The Social Validity and Pro-Social Impact of The FRIENDS for Life program in Newfoundland and Labrador Schools

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ABSTRACT

The current study examines the treatment acceptability of the FRIENDS For Life program in a Canadian context - specifically Newfoundland and Labrador, as well as examining how involvement with the FFL program may influence the prosocial behaviours reported by students. Using a quantitative pre-post survey design, data was collected from students and parents selected from ten elementary schools within the Eastern Region of the Newfoundland and Labrador English School District. Students indicated that they enjoyed the program, and felt that experiencing the program within the classroom environment, with their peers, was useful. Students within this study rated themselves more positively on the pro-social scales after completing the program. This was especially true when it came to helping others, sharing with others, and being nice to others. Results also indicated parents felt the program was useful, and that their children enjoyed participating in the program. In keeping with the Theories of Planned Behaviour, and Self-Efficacy, the belief that the program works can have a positive impact on the actual experience of anxiety for students. As such, this program may be a useful addition to the school experience for the students of Newfoundland and Labrador.

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List of Abbreviations

APA – American Psychological Association

CBT – Cognitive Behavioural Therapy

FFL – FRIENDS for Life

GCBT – Group Cognitive Behavioural Therapy

SVQ – Social Validity Questionnaire

SDQ – Strengths and Difficulties Questionnaire

DSM-IV – Diagnostic and Statistical Manual, Fourth Edition

DSM-V – Diagnostic and Statistical Manual, Fifth Edition

GAD – Generalized Anxiety Disorder

OCD – Obsessive Compulsive Disorder

WHO – World Health Organization

REBT – Rational Emotive Behavior Therapy

TPP – Theory of Planned Behaviour

SDT – Self-Determination Theory

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Terminology and Language Notes

The words ‘gender’, ‘male’, and ‘female’ are used throughout this paper to relay demographic information regarding participants within the current study. Neither the relevant literature, nor the demographic information collected through self-reporting within the current study, differentiated between gender and sex. As such, there is no distinguishing between those whose gender differs from that assigned at birth, and those whose gender aligns with that assigned to them at birth. This may result in individuals being placed in gender categories not reflective of their lives and experiences, thus impacting the data collection process. In the case of the present study, demographic information may be skewed as a result.

CHAPTER ONE

Introduction

Anxiety

Anxiety is defined as "an emotion characterized by feelings of tension, worried thoughts, and physical changes . . ." (American Psychological Association [APA], 2015a). While all people at some point in their lives typically experience anxiety, anxiety becomes disordered when it has a major impact on daily functioning and does not easily subside. The APA (2015b) outlines five different types of anxiety disorders: Generalized Anxiety Disorder; Panic Disorder; Phobia; Obsessive-Compulsive Disorder; and Post-Traumatic Stress Disorder with common symptoms of Anxiety Disorders including: "…extreme fear; shortness of breath; racing heartbeat; insomnia; nausea; trembling and dizziness. . .". The Anxiety Disorders Association of Canada (2003) reported that anxiety is one of the most prevalent mental health disorders, with the twelve-month prevalence for anxiety disorders being over 12%, and at least one in four Canadians having at least one anxiety disorder in their lifetime. Statistics Canada (2013) reported that 2.6% of Canadians ages fifteen and up reported symptoms consistent with generalized anxiety disorder, just one of the five anxiety disorders previously outlined.

Anxiety is not just an adult issue; it is also one of the most prevalent psychiatric issues in childhood and adolescence (Kessler et al., 2005; Esbjørn, Bender, Reinholdt-Dunne, Munck, & Ollendick 2012). In addition, most adolescents and adults who experience anxiety disorders often develop initial signs during childhood (Snyder et al.,

2009; Anxiety Disorders Association of Canada, 2003). This indicates that childhood development plays an important role in the development of anxiety disorders.

Anxiety symptoms have a serious impact on daily functioning for students who experience them. Miller, Short, Garland, and Clark (2010) describe these symptoms as interfering with normal, developmentally appropriate activities, relationships, and achievement, including school attendance, friendships, and expected developmental play. Despite the acknowledgement of the prevalence of anxiety development in childhood, Esbjørn et al. (2012) suggest that our knowledge and understanding of the development of anxiety disorders is limited, and that children who are developing and/or suffering from anxiety disorders are often untreated due to a lack of recognition of the signs. It has been proposed, however, that childhood anxiety can be reliably measured as early as five years of age (Snyder et al., 2009), and that early symptoms of anxiety are related to increased risk of adult major depression and anxiety disorder (Jakobsen, Horwood, & Fergusson, 2012).

Models of Anxiety Development

Identifying the causes or development of anxiety in childhood can be a complex issue. There have been many proposed theories which try to explain the development of anxiety. Weems and Stickle (2005) have provided an overview of some of the different theories and how they address anxiety development. These theories include: Biological Theories; Behavioural Theories; Cognitive Theories; and Interpersonal/Contextual Theories. Weems and Stickle also discuss combining components of these various theories to create a more integrative model of childhood anxiety disorders.

Biological theories, according to Weems and Stickle (2005) are theories which attribute anxiety development to genetic causes. Some examples of biological theories include: theories which focus on temperament, which posit that there is a biological predisposition to react negatively to novel events or situations; theories which place emphasis on brain function and neurochemistry; and theories which place emphasis on the hypothalamic-pituitary-adrenal (HPA) axis and the amygdala, attributing anxiety development to "an exaggeration of normal anticipatory reactions… which results in increased physiological reactivity, increased neuroendocrine activity, and increased reflexive responsiveness to stimuli". Weems and Stickle state that biological theories implicate the following traits which may be inherited, and may contribute to anxiety development: behavioural inhibition; trait anxiety; exaggerated fear-potentiated startle; cortisol reactivity; and physiological markers of arousal or relaxation.

The second type of theory highlighted by Weems and Stickle (2005) is Behavioural Theory. There are four different approaches to Behavioural Theory, which are discussed by Weems and Stickle, including: aversive conditioning; vicarious acquisition; verbal transmission of information; and operant conditioning. Aversive conditioning involves the pairing of previously neutral stimuli with aversive, traumatic, or sub-traumatic stimuli/events. Vicarious Acquisition involves observational learning or modelling. Verbal transmission of information involves talking about fearful things with others who are close (e.g. Parents, teachers). Operant conditioning involves the child learning to cope with negative events/stimuli through avoidance behaviours. According to Kimmel and Brennan (1981), the conditioning models of anxiety are based on the idea

that anxiety is a result of individuals being exposed to a very high frequency of unpredictable, highly aversive events. These aversive events have no connection to their own behaviour, and have no connection to regular preceding environmental stimuli. Individuals exposed to these events, become conditioned to be responsive in an excessive number of situations, resulting in a generalized anxiety disorder.

Cognitive theories, according to Weems and Stickle (2005), propose that "understanding the process of information at various stages in the cognitive system, such as encoding, interpretations, and recall, can help to elucidate the etiology and maintenance of anxiety disorders". In other words, cognitive errors and misinterpretations can result in the development of anxiety. Weems and Stickle describe four types of cognitive distortions that may impact the development of anxiety: interpretative bias; judgement bias; memory bias; and selective attention. Interpretive bias involves having disproportionately negative interpretations of unknown or potentially threatening stimuli/situations. This includes catastrophizing, expecting the worst possible outcome of an event/situation. Judgement bias includes negative and/or lowered estimates of the ability of the individual to cope with events/situations. Memory bias includes recalling disproportionately negative information about oneself, past situations, or events. Lastly, selective attention includes predominantly attending to threatening stimuli when such stimuli are placed in a context with neutral or other non-threatening stimuli.

The final type of theory described by Weems and Stickle (2005) is Interpersonal/Contextual. These theories propose that factors influencing the

development of anxiety do not occur in isolation, but within a social/interpersonal context in which the individual lives. This context determines how and which influences impact a child. Examples of this include poverty, parental psychopathology, exposure to trauma, or exposure to violence. These influences may worsen vulnerability to the development of anxiety. Attachment theories are included within the umbrella of interpersonal/contextual theories. Attachment theory asserts that the impact of the parent-child relationship can contribute to the development of the child, including the development of anxiety disorders.

Chorpita and Barlow (1998) state that models of childhood anxiety and adult anxiety can be integrated and used in combination with each other in order to gain an understanding of how anxiety develops. These models include the conditioning models previously discussed, and biopsychosocial models. The Biopsychosocial model proposes that the development of anxiety disorders is due to three types of causes: biological causes, psychological causes, and social causes (Jakobsen et al., 2012). This model presents anxiety development as a complex inter-mingling of these factors, with each having a different degree of impact on each individual. When looking at the relationship between these three factors, there is no individual cause of anxiety. Rather, there are any number of complex combinations of events throughout the three factors that may contribute to anxiety development. Through this model, in order to fully address the anxiety issues, one must understand the influence of each of these factors and how they are interconnected. Weems and Stickle (2005) also discuss an Integrative Model of Childhood Anxiety Disorders. This integrative model intertwines components of the

various theories to create a broader model of development. This model is described as a response system that involves behavioural, physiological, and cognitive components. They combine this model with the Developmental Psychopathology Model, which asserts that disordered anxiety develops because of a complex interaction of individual risk factors and problems within the immediate and broader psychosocial context of the individual. When combined, Weems and Stickle (2005) suggest that childhood anxiety development may result from a complex interplay of biological, cognitive, behavioural, and social influences. This model differs from the Biopsychosocial model in that it also includes behaviour as a component of anxiety development.

Similar to the Integrative Model proposed by Weems and Stickle (2005), Esbjørn et al. (2012) presented an overview of the factors that have been identified in current research and have been proposed as contributors to the development of anxiety. Some of the factors he described included: temperamental style of behavioural inhibition; difficulties with emotional regulation; information-processing and attention biases; family factors (such as rearing style, marital conflict, and parental beliefs); insecure attachments, parenting practices; and heredity. These factors were all highlighted by Weems and Stickle in their Integrative model, and so support the idea that the development of anxiety can be contributed to an interaction of factors and components, rather than one particular theory or individual factor.

With all of the factors discussed impacting the development of anxiety, Emotional Regulation is one of the factors that has been given significant attention within the research and seems to be one of the factors of great interest to researchers (Esbjørn et al.,

2012; Suveg, Southam-Gerow, Goodman, & Kendall, 2007; Craske & Zucker, 2001). The ability to regulate emotions is considered to play an important role in child functioning, well-being, and the development of psychopathology. This suggests that a child's ability to be emotionally self-aware, to be evaluative, and to develop control of emotional responses to both internal and external stimuli has an impact on the experience of anxiety for that child. One possible conclusion that may follow, is that the teaching of emotional regulation skills to children may have some positive influence on prevention of the development, or severity, of anxiety disorders. In fact, Craske and Zucker (2001) suggest that early intervention may actually offset the development of enduring anxiety disorders in adulthood.

There are many factors which contribute to anxiety. Gaining an understanding of the origins of anxiety can help with the development of a model of treatment for anxiety symptoms. Following this line of thinking, one may infer that individuals may be able to learn skills and techniques that can reduce the experience of anxiety. This leads to the development of treatment models, but also towards the prevention of the development of anxiety.

Treatment of Anxiety

In an attempt to treat the symptoms of anxiety, there have been a number of treatment models and approaches which have been employed by medical and mental health professionals. These treatments may be based on prescription drugs, therapy, or some combination of prescription drugs and therapy together.

Cognitive-Behavioural Therapy (CBT). One of the most common and widely supported models used in the treatment of childhood anxiety symptoms is Cognitive-Behavioural Therapy (CBT). CBT reflects the idea that anxiety is developed due to a combination of biological, psychological, and behavioural elements. This model of therapy was developed by Beck (1976). Beck put forward two assumptions at the core of his approach: "a person's consciousness contains elements that are responsible for upsets and blurred thinking" (p. 2); and, the client has at his or her disposal various rational techniques that can be used, with proper instruction, to deal with these elements of the consciousness. These assumptions come together to form the idea that people have the ability to understand and solve these psychological problems within themselves. Beck went on to describe the types of elements that can cause these disturbances, namely irrational thoughts, and assumptions and distortions of reality. As such, the purpose of CBT is to identify these elements and learn alternative, more realistic, ways of being.

Beck (1976) aimed to develop a therapeutic approach that focused on empowerment, with a belief that problems can be overcome by "sharpening discriminations, correcting misconceptions, and learning more adaptive attitudes" (p. 20). Beck suggested four steps in the process of correcting judgments: (1) develop an awareness of thoughts, both automatic thoughts and conscious thoughts; (2) recognize that things are awry; (3) replace the inaccurate judgments/perceptions/thoughts with more accurate ones; (4) provide feedback to inform the client if the changes that have been made are correct (p. 217).

One of the main cognitive techniques consists of training clients to recognize the irrational and problematic thought processes (Beck, 1993). These are the automatic thoughts that clients may not be fully aware are occurring. Clients can be trained to recognize and identify these thoughts when they occur. These thoughts can serve as connectors between events and feelings, often being the key to working through types of feelings that have a negative impact on life functioning.

Another core technique used in cognitive therapies is distancing (Beck, 1993). Once the problematic thoughts have been identified, the client may have difficulty examining the thoughts objectively. Distancing, helping the client to step back and observe the thoughts from the perspective of an 'outsider', serves to help the client objectively evaluate the thoughts. This objectivity helps the client to see the irrationality of the thoughts; the difference between the thought and the reality of the situation.

A third core technique is correcting cognitive distortions and deficiencies (Beck, 1993). Cognitive distortions are thoughts that are irrational or skewed from reality. Beck highlights a number of different distortions/deficiencies that can occur, including: arbitrary inferences – drawing a conclusion when evidence is contrary or lacking; overgeneralization – making a generalization based on a single incident; magnification – exaggerating the meaning or significance of a particular event; and cognitive deficiency – disregarding an important aspect of a life situation. The ability to consciously become aware of these distortions and deficiencies allows a person to also consciously put effort into changing them. When this is combined with the other techniques, they can be used

to create a treatment program that empowers the individual and enables them to work to reduce the experience of anxiety.

Other treatment approaches and techniques. While research on the treatment of childhood anxiety focuses primarily on the use of Cognitive-Behavioural Therapy, there are other techniques that have also been applied to CBT in order to help individuals with anxiety symptoms. One such approach is REBT, or Rational-Emotive Behaviour Therapy. Rational Emotive Behaviour Therapy is a form of CBT that is more direct in addressing the irrational thoughts that people have. REBT operates on the assumption that psychological disorders such as anxiety are the creation of the individual, through conscious or unconscious irrational thoughts and beliefs, and has been shown to be effective in the treatment of Generalized Anxiety Disorder (Crawford & Ellis, 1989; Cristea, Stefan, David, Mogoase, & Dobrean, 2016). REBT works to help individuals identify the different types of irrational beliefs that are impacting them, and replace those beliefs with more rational beliefs. Once the existing rational and irrational beliefs have been identified, the individual learns to identify the problem feelings and behaviours that are associated with those beliefs. There is less research available to support the use of REBT with children than CBT.

