills in their Work Books, filling in the gaps in the "Joining and leaving a group" exercise on p.22.
- E. In pairs, students then role play joining or leaving a group (one each). Partners give each other constructive criticism on one thing that could be improved on, and positive feedback on one thing that was done very well and write these comments in Work Books (p.22) ☺.

5. Positive statements.

- A. It is useful to internalise positive feedback and to accept it (often criticism is more common than praise). Explain that, even although we have a particular self-view, we may be ignoring certain of our positive attributes, and this is one way to incorporate these into our self-view. Students generate a list of positive attributes that can apply to their peer group (good sense of humour; sporty; a good friend; caring; musical; energetic; fit; pleasant; kind; capable; good job with a project etc.) and this is written up on the board.

Students are asked to give one or two of these, or another positive adjective, for each member of the group. (Done in Buzz groups). The trainer models this process first. Emphasise that support is mandatory here—no teasing. Students may respond to each compliment by saying "Thank you" and, if desired, adding a comment such as "I'm glad", or "Thank you for noticing". They then write each positive statement given to them in their Work Books (p.23) as they are stated by the other group members (adapted from Lamke et al., 1988) ☺.

- B. The trainer then shows transparency 5b of a large circle with smaller circles inside it. The small circles are labelled with positive and negative attributes generated by the group (approximately half of each—use an impermanent pen). The idea is to show that everyone is a mixture of characteristics. When one part of the whole is criticised it is therefore important to remember all the other parts (e.g., analogy—you

don't junk a car because of a flat tyre. Similarly we can choose to work on a negative characteristic to change it, or we can choose to accept it, but we don't junk ourselves). Students write in their characteristics and skills in the space provided in Work Books on p.23, and write a positive self statement below the ovals, such as "I'm Kathy and I'm somebody" (from Bernard & Joyce, 1984, citing Young's, 1983, method for combatting self-downing) ☺.

6. Problem-solving.

Before working on problem steps explain that first students will look at what problem-solving is about and then at strategies that can be used if there is a conflict.

- A. Problem-solving orientation (from Pope et al., 1987). This, and the coping strategies below, are printed on transparency 5c.

Explain that (or get a student to read out the list):

- * Problems are normal.
 - * Students can often solve problems without the help of adults.
 - * Feelings are cues—most times when students experience an uncomfortable feeling they can think of it as a signal to change self-talk and/or deal with a problem.
 - * When students realise that there is a problem, STOP and THINK.
- B. Read through the examples of coping strategies or courses of action that can be taken to deal with a problem situation containing a conflict.
- * **Plan** to take some action at some stage in the future.
 - * **Seek** extra information to find out more about the problem.
 - * **Redefine** elements of the problem so you see it differently.
 - * **Adapt** so your behaviour fits better to the problem's demands.
 - * **Shape** the environment to change aspects to fit your goals better.
 - * **Select** another environment to **avoid** the conflict in the problem (Berg & Calderone, 1994).
- C. Students look at their Work Books (at 4B on p.24). The problem and choices are detailed below. Read the problem together, go over the first choice, and students complete the rest in their Work Books, guessing from the above strategies ☺.

Problem (adapted from Berg and Calderone, 1994):

You have a school project due on Monday. If it is late your teacher will be cross and grade you down as you have already had an extension. It is Sunday night and it is still unfinished but a favourite television show is showing and your parents are strict about you bed time on nights before school next day. Your video machine is broken. Here are some choices you could make:

- * Decide to call your neighbour, ask to stay there the night, watch the programme and finish your homework (select to avoid).
- * Try to change your parents' minds about bed time (shape).
- * Plan for another way to watch the programme at a later date (plan).
- * Decide that the programme isn't worth the hassle (redefine).
- * Look up the television guide to see if there is information about the programme being rescheduled (seek).
- * Wait to see the programme when and if it is repeated (adapt).

Explain that these are examples of generating solutions. Solutions do not have to fit these categories, others can be created. Check students' responses ☺. Discuss and ask if any more choices come to mind. If so add these to Work Book list ☺.

7. Game

"What have I changed?" adapted from "The last detail", Rohnke & Butler, 1995, p.123.) In this game the students sit in two lines, or can pair up at desks, facing each other and study their opposite number. On a signal everyone faces the other way and changes one thing about their appearance that could be spotted by an observant partner. Pairs take turns at guessing. Students change partners and the game is repeated.

8. What I learned (p.25) ☺.

9. Evaluation ☺.

10. Homework (p.25).

Look for examples of positive thinkers this week. These can include yourself, a friend, teacher, parent, someone in the supermarket, a television character or similar, who is in a problem situation. Write down at least one positive adjective for the person; the positive or coping thoughts you think they have; and the positive behaviour this leads to. Remind students to complete the checklist on p.26 during the coming week ☺.

Session 6**Agenda:**

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Problem strategies.
- * Game.
- * The simple problem-solving model.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.**2. Discussion/review ☺.**

Ask students to share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance.

3. Quiz (p.27) ☺.**Answers:**

- A. action, future; seek; redefine; behaviour, demands; shape; environment;
- B. black and white, mind-reading or fortune-telling, self-downing or blaming, demanding;
- C. normal, adults, feelings, stop, think;
- D. situation, self-talk, behaviour;
- E. positive statement.

