July 2020

Evaluating the Effects of a Brief Assertiveness and Help Seeking Skill Intervention

Madeline S. Blocker
Louisiana State University and Agricultural and Mechanical College

EVALUATING THE EFFECTS OF A BRIEF ASSERTIVENESS AND HELP SEEKING SKILL INTERVENTION FOR YOUTH IN FOSTER CARE

A Thesis

Submitted to the Graduate Faculty of
the Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Arts

in
The Department of Psychology

by
Madeline Spearman Blocker
B.S., Louisiana State University and Agricultural and Mechanical College, 2017
August 2020

Table of Contents

Abstract

Children in foster care lead their lives at an increased risk for mental health issues that are often complicated by the unstable and unpredictable nature of their living arrangements and interpersonal relationships. As such, there is substantial need to examine brief therapies and interventions for use with children in foster care and children who have experienced similar trauma and instability. Mental health care providers for children in foster care often may not have sufficient periods of time to implement treatment with fidelity. The present study investigated the efficacy of a summer camp based, brief behavioral intervention targeting help-seeking behavior and assertiveness to create meaningful skill improvement in a sample of children in foster care. Three, 30-min group sessions of a targeted assertiveness skill intervention were conducted on a sample of 13 children in foster care between the ages of 6 and 12 and compared to an assessment only control. Measures of general assertiveness, emotions towards seeking help, and assertiveness skill related to asking for help were used in a pretest-posttest format to assess the efficacy of the intervention. Results showed that participants in the intervention condition significantly improved on measures of general assertiveness and assertiveness skill, though not on the measure of emotions towards situations in which they would use these skills. These findings support the use of a brief intervention to teach assertive communication and help-seeking skill. Limitations and future directions are discussed.

Introduction

Overview of Mental Health in Foster Care

Child maltreatment has emerged as a key risk factor for mental illnesses (McGuire et al., 2018, Scozzarro & Janikowski, 2018). Foster care is a protective system for children who often have experienced this maltreatment, have been removed from their parents, and now require temporary out-of-home placements. Although personal experiences in the foster care system vary, foster placements fundamentally involve instability, ambiguity, and impermanence into the lives and minds of children in foster care (Bass et al., 2004). These placements can vary by setting. According to Bass et al. (2004), placements often consist of non-relative families, relatives other than parents, therapeutic foster homes, or group forms of care, such as institutions or group homes. The number of children in foster care is rising and is of increasing concern (Scozzaro et al., 2015). In 2013, there were around 400,000 children in foster care in the United States; in 2017, that number had increased to approximately 440,000 (U.S. Department of Health and Human Services, AFCARS Report, 2018).

Foster care as a whole strives to give children the best outcomes and protection possible, though often the unstable nature of the children's experience brings with it a myriad of problems. Several researchers have found the rate of mental illness of children in foster care to be higher than in the general population (Conn et al., 2016; McGuire et al., 2018; Trupin et al., 1993). The current prevalence of mental illness in children in foster care is estimated to be between 40% and 60% (Auslander et al., 2002; Lehmann et al., 2013; Scozzaro et al., 2015; Stahmer et al., 2005), with some estimates as high as 71% (Dore, 2005). A study of the physical and mental health of children in foster care found that children placed in foster care were five times more likely than children residing with their families to have anxiety, six times as likely to have behavior

problems, and seven times as likely to have depression (Turney et al., 2016). It has been well established within the past few decades of research that children in foster care are indeed at an increased risk for mental health problems. According to Clausen et al. (1998), this increased risk could be due to two factors. Increased chance for mental health problems can stem from either the maltreatment that sparked the child's removal from the family or from the negative effects of the removal itself. Even in a situation in which the child is subject to abuse, neglect or other maltreatment, the necessary disruption of the complicated relationship between the family and the child can lead to feelings of guilt, hostility, shame, anger, and rejection, resulting in mental health problems (Clausen et al., 1998).

Factors that are associated with increased rates of mental illness in the foster system are important to identify in order to remedy them. A study of the occurrence of mental disorders in children in foster care found that factors related to the foster care experience such as prior exposure to violence, experience with neglect, and number of prior placements all increased the likelihood of a child meeting the criteria for at least one DSM-IV disorder (Lehmann et al., 2013). Another study found that placement instability or disruption, defined as changes to placement that do not result in a permanent solution, are associated with the increased internalizing and externalizing behaviors that are associated with mental health diagnoses (McGuire et al., 2018). Similarly, a comparison study of children with relatively stable or unstable placements found a significantly higher rate of new DSM diagnoses in the group of children in the unstable placement group (Koh et al., 2014). The inverse problem has also been found; Palmer (1996) suggests that children are moved to new placements more often when they have higher rates of a range of behavioral and emotional problems. This acceleration of placement instability for children who are already the neediest is likely only to exacerbate their

mental health concerns. Children in foster care with a higher number of placement changes have been found to have a greater severity of behavior problems, both internalizing and externalizing (Aarons et al., 2010; Newton et al., 2000; Zorc et al., 2013). Newton et al. (2000) also identified children's initial reports of externalizing behaviors as the most relevant predictor of multiple placement changes. The strain of these behavioral and emotional problems often drains foster families and can result in placement disruption. As solidified and well-documented as the problem of mental illness in foster care appears to be in the research, there is much less research available on effective management and treatment of these children's symptoms.

Foster System Instability

One of the most fundamental problems in the foster system is the lack of placement stability (Hurlburt et al., 2010). Instability of children's placements while in care has been related to poor outcomes for children in foster care in both the short and long term. Problems with placement instability include the potential disruption of relationships the child has built with foster parents and siblings, networks of peers and teachers at school, and access to health care providers or community resources (Price et al., 2008). Children's access to mental health care when in foster care varies widely across placements. Some foster parents provide more support and treatment for their foster child's academic, emotional, social, or behavioral problems than other foster families (Seaberg & Harrigan, 1999). Combined with the high rates of placement instability in the foster system today, this creates a multitude of problems with treatment completion.

Historically, there is a high rate of attrition from evidenced-based interventions while children are in foster care; not retaining involvement and engagement with the interventions and treatments designed to help children in foster care be successful can put them at further risk

(Akin & Gomi, 2017; Damashek et al., 2011). Damashek et al. found rates of treatment attrition in child welfare populations ranging from 40% to 80%. Treatment-seeking families that have been exposed to trauma, which is normative when children must be removed from their parents, face more obstacles to treatment completion than other families (Wamser-Nanney & Steinzor 2017). Wamser-Nanney and Steinzor (2017) examined treatment completion of Trauma-Focused Cognitive Behavioral Therapy in a population of trauma-exposed youth. They put forth several factors that may impede treatment completion: avoidance of trauma-related treatment content (from both the child and caregiver), perception of treatment as unnecessary, and secondary difficulties, such as legal involvement, child placement in protective custody, or increased family stress (Wamser-Nanney & Steinzor, 2017). In addition, researchers have established that placement in state custody, specifically living with a nonbiological family, is a factor associated with treatment attrition (Sprang et al., 2013; Warnick et al., 2012).