Research suggests that Play therapy may be effective for children experiencing and struggling with anxiety. There are different types of play therapy, such as client-centered play therapy and cognitive-behavioural play therapy (Russ & Fehr, 2016). Russ and Fehr outline four different functions of play that enables change to occur for children: play allows children to express emotions naturally; the therapist may engage with the

play in a way that helps develop a positive therapeutic relationship; it provides an avenue for the therapist and child to gain insight into the child and provide an opportunity to work through the issues; and lastly, it provides the child with an opportunity to practice a variety of different ideas, behaviour choices, and responses to a variety of situations. This play can occur in a safe setting, where the child can feel free to express him or herself and can be guided through play that is purposeful yet authentic. Russ and Fehr suggested that, after a review of research on therapeutic play and anxiety, therapeutic pretend play therapy can be an effective method of anxiety treatment for children.

When children receive medical treatment for anxiety disorders, a psychiatrist or family doctor may prescribe drug therapies. There are different types of drugs that are typically prescribed for anxiety disorders, and these are described by Bandelow et al. (2008). Bandelow et al. describe drug treatments as a leveled treatment system, with treatments starting with selective serotonin reuptake inhibitors (SSRIs), serotonin-noradrenaline reuptake inhibitors (SNRIs), and the calcium channel modulator pregabalin. When these drugs do not seem to work, medical practitioners will often move towards the next level of treatment, benzodiazepines. These researchers describe anxiety disorders as having a "waxing and waning course". They exert that once a disorder has gone into "remission", the elimination of all or most symptoms of anxiety, the treatment should continue for the period of a year in order to prevent relapse. Patients who receive drug therapies for anxiety may sometimes also avail of psychological treatments in conjunction with the drug treatments, such as CBT.

Prevention Programs

The emphasis of early intervention techniques as a means of treatment for children who experience anxiety disorders has led to the development of prevention programs. Prevention programs are interventions that are implemented before the initial onset of the disorder (Haggerty & Mrazek, 1994). Prevention programs can be classified in three different ways: universal, selected, or targeted/indicated (Stallard, 2010). Universal approaches are applied to an entire population, such as all students in a school population. Selected approaches are applied to members of a population who are not yet showing symptoms of a disorder, but who are deemed to be high risk for developing the disorder in the future. Targeted/Indicated approaches, also called early intervention approaches, are provided for individuals who have been identified as demonstrating signs of a developing disorder.

In terms of school-based interventions, all of these approach types can be seen in some form or another within the school environment. The school can be a beneficial setting for prevention programs for many reasons. Two of these reasons include that school is an entry point for individuals at a young age, and that all children have the opportunity to participate in the prevention program. School-based interventions and early intervention programs for anxiety can be effective in reducing the symptoms of anxiety (Neil & Christensen, 2009). Oftentimes, school-based interventions that are directed towards mental health fall within the umbrella of universal approaches. Within universal approaches, all students of a population will receive the programming. These approaches are generally based on awareness and education, as opposed to treating an

actual disorder. This universal approach is the most practical for school, as it uses the least amount of time and resources, and is also suggested to be positively effective (Stallard, 2010).

Selected prevention programs target students who are not yet presenting with a disorder, but have been deemed as being at high risk (Stallard, 2010). This type of intervention would serve to address concerns that may be emerging, but have not yet become clear problems. Within the school system, for example, this may look like group counselling by the school counsellor. Stallard suggests that while there may be evidence that a selected approach can help to improve coping skills for students, it has the same effect as universal programs and it can be more stigmatizing. For these reasons, universal programs may be a better option for schools than selected programs.

The targeted/indicated approach focuses on students who have presented with already established disorders. Within the school system, this will often be seen when students receive accommodations or alternate programming which address the diagnosed disorder. The purpose of this type of intervention, is to minimize the negative impact of disorder symptoms. This may take the form of group counselling or individual counselling provided by a school counsellor, or classroom accommodations to help the student develop strategies to cope within the classroom environment, for example. Shucksmith et al. (2007) completed a review of literature, which demonstrated support that a targeted/indicated approach may also be an effective approach (as cited in Stallard, 2010). They also suggested that such interventions were also positively effective when based on Cognitive-Behaviour Therapy (CBT). When participating in CBT-based

intervention, the students learned transferrable skills that should help reduce and/or cope with symptoms in a variety of environments.

FRIENDS for Life

One universal prevention program that has been implemented in schools throughout the world is the FRIENDS for Life program (FFL). The FRIENDS for Life program is a CBT based universal prevention program that is primarily used in a school setting, but can also be used in a community group setting (Barrett, 1998; McLoone, Hudson, & Rapee, 2006). The FRIENDS program has three different programs which, when delivered in the school setting, is typically delivered to all children in a particular class or grade. Each of these three programs are designed to meet the needs of different developmental levels. The Fun FRIENDS program is intended for primary school students, the FRIENDS for Life program is for elementary school students, and the FRIENDS Youth program is for junior high students. While each program is slightly different in delivery, they are all CBT based and teach the same basic objectives. The FRIENDS for Life program (for elementary students) consists of ten sessions, lasting an hour each, and is delivered by a trained facilitator, often a teacher or school counsellor. Facilitators are trained through a one day session in which they receive the leaders guide and are guided through the important elements of the program and how to effectively facilitate group sessions. Prior to the program, there is a parent session which educates parents in what their children will be doing and learning throughout the program, and how to support students with the home-work tasks. The sessions are focused on identifying feelings, cognitive strategies, exposure exercises, relaxation techniques, and

handling sudden onset of anxiety, or situations which are anxiety provoking (Barrett, Shortt, Fox, & Wescombe, 2001; McLoone et al., 2006). FRIENDS is used as an acronym to remember the skills taught in the program: F- Feelings; R- Remember to Relax; I- I Can Do It; E- Explore Situations; N- Now Reward Yourself; D- Don't Forget to Practice; S- Smile (Barrett, 2000). The program teaches students to be aware of themselves and their feelings, and how their feelings can influence thoughts and behaviours, based on cognitive-behavioural-therapy techniques. It then proceeds to give students strategies for self-control, self-confidence, and problem solving, in order to help develop better psychological resilience in anxiety-provoking situations.

Social Skills and Friends for Life

In addition to teaching self-control, self-confidence, and problem solving skills, FFL may also help students to develop social competence skills. Pahl and Barrett (2007) suggest that early development of social-emotional competence will increase the chances for children to do better at school, have increased confidence, have good relationships, take on and persist at challenging tasks, and communicate well. Social-emotional competence includes the following abilities and skills: self-awareness; empathy; motivation; self-regulation; and social skills (Parhomenko, 2014). This leads one to infer that perhaps social-emotional skill training will help children with interpersonal relationships, helping them to develop more pro-social skills, or positive social skills, over time, and making children more socially competent.

The FRIENDS for Life program teaches children not only about how to recognize their own emotions, but also how to recognize emotions in others. They learn about how

to use skills and strategies for themselves, but also the importance of support networks and empathy. In addition to this direct teaching about the importance of recognizing the feelings of others and support networks, students also learn about how to communicate emotional thoughts and feelings with others through the group setting created during the FFL sessions. This training should, essentially, help students to develop some emotional intelligence and competence, resulting in better emotional communication and healthier relationship skills. This relationship between the FFL program and social competence has also been identified by Liddle and Macmillan (2010). Findings within their research have lead them to suggest that the FFL program has a positive impact on children's social skills. It did, however, indicate that children may have difficulty sustaining these skills when engaging with students who have not also learned these skills.

Social skills may be an added benefit of school-based CBT programs, such as FFL. Unfortunately, research demonstrating the connection between FFL and social competency is fairly limited. This is an interesting area of research which may need to be further investigated.

Types of Program Evaluation

When implementing any type of program, such as universal treatment programs, evaluation is an important element in the process. Evaluation enables organizations and facilitators to obtain important feedback regarding the effectiveness and usefulness of a program. This ensures that the resources used to support the program are justified, and not irresponsibly allocated.

Program evaluation in social science research may be either qualitative, quantitative, or mixed in nature. The type of evaluation you choose depends on the purpose for the research. Three very important types of program evaluation are treatment effectiveness, treatment integrity, and Social Validity (also known as treatment acceptability). While treatment effectiveness is often quantitative in nature, treatment integrity and social validity can be quantitative, qualitative, or mixed.

Treatment effectiveness. Treatment effectiveness evaluates the actual change that occurs as a result of a program. This often is measured through pre-test and post-test measures. For example, if you are implementing a coping or resiliency program (i.e. FFL), you might take a measure of anxiety symptomology prior to the administration of the program, and then take another measure of anxiety symptomology following the administration of the program. When comparing the two measures, one can determine the degree of significant change or difference that has occurred as a result of the program. With a control group, you can compare measures again to reduce the possibility of confounding variables. Results of this type of evaluation are used to inform of the effectiveness of the program, to what degree the program is successful in significantly accomplishing what it is attempting to accomplish.

Treatment integrity. Treatment integrity evaluates the degree to which the treatment/program is being implemented as it 'should' be. In other words, to what degree is the delivery of the program authentic and true to the design of the program. In the case of the Friends for Life program, treatment integrity evaluations examine how well the facilitators are teaching the objectives specified in the program, and if they are facilitating

the components of the program appropriately (e.g. Parent communication, homework, activities that teach the objectives of the program). This is important as changes in the delivery of the program can impact the effectiveness of the delivery and results would not reflect the true effectiveness of the program.

Treatment integrity is especially important when you are evaluating the same program being delivered in different settings (i.e. different facilitators, groups, or locations). Using treatment integrity measures helps the researcher to ensure that each setting in which the program is being delivered is as close to the others as possible, and that important components of the program are being experienced in each setting.

Social Validity (Treatment Acceptability). In exploring the types of programs to be implemented within the school system, stakeholders and decision makers will often look at program evaluation data to determine if the program is worth the resources it requires. Researchers have evaluated the impact of beliefs, attitudes, and perceptions, through the study of social validity. Social Validity can be used to unify research and practice for behavioural interventions (Gresham & Lopez, 1996; Wolf, 1978). When social validity data is combined with treatment effectiveness data, it can "facilitate the choice of targets and an evaluation of the attainment of behavior-change goals", with the ideal evaluation of behavioural interventions consisting of researcher evaluation as well as consumer evaluation (Finney, 1991). In this way, social validity can be used to inform how the intervention can be improved, facilitate further development of the intervention program, and then aid the reimplementation of the intervention program. Finney (1991) recommends that social validity should be an on-going measure which helps to

continuously better an intervention and improve program effectiveness. This suggests that the results of social validity research can help to inform changes that need to be implemented within the program. Once these changes have been implemented, further social validity research should be conducted to determine how the program changes have been received and if further changes should be implemented.

The concept of social validity was coined by Wolf (1978), who referred to social validity as the social importance or social relevance of a program. Wolf described three aspects of social validity: the social significance of goals; the social appropriateness of procedures; and the social importance of effects. Wolf described the social importance of effects for behavioural treatments as the evaluation by participants of how helpful the treatment program was for them. Wolf expressed the importance of this, as he described this concept as bringing the 'consumer' into the process, and obtaining important information from the consumer regarding the perceptions of the program. Kazdin (as cited in Finn & Sladeczek, 2001) was a pioneer of social validity research. Kazdin referred to social validity as treatment acceptability. According to Kazdin, social validity is how lay people, clients, and other concerned individuals judge the intervention as being appropriate, fair, and reasonable to meet the goals of the intervention. Another definition of social validity is, the degree of ability or willingness of the participant to accept the intervention, leading to the term 'treatment acceptability' often being used interchangeably with social validity (Greshem & Lopez, 1996). This is not the same as program effectiveness, which is taken from a more scientific standpoint and looks at data which, in the case of treatment programs, measures in some concrete way the degree of

change or effectiveness of the program. Rather, treatment acceptability reflects the attitudes and beliefs of the participants of the program, measuring how participants judged the program and how they rate their experience of the program. The best programs would be demonstrated to have a high degree of both treatment effectiveness and social validity.

Fawcett (1991) suggests that "social validation offers an explicit tactic for assessing whether these applied research goals are met, and an implicit strategy for helping ensure their attainment". When evaluating the social importance of the effects of a behavioural intervention, Fawcett describes three levels of effects that may be evaluated: proximal effects (e.g. increased awareness of coping skills); intermediate effects (e.g. increased use of coping skills); and distal effects or outcomes (e.g. increased ability to cope in a variety of anxious situations). In this way, these effects can be compared to more empirical research as a means of connecting researchers and practitioners, and as a result providing a more well-rounded perspective of the effectiveness of the specific program (Marchant, Heath, & Miramontes, 2012).

Strain, Barton, and Dunlap (2012) suggest that social validity is important for the following reasons: it can influence how programs and interventions are delivered; it ensures that the program is addressing the true need of the participants; it helps gain information about how participants/clients are responding to the intervention, and the degree of support that is needed for the participants; it helps obtain an understanding of the perceptions of the intervention or program, as well as helps to change the perceptions of the interventions among stakeholders; it helps to reveal intervention results that may

not have been otherwise discovered; and it helps guide future research and development of interventions/programs. For these reasons, social validity data is an important aspect of research when investigating treatment and intervention programs. This is especially true in educational research, as much of this research is focused on interventions, programming, and practical implementation of theory.

Social validity/treatment acceptability measures are being used in education in a number of different ways. For example, two important ways in which social validity is used includes: to make decisions about how to implement the interventions in natural, real-life settings; and to enable researchers to engage and gain the perspective of a wider variety of stakeholders in the educational community (e.g. students, teachers, parents, school counsellors) (Nastasi & Truscott, 2000). This concept has been used to extend understanding from the empirical to the practical. In this way, the success of the intervention is based not only on the measured behavioural change or the experience of the direct participants, but also the rest of the school community. This helps the educational institution to better fit an intervention to the needs of the specific community it services.

The Theory of Planned Behaviour and Self Efficacy – A Theoretical Framework

The importance of studying how participants perceive treatment interventions, and their beliefs, attitudes, and perceptions of interventions, is supported within theory. The Theory of Planned Behaviour proposes a connection between attitude, belief, intention, and behaviour. This theory was based on the Theory of Reasoned Action and was proposed by Azjen and Fishbein (Azjen, 1991). Azjen (1991) describes intentions as

"indications of how hard people are willing to try, how much effort they are willing to exert, in order to perform the behaviour" (p. 181). Azjen goes on to explain the importance of volitional control over the behaviour, the ability for the individual to choose to perform the behaviour, or not to perform the behaviour. While control is important, however, there is also a need to distinguish between actual control and perceived control. There are some cases in which control is not actual, or volitional. In these cases, perceived control may be factored in and provide influence on behaviour. Perceived behavioural control refers to the belief that individuals hold regarding the degree of control they have over behaviour, and may or may not reflect actual control. Ajzen's idea of perceived behavioural control is based on Bandura's concept of Perceived Self-Efficacy, which proposes that the behaviour of individuals is strongly influenced by their belief that they are able to perform the behaviour (Azjen, 1991; Bandura, 1977).

