

Technical Report:

**Evaluation of the UNICEF School-Based Psychosocial Program for
War-Exposed Adolescents
as Implemented During the 2000-2001 School Year**

Christopher M. Layne, Ph.D.^{1, 2}

Rob Davies, M.A.¹

Gary M. Burlingame, Ph.D.¹

William R. Saltzman, Ph.D.²

Nicole Thomas, B.A.¹

Robert S. Pynoos, M.D.²

¹ Department of Psychology, Brigham Young University, Provo, Utah, USA

² Trauma Psychiatry Service, University of California, Los Angeles, USA

Executive Summary

This report summarizes an evaluation of the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents. This specialized program has been implemented since the 1997-1998 school year in Bosnian secondary schools by specially trained school counselors (psychologists and pedagogues) under the supervision of trained mental health professionals working in the community (clinical psychologists and psychiatrists). The program is designed to identify and therapeutically support Bosnian adolescents with histories of severe war trauma who continue to experience significant psychosocial problems after the war. A centerpiece of the program is a manualized, 20+-session trauma/grief-focused group treatment program in which the school counselors lead a specialized trauma/grief-focused therapy group with up to 10 of the most severely traumatized students at the school.

Overview of Program Evaluation Findings

The evaluation revealed consistently positive results across a broad variety of program dimensions. In particular, focus groups conducted with the school counselors and students revealed a broad program impact on the levels of individual student group members, their families, peers, the classroom and school environment, and the larger community. These impacts included:

1. The great majority of school counselors reported that they incorporated the program materials and training into their other professional work at the schools, which greatly increased the number of direct beneficiaries.
2. The school counselors generally reported that participation in the program had brought about a change/expansion in their roles in the schools from one of “disciplinarians” of disruptive students to valued providers of mental health services. The counselors attributed their participation in the program as instrumental in increasing their expertise and expanding their professional roles.
3. A large and skilled professional network of school counselors, community mental health professionals, and local universities has been created via the program. This network has great potential for assuming an advocacy role for public policy, defining the professional role of the pedagogue/psychologist in the schools, and mental health program development and implementation in the schools.
4. Students identified a wide range of program benefits, including the acquisition of effective coping and problem-solving skills, increased self-esteem, hope in the future, improved family and peer relationships, and improved school performance. They also reported that they advocated for the program by passing on skills and materials to family and peers, making referrals to the school counselor, and “sticking up” for other students with similar problems. Teachers generally concurred with the students, identifying gains in school performance and peer relationships at higher rates in the treatment group compared to the control group.
5. Quantitative analyses revealed significant pre- to post-treatment reductions in targeted distress symptoms (as measured by measures of posttraumatic stress, depression, and grief symptoms). Rates of reliable improvement were higher in the treatment group compared to the wait list control group, indicating that treatment was generally of greater benefit than holding intermittent “assessment” visits with the school counselor.
6. The supervision structure of the program (in which the counselors meet with community mental health professionals in group supervision meetings) worked well throughout the 2000-2001 school year. In particular, the program operated with only minimal off-site support by the UCLA/BYU Team throughout the entire 2000-2001 school year.

Lessons Learned

Since the spring of 1997, a total of 43 secondary schools located in 6 major regions throughout the country have been trained to implement the program. At the close of the 2000-2001 school year, a total of 22 schools were participating in three regions throughout the country, producing a retention rate of 58% among the schools and 50% among the regions. Why did the program “take root” in some regions, and die out in other regions with equal or higher levels of need for psychosocial support? Lessons learned will now be reviewed and summarized in the form of good practice recommendations.

1. Design a program that the local participants perceive and treat as “locally owned and operated” rather than as an externally imposed set of obligations. In particular, the program will take root and become sustainable only when the local participants become personally convinced that the program helps them to carry out their professional work in a more competent, effective fashion.

2. Select the right government administrators to support program implementation. The program has generally flourished in regions where informed, competent, and committed administrative support is present, and perished or struggled in areas where such administrative support is lacking. The importance of selecting, educating, supporting, and regularly monitoring the activities of government coordinators cannot be overstated.
3. Recruit and retain competent and committed community mental health professionals to work as program supervisors.
4. Recruit school counselors to implement the program who have received specialized training in implementing the program, who have good rapport with their students, good interpersonal skills, competence in their professional roles, and who are compassionately dedicated to helping their students.
5. The program must contain built-in incentives to continue implementation, such as observing improvements in students, receiving recognition for the counselors' increased expertise, and receiving expressions of gratitude from parents and teachers. Attending supervision meetings and increasing their professional expertise also served as powerful incentives.
6. Create a local program administrative infrastructure that is as self-supporting and self-sustaining as possible. The supervisors, in particular, have played an invaluable role in providing timely and effective on-site support.
7. As needed, especially in the initial stages of implementation, support sustained external commitment. Repeated and intermittent "pulsed" visits by external consultants that are focused on current problems and upgrading skills have helped to generate momentum, maintain local commitment, reinforce interpersonal and inter-institutional ties, update understanding of local needs, and to promote the quality of program implementation and evaluation.

Recommendations

The results of this program evaluation strongly support the work of the local Pedagogic Institutes of the RS and the Federation, in collaboration with the German humanitarian organization GTZ and UNICEF BiH, to develop the trauma group program into a general psychosocial support program. Specifically, these results support the need for (a) a systematic review and adaptation of existing program materials, (b) development of plans to develop other needed materials based on a survey of local needs, and (c) development of an implementation strategy and plan for widespread dissemination of a general psychosocial support program.