4. Problem strategies.

- A. Discuss how you know that there is a problem in the first place (negative feelings in yourself or other people's reactions), and what physical symptoms might let you know about the negative feelings (sinking feeling in the tummy; tense arms and shoulders; screwing up your face).

Check understanding of coping strategies, detailed on p.28 of Work Books) with a second example that pupils complete in their Work Books (also on p.28) as in the last session (see problem below).

Problem

Your mother wants you to look after your small sister while she goes shopping. You want to fix your bike tyre because your friend is coming round in an hour for a bike ride. You can't fix your bike and look after your sister as she is very active. What do you do? Fill in the name of the coping strategy (e.g., plan or seek etc.) beside each solution. (One of these solutions is an example of two strategies). The idea is not to make this a test, but to make students aware of generating different solutions.

- * Persuade your mother to go shopping later that day when you will have had your bike ride (shape).
 - * Take your bike down to your friends and fix it there (select and avoid).
 - * Plan with your friend to go later for your ride (plan).
 - * Tell yourself the bike ride doesn't matter and that you will look after your sister and do something else with your friend (redefine and adapt).
 - * Ask your mother what important shopping she needs, to then decide what to do (seek).
- B. After the students have filled these out in Work Books go over them—students can fill in correct solutions now ☺. Discuss possible consequences of each solution given above with respect to advantages and disadvantages (including how other people might react with respect to the solution). Ask for examples where students have used any of these strategies ☺.
- C. Introduce the idea of problem interpretation, which, depending on whether you are concerned with the task problem, the people problem, or both, will help determine your choice of a solution. Discuss with students if the homework example and the bike one are task or people problems for them ☺.
- D. Also discuss helpful and unhelpful thoughts which may be held about a problem—what twists might occur with the above example? (e.g., It's not fair that I have to look after my sister. Is this thought helpful or unhelpful and why would it be useful to change it?) ☺.

5. Game.

Miming "I'm good at". Students form a circle or get into small groups—the student in the middle mimes using a common object, such as badminton racquet, to indicate "I'm good at badminton." The student who guesses then has a turn. Ideas for mimes: baby sitting; using a computer; using a pot—good at cooking; fishing; dancing etc.

6. Simple Problem-solving model.

(Information on problems has been obtained from Berg and Calderone, 1994; Elias et al., 1991; and Spivack et al., 1976. The simple problem-solving method is adapted from Pope et al., 1987, p.46).

Explain to students that the simple problem-solving model will now be practised with two examples, and will also be used for homework. Show transparency 6 and ask a student to read the steps through.

1. What is the problem?
2. What are some solutions?
3. What would happen if I tried these solutions? (What are the consequences?)
4. Which is the best solution? Which could be a fall-back solution?

The trainer explains that sometimes a fall-back solution is useful to add to the "best solution" and asks what this is for? (To have a back-up to try if the first one fails to achieve the goal).

Students first practice solutions and consequences using the example in their Work Books (p.29) to be set out in table form as shown at the bottom of transparency 6. Discuss solutions, consequences, best solution and fall-back ☺.

Students now practise with the problem provided on page 30—ask how they would describe the problem using an I statement (e.g., I am upset because I got a lower grade and I did as much work). Students now complete page 30. When finished they are asked to tell their partner their solutions, consequences and why they chose the "best solution" and fall-back. This is followed by a brief class feed-back session. The trainer then points out homework on p.31, as this is a similar exercise.

7. What I learned (p.31) ☺.

8. Evaluation ☺.

9. Homework.

Remind students to complete the checklist on p.32 during the coming week.

Session 7

Agenda:

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Shaping.
- * Alternative strategies.
- * If nothing works.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.

2. Discussion/review ☺.

Ask students to share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance. Trainer will collect Work Books after the session to check homework—books will be returned next day.

3. Quiz (p.33) ☺.

Answers:

- A. uncomfortable feelings in yourself, or another person's behaviour points to a problem;
- B. people problem;
- C. to have a choice;
- D. consequences or possible results;
- E. a back-up so that you are not left frustrated or without a plan;
- F. a fact is generally considered to be a true statement which usually can be proven, whereas an opinion can differ depending on one's perspective;
- G. as p.30 Work Book.

4. Shaping.

Explain that the shaping aspect of problem-solving is used with problems where someone has done something you don't like (e.g., asked you questions when you were on the telephone; or borrowed your calculator without asking) and you want to change (or shape) the other person's behaviour but keep things friendly. Students are asked to fill in the missing part of both the stories in their Work Books (p.34) to find out how many strategies they can think of to arrive at the "happy ending". At this stage no suggestions

are given ☺. Ask for responses and reinforce helpful solutions.

Now ask a student to read transparency 7—emotions, goals and self-talk (cover the bottom half) and go over this. Next, look at the bottom half of transparency 7 and act out the communication method, using the calculator example. Explain to students that tone of voice and attitude are important—ask where these come from? (self-talk). It may be necessary to act out several examples, asking the students for personal concerns (e.g., your mother makes jokes in front of friends which embarrasses you).

Students then choose their own problem example, or use the example given, role-play this with a partner, then write in the communication steps in their Work Books (p.35, Shaping Practice). Discuss ☺.