In connecting the Theory of Planned Behaviour with Bandura's Theory of Self-Efficacy (Bandura, 1977), there are implications for psychological treatment programs. Bandura asserts that the level of self-efficacy an individual has will determine the level of engagement in coping behaviors, as well as how much effort an individual will put into the coping behaviours, and the degree to which the individual will persist with these behaviours through difficulties and adversities. For example, if an individual believes that deep breathing exercises are helpful for him or her, the individual will put more effort into the practice and use of this technique than an individual that believes that it is not helpful. As a result, the deep breathing technique will obtain greater results for the individual. This suggests that the beliefs and attitudes that an individual has towards a

treatment program or intervention, as well as the beliefs about what they have learned and their ability to use learned skills in the real world, have a significant impact on the ability for individuals to develop stronger coping behaviours. In addition, a greater sense of self-efficacy may result in more meaningful participation by the individual, with more efforts towards change being evident. Given the significance of belief, attitude, intention, and self-efficacy in the engagement and behaviour change for individuals, it is important that practitioners ensure that interventions do not just have proven actual effectiveness, but that participants have positive beliefs and attitudes regarding their ability to participate and the ability of the program to help them make positive change.

The Current Study: Research Question and Hypothesis

The current study was part of a larger research project which explored the impact that the FFL program had when employed in Newfoundland and Labrador schools. The current study looked at two aspects of this research: (1) what were student and parent participant beliefs, perceptions, and attitudes towards the program, as determined by a social validity measure? And (2) did FFL have a positive impact on the prosocial behaviours of student participants? These questions have been asked and studied in locations around the world, but had not yet been examined in a Newfoundland and Labrador context.

The current study examined the social validity of the FRIENDS for Life program in a Canadian and, more specifically, Newfoundland and Labrador context. Social validity assesses how a treatment is accepted or perceived by participants (Schwartz & Baer, 1991; Barrett Short, Fox, & Wescombe, 2001). Social validity measures the

perceived effect and value of the program from the perspective of the participants and, in the case of this study, parents of students participating in the program. Gallegos, Rodriguez, Gómez, Rabelo, and Gutiérrez (2012) suggest that all intervention programs should include a social validity evaluation, especially when the interventions are addressing the prevention of anxiety and/or depression. As a part of a larger study evaluating the FRIENDS for Life program (Doyle, 2016), this study explored whether social validity for this program was positive, based on the attitudes, beliefs, and perceptions of participants. Based on previous reports and studies, it was expected that the FRIENDS for Life program would be positively evaluated by students and parents, with both sets of participants rating the program as useful and beneficial, and having learned useful coping skills.

The present study also examined how involvement with the FRIENDS for Life program may have influenced the pro-social behaviours of students. This was evaluated through a measure of psychological strengths and difficulties. Psychological strengths and difficulties include: Emotional Symptoms, such as headaches, worry, unhappiness, nervousness, fears; Conduct problems, such as anger, obedience, fighting, lying/cheating, or stealing; Hyperactivity, involving restlessness, fidgeting, distractibility, and impulsivity; Peer problems, including ability to create and maintain friendships with peers, and the experience of being bullied; and Prosocial issues, such as being nice to others, sharing, helping others, kindness (Goodman, 1997). The current study focused specifically on the area of pro-social behaviour. As seen through the work of Liddle and MacMillan (2010), and Pahl and Barrett (2007), it was expected that student participants

would experience positive change in the area of pro-social behaviour, with students rating themselves more positively on the scale of social competence after participating in the program, than they were before participating in the program.

CHAPTER TWO

Literature Review

Canadian research has suggested that, at any given time, 3.8% of children and youth, ages 4-17, may be experiencing anxiety disorders, with 50-75% of all individuals with a mental disorder being first diagnosed in childhood/adolescence (Waddell, Shepherd, Schwartz, & Barican, 2014). This suggests that childhood and adolescence are periods of great importance when considering the prevention of mental health disorders. Despite this evidence, Rose, Miller, and Martinez (2009) have reported that while anxiety symptoms were the most frequently occurring mental health issues faced by children and adolescents, they were the least treated. This suggests that more focus and awareness needs to be placed on the prevention and identification of childhood and adolescent mental health issues.

Current Research-Based Treatment for Anxiety – CBT

One successful approach/theory used to address anxiety symptoms is Cognitive Behavioural Therapy (CBT). One key aspect of CBT that is used to treat individuals presenting with symptoms of anxiety is cognitive restructuring. Cognitive Restructuring teaches about the connection between thoughts, emotions, and behaviours and helps individuals to develop an understanding of how each of these components influence each other (McLoone et al., 2006). Other CBT techniques that are used with children who struggle with anxiety include coping self-talk, in vivo exposure, modeling, and relaxation training (Muris, Mayer, den Adel, Roos, & van Wamelen, 2009). Muris et al. (2009) conducted a study in The Netherlands that examined the effectiveness of CBT in

reducing anxiety symptoms for 55 children who scored in the significant range on the SCARED-R anxiety screening assessment. Student participants were provided with CBT through the *Coping Koala* program, which was delivered in a group format and included 12 sessions. This program focused on cognitive restructuring, coping self-talk, exposure, evaluating performance, and administering self-reinforcement. Students were then administered the SCARED-R again, after participating in the intervention, to determine if there were significant changes. Results of this study indicated that the CBT intervention resulted in the decrease of anxiety symptoms for participants. It was also found that there was a significant decrease in negative automatic thoughts and an increase in anxiety control. These results indicate that CBT can be an effective method of treatment for anxiety disorders in children, even when provided in a group format and using a generalized curriculum.

Further evidence for CBT was found through a meta-analysis conducted by Edwig, Monsen, Thompson, Cartwright-Hatton, and Field (2015), which attempted to determine if a general CBT format would be effective in the treatment of multiple types of anxiety disorders in children and young people. The meta-analysis included a systematic search of literature, as well as a process for the inclusion/exclusion of studies. After going through this process, 20 studies were included in the analysis, with a total of 2099 participants across the chosen studies, including both participants in treatment groups and participants in control groups. Anxiety disorders that were represented amongst participants included: generalized anxiety disorder; panic disorder; separation anxiety disorder; social phobia; specific phobia; agoraphobia; and over-anxious disorder.

The results of this meta-analysis indicated that a general CBT program seemed to be effective in reducing the symptoms of anxiety in children and young people. This supports the use of CBT for addressing all types anxiety disorders in children, especially when disorder-specific interventions may not be possible for individuals.

It has been suggested that children who are exposed to intervention programs that focus on teaching children to change their thoughts and feelings, and to develop skills that help them to cope in a variety of everyday anxiety-provoking situations, are better able to use these skills in daily life (Pincus & Friedman, 2004). In fact, it has been suggested that CBT, which incorporates these elements, is the only significantly empirically based treatment for childhood anxiety disorders (Mohr & Schneider, 2013). Cognitive Behavioural Therapy in a group setting has produced positive effects in comparison to control groups in a variety of settings, and has been shown to reduce the occurrence of anxiety disorders in children (Barrett, 1998; Shortt, Barrett, & Fox, 2001; Silverman et al., 1999). Barrett, Duffy, Dadds, and Rapee (2001) found that students who participated in Group Cognitive Behavioural Therapy (GCBT) demonstrated significant improvements, and no longer qualified for a primary diagnosis, as compared to the control group. This finding is also supported by McLoone et al. (2006), who state that between 50-80% of children who participate in CBT programs experience relief from a primary diagnosis.

A study conducted by Hudson et al. (2015) investigated the impact of a GCBT program on different types of anxiety disorders. The study included 842 children and adolescents who were diagnosed with an anxiety disorder, as outlined by the Diagnostic

and Statistical Manual – fourth edition (DSM-IV). Student participants in this study participated in the Cool Kids program, a group cognitive behavioural program. The results of this study suggested that anxious children may have varied responses to this type of program, depending on the type of anxiety with which they have been diagnosed. Participants diagnosed with social anxiety disorder appeared to have a poor response to the program in comparison to participants diagnosed with general anxiety disorder (GAD) or obsessive-compulsive disorder (OCD). Participants diagnosed with GAD and OCD, however, showed signs of significant improvements after participating in the program. This indicates that group cognitive behavioural therapy programs may be more effective for certain types of anxiety disorders experienced by children and adolescents. This contrasts somewhat with the findings of Edwig et al. (2015), which state that CBT is effective in the treatment of all types of anxiety disorders.

Family Cognitive Behavioural Therapy

Another aspect of CBT that has been studied, especially for the treatment of childhood anxiety disorders, is the impact of parental involvement in the treatment of anxiety. Brendel and Maynard (2014) conducted a review/meta-analysis, which compared the impact of family based CBT interventions to child-focused CBT interventions. Using Campbell's Collaboration guidelines, a systematic review was conducted on eight separate studies. The results of this review indicated that there was a significantly positive effect of the parent-child interventions, as compared to child-focused interventions.

A study that compared the effectiveness of family-focused CBT with child-focused CBT was conducted by Wood, Piacentini, Southam-Gerow, Chu, and Sigman (2006). They studied 40 clinically anxious youth, randomly distributed between the family-focused CBT group and the child-focused CBT group. Both groups included the same skills training, however the family-focused group included parental communication training. The program intervention that was delivered to each group was the 'Building Confidence' program. Data was collected using independent evaluators, parental ratings, and child ratings. Results of this study indicated that there were greater improvements in the family-focused CBT group noted by both independent evaluators and parental raters, but not by child raters. While both of the treatment groups showed improvement, it was noted that there were additional improvements and benefits when a family component is included with program delivery.

Bögels and Siqueland (2006) conducted a study, which developed and evaluated a family CBT program for children and adolescents. Seventeen families participated in the study, with data taken prior to program participation, after a period of time on the waitlist (a control measure), after the intervention was complete, and at 3-month and 1-year follow-ups. Results of this study indicated that there were large effect sizes showing improvements in children's fears, dysfunctional beliefs, and interpretations of ambiguous circumstances, and medium effect sizes for children's internalizing and externalizing symptoms. There were also large improvements noted in parents' dysfunctional beliefs about their child's anxiety and their role as a parent. It was concluded that family-based CBT was effective for clinically anxious children.

Yet another study compared the impact of individual child-focused CBT, Family focused CBT, and a family-based education/support/attention control group (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008). A total of 161 participants were included in the study, all of who had a diagnosis of anxiety disorder. Results of this study indicated that both family based CBT and child based CBT were more effective than the control group. Family-based CBT was demonstrated to be more effective than child-based CBT when both parents had an anxiety disorder.

While many studies indicate that family-focused interventions are successful for addressing anxiety disorders in children, Bodden et al. (2008) found that these results may not always be clear. They also compared the efficacy and effectiveness of child-focused and family-focused CBT. They used child participants who were referred with anxiety disorders, and their parents, with a total of 25 families being measured. Participants were randomly assigned to the treatment group, and were evaluated prior to treatment, after treatment, and at a 3-month follow up. Measures were also taken from children who were on the waitlist, and had not yet received the treatment. It was found that significantly more children were free of anxiety disorders in the child CBT group as compared with the family CBT group at post-treatment, though this effect was not significant at the 3-month follow-up. Results of this study, in contrast to the previously discussed studies, indicated that child-focused CBT was slightly more beneficial in this case than family-focused CBT.

Despite some varied results, it appears that family involvement in the treatment of child and adolescent anxiety disorders may be beneficial. This information is important

for practitioners, as treatment programs that are delivered to clients may be more effective when family involvement is incorporated. While CBT-based treatments appear to be effective as child-focused interventions or as family-focused interventions, involvement of the family may result in slightly better results than if family was not incorporated within the treatment process.

School – Based CBT Programs for Anxiety and Resilience

Prevention programs for anxiety can be found within a variety of settings. One setting where CBT prevention programs can be implemented is within the school system. Stallard (2010) describes the following core elements of a CBT, school-based, prevention program: (1) a psycho-educational aspect which involves teaching about the connection between thoughts, feelings, and behaviours for both students and parents; (2) training on emotional regulations, including how to recognize and manage emotions; (3) training on cognition, including how to identify thoughts in high anxiety situations, and how to recognize the distortions and biases that may be present in these cognitions; (4) teaching students to challenge the distorted thoughts, and replace them with more positive thoughts and practices (self-talk); (5) opportunities for practice and exposure in order to help students become more proficient at using the skills taught; (6) encouragement and development of self-awareness (i.e. self-monitoring) and self-reinforcement; and (7) looking to the future and focusing on prevention for relapse and preparing for future situations which may be challenging for the student. A good prevention program would include these core elements in order to provide effective CBT training for the students and to effectively impact the ability of students to function.

A study was conducted to investigate the impact of a modular CBT program for child anxiety within elementary schools (Chiu et al., 2013). This study included 40 children in two elementary schools, who were randomly distributed between the intervention group and a 3-month waitlist (control) group. Participants in the intervention group participated in the '*Building Confidence'* program, which included child sessions, parent training, teacher training, and school nurse training components. Criteria for participation in the study included the presence of at least one clinically significant anxiety disorder. Results of this study indicated that the students who participated in the CBT program in a school setting experienced a reduction in anxiety symptoms.

Gillham, Reivich, Freres, and Lascher (2006) conducted a study on the effectiveness of a school-based GCBT program on reducing symptoms of depression and anxiety in early adolescence. This study used the Penn Resilience Program (PRP), with a control group and two test groups, one including a parent intervention program and one not including a parent intervention program. Measures of anxiety symptoms were taken at four points, upon completion of the program, 2 months post-intervention, 6 months post-intervention, and 1 year post-intervention. This study found that this school-based CBT program resulted in significant differences in the reduction of anxiety symptoms for students, especially when a parent component was incorporated into the program. This provides more evidence not just for the effectiveness of CBT as a treatment for anxiety, but also for GCBT, and even more specifically, for school-based GCBT programming.

This also provides support for a program which incorporates parent participation, connecting the school program to the home.

In a study by Kraag, van Bruekelen, Kok, and Hosman (2009), the effectiveness of a school-based universal prevention program for stress management in children was examined. Through the implementation of a universal prevention program, they evaluated the effectiveness of stress awareness in reducing the experience of stress symptoms, and how this in turn impacted measures of anxiety and depression. Based on pre-post test results, it was found that the universal prevention program, 'Learn Young, Learn Fair' was effective in increasing stress awareness and emotion-focused coping. Post-test results demonstrated that the program reduced stress and anxiety, and generated no negative psychological stress symptoms.

FRIENDS for Life

One widely used universal, CBT-based program that has been found within schools is the FRIENDS for Life program (FFL). The FFL program was developed in Australia, and there have been a number of studies conducted that provide evidence for the success of the program in that setting (Barrett, Farrell, Olendick, & Dadds, 2006; Barrett, Sonderegger, & Sonderegger, 2001; Barrett & Turner, 2001; Iizuka, Barrett, Gillies, Cook, & Marinovic, 2015; McLoone et al., 2006; Stopa, Barrett, & Golingi, 2010). As a result of positive empirically based support, the program has been endorsed by the World Health Organization [WHO] (2004). The program has spread past Australian borders and has been implemented in numerous other countries and cultural

contexts, with research based success (Barrett, Sonderegger, & Sonderegger 2001; Liddle & MacMillan, 2010).

The initial research in support of the FRIENDS for Life program was conducted in Australia, where the program was developed (Barrett & Turner, 2001). This study included a sample of 489 children from the ages of 10 to 12 years of age. The participants were assigned to three different testing groups: an intervention group in which the program was facilitated by a psychologist; an intervention group in which the program was facilitated by teacher; and a control group, in which students did not participate in the program. The results of this study indicated that the students who participated in the intervention groups reported experiencing fewer symptoms of anxiety post-intervention than participants who did not participate in the intervention program. Barrett and Turner also suggested that there was evidence of generalizability within the school environment, and that there was no significant difference between results for psychologist led and teacher led groups.