Few trauma-exposed youth are enrolled in evidence-based psychotherapies, though they exist and have been demonstrated to be useful (Barnett et al., 2019). An even smaller number of these children complete treatment once they begin; Barnett et al. (2019) found that, within the study's 9-12 month tracking period, 47% of the children participating in treatment had dropped out. In foster care specifically, treatment completion is often impeded by placement disruption. Zorc et al. (2013) found that children with unstable placement histories had higher rates of absences and changed schools an average of 3.6 times over a period of 2 years. High rates of absenteeism and school changes impact children not only in their social networks, but also in their school and community-based service networks as well, including any mental health care or treatment the child may be receiving.

Overview of Brief Therapy

Although the issue of the instability of the lives of children in foster care with mental health problems is one that urgently needs addressing, a practical approach to the problem involves the creation of more accessible treatment options for children in foster care with mental health concerns. Researchers have been experimenting with brief versions of evidence-based psychotherapies for some time now. For example, Solution Focused Brief Therapy (SFBT, de Shazer et al., 1986) has shown marked success in adult (Macdonald, 2007) and child populations (Bond et al., 2013). SFBT was created out of systemic and brief family therapy, involving therapist and client focus on relevant solutions, goals, and past successes instead of dwelling on client problems (Franklin et al., 2011). Cepukiene et al. found success utilizing SFBT in a population of adolescents in foster care, reporting clinically significant and reliable positive changes in areas of problem behavior in 31% of the treatment group (2011). Another evidence-based psychotherapy, Brief Cognitive Behavioral Therapy (BCBT), has proven efficacious in as little as five sessions (Otto et al., 2012). BCBT is a streamlined extension of traditional cognitive behavioral therapy, structured similarly with a progression of phases and treatment strategies designed for skill mastery (Rudd, 2012). The main benefits of a brief intervention include providing an evidence supported treatment in a format in which it is practical to complete the course of treatment.

Research on brief therapy suggests that it is potentially valuable for use in child populations, with treatment completion leading to positive changes in the client's behavior and situations (Cepukiene et al., 2011). In a population of children in foster care, it is hypothesized that brief therapies will be especially beneficial; shorter treatment duration will increase the probability of children successfully completing treatment and attaining the full benefits of

treatment. Research has also suggested that a brief, evidence-based treatment plan may increase client satisfaction and motivation to continue therapy (Cepukiene et al., 2011). Koob and Love (2010) examined Solution Focused Brief Therapy (SFBT) in a population of children in foster care to determine its effectiveness in increasing placement stability. They found that children's number of placement changes significantly decreased after the implementation of SFBT, decreasing the mean number of placement disruptions from 6.29 pre-implementation to 1.45 post-implementation (Koob & Love, 2010). The establishment of brief, evidence-based psychotherapies would allow for the therapeutic treatment of mental health problems to reach more children than currently possible.

Help Seeking of Mental Health Care and Other Needs

Children in foster care, as a group, utilize more mental health services than children not in care due to their elevated level of mental health concerns (Johnson & Menna, 2017). However, a national survey of mental health need and access to services has shown that around two thirds of youth involved with the child welfare system do not obtain the treatments or services they need (Burns et al., 2004). Help-seeking pathways are the steps individuals take that lead to the solution of a problem. Help-seeking research among youth often examines informal (e.g. seeking help from friends, parents, siblings) and formal (e.g. seeking help from a doctor, mental health professional) strategies to address mental health and other concerns (D'Avanzo et al., 2012; Neighbors & Jackson, 1984; Scott et al., 2015; Whittaker, 1986), with some finding informal help seeking strategies as utilized first and most commonly (Scott et al., 2015). This poses a unique issue for populations of children in foster care; due to a lack of consistent support from their families and their frequent physical moves, resulting in the interruption of their social

networks, children in foster care are disadvantaged in their access to comfortable, informal help seeking avenues (Johnson & Menna, 2017).

In addition to children in foster care needing support regarding their mental health, this vulnerable population often encounters many types of problem situations in which they may need to seek help, some related to mental health, some not. In their study of help seeking among adolescents in foster care, Johnson and Menna (2017) identified several problems that are often encountered: biological family issues, changing schools and school stress (e.g. academic struggles), conflict with other people in the system, housing issues, interpersonal stressors (e.g. problems with friends, dating), and personal medical issues or injuries (e.g. starting menstruating). While children not in care may be able to address these issues as they arise, children in foster care are often in a poorer position to seek assistance for common problems like these.

Assertiveness and Help Seeking

Assertiveness is a quality of communication that is essential to effective help seeking. Assertive communication involves respectfully and effectively making requests of others, in addition to conveying opinions, needs, rights and boundaries, all without infringing on the rights of others (Duckworth & Mercer, 2006). Often, assertiveness is taught in contrast with aggression and passivity to emphasize the interpersonal benefits of assertive communicating. Assertiveness training for skill-based deficits and cognition-based deficits consists of several strategies, requiring psychoeducation with skill-building and cognitive restructuring with reframing, respectively. Most successfully, assertiveness training combines explanations of effective communication, practice, self-monitoring, and in-session role plays with feedback and reinforcement (Duckworth & Mercer, 2006).

Speed et al. (2017) discuss assertiveness, finding that though assertiveness training has been demonstrated to be a valuable evidence-based treatment associated with many clinical diagnoses and populations, research on the subject has all but disappeared. Most of the research on assertiveness was completed in the 1970s and 1980s during an early wave of cognitive behavioral therapy research (Speed et al., 2017). Speed et al. posit that psychotherapy researchers have tended to give preference to new lines of research, while paying less attention to what has been previously found and evidenced; additionally, they warn that the tendency to disregard past research may "undermine progress," with the repetition of the same findings wasting time and resources. Assertiveness training has been used as a strategy to decrease anxiety and as a psychotherapy for depression as effectively as other CBT interventions (Cuijpers et al., 2008; Wolpe, 1958). Speed et al. (2017) described a substantial amount of research supporting assertiveness training as an effective psychotherapy for several clinical and personal issues: anxiety, depression, serious mental illness, low self-esteem, and relationship satisfaction. In addition, Tanner and Holliman (1988) found an assertiveness training program significantly increased cooperative interactions and decreased physical aggression in a group of 1st-3rd graders. These problems are relevant to populations at increased risk for mental illness, such as with children in foster care.

