

EVALUATION OF A GROUP TREATMENT OF URBAN BLACK ADOLESCENT
FEMALES EXPOSED TO VIOLENCE

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ABSTRACT**EVALUATION OF A GROUP TREATMENT OF URBAN BLACK ADOLESCENT
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The current study examined the effectiveness of GTREM, a group treatment for urban Black adolescent females exposed to violence on their symptoms of aggression, anger, and depression. Aggression was measured using the Aggression Questionnaire-AQ (Buss and Warren, 2000). Depressive symptoms were measured using the Reynolds Adolescent Depression Scale-2-RADS-2 (Reynolds, 2002). Participants consisted of 110 urban Black adolescent females selected from six DC Public and Public Charter Schools. Results confirmed that the G-TREM group treatment significantly decreased the externalizing behaviors of aggression and anger and the internalizing symptoms of depressive symptoms for urban black females exposed to violence. The results indicated that the differences in decrease of symptoms experienced by the G-TREM participants were meaningful. One final result showed that treatment was more effective as participants' grade level increased.

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CHAPTER 1. INTRODUCTION

Statement of the Problem

“The ultimate weakness of violence is that it is a descending spiral, begetting the very thing it seeks to destroy. Instead of diminishing evil, it multiplies it” (King, 1990, p. 594). It has been well-documented that exposure to violence continues to be a serious problem for adolescents in the United States (Osofsky, 2001). Violence exposure, which includes personally witnessing or directly experiencing a violent event, has been demonstrated to have a serious impact on the socioemotional health and behaviors of adolescents (Erickson & Megivern, 2006; Neal-Barnett, Contreras, & Kerns, 2001; Rosenthal, 2000). Through collaboration among the Community Connections agency, the DC Department of Mental Health (DMH), and the DC public schools, a grant, Project Hope, was funded by SAMSHA to provide services for urban adolescent females exposed to violence. Educational programs and a group intervention, Girls’ Trauma Recovery and Empowerment (G-TREM), were developed as a part of this grant. The focus of this study is to examine the effectiveness of the group treatment, GTREM, for urban Black adolescent females exposed to violence.

Recent surveys have revealed an increasingly disheartening picture of violence in the lives of American adolescents (Finkelhor, Turner, Omrod, Hamby, & Kracke, 2009; Pipher, 1994; Schwab-Stone, 1999; Tienda & Wilson, 2002; U.S. Surgeon General, 2001; Zimring, 1998). Homicide has become the leading cause of death among African-American youth ages 15 to 19 and the second leading cause of death among all youth in that age group (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002). Homicide is second only to motor vehicle accidents as a cause of death among all adolescents (Tienda & Wilson, 2002). Statistics suggest that more than 80% of urban adolescents have witnessed an assault, one-third to 40% have witnessed a

shooting or stabbing, and an alarming 22% to 23% have witnessed a murder (Schwab-Stone, 1999). According to a Bureau of Justice Statistics crime survey (2001), adolescents are twice as likely to be victims of violence as adults over the age of 25 years. Further, studies report that the current estimates of youth who are victims and/or witness violence are likely to be conservative and underrepresent the magnitude of the problem (Finkelhor, Ormrod, Turner, & Hamby, 2005).

Specifically, the prevalence rates of exposure to violence, including childhood physical and sexual abuse, of urban youth are at epidemic proportions (CDC, 2010; Fitzpatrick, 1997; Stein, Jaycox, Kataoka, Rhodes, Vestal, 2003; U.S. Surgeon General, 2001). Fitzpatrick (1997) has reported that in a group of 150 low-income urban African-American youth, 79% had been victims of violence and 87% reported witnessing at least one violent act. Weist and Acosta (2001) found that 47% of surveyed urban adolescent students reported a history of victimization and 77% reported witnessing violence. According to another survey, 88% of these urban adolescents reported that they had been exposed to violence (Gladstein, Rusonis, & Heald, 1992; McCart, Smith, Saunders, Kilpatrick, Resnick, & Ruggiero, 2007). Further, The Youth Risk Behavior Survey (2007), compiled by the Centers for Disease Control, indicates that the rates of violence exposure for youth residing in Washington, DC, consistently exceeds the national averages for their counterparts and continues to increase significantly. Compared to all youth in the United States, youth residing in Washington, DC had higher rates of suicide attempts, physical altercations and serious injuries due to fights, dating violence, carrying and threatening others with weapons (CDC, 2007).

Trauma in adolescence has been linked to long-term developmental disturbances, including disrupted moral development, missed developmental opportunities, delayed preparation for professional and family life, and disruptions in close relationships (Goenjian,

Stilwell, Steinberg, Fairbanks, Galvin, Karayan, & Pynoos (1999); Saltzman, Pynoos, Lane, Steinberg, & Aisenberg, 2001). Research has shown that youth who experience a traumatic experience after the age of 12 are more likely to display the clinical symptoms of PTSD which includes irritability and outbursts of anger for youth (Joop, 2001). Further, the impact of witnessed violence goes beyond the period of exposure affecting individuals into adulthood (Margolin & Gordis, 2000).

Exposure to violence also has been linked to a number of negative outcomes including violent behaviors, risky sexual behaviors, and delinquency. Socio-emotional difficulties including depression, PTSD, substance abuse, stress-related anxiety symptoms, and relational difficulties with trust and intimacy have been related to childhood abuse (Acosta, Albus, Reynolds, Spriggs, & Weist, 2001; Boxer, P., Sheffield Morris, A., Terranova, A., Kithakye, M., Savoy, S, & McFaul, A., 2008; Hall, 2000; Kendall-Tackett, Williams, & Finkelhor, 1993; McDonald & Richmond, 2008; Self-Brown, LeBlanc, Kelley, 2004). In addition to socioemotional issues, violence exposure has been linked to low school achievement and to an elevated level of anger, anxiety, externalizing behaviors such as aggression, antisocial behaviors, and alcohol use for adolescents (Boney-McCoy & Finkelhor, 1995; Erickson & Megivern, 2006; Schwab-Stone, 1995). Further, although research suggests that violent victimization has a greater negative impact on the development of youth than does witnessed violence (Martinez & Richters, 1993), the potential negative impact of witnessed violence should not be dismissed. According to the National Survey of Adolescents (2000), witnessing violence triples the risk of substance abuse after the effects of demographics, familial substance abuse, and victimization are controlled (Hanson, Saunders, Kilpatrick, & Resnick, 2000).

Studies have shown a gender-specific emotional response in witnessing and experiencing chronic violence that indicated adolescent females are especially vulnerable to violence (Cooley-Strickland, Ouille, Griffin, Stuart, Bradshaw, Furr-Holden, D., 2009; Gladstein et al., 1992; Schwartz & Kowalski, 1991). Females exposed to violence experience greater levels of internalizing behaviors including depression and PTSD than their male counterparts (Fitzpatrick, 1993; Fitzpatrick & Boldizar, 1993). Further, adolescent females exposed to violence were more likely to abuse substances, carry weapons, and experience school-related behavioral problems than their male counterparts (Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F.J., 2001; Titus, Dennis, White, Scott, & Funk, 2003).

Despite the increasing problem of violence in urban areas, there has been only limited attention to the psychological impact and treatment of victimization and even less attention to the effects of witnessing violence (Jacobson, Koehler, and Jones-Brown, 1987; Maholmes & Printz, 2009; Warner & Weist, 1996). “Research in the field of community violence is in its infancy” (Rosenthal, 2000). “The mental health disciplines are presently limited in both their knowledge of and capacity to respond to this phenomenon” of community violence (Lorion & Saltzman, 1993, p.56).

The relatively widespread exposure to violence in adolescence indicates the need to further examine its negative psychological sequelae and treatment options. Among urban youth, the psychological sequelae of exposure to violence are likely to go untreated due to limited resources and under- utilization of mental health care (Ozer & Weinstein, 2009; Stein et al. (2003); Warner & Weist, 1995).

Notably, growing evidence supports the effectiveness of group therapeutic approaches for the treatment of traumatized individuals, especially adolescents, because of the benefits of this

modality (Foa, Keane, & Friendman, 2000). Group approaches for adolescents are beneficial in many areas including the use of the adolescent peer group to help with self and other judgments about normality, emotional support and affect regulation, and promotion of developmental recovery (Foa et al., 2000). However, there are few interventions geared specifically toward reducing the effects of witnessing or experiencing violence for adolescents (Erickson & Megivern, 2006; Warner & Weist, 1995; Weist, Acosta, & Youngstrom, 2001). Further, most studies of violence exposure have presented results from single-group pre-post designs where comparison groups were not included (Foy, Eriksson, & Trice, 2001). The developers of the group intervention, GTREM, have reported that GTREM addresses effects of violence exposure and shares many of the characteristics of effective trauma focused groups including cognitive restructuring, psychoeducation, and coping skills training (Harris & Fallot, 2001; Fallot & Harris, 2002; Foy, Eriksson, & Trice, 2001). The GTREM developers also have reported that this intervention has the additional advantages of gender specificity and cultural competence unlike other group interventions for traumatized adolescents (Harris & Fallot, 2001).

The costs of the lack of effective interventions for adolescents who have suffered violence exposure include increased likelihood of revictimization, reenactment of violence, psychosocial maladjustment, and adolescents who develop into dysfunctional adults (Finkelhor et al., 2009). Further, in some communities the initial costs of violence exposure occurring at the individual level multiply into epidemic proportions resulting in communities in crisis. The direct costs of victimization in terms of financial loss and physical injury, the high rate of violent victimization in adolescence, and the pervasive effects of adolescent violent victimization in later life strongly suggest the need for interventions to reduce violent victimization during adolescence (Menard, 2002).

In sum, although the prevalence of mental health correlates of adolescents' exposure to violence have been studied, mental health clinicians' understanding of effective treatment approaches for urban Black adolescent females exposed to violence remains limited.

Purpose of the Study

The goal of this study is to examine the effectiveness of a group treatment approach for urban adolescent females exposed to violence. The purpose of this study was to determine if the group intervention, Girls' Trauma Recovery and Empowerment (GTREM), assisted in averting psychological distress, risk-taking, and aggressive behaviors of urban Black adolescent females. Specifically, it will a) examine the effects of the group intervention, G-TREM, on the externalizing symptoms of urban Black adolescent females exposed to violence; and b) examine the effects of the group intervention, G-TREM, on the internalizing symptoms of urban Black adolescent females exposed to violence.

Research Questions and Hypotheses

The specific research questions and hypotheses that were tested in this study are the following:

Question 1: Does the G-TREM group intervention decrease aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females?

Hypothesis 1: The G-TREM group intervention will decrease the levels of aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females as measured by the Aggression Questionnaire.

Question 2: Does the G-TREM group intervention decrease depressive symptoms (internalizing symptoms) in urban Black adolescent females.

Hypothesis 2: The G-TREM group intervention will decrease the levels of depressive symptoms (internalizing symptoms) in urban Black adolescent females as indicated by the Reynolds Adolescent Depression Scale-2 (RADS-2).

Definition of Terms

Aggression – “Aggression” is defined as hostile or violent behavior or attitudes (“Aggression,” 2006). The expression of aggression can manifest verbally, physically, emotionally, and socially. Aggression in adolescents has been referred to by a variety of terms, including delinquency, perpetration of violence or physical force, oppositionalism, antisocial behavior, hostility, argumentative speech, and anger and aggressive behaviors. For the purposes of this study, the term aggression will be used as an indicator of these terms.

Black – Black will be used to describe a member of a racial group of African descent; an African-American. For the purposes of this study, the terms Black and African-American will be used interchangeably.

Culture – Culture will be defined as the customary beliefs, social forms, and material traits of a racial, religious, or social group; the characteristic features of everyday existence shared by people in a place or time. For the purposes of this study, the term culture will be used to describe the specific beliefs, social forms, and material traits of adolescents residing in Washington, DC. The developers of G-TREM created a culture specific intervention by including the beliefs (perceptions of violence), language (i.e. names in G-TREM vignettes), customs (G-TREM activities), and material traits of urban Black adolescent females residing in Washington, DC. Focus groups were used to obtain this information from the target population and clinicians providing treatment to the target population in Washington, DC (Harris, 2004, 2005).

Depression – Depression will be defined using the associated symptoms characteristic of depression including sadness, irritability, dysphoric mood, anhedonia or negative affect, social isolation, low motivation, negative self-evaluation, worthlessness, hopelessness, and somatic complaints (Reynolds, 2002).

G-TREM – Girls’ Trauma Recovery and Empowerment Model- G-TREM, also known as the Love and Life Group, is a group intervention designed to address adolescent females’ violent victimization and assist in trauma recovery (Harris, 2000, 2004, 2005; Harris & FalLOT, 1998).

Externalized behaviors–Externalized behaviors are an individual’s reactions to a stressor (i.e. violence) that manifests in external ways or through an individual’s actions. Externalizing behaviors include aggression, conduct problems, and delinquent behaviors (Neal-Barnett et al., 2001).

Internalized symptoms – Internalized symptoms are an individual’s reactions to a stressor (i.e. violence) that manifests in internal ways or within the individual. Internalizing problems include anxiety, depression and symptoms of posttraumatic stress disorder (PTSD) (Neal-Barnett et al., 2001).

Urban- Urban will be used to describe individuals residing in a city in the United States.

Violence- Violence is defined as the threatened or actual use of physical force or power against another person, against oneself, or against a group or community that either results or is likely to result in injury, death or deprivation (CDC, 1998).

Violence exposure – Violence exposure will be defined as witnessing or experiencing violence (Fallot & Harris, 2002).

Youth – Youth will be used to define the period of human life between childhood and maturity.

CHAPTER 2. REVIEW OF THE LITERATURE

Exposure to Violence

Experiencing or witnessing violence continues to be a major problem for urban Black adolescents. Adolescents who are exposed to violence are at an increased risk for experiencing socio-emotional difficulties and antisocial behaviors. However, there are few therapeutic interventions for treating urban adolescents exposed to violence (Maholmes & Printz, 2009). The lack of effective treatment for adolescents who are exposed to violence are psychosocial and community costs.

Rapidly growing numbers of people in urban areas are being victimized by and exposed to violence (CDC, 2010; Warner & Weist, 1995). Despite recent declines in the violent crime rate in this country, violence and the threat of violence remain a central feature in the lives of many African-American children (Neal-Barnett et al., 2001). More than 80% of urban adolescents have witnessed a physical assault (Schwab-Stone, 1999). In fact, children's experience with violence, either as victims or as witnesses, has been described as a public health problem of epidemic proportions (Margolin & Gordis, 2000). Homicide has become one of the top two leading causes for death for adolescents between 15 to 19 years and the leading cause of death of African-American youth in the same age group (Tienda & Wilson, 2002).

Exposure to violence can occur either by being the victim of an act or by witnessing a violent act (Neal-Barnett et al., 2001). Many children experience or observe violence within the confines of their own homes or within their own neighborhoods. Data suggest that in urban neighborhoods, one-third or more of prepubescent and adolescent children have been directly victimized, and almost all children have been exposed to community violence (Margolin & Gordis, 2000). Low-income urban youth are more likely than their upper-middle-class

counterparts to experience community violence (Lauritsen, 2003). Boney-McCoy and Finkelhor (1995) revealed in a study that over one-third of their sample had been victims of assault. Fitzpatrick and Boldizar (1993) found that approximately 70% had seen someone suffer a gunshot wound and 43% had witnessed a murder. Buka and colleagues (2001) concluded that the reported rates of adolescents who witness community violence are “disturbingly high” among ethnic minorities and urban residents. Although not the direct targets of violence, children who witness family and community violence also suffer negative consequences (Osofsky, 2003). The relatively limited research on witnessing violence indicates long-term developmental effects on children exposed to violence at the individual, family, school, neighborhood, and community levels (Carter, Weithorn, & Behrman, 1999; Kracke & Hahn, 2008). Growing evidence links children’s witnessing violence to a wide range of psychological, emotional, behavioral, social, and academic problems (Kracke & Hahn, 2008; Margolin & Gordis, 2000; Straus, 1994).

Violence Exposure and Mental Health Needs among DC Youth

Specifically, the rates of violence exposure for youth residing in Washington, DC, consistently exceeded the national averages for their counterparts (CDC, 2007). Compared to all youth in the United States, Washington, DC youth had significantly higher rates of suicide attempts, greater fear of safety at school, more concerns about being threatened with weapons, physical fighting and serious injuries due to fights, dating violence, and instances of carrying weapons. The teen death rate by accident, homicide, or suicide for DC adolescents ages 15 to 19 was twice the national average of their counterparts (CDC, 2007). Elevated exposure to violence in Washington, DC places youth at a significantly higher risk for trauma and victimization than their counterparts nationally. The problems posed by children’s exposure to violence not only

affect children's physical health and safety, but also their psychological adjustment and social relations (Margolin & Gordis, 2000).

The rates of aggression and violence for youth residing in Washington, DC continue to increase at alarming rates. The 2007 Youth Risk Behavior Survey (YRBS), compiled by the Centers for Disease Control (CDC) indicated that 43% of DC high school students reported that they were in a physical fight one or more times, 9.6% reported that they were injured while engaging in a physical fight, and 19.8% reported engaging in a physical fight while on school property during the preceding 12 month period. These statistics were compared to the national averages of their adolescent counterparts which were 35.5%, 4.2%, and 12.4% respectively. In addition, 17.1% of DC adolescents reported that they were hit, slapped, or physically hurt by a boyfriend or girlfriend while only 9.9% of the national adolescent sample reported experiencing the incident. According to the YRBS (2007), female adolescents residing in Washington, DC were significantly more likely to have been forced to have sexual intercourse against their will than their male counterparts after accounting for the increases in rates of the DC averages compared to the national averages (CDC, 2007).

According to national statistics, DC adolescents continue to struggle with depression and were at a high risk for suicide (CDC, 2007). Specifically, female adolescents residing in Washington, DC were significantly more likely to feel sad or hopeless almost every day for two or more weeks in a row than their male counterparts. Although the rates at which DC high school students reported feeling sad or hopeless almost every day for more than two weeks (26.8%) were slightly lower than their national counterparts (28.5%), the rates at which DC high school students reported making a suicide attempt (12.2%) and reported that the attempt was serious enough to warrant medical attention (4.0%) were twice as high as their national

counterparts (6.9% and 2.0% respectively). The results of the YRBS (2007) indicated that DC high school students were more likely to engage in suicidal ideation, plan, and suicide attempts than a typical high school student even if the prevalence rates for depression were similar.