Following the positive findings of Barrett and Turner (2001), Lock and Barrett (2003) conducted a longitudinal study in a school setting to examine the long term effects of the FRIENDS for Life program on anxiety symptoms. This study was conducted in Australia and included 733 children in grade six and grade nine, ages 9 to 10 years old and ages 14 to 16 years old. The participants were placed in either the test group, to which the program was delivered, or a control group, which was not exposed to the program. This study found that there was a preventative effect, with the intervention group reporting greater changes in self-reported anxiety than the control group, with

indications of general reductions in anxiety symptoms over time. It was also found that the program was effective in reducing behavioural avoidance, and increasing cognitive-behavioural problem-solving strategies immediately following the program, though these effects had diminished in the data at follow up. This study also suggests that the younger the student, the more receptive he or she may be to many aspects of the program, with these students reporting greater decrease of anxiety symptoms. This provides evidence that early intervention of these skills is important, and possibly more effective, than later intervention.

Following this research, Barrett et al. (2006) furthered the Lock and Barrett (2003) research and conducted a 24 month and 36 month follow up as a means of determining further long term effects of the program on anxiety symptoms. This study supported the idea that younger students find greater long-term effects of the program on anxiety symptomology, suggesting that early intervention has greater long-term effects than later intervention. This study provided evidence for the long-lasting positive effects of the FRIENDS for Life program up to 24 months after the intervention program has been delivered.

In addition to these studies, Iizuka et al. (2015) evaluated the effectiveness of the FRIENDS for Life program when conducted in a low socio-economic status area in Australia. The study included 69 students from grades six and seven. Within this study, students who were initially identified as at-risk were reported to have experienced a significant decrease in separation anxiety, obsessive-compulsive symptoms, and physical anxiety after participating in the FRIENDS program.

Research positively supports the use of the FRIENDS for Life program in Australia, where it was first developed. In order to ensure/support generalizability, there has also been research conducted to examine the effectiveness of the FRIENDS for Life program in other cultural contexts, including the UK and Canada.

In the UK, specifically in Southwest England, Stallard et al. (2005) conducted a study to examine the effectiveness of the FRIENDS program in that specific cultural context. The study included 213 participants ages 9-10 years old, from six separate schools. The findings of this study indicate that there were significantly lower reports of anxiety symptoms, as well as significantly improved levels of self-esteem. In addition, the results of this study indicated that 60% of the participants who had been deemed high risk reported significantly improved experiences of anxiety symptoms and no longer fell within the high-risk category. Continuing this research, Stallard, Simpson, Anderson, Hibbert, and Osborn (2007) conducted a study consisting of 106 participants, ages 9-10 in three different schools, who participated in the FRIENDS program as delivered by trained school nurses. This study indicated that 3 months after completing the FRIENDS program, there continued to be a decrease in anxiety and an increase in self-esteem by participants, indicating that there is a potentially lasting impact of the program. A follow-up study conducted by Stallard, Simpson, Anderson, and Goddard (2008) looked at the lasting impact of program participation at a 12 month follow-up. This study reported that the improvements in emotional health that were found at the 3 month follow up continued to be present in this 12 month follow-up, again providing additional evidence for the longevity of the program impact.

In an attempt to demonstrate the applicability and usefulness of the FRIENDS for Life program in the North American context, studies have been conducted in Western Canada. Rose et al. (2009) conducted a study with 52 participants in two separate grade four classrooms, in an urban elementary school. The study provided more evidence for the effectiveness of the FRIENDS for Life program, reporting that as a group, all participants reported lower rates of self-reported anxiety after receiving the intervention, with no statistically significant changes for the control group or the intervention group. This is contrary to all previous research, and the researchers suggest that small sample size may have contributed. In addition, it was reported that the participants were not reporting experiences of anxiety prior to participation in the intervention. Given that there were no prior anxiety symptoms reported, it would be safe to assume that there would be no significant reduction of anxiety symptoms. There have been few Canadian studies conducted on the effectiveness of the FRIENDS for Life program, especially outside of Western Canada. The studies that have been conducted, have demonstrated inconsistent results and generalizability factors, as compared to the results from Australia and the UK (Miller, Laye-Gindhu, Bennett, et al., 2011; Miller, Laye-Gindhu, Liu, et al., 2011; Rose et al., 2009). Despite inconsistency within Canadian studies, the FRIENDS for Life program has been finding its way into schools and communities across the country as a way of dealing with the increasing levels of anxiety experienced by children in Canadian society.

A more recent study on the treatment effectiveness of the Friends for Life program was conducted in Newfoundland and Labrador schools, in conjunction with the

current study (Doyle, 2016). This study investigated how child anxiety, resiliency, and parent anxiety were related to the FFL program. This study included student participants from nine Newfoundland and Labrador schools. There were 310 student participants, with 210 students in the experimental group and 100 students in the control group, and 165 parent participants. Participants ranged from 8-11 years old and were in grades four to five. It was found that while there were some decreases in anxiety and increases in resiliency observed, they were observed in both the experimental and control groups. In other words, while decreased anxiety and increased resiliency was identified; this cannot be directly connected solely to participation in the FFL program. This study was a part of the larger project that the current study is a part of, and so used the same participants.

FRIENDS for Life: Social Validity

In connecting the Theory of Planned Behaviour and Self Efficacy (Azjen, 1991; Bandura, 1977), the beliefs of individuals about whether the FFL program works or not is also an important indicator of effectiveness. This leads us to another important body of research, helping establish effectiveness and efficacy, which focuses on evaluating the social validity of the FRIENDS for Life program in a variety of settings. The primary study relating to this construct which is often cited was conducted in an Australian setting by Barrett, Shortt, Fox, and Wescombe (2001). In this study, a questionnaire was administered to both student participants and their parents. Parents were found to be highly satisfied with the FRIENDS for Life program, and would highly recommend the program to others. These parents rated self-rewarding – a system of positive reinforcement for brave behaviour - as the most useful skill of the FRIENDS program.

The children reported that the program was fun, and they also rated the self-rewarding skill as the most useful skill within the program. In an attempt to determine generalizability of the program, similar social validity studies were conducted throughout the world.

In Sweden, Ahlen, Breitholz, Barrett, and Gallegos (2012) conducted a study to evaluate the social validity of FRIENDS. In this study, social validity was measured using the FRIENDS evaluation form for children. It was reported that 98% of the sample enjoyed the program either a lot or quite a lot, and felt that they had learned a lot about their feelings through the program, and 87% of the sample felt that they learned quite a lot or a lot about how to cope when feeling worried or upset. In this same study, 67% of participants reported that they used the skills that they learned in the program either a lot, or quite a lot, and that they would continue to use the skills that they have learned. The skills that were reported in this study as the most useful were thinking green (helpful) thoughts, helping others feel good, and understanding their own emotions.

In Germany, another study was conducted by Essau, Conradt, and Ederer (2004) examining the social validity of the FRIENDS for Life program (as cited by Gallegos et al., 2012). This study used the data from a large-scale study on the prevention of anxiety disorders in school-aged children. The measures used included the FRIENDS Child Social Acceptability Measure (administered in German) and the FRIENDS Parent Social Acceptability Measure (administered in German). The results of this study indicated that both children and parents reported feeling highly satisfied with the program. Both

parents and children rated relaxation exercises and thinking green (helpful) thoughts as being the most useful skills learned within the program.

In Mexico, the social validity of the FRIENDS for Life program was evaluated for girls living in an orphanage (Gallegos et al., 2012). Results of this study indicated that participants rated the program as enjoyable and helpful. Participants reported feeling that the program helped them to cope when feeling upset or worried. The skill that participants in this study rated as the most helpful included green (helpful) thoughts, the coping step plan, deep breathing and creating positive and powerful thoughts, relaxation exercises, and acknowledging your own feelings. Overall, the acceptability for these participants was high. This study was then followed by a study of the acceptability of the program to a larger population of Mexican grade four and five students (Gallegos-Guajardo, Ruvalcaba-Romero, Garza-Tamez, & Villegas-Guinea, 2013, as cited in Barrett, Cooper, & Guajardo, 2014). Again, the students, parents, and teachers reported high levels of satisfaction with the program, with parents and teachers indicating that it was useful for themselves and for their children, and children reporting that they found the program skills helpful when they find themselves in difficult situations. The skills that students reported finding the most useful included: changing red (unhelpful) thoughts to green (helpful) thoughts, and the relaxation techniques. Parents reported that the skills that were most useful included: changing red (unhelpful) thoughts to green (helpful) thoughts, and recognizing your own feelings. In addition, this study found that the more enjoyable the students rated the program, the lower the students rated on the depression scale.

In Canada, a study by Rose et al. (2009) evaluated the effectiveness of the FRIENDS for Life program in two grade four Western Canadian classrooms. This study provides a Canadian context for the FRIENDS for Life program, and the results indicated that eighty-six percent of students liked the program, and reported that they felt that they understood the difference between red (unhelpful) thoughts and green (helpful thoughts), as well as how to calm themselves down (relaxation techniques). Parents reported that they felt that the most useful skill the students learned was the 'positive cognitive training' (changing red thoughts to green thoughts).

Generalizability is difficult to assume, unless research has been conducted in similar cultural contexts. Canadian studies have resulted in the implementation of the FFL program in British Columbia schools. Cultural contexts, however, are quite different in British Columbia and Newfoundland and Labrador. In order to generalize the effectiveness and acceptability of FFL, Newfoundland and Labrador-based research must be conducted to provide evidence that there will be positive results following the implementation of the program in this context. The present study is part of a larger research project which conducted an evaluation of the FRIENDS for Life program in Newfoundland and Labrador. Other research questions in the project have looked at the Treatment Effectiveness component of program evaluation. The current study will examine the Treatment Acceptability aspect of the program evaluation for the FRIENDS for Life program in a Canadian and, more specifically, Newfoundland and Labrador context. It is expected that there will be a high degree of acceptability, with participants giving the program positive ratings. The present study will also examine how

involvement with the FRIENDS for Life program may influence social competence for students, specifically the self-reported prosocial skills of students. It is expected, based on previous research, that this would also be positive, with students reporting themselves as engaging in an increased amount of prosocial behaviours. This information helps to inform researchers and practitioners of the overall impact of the FFL program in and possible benefits of the incorporation of this program into Newfoundland and Labrador schools.

CHAPTER THREE

Methodology

The current study made use of a data set that was collected as part of a larger research project within Memorial University. Ethical approvals were applied for and obtain by the lead supervisor from both the Interdisciplinary Committee on Ethics in Human Research at Memorial University of Newfoundland and Labrador (ICEHR) and the Newfoundland and Labrador English School District. Training for individuals who wish to become facilitators of the FRIENDS for Life program is offered through Eastern Health at the Janeway Family Centre. A quantitative pre/post survey methods design was used to gather data for the study. This design was effective in gathering data relevant to the social validity of the FRIENDS for Life program as perceived by students and parents involved in the program. These methods are described in the following sections. Informed assent was gathered from student participants through a signed form (see Appendix A). Signed informed consent for student and parent participation was obtained from parents (Appendix B). Parents and students were informed of confidentiality and participation requirements prior to the administration of questionnaires and prior to participation in the program.

Participants

Ten elementary schools within the Eastern Region of the Newfoundland and Labrador English School District, nine metro and one rural, were involved in the implementation of this study. Descriptive and frequency analyses were conducted to derive demographic information of participants from these schools. There were a total of

310 participants for this study. Students within this study were in grades four and five, with 35.5% of students in grade four (N = 110), 63.9% of students in grade five (N = 198) and grade information missing for 0.6% of students (N = 2). Within the overall participant sample, 47.1% of participants identified as male (N = 146) and 52.3% of participants identified as female (N = 162), with 0.6% of participants not providing this information. Within this sample of participants 67.7 % (n = 210) were a part of the experimental group, while 32.3% (n=100) were in the control group. While all student participants were administered a Strengths and Difficulties Questionnaire, an administration error resulted in the social validity questionnaire not being administered to the whole population of participants, resulting in a lower participant sample size (98 children) for the social validity measure.

Social validity demographics were obtained for student participants. Participants ranged from 8-10 years of age, with 4.1% (n = 4) of participants being 8 years of age, 25.8% (n = 25) of participants being 9 years of age, and 70.1% (n = 68) of participants being 10 years of age. Demographic information was not provided by 1% of students (n = 1). Social validity participants were from grades four and five, with 21.6% (n = 21) of participants being in grade four and 78.4% (n = 76) of participants being in grade five. Of these participants, 43.3% (n = 42) identified as male, and 56.7% (n = 55) identified as female, with 1.0% (n = 1) not providing a response. There was no great diversity of ethnicity within the participant sample, with 97.9% (n = 93) of participants identifying themselves as white.

Parent participants provided only social validity data, and consisted of a sample of 53 parents who also had students participating in the study. Parental ages ranged from 27 to 52 years old, with a mean age of 40.66 (SD = 5.66) years of age. Participants identifying as female/mother made up 88.7% (n = 47) of parental participants, while participants identifying as male/father made up 1.9% (n = 1) of parental participants, and 9.4% (n = 5) of parental participants identified themselves in the 'other' category. Due to attrition, a total of 24 parents who provided demographic information responded to the social validity survey for parents.

Treatment Materials

The FRIENDS for Life program is a prevention program that includes peer and family interventions, using cognitive-behavioural strategies, to help children develop coping skills and build resilience. (Barrett, Lowry-Webster, and Turner, 1999). Prior to the administration of the FRIENDS program, a session is offered to parents explaining the format of the program, the concepts being taught, and how they may support at home with the homework that the students are assigned throughout the program. The FFL student program consists of 10 one-hour sessions that teach students: how to identify feelings; recognizing the somatic (physical) symptoms of anxiety; identifying unhelpful thoughts and helpful thoughts; and coping skills, such as relaxation, coping step plans, problem-solving skills, and self-reward (Barrett, 2010).

The FFL program is formatted to take place in a group setting, with a trained facilitator. Facilitators are trained through the program distributor, in sessions that are offered in a variety of locations, depending on the demand. The program is psycho-

educational in nature, and is based on CBT intervention approaches. The sessions involve teaching (often including the use of children's literature), discussion, practice of skills, and a workbook/homework component. The homework component of the program serves to connect the learning to the home environment, and is meant to help parents become involved in the process (Barrett, 2010).

Measures

Participants were administered a battery of measures, both pre-test and post-test. This study does not use all of the measures, but rather focuses on the Social Validity measure for students and parents, and the Strengths and Difficulties measure for students.

The Social Validity Questionnaire. Social validity questionnaires were administered post-test to both parent and student participants in order to gather information about the acceptability of the treatment, or the social validity of the program. The student questionnaire included seven questions (Appendix C). For each of the first five questions, participants were asked to answer based on a likert scale, ranging from 1 (not at all) to 4 (a lot). The questions asked if the participants enjoyed the program, how much they felt that they learned by doing the program with their friends, how much they learned about feelings and coping with worries or upset, and how much they feel they will use the information learned through the FRIENDS for Life program. Provided with a list, question six asked the students to identify all of the aspects of the program that they felt were the most helpful. The final question was an open-ended question that gave participants opportunity to share any other information about their experience with the program that they might not have reported already.