Unassertiveness has been associated with high rates of victimization in populations of adult women and children, though little research has been conducted with child populations. Many studies of assertiveness in women tie unassertiveness to increased sexual victimization, vulnerability, and psychological distress (Greene & Navarro, 1998; Kidder et al., 1983; Rowe et al., 2015). A study of unassertiveness in preadolescent girls found that an interaction between low levels of assertiveness and high peer victimization led to a higher measure of depressive

symptoms at a follow up two years later (Keenan et al., 2010). Low levels of assertiveness are associated with levels of social anxiety and distressing thoughts (Aoki et al., 2017; Duckworth & Mercer, 2006). Exposure to a stressful event or trauma, as is common in populations of children in foster care, has been shown to decrease levels of assertion, as well as increase anxious and depressive symptoms (Saigh, 1988). Though there is not yet conclusive research on this relationship, it may be the case that youth exposed to trauma (e.g. children in foster care) demonstrate lower levels of assertiveness and as a result are at increasing risk for mental health disorders in the future.

The Present Study

Assertiveness interventions have been shown to improve a variety of clinical psychological problems (Speed et al., 2017). Combined with the development of effective help seeking strategies, assertiveness is a valuable skill to develop in vulnerable, at-risk populations. Past research has been limited in its study of assertiveness and help seeking behavior in foster youth; even less prevalent are studies examining mental health treatments for children in foster care in a brief therapy format. The present study sought to utilize the past research on assertiveness and help seeking to design an effective brief therapy for a vulnerable population of children in foster care. Participants completed assessments measuring assertiveness, knowledge of help seeking techniques, and feelings towards asking for help before being randomly assigned to a treatment condition involving a targeted assertiveness intervention or a control condition in which no treatment took place. The same assessments of assertiveness and help seeking were conducted on all participants at the conclusion of the study and differences between groups were examined. The hypothesized results were that participants in the intervention group would report

higher levels of assertiveness, greater knowledge of help-seeking strategies, and more positive feelings towards asking for help than levels reported in the control group.

Method

Participants

Participants were 23 children between the ages of 6 and 12. Nine of the children were male. The ethnic makeup of the sample was 65.2% White, 30.5% Black, and 4.3% other ethnicities. All participants were under legal guardianship of a parish child protection agency in Louisiana living in foster homes in the area at the time of the study. The participants all attended Royal Family Kids Camp (RFKC), a week-long summer-camp for children in foster care, at which the study took place. The camp utilizes trauma-informed counselors and staff, ensuring that the children in attendance who may have experienced physical, sexual, or emotional abuse and neglect are successfully supported throughout the week. There were no other exclusionary criteria for participation. Informed consent was obtained for each participant when the children were dropped off by their guardians for camp. All participants had the option to not participate in the study or withdraw at any time with no consequences. Child assent was obtained at the beginning of the sessions.

Procedure

This study and all assessment materials were approved by the Instructional Review Board at Louisiana State University. Data were gathered via pre- and post-intervention assessments of help-seeking behavior and assertiveness, conducted at the beginning and end of camp. Participants were matched for age and randomly assigned to conditions in camper-pairs. Campers had a "buddy" and a counselor that they spent the week with; the random assignment of the participants in their camper-pairs was necessary to manage scheduling. Three thirty-minute group sessions of targeted assertiveness skills intervention were conducted with 13 children. Assessment results were compared to an assessment-only control group of 10 participants.

Initially, groups were equal; however, three children in the control condition chose to withdraw from the study. These three participants chose to withdraw at the post-assessment time point as a result of their preference to participate in another camp activity over completing the assessments again.

All intervention sessions consisted of approximately four campers (sometimes three) and two therapists, a primary therapist and an assistant. The researcher was the primary therapist for all sessions. Assistants were camp counselors. All assistants were screened, background checked, interviewed, and trained in working with children who have experienced trauma prior to the camp. The assistants were trained in preparation for camp at two four-hour training sessions of presenters on topics relevant to their role (e.g. mandatory reporting, adverse childhood experiences, forms of abuse and neglect). At this camp training, counselors and staff were told about this study and the assertiveness intervention that would be taking place, in addition to the role they would play as session assistants.

Of the five days at camp, participants in the treatment condition attended three daily sessions lasting approximately 30-min each. The participants in the control condition attended an alternate activity (e.g. story and snack time). Each of these assertiveness intervention sessions consisted of two parts. The first was a psychoeducational introduction in which the therapist presented material such as the rationale for assertive communication (versus passive and aggressive communication), the goals of assertiveness training, and the benefits of increasing assertiveness. The second part included a skill building and practice period in which participants learned assertive communication skills (e.g. eye contact, effectively making requests), determined and practiced real-life situations in which these skills can and should be used, and then received feedback on which skills were mastered and which needed more practice. Session

assistants completed treatment integrity checklists provided by the researcher during each session. The treatment was implemented as prescribed 100% of the time.

Measures

Sessions on the first and last days of camp were reserved for the study assessments. Assessments were conducted by the researcher and two assistants, a Louisiana State University School psychology graduate student and a camp staff member, both trained on the study measurement procedures during a session prior to camp. The measures for this study included assessments of assertiveness and help-seeking behavior relevant to children in foster care. All three measures for this study were developed and modeled after previously successful measures due to the absence of measures available that were specific to the targets and appropriate to the context of this study. Three measures were used pre-intervention and post-intervention: a modified version of the *Children's Action Tendency Scale* (*CATS*, Deluty, 1979), measuring assertiveness, aggressiveness, and passivity; an assessment of emotions towards scenarios in which assertive communication is required to seek help; and a role-play assessment of assertiveness skills. Differences between groups were statistically analyzed at the pre-intervention and post-intervention time points.

Children's Action Tendency Scale (CATS)

The assessment of assertive behavior utilized in this study was modeled after the *Children's Action Tendency Scale* (*CATS*; Deluty, 1979). The subscales of the instrument are highly correlated with multi-informant reports of children's behavior and have been found to have moderate split-half reliability and test-retest reliability (Deluty, 1979; Deluty, 1984). Items in the test involve situations relevant to children (e.g. meeting a new adult, peer conflict) and offer answer choices representing assertive, aggressive, and passive communication contrasted

against each other. The items involve making requests of peers and conveying needs, addressing both help seeking and assertiveness. The *CATS* in its original form is presented in Appendix A. For the purposes of this study, the *CATS* was modified for efficiency; the educational levels of the participants in this study were highly variable, therefore, the *CATS* was read aloud to all participants to assure that all children had the highest chance of understanding the content. To shorten administration time, the answer choices were not presented multiple times in contrast with each other, as in the original administration of the *CATS*, but as options in a multiple-choice format. There were fourteen items, and possible scores on this assessment ranged from 0-14.