Children and adolescents in Washington, DC live in a city where persistent poverty, chronic violence, and unemployment exceed the national average (CDC, 2007; Giorgis & Roberts, 2001). Forty-nine percent of school-aged youth in DC are eligible for free lunch. Thirty-three percent of the population of youth 18 years and younger in DC live below the poverty level and over 54% of youth reside in high-poverty neighborhoods. Additional environmental factors place children in the District of Columbia at increased risk for mental health problems. These factors include high/elevated exposure to lead levels, increased exposure to aggression and violence, increased risk of substance abuse, particularly marijuana, and high risks of depression and suicidal behaviors (CDC, 2003; CDC, 2007).

Further, the public educational system in Washington, DC continues to be plagued with problems as the system has been rated as one of the lowest performing school districts in the country and the high school drop-out rate continues to exceed the national average (NCES, 2010; CDC, 2007). The most frequently reported major presenting problems of students as indicated by the DC Department of Mental Health School Mental Health Program included depression, aggression, disruptive behavior, and anger (Acosta Price, Mack, & Spencer, 2005; Parks, B., Dubenitz, J., & Sullivan, M. 2008). Thus, these presenting problems are the clinical domains that have demanded attention, not only of clinicians and schools but community stakeholders and policy makers in Washington, DC.

Research on rates of violent criminal activity, child victimization, and families living in poverty in Washington, DC suggested the critical necessity for mental health programs to

provide interventions and support services that target violence exposure, abuse, neglect, and their implications. However, dependence on a DSM-IV TR (2000) diagnosis for third party billing for treatment presented a potential barrier for services for adolescents. Studies of trauma exposure revealed that the many urban adolescents who have experienced or witnessed a traumatic event did not meet the criteria for a particular DSM diagnosis. Consequently, these adolescents failed to meet the eligibility requirements for most outpatient mental health services resulting in epidemic numbers of trauma exposed adolescents without supports or services (Acosta Price et al.; Breslau, Wilcox, Storr, Lucia, & Anthony, 2004)

Violence Exposure and Black Adolescent Female Development

Adolescence is a developmental period, typically ages 13-21 between childhood and adulthood, during which certain physical, cognitive, non-cognitive, legal and educational events occur (Jones, 1989). Western psychologists usually describe adolescence as a period during which an individual strives for independence from parents and experiences sexual and career adjustment. The developmental tasks that are considered central in theories of adolescence include achieving greater autonomy from parents, engaging in dating behaviors, and acquiring skills required in adulthood (Montemayor, Adams, & Gullotta, 2000). For Erikson, these developmental tasks are supplemental to the quintessential task of adolescence- the formation of identity (Montemayor et al., 2000).

Researchers have noted that the actual time span for development during adolescence varies within cultures and socioeconomic group (Lerner, 1999). There is evidence that minority group status and associated disadvantages generate experiences and identity conflicts specific to Black adolescents (Jones, 1989). One trend in the sparse literature has been to challenge the deficit-pathology model and explore the mechanisms underlying “positive” Black adolescent

psychological and social functioning (McKenry, Everett, Ramseur, & Carter, 1989). This “emergent” model views the positive and adaptive features of Black youth as products of an interaction between their African cultural heritage and United States environment (McKenry et al., 1989). Although Black adolescents account for a significant and rapidly growing segment (17.6%) of the Black American population, there have been few empirical studies or theories on Black adolescent female development to date (McKenry et al., 1989; McLoyd & Steinberg, 1998).

The dominant paradigm for adolescent development appears to be a deficit model for Black adolescents and fails to include the effects of important historical social factors (McAdoo & McAdoo, 1985). This paradigm assumes that, at critical developmental periods, Black children lack quantities and qualities of stimulus inputs (i.e., linguistic, visual, tactile, psychomotor experiences) which are essential for normative development (McAdoo & McAdoo, 1985). Consequently, this paradigm fails to accurately predict Black adolescents’ development into adulthood and fails to explain the adequate social adjustment demonstrated by many Black adults. Bronfenbrenner (as cited in McAdoo & McAdoo, 1985) astutely explains that the typical deficit-oriented comparative study investigates race merely as a “sign on the door of an environmental context that leaves nature unspecified” which results in inferences that are “little more than speculation” (McAdoo & McAdoo, 1985, p. 109).

Strength-based models of Black adolescent development explore the mechanisms behind positive Black adolescent development. Emergent models of Black adolescent development considers cultural heritage as a critical aspect of development (McKenry et al., 1989). Therefore, it is clear that research on Black adolescent development, especially social development, is incomplete without attention to culture (Barbarin & Soler, 1993). Aspects of identity, including

cultural identity, become more significant during adolescence (Whaley, 1993). Multiple ecological dimensions or social contexts must be considered when observing the urban Black adolescent including the community and the social structure (McAdoo & McAdoo, 1985; Sanders-Phillips, 2002).

When including race and socioeconomic status factors into the existing developmental paradigm, adolescence is usually perceived as ending at about age 18 within the lower socioeconomic Black culture. This may be attributed to the conditions that Black adolescents of a lower socioeconomic status confront. In homes of lower socioeconomic statuses, adolescent girls tend to assume many adult responsibilities at an early age. There are cumulative effects from multiple experiences of poverty, violence, racism, and oppression. These experiences reinforce feelings of alienation, helplessness, and powerlessness in society potentially impacting their responses to violence (Sanders-Phillips, 2002).

A developmental framework is critical in assessing the impact of victimization in children and adolescents (Gil, 1996). Finkelhor (1995) proposed that the victimization children suffer “depends on their age and level of development in a very basic way”. He also suggested that “how children respond to victimization depends on stage specific capacities and vulnerabilities” (Finkelhor, 1995). Children are quite vulnerable to the effects of violence because violence exposure may alter the timing of typical developmental trajectories (Boney-McCoy & Finkelhor, 1995). Specifically, violence initially may result in primary effects, such as anxiety, depression, or Posttraumatic Stress Disorder (PTSD) symptoms. This symptomatology causes secondary reactions by disrupting children’s progression through age-appropriate developmental tasks. Exposure to violence can result in regressive symptoms, such as decreased verbalization or separation anxiety (Osofsky, 1995). These symptoms secondarily may affect

children's socialization skills or concentration ability. Further, at a time when children may have difficulty with typical developmental tasks, exposure to violence can result in having to manage adult issues (Margolin & Gordis, 2000).

Due to the developmental changes that occur in adolescents' psychology, they may suffer greater consequences of being exposed to violence as compared with younger children (Rosenthal, 2000). Among traumatized adolescents, there are frequently conflicts regarding dependency issues. These dependency issues manifest into excessive dependence (i.e. difficulties leaving home) or independence (i.e. sexual promiscuity) from parents and guardians. Adolescents who have witnessed or experienced trauma also show elevated levels of substance abuse, delinquency, and risk-taking that may parallel the event they witnessed (Pynoos & Nader, 1990).

From a developmental psychopathology perspective, the effects of violence can only be understood within the context of the changing child and the child's changing environment (Margolin & Gordis, 2000). The child's experience of violence is not only determined by the nature of the violent events but by the child's ability to appraise and understand violence, to respond to and cope with danger, and to garner environmental resources that offer protection and support. These responses are inextricably linked to the child's general cognitive, emotional, and physical capabilities (Finkelhor & Kendall-Tackett, 1997; Margolin & Gordis, 2000).

At different stages, children face different developmental challenges that can be disrupted by violence. Although the normal development of Black adolescents may tend to vary due to culture, the basic developmental tasks remain similar to their White counterparts. Therefore, an understanding of the sequelae of exposure to violence must be informed by an understanding of general adaptation across developmental stages. For instance, violence can destroy the essential

assumptions critical to the developmental task of learning to trust others and form secure attachment relationships (Janoff-Bulman, 1992). These events may result in difficulties in maintaining relationships throughout life.

In adolescence, the increasing need for independence may garner additional exposure to violence or abuse for adolescents living in a family that is unable to negotiate this transition from dependence. Violence may exacerbate adolescents' risk-taking and escape behaviors including running away, substance abuse, and sexualized behaviors (Rossman & Rosenberg, 1998). These behaviors may increase the likelihood of additional psychological or health problems.

Adolescents may also begin to assume an active role in violence (Rossman & Rosenberg, 1998). Further, although children exposed to violence may have a greater need for nurturance than children without such stressors, they generally have less access to social supports from their caretakers highlighting the need for specialized interventions and supports for this population.

Despite the significance of environmental variables in violence exposure, there has been little attention given to culture. Culture influences norms, beliefs, and values surrounding the use of violence, expectations and reactions by caretakers of victimized children, and the way that children perceive and comprehend their own experiences. Sternberg (1993) demonstrated that attending to culture delineates the different pathways by which violence affects children. Factors within this realm must be taken into consideration in an analysis of children's exposure to violence (Dawes & Donald, 2000). However, there have been only a few studies that have examined the impact of violence in ethnically diverse samples (Dawes & Donald, 2000; Lindahl & Malik, 1999; McCloskey, Figueredo, Koss, 1995; Okeefe, 1995).

Psychological Distress

Research indicates that Black children living in urban environments tend to have a number of problems including internalizing and externalizing disorders, aggression, impulsivity, attention deficits and hyperactivity, substance abuse, teenage pregnancy, self-esteem issues, and low academic achievement (Barbarin, 1993; Sewell, Farley, Manni, & Hunt, 1982; Whaley, 1993). Ladner (as cited in Brown, Powell, & Earls, 1989) noted that Black adolescents growing up in the inner cities have similar concerns, fears, and joys to those of other social class and racial groups. However, there are other concerns thrust upon them through environmental circumstances, including violence exposure, superimposing on them early emotional development that often exceeds their chronological age.

Internalizing Symptoms

Violence exposure can be interpreted by adolescents to mean that the world is unsafe and that they are unworthy of being kept safe. These perceptions can contribute to negative self-perceptions and internalizing problems. Internalizing problems include anxiety, depression and symptoms of posttraumatic stress disorder (PTSD) (Neal-Barnett et al., 2001). Research suggests that both witnessing and being a victim of community violence may put adolescents at risk for increased anxiety and depressive symptoms (Lynch, 2003; Neal-Barnett et al., 2001). Exposure to recurring community violence during late adolescence has been linked to a number of psychological trauma symptoms including anger, anxiety, depression, and dissociation (Rosenthal, 2000).

Depression and anxiety are two psychological trauma symptoms that have frequently been identified in relation to violence exposure in inner-city adolescents (Lubin & McCollum, 1994; Mazza & Reynolds, 1999). Schwab-Stone (1995) found that exposure to violence

predicted a depressed and anxious mood among adolescents. Several studies have indicated that violence exposure and victimization were related to anxiety and depression among 14 to 19 year old adolescents (Singer, Anglin, Song, Lunghofer, 1995; Hilton, 1992). Fitzpatrick and Boldizer (1993) found that violent victimization was related to depression among African-American youth. Exposure to aggression and violence has been associated with PTSD symptoms in adolescents (Margolin & Gordis, 2000). Malmquist (1986) documented flashbacks, hypervigilance, nightmares, and recurrent thoughts in his sample of children exposed to violence. Pynoos and Nader (1988) reported that children exposed to violence experienced increased anxiety, anger, feelings of vulnerability, and constricted affect and range of emotion. Further, the rates at which DC youth reported feeling sad or hopeless almost every day for at least two weeks continued to increase significantly in relation to urban youth in the United States (CDC, 2009).

Studies of African-American youth have found symptoms consistent with clinical descriptions of traumatized children. African-American youth exposed to violence are more likely to report PTSD symptomatology, depression, anxiety, dissociation, and anger. They are also more likely to report feelings of hopelessness, less purpose in life, and a belief that they will die violently (Neal-Barnett et al., 2001). Young Black females tend to exhibit more difficulties related to anxiety and depressive disorders than their male counterparts and this gender discrepancy increases with age (Barbarin & Soler, 1993). Therefore, violence exposure would likely exacerbate their anxiety and depressive symptomatology.

Externalizing Behaviors

Research on the consequences of violence exposure has increasingly focused on externalizing behaviors. Externalizing behaviors include aggression, conduct problems, and delinquent behaviors (Neal-Barnett et al., 2001). Externalizing behavior rates including aggression, fighting, weapon use, and substance use among DC youth consistently exceed the national averages of their counterparts (CDC, 2009; CDC, 2007). Traumatized adolescents may engage in acting out and self-destructive behaviors such as substance abuse, promiscuity, delinquent and aggressive behaviors, and life-threatening reenactments (Lynch, 2003, Pynoos & Nader, 1988). Adolescents may engage in risk-taking behaviors as a form of reenactment of the trauma or as a defense mechanism used to distract them from painful memories and anxiety (Neal-Barnett et al., 2001). Black adolescent females tend to mask their depressed feelings with externalizing behaviors including minor delinquency, somatic symptoms, and sexual promiscuity (Gibbs & Hines, 1989).

Research has generally demonstrated a relationship between violence exposure and externalizing behaviors including aggression (Schwab-Stone, 1999). Victimization or witnessing of community violence is positively related to fighting and weapon carrying (Neal-Barnett et al., 2001). Increasingly, studies are finding that violence exposure is more significantly related to aggression and acting out than internalizing symptoms such as depression and anxiety (Martinez, 2001). Researchers have suggested that violence-exposed children may experience distress in the form of internalizing symptoms, but attempt to mask them in order to avoid appearing weak and vulnerable in a hostile environment (Neal-Barnett et al., 2001).

Several studies have documented the link between exposure to community violence and aggressive behavior. Miller, Wasserman, Neugebauer, Gorman-Smith, and Kamboukos (1999)

found that exposure to community violence was associated with increases in parents' reports of antisocial behavior among children. Violence exposure was positively related to self-reported violent behavior among urban adolescent females (Neal-Barnett et al., 2001). DuRant, Pendergrast, & Cadenhead (1994) found that among urban Black adolescents, exposure to violence and victimization were associated with self-reports of violence.

Treatment for Violence Exposure

The high incidence of violence exposure among adolescents highlights the need for providing trauma-exposed adolescents with specialized mental health services, given the recent trend toward developing trauma-focused and empirically validated treatment protocols (Rozie-Battle, 2002; Saltzman et al., 2001). Current popular adolescent prevention programs with an educational approach focus on the development of negotiation, communication, anger management, problem-solving, and coping skills (Eron, Gentry, & Schlegel, 1994; Valentine Foundation, 1999). These programs reinforce the idea that violence is an unacceptable form of resolving conflict and assume that individual skill development will help reduce violence and violent interactions (Cunningham & Henngeler, 2001; DeYoung, & Corbin, 1994; Eron et al., 1994; Horowitz, Putnam, Noll & Trickett, 1996).

Growing evidence supports the effectiveness of group-based therapeutic approaches for the treatment of traumatized individuals because of the benefits that this modality offers (Foa et al., 2000; Foy et al., 2001). Group approaches for adolescents are beneficial in many areas including the use of the adolescent peer group to help with self and other judgments about normality, emotional support and affect regulation, and promotion of developmental recovery (Foa et al., 2000; Kruczek & Vitanza, 1999). Group counseling can be an effective vehicle for retaining African-American females in treatment and has been identified as a practical

intervention in empowerment (Brown et al., 1989). Dyson (1990) reported that a school-based group therapy program resulted in improved academic and behavioral adjustment for African-American adolescents who had been chronically exposed to violence.

However, there are few interventions geared specifically toward reducing the effects of witnessing community violence. The empirical literature on group therapy for children exposed to trauma is sparse and almost exclusively concerned with child sexual abuse survivors. In general, researchers have concentrated more on assessing the correlates and sequelae of violence than on validating the effectiveness of treatment programs for violence exposure or analyzing violence prevention programs for youth (Acosta et al., 2001; Kazdin & Weisz, 1998). In fact, there has been a decline in the relative percentage of studies focused on treatment of violence-related problems among youth (Acosta et al., 2001). Further, the few randomized controlled studies available that assess treatments for violence exposed youth have presented results from single group pre-post designs (Foy et al., 2001).

Researchers have also identified the factors of consumer involvement and the integration of consumer feedback in treatment design as critical elements in an effective intervention for children exposed to violence (Cohen, 2002). Specifically, Cohen emphasized the importance of integrating developmental and cultural perspectives in treatment models (2002). An additional critical element is therapists' assistance with the construction of treatment models targeting violence exposure. The inclusion of this factor will increase the likelihood of therapists' fidelity and adherence with the treatment model (Cohen, 2002; Hill, 2002).

There are several challenges to providing appropriate services to adolescents exposed to community violence. One challenge involves the need for systematic, accurate, and efficient means of identifying youths with histories of trauma. Traumatized youths generally do not seek

professional assistance and these youths are rarely identified and referred by school personnel (Lerner, 1999; Saltzman et al., 2001). An additional challenge is the dependence on a diagnosis in order to bill a third party for treatment. Epidemiological studies of trauma exposure among urban youth have found that most youth who have experienced a traumatic event do not meet the diagnostic criteria for PTSD. As a result, these traumatized children fail to meet the eligibility criteria for most outpatient mental health services (Breslau et al., 2004; Johnson, 1993). Further, the recruitment and retainment of traumatized youths in appropriate treatment presents another challenge to the provision of services for adolescents exposed to community violence. Services must be easily accessible, engage the adolescent, and minimize attrition (Saltzman et al., 2001).

The purpose of the current investigation is to examine the effectiveness of increased knowledge of trauma in a group treatment for urban Black adolescent females to avert reenactment, psychological distress, and risk-taking behaviors. Specifically, I examined the effects of a group intervention for urban Black adolescents females (G-TREM) exposed to violence on their externalizing symptoms of aggression and antisocial behaviors. Next, I examined the effects of the group intervention for urban Black adolescent females (G-TREM) exposed to violence on their internalizing symptoms of depression.

CHAPTER 3. RESEARCH DESIGN AND METHODS

Research Design

The current research utilizes existing data sets compiled by the District of Columbia Department of Mental Health School Mental Health Program during the years of 2004 to 2006. This is an experimental design consisting of pre-test, post-test, and control groups. This research study assessed the effects of a group intervention on the internalizing symptom of depression in urban Black adolescent female students. This study also examined the effects of a group intervention on the externalizing behavior of aggression in urban Black adolescent female students.

Sample

The sample consisted of 110 female participants who ranged in age from 14 to 20. Participants were in grades 9 through 12 and represented six different public and public charter schools located in the Northeast, Northwest, and Southeast corridors of Washington, DC.