The parent questionnaire included ten questions (Appendix D). For each of the first eight questions, parent participants were asked to answer based on a likert scale. For the first two questions, the scale ranged from 0 (very useful) to 4 (not at all useful), the third question ranged from 0 (very important) to 4 (not at all important), questions four to seven ranged from 0 (a lot) to 4 (not at all), and question eight ranged from 0 (very often) to 4 (not at all). The questions asked: how useful they thought positive coping skills programs were; how useful the FRIENDS program was; how important they thought it was for schools to incorporate such programs into curriculum; how much parents learned; how much parents felt the students learned; how much parents thought their student enjoyed the program; and how often parents thought that their child used the skills learned within the program. Question nine provided parents with a list of the skills that were taught in the FFL program. Parents were asked to place a checkmark next to the skills within the list that they thought their child found the most useful. The final question was an open ended question allowing parents to add any additional feedback regarding the program that may not have already been reported.

The Strengths and Difficulties Questionnaire (Goodman, 1997). The Strengths and Difficulties Questionnaire (SDQ) (see Appendix E) was administered to student participants, though this study examined only a portion of the items administered. The SDQ is used to briefly measure psychological attributes for students from the ages of 3 to 16 years old. The SDQ is designed to measure 25 different attributes, some of which are positive and some of which are negative. The attributes measured are divided between five scales: emotional symptoms; conduct programs; hyperactivity/inattention;

peer relationship problems; and pro-social behaviour (Youth in Mind, 2012). While the whole questionnaire was administered to students, the scale that is of interest for this particular study is the pro-social behaviour scale. This scale, which included five questions, looks at the degree to which the student is considerate, caring, sharing, kind, and helpful (Dohl, 2013). This questionnaire was administered both pre-test and post-test, in order to measure the potential impact that the intervention might have on social functioning of participants. The SDQ scales are scored using a scoring template (see Appendix F).

Design and Procedures

The design used for this study was primarily a quantitative survey method design, with some qualitative aspects found within the survey design (one question on each of the social validity questionnaires). This study was a part of a larger research project, in which data was collected in a pre-test/post-test, whole group format. As such, this data was collected in a survey form in which all students in a classroom could receive administration at the same time. A closed question, rather than open-ended, design was chosen to eliminate potential difficulties with writing and the need that some children would have for accommodations such as transcribing and/or scribing. By using a likert scale survey, all students could have the questions read to them and could more easily respond. In addition, the Social Validity Questionnaire has also been used in many other studies on this topic, and was developed by the creators of the FRIENDS for Life program as a social validity measure. This makes for easier comparison where generalizability is concerned. While the questionnaire was mostly quantitative in nature,

there was a section at the end of the questionnaire where participants could add comments if they chose to do so, in order to share any thoughts or feelings they may have about the program that were not reflected within the questionnaire.

Participants were selected from schools which were offering the FRIENDS for Life program, and who agreed to participate in the research. Pre-test data was collected for participants 3 weeks prior to the onset of the program. Parents were asked to complete and return informed consent forms for the participation of their child. Pre-test data collected for this study included the Strengths and Difficulties Questionnaire (Goodman, 1997) for children, which measured general social and behavioural skills. This data was collected from child participants in a whole-group, classroom setting. Any students who did not participate in the study/program were either removed from the classroom or remained in the classroom and engaged in alternate activities (depending on the request from the parent).

During facilitation of the FRIENDS for Life program in each school, 25% of group sessions were observed by researchers in order to ensure treatment integrity – with group activities being rated on a checklist to evaluate the extent to which the group facilitator delivered the program objectives as presented in the manual. These observations were conducted randomly throughout the administration of the program at each school, to ensure that the program delivery was in accordance with the program and the objectives set out within each lesson. This ensured that all study participants were being taught the objectives as outlined within the program, ensuring the integrity of the

program administration. As all observations had positive reports, there was no concern with the consistency of program delivery between the schools involved.

Upon the completion of the program at each selected school, post-test data was collected. Child participant post-test data relevant to this study included the Strengths and Difficulties Questionnaire (Goodman, 1997) and the FRIENDS for Life Social Validity Questionnaire. This data was collected in a whole group, classroom setting with the researchers and/or assistants present, and with the help of the classroom teachers. Questions were read for students, and students were able to ask questions of the administrator or teacher when needed.

CHAPTER FOUR

Results

This study investigated the treatment acceptability of FFL, a program designed to help grade four and five students develop coping and resiliency skills, within Newfoundland and Labrador schools. This study also investigated how participating in FFL impacted student pro-social behaviours. Students from a number of schools participated in the 10-session program, and completed pre-test and post-test measures (SVQ and SDQ). In addition, parents of participants completed post-test measures (SVQ) as an evaluation of the perceived usefulness of the program. Each of these measures involved the use of a rating scale in which different aspects of the program (SVQ) or self-perceived behaviour (SDQ) were evaluated. Descriptive Frequencies were conducted on each SVQ item to determine the perceived usefulness and effectiveness of the program, while Chi-Square cross-tabulations were conducted on pre-and post-test pro-social SDQ items to determine if there was significant change between self-reports.

Social Validity Questionnaire for Students

Students were given a questionnaire, which contained seven questions. Five questions were scaled, with students rating their answers on a likert scale. Two questions were of a more open-ended nature, with question six having students check off the skills that they found the most useful, and question seven allowing the students to add additional comments or thoughts regarding the program. The results of the scaled questions can be found in Table 1.

Table 1

Scaled Questions for Student SVQ

Question	A Lot	Some	A Little	Not at All
How much did you enjoy the FRIENDS program	55.7% (54)	29.9% (29)	13.4% (13)	1.0% (1)
How much did you learn by doing the program with your classroom friends?	51.0% (50)	30.6% (30)	17.3% (17)	1.0% (1)
How much did you learn about feelings?	71.4% (70)	17.3% (17)	9.2% (9)	2.0% (2)
How much did you learn about how to cope with feeling worried or upset?	68.0% (68)	21.6% (21)	8.2% (8)	2.1% (2)
How often do you use the ideas that you learned in the FRIENDS program?	27.4% (26)	47.4% (45)	14.7% (14)	10.5% (10)

Note. Number in brackets indicates n, the number of participants. Total N = 98

How much did you enjoy the FRIENDS program? The first question on the SVQ for students measured how enjoyable the students rated the program overall. The descriptive frequencies indicated that 1.0% of students (n = 1) did not enjoy the FFL program at all, 13.4% (n = 13) of students enjoyed the FFL program a little; 29.9% (n = 29) of students enjoyed the FFL program somewhat; and 55.7% (n = 54) of students enjoyed the FFL program a lot. These numbers suggest that 98% (n = 96) of students enjoyed the FFL program, with most of these students reporting that they enjoyed the program a lot.

How much did you learn by doing the program with your classroom friends? The next question on the SVQ for students measured how useful the program was in the

classroom setting by asking students how beneficial they felt it was to participate in the program in this environment. The descriptive frequencies indicated that 1.0% (n = 1) of students found that they did not learn anything by doing the program with their friends; 17.3% (n = 17) of students found that they learned a little by doing the program with their friends; 30.6% (n = 30) of students found that they learned some by doing the program with their friends; and 51.0% (n = 50) of students found that they learned a lot by doing the program with their friends. These results indicated that most students, 98.9% (n = 97) found it useful to do the program with their friends, in a group environment.

How much did you learn about feelings? One of the objectives of the FFL program is to teach students about feelings and how to become more aware of feelings in themselves and others. The questionnaire asked students to rate how much they felt that they learned about feelings throughout the program. Descriptive frequencies indicated that 2.0% (n = 2) of students reported that they did not learn about feelings at all; 9.2% (n = 9) of students reported that they learned a little about feelings; 17.3% (n = 17) of students reported that they learned some about feelings; and 71.4% (n = 70) of students reported that they learned a lot about feelings. In total, 97.9% of students (n = 96) felt that they learned about feelings while participating in the FFL program.

How much did you learn about how to cope with feeling worried or upset? The other objectives of the FFL program focus on teaching coping skills for dealing with negative feelings. The questionnaire asked students to rate how much they felt they learned about how to cope with their feelings. Descriptive frequencies indicate that 2.1% (n = 2) of students felt that they had not learned how to cope with worry or upset at all;

8.2% (n = 8) of students felt that they had learned a little about how to cope with worry and upset; 21.6% (n = 21) of students felt that they had learned some about how to cope with worry and upset; and 68.0% (n = 68) of students felt that they had learned a lot about how to cope with worry and upset. In total, 97.8% (n = 96) of students felt that they learned about how to cope with feeling worried or upset by participating in the FFL program.

How often do you use the ideas that you learned in the FRIENDS program? The last scaled question of the SVQ asked students how often they felt that they used the ideas that they learned in the FFL program. This question is looking at how the skills transfer from the classroom sessions to everyday life. Descriptive frequencies indicate that 10.5% (n = 10) of students felt that they did not use the ideas that they learned at all; 14.7% (n = 14) of students felt that they used the ideas that they learned a little; 47.4% (n = 45) of students felt that they used the ideas that they learned sometimes; and 27.4% (n = 26) of students felt that they used the ideas that they learned a lot. Overall, 89.5% (n = 85) of students felt that they used the skills taught within the FFL program in their everyday life.

Which activities from the FRIENDS program did you find most useful? The last portion of the student SVQ asked students to choose, from a list of activities that were taught in the FFL program, the skills that they found the most useful. These skills included: *relaxation exercises; deep breathing; thinking helpful thoughts; changing negative thoughts to positive thoughts; step plan (breaking your fears into small steps); 6 block problem-solving plan (e.g. what is the problem, what can we do?, list all ideas);*

recognizing feelings in yourself; recognizing feelings in others; and helping others to feel good. Students were able to select more than one activity from this list and student responses ranged from indicating nine activities as most helpful, to indicating none of the activities as most helpful. Table 2 outlines the results:

Table 2

Percentage of Students Rating each Activity as Useful

Activity	n	Percentage of students
Relaxation Exercises	76	77.6%
Deep Breathing	68	69.0%
Helping Others Feel Good	67	68.0%
Thinking Helpful Thoughts	64	65.0%
Changing Negative Thoughts to Positive Thoughts	62	63.0%
Recognizing Feelings in Yourself	52	53.0%
Recognizing Feelings in Others	48	49.0%
Coping Step Plan	44	45.0%
6 Block Problem Solving	35	36.0%

Note. n indicates the number of students who chose each activity. Total N = 98.

When asked to choose which activities students found useful, 77.6% of students (n = 76) found *Relaxation Exercises* to be useful; 69.0% of students (n = 68) found *Deep Breathing* to be useful; 68.0% of students (n = 67) found *Helping Others Feel Good* to be useful; 65.0% of students (n = 64) found *Thinking Helpful Thoughts* to be useful; 63.0% of students (n = 62) found *Changing Negative Thoughts to Positive Thoughts* to be useful; 53.0% of students (n = 52) found *Recognizing Feelings in Yourself* to be useful;

49.0% of students (n = 48) found *Recognizing Feelings in Others* to be useful; 45.0% of students (n = 44) found the *Coping Step Plan* to be useful; and 36.0% of students (n = 35) found *6 Block Problem Solving* to be useful.

Social Validity Questionnaire for Parents

Parent participants were administered a questionnaire, which contained ten questions (Appendix D). Eight questions were scaled, with parents rating their answer on a likert scale ranging from 0-4, with a variety of descriptors. Two questions allowed less restrictive responses, with question nine having parents check off all skills that they thought their children found the most useful, and question ten being open-ended and allowing the parents to add additional comments or thoughts regarding the program. The results of the scaled questions can be found in Table 3.

Table 3

Scaled Question Results for Parent SVQ

Question	Very Useful	Somewhat Useful	Not sure	Not Really Useful	Not at all Useful
How useful do you think positive coping skills programs are in general?	77.3% (17)	13.6% (3)	9.1% (2)	0.0% (0)	0.0% (0)
How useful did you find the FRIENDS program for enhancing your child's coping skills?	50.0% (12)	20.8% (5)	29.2% (2)	0.0% (0)	0.0% (0)
	Very Important	Somewhat Important	Not Sure	Not really Important	Not at all Important
How important do you think it is that your child's school incorporates a program like this into the curriculum?	66.7% (14)	23.8% (5)	9.5% (2)	0.0% (0)	0.0% (0)
	A Lot	Some	Not Sure	A Little	Nothing at All
How much did you learn about enhancing your child's coping-skills?	19.0% (4)	38.1% (8)	28.6% (6)	4.8% (1)	9.5% (2)
How much do you think your child learned about understanding feelings in themselves and others?	45.8% (11)	37.5% (9)	16.7% (4)	0.0% (0)	0.0% (0)
How much do you think your child learned about coping with these feelings?	28.6% (6)	47.6% (10)	23.8% (5)	0.0% (0)	0.0% (0)
How much do you think your child enjoyed the FRIENDS program?	30.0% (6)	50.0% (10)	10.0% (2)	5.0% (1)	5.0% (1)
How often does your child use the ideas (skills) that they learned in the FRIENDS program?	9.5% (2)	38.1% (8)	47.6% (10)	4.8% (1)	0.0% (0)

Note. Total N = 24. Number in brackets indicates number of participants for each response.

How useful do you think positive coping-skills programs are in general? The first question on the SVQ for parents asked parents how useful they felt positive coping-skills programs are in general. The descriptive frequencies indicated that 9.1% (n = 2) of parents felt that they were unsure of the importance of positive coping skill programs; 13.6% (n = 3) of parents felt that positive coping-skills programs are somewhat useful; and 77.3% (n = 17) of parents who responded to the questionnaire felt that positive coping skills programs are very useful. In total, 90.9% (n = 20) of parents reported feeling that positive coping-skills programs in general are useful for students.

How useful did you find the FRIENDS program for enhancing your child's coping skills? The second question on the SVQ for parents asked parents how useful they felt that the FRIENDS program was for enhancing their child's coping skills. The descriptive frequencies indicate that 29.2% (n = 7) of parents felt unsure if the program was useful for enhancing their child's coping skills; 20.8% (n = 5) of parents felt that the FFL program was somewhat useful for enhancing their child's coping skills; and 50.0% (n = 12) of parents felt that the FFL program was very useful for enhancing their child coping skills. Overall, 70.8% (n = 17) of parents felt that the program was useful and helpful for their child.

How important do you think it is that your child's school incorporates a program like this into the curriculum? The third question on the SVQ for parents asked parents how important they felt it was for their child's school to offer a program such as FRIENDS as a part of the school curriculum. The descriptive frequencies indicate that 9.5% (n = 2) of parents felt that they were not sure if it was important for a

program such as FFL to be incorporated into the school curriculum; 23.8% (n =5) of parents indicated that they felt that it was somewhat important for schools to incorporated programs such as FFL into the curriculum; and 66.7% (n = 14) of parents felt that it was very important for schools to incorporate a program such as this into the curriculum. Overall, 90.5% (n = 19) of parents indicated that they felt that it may be beneficial for program such as these be incorporated into the school curriculum.