1. Group members identified skills as being the most important and valuable positive outcome for the trauma group program. These skills are adaptable for use in a classroom setting with a well-trained and well-supported teacher or pedagogue, and carry a relatively low risk of negative impacts. Thus, efforts should be undertaken to systematically review the program materials and to import and/or adapt them for classroom instruction.
2. Teachers and pedagogues have requested in-depth training regarding prior to implementing a general classroom-based psychosocial program. Specifically, they requested training in the underlying theoretical model, and in the correct practice/ presentation of the specific skills and concepts covered. Thus, the development of an implementation strategy should also include plans for a formal initial training of the implementing teachers/pedagogues. Ongoing supervision should also be made available as needed.
3. The working group that is charged with developing recommendations and methods for guiding this adaptation/development of a general psychosocial program should draw liberally on the experiences of the school counselors and their supervisors who have taken personal initiative in adapting the program for use in their regular counseling work and in the classroom.
4. A valuable impact of the program is the development of a large professional network of trained school counselors, and the establishment/strengthening of formal ties between local schools, mental health clinics, universities, and Pedagogical Institutes. This network has the potential of evolving to become an advocate for the role of the pedagogue/psychologist in the schools and the professional training of pedagogues and psychologists during and after their formal schooling. Generally, this network may serve as an important mechanism for promoting and expanding mental health services in various forms throughout Bosnian schools. Thus, the support and continuation of this network should be designated a high priority, and it be provided the support needed to continue both its appointed work and its own evolution.

Technical Report:

Evaluation of the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents As Implemented During the 2000-2001 School Year

Brief History of the Program

In 1996, UNICEF contracted the UCLA Trauma Psychiatry Team (hereafter referred to as the Team) to consult with Bosnian government agencies in designing and implementing a school-based program to promote post-war adaptation in war-exposed youths. After conducting a 7-week on-site needs assessment in mid 1996, the Team developed an intervention program consisting of psychoeducational presentations, a risk-screening survey, a screening interview, and a manualized trauma/grief-focused group therapy protocol. The Team proposed that trained school counselors under the supervision of trained local community mental health professionals should implement the program. The program was designed to be implemented within local secondary schools by trained and regularly supervised school counselors, consistent with UNICEF best-practice recommendations that intervention with traumatized youths take place in a stable and supportive environment by care-givers who have solid and continuing relationships with the child (Machel, 1996). Last, the Team recommended that school and regional sites should be selected based on local base rates of severely war-traumatized students, local government interest and support, and the availability of school counselors and mental health professionals to implement the program.

After implementing a pilot version of the program in spring 1997, the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents was implemented in 12 secondary schools in 1997-1998, and was further expanded to 32 total secondary schools in 1998-1999. During these two academic years, the Team collaborated with the local program supervisors in conducting intermittent training seminars (e.g., 3-day seminars held in the fall, winter, and spring) and program materials; the Team and the supervisors also conducted on-site visits to participating schools to encourage local support for the program. In spring 2001, the program concluded its fourth full year of implementation, and was in place at 26 secondary schools throughout Bosnia and Hercegovina. Throughout the program implementation, the Team and its Bosnian counterparts have collaborated in revising and adapting the program to meet local needs. Three teams of trained local Bosnian mental health professionals now serve as clinical supervisors and carry out their activities in the form of regular (bi-weekly to monthly) group supervision meetings, telephone consultations, on-site visits to participating schools, and participation in the training seminars. The Team continues to support program implementation with intermittent on-site visits devoted to training, consultation, advocacy, needs assessment, program evaluation, and program revision. A detailed description of the program's history is found in Appendix A.

Overview of Program Evaluation Activities Conducted

An evaluation of the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents was conducted throughout its 2000-2001 school year implementation. A total of 10 secondary schools located in the Central Bosnia (Travnik and Novi Travnik) and Sarajevo Cantons took part in the evaluation. Drs. Gary Burlingame and Christopher Layne traveled to Bosnia in September 2000 to consult on the evaluation methodology. During this visit, Drs. Burlingame and Layne worked with the program supervisors, the group leaders, and with UNICEF Project Officers Berina Arslanagic, M.D., and Mary Black, M.D., in developing an appropriate quantitative evaluation methodology. Issues given particular attention included the use of a "wait list" control group and the use of random assignment to conditions. This question was ultimately put before the group leaders, who decided to implement this rigorous method of program evaluation. Quantitative data were collected throughout the school year as indicated by the implementation plan and utilized measures completed by the student group members, their primary caretakers, and their teachers. The post-treatment follow-up was conducted at the end of the school year and utilized the same sources.

Qualitative data collection and analysis. Gary Burlingame, Ph.D., and Rob Davies, M.A. conducted the qualitative portion of the program evaluation, assuming the role of external evaluators to minimize positive bias. Data were collected from both students and group leaders using a semi-structured focus group format. The student and leader groups were held at the end of the implementation period

(post treatment) in late May to early June, 2001. Student groups ranged from 7-9 members and were held in participating Sarajevo and Travnik area schools. Group leader focus groups ranged from approximately 10-15 members and were held at the end of the post-year supervision meeting in Travnik. Transcripts from the focus groups were translated and back translated to ensure accuracy, and were then coded by teams of trained raters using a coding scheme developed from the transcripts. Percentages of responses were then coded for the developed categories using the qualitative data analysis program Ethnograph.

Quantitative data analysis. The potential impact of the group was examined using several methodologies. First, a Reliable Change Index score (RCI) was calculated at the level of individual students (Tingey, Lambert, Burlingame, & Hansen, 1996). This index is a relatively precise index of whether the degree of change (pre- to post-treatment) reported by individual students is sufficiently large to be attributable to treatment versus random variation. RCI values were calculated at the levels of *individual impacts* (e.g., distress symptoms), *school and community impacts* (e.g., school interest and behavior), and *interpersonal relationships* (e.g., peer social skills). As a conservative step, a 95% confidence cutoff value was used, indicating that “reliable” changes have only a 5% likelihood of resulting from random variation.

Second, correlations were calculated between pre- to post-treatment change in distress symptoms and measures of psychosocial adjustment. These correlations helped to address the question whether reductions in distress symptoms—a targeted outcome of the group program—are associated with improvements in general functioning.

A detailed description of program evaluation activities, including the implementation plan and terminology used in this report, is presented in Appendix B.