Treatment (Experimental) Group

All fifty-six treatment participants were identified as Black or African-American. Their ages ranged from 14 to 20 and included the following: eight 14 year-olds, twenty-five 15 year olds, sixteen 16 year-olds, two 17 year-olds, four 18 year olds, and one 20 year-old ($M = 15.52$, Median = 15, Mode = 15). The treatment participants represented grades ranging from 9 to 12 with twenty 9th graders, twenty-two 10th graders, and eleven 11th graders, and three 12th graders. The participants represented six different public and public charter schools in the District of Columbia with 4 participants from Fletcher-Johnson Educational Center, 8 from Booker T. Washington Public Charter School, 6 from Friendship-Edison Public Charter School,

5 from Caesar Chavez, 19 from Spingarn High School, and 14 from Eliot JH School (See Table 4.1).

Waiting List Control Group

The fifty-four waiting list control group participants were identified as Black or African-American. Their ages ranged from 14 to 20 and included the following: nine 14 year-olds, twenty-two 15 year olds, sixteen 16 year-olds, two 17 year-olds, and five 18 year olds. ($M = 15.48$, Median = 15, Mode = 15). The treatment participants represented grades ranging from 9 to 12 with twenty-two 9th graders, eighteen 10th graders, and eleven 11th graders, and three 12th graders. The participants represented six different public and public charter schools in the District of Columbia with 4 participants from Fletcher-Johnson Educational Center, 8 from Booker T. Washington Public Charter School, 5 from Friendship-Edison Public Charter School, 5 from Caesar Chavez, 20 from Spingarn High School, and 12 from Eliot JH School (See Table 4.1).

Table 4.1: Demographic Information for Each Group of Participants

Variable	Category	Waiting List Control Group	Treatment/ Experimental Group
Total		54	56
Age	14	9	8
	15	22	25
	16	16	16
	17	2	2
	18	5	4
	19	0	0
	20	0	1
Grade	9	22	20
	10	18	22
	11	11	11
	12	3	3
School Code	Fletcher– Johnson	4	4
	Booker T. Washington	8	8
	Friendship– Edison	5	6
	Caesar Chavez	5	5
	Spingarn	20	19
	Eliot JH	12	14

These adolescent females had histories of violent victimization and/or witnessing violence. Participants did not need to meet criteria for any DSM-IV diagnosis. The students may have referred themselves or have been referred by school staff (teachers, counselors, administrators) or DC Department of Mental Health (DMH) clinicians for services. Participants attended high schools that included existing DC Department of Mental Health programs, which offered mental health services in the school setting. Prospective participants were identified primarily through trauma sequelae such as hostility, depression, anxiety, and only secondarily through documented abuse and victimization histories.

The study sample consisted of two treatment groups: Treatment I (Girls' Trauma Recovery and Empowerment Model – G-TREM intervention) and Treatment II (waiting-list control group). Participants in the control group received violence exposure treatment following the completion of the first group. Participants were randomly assigned to one of the two possible treatment groups.

Inclusion criteria were that adolescents were urban Black females between the ages of 14 and 18 years meeting the stated violence exposure history prerequisite.

Exclusion criteria included adolescents other than urban Black adolescents between the ages of 14 and 18, who did not have a history of violence exposure.

Power Analysis

Results of the power analysis implemented for this research indicated that to achieve a medium effect size (power of .80.) data should be collected from a sample of 102 participants (Cohen, 1992).

Study Procedures

Community Connections, the grant funded agency on the project in Washington, DC, worked in collaboration with the District of Columbia Department of Mental Health School Mental Health Program (DMH SMHP) to collect data for the research. As a part of the SAMHSA funded DC Trauma Collaboration Study to understand the impact of violence, the Girls' Trauma Recovery and Empowerment Model (G-TREM-Love and Life) groups were implemented in several public and charter high schools in the District of Columbia. G-TREM was offered in high schools that included DC Department of Mental Health programs that offered mental health services in the school setting. The DC Department of Mental Health school-based clinicians co-led the G-TREM groups on site at the schools. The DMH school-based clinicians received training (one week in duration) on the G-TREM intervention from clinicians at Community Connections. Noteworthy was the fact that many of the DMH clinicians had been active participants in the construction of the GTREM intervention and revision of the G-TREM manual.

Students were introduced to G-TREM through meetings with their DMH clinicians. Clinicians screened the referred students by conducting a clinical interview and using the DMH school-based intake form. Students who positively endorsed responses to the items for Traumatic Events on the intake form, which included witnessing/experiencing violence and Sexual/Physical Abuse/Assault, were considered candidates for the G-TREM intervention. Clinicians conducted a pre-group clinical interview of the selected students to determine their appropriateness for group participation. If a student required more intensive clinical support (i.e. crisis intervention), the student was referred to the school mental health clinician or an outside agency or provider for services. G-TREM group participants and wait-listed participants were

provided with access to each school's Resource Room filled with brochures and referrals to outside agencies and providers if students desired additional support. Students were sent home with consent forms and asked to return them no later than one week. The informed consent outlined the G-TREM group and the research protocol. Students who had not returned completed informed consent forms with parent or guardian signatures were excluded from the group. Although the law in the District of Columbia permits a minor to voluntarily engage in outpatient mental health services (but not medication) without parental/guardian consent, the DMH School Mental Health Clinicians engaged in the best practice of obtaining parental/guardian consent for participation in this group (DMH Establishment Amendment Act, 2001).

A total of sixteen to twenty adolescent females were selected at each school as participants for the G-TREM intervention during the academic year. Participants were randomly assigned to one of two possible treatment groups: Treatment I (GTREM intervention/Fall Group) or Treatment II (waiting-list control group/Spring Group). Eight to ten adolescent females were assigned to Treatment I (the G-TREM intervention) and eight to ten adolescent females were assigned to participants for the waiting-list control group. Participants in the control group received violence exposure treatment following the completion of the first group.

Before the G-TREM group began, students completed a packet of assessments in a pre-group interview, which prepared the adolescent for group participation. The packet of assessments consisted of: the Aggression Questionnaire (AQ) (Appendix A); The Reynolds Adolescent Depression Scale- Second Edition (RADS-2) (Appendix B), and the debriefing/request for study results letter. Each assessment was given a six-digit identification code. The identification code appeared in the Name section of the assessment. Requests for

study results were immediately separated from questionnaire responses and kept separate in a locked filing cabinet to ensure participant anonymity.

In addition, advertisements (Appendix C) were posted in Washington DC Public Schools and Public Charter Schools. Advertisements included the nature of the study and group. Contact information of the School Mental Health Program Clinician was also included so that interested participants who met the criteria of the study could receive additional information regarding the GTREM (Love & Life) group and Project Hope.

The proposed group intervention for adolescent female survivors of violence was called the Girls' Trauma Recovery and Empowerment Model (G-TREM) group. The G-TREM groups were also referred to as the Love and Life Groups in an effort to reduce any associated stigma and increase the group's appeal to its stakeholders and target population. G-TREM was a fully manualized group approach, designed to be implemented in 16 weekly, 60-90 minute sessions (Harris, 2000, 2004). G-TREM was an extrapolation of the Trauma Recovery Empowerment Model (TREM), which was the group approach for trauma exposed adult women (Harris & Anglin, 1998).

Using psychoeducation, skills training, and cognitive-behavioral techniques, G-TREM had the advantages of gender-specificity and cultural competence (Fallot & Harris, 2002; Harris & Anglin, 1998). Specifically, the advantages included GTREM's development in Washington, DC with feedback from the project's target population, Black adolescent females, and therapists (psychologists, clinical social workers, mental health workers) that provided services to the target population. Focus groups with the target population and clinicians were utilized in the development of G-TREM where students and clinicians gave feedback to the authors and researchers. The inclusion of students and clinicians in the construction of G-TREM enhanced

the cultural specificity of the intervention including the nuances of communication, socialization, and perceptions of violence (Fallot & Harris, 2002; Harris & Wolfson Berley, 2005).

G-TREM was a manualized group model, designed to be implemented in weekly sessions with a “closed” group format to allow for group cohesion and the development of safety and trust (Harris, 2004). Group membership included 8-10 adolescent females and 2 female co-leaders. Following an introductory session, the topics included: What It Means to Be Female and What I Know About My Body; Managing Emotional and Physical Boundaries in Relationships; Self-Esteem; Self-Soothing; and Self-Care; Expressing Feelings and Developing Communication Skills; Peer Pressure; Understanding Emotional, Physical, and Sexual abuse; Understanding the Blame Game; Understanding the Impact of Sexual Abuse on Relationships; Development Intimacy and Trust; Sex with a Partner: How to Negotiate the Relationship Successfully; Sexual Abuse and Drug and Alcohol Use; How to Manage Overwhelming Feelings and Self-Destructive Behaviors; Anger and Anger Management; Working on Relationships Within Your Family; and Hope, Accomplishments, and Saying Goodbye (Harris, 2004).

Each topic-focused session had specified learning goals for the group members. Each session began with an icebreaker, continued with a series of discussion questions designed to accomplish the goals of the session, and concluded with an exercise. The format combined discussion and disclosure with experiential exercises and non-verbal modalities of expression designed to facilitate the development of trauma recovery skills. Leaders emphasized educational techniques throughout the intervention (Harris, 2004).

Although no physical or psychological harm from participation in this study was anticipated, it was possible that some of the group discussions or the assessment items could cause a participant some emotional distress. If a participant experienced any emotional

discomfort, she could withdraw from the study at any time with no consequence. If this occurred, students were able to contact the School Mental Health Program Clinician at their respective schools or the Director of the School Mental Health Program (Dr. Olga Acosta) and GTREM grant coordinators (Rebecca Wolfson-Berley, Dr. Maxine Harris) at the phone numbers provided on the consent form. In addition, participants were encouraged to contact the School Mental Health Program Clinician to request referral information for free to low cost counseling services. They were assured a reply from the respective contacts within 24 hours. If needed, referral information was given for counseling services. The following referral agencies and/or persons were provided to participants if they experienced any emotional distress.

Dr. Olga Acosta
School Mental Health Program Director
DC Department of Mental Health
64 New York Avenue
Washington, DC 20002
(202) 671-3107

Rebecca Wolfson-Berley
Community Connections
801 Pennsylvania Ave., SE #201
Washington, DC 20003
(202) 546-1512

George Washington University Center Clinic
1922 F Street NW, Suite 103
Washington, DC 20052
(202) 994-4937

Georgetown University Center Child and Human Development Center
Georgetown University Children's Medical Center
3800 Reservoir Road, NW
Washington, DC 20007.
(202) 687-7447

ACCESS Helpline
DC Department of Mental Health
64 New York Avenue
Washington, DC 20002
1-888-793-4357

Participants also were assured that all of their responses on the assessments and in group remained confidential under the guidelines established by HIPAA, the District of Columbia Mental Health Information Act, and other applicable legal requirements. The limits of confidentiality including exceptions such as danger to self or others, child abuse and/or neglect were discussed with participants. Participants were also given debriefing forms and the option to receive information regarding the study at a later date.

Measures

Aggression Questionnaire (AQ)

Aggression was assessed by the items on the Aggression Questionnaire (AQ) (See Appendix A) (Buss & Warren, 2000). The Aggression Questionnaire was an update of the Buss-Durkee Hostility Inventory. The AQ measured a student's self-perceived levels of aggression and anger. It provided a measure of treatment need or treatment outcome and could be used in clinical and school settings to aid in treatment planning and program evaluation. There were thirty-four items consisting of five scales which are physical aggression (physical expression of anger), verbal aggression (argumentative and hostile language), anger (agitation and sense of control), hostility (resentment, social isolation, and paranoia), and indirect aggression (expression of anger without direct confrontation). Each AQ item described a characteristic related to aggression. The student rated the description on a scale from 1 = "Not at all like me" to 5 = "Completely like me". The reading level of the AQ was noted as "at least a 3rd grade reading ability" (Buss & Warren, 2000).

An AQ Total score was also generated from the assessment. Both the AQ Total and the subscale scores were reported as standardized T-scores, with higher scores reflecting higher levels of anger or aggression. Scores ranging from 45 and 55 were considered to be average. Scores ranging from 56 to 59 were considered high average. Scores from 60-69 were considered high scores and 70 or higher were considered to be very high (Buss & Warren, 2000).

The AQ Total scale was a measure of the general level of anger and aggression based upon the answers to all thirty-four items. It highlighted both the frequency and intensity of aggressive thoughts, feelings, and behaviors. Clinicians are recommended to further investigate the subscales for those students with a high AQ Total Score to better understand its implications. The Physical Aggression subscale focused on the use of physical force to express anger or aggression. High scores on this subscale implied an inability to control aggressive urges. This could be due to high levels of arousal, anger, lack of knowledge of the alternatives available. The Verbal Aggression subscale pertains to hostile or argumentative speech. Individuals with high scores on this subscale often responded with anger to situations they perceive as unfair and might feel alienated from their current situations. The Anger subscale measured aspects of anger related to a sense a control. Elevated scores were often seen in those individuals expressing irritability, frustration, and mood swings. The Hostility subscale, which was associated with social maladjustment, assessed bitterness, alienation, and paranoia. High scores often highlighted elevations observed on other scales, as the individual was unable to empathize or consider the feelings or needs of others. The final subscale on the AQ is the Indirect Aggression subscale, which measured the extent to which an individual tended to express anger in ways that attempted to avoid direct confrontations. Elevated scores on this subscale suggested that

individuals might feel chronically frustrated and were often viewed as oppositional (Buss & Warren, 2000).

The Inconsistency Responding Index identified unusual levels of inconsistency stemming from deception, carelessness, or inattentiveness. There were 12 pairs of items on the Inconsistent Responding Scale. The INC score was comprised of the number of item pairs for which the student's responses differed by more than one point. When the INC score is 5, there was a 69% likelihood that the item responses were not consistently based on the content of the AQ items. This likelihood increased to 83% when the INC score is 6, 91% when the INC score was 7, and 95% when the INC score was 8. Therefore, when the INC score was 5 or higher, the accuracy of the responses were called into question (Buss & Warren, 2000).

The Cronbach alpha value of this scale (a measure of whether instrument in question assessed a unitary construct in this case aggression) was reported between .80 and .85 (Reynolds, 1998). Additional reports of reliability or coefficient alpha suggested good to moderate reliability for the AQ and its subscales. According to Buss and Warren (2000), the values were as follows: Physical Aggression was ($r=.88$), Verbal Aggression ($r=.76$), Anger ($r=.78$), Hostility ($r=.82$), Indirect Aggression ($r=.71$) and the Total Scale ($r=.94$).

Researchers have correlated scores on the AQ with a number of other instruments that assert to measure a similar construct. Validity studies of this measure yielded the physical aggression scale on the AQ was positively correlated to all scales of the Attitude Toward Guns and Violence Questionnaire ($r=.38$) (Shapiro, 2000). Therefore, students with high AQ scores were likely to possess favorable attitudes toward aggression and ownership of guns. The Children's Inventory of Anger had a correlation coefficient of $=.37$ with the AQ (Nelson & Finch, 2000). There was a positive correlation between high scores on the Anger and Hostility

subscales of the AQ and high scores on the CHIA in all challenge areas including peer and authority relationship difficulties, being a victim of bullying, and problem-solving behaviors. The AQ also had positive correlations with the Novaco Anger Scale ($r = .74$) and the Provocation Inventory ($r = .59$) (Novaco, in press). The Hostility Scale on the AQ was most similar to the Angry Cognition Scale on the Novaco Anger Scale. The Anger Scale on the AQ was most correlated to the Arousal Scale on the Novaco Anger Scale and most negatively correlated with the Anger Regulation Scale on the Novaco Anger Scale. Further, the AQ Hostility Scale was the most correlated of the AQ scores with all of the Provocation Inventory scales.

Reynolds Adolescent Depression Scale – Second Edition (RADS-2)

The Reynolds Adolescent Depression Scale- Second Edition (RADS-2) (Appendix B), developed by Reynolds (2002), was used to assess depressive symptoms. The RADS-2 was a self-report measure that assesses the severity of depressive symptomatology in adolescents in both schools and clinical settings (Reynolds, 2002). The RADS-2 was designed for use with adolescents ages 13-18 years. Reading level analyses of the scale items indicated that students should possess a reading ability at the third-grade level to complete the assessment (Reynolds, 2002).

The assessment consisted of thirty items with a Likert response format. The Total Depression score served as an overall measurement of the severity of the symptoms with higher scores indicating greater distress. Four subscales (Dysphoric Mood, Anhedonia/Affect, Negative Self-Evaluation, and Somatic Complaints) were descriptive components that were measured by the tool and were clinically meaningful for depression. Raw scores on all measures were converted to standardized T-scores. Students with T-scores less than 61 fell within the Normal

range of symptom endorsement. Students with scores between 61 and 64 fell within the Mild Clinical Depression range indicated a mild, yet clinically relevant level of depression. In addition, students with scores between 65 and 69 represented Moderate Clinical Depression severity. Scores 70 and higher were considered to be within the Severe Clinical Depression range of scores.

The Dysphoric Mood subscale evaluated “a distinct negative emotional state,” including symptoms such as sadness, crying, loneliness, irritability, worry, and self-pity (Reynolds 2002). High scores on this subscale suggested feelings of misery and distress. The Anhedonia/Negative Affect subscale evaluated a lack of interest in activities that were normally pleasurable. Adolescents presenting high scores on this subscale might exhibit a lack of motivation and social withdrawal. Items on the Negative Self-Evaluation subscale examined low self-worth, self-deprecation, and thoughts of self-harm. High scores on this scale suggested an unrealistic negative self-evaluation and feelings of worthlessness. Finally, the Somatic Complaints subscale evaluated the physical components of depression as well as irritability and boredom. High scores might suggest not only somatic involvement in students’ depression, but could also indicate an illness.

There were six items on the RADS-2, identified as “critical items” that discriminated between clinically depressed and non-depressed adolescents. When a student endorsed the maximum level of four on items 3, 6, 19, 20, and 30, these items were considered to be critical items. A score of three or greater on question 14, which assessed self-destructive and self-injurious behavior, was indicative of a clinically relevant level. Cases where four or more of these six items were endorsed, the student’s symptomatology was viewed as serious regardless of the overall score on the Depression Total (Reynolds, 2002).

The Cronbach alpha value ranged from .909 to .939 in 2002 (Reynolds, 2002). The split-half reliability coefficient for the standardization sample was .91 (Reynolds, 1987). Reynolds (1987) reported the test-retest reliability values across several studies as .80, .79, and .63.