How much did you learn about enhancing your child's coping-skills? Parents were asked how much they learned about how to enhance their child's coping-skills. Descriptive statistics indicated that 9.5% (n = 2) of parents felt that they learned nothing at all about enhancing their child's coping skills; 4.8% (n = 1) of parents felt that they learned a little about enhancing their child's coping skills; 28.6% (n = 6) of parents felt that they were not sure how much they learned about enhancing their child's coping skills; 38.1% (n = 8) of parents felt that they learned some about enhancing their child's coping skills; and 19.0% (n = 4) of parents felt that they learned a lot about enhancing their child's coping skills. While responses to this question were more diverse than the previous results, 61.9% (n = 13) of parents responded positively and felt that they learned about enhancing their child's coping skills, while 28.6% (n = 6) were unsure and 9.5% (n = 2) felt that they did not learn anything.

How much do you think your child learned about understanding feelings in themselves and others? Parents were asked how much they felt that their child learned about understanding feelings in themselves and others. Descriptive frequencies indicated that 16.7% of parents felt unsure of how much their children learned about understanding

feelings in themselves and others; 37.5% (n = 9) of parents felt that their children learned some about understanding feelings in themselves and others; and 45.8% (n = 11) of parents felt that their children learned a lot about understanding feelings in themselves and others. Overall, 83.3% (n = 20) of parents felt that their children learned about understanding feelings in themselves and others, while the remaining parents reported being unsure.

How much do you think your child learned about coping with these feelings? Parents were asked how much they felt that their child learned about coping with feelings throughout the program. Descriptive frequencies indicated that 23.8% (n = 5) of parents felt unsure of how much their child learned about how to cope with feelings; 47.6% (n = 10) of parents felt that their child learned some about how to cope with feelings; and 28.6% (n = 6) of parents felt that their child learned a lot about how to cope with feelings. Overall, 77.2% (n = 16) of parents felt that their child learned about coping with feelings, while the remaining 23.8% (n = 5) of parents felt unsure of what their children learned.

How much do you think your child enjoyed the FRIENDS program? Parents were asked how much they thought that their child enjoyed the FRIENDS program. Descriptive frequencies indicated that 5.0% (n = 1) of parents felt that their child did not enjoy the program at all; 5.0% (n = 1) of parents felt that their child enjoyed the program a little; 10.0% (n = 2) of parents felt that they were unsure of how much their child enjoyed the program; 50.0% (n = 10) of parents felt that their child enjoyed the program some; and 30.0% (n = 6) of parents felt that their child enjoyed the program a lot. Overall, 85% (n = 17) of parents indicate that they felt that their child enjoyed the FFL

program, while 5.0% (n = 1) of parents felt that their child did not enjoy the program, and 10.0% (n = 2) of parents felt unsure.

How often does your child use the skills that they learned in the FRIENDS program? Parents were asked how often their child used the skills that they learned in the FRIENDS program. Descriptive frequencies indicated that 4.8% (n = 1) of parents indicated that their child rarely used the skills; 47.6% (n = 10) of parents indicated that they were unsure of how often their child used the skills learned; 38.1% (n = 8) of parents indicated that their child used the skills some of the time; and 9.5% (n = 2) of parents indicated that their child used the skills learned in the FFL program a lot. Overall, 45.6% (n = 10) felt that their children used the skills learned, while 47.6% (n = 10) of parents felt unsure if their children used the skills and 4.8% (n = 1) of parents felt that their children did not use the skills learned.

Pro-Social Behaviour Results

Pro-Social behaviour includes behaviours that encourage positive social interactions. In the case of the FRIENDS for Life program, it is expected that pro-social behaviours would improve as a result of participation in the program, given the skills and concepts taught to participants. To obtain data regarding pro-social behaviour, students were given the SDQ – a rating scale in which students self-rated the degree to which they felt they demonstrated these behaviours. The pro-social items on the SDQ which were used in this study include: (item 1) I try to be nice to other people; (item 4) I usually share with others; (item 9) I am helpful if someone is hurt, upset, or feeling ill; (item 17) I am kind to younger children; and (item 20) I often volunteer to help others. This scale

was administered both pre-test and post-test. Pearson's Chi Square (X^2) analysis was conducted for each question to determine if frequencies differed significantly from what would be expected if there was no effect due to program participation. Effect sizes were determined using Cramér's V (φ_c). The effect size indicates the strength of association, with 0 indicating no association and 1 indicating a maximum degree of association.

SDQ Pro-social item 1: I try to be nice to other people. I care about their feelings. When students were asked to rate if they are kind to others and care about their feelings, 90.4% rated this as certainly true both pre-test and post-test (n = 189). Of the students who rated this item as being not true pre-test (n = 4), there was a positive improvement in the post-test administration, with 75.0% of these students changing their rating from not true, to somewhat true or certainly true (n = 3). Likewise, of the students who rated this item as somewhat true pre-test (n = 30), 73.3% changed their rating to certainly true during the post-test administration (n = 22), while only 26.7% continued to rate the item as somewhat true (n = 8), showing no changes, and none of the students showed regression into the not true category. Of the students who rated this item as certainly true during pre-test administration, 7.2% of students changed their rating to somewhat true (n = 15) and 2.4% of students changed their rating to not true (n = 5). A chi-square analysis was conducted to determine the degree of relationship between pre-test and post-test ratings. Overall, there was a significant positive change reported by students, X^2 (4, N = 243) = 21.53, $p < .01$. This represents a medium effect size, φ_c = .210. Table 4 displays the pre-test and post-test ratings for this item.

Table 4

Comparisons of Participant Pre-Test and Post-Test Responses for SDQ Question Item 1.

Item: I try to be nice to other people. I care about their feelings.

Post-Test Responses	Pre-Test Responses		
	Not True	Somewhat True	Certainly True
Not True	25.0% (1)	0.0% (0)	2.4% (5)
Somewhat True	25.0% (1)	26.7% (8)	7.2% (15)
Certainly True	50.0% (2)	73.3% (22)	90.4% (189)
Total	100.0% (4)	100.0% (30)	100.0% (209)

Note: Number in brackets indicates number of students. Total N = 243.

SDQ pro-social item 2: I usually share with others. When students were asked to rate if they usually share with others, 57.3% of students rated this as certainly true both pre-test and post-test (n = 63). Of the students who rated this item as being not true pre-test (n = 38), there was a positive improvement in the post-test administration, with 68.4% of these students changing their rating from not true, to somewhat true or certainly true (n = 26). There were 31.6% of students who continued to rate this item as not true during the post-test administration. Of the students who rated this item as somewhat true pre-test (n = 96), 32.3% changed their rating to certainly true during the post-test administration (n = 31), while 55.2% continued to rate the item as somewhat true (n = 53), showing no changes, and 12.5% of the students showed regression into the not true category (n = 12). Of the students who rated this item as certainly true during pre-test administration, 34.5% of students showed a slight regression and changed their rating to somewhat true (n = 38) and 8.2% of students changing their rating to not true (n = 9). A

chi-square analysis was conducted to determine the degree of relationship between pre-test and post-test ratings. Overall, there was a significant positive change reported by students, X^2 (4, N = 244) = 26.89, $p < .01$. This represents a medium effect size, φ_c = .210. Table 5 displays the pre-test and post-test ratings for this item.

Table 5

Comparisons of Participant Pre-Test and Post-Test Responses for SDQ Question Item 4

Item: I usually Share with Others.

Post-Test Responses	Pre-Test Responses		
	Not True	Somewhat True	Certainly True
Not True	31.6% (12)	12.5% (12)	8.2% (9)
Somewhat True	42.1% (16)	55.2% (53)	34.5% (38)
Certainly True	26.3% (10)	32.3% (31)	57.3% (63)
Total	100.0% (38)	100.0% (96)	100.0% (110)

Note. Number in brackets indicates number of students. Total N = 244.

SDQ Prosocial item 3: I am helpful if someone is hurt. When students were asked to rate if they are helpful if somebody is hurt, 82.0% of students rated this as certainly true both pre-test and post-test (n = 146). Of the students who rated this item as being not true pre-test (n = 9), there was a positive improvement in the post-test administration, with 77.8% of these students changing their rating from not true, to certainly true (n = 7). Likewise, of the students who rated this item as somewhat true pre-test (n = 53), 47.2% changed their rating to certainly true during the post-test administration (n = 25), while 41.5% continued to rate the item as somewhat true (n = 22), showing no changes. There was a slight degree of negative movement, with 11.3%

of students (n = 6) changing their rating from somewhat true to not true. Of the students who rated this item as certainly true during pre-test administration, 11.2% of students changed their rating to somewhat true (n = 20) and 6.7% of students changed their rating to not true (n = 12). A chi-square analysis was conducted to determine the degree of relationship between pre-test and post-test ratings. Overall, there was a significant positive change reported by students, X^2 (4, N = 240) = 32.92, $p < .01$. This represents a medium effect size, $\varphi_c = .262$. Table 6 displays the pre-test and post-test ratings for this item.

Table 6

Comparisons of Participant Pre-Test and Post-Test Responses for SDQ Question Item 9

Item: I am helpful if someone is hurt (SDQ question item 9)

Post-Test Responses	Pre-Test Responses		
	Not True	Somewhat True	Certainly True
Not True	22.2% (2)	11.3% (6)	6.7% (12)
Somewhat True	0.0 % (0)	41.5% (22)	11.2% (20)
Certainly True	77.8% (7)	47.2% (25)	82.0% (146)
Total	100.0% (9)	100.0% (53)	100.0% (178)

Note. Number in brackets indicates number of students. Total N = 240.

SDQ Pro-social item 4: I am kind to younger children. When students were asked to rate if they are kind to younger children, 87.7% of students rated this as certainly true both pre-test and post-test (n = 179). Of the students who rated this item as being not true pre-test (n = 11), there was a positive improvement in the post-test administration, with 81.8% of these students changing their rating from not true, to somewhat true or

certainly true (n = 9). For students who rated the item as somewhat true during pre-test (n = 25), 76.0% changed their rating to certainly true during the post-test administration (n = 19), while only 12.0% continued to rate the item as somewhat true (n = 3), showing no changes, and 12.0% of students showed a slight regression and rated the item as not true post test (n = 3). Of the students who rated this item as certainly true during pre-test administration, 5.9% of students changed their rating to somewhat true (n = 12) and 6.4% of students changing their rating to not true (n = 13). A chi-square analysis was conducted to determine the degree of relationship between pre-test and post-test ratings. Overall, there was no significant change reported by students, X^2 (4, N = 240) = 4.63, $p >$ .01. This represents a small effect size, $\varphi_c = .98$. Table 7 displays the pre-test and post-test ratings for this item.

Table 7

Comparisons of Participant Pre-Test and Post-Test Responses for SDQ Question Item 17

Item: I am kind to younger children (SDQ question item 17)

Post-Test Responses	Pre-Test Responses		
	Not True	Somewhat True	Certainly True
Not True	18.2% (2)	12.0% (3)	6.4% (13)
Somewhat True	9.1% (1)	12.0% (3)	5.9% (12)
Certainly True	72.7% (8)	76.0% (19)	87.7% (179)
Total	100.0% (11)	100.0% (25)	100.0% (204)

Note. Number in brackets indicates number of students. Total N = 240.

SDQ Pro-social item 5: I often offer help to others. When students were asked to rate if they often offer to help others, 77.2% of students rated this as certainly true both

pre-test and post-test (n = 125). Of the students who rated this item as being not true pre-test (n = 9), there was a positive improvement in the post-test administration, with 77.7% of these students changing their rating from not true, to somewhat true or certainly true (n = 7). Of the students who rated this item as somewhat true pre-test (n = 67), 29.9% changed their rating to certainly true during the post-test administration (n = 20), while 65.7% continued to rate the item as somewhat true (n = 44), showing no changes, and 4.5% of students showed regression into the not true category (n = 3). Of the students who rated this item as certainly true during pre-test administration, 17.9% of students changing their rating to somewhat true (n = 29) and 4.9% of students changing their rating to not true (n = 8). A chi-square analysis was conducted to determine the degree of relationship between pre-test and post-test ratings. Overall, there was a significant positive change reported by students, X^2 (4, N = 238) = 56.99, $p < .01$. This represents a large effect size, $\varphi_c = .346$. Table 8 displays the pre-test and post-test ratings for this item.

Table 8

Comparison of Participant Pre-Test and Post-Test Responses for SDQ Question Item 20

Item: I often offer help to others (SDQ question item 20)

Post-Test Responses	Pre-Test Responses		
	Not True	Somewhat True	Certainly True
Not True	22.2% (2)	4.5% (3)	4.9% (8)
Somewhat True	44.4% (4)	65.7% (44)	17.9% (29)
Certainly True	33.3% (3)	29.9% (20)	77.2% (125)
Total	100.0% (9)	100.0% (67)	100.0% (162)

Note. Number in brackets indicates number of students. Total N = 238.

Summary of Results

Descriptive Frequencies were conducted on each of the question within the Social Validity questionnaires for both students and parents. This data indicates that students enjoyed the program, and that they felt that they learned a lot about feelings within themselves and others, as well as how to cope when worried by using specific skills taught within the program. Parents indicated that they felt that the program was useful and important. While parents were generally unsure of how much their children learned in the program, the data indicated that parents felt that their children learned something about feelings within themselves and others, as well as some coping skills. However, parents were unsure as to how their children used these skills daily.

Chi-square analysis was conducted to compare pre-test and post-test responses for the Strength and Difficulties Questionnaire. These results indicated that students reported

improvements in pro-social skills after participation in the FFL program. The skill that obtained the greatest positive impact was helping others, for which there was a large effect size, or a large impact. There was a medium effect size found for sharing with others, being nice to others, and helping people who are hurt. There was a small effect size for being kind to younger children, but the relationship between pre-test and post-test results was not significant.

CHAPTER FIVE

Discussion

The FRIENDS for Life program, a coping and resilience-building program for children and youth, has been gaining support worldwide. This program takes a CBT approach, teaching students about feelings in themselves and others, as well as skills such as changing unhelpful thoughts to helpful thoughts, relaxation techniques, and coping step plans. The program was developed in Australia, but research on the program has been conducted worldwide. In addition to the developing body of research to support this program, it has also been endorsed by the World Health Organization (2004). Research evaluation for the FFL program has been focused on two important types of program evaluation, treatment effectiveness and social validity. This evaluation has provided evidence for the usefulness and effectiveness of FFL across a variety of cultural contexts, such as Australia, the United Kingdom, Mexico, and Canada (Barrett & Turner, 2001; Barrett et al., 2006; Iizuka et al., 2015; Lock & Barrett, 2003; Stallard et al., 2005; Stallard et al., 2007; Stallard et al., 2008; Rose et al., 2009). Studies have shown that the FFL program has demonstrated positive results in both areas of evaluation in these contexts. The current study is a part of a larger study, intended to provide evaluative information regarding the administration of the FFL program as a prevention program in a Newfoundland and Labrador context. The current study explored the social validity of FFL in this context, for the purpose of providing useful information for program facilitators and Newfoundland and Labrador schools who may be considering implementing the program.