Organizational Structure of This Report

This program evaluation is divided into three sections that correspond with three basic evaluative questions. The first section will address the question, “*What happened and how does this compare with what was expected?*” In this section, the results of the evaluation will be reviewed according to program objectives. The second section will address the question, “*Why and how did it happen or not happen?*” by reviewing factors that appear to have contributed to the program’s effectiveness in some regions, and its lack of effectiveness in other regions. The third section will address the question, “*What should be done about it?*” by making recommendations that reflect the findings of this evaluation and the cumulative experience of the Team and its local partners.

The purpose of this report is to summarize, from a broad perspective, the most significant impacts of the program at varying levels. Thus, it will *selectively* review those evaluation findings that are expected to be of greatest interest in answering the question of whether the program was effective, and how. A more technical and detailed report of the program evaluation is available upon request from the first author.

In this first section, an analysis of the program will be carried out according to the program’s objectives. These objectives and the degree to which they were attained will be presented at varying levels of impact, including (a) an overall perspective on the program’s impact, (b) the level of individual students, (c) the school and classroom environment, and (d) relationships with peers and family members.

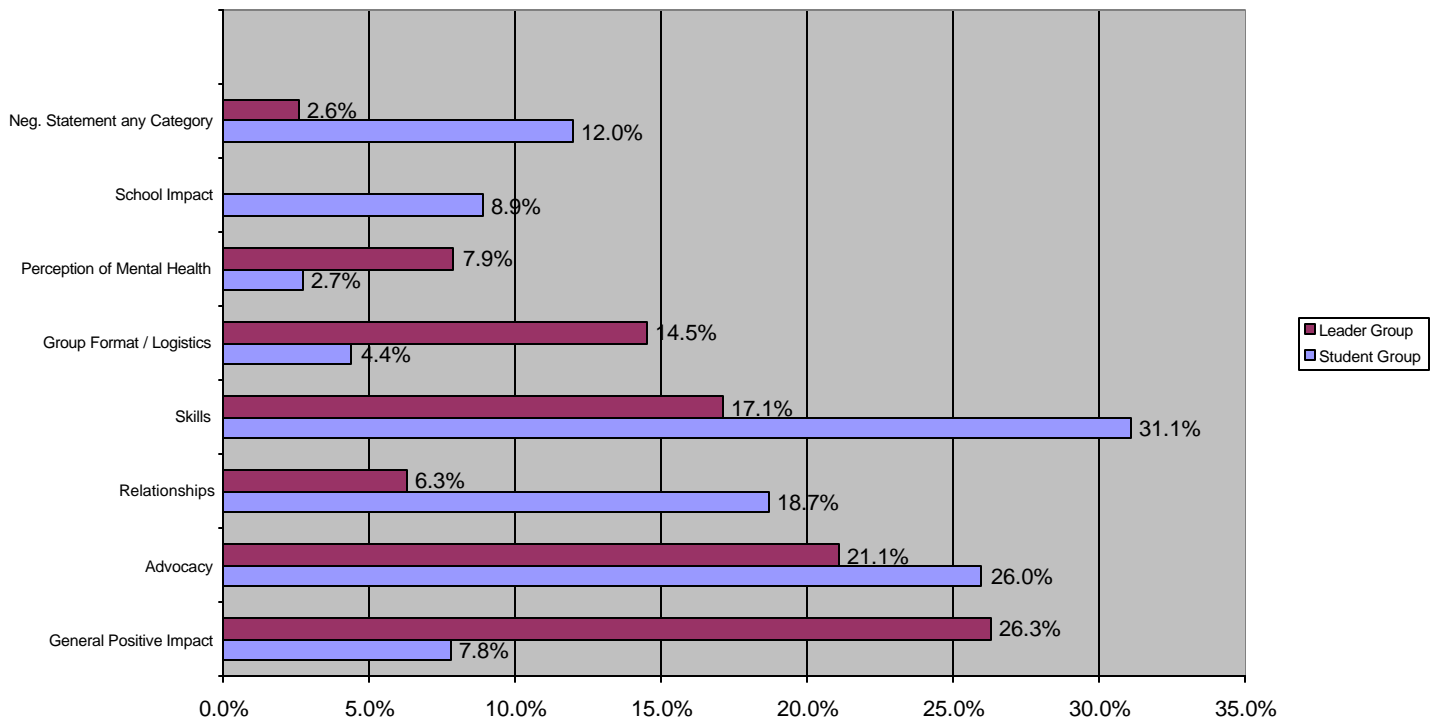
SECTION 1: WHAT HAPPENED, AND HOW DOES THIS COMPARE WITH WHAT WAS EXPECTED?

Global Summary of the Qualitative Evaluation: Overall Impact

The first primary feature to emerge from the qualitative portion of the program evaluation is the generally positive impact of the program. More specifically, the evaluation results indicate that the program had a positive impact on student’s relationships, interpersonal and coping skills, and the manner in which mental health services and service providers in the schools are viewed. It is particularly noteworthy that, although both negative and positive effects of the program were actively sought in the focus groups, only 2.6% of the comments given by the group leaders and 12% of the comments given by

students could be identified as negative in any form. As will be discussed later, many of the negative impacts identified by the leaders focused on the concept that the program was effective but was too limited in the number of direct student beneficiaries. Among students, the most commonly mentioned negative impact was peer stigmatization. Notably, this stigmatization was described as being most intense at the beginning of the program, and diminishing as fellow students observed the positive impacts in the student group members, such as the use of coping skills and improved mood. Thus, the results of the focus group analysis indicate that the program generated a broad range of positive impacts and was widely viewed by both group leaders and student group members as beneficial and effective (see Figure 1).

Figure 1: General Response Categories



Impacts at the Level of Individual Students

Program Objectives:

- a) To reduce psychological distress in war-exposed Bosnian secondary school students.
- b) To promote positive post-war adjustment in war-exposed Bosnian secondary school students through psychoeducation and skills training.

Qualitative Results

The single most commonly identified benefit from the program, as assessed across both the leader and student focus groups, was the acquisition of effective coping skills by the group members. Leaders identified skills as a positive impact in 17.1% of their comments about the program, and students identified skills as a positive impact at nearly twice this rate (31.1%). The high frequency with which these skills were identified is not surprising, given the strong psycho-educational emphasis of the program, and confirms that the program was quite successful in meeting one of its main objectives--that of increasing students abilities to cope effectively with both general developmental and war-related adversities.