The content validity was obtained by examining the congruence of item content with depressive symptomatology and item to total scale correlations and was reported at .53. The moderately high concurrent validity was indicated by the high correlation (.83) between scores on the RADS and the Hamilton Rating Scale. The RADS is also a valid measure of depression given that total scores on the measure have been correlated with scores on other psychological tests. Validity studies of the measure yielded that it was positively correlated to the Beck Depression Inventory ($r = .73$, $n = 9583$) as well as the Children's Depression Inventory ($r = .73$, $n = 3728$) (Reynolds, 1987). The RADS also had positive correlations with the Epidemiological Studies Depression Scale ($r = .75$, $n = 2,881$) and the Self Rating Depression Scale ($r = .72$, $n = 723$) (Reynolds, 1987).

Table 4.2 provides a brief description of the scores that are generated by the Aggression Questionnaire (AQ) and the Reynolds Adolescent Scale-2 (RADS-2). Scoring for the AQ and RADS-2 yielded raw scores which were converted to T-scores by utilizing the Profile Sheet for the AQ and the Score Summary Table for the RADS-2.

Table 4.2: Clinically Important Ranges for Understanding the AQ and RADS-2

AQ: Aggression and Anger		RADS-2: Depression	
T \geq 70	Intense Anger/Very High Clinically Significant	T \geq 70	Severe Clinical Depression Range
T = 60-69	Above Average Anger/High/Clinically Significant	T = 65-69	Moderate Clinical Depression Range
T = 40-59	Average Anger	T = 61-64	Mild Clinical Depression Range
T = 30-39	Below Average Anger/Low/Clinically Significant	T < 61	Normal Range
T < 30	Extremely Low Anger/Very Low/Clinically Significant		

Data Analysis

Data Analysis Procedure

The Statistical Package for the Social Sciences (SPSS) software was used to create the study database and conduct all relevant statistical analyses. The first step of data analysis entailed checking all variables for normality and the presence of outliers. Each variable was examined for missing values, skewness, outliers, and accuracy of data entry. Data of participants who omitted more than six items on an assessment were not included in the final analysis.

Research Question 1: Does the G-TREM group intervention decrease aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females?

Research Hypothesis 1: The G-TREM group intervention will decrease the levels of aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females. This hypothesis is based on research that indicated that group therapeutic approaches for traumatized

adolescents are effective. Group therapeutic approaches offered the use of the adolescent peer group to help with self and other judgments about normality, emotional support and affect regulation, and promotion of developmental recovery (Foa et al., 2000). The components of gender specificity and cultural competence of the G-TREM intervention are expected to enhance the results as research indicates that adolescent females exposed to violence are more likely to experience school-related behavioral problems than their male counterparts (Buka et al., 2001).

Analysis Plan: A repeated measures ANOVA was conducted to compare AQ scores of both the G-TREM group and the waiting list control group.

Research Question 2: Does the G-TREM group intervention decrease depressive symptoms (internalizing symptoms) in urban Black adolescent females.

Research Hypothesis 2: The G-TREM group intervention will decrease the levels of depressive symptoms (internalizing symptoms) in urban Black adolescent females. This hypothesis is based on research that group therapeutic approaches, are effective for traumatized adolescents (Foa et al., 2000). Further, since research indicates that females tend to demonstrate a gender-specific emotional response to violence (i.e. depression), a gender-specific intervention will likely increase the effectiveness of the intervention (Cooley-Strickland et al., 2009; Fitzpatrick, 1993; Fitzpatrick & Boldizar, 1993; Gladstein et al., 1992; Schwartz & Kowalski, 1991).

Analysis Plan: A repeated measures ANOVA was conducted to compare RADS-2 scores of both the G-TREM group and the waiting list control group.

CHAPTER 4. RESULTS

Each research question and corresponding hypothesis was reviewed. Findings for each research question were addressed in order. The general analysis procedures for research questions I and II are discussed together, since each has to do with a variable increasing or decreasing from pre-treatment to post-treatment. Research question I assessed how the effectiveness of the G-TREM group intervention on the aggression and antisocial behaviors of participants. Research question II evaluated the impact of the G-TREM group intervention on depressive symptoms of participants.

Research Question 1

Does the G-TREM group intervention decrease aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females?

It was hypothesized that the G-TREM group intervention would decrease the overall levels of aggression and antisocial behaviors (externalizing behaviors) as measured by the AQ (Buss & Warren, 2000) in urban Black adolescent females.

Research Question 2

Does the G-TREM group intervention decrease depressive symptoms (internalizing symptoms) in urban Black adolescent females?

A second hypothesis of the study was that the G-TREM group intervention will decrease the overall levels of depressive symptoms (internalizing symptoms) as measured by the RADS-2 (Reynolds, 2002) in urban Black adolescents.

Overview of Analysis Procedures

The analyses for hypotheses 1 and 2 follow the same sequence. For each variable of interest (depression and aggression), a repeated measures analysis of variance (ANOVA) was conducted using the subscale T-scores for the AQ and the RADS-2 at the pre-test Assessment and post-test assessment points for the group of 56 treatment and 54 waiting-list control participants. The goal of these analyses was to discover whether the treatment group changed appreciably more than did the waiting-list control group over time. In fact, it was hypothesized that the control groups should remain fairly steady from pre-Test to post-test since they received no intervention; while the treatment group should have made marked changes in the desired directions. Pre-test/post-test designs can be analyzed by two different methods: a repeated measures analysis of variance or an analysis of covariance. If there are no differences between the groups at the pre-test, then either analysis is appropriate. If there are differences, then only an analysis of covariance can be employed. For each of the analyses presented in this chapter, the experimental and control groups were compared at the pre-test and there were no differences found. As such, all of the analyses will use the repeated measures ANOVA, since this analysis is considered to be easier to understand. A repeated measures ANOVA produces three relevant terms: the main effect for pre-post, the main effect for group, and the interaction. Of these, the critical term is the interaction since its significance indicates that the experimental group is performing differently from the control group across time. The F statistics and their level of significance were reported for these three terms. Further, the partial eta squared statistic for each of the terms in the ANOVA will be reported. This is the recommended statistic to report the effect size in ANOVAs. Since partial eta squared is a metric based on the variance explained,

the current usage is to consider any effect which explains more than 10% of the variance as meaningful.

Research Question 1: Aggression Questionnaire (AQ) Results

Research Question 1 assessed the effectiveness of the G-TREM group intervention decrease aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females. The Aggression Questionnaire measured five components of aggressive behavior in adolescents which were the following: physical aggression (physical expression of anger), verbal aggression (argumentative and hostile language), anger (agitation and sense of control), hostility (resentment, social isolation, and paranoia), and indirect aggression (expression of anger without direct confrontation). In this segment, the results were presented on the Aggression Questionnaire total and subscales findings.

Mean values and standard deviations for the Total AQ are presented in Table 4.3.

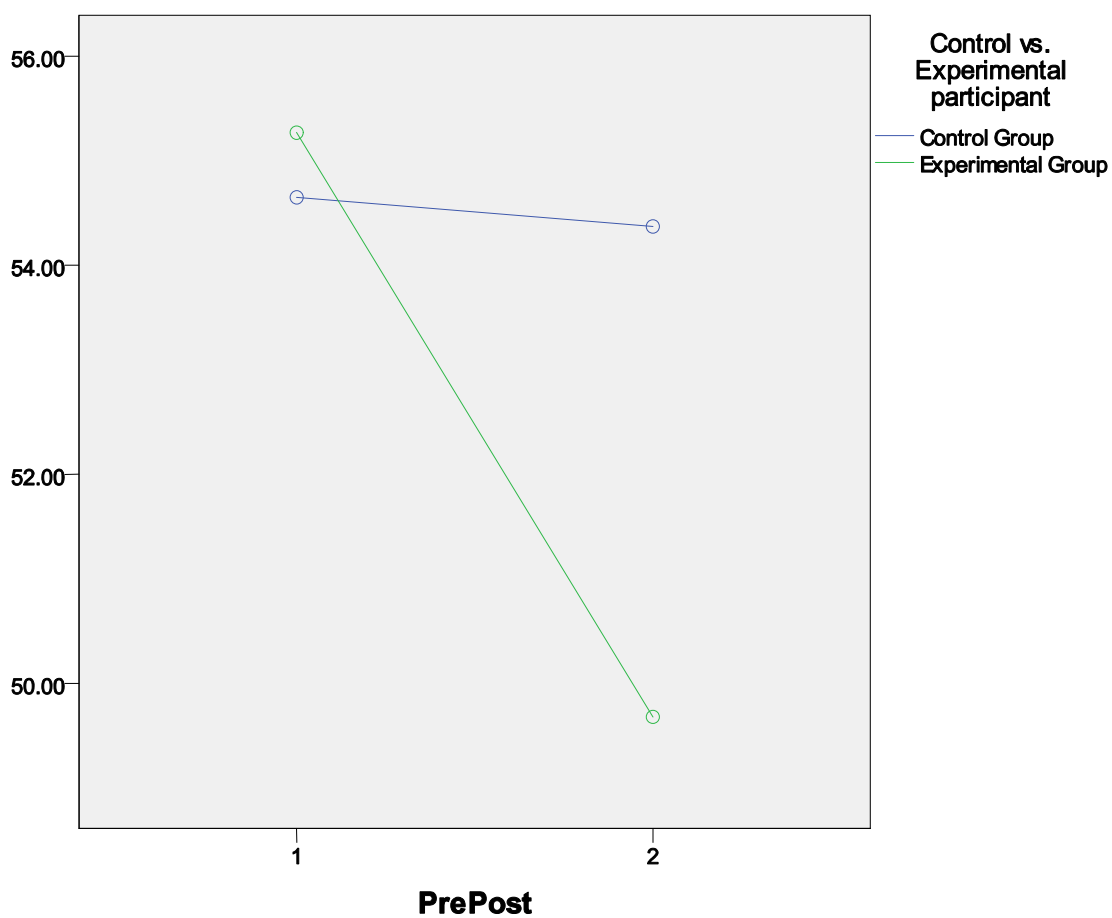
Table 4.3: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Total Score

	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	55.27	8.89	46.68	10.02
Waiting List Control (N = 54)	54.65	9.35	54.37	9.29

The repeated measures ANOVA produced a significant interaction ($F = 26.205_{1,108}$, $p = .000$, partial eta squared = .195), and for time ($F = 31.97_{1,108}$, $p = .000$, partial eta squared = .228) but not for group ($F = 1.418_{1,108}$, $p = .238$, partial eta squared = .013). As indicated in Table 4.3, the overall levels of self-reported aggression of participants in the G-TREM treatment group decreased significantly, while the levels of self-reported aggression of the waiting list control group remained steady.

A plot of the interaction is presented in Figure 4.1. As demonstrated in Figure 4.1, the control group remained relatively unchanged from pre-test to post-test, while the treatment group improved in the intended direction with a decrease in scores on the AQ. The partial eta squared for the interaction indicated that this was a meaningful difference between the two groups.

Figure 4.1: Changes in self-reported Aggression and Anger from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group.



Aggression Questionnaire Subscale Results

Next, the same analysis was applied to the two groups for means on the AQ subscales for a more detailed analysis of scores regarding the various types of anger and aggression assessed. These subscales include Physical Aggression, Verbal Aggression, Anger, Hostility, and Indirect Aggression. The subscales on the AQ consistently demonstrated similar results to the AQ Total score. Specifically, all of the subscales showed a significant difference between the G-TREM treatment group and the control group. As demonstrated by the AQ Total Score results, the levels of self-reported physical aggression, verbal aggression, anger, hostility, and indirect aggression of participants in the G-TREM treatment group decreased significantly. The levels of self-reported physical aggression verbal aggression, anger, hostility, and indirect aggression of the waiting list control group remained unchanged. The F values, levels of significance, and partial eta squares will be presented for each analysis.

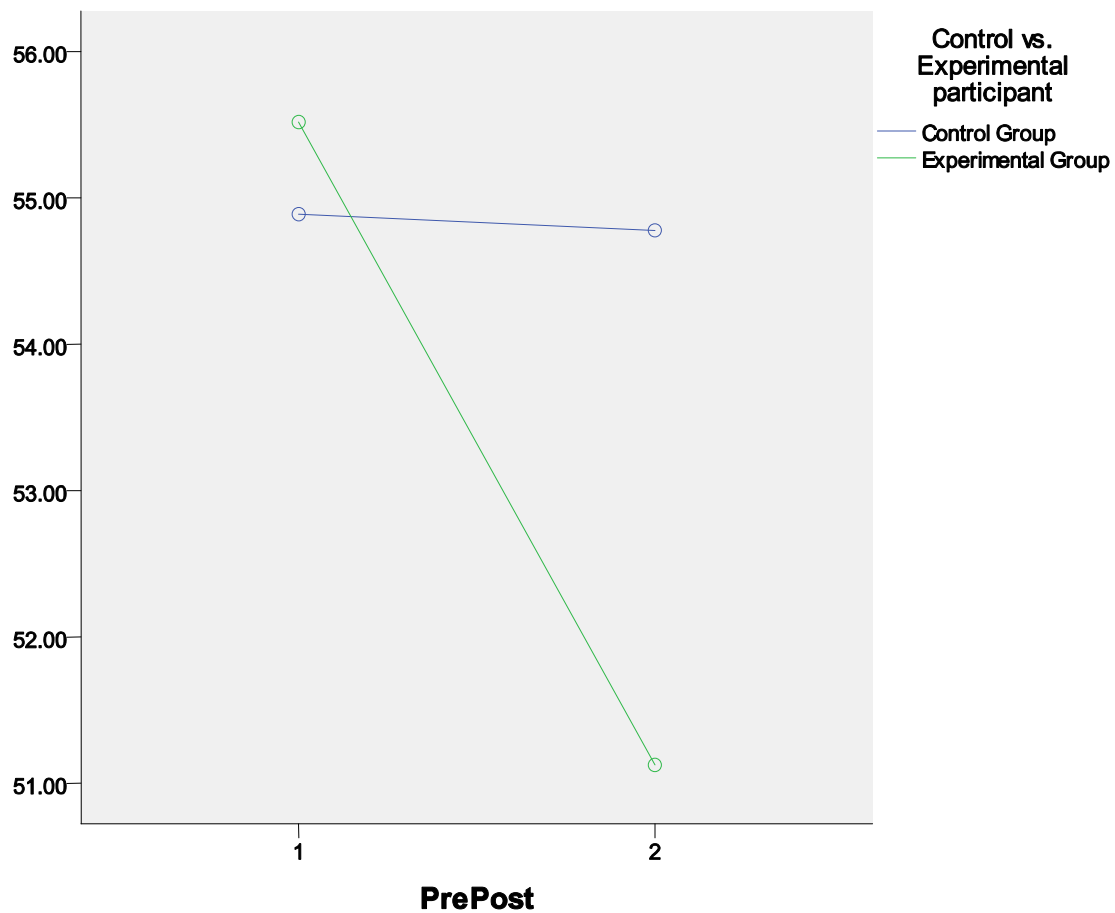
The means and standard deviations for Physical Aggression are presented in Table 4.4 with a plot of the interaction presented in Figure 4.2.

Table 4.4: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Physical Aggression Subscale

	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	55.52	7.75	51.13	8.58
Waiting List Control (N = 54)	54.89	8.67	54.78	8.79

Main Effect for Pre-Post: $F = 26.16, p = .000, \text{partial eta squared} = .195$
 Main Effect for Group: $F = .951, p = .138, \text{partial eta squared} = .009$
 Interaction: $F = 23.64, p = .000, \text{partial eta squared} = .180$

Figure 4.2. Changes in self-reported Physical Aggression from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group.



Means standard deviations for the Verbal Aggression subscale are presented in Table 4.5.

Table 4.5. Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Verbal Aggression Subscale

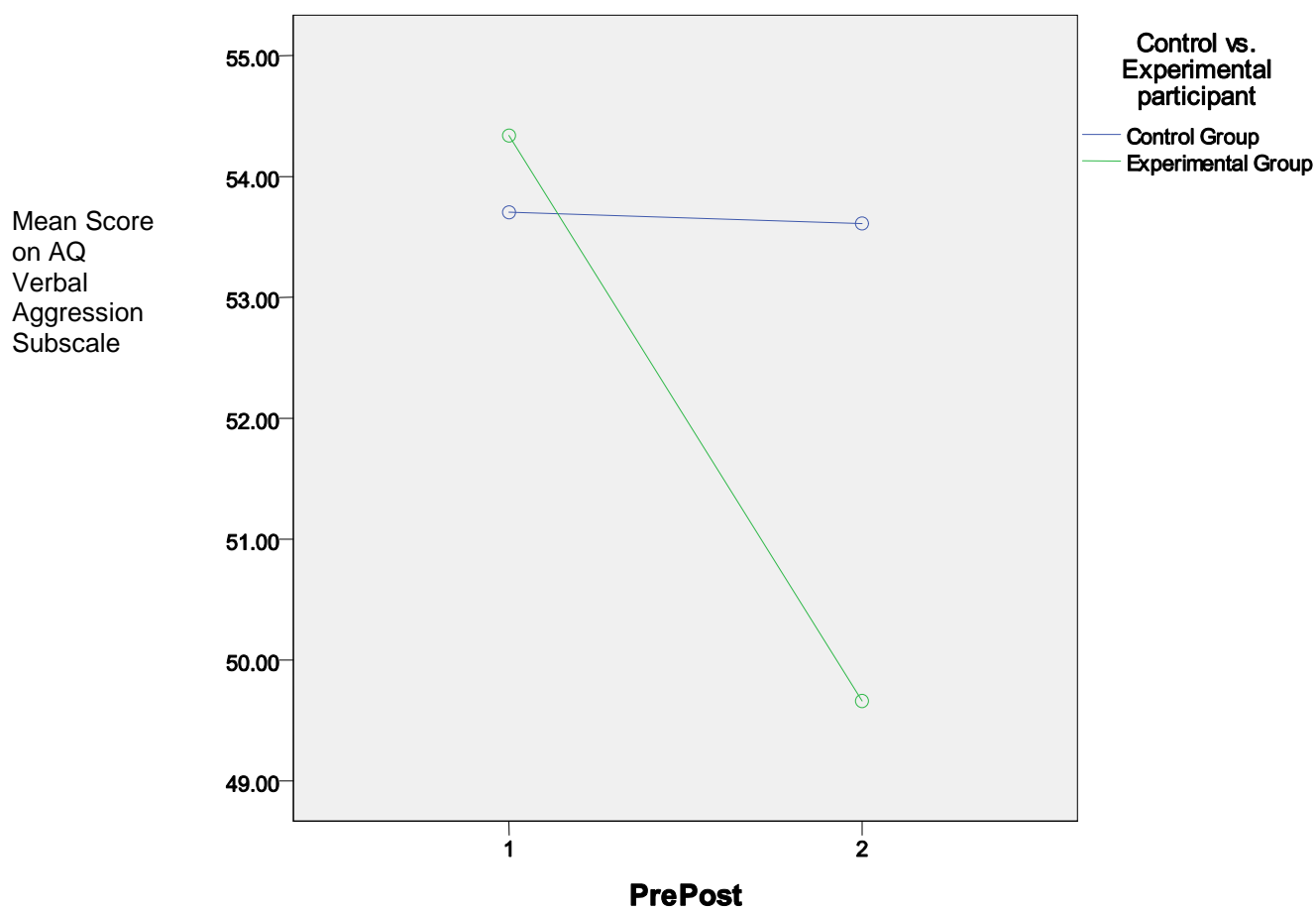
	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	55.52	9.27	51.13	9.51
Waiting List Control (N = 54)	54.89	8.30	54.78	8.29

Main Effect for Pre-Post: $F = 49.45$, $p = .000$, partial eta squared = .314

Main Effect for Group: $F = 1.001$, $p = .314$, partial eta squared = .009

Interaction: $F = 45.69$, $p = .000$, partial eta squared = .297

Figure 4.3. Changes in self-reported Verbal Aggression from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group.