The first research question addressed asked, what are participant beliefs, perceptions, and attitudes towards the program, as determined by a social validity measure? Social validity is the social importance or social relevance of a program (Wolf, 1978). This type of data can give researchers and practitioners information about how the participants in a given treatment program have experienced the program, their perceptions of the program. This data relayed if participants enjoyed the program, as well as how effective they felt the program was for them. Throughout a variety of countries, as well as within Western Canada, research on the social validity of the FFL program has shown that the program is well accepted amongst both student and parent participants, and has been described as being fun, helpful, and delivered in a setting that was useful (Ahlen et al., 2012; Barrett, Shortt, Fox, & Wescombe, 2001; Gallegos et al., 2012; Barrett et al., 2014; Rose et al., 2009). Results from this study indicated that within the Newfoundland and Labrador context, similar acceptability results were obtained from both students and parents.

In keeping with results from previous studies, students within the current study indicated that they enjoyed the program, and that they felt that it was useful to participate in the program in the classroom environment. Parents also felt that the program was useful and that their children enjoyed participating in the program. The positive attitude towards the program, and engaging in the program within the classroom environment, is meaningful because it suggests that the school environment may be a beneficial place to implement this type of program. Students felt that they learned more by doing the program with their peers. When delivered universally, this also ensures that all students

are taught beneficial coping skills, whether diagnosed with an anxiety disorder or not. These skills may help students who do not have anxiety disorder, but may experience anxiety more often than most. With strong research indicating that the FFL program, and CBT in general, helps to reduce anxiety symptoms, this is promising approach to prevention.

One difference in the results amongst the literature is found when participants are asked which skills they found the most useful or the most helpful. The FFL program focuses on the teaching of specific coping skills/strategies that can be used when experiencing negative emotions (e.g., sadness, anger, worry). The SVQ, which is the measure used in a large portion of the social validity research for FFL, specifically asks students to identify which skills are the most beneficial for them. There have been some inconsistencies in the responses that program participants have given for this question throughout the various studies. For example, one study reported that *thinking helpful thoughts, helping others feel good, and understanding their emotions* were the most useful (Ahlen et al., 2012). Another study, however, indicated that the skills rated most helpful included *thinking helpful thoughts, the coping step plan, deep breathing, relaxation exercises, and acknowledging your own feelings* (Gallegos et al., 2012). The current study indicated that the skills rated as most helpful (determined in this study as those skills rated as helpful by 50% or more of students) included *relaxation exercises, deep breathing, helping others feel good, thinking helpful thoughts, changing negative thoughts to positive thoughts, and recognizing feelings in yourself.* It is unclear as to why there is variability reported for skills most rated as useful. Perhaps it is based on

individual differences within students, or perhaps differences within culture, for example. Despite the varied responses, all studies indicated that there were strategies that participants found helpful, which means that all participants throughout the studies had learned skills which were beneficial and useful for helping them feel that there was a reduction in anxiety symptoms.

Knowing that participants believe the program to be beneficial and helpful is useful information. Research on Azjen's Theory of Planned Behaviour, and Bandura's theory of Self-Efficacy, indicates that if individuals believe that they have the skills to handle anxiety, if they perceive that they have some control over anxiety-related events and experiences, there has been evidence that individuals will report experiencing lower levels of anxiety (Azjen, 1991; Bandura, 1977). While this relationship is not cause-effect in nature, it suggests that there is a connection between what individuals perceive and what they experience (Weems, Silverman, Rapee, & Pina, 2003). It may be that the belief that they have obtained skills and knowledge to combat anxiety by participating in the FFL program can impact the ability of participants to cope with anxious situations more positively. In the case of the current study, participants indicated that they believed that they had learned skills that were helpful for them. In keeping with theory, it would follow that these students then would be more likely to use these skills in the appropriate situations, and would thus see significant differences in the development of these coping skills.

Parent participants were also used to evaluate the treatment acceptability of the program. Student participants in the FFL program are minors, and as such, parents are

generally the people who make decisions for these students. In addition, there are many studies which indicate that family involvement in CBT interventions provides and added benefit to interventions that are solely child-focused (Brendel & Maynard, 2014; Wood et al., 2000; Bögels & Siqueland, 2006; Kendall et al., 2008). As such, parent perspectives on the acceptability and usefulness of the treatment program are also important, as parent participation in the treatment of their child may have a positive impact on the reduction of anxiety symptoms. In previous research, parents reported feeling that the program was useful and they were highly satisfied with the program (Gallagos et al., 2012; Rose et al., 2009). In comparison to the past research, the current study obtained similar results. As a whole, parents reported a generally positive acceptance of the program. Parents felt that the program had been useful in some way for their child and that programs of this type are beneficial within the school environment. Parent participants in the current study were less confident in what they had learned. Parent responses indicated that they felt that they had learned something from their child's participation in the program, though the specific skills that were learned were not specified. This is positive for the program, as research has shown that there is a connection between parent anxiety and child anxiety, and that attitudes and inclusion of parents in intervention strategies can be beneficial for reduction of anxiety levels in children (Fox et al., 2012). For this reason, it would seem important that parents also learn the skills and be invested in their child's development of skills.

Fawcett (1991) proposed that there are three levels of effects which may be evaluated with Social Validity: proximal (increased awareness, for example);

intermediate (increase use of skills, for example); and distal (generalization of skill usage, for example). Results of the current study indicate that there is strong evidence for proximal effects and intermediate effects, and that there were some distal effects noted. The distal effects, or the ability to generalize the skills learned to daily life, were not reported as strongly in this study as the other types of effects. This may indicate an area for further investigation, or the need for some slight changes in the program that fosters the transfer of skills to multiple environments.

The second research question addressed by the current study asked, was there a positive relationship between participation in the FFL program and pro-social behaviours of participants? The characteristics included in the pro-social behaviour scale used for the current study included being kind, being helpful, sharing, and being nice to others (Goldman, 1997). The FFL program teaches children to understand feelings within themselves, but also to understand more about feelings in others as well. The program also emphasizes how helping others can also help yourself. Given the teaching of these skills, it seems that pro-social behaviours should increase as students finish the program and have acquired skills. Liddle and Macmillan (2010), in fact, suggest exactly that. They found that the FFL program had a positive impact on children's social skills. The results of the current study produced similar results. Students within this study rated themselves more positively on the pro-social scale after completing the program, than they did before completing the program. This is especially true for the characteristics of helping others, sharing with others, and being nice to others. When asked about being kind to younger children, however, while there was no significant difference, the results

indicated a positive trend. A large portion of the sample, however, rated this statement as being certainly true both before and after, indicating that they were already kind to younger children before engaging in the program. Overall, these results indicate that there was a positive change in pro-social behavior over the course of program participation, which supports previous research.

Limitations

This study was conducted in an authentic school environment. As such, there are some inherent limitations as full control over administration of the program in a school setting is difficult to attain. One such limitation is that the facilitator of the program in each school differed. With different facilitators comes a different relationship with participants, different dynamics throughout the delivery of the program, and ultimately small differences in program delivery. The core parts of the program were maintained throughout each school, as determined through the treatment integrity measures, but the discussions differed depending on the facilitator and the student contributions. This is also true of the group as a whole. With each different group comes different dynamics, leading to different experiences within the program for participants at each location. This is true between schools, but also between different classrooms within the same school. Even with the same facilitator, when the program is delivered to a different group of participants you may obtain a different level of interaction and thus a different level of understanding of the skills and ideas delivered through the program. This is very difficult to control, as it is really due to individual differences and there is no way to guarantee the exact same delivery to each group. As such, the usefulness and effectiveness of the

program may be rated differently depending on the classroom or school in which the program is being delivered. In an attempt to ensure some control over these things, treatment integrity was evaluated through periodic researcher observation at each of the participation sites. These observations included notes from the researcher reflecting on how the primary objectives of the lessons were delivered, and ensuring that all of the key points were covered and objectives met. So, while all participants experienced the same types of activities and teaching of the same concepts and skills, there were variations in the delivery of these that cannot be controlled.

Another limitation due to the school environment is the way in which the program was delivered. The program was delivered in this environment based on time, priority, and what was happening in the school at any given time. Some schools delivered the program on one particular day of the week (for example, every Tuesday at 10 AM) whereas other schools delivered the program based on the school cycles (for example, second period on day 4). As such, the time between sessions varied by school and may have had an impact on the effectiveness of the program, or how engaged students were in the program. With the school counsellor often being the facilitator of the program, the delivery time also depended on what was happening at the school at any given time. In one school, a session had to be cancelled because of an emergency situation that was happening in the school at the time. This resulted in the session being pushed until the next time slot, with a longer time between sessions. This may have impacted how engaged the students were in the program, and how useful and effective the program was rated to be. As with the previous issues, this was very difficult to control as school

environments are dynamic and emergency situations are not predictable. One way to avoid this situation, however, would be to have an outside agent coming into the school to facilitate the program, rather than having the program delivered by the school counsellor. Another option would be to have the classroom teacher trained to deliver the program, in order to maintain continuity through the school day and reinforcement of concepts, providing more emphasis on the practice component of the program.

The involvement of the classroom teacher, and the inconsistency of such, is another limitation. This was observed throughout the treatment integrity sessions. In some classrooms, the teacher remained in the room for each session and engaged with the program. These teachers often were able to reinforce the skills taught throughout the time between sessions with the students, thus impacting the degree of effectiveness and the ability of students to use the skills taught. Other teachers were not as engaged, using the time that the facilitator was in the classroom to catch up on work or do some errands around the school, and so may not have been as able to reinforce the skills taught between sessions. It may be useful to speak with teachers and give them a more active role during sessions, in order to increase teacher engagement and thus, the ability for teachers to reinforce and help students to further develop skills between sessions.

Participant numbers were also a limitation identified within this study. The full research cohort had included 311 students. Attrition reduced the number of students who participated in the strengths and difficulties questionnaire to 243. In addition, the social validity questionnaire was only administered to a portion of the population, reducing those numbers even further to 98. If social validity participation had been greater, there

would have been more schools participating, and as such it would provide information that had a stronger generalizability. In terms of the pro-social behaviour measures, the numbers of students who rated themselves as not demonstrating positive social skills on the pretest measure was very low, and so while those students reported positive movement, the numbers were low and this must be kept in mind as the results are being interpreted.

Lastly, there was no way to control or randomize school selection or participation. School participation within the study was dependent on the volunteering of the individual schools, as well as the availability of personnel trained to deliver the program. Given this limitation, there is no way to eliminate extraneous variables such as: school climate; school resources, the beliefs of school staff, students, and other members of the community, and amount of diversity within the sample population.

Conclusion

The current study investigated the treatment acceptability of the FFL program in a Newfoundland and Labrador context. In keeping with previous research, it was expected that both parents and students alike would rate the program positively and demonstrate satisfaction with the program. Results of the current study indicated that this was, indeed the case. Parents and students felt that the FFL program was helpful, fun, and that they had learned coping skills that were helpful for them. While the program may not be more effective in reducing anxiety or increasing resiliency than other mental health programs (Doyle, 2016), the program acceptability is quite high and there was an increase in the report of pro-social behaviours by students. It may be that while students are learning

skills that they find useful, they need more time and practice before the skills are able to be used consistently to reduce significant experiences of anxiety. Whatever the case, it is apparent that the program is well accepted and that participants feel that the program had an impact on their ability to cope with anxiety and negative emotions.

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Appendix A

Child Assent Form

Title: Program Evaluation of the FRIENDS Anxiety Prevention Program

Researcher(s): Sarah Francis, Ph.D., R.Psych., Associate Professor, Department of Psychology, Memorial University of Newfoundland, (709) 864 4897, sfrancis@mun.ca

You are invited to take part in a research project entitled "Program Evaluation of the FRIENDS Anxiety Prevention Program".

I understand that I am being asked to take part in a study to help people find out more about the FRIENDS program that I am taking part in at my school. I am going to be asked to fill out some questionnaires about how I think and feel. My parents will also be asked to fill out some forms.

I understand that I do not have to take part in the study if I do not want to.

I can ask for help at any time, and I can ask to stop or to take a break at any time. If I am uncomfortable with any of the questions, I can stop. I know I do not have to answer any questions I do not want to answer.

Whatever I write on my questionnaires is private. No one here will use my name to talk about anything that I write or say.

This is not a test. There are no right or wrong answers. I can answer these questions however I think or feel.

If I have questions for anyone, I can ask them now before we begin or at any time I need help.

I understand what I just read, and I agree to take part in this study.

Assent of minor participant:

_____ _____

Signature of minor participant Date

Appendix B

Parent Consent Form
Informed Consent Form – Parents

Title: Program Evaluation of the FRIENDS Anxiety Prevention Program

Researcher(s): Sarah Francis, Ph.D., R.Psych., Associate Professor, Department of Psychology, Memorial University of Newfoundland, (709) 864-4897, sfrancis@mun.ca

You are invited to take part in a research project entitled "Program Evaluation of the FRIENDS Anxiety Prevention Program".

This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process.

Take time to read this carefully and to understand the information given to you. Please contact the researcher, Dr. Sarah Francis, if you have any questions about the study or for more information not included here before you consent.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Introduction

I am an associate professor in the Department of Psychology at Memorial University of Newfoundland. I am studying the FRIENDS anxiety prevention program that is being run in your child's school.

Purpose of study:

The FRIENDS program has been used in many different countries. It has been run in St. John's schools for the past two years. No one has studied how this program is working here yet. We do not yet know what its benefits are to the students who take part in it.

In this study we want to find out how the FRIENDS program works in St. John's. We also want to know if it helps lower child anxiety and increase child well-being. Knowing this will help schools understand better the effects of the FRIENDS program for students and parents. To find out more about the FRIENDS program, we are asking children who are participating in the FRIENDS program this year and children who are not participating in the program to take part in this study. If your child is not taking part in the program this year, this program might be offered to him or her at a later time.

What you will do in this study:

In this study you and your child will be asked to fill out some questionnaires. Parents will be asked to fill out 4 questionnaires and children will be asked to fill out 5 questionnaires.

Parents and children will be asked to fill out these questionnaires at 3 times: (1) before the FRIENDS program starts, (2) when it ends, and (3) one year after the program is finished. Parents will be asked to fill out their questionnaires over the phone or online. Children will be asked to fill out their questionnaires in their classrooms at school. For children in the FRIENDS program, we will also watch about 25% of the group sessions at school. When we watch a group session, a research assistant will take notes on the group activities. This is to find out whether the group is running the way it was intended to. We will also ask each group leader to let us know what they thought about the group at the end of the program.

Length of time:

Parent questionnaires will take about 15 minutes. Child questionnaires will take about 30 minutes.

Withdrawal from the study:

You can choose to stop taking part in this study at any time. If you choose to stop taking part in this study, any data collected from you or your child will be destroyed. If you choose to stop taking part in this study at any time, it will not have any consequences for you or your child or for your child's participation in the FRIENDS program at school now or in the future.

Possible benefits:

Taking part in this study will help your child's school understand better how the

FRIENDS program is working. It will also help the school know more about its specific benefits (for example, being able to cope better, having better friendships) for your child. Taking part in this study will help schools and researchers understand better how the FRIENDS program affects child anxiety, child well-being and coping, and parents' feelings about their child's anxiety. Taking part in this study will also help your child's school compare the FRIENDS program in St. John's schools to the FRIENDS program in other provinces and countries.