Emotion Meter

The test of emotions about help seeking was created for the purposes of this study. The assessment utilized a feelings meter to rate feelings of worry regarding social situations that potentially could be anxiety-provoking and require the use of assertiveness skills (e.g. asking a foster parent for help with homework). Participants were presented seven scenarios one by one and asked to rate their feelings of worry on a scale from 1-10. These responses were then summed, resulting in a total assessment score ranging from 0-70. The emotion meter has been used to assist individuals in measuring their intense emotions effectively (Burg, 2005). A systematic review of the emotion meter showed its efficacy in detecting research participants' intense emotions promptly and accurately (Harju, Michel, & Roser, 2019). In this study, a visual meter was presented with colors (ranging from red to green) and emoticon representation of points on the scale from 1 (very worried) to 10 (not at all worried) to assist participants in choosing the most accurate rating of their emotions.

Role-Play

Role play assessments allow for observations of assertive behavior in a clinical context (Duckworth & Mercer, 2006). The role play assessment of assertive behavior created for this study consisted of situations that allow for interaction between the therapist and participants that mimic interpersonal interactions relevant to children and children in foster care (e.g. peer conflict). For instance, one role-play assessment item asked participants to pretend they were being introduced to new foster parents and to introduce themselves as they normally would. This assessment included four role-play scenarios and subsequent observations. Participants' responses were rated by the therapist on relevant assertiveness skills: eye contact, body language, clarity of voice, assertiveness of word choice, effective goal communication, and appropriate speaking volume. Ratings were on a three-point scale of 0, 1 or 2 with behaviorally defined anchors (e.g. does not make eye contact, makes eye contact intermittently, makes and sustains eye contact). Ratings for each of the 4 scenarios were summed, resulting in a total possible score of 48 points.

Data Analysis

The dependent variables measured in this study were the modified *CATS*, emotion meter rating of assertive help seeking, and role play performance. Scores on each of the three measures of assertiveness and help-seeking skill were statistically evaluated. Initial means of the randomly assigned treatment and control groups' scores on the study measures were examined using two sample *t*-tests to ensure no pre-intervention differences between groups before running the primary analyses. Initial omnibus tests included repeated measures ANOVAs conducted to determine any generally significant differences relevant to each of the dependent variables. For further analysis, comparisons were made between participants' pre-intervention and post-intervention test scores across both the treatment and control groups by using a family of paired

samples *t*-tests using R. Additionally, a between-groups comparison of the control and treatment groups' scores at the post-intervention time point was made to further assess the efficacy of the intervention.

The hypothesized result was that the study's treatment group, the recipients of the brief-assertiveness intervention, would have greater scores of assertiveness knowledge and skill, in addition to more positive feelings towards help seeking, as captured by the study assessments. Significant statistical differences between the means of the treatment and control groups would result in rejection of the null hypothesis. This result would suggest that the proposed assertiveness intervention, while brief, was effective in developing meaningful assertiveness and help-seeking skill improvement in this sample of children in foster care.

Results

Preliminary Analyses

Descriptive statistics of participants' scores on all measures were examined. Means and standard deviations are reported in Table 1. Before primary analyses were conducted, a comparison of pre-intervention test scores of the control and treatment groups was carried out with two sample *t*-tests in R. No significant differences in scores on the *CATS*, $t(21)=-0.272$, $p=0.788$, $d=.11$; the emotion meter, $t(21)=-1.219$, $p=0.236$, $d=0.21$; or the role play assessment, $t(21)=0.324$, $p=0.749$, $d=0.14$, were found between the control and treatment groups prior to intervention. These results are summarized, in addition to the post-intervention comparisons, in Table 3.

Table 1. Means and Standard Deviations, M(SD)

	Pre-test		Post-test	
	Control	Treatment	Control	Treatment
CATS	7.3 (2.31)	7.54 (1.90)	8.6 (2.07)	11.38 (2.10)
Emotion Meter	33.0 (10.24)	38.46 (10.94)	29.6 (6.93)	36.77 (11.35)
Role-Play	27.2 (10.34)	25.77 (10.61)	24.8 (11.23)	39.77 (5.43)

Primary Analyses

Initial analyses of the data involved a repeated-measures mixed ANOVA for each of the three outcome measures, as each measure was designed to capture a different aspect of participant performance. On mean scores of the *CATS* assessment of assertiveness, there was a significant main effect of time, $F(1, 21) = 22.169$, $p < .001$, $\eta_p^2=0.514$, and a significant interaction between time and group, $F(1, 21) = 5.427$, $p < .05$, $\eta_p^2=0.205$. Analyses showed no significant main effect of time, $F(1, 21) = .842$, $p = .369$, $\eta_p^2=0.039$, and no interaction between time and group, $F(1, 21) = .095$, $p = .761$, $\eta_p^2=0.005$, when examining participant scores on the emotion meter assessment. On mean scores of the role-play assessment of assertiveness, there

was both a significant effect of time, F (1, 21) = 8.172, p < .01, η_p^2=0.280, and a significant interaction between time and group, F (1, 21) = 16.335, p < .001, η_p^2=0.437. To probe these results, data were analyzed further using a family of paired *t*-tests to allow for a more specific examination of each group's performance at each time point.

Within Group Effects

Within the control condition, effects of the intervention on each measure were analyzed at both time points. Comparisons of the control condition's scores across all measures were non-significant, as summarized in Table 2. There were no significant differences between the pre-intervention and post-intervention evaluations in the *CATS* assessment, t(9)=1.646, p=0.134, d=.59; the emotion meter, t(9)=0.942, p=0.371, d=.39; or the role-play assessment, t(9)=-0.741, p=0.477, d=.22.

The treatment condition, consisting of the participants who underwent the brief assertiveness intervention, was also analyzed with paired *t*-tests comparing the pre-intervention and post-intervention scores (see Table 2). The emotion meter assessment showed no significant difference between the scores pre-intervention and post-intervention, t(12)=0.424, p=0.68, d=.15. However, tests of the remaining two measures showed participants had significantly higher scores post-intervention than their original scores. The *CATS* assessment, t(12)=5.189, p<0.01, d=1.92, and the role-play assessment, t(12)=5.502, p<0.01, d=1.66 both showed significant increases in scores of participants in the treatment condition. The intervention had a large effect on both of these measures.

Table 2. Within-Group *t*-Tests Reflecting Pre And Post-Intervention Score Comparisons

	CATS	Emotion	Role-Play
Control	1.646	.942	-.741
Treatment	5.189***	.4245	5.502***

*p < .05. **p <.01. ***p < .001.