5. Alternative strategies.

A. Discuss what students can do if the previous communication strategies do not work. Ask for ideas first and then display the following strategies on transparency 7b (adapted from Wexler, 1991):

- * The broken record technique: don't let other issues side-track you—go back to your point (e.g., "I need to make an important call now").
- * State the Importance (e.g., "It's really important to me because I need to get information before Joy goes to bed").
- * Ask for time out—discuss the situation a bit later when tempers have cooled down.

(There are two other alternatives for interested students on p.36 of Work Books).

Role play the above three, as appropriate, with a student, using some of the following situations, or students' examples, and assume you have tried the communication steps which don't work:

- * Your sister is using the computer and it is your turn. She keeps on going—"just to finish the game".
- * Your friend and yourself usually get on really well but she has ignored you a lot lately to socialise with another friend.
- * Your friend and yourself have a serious disagreement—use student example of disagreement.

B. Discuss the fact that sometimes nothing does work, but that the above are strategies students can try out to feel more in control and to increase the chances of working problems out. Discuss best options if a situation cannot be changed and nothing works? (Protection by using helpful self-talk or thinking of ways to cope e.g., by seeing an image of the self as a Champion Coper, show bottom of transparency 7b).

Ask students to complete the section "If Nothing Works" in Work Books (p.36) where they write down a helpful statement they can give to themselves, then draw a picture of their Champion.

Also mention that sometimes a student may want support which is not available from someone who is important to them (e.g., mother, friend, teacher). In this case what can be done? (Find alternative support from someone—school counsellor, *Youthline*, another friend etc.) ☺.

6. Game

"Have you ever" (from Rohnke & Butler, 1995, p.224). In this game students sit in a circle. The leader starts and asks "Have you ever _____" (e.g., eaten haggis; run a 5 km. or longer race; driven a Go-cart; done a one-armed push-up; been stung by a bee; walked out of a movie; kept a live goldfish for more than three years; buried a pet etc.) Students raise their hands if they have and can briefly discuss the issue. Continue the game, going round in a circle. The rule is that the person asking must have had that particular experience themselves.

7. What I learned (p.37) ☺.

8. Evaluation ☺.

9. Homework.

Students are asked to complete the homework problem in their Work Books (p.37) using the communication steps, an alternative strategy for a fall-back, and helpful self-talk in case nothing works. Students are also reminded about the checklist (p.38) ☺.

Session 8**Agenda:**

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Over-confidence, lack of confidence, self-esteem.
- * Self-Criticism.
- * Game.
- * What I learned.
- * Evaluation.
- * Homework.

1. Feelings about yourself; skills checklist ☺.**2. Discussion/review ☺.**

Review the communication steps by asking students to recall them—what's wrong, how you feel, what you want, what that will mean. Ask students to now share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance.

3. Quiz (p.39) ☺.

Answers:

- A. feelings (e.g., embarrassment as well as anger), your goals—do you want to keep the friendship? and self-talk;
- B. wrong, feel, want, mean;
- C. broken record, state the importance, admit past errors, be a detective, ask for time out;
- D. give yourself helpful self-talk and use your Champion.

Also, remind students of the ABC model—what is it? (It is not just what is happening that can make you upset but also your self-talk and actions).

4. Over-confidence, lack of confidence and self-esteem.

Explain that this section is to practise on the action part of the personality. Firstly, students are asked to fill in the exercise in Work Books (p.40). They can also do sketches to show body-language and facial expressions of the different attitudes, if desired. Possible answers are detailed below. Any appropriate responses are fine.

Over-confidence

description: boastful, conceited or pompous

actions: neglecting others' feelings, self-involved

Lack of confidence

description: scared to try new things or accept challenges, self-protective

actions: possibly scared of others' opinions, afraid to take chances

High Self-esteem

description: worthy, feeling good about the self even when something goes wrong, but not boastful, able to change negative self-talk

actions: respect for others in the same way

Discuss students' responses ☺.

In pairs, role play each of the situations on transparency 8, as an over-confident person, a person lacking in confidence and a person with high self-esteem. Students take turns and their partner has to guess which type of person they are playing. The trainer may model an example ☺.

5. Self-Criticism.

Often worrying about body image or academic achievement can be linked to feeling bad about the self (appearance or competence) and it can be useful to think about the following strategies for body image or success problems and worries. (Some of the information below, particularly on body image, was derived from Pope et al., 1987, and Pruzinsky & Cash, 1990).

- A. Ask the students which attitude is often paramount in worry about appearance or doing well at school (the Self-Critic). Ask what the Self-Critic leads to (low motivation, low self-esteem—the self-downing twist). If appropriate individual students may give an example of a self-critic(al) problem for them.

Explain that a related twist is called mental filter (Burns, 1980)—where you focus on one thing you don't like, such as the shape of your nose, and forget about or discount your positive aspects. (The trainer may have observed this occurring—e.g., a student saying "but that doesn't count"—the response is "Why not?").

- B. To weaken the Self-Critic there are several strategies we can use ☺. Go through each of the strategies below, which are put up on transparency 8b, asking students for ideas to help two people with different concerns: 1. a person with the worry—"I'm not good-looking—I've got horrible spots" and 2. a person worried about their progress in maths. **Cover the "For example" section below each strategy** on the transparency until students have suggested a few examples of their own. Go over the following strategies for weakening the Self-Critic:

- * Check out what can be done? Ask for examples for improving spots or maths grades.