Possible risks:

For some parents and children, it is possible that reading certain questions may cause some upset or bad feelings. This is unlikely, but it is possible that this might happen for some parents or children. Parents and children can stop taking part in this study at any time they choose. If you or your child becomes upset while taking part in this study, the researcher will be available to answer your questions and address your concerns. If you have questions or concerns about taking part in the study after you or your child has finished the questionnaires, the investigator will also be available to answer any questions and address any concerns. The investigator will also be able to provide you with a referral to a registered counsellor or psychologist if you need to ask for one.

Confidentiality vs. Anonymity

There is a difference between confidentiality and anonymity: Confidentiality is ensuring that identities of participants are accessible only to those authorized to have access. Anonymity is a result of not disclosing participant's identifying characteristics (such as name or description of physical appearance).

Confidentiality and Storage of Data:

Your child will be asked to fill out questionnaires at school in the classroom. Because there will be other children in the room while your child is completing the questionnaires, your child's participation in this study will not be anonymous. That is, other children at your child's school will know that your child is taking part in this study. Every effort will be made to ensure your child's confidentiality. That is, no one else will see your child's responses to the questionnaires other than the researchers in this study. Each research assistant working on this study will also be required to sign a confidentiality agreement. The questionnaires that you fill out will be assigned a code. Your child's questionnaires will be assigned the same code. This is so that your responses can be compared to your child's responses. Also, your responses at the beginning of the study can be compared to your responses at the end of the study. Neither your name nor your child's name will be

on the questionnaires after this code has been assigned and the questionnaires have been linked. The information collected on these questionnaires might be re-analyzed at a later time as part of a future study. Your responses will remain anonymous. Your name or any information that can identify you will never be associated with presentations, reports, or articles using information collected in this project.

The questionnaires that you and your child fill out will be kept in secure locked file cabinets in a locked room in the Department of Psychology, Science Building, Memorial University of Newfoundland. The primary investigator and her research assistants will have access to these questionnaires. Paper copies of these questionnaires will be kept for a minimum of five years, as per Memorial University policy on Integrity in Scholarly Research. Electronic copies of your responses to these questionnaires will be stored on password-protected computers in a locked room in the Department of Psychology; the primary investigator and her research assistants will have access to these files.

Anonymity:

Every reasonable effort will be made to assure your anonymity. Neither you nor your child will be identified in any reports and publications.

Reporting of Results:

Data collected will be used in the context of a report to the school board, journal articles, conference presentations, and graduate-level theses. These documents will report data in an aggregated or summarized form; no identifying information from individual participants will be included in these reports.

Sharing of Results with Participants:

A report of the findings from this study will be provided to each participating school after the project is complete. Participants may obtain copies of this report by contacting their school directly or by contacting the primary investigator. You will not receive any test results from participating in this study.

Assent of your child:

Your child will be independently asked to provide his/her assent to take part in this study.

Questions:

You are welcome to ask questions at any time during your participation in this research. If you would like more information about this study, please contact: Dr. Sarah Francis at sfrancis@mun.ca or 709-864-4897.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Consent:

Your signature on this form means that:
• You have read the information about the research.
• You have been able to ask questions about this study.
• You are satisfied with the answers to all your questions.
• You understand what the study is about and what you will be doing.
• You understand that you are free to withdraw from the study at any time, without having to give a reason, and that doing so will not affect you now or in the future.
You understand that any data collected from you up to the point of your withdrawal will be destroyed.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your signature:

I have read what this study is about and understood the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

- ☐ I AGREE for myself and my child to participate in the research project understanding the risks and contributions of my participation and my child's participation, that my participation and my child's participation is voluntary, and that my child and I may end our participation at any time. A copy of this Informed Consent Form has been given to me for my records.

- ☐ I DO NOT AGREE for myself and my child to participate in the research project.

_____ _____

Signature of parent participant Date

_____
Printed name of parent participant

_____
Printed name of child participant

_____ _____
Name of child's school Name of child's teacher

Please complete the information below only if you are interested in participating:

I would like to complete my questionnaires by phone. My phone number is:_____. The best time to reach me by phone is: _____.

I would like to complete my questionnaires online. My email address is: _____

Appendix C

Social Validity Measures

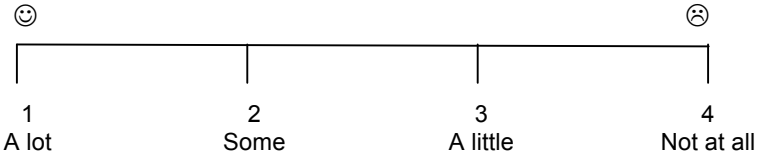
FRIENDS for LIFE
Children

The questions below ask you about the FRIENDS group that you have been doing. We are interested in finding out how much you enjoyed the program, and how helpful it was for you. Your answers to these questions will help us to improve the program.

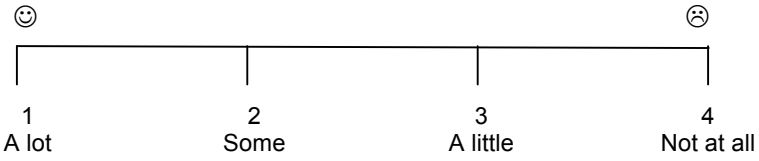
Please circle the answer that best describes the way you feel. Remember, there are no right or wrong answers, so please be as honest as you can.

Class: _____

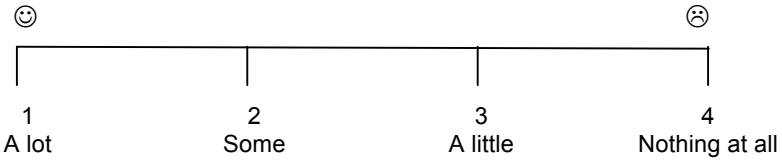
1. How much did you enjoy the FRIENDS program?



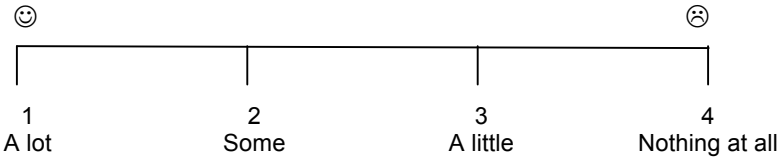
2. How much did you learn by doing the program with your classroom friends?



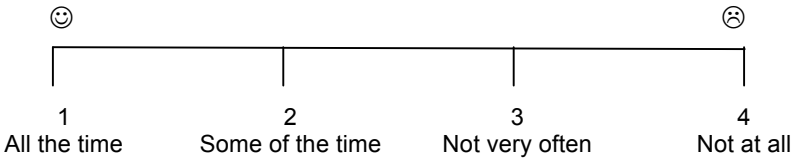
3. How much did you learn about feelings?



4. How much did you learn about how to cope with feeling worried or upset?



5. How often do you use the ideas that you learned in the FRIENDS program?



6. Which activities from the FRIENDS program did you find most useful? Please tick.

- ☐ relaxation exercises
- ☐ deep breathing
- ☐ thinking helpful thoughts
- ☐ changing negative thoughts to positive thoughts
- ☐ step plan (breaking your fears into small steps)
- ☐ 6 block problem-solving plan (e.g., what is the problem, what can we do?, list all ideas)
- ☐ recognizing feelings in yourself
- ☐ recognizing feelings in others
- ☐ helping others to feel good

7. Is there anything else about the FRIENDS program that you would like us to know?

_____

_____

_____

THANK YOU VERY MUCH !!!

Appendix D

Social Validity Measures

FRIENDS for LIFE
Parents

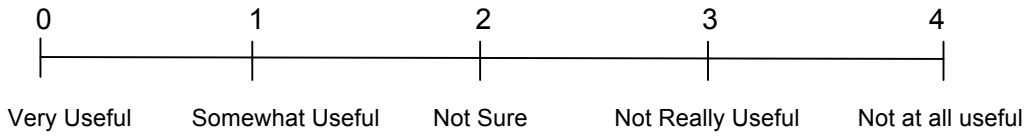
In order to continue to evaluate our program, and improve how the program can be implemented into both primary and high-schools, we would appreciate your comments and feedback.

The questions below ask about your thoughts regarding the FRIENDS program. For each of the questions, please circle the response that best reflects your answer. Please feel free to add any further comments in the space provided. We are interested in both your positive feedback, as well as any suggestions for change.

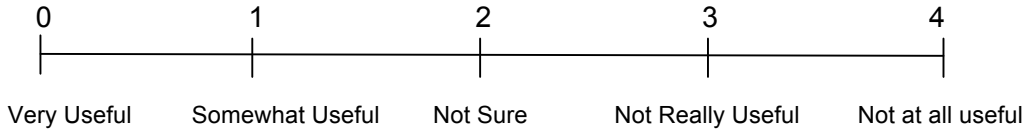
Your child's school: _____

Your child's grade: _____

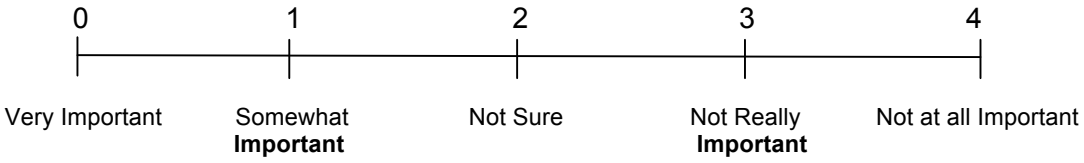
1. How useful do you think positive coping-skills programs are in general?



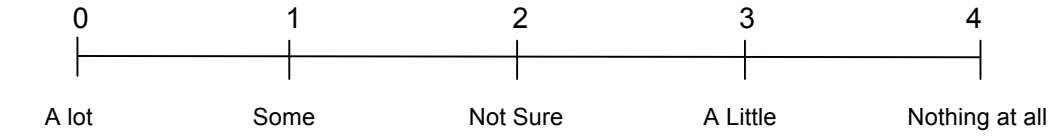
2. How useful did you find the FRIENDS program for enhancing your child's coping skills?



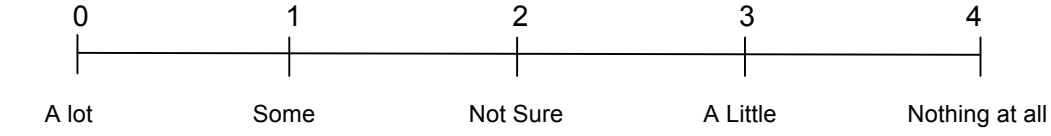
3. How important do you think it is that your child's school incorporates a program like this into the curriculum?



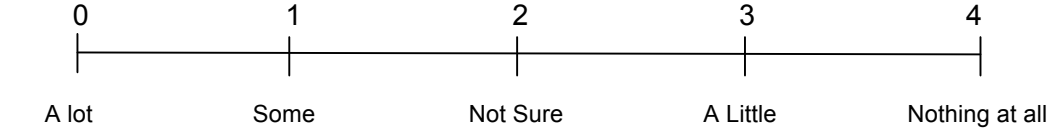
4. How much did you learn about enhancing your child's coping-skills?



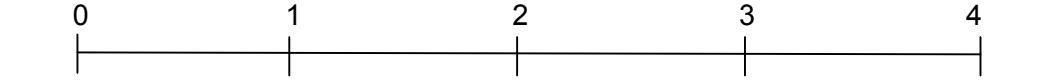
5. How much do you think your child learned about understanding feelings in themselves and others?



6. How much do you think your child learned about coping with these feelings?

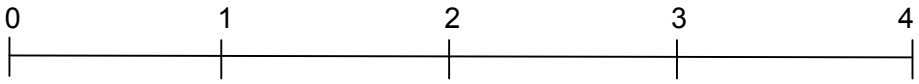


7. How much do you think your child enjoyed the FRIENDS program?



A lot Some Not Sure A Little Not at all

8. How often does your child use the ideas (skills) that they learned in the FRIENDS program?



Very often Sometimes Not Sure Rarely Not at all

9. Which skills from the FRIENDS program does your child find most useful? Please tick.

- ☐ relaxation exercises
- ☐ deep breathing
- ☐ thinking helpful thoughts
- ☐ changing negative to positive thoughts
- ☐ step plan (breaking your fears into small steps)
- ☐ 6 block problem-solving plan
- ☐ recognizing feelings in yourself
- ☐ recognizing feelings in others
- ☐ helping others to feel good

10. Please provide any other feedback (positive or negative) that you have.

THANK YOU VERY MUCH !!!

Appendix E

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings.			
I am restless, I cannot stay still for long.			
I get a lot of headaches, stomach-aches, or sickness.			
I usually share with others, for example CD's, games, food			
I get very angry and often lose my temper			
I would rather be alone than with people of my age			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset, or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, depressed, or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence.			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often offer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school, or elsewhere			
I get along better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I'm doing. My attention is good.			

Your Signature _____

Today's Date _____

Thank You Very Much for Your Help

Appendix F

Scoring the Self-Report Strengths and Difficulties Questionnaire

The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. Somewhat True is always scored as 1, but the scoring of Not True and Certainly True varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all 5 items were completed. Scale score can be prorated if at least 3 items were completed.

Emotional Symptoms Scale	Not True	Somewhat True	Certainly True
I get a lot of headaches, stomach-aches or sickness	0	1	2
I worry a lot	0	1	2
I am often unhappy, downhearted or tearful	0	1	2
I am nervous in new situations	0	1	2
I have many fears, I am easily scared	0	1	2

Conduct Problems Scale	Not True	Somewhat True	Certainly True
I get very angry and often lose my temper	0	1	2
I usually do as I am told	2	1	0
I fight a lot	0	1	2
I am often accused of lying or cheating	0	1	2
I take things that are not mine	0	1	2

Hyperactivity Scale	Not True	Somewhat True	Certainly True
I am restless. I cannot stay still for long	0	1	2
I am constantly fidgeting or squirming	0	1	2
I am easily distracted	0	1	2
I think before I do things	2	1	0
I finish the work I am doing	2	1	0

Peer Problems Scale	Not True	Somewhat True	Certainly True
I am usually on my own	0	1	2
I have one good friend or more	2	1	0
Other people my age generally like me	2	1	0
Other children or young people pick on me	0	1	2
I get on better with adults than with people my age	0	1	2

Prosocial Scale	Not True	Somewhat True	Certainly True
I try to be nice to other people	0	1	2
I usually share with others	0	1	2
I am helpful if someone is hurt, upset of feeling ill	0	1	2
I am kind to younger children	0	1	2
I often volunteer to help others	0	1	2

The Total Difficulties Score:
is generated by summing the scores from all the scales except the prosocial scale. The resultant score can range from 0 to 40 (and is counted as missing if one of the component scores is missing).

Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on the total difficulties score can be used to identify likely "cases" with mental health disorders. This is clearly only a rough-and ready method for detecting disorders – combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10% of a community sample scores in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the web site. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

Self Completed

	Normal	Borderline	Abnormal
Total Difficulties Score	0 - 15	16 - 19	20 - 40
Emotional Symptoms Score	0 - 5	6	7 - 10
Conduct Problems Score	0 - 3	4	5 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 3	4 - 5	6 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

Generating and Interpreting Impact Scores

When using a version of the SDQ that includes an "Impact Supplement", the items on overall distress and social impairment can be summed to generate an impact score that ranges from 0 to 10.

	Not at all	Only a little	Quite a lot	A great deal
Difficulties upset or distress me	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered "no" to the first question on the impact supplement (i.e. when they do not perceive themselves as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to classify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.