Between Group Effects

In the same manner as the preliminary analyses, the control and treatment groups' post-intervention scores were compared using two-sample *t*-tests. There were no significant differences in post-intervention scores of the treatment and control groups on the emotion meter assessment, $t(21)=-1.756$, $p=0.094$, $d=.37$. However, participants in the treatment group scored significantly higher than the control group post-intervention on the *CATS* assessment, $t(21)=-3.272$, $p<0.01$, $d=1.33$, and on the role-play assessment, $t(21)=-4.2251$, $p<0.01$, $d=1.78$. Both of these groups showed a large effect of the intervention. These results are consistent with the within groups effects, as the treatment group's post intervention score mean on the CATS and the role-play assessment was significantly higher than both the treatment group's pre-intervention score mean and the control group's post-intervention score mean. This suggests that the brief assertiveness intervention was effective at increasing knowledge of assertive communication and associated skills.

Table 3. Between-Group *t*-Tests Reflecting Control and Treatment Group Comparisons

	CATS	Emotion	Role-Play
Pre-Intervention	-0.273	-1.220	0.324
Post-intervention	-3.172***	-1.760	-4.225***

*p < .05. **p <.01. ***p < .001.

Discussion

The goal of this study was to examine the efficacy of a brief behavioral intervention designed to increase assertive communication and help-seeking skills in a population of children in foster care. The study's focus on assertiveness and help-seeking utilizes past research on assertive communication and its ties to positive clinical outcomes across many areas relevant to children in the foster system, such as decreases in victimization (Keenan et al., 2010), improvements of clinical symptoms such as anxiety and low self-esteem (Speed et al., 2017), and increases in cooperative interaction and decreases in aggression (Tanner & Holliman, 1988). Because of its diverse utility, assertive communication training is an intervention that can be strategically applied to benefit various populations.

This study sought to determine the efficacy of the intervention when implemented in a brief format, consisting of three thirty-minute sessions. While past research on brief interventions has demonstrated effectiveness in as little as five sessions (BCBT, Otto et al. 2012), this study pushed that boundary by utilizing only three relatively short sessions. Koob and Love (2010) found that a brief therapy, SFBT, was successful in promoting placement stability for children in the foster system. The findings from the current study support the use of brief therapy with children in the foster system. Though Koob and Love (2010) utilized a treatment nonspecific to assertiveness, meaningful improvement in assertive communication skill could be a factor important to placement stability.

Participants in this study completed an assessment of their assertiveness, emotion towards seeking help, and help-seeking skill at the start and the conclusion of the study. They were then randomly assigned to either the intervention condition or the assessment-only control condition. When comparing each group independently across time-points, results showed that the

assessment-only control group's post-intervention scores did not significantly differ from their pre-intervention scores. Interestingly, the differences in the treatment group's scores between pre-intervention and post-intervention were statistically significantly different on two of the three study measures: the modified *CATS* assessment of assertiveness and the role-play assessment of assertiveness skill. This expands on past research that supports the use of similar assertiveness training curricula to increase related social and communication skills (Cuijpers et al., 2008; Tanner & Holliman, 1988; Thompson, Bundy & Wolfe, 1996; Wolpe, 1958). The dimension of the study with scores that did not differ significantly across time-points within the treatment group was the emotion meter assessment of feelings towards anxiety-provoking situations. This suggests that while the intervention seems to have increased assertiveness and taught participants skills for communicating assertively, these skill improvements did not significantly influence the participants' emotions about situations in which they should use them. It is probable that participants would require *in-vivo* experiences with using assertive help-seeking skills to positive effect before their feelings about those skills would change.

Between groups comparisons showed that the treatment group scored significantly higher than the control group on both measures of assertiveness and help-seeking skill, but there was no significant difference between the treatment and control group's reported positive emotion towards seeking help or on the total measure of assertiveness and help-seeking skill. This supports the finding that although the assertiveness training was effective in increasing the participants' ability to communicate assertively, this was not reflected in the way they felt about needing to use their acquired skills. The same pattern of significance shown when comparing results within groups, as discussed previously, was reflected in the between-groups comparisons. Overall, these findings support the use of a brief intervention to allow for teaching assertive

communication and help-seeking skill acquisition, though the mastery of these skills may not affect emotions towards situations in which they may be needed.

Limitations

This study had several important limitations that must be considered when interpreting results. First, the assessments created for the purposes of this study have not been empirically evaluated. The measures used were generated to meet this study's unique goals when validated assessments could not be found. Though the *CATS* as implemented by Deluty (1979) was shown to have moderate split-half and test-retest reliability, necessary modifications to the item response format were made for use in this study. Though care was taken to consider relevant research in the development of these assessments, the lack of reliability and validity data available on the measures used should be taken into consideration. An additional limitation of this study is that no long-term follow up data were collected to evaluate the durability of the skills acquired. Therefore, we are unable to make claims about the persistent effects of the intervention on the participants' daily lives. Further research should be conducted to examine the persistence of the effects of brief interventions compared to those of standard length. Special examination of brief versus standard-length interventions and their impact on factors related to children in the foster system, such as treatment attrition, would be particularly useful in increasing this vulnerable population's access to the benefits of completed treatment.

The pretest-posttest format of this summer-camp setting also may have presented complications. There is a possibility that the experience of the camp could be a potential exogenous variable influencing the assessment results. For instance, at the beginning of the week (the pre-intervention assessment time point), campers were generally excited and happy whereas at the end of the week (the post-intervention assessment time point) they were disappointed to be

leaving. The difference in emotional state at each assessment potentially could have influenced some participants' responses to prompts of their emotions. Another possible factor that may have influenced participants' responding is that a week of supportive adult attention may have allowed for participants to become more confident and assertive communicators naturally. As these variables are unique to the study setting and not relevant to brief interventions or assertiveness training broadly, they should be considered in interpretation of this study's findings. It is also important to recognize that these contextual variables were the same for both groups.

Future Directions

Though the findings of this study support the use of a brief assertiveness intervention to increase children's ability to communicate assertively and to seek help, more research is needed to confidently claim that this is an effective intervention to recommend for children in the foster system. Previous research has shown that brief interventions can be effective in several scenarios, including SFBT with adults (Macdonald, 2007), SFBT with children in school settings (Franklin et al., 2011), BCBT for adults with panic disorder (Otto et al., 2012), and SFBT with children in the foster system (Cepukiene et al., 2011; Koob & Love, 2012). Although brief therapy is gaining supporting evidence, not enough is known about the length of treatment at which the intervention's brevity is detrimental. This study's treatment consisted of a very brief duration that did not seem to impact the effectiveness of the intervention; however, because of the limitations of this study and others, substantially more research on brief therapies must be carried out before any considerable claims can be made regarding their clinical utility. As a step further, more research should analyze brief therapies in populations that have experienced trauma, as have children in the foster system, for the potential benefits of increased treatment efficiency and accessibility to evidence-based mental health services.