For example, see a health professional for advice (for acne medication); eat healthy foods; exercise more; wash hair more often; get tutoring for maths; spend more time on revision.

- * Check if you are expecting too much. Ask students how this can be done.

For example, look at self-talk—are you forgetting other good things, or forgetting your Champion and using the Worrier. (Nick on Shortland Street would not be considered physically attractive by some people).

- * Who are you comparing yourself to? (Rachel Hunter or Einstein or an average person). What would the Champion say?

For example, "I may not be the prettiest or fantastic at maths but I'm OK compared to lots of other kids. Why should I be perfect?"

- * Try distraction.

For example, if you find yourself brooding about your appearance try playing a CD, watching a movie, going for a walk etc.

- * Aim for a middle ground or buffer zone as a protection. You are therefore not aiming for overly high (perfectionistic) or unreasonably low standards, and it's OK to be yourself.

Students may choose this phrase as a Champion sentence if they wish. Also, remind students of the exercise where they remember all their good points as well as ones they don't like, while, **in some cases** it may be useful to get other students' feedback about a point a student doesn't like (such as her hair).

- C. The students are then asked to go through the strategies which are printed in their Work Books (p.41, A), and to write some ways of coping with two of the worries (p.41, B) with reference to the strategies (e.g., I could talk to my mother about it, I could change my self-talk to...).

6. **Game.** Repeat the miming game "I'm good at".

7. **What I learned** (p.42) ☺.

8. **Evaluation** ☺.

9. **Homework.** (p.42) and checklist reminder ☺.

Session 9

Agenda:

- * Feelings about yourself; skills checklist.
- * Discussion/review.
- * Quiz.
- * Summary.
- Goal-setting.
- * Game.
- * Set-backs.
- * What I learned.
- * Evaluation.

1. Feelings about yourself; skills checklist ☺.

2. Discussion/review ☺.

Ask students to now share their homework examples with a partner while trainer quickly checks to see homework has been completed and to reinforce its importance.

3. Quiz (p.44) ☺.

Answers:

- A. e.g., boastful; self-protective; worthy;
- B. may disregard others' feelings; afraid to take chances; respects others;
- C. Worrier, Resenter, Despairer;
- D. the focus is on one negative aspect, such as nose shape, and other positive qualities are discounted;
- E. it is an example of self-talk where the message is supportive of e.g., something you want to do, and the coping message is to help you feel OK about trying that out or OK even if the trial is unsuccessful.

4. Summary.

Review Summary Sheet (transparency 9). (More detail is given on the Summary outline below and in student Work Books, p.47, than is printed on transparency 9). Explain that this session will work on goal-setting and set-backs but that we have covered the other topics in previous sessions—briefly discuss these, asking the students what they remember about them and what was useful or otherwise.

Summary

Changing thoughts.

- * **Beliefs**—are they fact or opinion? How do I know?
- * **Emotions**—how bad is it really? Cut down the strong emotions e.g., from rage to irritation.
- * **The ABC model** and arguing against hurtful thoughts. Sometimes it is my thoughts, not just the situation, that makes things seem worse.
- * **Twisted thinking** (Black and white, fortune telling, self-downing, demanding).
- * **Attitudes** (Resenter, Despairer, Self-Critic, Worrier).
- * **Weakening the Self-Critic** (What can you do? Look at your expectations; who you are comparing yourself to; try distraction; Aim for the middle—it's OK to be yourself).
- * **Planning for set-backs** (look at what's been happening; look at self-talk; argue against negative self-talk; find pleasant activities).

Working on actions.

- * **Problem-solving:**
 - strategies (plan, seek extra information, redefine, adapt, shape, select).
 - communication (what's wrong, how you feel, what you want, what this will mean).
 - other strategies (broken-record, state the importance, ask for time out).
- * **Goal-setting.**
- * **Social Skills** (introductions, developing a conversation, joining and leaving a group, understanding versus judgement).

5. Goal setting ☺.

- A. Discuss ways in which to set realistic goals. Put up some guidelines as below (transparency 9a) after asking for suggestions. Ask two students to role play the scenario of a counsellor explaining to a college student how to set goals, using the guidelines given on the transparency—it is important that the "counsellor" put these guidelines into simple terms:
 - * Be specific.
 - * Be realistic—don't set impossibly high or unrealistically low goals.
 - * Set small steps.
 - * Examine self-talk that might be a hindrance (e.g., "I could never do that" and dispute it with "I can give it a go. Lots of people take years to be successful"). Students add any other suggestions to the list in their Work Books on p.45 which are important to them ☺.

- B. Now discuss after-college (long-term) goals with respect to employment or further education. Discuss with students how they can start to plan now to meet these goals (emphasising that it doesn't matter if goals change—planning can be modified). For example, if a student has the long-term goal of being a doctor, what specific steps can the student take now? (Concentrate on science subjects, develop good study

skills etc). It could be useful for the trainer to tell a story of successful goal-setting.