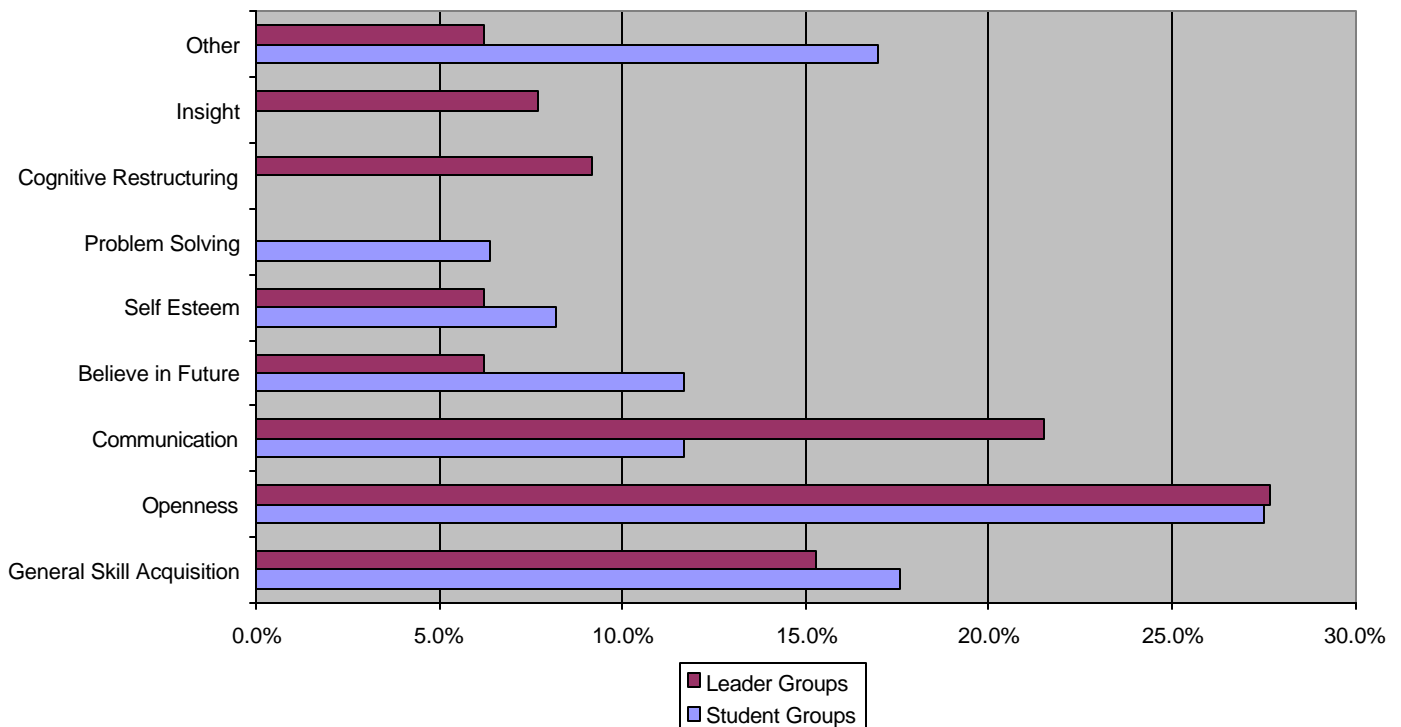
Of the comments relating to skill acquisition, between 15-17% of the comments in both the leader and student focus groups indicated that the program had enhanced students' repertoire of skills with which to deal with trauma (see Figure 2).

As stated by one group leader, “the children realized that they have to learn what they feel.” A student focus group participant summarized the source of the program’s benefits by stating, “I think that 70% of it is the skills we learned in the group.” Notably, the most frequently identified skill acquired was the ability to communicate openly with others. There was general agreement on this point by both leaders and students. Additional student comments included “we could speak about everything” and “this group has helped me arrange my home life and to talk with my parents and tell them what is the problem. I tell them my opinions now”. A group leader stated, “this program gave (the students) the opportunity to speak about their traumatic experiences for the first time. Many students have never been in a position to speak to anyone, even those they are closest to.”

Gains in communication skills were also frequently identified (see Figure 2). Leaders identified impacts in this area more than did students, but both groups identified improvements in this area made as a result of the program. One leader identified communication skills as the single most helpful program component: “I think my colleagues will agree that the most helpful part of the program was the good communication exercises.”

Other areas of program impact identified included increased self-esteem and confidence, as well as an increased belief in the future. One student mentioned, “I am more open, stronger, and have more self-respect. I have self-respect that I never had before.” Another student reported that, after going through the program, “I have a different view of life, that there is hope for a better tomorrow.”

Figure 2: Skills



Quantitative Results

In a first step, Reliable Change Indices were calculated at the level of individual students for targeted outcomes. The analyses revealed that:

- ▲ 47% of the treatment group’s posttraumatic stress scores improved reliably and 6% worsened reliably, whereas 22% of the control group’s posttraumatic scores improved reliably and 12% worsened reliably.
- ▲ 42% of the treatment group’s depression scores improved reliably and 5% worsened reliably, whereas 27% of the control group’s depression scores improved reliably and 4% worsened reliably.

▲ 36% of the treatment group's complicated grief scores improved reliably and 6% worsened reliably, whereas 9.2% of the control group's complicated grief scores improved reliably and 17% worsened reliably.