Summary

This study evaluated the efficacy of a brief assertiveness intervention in a population of children in the foster system. Participants randomly assigned to treatment and control groups completed pre-intervention and post-intervention assessments of assertiveness, emotions towards situations in which assertive communicating is required, and role play assessments of assertiveness skill. The assessments' mean scores for each group were statistically analyzed, and results confirmed the study hypothesis that the treatment group, recipients of the assertiveness intervention, would score significantly higher on measures of assertiveness and help-seeking skill than the control group. However, the recipients of the intervention did not significantly differ from the control group in reports of emotions towards situations requiring assertive communication to seek help. This result suggests that while the brief intervention was effective in teaching successful communication skills, this skill improvement did not significantly increase participants' confidence in implementing them. Although this result is encouraging, this is a preliminary study and is not without limitations. Further research on brief assertiveness interventions for children in the foster system is essential to allow for informed decisions to be made regarding the clinical utility of this and similar interventions.

Appendix

Note to Administrators of the

Children's Action Tendency Scale (CATS)

(1) For a general description of the administration and scoring procedures for the CATS, please refer to p. 1065 of Deluty, R. H. Children's Action Tendency Scale: A self-report measure of aggressiveness, assertiveness, and submissiveness in children. Journal of Consulting and Clinical Psychology, 1979, 47, 1061-1071.

(2) For children below a 4th - 5th grade reading level, read aloud each conflict situation and then each of the three pairs of response alternatives following that situation. Explain to the children that each of the three pairs of alternatives applies to the same situation. (You may wish to repeat the conflict situation before each pair of alternatives.)

(3) Have the children make sure that, for each of the 13 situations, they have circled three alternatives. If a child asserts that s/he cannot choose between two particular responses, acknowledge how some choices are very difficult to make, but that the child should choose the thing s/he "would be more likely to do if you had to make a choice."

(4) Throughout the administration of the CATS, emphasize the importance of answering honestly, and mention that the children will not be graded or evaluated on their responses and that no one besides the administrator (i.e., no teacher, no parent, no fellow student) will see their responses.

(5) At the end of the administration period, have the children look over their booklets to make sure that they have circled 39 alternatives (3 choices for each of the 13 situations).

Name _____

Grade _____

QUESTIONNAIRE

1. You're playing a game with your friends. You try your very best but you keep making mistakes. Your friends start teasing you and calling you names. What would you do?

   a. Quit the game and come home. or

   b. Punch the kid who's teasing me the most.

   a. Tell them to stop because they wouldn't like it if I did it to them. or

   b. Quit the game and come home.

   a. Punch the kid who's teasing me the most. or

   b. Tell them to stop because they wouldn't like it if I did it to them.

2. You and a friend are playing in your house. Your friend makes a big mess, but your parents blame you and punish you. What would you do?

   a. Clean up the mess. or

   b. Ask my friend to help me clean up the mess.

   a. Refuse to talk to or listen to my parents the next day. or

   b. Clean up the mess.

   a. Ask my friend to help me clean up the mess. or

   b. Refuse to talk to or listen to my parents the next day.

3. One morning before class, a friend comes over to you and asks if they can copy your homework. They tell you that if you don't give them your answers, they'll tell everyone that you're really mean. What would you do?

   a. Give them the answers. or
   b. Tell them to do their own work.

   a. Tell them that I'll tell everyone they're a cheater. or
   b. Give them the answers.

   a. Tell them to do their own work. or
   b. Tell them that I'll tell everyone they're a cheater.

4. You're standing in line for a drink of water. A kid your age and size walks over and just shoves you out of line. What would you do?

   a. Push the kid back out of line. or
   b. Tell them, "You've no right to do that."

   a. I'd go to the end of the line. or
   b. Push the kid back out of line.

   a. Tell them, "You've no right to do that." or
   b. I'd go to the end of the line.

5. You lend to a friend your favorite book. A few days later it is returned, but some of the pages are torn and the cover is dirty and bent out of shape. What would you do?

   a. Ask my friend, "How did it happen?" or

   b. Ignore it.

   a. Call the kid names. or

   b. Ask my friend, "How did it happen?"

   a. Ignore it. or

   b. Call the kid names.

6. You're coming out of school. A kid who is smaller and younger than you are throws a snowball right at your head. What would you do?

   a. Beat the kid up. or

   b. Ignore it.

   a. Tell the kid that throwing at someone's head is very dangerous. or

   b. Beat the kid up.

   a. Ignore it. or

   b. Tell the kid that throwing at someone's head is very dangerous.

7. You see some kids playing a game. You walk over and ask if you can join. They tell you that you can't play with them because you're not good enough. What would you do?

   a. Walk away, feeling hurt. or

   b. Interfere with their game so that they won't be able to play.

   a. Ask them to give me a chance. or

   b. Walk away, feeling hurt.

   a. Interfere with their game so that they won't be able to play. or

   b. Ask them to give me a chance.

8. You're watching a really terrific show on television. In the middle of the show, your parents tell you that it's time for bed and turn off the television. What would you do?

   a. Scream at them, "I don't want to!" or

   b. Promise to go to bed early tomorrow night if they let me stay up late tonight.

   a. Start crying. or

   b. Scream at them, "I don't want to!"

   a. Promise to go to bed early tomorrow night if they let me stay up late tonight. or

   b. Start crying.

9. You're having lunch in the cafeteria. Your friend has a big bag of delicious chocolates for dessert. You ask if you can have just one, but your friend says, "No." What would you do?

   a. Offer to trade something of mine for the chocolate. or
   b. Call the kid mean and selfish.

   a. Forget about it and continue eating my lunch. or
   b. Offer to trade something of mine for the chocolate.

   a. Call the kid mean and selfish. or
   b. Forget about it and continue eating my lunch.

10. A kid in your class brags that they're much smarter than you. However, you know for sure that the kid is wrong and that really you're smarter. What would you do?

   a. Tell the kid to shut up. or
   b. Suggest that we ask each other questions to find out who is smarter.

   a. Ignore the kid and just walk away. or
   b. Tell the kid to shut up.

   a. Suggest that we ask each other questions to find out who is smarter. or
   b. Ignore the kid and just walk away.

11. You and another kid are playing a game. The winner of the game will win a nice prize. You try really hard, but lose by just one point. What would you do?

    a. Tell the kid that they cheated. or
    b. Practice, so I'll win the next time.

    a. Go home and cry. or
    b. Tell the kid that they cheated.

    a. Practice, so I'll win the next time. or
    b. Go home and cry.