Students are then asked to set goals for the form 2 year, for college, and for after college with reference to the following areas—work (academic or paid); social (fun activities); personal (relationships with peers, parents or a partner); sports/hobbies; self-esteem goals; other (religious etc.). The goals are private and do not have to be shared unless students choose to do so, but some students may like to work in pairs. Remind students about the need for specificity and ask for examples—e.g., start a positive comments diary in the form 2 year to focus on strengths (in self-esteem category). It may be beneficial to start with after college (long-term) goals and work backwards to set specific steps for the form 2 year in relation to these goals (particularly with reference to employment as marked with an x in the table—see bottom of transparency 9a). Students then fill in the table in their Work Books (p.45) 😊. Discuss any issues if appropriate.

6. **Game**—choice of favourite game.

7. **Set-backs.**

- A. Ask students what is likely to happen if these strategies have been working really well for a time? (It is likely that at some stage negative patterns will recur). What could students do? Discuss and then show transparency 9b as below:

Set-backs.

- * Look at what has happened around the time of the set-back (tiredness, put-down).
- * Examine self-talk (which twists or negative attitudes are present).
- * Argue against negative self-talk; examine evidence; enlist your Champion; write out coping messages; list your good points.
- * Find some pleasant activities (talk to a friend; get some exercise; see a movie).
- * Reread this Work Book and the Summary (p.47).

Students add any other ideas to the Work Book list on p.46 and/or draw their Champion.

- B. Students then discuss with a partner the hypothetical example of David's problem in their Work Books (p.46) and fill in ideas to help him 😊. Discuss the students' ideas.

8. **What I learned** (p.47) 😊.

9. **Final Evaluation Sheet and Game.**

Appendix C

PARENT/GUARDIAN AND STUDENT INFORMATION PACKS

Information Sheet for Parents/Guardians

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

Researcher: Sheila Bagby
Telephone: 443-9691

Supervisors: Dr Jennifer Stillman and Dr Philip Voss
Department of Psychology
Massey University Albany
Telephone: 443-9770 or 443-9663

My name is Sheila Bagby and I am a Ph.D student in the Psychology Department at Massey University Albany. Before becoming a graduate student at university, I was a primary/intermediate school teacher for many years and first became interested in adolescent mental health and self-esteem at that time.

This sheet provides information about my Ph.D research concerned with self-esteem in young people. For this research, I have developed a self-esteem programme to teach skills in coping with negative emotions (such as learning to argue against unhelpful thoughts), problem solving (such as learning to think of lots of ways to deal with problems) and communication (such as introducing oneself and making conversation). The Principal and staff are interested to see how this programme works for the students and it will therefore be taught as a research programme to some classes, provided parents/guardians and students of these classes give their consent. Students who take part in the programme will be asked to complete some psychological survey questions before the programme begins. After that, these classes will be split into two groups where one group of classes will be taught this programme and the other group will continue with normal classes. It is necessary to have two groups completing the survey questions and only one completing the programme while one continues with normal classes, so that we can compare the results of the surveys between the two groups to see how useful the programme is.

After the self-esteem programme is finished—it runs for about eighty minutes each week for 9 weeks—children who completed the first survey questions will be surveyed again. The survey will be done a third time, approximately 6 months later. This survey asks questions about how the child sees her or himself in terms of school work, friends, appearance, well-being and so on. At the same time as these surveys occur, you will be asked to fill out a short checklist about your child, discussing things like communication skills, coping with negative emotions and problem solving. The first checklist is included in this pack for you to return with the consent forms. The other two checklists will be sent to you at the appropriate times.

If you agree to your child taking part in this study please fill out the forms and return them in the plastic envelope provided, to the child's teacher, writing the class room number on the front of the envelope. A checklist of the items to be returned is noted at the bottom of this information sheet. These are as follow: a parent/guardian consent

form to allow the child to take part, with a section for your child to sign to agree to completing the surveys; a consent form to allow the researcher access to the PAT test results in maths, reading and language; a section at the bottom of the PAT consent form for you to record your child's ethnic group, which is for statistical purposes only; the parent/guardian checklist (as described above). It is important that your child does not open the envelope that you return the checklist and consent forms in because they are private. Therefore we have included the special plastic envelope that cannot be opened and have asked the teachers to keep returns in a secure place. If you are still concerned that your child may open the envelope please post the form to us (the address is stamped on the envelope).

If you and your child agree to take part in this study, you have the right to:

- ¶ Refuse to answer any particular question, and to withdraw yourselves or any information you have provided (before the study is completed), without having to give reasons.
- ¶ Ask any questions about the study that occur to you during your participation.
- ¶ Complete confidentiality—all information is collected anonymously, and it will not be possible to identify you or your child in any reports that are prepared from the study.
- ¶ Be given access to a summary of the overall findings when the study is completed.

If you have any questions regarding this research, please ring me, or one of my supervisors, at the telephone numbers listed near the top of the previous page.

Checklist of items to be filled out and returned now:

- Parent/guardian and student consent form (to allow child's participation—his or her signature needed to agree to complete the surveys).
- Parent/guardian consent form (access to standardised test results) with an additional section to record ethnic group.
- The first parent/guardian checklist - 1.
- Plastic envelope: please record student's room number on the front.

Checklist of items to be filled out and returned at the end of the 9 week programme:

- The second parent/guardian checklist - 2.

Checklist of items to be filled out and returned after approximately 6 months:

- The third parent/guardian checklist - 3.