Mean values and standard deviations for the AQ Anger subscale are presented in Table 4.6.

Table 4.6: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Anger Subscale

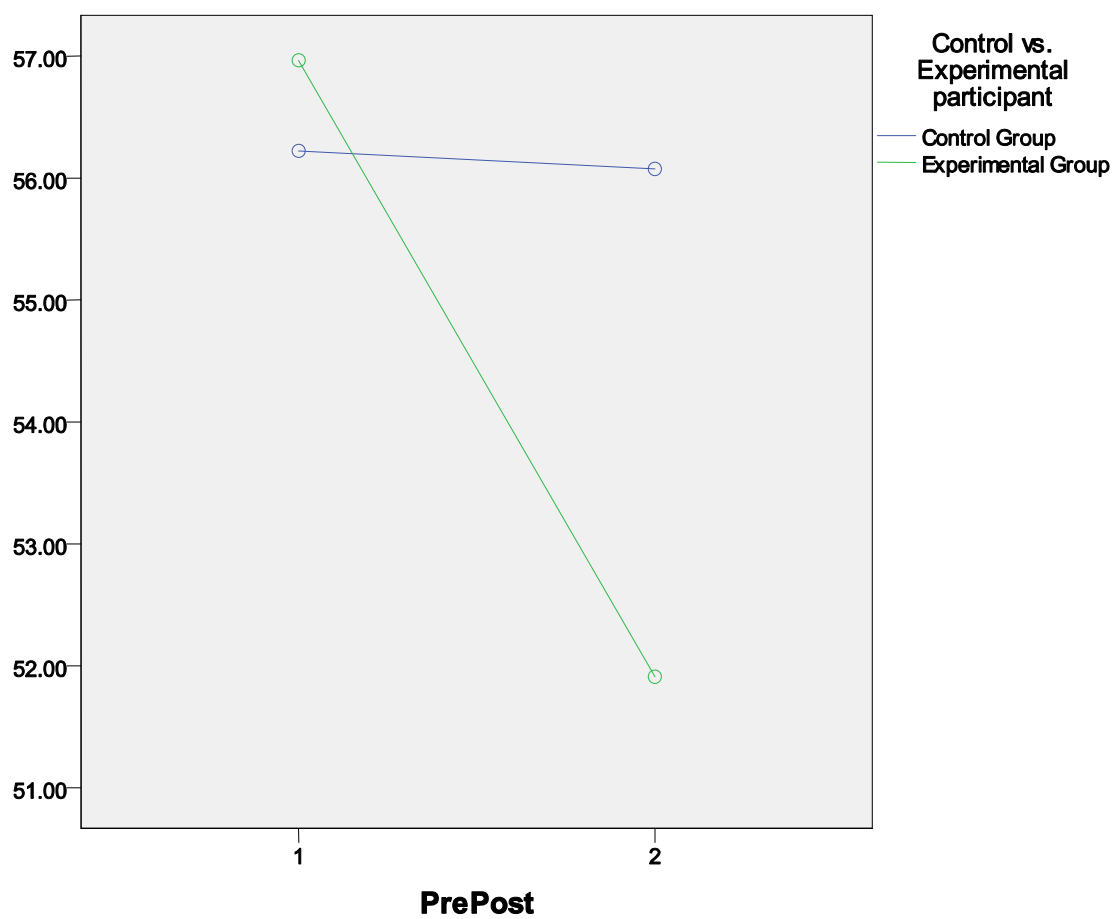
	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	55.52	10.13	51.13	10.13
Waiting List Control (N = 54)	54.89	11.16	54.78	11.09

Main Effect for Pre-Post: $F = 22.52$, $p = .000$, partial eta squared = .173

Main Effect for Group: $F = .772$, $p = .382$, partial eta squared = .007

Interaction: $F = 20.03$, $p = .000$, partial eta squared = .156

Figure 4.4: Changes in self-reported levels of anger from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group



Mean values and standard deviations for the AQ Hostility Subscale are presented in

Table 4.7.

Table 4.7. Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Hostility Subscale

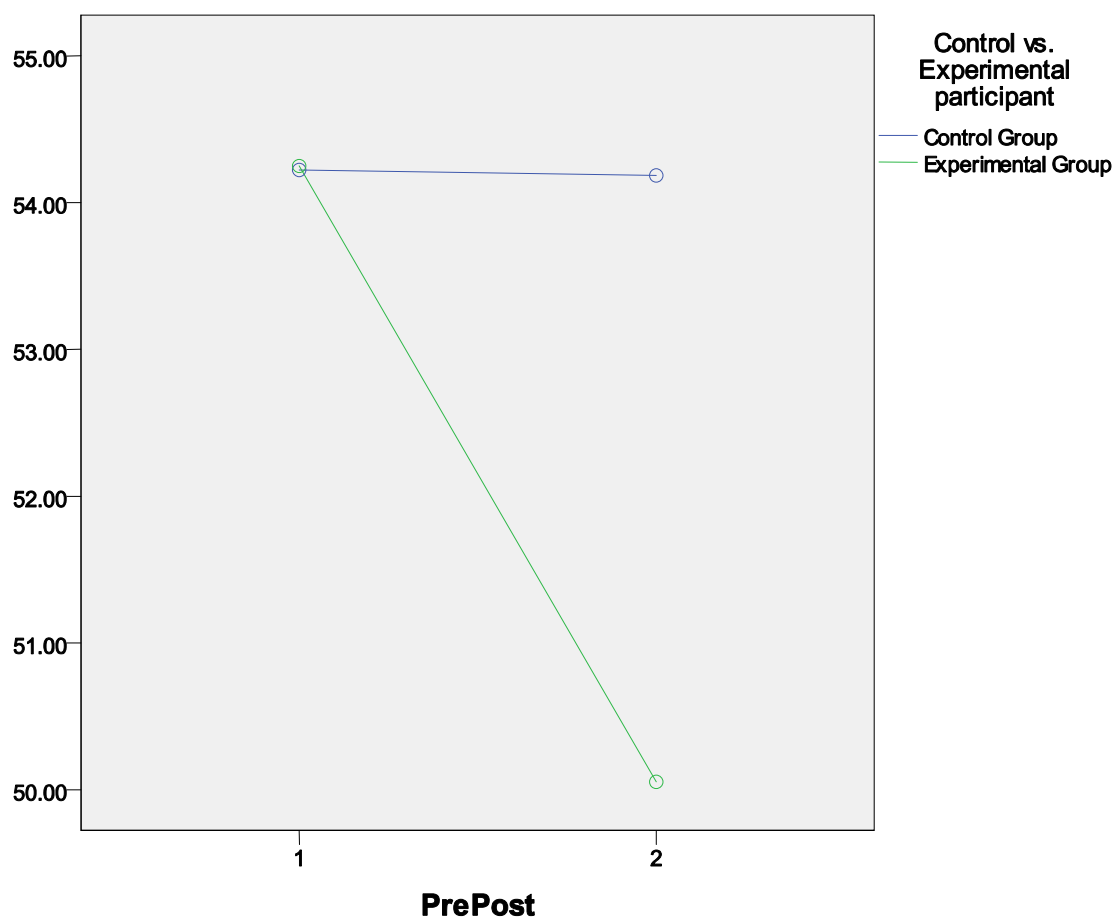
	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	54.25	8.45	50.05	9.62
Waiting List Control (N = 54)	54.22	8.71	54.19	8.74

Main Effect for Pre-Post: $F = 15.03, p = .000, \text{partial } \eta^2 = .122$

Main Effect for Group: $F = 1.69, p = .202, \text{partial } \eta^2 = .015$

Interaction: $F = 14.51, p = .000, \text{partial } \eta^2 = .118$

Figure 4.5: Changes in self-reported levels of Hostility from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group



Mean values and standard deviations for the Indirect Aggression Subscale are presented in Table 4.8.

Table 4.8. Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the AQ Indirect Aggression Subscale

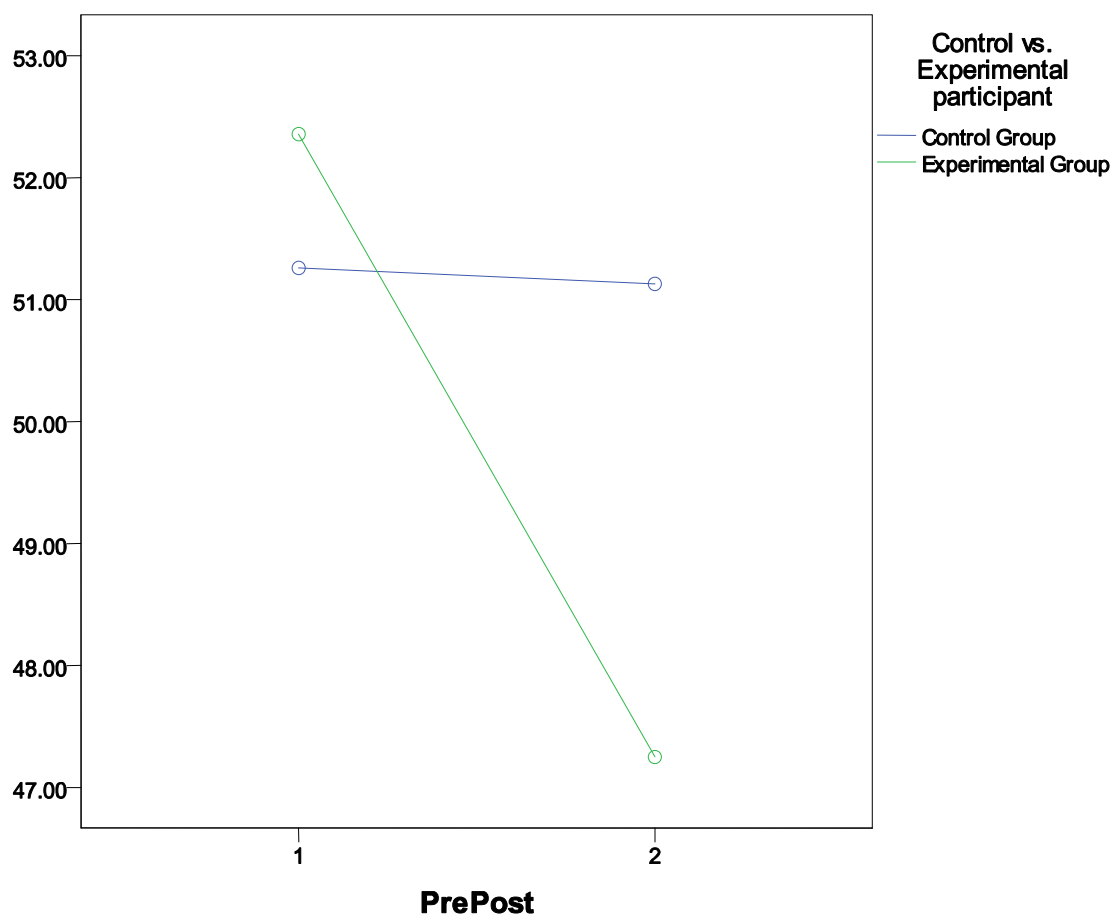
	PreTest AQ		Post Test AQ	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	55.36	9.64	47.25	9.55
Waiting List Control (N = 54)	51.26	8.86	51.13	8.77

Main Effect for Pre-Post: $F = 24.28, p = .000, \text{partial eta squared} = .184$

Main Effect for Group: $F = .688, p = .409, \text{partial eta squared} = .006$

Interaction: $F = 21.94, p = .000, \text{partial eta squared} = .169$

Figure 4.6: Changes in self-reported indirect aggression from Pre-test to Post-test for two groups: Treatment group and Waiting-list control group.



Summary for Research Question 1

It is evident from the data presented above that the treatment had a significant effect for all of the components of AQ. Moreover, the pattern of data in all cases is essentially the same. That is, the control group remains relatively unchanged from pre-test to post-test, while the treatment group significantly decreases. In this sample of participants, aggression variables decreased on all of the subscales. In essence, the treatment group expressed less hostile, angry, and aggressive behaviors as a result of the G-TREM intervention. The waiting-list control group, conversely, remained the same from pre to post assessments. Further, there was no main effect for the G-TREM treatment group on any of the subscales. Overall, the sample's pretest and posttest scores on the AQ were not clinically significant. However, the participants of the G-TREM group intervention demonstrated a significant decrease in their self-reported levels of aggression while the waiting-list control group's scores remained steady.

Research Question 2: Reynolds Adolescent Depression Scale 2 (RADS-2) Results

Research Question 2 assessed the effectiveness of the G-TREM group intervention depressive symptoms (internalizing behaviors) in urban Black adolescent females. The Reynolds Adolescent Depression Scale measured four components of depressive symptoms in adolescents which were the following: Dysphoric Mood, Anhedonia/Affect, Negative Self-Evaluation, and Somatic Complaints. In this segment, the results were presented on the Reynolds Adolescent Depression Scale total and subscales findings.

Mean values and standard deviations are for the presented in Table 4.9.

Table 4.9. Means and Standard Deviations for the Treatment Group and Waiting List Control Group for Total Depression of the RADS-2

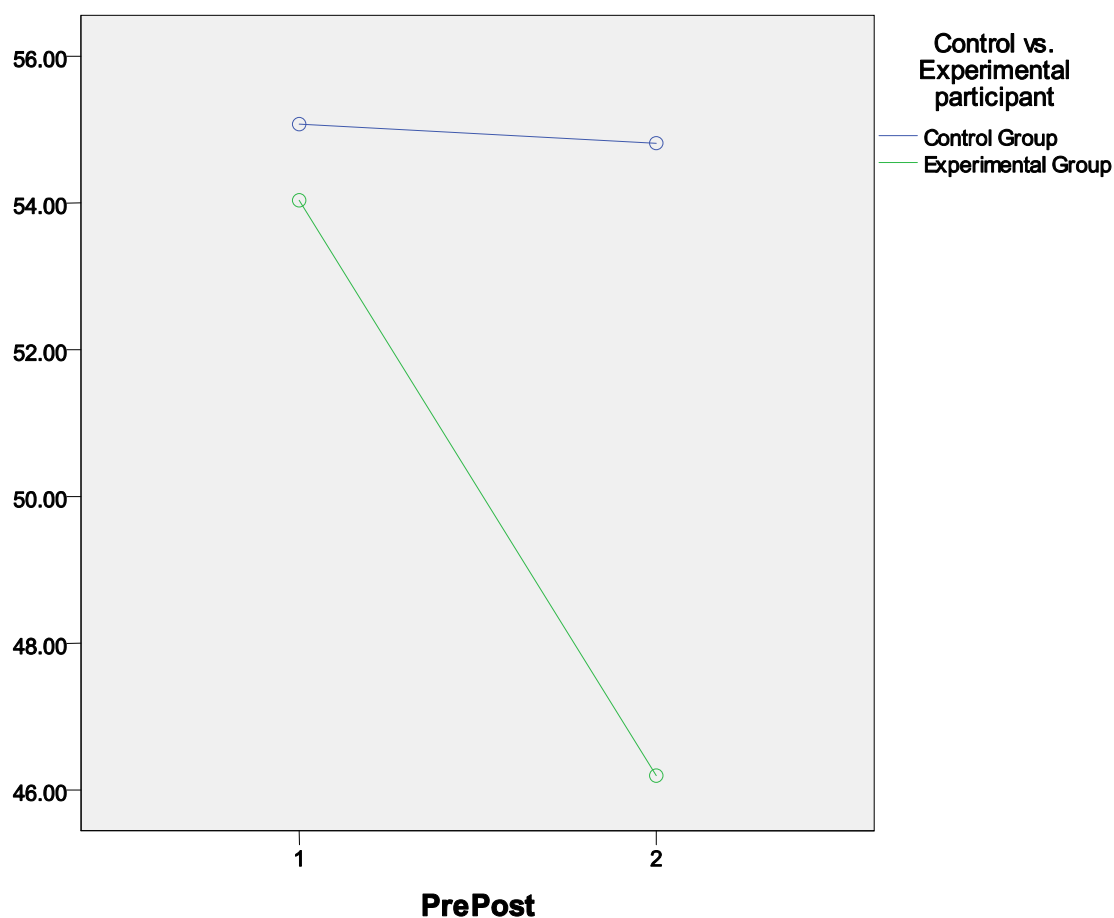
	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	54.04	8.67	46.20	9.19
Waiting List Control (N = 54)	55.07	8.80	54.81	8.79

Main Effect for Pre-Post: $F = 61.66, p = .000, \text{partial eta squared} = .363$

Main Effect for Group: $F = 8.99, p = .003, \text{partial eta squared} = .077$

Interaction: $F = 54.02, p = .000, \text{partial eta squared} = .333$

Figure 4.7: Changes in self-reported Total Depression from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group.



As shown in Table 4.9 and Figure 4.7, the pattern of results for the Total Depression scale of RADS-2 is identical to the data reported for the AQ. Specifically, the control group remains essentially unchanged from pre-test to post-test, while the treatment group significantly decreased. As before, the effect size metric indicated that this was a large effect.