In a second step, when evaluating a program designed to both *reduce* symptoms of psychological distress and *increase* positive psychosocial adjustment, a critical question is, "*are the two associated with each other?*" That is, are reductions in symptoms of distress linked with increased psychosocial adjustment? This question was addressed in an exploratory manner using a matrix of Pearson correlation coefficients. Reductions in symptoms were measured by calculating change scores (pre-treatment minus post-treatment) for tests measuring posttraumatic stress, depression, and grief symptoms. Change scores were also calculated for a number of psychosocial outcomes, including rule compliance, peer social skills, assertiveness, school interest, and behavior control. These correlations among the pre-post change scores revealed a large number of significant correlations. Selected findings include:

- *Reductions in symptoms of post-traumatic stress*, as reported by students, are:
 - correlated with increased behavior control, as reported by teachers ($r = .20$)
 - correlated with increased school interest, as reported by students ($r = .23$)
 - correlated with increased rule compliance, as reported by students ($r = .24$)
- *Reductions in symptoms of depression*, as reported by students, are:
 - correlated with increased school interest, as reported by students ($r = .16$)
- *Reductions in complicated grief reactions*, as reported by students, are:
 - correlated with increased behavior control, as reported by teachers ($r = .21$)
 - correlated with increased social assertiveness, as reported by teachers ($r = .20$)
 - correlated with increased rule compliance, as reported by students ($r = .17$)
- *Reductions in somatic symptoms* (such as headaches, stomachaches, etc.), as reported by students, are:
 - correlated with increased school interest, as reported by students ($r = .21$)
 - correlated with increased rule compliance, as reported by students ($r = .25$)
- *Reductions in feelings of hopelessness*, as reported by students, are:
 - correlated with increased task orientation, as reported by teachers ($r = .26$)
- *Reductions in preoccupations with danger*, as reported by students, are:
 - correlated with increased rule compliance, as reported by students ($r = .23$)
- *Reductions in anxious withdrawal*, as reported by students, are:
 - correlated with increased task orientation, as reported by teachers ($r = .19$)
 - correlated with increased behavior control, as reported by teachers ($r = .25$)
 - correlated with increased school interest, as reported by students ($r = .25$)
 - correlated with increased rule compliance, as reported by students ($r = .21$)
- *Increases in peer social skills*, as reported by teachers, are:
 - correlated with increased task orientation, as reported by teachers ($r = .42$)
 - correlated with increased behavior control, as reported by teachers ($r = .27$)
 - correlated with increased peer assertiveness, as reported by teachers ($r = .40$)

It is important to note that finding correlations across multiple informants (e.g., between student and teacher reports, as opposed to within student reports only) lends extra credibility to the assertion that decreases in symptoms of distress are significantly (*and noticeably*) linked to improved role performance in important domains, including school and peer relationships.

When evaluating a group treatment program, it is also important to examine whether *group processes theorized to be therapeutic* are associated with positive psychosocial outcomes. This question was, again, addressed in an exploratory manner using a matrix of Pearson correlation coefficients. These correlations reveal that:

- *Satisfaction with the group experience*, as reported by students, was positively correlated with behavioral control as reported by teachers ($r = .24$).
- *Group engagement*, as reported by students, was correlated with increased school interest ($r = .25$) and with improved peer social skills ($r = .36$).
- *Group catharsis*, as reported by students, is correlated with improvements in peer social skills ($r = .39$) and reductions in anxious/withdrawn behavior ($r = .32$).
- *Group cohesion*, as reported by students, is positively associated with school interest ($r = .24$), with improved peer social skills ($r = .35$), and with reductions in anxious/withdrawn behavior ($r = .26$).

- *Group-facilitated insight*, as reported by students, is positively associated with improved peer social skills ($r = .38$), with reductions in self-blaming ($r = .26$), with reductions in hopelessness ($r = .25$), and with reductions in anxious/withdrawn behavior ($r = .30$).

Impacts at the Level of the School and Community

Program Objectives:

- a) **To increase the perceived relevance and legitimate role of mental health in the schools.**
- b) **To expand the role of school psychologists/pedagogues to include that of provider of specialized mental health services.**
- c) **Students directly benefiting from the groups will transmit an indirect benefit to their classrooms and the school environment by promoting a positive atmosphere and sharing their knowledge with others.**

Qualitative Results

Dissemination of Program Skills and Materials. One of the unexpected, but widespread, impacts of the program identified by the qualitative evaluation was the extent to which group leaders and students were disseminating various parts of the program (see Figure 3).

Forms of dissemination included modeling coping skills to others and distributing program materials. Both students and group leaders reported that the student group members transmitted at least some of the skills and information learned in the program to others outside the group. This material was typically shared via informal discussions with parents, siblings, and peers. One student related “I already do that (share information) with my sister. I share things I have learned here. For example, if she is sad, I help her look into it, to see why.” Another student said, “I have a friend for 8 or 9 years now, and she is not in this group. She has had difficulties in organizing her time, and I helped her. I have shared information about how we were working on that problem in group so that she could achieve better performance.”