Information Sheet for Students

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

Researcher: Sheila Bagby
Telephone: 443-9691

Supervisors: Dr Jennifer Stillman and Dr Philip Voss
Department of Psychology
Massey University Albany
Telephone: 443-9770 or 443-9663

This sheet provides information about a fun programme to help students feel good about themselves, which is to be run with some classes in health time. The exercises that are to be practised are to help students have control in problem situations which are likely to come up as students move into college years. Because this is also a research programme we cannot use the programme with all classes.

At first, students will be asked to fill out some survey questions with the researcher and your teacher. After that classes will be split into a programme group and a control group. Students in the programme group will take part in an eighty minute session with the researcher and class teacher each week for 9 weeks in health time. The exercises in the programme will involve a mix of discussion, writing, role-play, games, social skills, problem solving, and so on. Students in the control group will simply attend their normal classes.

After the programme is completed all students will fill out the survey questions again. This will happen once more towards the end of the year. The questions are about you and they are not difficult and do not take long to complete. Your name will not be on the survey sheets so all your answers will be private. Only the researcher will see the answers. If you have any questions you can ask the researcher before you fill in the survey. You can also talk to her afterwards.

If you agree to participate in this study, you have the right to:

- ¶ Refuse to answer any particular question and to withdraw from the study at any time.
- ¶ Ask any questions about the study at any time during participation.
- ¶ Provide information on the understanding that your name will not be used.
- ¶ Be given access to a summary of the findings of the study when it is concluded.

If you agree to fill out the survey questions please sign the consent form under your parent/guardian signatures.

Consent Form for Parents/Guardians and Students

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

We have read the Information Sheet for this study and have had the details of the study explained to us. Our questions about the study have been answered satisfactorily, and we understand that we may ask further questions at any time. We also understand that we are free to decline to answer any particular questions in the study, and to withdraw ourselves or any information we have provided (before the study is completed), without having to give reasons. We agree to provide information to the researcher on the understanding that it is completely confidential.

Parent/Guardian Section

I agree that _____, who is under my guardianship, may participate in this research.

Signed: _____

Signed: _____

Name: _____

Name: _____

Date: _____

Date: _____

Student Section

I agree to complete the survey questions for the self-esteem study.

Signed: _____

Name: _____

Date: _____

Consent Form for Parents/Guardians and Students

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

I give permission for the researcher to have access to the results of standardised tests (e.g., P.A.T. maths and reading scores) administered by Wairau Intermediate School for the student _____, Room _____, who is under my guardianship, on the understanding that these results are completely confidential.

Signed: _____

Signed: _____

Name: _____

Name: _____

Date: _____

Date: _____

Ethnic Group

The ethnic group my child belongs to is _____

PARENT/GUARDIAN CHECKLIST - 1 ID No: _____

Please tick the box that is most usual for your child.

1	<p>When your child wants to talk to new people or kids she/he is not sure of:</p> <p><input type="checkbox"/> The child usually avoids this.</p> <p><input type="checkbox"/> The child can talk to them and can handle any uncomfortable feelings.</p>
2	<p>When your child feels angry:</p> <p><input type="checkbox"/> Things often work out wrongly.</p> <p><input type="checkbox"/> The child knows what to do to feel better.</p>
3	<p>When your child needs to talk to you about something tricky:</p> <p><input type="checkbox"/> He/she knows how to get the message across.</p> <p><input type="checkbox"/> Your child does not discuss the problem or it comes out wrongly.</p>
4	<p>When things go wrong:</p> <p><input type="checkbox"/> Your child knows how to keep things in proportion and keep a balanced view.</p> <p><input type="checkbox"/> Your child gets more upset that you would like.</p>
5	<p>When your child feels down:</p> <p><input type="checkbox"/> She/he doesn't really know what to do.</p> <p><input type="checkbox"/> The child can think of positive things to think or do to help.</p>
6	<p>When your child is criticised:</p> <p><input type="checkbox"/> Your child is self-critical and "tells him/herself off".</p> <p><input type="checkbox"/> Your child can use positive messages to make him/herself feel better.</p>
7	<p>When your child is teased:</p> <p><input type="checkbox"/> She/he knows what to say or do.</p> <p><input type="checkbox"/> She/he usually feels upset.</p>
8	<p>When something happens that worries your child:</p> <p><input type="checkbox"/> He/she doesn't feel good and/or worries quite a bit.</p> <p><input type="checkbox"/> The child knows of some ways to think or act that help.</p>
9	<p>When your child needs to talk to an adult about a problem:</p> <p><input type="checkbox"/> The child can get the message across.</p> <p><input type="checkbox"/> She/he can't seem to say what is meant.</p>

Appendix D

TEACHER INFORMATION PACKS

Information Sheet for Teachers

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

Researcher: Sheila Bagby
Telephone: 443-9691

Supervisors: Dr Jennifer Stillman and Dr Philip Voss
Department of Psychology
Massey University Albany
Telephone: 443-9770 or 443-9663

This sheet provides information about my Ph.D research concerned with self-esteem in young people. I have developed a self-esteem programme and accompanying workbook to teach skills in coping with negative emotions (such as learning to talk back to unreasonable thoughts), problem solving, and communication (such as introducing oneself and making conversation). This programme was piloted successfully in 1996.