Reynolds Adolescent Depression Scale 2 (RADS-2) Subscale Results

Finally, the same analysis was applied to the two groups for means on the RADS-2 subscales. These subscales include the RADS-2 Total Critical, Dysphoric Mood, Negative Affect, Negative Self Evaluation, and Somatic Complaints. The subscales on the RADS-2 yielded similar results to the overall Depression score which demonstrated significant decreases in the G-TREM treatment group while the waiting-list control group remained steady. The F values, levels of significance, and partial eta squares will be presented for each analysis.

Mean values and standard deviations for the RADS-2 Total Critical Subscale are presented in Table 4.10.

Table 4.10: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the RADS-2 Total Critical Subscale

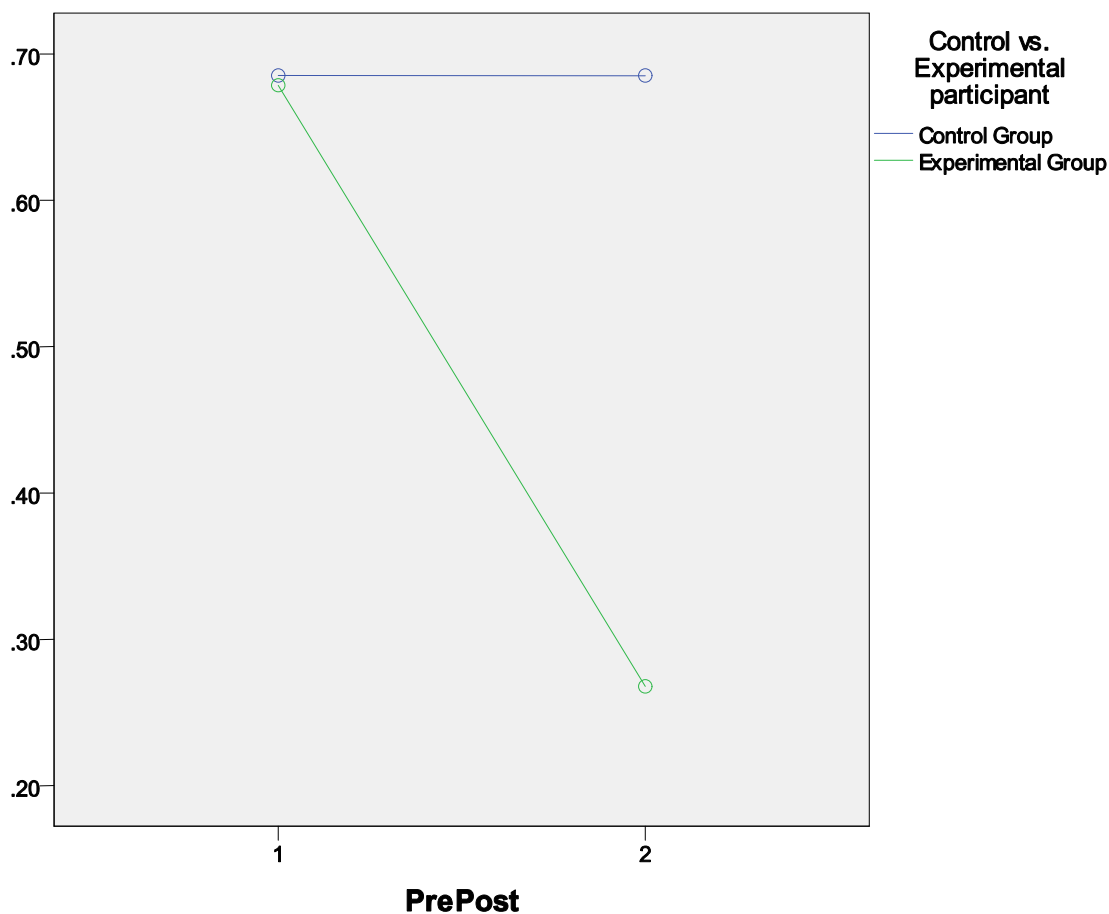
	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	.6786	.81	.2679	.65
Waiting List Control (N = 54)	.6852	.86	.6852	.81

Main Effect for Pre-Post: F = 25.61, p = .000, partial eta squared = .192

Main Effect for Group: F = 2.07, p = .003, partial eta squared = .019

Interaction: F = 25.61, p = .000, partial eta squared = .192

Figure 4.8. Changes in self-reported levels of Total Critical Items from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group.



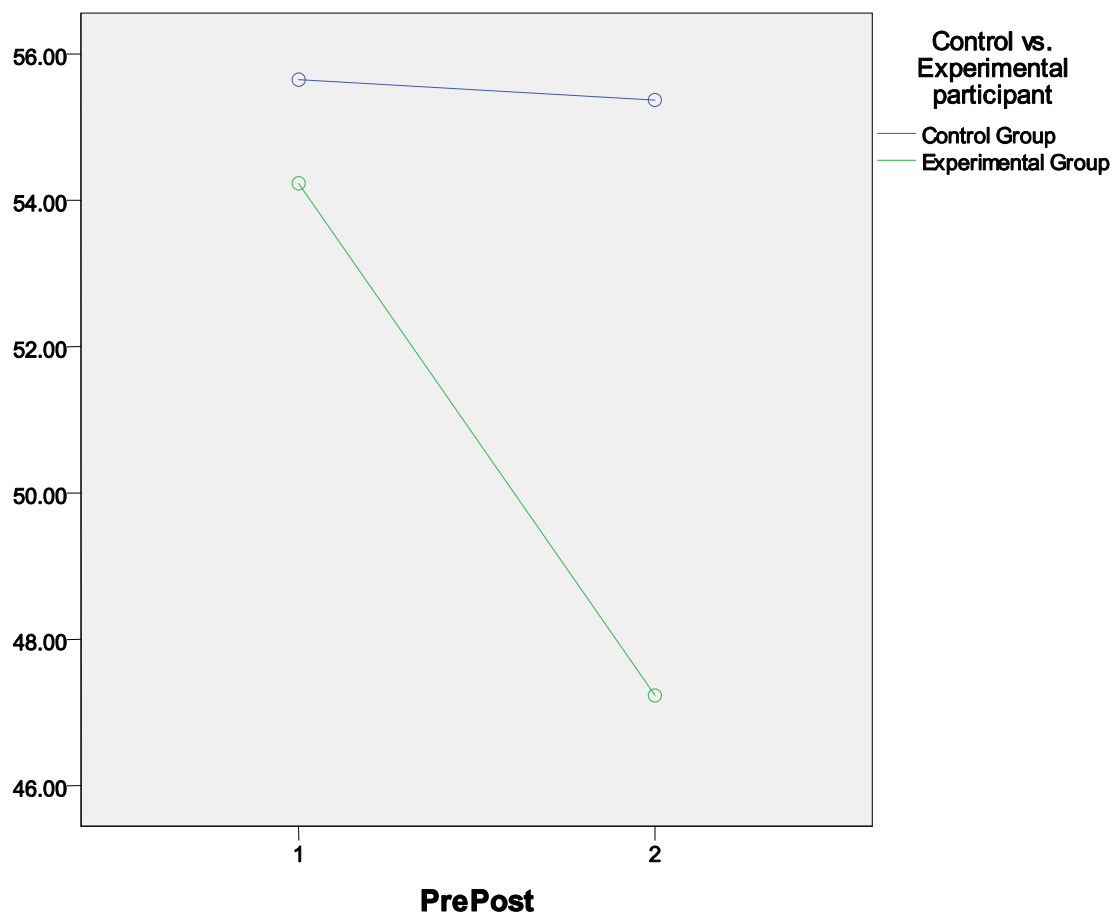
Mean values and standard deviations for the RADS-2 Dysphoric Mood Subscale are presented in Table 4.11.

Table 4.11: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the RADS-2 Dysphoric Mood Subscale

	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	54.23	9.33	47.23	10.84
Waiting List Control (N = 54)	55.65	8.34	55.37	8.23

Main Effect for Pre-Post: $F = 47.82, p = .000, \text{partial eta squared} = .307$
 Main Effect for Group: $F = 8.02, p = .006, \text{partial eta squared} = .069$
 Interaction: $F = 40.79, p = .000, \text{partial eta squared} = .274$

Figure 4.9. Changes in self-reported levels of Dysphoric Mood from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group



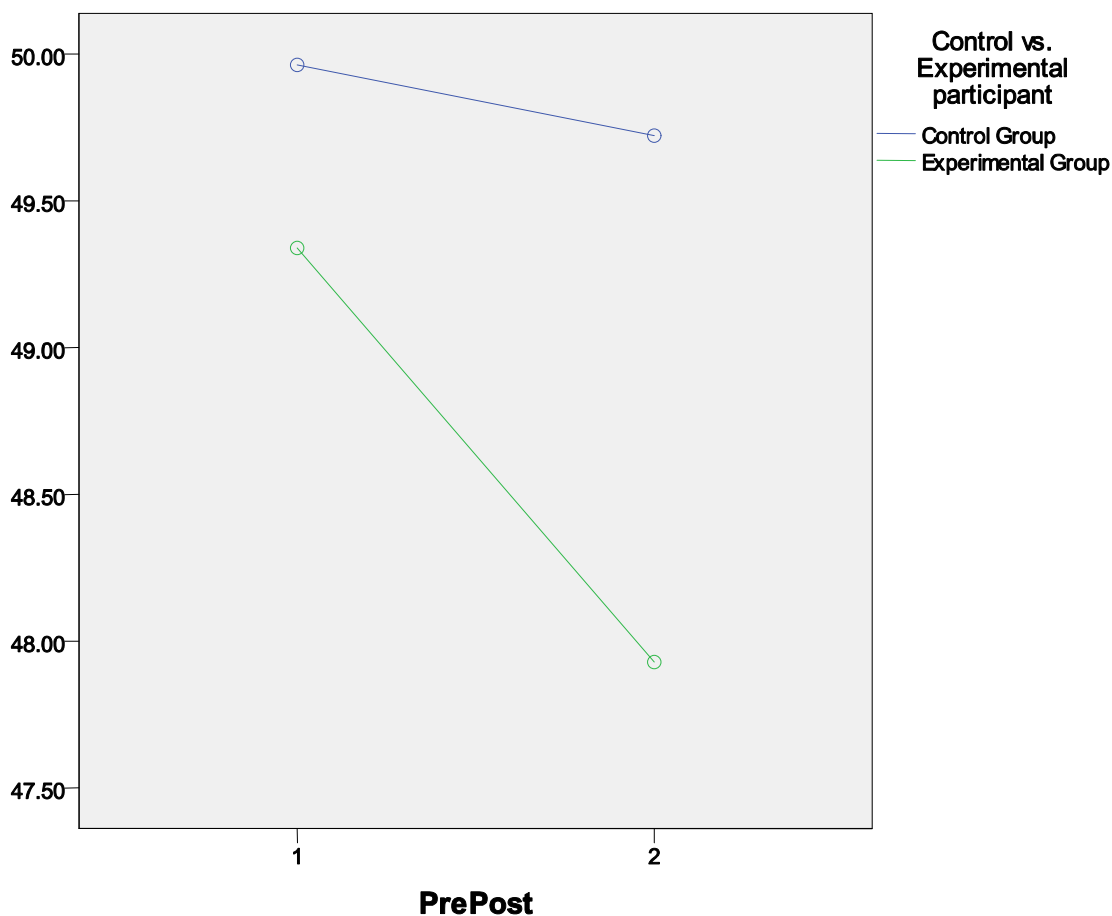
Mean values and standard deviations for the RADS-2 Negative Affect Subscale are presented in Table 4.12.

Table 4.12: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the RADS-2 Negative Affect Subscale

	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	49.96	8.01	47.93	7.55
Waiting List Control (N = 54)	49.34	7.72	49.72	7.71

Main Effect for Pre-Post: $F = 4.02, p = .048, \text{partial eta squared} = .036$
 Main Effect for Group: $F = .725, p = .397, \text{partial eta squared} = .007$
 Interaction: $F = 2.02, p = .158, \text{partial eta squared} = .018$

Figure 4.10: Changes in self-reported levels of Negative Affect from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group



Mean values and standard deviations for the RADS-2 Negative Self-Evaluation Subscale are presented in Table 4.13.

Table 4.13: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the RADS-2 Negative Self-Evaluation Subscale

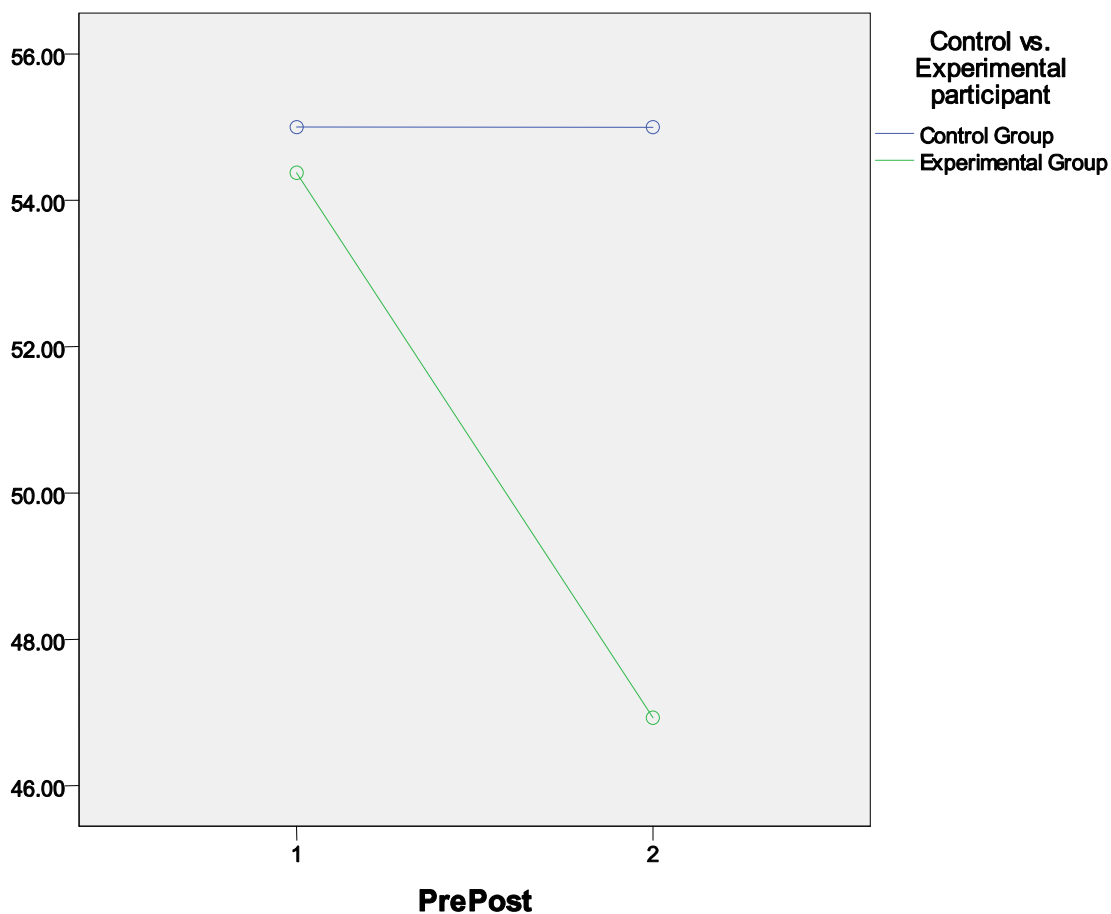
	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	54.37	10.01	49.93	9.14
Waiting List Control (N = 54)	55.00	9.96	55.00	9.94

Main Effect for Pre-Post: $F = 37.81, p = .000, \text{partial eta squared} = .259$

Main Effect for Group: $F = 6.09, p = .015, \text{partial eta squared} = .057$

Interaction: $F = 37.82, p = .000, \text{partial eta squared} = .259$

Figure 4.11: Changes in self-reported levels of Negative Self-Evaluation from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group



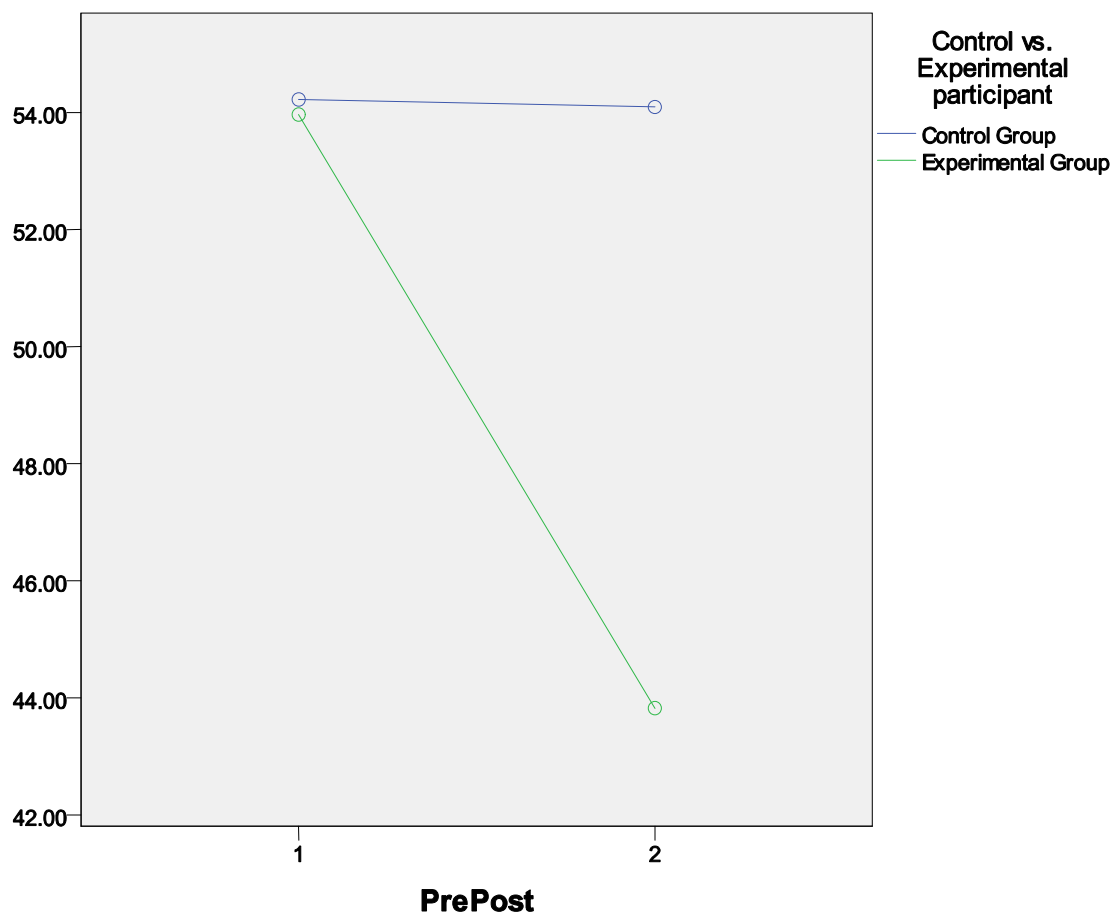
Mean values and standard deviations for the RADS-2 Somatic Complaints Subscale are presented in Table 4.14.