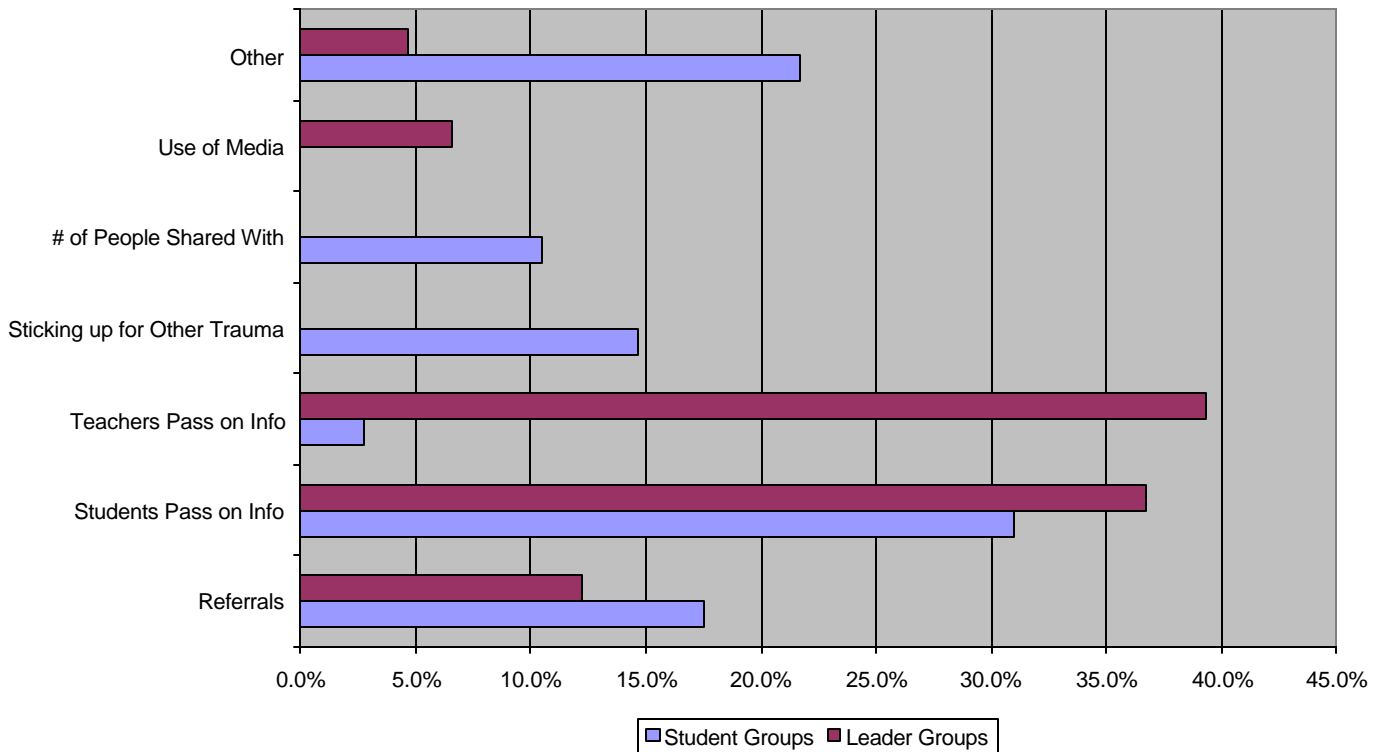
After these initial observations, an informal survey of the degree to which this sharing of skills and materials took place among group members was then conducted in two focus groups. The results indicate that this sharing was quite widespread, and varied widely among focus group participants (see Table 1). Some members reported sharing the materials and/or skills with their families, friends, and psychology/pedagogy classes at school; whereas others shared it on a more limited basis with their families or close friends.

Table 1: Number of Persons Student Group Members Shared Information With Outside of the Program	
<u># Of Students</u>	<u># Of Persons Shared With</u>
5	1-3
2	4-8
6	9-25
1	26-100
1	101+

Restricting our analysis to only this sample of 15 total focus group members, we estimate that between 141 and 238 people were given information. Given that the program being evaluated took place among 10 schools, assuming similar dissemination rates, and using the lower limit reported by the 2 schools interviewed above, we estimate that 700 or more people within the Central Bosnia and Sarajevo Cantons were the indirect recipients of program skills and/or materials.

Many group leaders also stated that they, too, transmitted materials and information from the program in both formal and informal settings. Methods of dissemination identified included presentations in staff meetings, head teacher class, creating handout materials for students, posters, radio shows, television coverage, flyers and newsletters. Representative comments made by the group leaders included “we teach mental health in the second grade with the help of the program materials, information, and education, and these lectures are evaluated very highly by the students”, and “regarding

Figure 3: Advocacy



sharing information from the program: I use it in teaching psychology, so each generation has had at least two or three class periods connected to this material. That is 100 students a year for three years. Plus the information shared in individual work and in the group work with the staff. Parents were also given information.” Another group leader stated: “These communication skills are very useful, even for us. We even teach them to our husbands!” Additional comments included:

- “Teachers tell us that the classroom atmosphere has benefited from the group members, because their behavior has improved. The group members talk more in class, they have more confidence, and they are less disruptive than before.”
- “I have invited some of my group members to come to the psychology class that I teach, to demonstrate the skills they have learned in the group.”

Last, it is interesting to note that, despite the many comments from group leaders regarding the widespread degree to which they shared this information at the schools, not many of the student focus group participants indicated that they were aware that their group leaders were doing so (see Figure 3).

Peer referrals to the school pedagogue or psychologist. In addition to advocating on behalf of the program by disseminating program skills and materials, both leaders and students reported that the group members had assisted other students who were troubled by trauma by referring them to the pedagogue. Many of the students reported that they had referred friends to the pedagogue because the information they had learned in their groups was helpful. The group leaders also reported that they knew of students who had been referred by participants in the program. Although this evaluation utilized no formal system for evaluating how many students outside of the program were referred, 17.5% of the student comments relating to advocacy and assistance of other students were descriptions of referring other students to the pedagogue or psychologist. Similarly, 12.2% of the group leader comments in this construct consisted of observations of group members referring other students to them for assistance.

“Sticking up” (advocating) for other students with trauma-related problems. The student focus group participants also reported that, after going through the program, they were able to identify others who were suffering from trauma-related problems. They reported that they often tried to educate these individuals about the symptoms that they were experiencing, or to take steps to relieve the stressors that troubled them. One student related, “If someone has problems who is outside of our group we do advocate for that person. For example, the father of one of our friends died, and she was not in school for a couple of days. When she came to school, a teacher wanted her to report. We advocated for her by asking the teacher to wait a day or two and she would learn it (the material). Her father had just died.”

Perceptions of mental health services in the schools. A final and largely unforeseen positive impact identified by this evaluation centered on the manner in which the program had enhanced the role of the pedagogues in the schools. A small percentage of the total comments (2.7% of the student focus group comments and 7.9% of the leader focus group comments) focused on how parents, students, and teachers viewed the delivery of mental health in the schools. The great majority of these comments centered on the perceptions of the role of the pedagogue. For example, a leader commented, “The work of the pedagogue has been cultivated (via this program).” Almost all of the group leaders surveyed in the focus groups reported that they believed that the role of the pedagogue had been enhanced by the program and was now better appreciated and understood by teachers, students, and parents.