Early in 1997 I hope to teach this programme, in a research capacity, to randomly selected classes from Wairau Intermediate School. Parent Information packs will be sent home and students who take part in the programme will be asked to complete some psychological survey questions before the programme begins. After that, these classes will be split into two groups, again by random (chance) selection. One group of classes (experimental) will be taught this programme and the other group (control) will continue with normal classes. It is necessary to have two groups completing the survey questions and only one completing the programme while one continues with normal classes, so that we can compare the results of the surveys between the two groups to see how useful the programme has been.

After the self-esteem programme is finished - it runs for about eighty minutes each week for 9 weeks - children who completed the first survey questions will be surveyed again. The survey will be done a third time, approximately 6 months later. This survey asks questions about how the child sees her or himself in terms of school work, friends, appearance, well-being and so on. At the same time as these surveys occur, class teachers will be asked to fill out a short rating scale about each student taking part, discussing things like communication skills, coping with negative emotions and problem solving. Parents will be asked to complete a similar form to be sent back to teachers, stored in a secure place, and collected by the researcher. Teachers whose classes are in the programme group will be given a training manual and asked to work with the researcher during the nine sessions. Control class teachers will continue normal classes and will only be involved in survey completion and collection of parental information.

I would ask, however, that no other self-esteem work is taught in any of the classes until after survey completion as this may confound results. If you have any questions, please ring me, or one of my supervisors, at the telephone numbers listed above.

Consent Form for Teachers

Research Project: A Programme for Promoting Self-Esteem in Young Adolescents

I have read and understood the Information Sheet for this study. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study as the class room teacher; to fill out the rating scales concerned; to collect parental information and to keep this in a secure place until it is collected by the researcher; and to participate in the programme as a teacher with the researcher, should my class be part of the experimental group.

Signed:

Name:

Date:

TEACHER CHECKLIST - 1

ID Number: _____

Please fill in the student's ID number, and tick the box that is most usual for the student.

1	<p>When the student wants to talk to new people or kids she/he is not sure of:</p> <p><input type="checkbox"/> The student usually avoids this.</p> <p><input type="checkbox"/> The student can talk to them and can handle any uncomfortable feelings.</p>
2	<p>When the student feels angry:</p> <p><input type="checkbox"/> Things often work out wrongly.</p> <p><input type="checkbox"/> The student knows what to do to feel better.</p>
3	<p>When the student needs to talk to you about something tricky:</p> <p><input type="checkbox"/> He/she knows how to get the message across.</p> <p><input type="checkbox"/> The student does not discuss the problem or it comes out wrongly.</p>
4	<p>When things go wrong:</p> <p><input type="checkbox"/> The student knows how to keep things in proportion to keep a balanced view.</p> <p><input type="checkbox"/> The student gets more upset that you would like.</p>
5	<p>When the student feels down:</p> <p><input type="checkbox"/> She/he doesn't really know what to do.</p> <p><input type="checkbox"/> The student appears able to think of positive things to think or do to help.</p>
6	<p>When the student is criticised:</p> <p><input type="checkbox"/> The student is self-critical or appears to "tell him/herself off".</p> <p><input type="checkbox"/> The student seems to use positive messages to make him/herself feel better.</p>
7	<p>When the student is teased:</p> <p><input type="checkbox"/> She/he knows what to say or do.</p> <p><input type="checkbox"/> She/he usually feels upset.</p>
8	<p>When something happens that worries the student:</p> <p><input type="checkbox"/> He/she doesn't feel good and/or worries quite a bit.</p> <p><input type="checkbox"/> The student knows of some ways to think or act that help.</p>
9	<p>When the student needs to talk to a parent or other adult about a problem:</p> <p><input type="checkbox"/> The student can get the message across.</p> <p><input type="checkbox"/> She/he can't seem to say what is meant.</p>

Appendix E

PROGRAMME SKILLS MEASURE

PROGRAMME SKILLS

ID Number: _____

Tick the box with the answer which is most like you.

1	<p>When I want to talk to new people or kids I'm not sure of:</p> <p><input type="checkbox"/> I usually don't.</p> <p><input type="checkbox"/> I talk to them and can handle my feelings.</p>
2	<p>When I feel angry:</p> <p><input type="checkbox"/> Things often work out wrong.</p> <p><input type="checkbox"/> I know what to do to feel better.</p>
3	<p>When I need to talk to my parents about something tricky:</p> <p><input type="checkbox"/> I know how to get the message across.</p> <p><input type="checkbox"/> I don't tell them or it comes out wrong.</p>
4	<p>When I feel bad:</p> <p><input type="checkbox"/> I don't really know what to do.</p> <p><input type="checkbox"/> I know positive things to think or do to help me.</p>
5	<p>When things go wrong:</p> <p><input type="checkbox"/> I know how to keep things in proportion to keep a balanced view.</p> <p><input type="checkbox"/> I get more upset than I would like.</p>
6	<p>When I feel bad about myself:</p> <p><input type="checkbox"/> I "tell myself off".</p> <p><input type="checkbox"/> I can use positive messages to make me feel better.</p>
7	<p>When I am teased:</p> <p><input type="checkbox"/> I know what to say or do.</p> <p><input type="checkbox"/> I usually feel upset.</p>
8	<p>When something happens that worries me:</p> <p><input type="checkbox"/> I don't feel good and I worry quite a bit.</p> <p><input type="checkbox"/> I know some ways to think or act that help.</p>
9	<p>When I need to talk to an adult about a problem:</p> <p><input type="checkbox"/> I can get my message across.</p> <p><input type="checkbox"/> I can't seem to say what I mean.</p>

Appendix F

ANOVA RESULTS

Table 19 ANOVA Results at pre-training (Measures transformed where relevant).