12. One of your parents does something which really bugs you. They know that it bugs you, but they just ignore how you feel and keep doing it anyway. What would you do?

    a. Try to ignore it. or
    b. Tell them that they're bugging me.

    a. Get back at them by doing something that bugs them. or
    b. Try to ignore it.

    a. Tell them that they're bugging me. or
    b. Get back at them by doing something that bugs them.

13. You're playing with a friend in your house and you're making a lot of noise. Your parents get really angry and start yelling at you for making so much noise. What would you do?

a. Tell them, "I'm sorry, but I can't play the game without making noise." or

b. Ignore their yelling and continue to make noise.

a. Find something else to do. or

b. Tell them, "I'm sorry, but I can't play the game without making noise."

a. Ignore their yelling and continue to make noise. or

b. Find something else to do.

References

Aarons, G. A., James, S., Monn, A. R., Raghavan, R., Wells, R. S., & Leslie, L. K. (2010). Behavior problems and placement change in a national child welfare sample: A prospective study. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 70–80.

Akin, B. A., & Gomi, S. (2016). Noncompletion of Evidence-Based Parent Training: An Empirical Examination Among Families of Children in Foster Care. *Journal of Social Service Research, 43*, 52-68. doi:10.1080/01488376.2016.1226229

Aoki, S. K., Mearns, J., & Kurpius, S. E. (2017). Social anxiety and assertiveness: The role of self-beliefs in Asian Americans and European Americans. *Journal of Mental Health Counseling, 39*, 263-274. doi:10.17744/mehc.39.3.06

Auslander WF, McMillen J, Elze D, Thompson R, Jonson-Reid M, Stiffman, A. (2002) Mental health problems and sexual abuse among adolescents in foster care: Relationship to HIV risk behaviors and intentions. *AIDS & Behavior.* 6:351–359.

Barnett, E. R., Jankowski, M. K., & Trepman, A. Z. (2019). State-wide implementation and clinical outcomes associated with evidence-based psychotherapies for traumatized youth. *Psychological Trauma: Theory, Research, Practice, and Policy. 11*, 775-783. doi:10.1037/tra0000444

Bass, S., Shields, M. K., & Behrman, R. E. (2004). Children, families, and foster care: Analysis and recommendations. *Future of Children, 14*, 5-29.

Bond, C., Woods, K., Humphrey, N., Symes, W., & Green, L. (2013). Practitioner Review: The effectiveness of solution focused brief therapy with children and families: A systematic and critical evaluation of the literature from 1990-2010. *Journal of Child Psychology and Psychiatry, 54*, 707-723. doi:10.1111/jcpp.12058

Burg, J. E. (2005). The Emotions Thermometer. *Journal of Family Psychotherapy, 15*, 47-56. doi:10.1300/j085v15n04_04

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 960–970.

Cepukiene, V., & Pakrosnis, R. (2011). The outcome of solution-focused brief therapy among foster care adolescents: The changes of behavior and perceived somatic and cognitive difficulties. *Children and Youth Services Review, 33*, 791-797. doi:10.1016/j.childyouth.2010.11.027

Conn, A., Szilagyi, M. A., Alpert-Gillis, L., Baldwin, C. D., & Jee, S. H. (2015). Mental health problems that mediate treatment utilization among children in foster care. *Journal of Child and Family Studies, 25,* 969-978. doi:10.1007/s10826-015-0276-6

Cuijpers, P., Straten, A. V., Andersson, G., & Oppen, P. V. (2010). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Focus, 8,* 75-75. doi:10.1176/foc.8.1.foc75

D'Avanzo, B., Barbato, A., Erzegovesi, S., Lampertico, L., Rapisarda, F., & Valsecchi, L. (2012). Formal and informal help-seeking for mental health problems: a survey of preferences of Italian students. *Clinical Practice & Epidemiology in Mental Health, 8,* 47-51. doi:10.2174/1745017901208010047

Damashek, A., Doughty, D., Ware, L., & Silovsky, J. (2010). Predictors of client engagement and attrition in home-based child maltreatment prevention services. *Child Maltreatment,16,* 9-20. doi:10.1177/1077559510388507

Deluty, R. H. (1979). Children's action tendency scale: A self-report measure of aggressiveness, assertiveness, and submissiveness in children. *Journal of Consulting and Clinical Psychology, 47,* 1061-1071. doi:10.1037//0022-006x.47.6.1061

Deluty, R. H. (1984). Behavioral validation of the children's action tendency scale. *Journal of Behavioral Assessment, 6,* 115-130. doi:10.1007/bf01350167

Dore, M. (2005). Child and adolescent mental health. In G. Mallon and P. Hess (Eds.), *Child welfare for the twenty-first century: A handbook of practices, policies and programs.* (148-172). New York: Columbia University Press.

Duckworth, M. P., & Mercer, V. (2006). Assertiveness training. In J. E. Fisher & W. T. O'Donohue (Eds.), *Practitioner's guide to evidence-based psychotherapy* (p. 80–92). Springer Science + Business Media. https://doi.org/10.1007/978-0-387-28370-8_7

Franklin, C., Trepper, T. S., Gingerich, W. J., & McCollum, E. E. (2012). Solution-focused brief therapy in school settings. In *Solution-focused brief therapy: a handbook of evidence-based practice* (pp. 231–246). New York: Oxford University Press. doi:10.1093/acprof:oso/9780195385724.003.0091

Greene, D. M., & Navarro, R. L. (1998). Situation-specific assertiveness in the epidemiology of sexual victimization among university women. *Psychology of Women Quarterly, 22,* 589-*604. doi:10.1111/j.1471-6402.1998.tb00179.x*

Harju, E., Michel, G., & Roser, K. (2019). A systematic review on the use of the emotion thermometer in individuals diagnosed with cancer. *Psycho-Oncology, 28,* 1803–1818. doi: 10.1002/pon.5172

Johnson, E., & Menna, R. (2017). Help seeking among adolescents in foster care: A qualitative study. *Children and Youth Services Review, 76*, 92-99. doi:10.1016/j.childyouth.2017.03.002

Keenan, K., Hipwell, A., Feng, X., Rischall, M., Henneberger, A., & Klosterman, S. (2010). Lack of assertion, peer victimization, and risk for depression in girls: testing a diathesis–stress model. *Journal of Adolescent Health, 47*, 526-528. doi:10.1016/j.jadohealth.2010.03.016

Kidder, L. H., Boell, J. L., & Moyer, M. M. (1983). Rights consciousness and victimization prevention: personal defense and assertiveness training. *Journal of Social Issues, 39*, 153-168. doi:10.1111/j.1540-4560.1983.tb00146.x