Table 4.14: Means and Standard Deviations for the Treatment Group and Waiting List Control Group for the RADS-2 Somatic Complaints Subscale

	PreTest RADS-2		Post Test RADS-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment (N = 56)	53.96	9.71	43.82	10.16
Waiting List Control (N = 54)	54.22	9.40	54.09	9.32

Main Effect for Pre-Post: $F = 79.82, p = .000, \text{partial eta squared} = .425$
 Main Effect for Group: $F = 9.05, p = .003, \text{partial eta squared} = .077$
 Interaction: $F = 75.84, p = .000, \text{partial eta squared} = .413$

Figure 4.12: Changes in self-reported levels Somatic from Pre-test to Post-test for two groups: Treatment group and Waiting List Control group



Summary of Research Question 2

The data presented above indicated that, with one exception, the data for Research Question 2 are almost identical to the data for Question 1. For this particular sample of participants, the depression variables decreased on three of four of the subscales. Essentially, the G-TREM treatment group reported a decrease in the depressive symptoms of dysphoric mood, negative self-evaluation, and somatic complaints as a result of the G-TREM treatment group. The waiting-list control group remained unchanged from pre to post assessments.

The sole exception was for Negative Affect where the interaction was not significant. However, the main effect for group was significant on the Negative Affect subscale indicating that the two groups (treatment and control) combined decreased significantly from pre to post test. Nevertheless, it remained clear from the graph of the results that the pattern of results were similar. Therefore, the data demonstrated that the treatment had the effect of significantly reducing depression in the Black, adolescent females who were in the G-TREM treatment group. Although, the sample's pretest and posttest scores on the RADS-2 were not at clinically significant levels, the participants of the G-TREM group intervention demonstrated a significant decrease in their self-reported levels of depressive symptoms.

Additional Research Question: The Effect of Grade Level on Pre-test/Post-Test Gains

As additional analysis, the data were analyzed to ascertain whether a student's grade in school affected the results. Given the data presented above, it was decided to analyze only the subjects from the Treatment group. The Total Depression Score from the RADS-2 and the Total Aggression Score from the AQ were used as the dependent variables. As before, a repeated measures ANOVA was used for the analysis.

RADS-2.

The means for the Total Depression Score from the RADS-2 along with the standard deviations for students in the four grade levels represented in the sample are presented in Table 4.15. The results of the repeated measures ANOVA and a graph of the results are also presented.

Table 4.15: Means and Standard Deviations for the Treatment Group by Grade Level on Total Depression

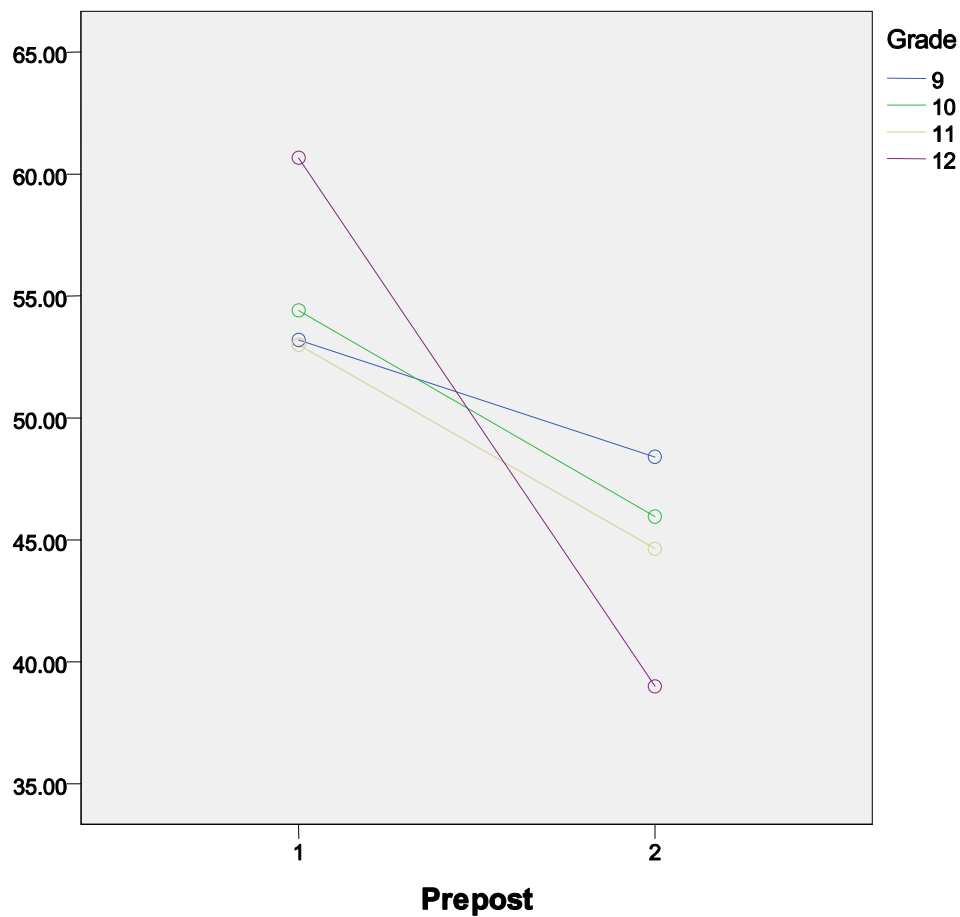
	Pre-Test Total Depression		Post-Test Total Depression	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Grade 9 (n = 20)	53.20	10.38	48.40	11.62
Grade 10 (n = 22)	54.41	6.12	45.95	7.84
Grade 11 (n = 11)	53.00	10.53	44.64	6.87
Grade 12 (n = 3)	60.67	4.04	39.00	3.63

Main Effect for Pre-Post: $F = 79.10, p = .000$, partial eta squared = .603

Main Effect for Grade: $F = .137, p = .938$, partial eta squared = .008

Interaction: $F = 5.63, p = .002$, partial eta squared = .245

Figure 4.13: Changes in self-reported levels of Total Depression for Treatment Group Subjects by Grade Level



Although the analysis presented above is somewhat questionable due to the small sample sizes for the two upper grades, the pattern of the data is fairly clear. Specifically, it is evident that the effect of the treatment increases as grade level increases. That is, the greatest change is demonstrated by the 12th grade students (remembering that this only represents three students), followed by the 11th grade, then the 10th and finally with the smallest change demonstrated by the 9th grade students.

CHAPTER 5. DISCUSSION

The current research is an attempt to expand the body of literature regarding effective treatments for adolescents who have been exposed to violence. Few interventions exist which are geared specifically toward reducing the effects of experiencing or witnessing violence. The empirical literature on group therapy for children exposed to trauma is sparse and almost exclusively concerned with child sexual abuse survivor. Generally, researchers have concentrated more on assessing the correlates and sequelae of violence than on validating the effectiveness of treatment programs for violence exposure or analyzing violence prevention programs for youth (Acosta et al., 2001). Not only has there been a decline in the relative percentage of studies specifically focused on treatment of violence exposed youth, the few randomized controlled studies available that assess treatments for violence exposed youth tend to possess design and generalizability issues (Foy et al., 2001). Consumer feedback and therapist involvement in treatment design have been identified as critical factors in treatment efficacy (Cohen, 2002). Further, the challenges of accurately identifying youths with histories of trauma, meeting the eligibility requirements for outpatient treatment, and treatment attrition issues present additional barriers to providing appropriate services to adolescents exposed to violence.

The current research attempted to examine the effectiveness of GTREM, a group treatment for urban Black adolescent females exposed to violence on their symptoms of aggression, anger, and depression. The following hypotheses were used for the current research:

Research Hypothesis 1: The G-TREM group intervention will decrease the levels of aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females. Aggression and antisocial behaviors were assessed using the Aggression Questionnaire- AQ (Buss & Warren). It was hypothesized that participants who received the GTREM treatment

group intervention would report a decrease in their levels of aggression, anger, and antisocial behaviors.

Research Hypothesis 2: the G-TREM group intervention will decrease the levels of depressive symptoms (internalizing symptoms) in urban Black adolescent females. Depressive symptoms were assessed using the Reynolds Adolescent Depression Scale 2- RADS-2 (Reynolds, 2002). It was believed that participants who received the G-TREM treatment group would report a decrease in their levels of depressive symptoms.

Community Connections, the grant funded agency on Project Hope, worked in collaboration with the District of Columbia Department of Mental Health School Mental Health Program (DMH SMHP) to collect data for research on the group intervention, Girls Trauma Recovery and Empowerment Model (G-TREM). G-TREM groups were implemented in three DC Public Schools and three DC Public Charter Schools which contained existing DC Department of Mental Health programs. Participants for the G-TREM groups were obtained through referrals by school staff or self-referred to the clinician who presented with trauma sequelae or documented abuse and victimization histories. A clinical intake and pre-group interview was conducted for each participant. A total of eight to twenty-six adolescent females were selected at each school for the G-TREM intervention and Waiting-List Control Group. Participants were asked to sign an informed consent along with their parent or guardian, complete the Aggression Questionnaire- AQ (Buss & Warren, 2000) (Appendix A), and complete the Reynolds Adolescent Depression Scale 2- RADS-2 (Reynolds, 2002) (Appendix B).

The AQ measured a student's self-perceived levels of aggression and anger. There were thirty-four items with a Likert response format. The AQ consisted of the following five

subscales: Physical Aggression (physical expression of anger), Verbal Aggression (argumentative and hostile language), Anger (agitation and sense of control), Hostility (resentment, social isolation, and paranoia), and Indirect Aggression (expression of anger without direct confrontation). Each AQ item described a characteristic related to aggression (Buss & Warren, 2000).

The Reynolds Adolescent Depression Scale- Second Edition (RADS-2) (Appendix B), developed by Reynolds (2002), was used to assess depressive symptoms. The RADS-2 was a self-report measure that assesses the severity of depressive symptomatology in adolescents in both schools and clinical settings (Reynolds, 2002). The assessment consisted of thirty items with a Likert response format. The Total Depression score served as an overall measurement of the severity of the symptoms with higher scores indicating greater distress. There were four subscales on the RADS-2. The Dysphoric Mood subscale evaluated “a distinct negative emotional state,” including feelings of misery and distress. The Anhedonia/Negative Affect subscale evaluated a lack of interest in activities that were normally pleasurable. Items on the Negative Self-Evaluation subscale examined low self-worth, self-deprecation, and thoughts of self-harm. The Somatic Complaints subscale evaluated the physical components of depression as well as irritability and boredom. Finally, the RADS-2 Critical Subscale discriminated between clinically depressed and non-depressed adolescents (Reynolds, 2002).

Interpretation of Findings

Questions 1 and 2 and their respective hypotheses pertained to the issue of treatment effectiveness, specifically the G-TREM group intervention. The analyses for hypotheses 1 and 2 follow the same sequence. For each variable of interest (depression and aggression), a repeated measures analysis of variance (ANOVA) was conducted using the subscale T-scores for the AQ and the RADS-2 at the pre-test Assessment and post-test assessment points for the group of 56 treatment and 54 waiting-list control participants.

Hypothesis 1: G-TREM and Aggression

It was hypothesized that the G-TREM group intervention would decrease the levels of aggression and antisocial behaviors (externalizing behaviors) in urban Black adolescent females. The AQ Total Score measured a student's self-perceived levels of aggression and anger (Buss & Warren, 2000). The results of the data analysis indicated that the G-TREM treatment had a significant effect for all of the components of AQ. Further, the pattern of data in all cases is essentially the same. The control group remains relatively unchanged from pre-test to post-test, while the treatment group significantly decreased in scores on the AQ. The partial eta squared for the interaction indicated that this was a meaningful difference. These results confirmed the hypothesis that participants' engagement in the G-TREM group intervention significantly reduced their externalizing behaviors of aggression, anger, and antisocial behaviors.

Although the sample's pretest and posttest scores on the AQ were not clinically significant, the participants of the G-TREM group intervention demonstrated a significant decrease in their self-reported levels of aggression. Research has indicated that group therapeutic approaches for traumatized adolescents are effective. In addition, studies have highlighted the effectiveness of the use of the adolescent peer group to help with self and other

judgments about normality, emotional support and affect regulation, and promotion of developmental recovery (Foa et al., 2000). The components of gender specificity and cultural competence of the G-TREM intervention were expected to enhance the results as research indicated that adolescent females exposed to violence were more likely to experience school-related behavioral problems than their male counterparts (Buka et al., 2001).

The results of the AQ subscales replicated the AQ Total findings which were that the treatment group demonstrated significant decreases in scores while the Waiting List Control Group scores remained fairly steady. This was an expected finding as the AQ score is highly related to all of the five subscales (Buss & Warren, 2000). According to the instrument's authors, the Physical Aggression subscale was one of the subscales that was most closely associated with the AQ Total Score (Buss and Warren, 2000). Specifically, the results of the data analysis of the AQ Physical Aggression subscale yielded significant results with a meaningful difference. The results of this subscale suggested that the participants' use of physical force when expressing anger or aggression significantly decreased after engaging in the G-TREM intervention. According to the literature, externalizing behaviors including physical aggression was reduced significantly when an individual was able to engage in a supportive milieu (Neal-Barnett et al., 2001).

The results from the data analysis of the Verbal Aggression subscale continued to reveal a pattern of significant decreases with a meaningful difference in scores demonstrated in the G-TREM group and fairly steady scores in the Waiting-List Control group. Participants' quarrelsome and hostile speech was significantly reduced as a result of their engagement in the G-TREM group intervention. The difference in scores of Verbal Aggression between the pre-test and post-test groups was particularly meaningful and a decrease in scores on the Verbal

Aggression subscale was expected as groups provided a vehicle for the appropriate expression of participants' thoughts and feelings of frustration, stress, and anger. In addition, the group milieu provided anger management strategies and alternatives to verbal arguments (Eron et al., 1994).

The AQ Anger subscale was also closely associated with the AQ Total score and as expected, the results from the data analysis revealed the same pattern of significant decreases in scores the G-TREM group and consistent Waiting-List Control scores across Pretest and Post Test assessment points. Participants in the G-TREM group treatment experienced marked decreases in their levels of anger, irritability, frustration, emotional lability, and temperamental gesturing. Individuals with anger management concerns usually have benefited from relaxation training, cognitive-behavioral interventions, arousal-reducing strategies coupled with concrete assistance in identifying and resolving their triggers for anger (Buss & Warren, 2000). The G-TREM intervention provided psychoeducation on anger management strategies and relaxation training for participants as well as a forum to identify and implement plans for their anger management challenges.

Results for the AQ Hostility subscale demonstrated a continued pattern of G-TREM group participants' scores significantly decreasing and the Waiting List Control group scores remaining steady. The data analysis indicated that there was a meaningful difference between the two groups. G-TREM group participants' attitudes of bitterness, social alienation, and paranoia significantly decreased as a result of their engagement in the G-TREM group treatment. The group format provided a structure to address the social isolation. The group format was also effective in addressing symptoms of paranoia as members could engage in reality testing with the other members of the group. Research has indicated the effectiveness of the use of the

adolescent peer group to help members with their self perceptions and judgments about normality (Foa et al., 2000).

The results for the final subscale on the AQ, Indirect Aggression, revealed the same pattern of the G-TREM group improving in the intended direction with a significant decrease in scores on the subscale and the control group remaining relatively unchanged. The data analysis also indicated that the difference between the G-TREM group and the Waiting List Control group was meaningful. The G-TREM group modality reduced participants' tendencies to express anger in actions that avoided direct confrontations. The group format provided opportunities for the members to directly and appropriately express their intense thoughts of anger and frustration. It also provided a way to enhance participants' assertiveness skills, conflict resolution strategies and alternative strategies for managing intense feelings of anger or aggression (Saltzman et al., 2001).

Hypothesis 2: G-TREM and Depressive Symptoms

It was hypothesized that the G-TREM group intervention will decrease the levels of depressive symptoms (internalizing symptoms) in urban Black adolescent females. It was evident from the data presented above that, with one exception, the data for Research Question 2 continued the same trends as in Question 1. Specifically, the control group remained unchanged from pre-test to post-test, while the treatment group significantly decreased with a large effect. The only exception was for Negative Affect where the interaction was not significant. Nevertheless, the data showed that the treatment had the effect of significantly reducing depression in the Black, adolescent females who were in the G-TREM treatment group. These results confirmed the research hypothesis that participants' engagement in the G-TREM group intervention would significantly reduce their internalizing symptoms of depression. Overall, the

sample's pretest and posttest scores on the RADS-2 were not clinically significant and as a result, the sample of the study was not clinically depressed. However, the participants of the G-TREM group intervention demonstrated a significant decrease in their self-reported levels of depressive symptoms. Research had indicated that group therapeutic approaches, were effective for traumatized adolescents (Foa et al., 2000). Further, since research indicated that females tended to demonstrate a gender-specific emotional response to violence (i.e. depression), a gender-specific intervention would have likely increased the effectiveness of the intervention (Cooley-Strickland et al., 2009; Fitzpatrick, 1993; Fitzpatrick & Boldizar, 1993; Gladstein et al., 1992; Schwartz & Kowalski, 1991).

The results of the RADS-2 subscales replicated the RADS Depression (overall level of depressive symptoms) findings which were that the treatment group demonstrated significant decreases in scores while the Waiting List Control Group scores remained fairly steady with the exception of the Negative Affect. The data analysis results of the RADS-2 Total Critical subscale produced significant results with a meaningful difference. The results of this subscale indicated that the G-TREM group treatment significantly reduced the clinical level of depressive symptoms of participants including self-destructive, suicidal, and self-injurious behaviors. The therapeutic elements of the G-TREM group provided a safe environment to express intense feelings of anger that might result in self-destructive behaviors. The group also provided therapeutic elements including cognitive restructuring and support to offer alternative strategies in managing intense thoughts and feelings (Foa et al., 2000).