Measures	Main Effects		
	Group	Gender	2-Way Interactions
Programme Skills	$F(1,127) = 3.652, p=.058$	$F(1,127) = 0.123, p=.727$	$F(1,127) = 0.144, p=.705$
CDI	$F(1,127) = 0.104, p=.748$	$F(1,127) = 8.026, p=.005$	$F(1,127) = 1.122, p=.291$
Athletic Competence	$F(1,125) = 0.106, p=.746$	$F(1,125) = 25.39, p=.000$	$F(1,125) = 2.029, p=.157$
Behavioral Conduct	$F(1,125) = 2.747, p=.100$	$F(1,125) = 0.052, p=.819$	$F(1,125) = 1.619, p=.206$
Global Self-Worth	$F(1,125) = 1.938, p=.166$	$F(1,125) = 14.57, p=.000$	$F(1,125) = 2.548, p=.113$
Physical Appearance	$F(1,125) = 3.104, p=.081$	$F(1,125) = 16.38, p=.000$	$F(1,125) = 0.855, p=.357$
Scholastic Competence	$F(1,125) = 1.325, p=.252$	$F(1,125) = 0.075, p=.784$	$F(1,125) = 0.425, p=.516$
Social Acceptance	$F(1,125) = 1.800, p=.182$	$F(1,125) = 4.002, p=.048$	$F(1,125) = 1.228, p=.270$
Teacher Checklist	$F(1,127) = 6.188, p=.014$	$F(1,127) = 2.298, p=.132$	$F(1,127) = 0.826, p=.365$
Parent Checklist	$F(1,100) = 0.001, p=.982$	$F(1,100) = 1.012, p=.317$	$F(1,100) = 1.856, p=.176$

Table 20 REPEATED-MEASURES ANOVA RESULTS (Measures transformed where relevant).

Measures	Phase	Main Effects		
		Group	Gender	2-Way Interactions
Programme Skills	Post-training Follow-up	$F(1,125) = 5.987, p=.016$ $F(1,125) = 3.395, p=.068$	$F(1,125) = 2.671, p=.105$ $F(1,125) = 1.783, p=.184$	$F(1,125) = 5.455, p=.021$ $F(1,125) = 0.969, p=.327$
CDI	Post-training Follow-up	$F(1,125) = 0.015, p=.902$ $F(1,125) = 0.138, p=.711$	$F(1,125) = 0.347, p=.557$ $F(1,125) = 0.909, p=.342$	$F(1,125) = 3.548, p=.062$ $F(1,125) = 1.277, p=.261$
Athletic Competence	Post-training Follow-up	$F(1,122) = 2.736, p=.101$ $F(1,122) = 0.236, p=.628$	$F(1,122) = 3.911, p=.050$ $F(1,122) = 0.052, p=.821$	$F(1,122) = 8.236, p=.005$ $F(1,122) = 0.280, p=.598$
Behavioral Conduct	Post-training Follow-up	$F(1,122) = 4.162, p=.043$ $F(1,122) = 2.445, p=.120$	$F(1,122) = 4.281, p=.041$ $F(1,122) = 2.221, p=.139$	$F(1,122) = 0.003, p=.960$ $F(1,122) = 0.575, p=.450$
Global Self-Worth	Post-training Follow-up	$F(1,122) = 3.009, p=.085$ $F(1,122) = 0.000, p=.990$	$F(1,122) = 7.911, p=.006$ $F(1,122) = 0.756, p=.386$	$F(1,122) = 0.383, p=.537$ $F(1,122) = 3.127, p=.080$
Physical Appearance	Post-training Follow-up	$F(1,122) = 4.071, p=.046$ $F(1,122) = 1.216, p=.272$	$F(1,122) = 1.523, p=.219$ $F(1,122) = 0.129, p=.720$	$F(1,122) = 0.187, p=.666$ $F(1,122) = 3.148, p=.079$
Scholastic Competence	Post-training Follow-up	$F(1,122) = 0.807, p=.371$ $F(1,122) = 1.027, p=.313$	$F(1,122) = 0.506, p=.478$ $F(1,122) = 1.027, p=.313$	$F(1,122) = 0.567, p=.453$ $F(1,122) = 0.000, p=.998$
Social Acceptance	Post-training Follow-up	$F(1,122) = 0.443, p=.507$ $F(1,122) = 0.010, p=.919$	$F(1,122) = 3.029, p=.084$ $F(1,122) = 0.726, p=.396$	$F(1,122) = 0.249, p=.619$ $F(1,122) = 0.300, p=.585$
Teacher Checklist	Post-training	$F(1,127) = 2.960, p=.088$	$F(1,127) = 0.010, p=.908$	$F(1,127) = 0.180, p=.669$
Parent Checklist	Post-training Follow-up	$F(1, 96) = 0.098, p=.754$ $F(1, 96) = 0.509, p=.477$	$F(1, 96) = 0.861, p=.356$ $F(1, 96) = 0.927, p=.338$	$F(1, 96) = 1.366, p=.245$ $F(1, 96) = 1.122, p=.342$