Koh, E., Rolock, N., Cross, T. P., & Eblen-Manning, J. (2014). What explains instability in foster care? Comparison of a matched sample of children with stable and unstable placements. *Children and Youth Services Review, 37*, 36-45. doi:10.1016/j.childyouth.2013.12.007

Koob, J. J., & Love, S. M. (2010). The implementation of solution-focused therapy to increase foster care placement stability. *Children and Youth Services Review*, 32, 1346-1350. doi:10.1016/j.childyouth.2010.06.001

Lehmann, S., Havik, O. E., Havik, T., & Heiervang, E. R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child and Adolescent Psychiatry and Mental Health, 7*, 39. doi:10.1186/1753-2000-7-39

Macdonald, A. (2007). *Solution-focused therapy: Theory, research & practice*. London: SAGE Publications Ltd. doi: 10.4135/9781446288764

Mcguire, A., Cho, B., Huffhines, L., Gusler, S., Brown, S., & Jackson, Y. (2018). The relation between dimensions of maltreatment, placement instability, and mental health among youth in foster care. *Child Abuse & Neglect, 86*, 10-21. doi:10.1016/j.chiabu.2018.08.012

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24*, 1363-1374. doi:10.1016/s0145-2134(00)00189-7

Otto, M. W., Tolin, D. F., Nations, K. R., Utschig, A. C., Rothbaum, B. O., Hofmann, S. G., & Smits, J. A. (2012). Five sessions and counting: considering ultra-brief treatment for panic disorder. *Depression and Anxiety, 29*, 465-470. doi:10.1002/da.21910

Price, J. M., Chamberlain, P., Landsverk, J., Reid, J., Leve, L., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. Child Maltreatment, 13, 64–75. doi: 10.1177/1077559507310612

Rowe, L. S., Jouriles, E. N., & Mcdonald, R. (2015). Reducing sexual victimization among adolescent girls: a randomized controlled pilot trial of my voice, my choice. *Behavior Therapy, 46,* 315-327. doi:10.1016/j.beth.2014.11.003

Rudd, M. D. (2012). Brief cognitive behavioral therapy (BCBT) for suicidality in military populations. *Military Psychology, 24,* 592-603. doi:10.1080/08995605.2012.736325

Saigh, P. A. (1988). Anxiety, depression, and assertion across alternating intervals of stress. *Journal of Abnormal Psychology, 97,* 338-341. doi:10.1037//0021-843x.97.3.338

Scott, L. D., Mcmillen, J. C., & Snowden, L. R. (2013). Informal and formal help seeking among older black male foster care youth and alumni. *Journal of Child and Family Studies, 24,* 264-277. doi:10.1007/s10826-013-9832-0

Scozzaro, C., & Janikowski, T. P. (2015). Mental health diagnosis, medication, treatment and placement milieu of children in foster care. *Child and Family Studies, 24,* 2560-2567. doi:10.1007 /s10826-014-0058-6

Seaberg, J. R., & Harrigan, M. P. (1999). Foster families functioning, experiences and views: Variations by race. *Children and Youth Services Review, 21,* 31-55. doi:10.1016/s0190-7409(99)00004-3

Speed, B. C., Goldstein, B. L., & Goldfried, M. R. (2017). Assertiveness training: a forgotten evidence-based treatment. *Clinical Psychology: Science and Practice, 25,*1-20. doi:10.1111/cpsp.12216

Sprang, G., Craig, C. D., Clark, J. J., Vergon, K., Tindall, M. S., Cohen, J., & Gurwitch, R. (2013). Factors affecting the completion of trauma-focused treatments: What can make a difference? *Traumatology, 19,* 28-40. doi:10.1177/1534765612445931

Stahmer, A. C., Leslie, L. K., Hurlburt, M., Barth, R. P., Webb, M. B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics,* 116, 891-900. doi:10.1542/peds.2004-2135

Tanner, V. L., & Holliman, W. B. (1988). Effectiveness of assertiveness training in modifying aggressive behaviors of young children. *Psychological Reports, 62,* 39–46. doi:10.2466/pr0.1988.62.1.39\

Thompson, K. L., Bundy, K. A., & Wolfe, W. R. (1996). Social skills training for young adolescents: Cognitive and performance components. *Adolescence, 31,* 505-521

Trupin, E. W., Tarico, V. S., Low, B. P., Jemelka, R., & Mcclellan, J. (1993). Children on child protective service caseloads: Prevalence and nature of serious emotional disturbance. *Child Abuse & Neglect, 17,* 345-355. doi:10.1016/0145-2134(93)90057-c

Turney, K., & Wildeman, C. (2016). Mental and physical health of children in foster care. *Pediatrics, 138,* 1-11. doi: 10.1542/peds.2016-1118

United States. (2018). *The AFCARS Report*, no. 25. Washington, D.C.: U.S. Dept. of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. https:/www.acf.hhs.gov/cb

Wamser-Nanney, R., & Steinzor, C. E. (2017). Factors related to attrition from trauma-focused cognitive behavioral therapy. *Child Abuse & Neglect, 66,* 73-83. doi:10.1016/j.chiabu.2016.11.031

Warnick, E. M., Gonzalez, A., Weersing, R., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: how definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health, 17,* 76–85. http://dx.doi.org.libezp.lib.lsu.edu/10.1111/j.1475-3588.2011.00606.x

Whittaker, J. K. (1986). Formal and informal helping in child welfare services: implications for management and practice. *Child Welfare: Journal of Policy, Practice and Program, 65,* 17-25.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

Zorc, C. S., Oreilly, A. L., Matone, M., Long, J., Watts, C. L., & Rubin, D. (2013). The relationship of placement experience to school absenteeism and changing schools in young, school-aged children in foster care. *Children and Youth Services Review, 35,* 826-833. doi:10.1016/j.childyouth.2013.02.006

VITA

Madeline S. Blocker, originally from Walker, Louisiana, completed her Bachelor of Science with honors in Psychology from Louisiana State University Agricultural and Mechanical College in 2017. After obtaining her undergraduate degree, Madeline worked as an educator and volunteer for one year, during which time she worked with children in the foster system, in poverty, and those victims of abuse and neglect. This began her interest in developing mental and behavioral health treatment designed to increase vulnerable populations' access to the associated benefits. Madeline's interest in education and mental health led her to Louisiana State University where she is receiving her Doctor of Philosophy in school psychology under the supervision of Dr. George Noell and Kelly Clark. Upon the completion of her second year in the program, she plans to graduate with her master's degree in August 2020. Her research interests center on increasing the accessibility of evidence-based treatments to underserved populations.