Quantitative Results

In a first step, Reliable Change Indices were calculated for targeted outcomes. The analyses revealed that:

- ▲ 26% of the treatment group’s task orientation scores, as rated by teachers, improved reliably and 4% worsened reliably, and 23% of the control group’s task orientation scores improved reliably and 8.8% worsened reliably.
- ▲ 16% of the treatment group’s behavioral control scores, as rated by teachers, improved reliably and 5% worsened reliably, whereas 9% of the control group’s behavioral scores improved reliably and 8.8% worsened reliably.
- ▲ 17% of the treatment group’s appropriate assertiveness scores, as rated by teachers, improved reliably and 2.6% worsened reliably, whereas 6% of the control group’s behavioral scores improved reliably and 8.75% worsened reliably.

Second, because the incorporation of program materials into the pedagogues’/psychologists’ other professional work at the schools was not directly assessed in this evaluation, an excerpt from last year’s (1999-2000) school year evaluation will be cited which directly measured this impact. In this questionnaire, the school counselors filled out specific questions inquiring to what extent the counselors had incorporated program materials into their other work in the schools:

Program Materials	I Use It In My Other Professional Counseling Work: number/total respondents; (%)	I Use It in My Teaching
1. Psychoeducational handouts explaining distress symptoms	15/17 (88%)	13/14 (93%)
2. Handouts explaining how to control your thoughts/emotions	16/17 (94%)	11/14 (79%)
3. Handouts explaining how to seek social support	15/17 (88%)	10/14 (71%)
4. Handouts describing the different types of social support	15/17 (88%)	9/14 (64%)
5. Handouts explaining how to tell when a problem is my job to fix, and when it isn’t my job to fix.	13/17 (77%)	8/14 (57%)

These (1999-2000 evaluation) results indicate that the program materials have been disseminated to a much broader audience than the 8 to 10 group members involved in trauma/grief-focused group work. Rather, they suggest that, in the great majority of schools, multiple classrooms are regularly taught coping skills and provided with psychoeducational information. Further, although the number of individual students referred to the pedagogues/psychologists has not been precisely assessed, it is clear that troubled students other than group members directly benefit from the program materials and specialized training of the school counselors.

Impacts at the Level of Interpersonal Relationships

Program Objectives:

- a) To promote positive peer and family relationships through building trust, empathy, and communication/social support skills.
- b) To use the group to promote personal growth and positive psychosocial adjustment in group members.

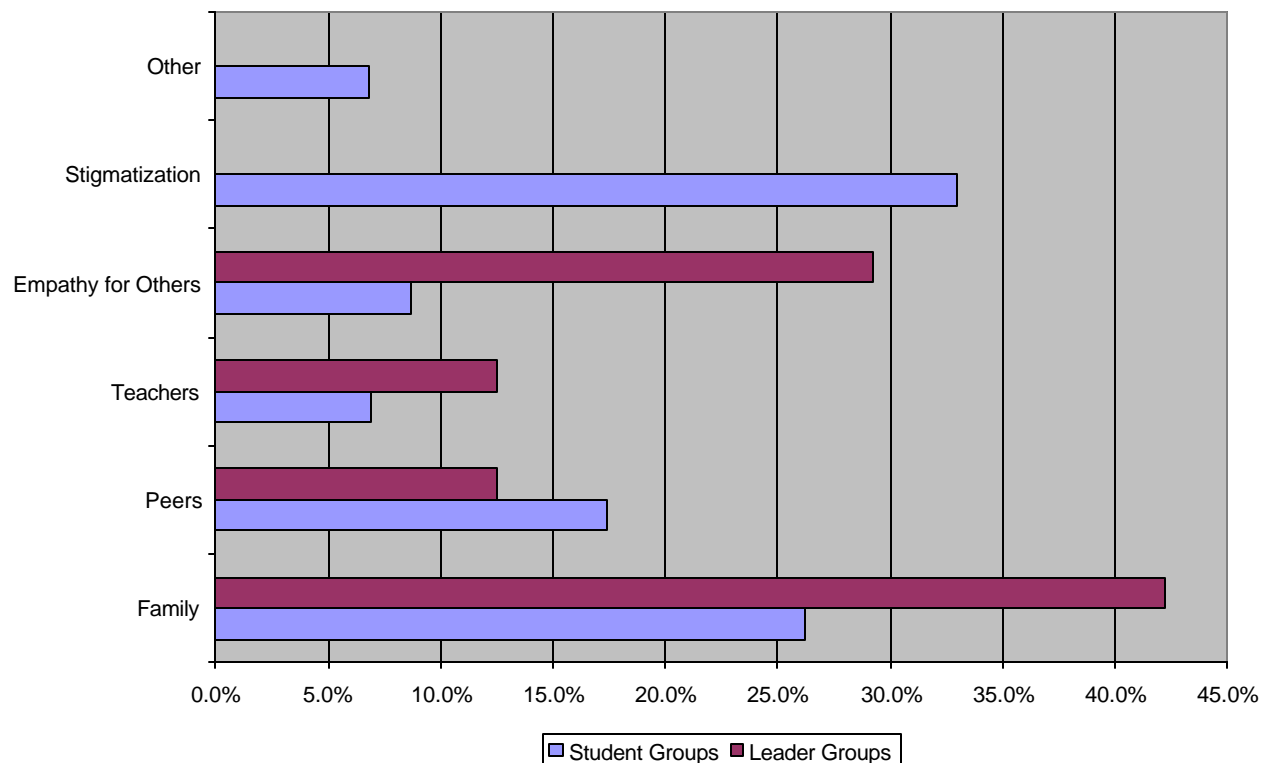
Qualitative Results

A third major impact domain identified by this evaluation consisted of improvements in group members' relationships with others outside the group. Leaders and students cited the program's impact on family relationships as being the most significant (see Figure 4). One student related, "I had problems with my sister—we did not get along very well, and that influenced our mother. My mother has a heart-related illness and she could not bear our quarrels. She begged us to stop. Our leader helped me reconcile with my sister and now we have better relationships in our family." A second student said, "I quarreled with my brother. This group helped me to make things better. Not all the things are OK, but up to some degree it is alright."

The group leaders also identified the positive impact of the group on family relationships. One leader said, "Some of the members tried to help their mothers and their younger siblings. They have shared some of the skills with their families. They were very successful and content with the results they achieved."