The results of the data analysis of the RADS-2 Dysphoric Mood subscale yielded significant results with a meaningful difference. The results of this subscale suggested that the participants' symptoms of crying spells, loneliness, irritability, misery, and distress significantly

decreased after engaging in the G-TREM group intervention. According to the literature, depressive symptomatology such as feelings of distress, loneliness, irritability, and crying were reduced significantly when an individual was able to engage in a supportive milieu. Group therapy offered a safe and supportive place to explore individual concerns and targeted feelings of loneliness and isolation. G-TREM utilized the therapeutic element of cognitive restructuring which has been consistently demonstrated to be a particularly effective therapy for symptoms of depression (Fallot & Harris, 2002).

The results of the data analysis for the Anhedonia/Negative Affect Subscale were not significant for the participants of the G-TREM group treatment. Consequently, the G-TREM group modality did not significantly improve the group members engagement in activities that were normally pleasurable or motivation. Although the G-TREM group treatment significantly improved many of the group members depressive symptoms, a level of depression likely remained among some group members due to the complicated nature of their presenting stressors. These members might require additional treatment options and sessions beyond the length of the G-TREM sessions (4 months) to fully address their complex and chronic stressors. In addition, the normal developmental activities that adolescents experienced as pleasurable might have been the source of trauma and as a result, might be avoided rather than engaged by participants. Nevertheless, G-TREM was successful in engaging and retaining these adolescents in the treatment. Since engagement and retainment continued to present as issues for this population, G-TREM might have been the beginning of their therapeutic journey to emotional wellness.

Results for the Negative Self-Evaluation subscale revealed a continued pattern of G-TREM group participants' scores significantly decreasing and the Waiting List Control group

scores remaining steady. The data analysis indicated that there was a meaningful difference between the G-TREM and Waiting List Control groups. G-TREM group participants' feelings of worthlessness, self-deprecation, and thoughts of self-harm significantly decreased as a result of their engagement in the G-TREM group treatment. The group format provided a supportive milieu to provide a sense of belonging and value (Foa et al., 2000). The therapeutic elements of Cognitive Behavioral Therapy challenged and restructured participants' thoughts and beliefs about themselves.

The results for the final subscale on the RADS-2, Somatic Complaints, revealed the same pattern of the G-TREM group improving in the intended direction with a significant decrease in scores on the subscale and the control group remaining relatively unchanged. The data analysis also indicated that the difference between the G-TREM group and the Waiting List Control group was particularly meaningful producing a large effect. G-TREM group members' reports of physical symptoms and illnesses were significantly reduced as a result of their participation in the G-TREM group treatment. Research indicated that when individuals were able to appropriately express their intense feelings in a supportive context, their somatic complaints and their physical illnesses decreased. The group and therapeutic components of GTREM provided a format for members to express their feelings in a supportive, safe, and therapeutic setting (Foy et al., 2001) G-TREM also provided psychoeducational training on the importance of self-care as a way to manage intense feelings in an effort to decrease any physiological consequences of emotional distress (Harris & FalLOT, 2001).

As additional analyses, the data were analyzed to ascertain whether a student's grade in school affected the results. It was evident that the effect of the treatment increased as grade level increases. The greatest change was demonstrated by the 12th grade students followed by the

11th grade, then the 10th and finally with the smallest change demonstrated by the 9th grade students. Although these results should be interpreted with caution due to the small sample size for the 11th and 12th grades, treatment was more effective as participants' grade level increased. Participants in higher grades might possess a greater ability to process emotionally-laden material due to increased development of coping strategies. Neuropsychology indicated that an older participants' frontal lobe may also be more developed than a younger participants frontal lobe increasing their their decision-making abilities and impulse control. Further, early traumatic experiences might likely result in younger children confronting adult issues which they were likely less equipped to manage in comparison to their adolescent counterparts (Margolin & Gordis, 2000).

Summary

The current study evaluated the effectiveness of the G-TREM group treatment on the aggression and depressive symptoms of urban black females exposed to violence. Results confirmed that the G-TREM group treatment significantly decreased the externalizing behaviors of aggression and anger and the internalizing symptoms of depressive symptoms for urban black females exposed to violence. The results indicated that the differences in decrease of symptoms experienced by the G-TREM participants were meaningful. One final result showed that treatment was more effective as participants' grade level increased.

Limitations of the Study

There were several limitations of my study. Due to the pretest-posttest control design of my study, other hypotheses that infer the degree to which treatment was effective was possible. The pretest might have a potential sensitizing effect relating to external validity, which might affect the generalizability of the results of the study. Since the participants are urban, Black

adolescent females, the generalizability of this study's findings might be limited primarily to urban Black populations. In addition, attrition might have occurred due to students' failure to return the consent form. Since the participants were not randomly selected for the study, variables such as finances or access and/or restriction to resources at a particular school could also confound the data (Heppner, Kivlighan, & Wampold, 1999). The assessment and coding of each participant's type of violence exposure with specifiers indicating type and frequency could have been more structured by using a standardized assessment such as the Exposure to Violence Survey, thereby reducing potential confounding variables and yielding possibly additional clinical implications (Richters, 1998). The study also included one participant who was 20 years of age, which exceeded the G-TREM intervention age limit and, as a result, could have confounded the data. Some participants might not have felt comfortable candidly sharing their feelings, perceptions, and experiences, since this study relied on assessments based on the self-reports of participants. The cognitive restructuring variables in the G-TREM intervention may prompt participants to provide perceived acceptable responses in the groups and on the assessments. Finally, although G-TREM was a manualized intervention and group leaders received training in the G-TREM intervention, group leaders might have varied in their level of comfort and expertise in leading a group.

Conclusions

The problem of violence exposure for urban Black adolescents has been well-documented. However, effective treatment interventions remained sparse for urban Black adolescents exposed to violence. Results from the current research might offer insight into methods of working with urban Black adolescent females exposed to violence. Urban Black adolescent females exposed to violence experienced a decrease in their self-reported aggressive

behaviors as a result of their participation in the G-TREM group intervention. The G-TREM group provided a safe therapeutic milieu for the participants to discuss the nature of their intense emotions of aggression and anger and develop coping strategies to appropriately manage these emotions. The G-TREM group structure provided a setting for participants to observe the struggles of their peers resulting in social learning and development of empathy for others, which might be critical in decreasing antisocial behaviors. The G-TREM group also provided a setting to receive information about social normality as participants received feedback regarding their behaviors from their peers and through the G-TREM exercises (i.e. vignettes). The findings from the study confirmed the research that group-based therapeutic approaches for traumatized adolescents were effective due to the components of emotional regulation and judgments about normality (Buka et al., 2001).

In addition, urban Black adolescent females exposed to violence experienced a decrease in their self-reported depressive symptoms as a result of their participation in the G-TREM group intervention. The structure of the G-TREM group provided a sense of belonging for the participants, which addressed the depressive symptoms of social isolation, withdrawal, and loneliness. The G-TREM group also provided a supportive therapeutic milieu for the participants to discuss and implement coping strategies for their feelings of sadness and associated symptoms of depression reducing their tendencies to internalize their emotions. The cognitive restructuring element of G-TREM challenged and reframed the way participants perceived situations and their difficulties. The findings from this study also confirmed the research that group-based therapeutic approaches for traumatized adolescents were effective due to the components of emotional support, affect regulation, and developmental recovery (Buka et al., 2001).

In addition, clinicians and stakeholders should focus on the recruitment and retainment of urban Black adolescents females exposed to violence in treatment. Early identification of adolescents exposed to violence might likely result in improved treatment outcomes for adolescents with less expense to self and the community. Although many of the participants in this study were not identified and assessed at clinically significant levels for aggression or depression, the participants experienced a significant decrease in their aggressive and depressive symptomatology, which resulted in improved psychosocial functioning and wellness. The creation of a safe, supportive, and culturally relevant intervention assisted in the retainment of the participants. Group counseling can be an effective vehicle for retaining African-American females in treatment and has been identified as a practical intervention in empowerment (Brown et al., 1989). The effective recruitment, retainment, and engagement of urban Black adolescents exposed to violence in G-TREM were additional key components in the effectiveness of this intervention. In conclusion, this research was a crucial strategy in addressing the problem of violence exposure for urban Black adolescent females and its implications.

Future Research Implications

There are numerous and significant implications for this study. The results of this study will add to the sparse body of literature and research on empirical studies of trauma-specific interventions for adolescents. The results of this study will also inform treatment for urban Black adolescent survivors of violence by providing effective interventions for this population.

One of the more compelling implications of this study is that the research will assess the effectiveness of a group intervention (G-TREM) that was created and normed for the specific population that it proposes to treat- Black adolescent females residing in the District of Columbia who have been exposed to violence. The developers of the G-TREM intervention utilized focus

groups to create the intervention comprised of Black adolescent females exposed to violence who were Washington, DC residents and clinicians providing treatment in Washington, DC. Thus, the G-TREM intervention will be treating the target population that it was specifically designed to treat. Current research remains sparse in providing effective evidenced based treatment for this particular population.

In addition, schools, governments, and community stakeholders are seeking specific evidenced based practices to target the negative effects of exposure to violence specifically on urban Black and Latino adolescents. Stakeholders have become increasingly alarmed with the behaviors of violence-exposed adolescents including violence towards oneself (i.e. suicide, depression) and the violence towards others (i.e. homicide, aggression). Depression, aggression, and the ways in which these clinical concerns manifest in adolescents are the most frequently reported presenting problems amongst stakeholders including DC schools, community agencies, and policy makers. This research study may assist in informing treatment of Black urban adolescent females exposed to violence by providing an intervention that targets the specific symptoms of depression and aggression which may potentially lead to suicide and homicide. Further, this research may also uncover moderating variables that may be viewed as strengths or coping strategies for violence exposed adolescents.

Future research studies conducted on the treatment efficacy of urban Black adolescents exposed to violence is critical and warranted. Follow-up studies of the participants included in this particular research that assesses the current level of their aggressive behaviors and depressive symptoms and treatment engagement will provide additional data regarding the treatment efficacy of G-TREM. Also the comparison of individual counseling to the G-TREM group treatment may also give further data regarding the treatment effectiveness of G-TREM.

The comparison of the G-TREM group treatment with other group treatments for traumatized adolescents may also yield further treatment implications for this population. The assessment and coding of students' type of violence exposure by using a standardized assessment will enhance research findings and treatment implications. In addition, assessing the posttraumatic symptoms of this population in a controlled study may also produce additional treatment implications for this population. Further, it may prove interesting and compelling to assess the sex differences in treatment effectiveness for urban Black adolescents exposed to violence.

Empirically validated research on this population will translate into improved and effective strategies for counseling Black American adolescent females. If such interventions are successful, the result should be substantial financial, health, and behavioral benefits in both the short and long term (Menard, 2002). Black adolescent females eventually develop into Black adult females and may assume the invaluable roles of citizen, mother, mentor, leader, colleague, teacher, and policy maker. The improved coping and welfare of Black American adolescent females can only have beneficial effects for society.

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APPENDIX A

AGGRESSION QUESTIONNAIRE (BUSS & PERRY, 1992)

AQ

PC Answer Form

Arnold H. Buss, Ph.D.

Directions

The statements on this form ask you to describe how you interact with other people. There are no right or wrong answers, so please just describe yourself as honestly as you can. When you are ready to begin, read each statement carefully and decide how well it describes you, using the following response scale. Then circle the number of the one response that best fits your answer.

- 1 Not at all like me
- 2 A little like me
- 3 Somewhat like me
- 4 Very much like me
- 5 Completely like me

Please circle only one response for each statement. If you want to change an answer, draw an X through your first response. Then circle the number that shows your new choice.

Name _____

ID (Ask your examiner what to write in this space.) _____

Date _____ Age _____

Gender: Male Female

Last Grade Completed: (Mark one.)

1 <input type="checkbox"/>	9 <input type="checkbox"/>
2 <input type="checkbox"/>	10 <input type="checkbox"/>
3 <input type="checkbox"/>	11 <input type="checkbox"/>
4 <input type="checkbox"/>	12 <input type="checkbox"/>
5 <input type="checkbox"/>	13 <input type="checkbox"/>
6 <input type="checkbox"/>	14 <input type="checkbox"/>
7 <input type="checkbox"/>	15 <input type="checkbox"/>
8 <input type="checkbox"/>	16 <input type="checkbox"/>
	>16 <input type="checkbox"/>

Ethnicity: Asian Black Hispanic Native American White Other

Examiner Name _____

Examiner ID (Ask your examiner what to write in this space.) _____

W-371C

Circle one response number for each statement.

Not at all like me A little like me Somewhat like me Very much like me Completely like me

1	2	3	4	5	1. My friends say that I argue a lot.
1	2	3	4	5	2. Other people always seem to get the breaks.
1	2	3	4	5	3. I flare up quickly, but get over it quickly.
1	2	3	4	5	4. I often find myself disagreeing with people.
1	2	3	4	5	5. At times I feel I have gotten a raw deal out of life.
1	2	3	4	5	6. I can't help getting into arguments when people disagree with me.
1	2	3	4	5	7. At times I get very angry for no good reason.
1	2	3	4	5	8. I may hit someone if he or she provokes me.
1	2	3	4	5	9. I wonder why sometimes I feel so bitter about things.
1	2	3	4	5	10. I have threatened people I know.
1	2	3	4	5	11. Someone has pushed me so far that I hit him or her.
1	2	3	4	5	12. I have trouble controlling my temper.
1	2	3	4	5	13. If I'm angry enough, I may mess up someone's work.
1	2	3	4	5	14. I have been mad enough to slam a door when leaving someone behind in the room.
1	2	3	4	5	15. When people are bossy, I take my time doing what they want, just to show them.
1	2	3	4	5	16. I wonder what people want when they are nice to me.
1	2	3	4	5	17. I have become so mad that I have broken things.
1	2	3	4	5	18. I sometimes spread gossip about people I don't like.
1	2	3	4	5	19. I am a calm person.
1	2	3	4	5	20. When people annoy me, I may tell them what I think of them.
1	2	3	4	5	21. I sometimes feel that people are laughing at me behind my back.
1	2	3	4	5	22. I let my anger show when I do not get what I want.
1	2	3	4	5	23. At times I can't control the urge to hit someone.
1	2	3	4	5	24. I get into fights more than most people.
1	2	3	4	5	25. If somebody hits me, I hit back.
1	2	3	4	5	26. I tell my friends openly when I disagree with them.
1	2	3	4	5	27. If I have to resort to violence to protect my rights, I will.
1	2	3	4	5	28. I do not trust strangers who are too friendly.
1	2	3	4	5	29. At times I feel like a bomb ready to explode.
1	2	3	4	5	30. When someone really irritates me, I might give him or her the silent treatment.
1	2	3	4	5	31. I know that "friends" talk about me behind my back.
1	2	3	4	5	32. Some of my friends think I am a hothead.
1	2	3	4	5	33. At times I am so jealous I can't think of anything else.
1	2	3	4	5	34. I like to play practical jokes.

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APPENDIX B

REYNOLDS ADOLESCENT DEPRESSION SCALE-2nd EDITION (REYNOLDS, 2002)

RADS-2 Test Booklet

by William M. Reynolds, PhD

Name _____	Age _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Today's Date: _____/_____/_____ Mo. Day Yr.
Grade in School: _____	Ethnicity/Race: _____	School/Agency _____	

Directions: Listed below are some sentences about how you feel. Read each sentence and decide how often you feel this way. Decide if you feel this way almost never, hardly ever, sometimes, or most of the time. To answer each item, circle the number under the answer that best describes how you really feel. Remember, there are no right or wrong answers. Just choose the answer that tells how you usually feel.

	Almost never	Hardly ever	Some- times	Most of the time
1. I feel happy	1	2	3	4
2. I worry about school.....	1	2	3	4
3. I feel lonely.....	1	2	3	4
4. I feel my parents don't like me	1	2	3	4
5. I feel important	1	2	3	4
6. I feel like hiding from people.....	1	2	3	4
7. I feel sad	1	2	3	4
8. I feel like crying	1	2	3	4
9. I feel that no one cares about me	1	2	3	4
10. I feel like having fun with other students.....	1	2	3	4
11. I feel sick	1	2	3	4
12. I feel loved.....	1	2	3	4
13. I feel like running away.....	1	2	3	4
14. I feel like hurting myself	1	2	3	4
15. I feel that other students don't like me.....	1	2	3	4
16. I feel upset	1	2	3	4
17. I feel life is unfair	1	2	3	4
18. I feel tired	1	2	3	4
19. I feel I am bad.....	1	2	3	4
20. I feel I am no good	1	2	3	4
21. I feel sorry for myself.....	1	2	3	4
22. I feel mad about things	1	2	3	4
23. I feel like talking to other students.....	1	2	3	4
24. I have trouble sleeping.....	1	2	3	4
25. I feel like having fun	1	2	3	4
26. I feel worried	1	2	3	4
27. I get stomachaches.....	1	2	3	4
28. I feel bored.....	1	2	3	4
29. I like eating meals.....	1	2	3	4
30. I feel like nothing I do helps any more	1	2	3	4

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APPENDIX C
ADVERTISEMENT



Love & Life

A GROUP

for:

Young Women 12-18

For more information

Contact:

(Insert Contact Information of
School Mental Health Clinician)

**Sometimes life can feel
like a struggle:**

Stress
Community Violence
No one to count on

Join a group of young women determined to succeed!

The Love & Life Group focuses on issues such as: relationships, stress, anxiety, peer pressure, depression, shame, concentration, anger/hostility, substance abuse, violence, self-esteem, and victimization.

Project Hope aims to educate girls, parents, teachers, school administrators, and counselors about the signs that a girl needs support, and provide information about what kinds of supports are available to help girls better cope with these problems.

Group

Information:

- Talk, listen, learn, act, and create.
- Lasts one hour
- Snacks provided



APPENDIX D
LETTER OF SUPPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH



To Whom It May Concern:

I am writing in my role as Program Manager for the School Mental Health Program within the Department of Mental Health in Washington, D.C. We recognize that Ms. Taiwan Lovelace is a graduate student at Temple University who desires to use our Girls Trauma Recovery Empowerment (G-TREM) data for completion of her dissertation research requirement. I am confirming that Ms. Lovelace has been granted access to our Girls Trauma Recovery Empowerment Module (G-TREM) collected data.

Sincerely,

A handwritten signature in black ink that reads "Charneta C. Scott".

Charneta C. Scott, Ph.D.
Program Manager
School Mental Health Program
Department of Mental Health