Some students also reported that the groups helped to improve their relationships with peers. Typical student comments included "I used it (skills from the program) in dealing with my friends from class, with peers. It (the group) helps us think more positively, to not only be concerned with ourselves

Figure 4: Relationships



only, but to turn to our friends as well."

Last, both leaders and students felt that the program had helped students gain more empathy and understanding for themselves and others.

Quantitative Results

Reliable Change Indices were first calculated for targeted outcomes. The analyses revealed that:

- ▲ In general, parents' ratings of their children's behavior were relatively stable across both groups. Specifically, 5.25% of the treatment group's assertiveness scores, as rated by parents, improved reliably and 2.6% worsened reliably. In contrast, 2.6% of the control group's assertiveness scores improved reliably and 6.6% worsened reliably.
- ▲ Peer social skills were also relatively stable across groups. 17% of the treatment group's peer social skills, as rated by their teachers, improved reliably and 5.26% worsened reliably, and 13.75% of the control group's peer social skills improved reliably and 3.75% worsened reliably.

Negative Impacts and Problems With Implementation

Qualitative Results

The qualitative evaluation identified four negative program impacts across the domains assessed. These negative impacts fell in the areas of logistical difficulties associated with program implementation, the limited number of direct beneficiaries, the hassles of conducting a program evaluation, and the stigmatization of group members. Notably, 8.5% of the total comments made were directed towards the group format or logistics. Of this percentage, most comments were complaints or critiques of the difficulties involved in implementing a program of this magnitude. These comments generally centered around getting parents, teachers and schools to become committed to the program goals. A group leader stated:

“You can speak about problems too, simply how the program was accepted in the school. At the beginning, when we started, we had many problems and we had to put a lot of our energy into it, to protect the program. Presently, the program does not need protection. On the contrary, the school environment has accepted it.”

A second negative impact of the program centered on activities associated with this program evaluation. More specifically, several group leaders stated that they felt the evaluation was too long and involved, and that some of the questions were culturally insensitive. These opinions, however, were not universally shared.

A third negative impact consisted of complaints regarding the limited number of direct student beneficiaries, and particularly that the groups were unavailable to large numbers of people who needed them. Many group leaders expressed the wish that more students could be directly helped, but that resources only allowed them to reach limited numbers, despite their efforts to disseminate program skills and materials via their individual efforts.

A fourth negative impact centered on issues of stigmatization of group members. This issue was of particular importance to the students, as it constituted 50% of all negative comments made in the focus groups. In particular, a significant number of focus group participants reported that, in the fall when the groups were initially formed, many of the group members felt stigmatized and ostracized by their peers, teachers, and even family members. However, by the end of the school year, some, but not all, students reported that these problems were either less important to them, or that the problems had dissipated as a result of the positive effects that others had seen in them. A selection of these negative comments follows:

- “Professors are the worst. They were angry because we were attending the group and not their classes, but I corrected it. I improved my marks.”
- “Professors who are better informed about the program understand. When we explained the purpose of the program, they did not make any more problems. Professors might be angry before we explain the goals of this group.”
- “90% of the people in the school say ‘look at those madmen’ when they see us going into the pedagogue’s office.”
- “One or two members left the group so that others would not think they were crazy.”
- “In the beginning they (my parents) told me I was crazy, but later we made our relationship better, my parents and me.”

- “Most of the students in our class asked if they could be in this kind of group but it was at the end when they realized what the group sessions are working at.”
- “At the beginning of the school year, our classmates made fun of us for being in the group. However, after they saw us using our skills to look more positively at a situation, they said, ‘Where did you learn how to do that?’ and I said, ‘In the group’. And then they said, “Why can’t *WE* be in the group?”

Program Problems: Limited Number of Beneficiaries and Breadth of Coverage

It is clear that a major weakness of the School-Based Psychosocial Program for War-Exposed Adolescents throughout its history has been its limited number of direct beneficiaries. Typically, only one student group, comprised of between 6 and 10 students, has been conducted at each school per school year. A second major weakness of the program is its limited breadth of coverage among Bosnian secondary schools. The program is currently in place in 10 secondary schools throughout the Federation, which has 210 total secondary schools, leading to a total coverage rate of approximately 5%. Moreover, the program is in place at 16 out of 88 secondary schools in the Republika Srpska, leading to a total coverage rate of approximately 18%. Indeed, were it not for the resourceful manner in which the group leaders and group members have disseminated the materials in their teaching, other professional work, and through their informal networks, and the creation of the professional network of group leaders and community mental health professionals, the program would, on the surface, appear to be an inefficient use of UNICEF resources. These criticisms, however, should be balanced against the following observations:

1. The program is a *specialized* program designed to identify and provide time-limited, specialized support to severely traumatized students experiencing *severe, persisting* distress. In designing this program, the Team operated on the assumption that treating the most severely distressed students in the schools was an effective means of improving the overall classroom and school environment. Limited evidence in support of this assertion was found in compliments the group leaders received from teachers that the groups had helped students to improve their marks and to decrease their disruptive classroom behavior.
2. It is not fair to criticize a *specialized* program that specifically targets a relatively small proportion of students for failing to directly target *all* students. This assertion is consistent with the observation that it is not fair to criticize a speech pathology program for failing to treat all students throughout Bosnian schools irrespective of whether they possess speech impairments or not. A fair “denominator” for calculating breadth of coverage, then, is the proportion of students throughout Bosnia who currently suffer from severe, persisting trauma-related distress and who are at risk for significant developmental problems. Given the group leaders’ estimates that between 15% and 30% of the students at their schools currently show significant signs of trauma-related problems, the problems of a limited number of direct beneficiaries and a limited breadth of coverage still remain. Notably, the widespread *dissemination* (discussed in the *advocacy* section above) of the program reported by both group leaders and students has addressed this problem to a limited degree. It is hoped that the adaptation of some of the program materials for wide-scale classroom-based use, in combination with the support of the trained professional network, will address this problem to a much greater degree.
3. The issue of geographic location, culture, and local human resources are also important factors that have relevance for evaluating whether the program is a good “fit” for the region in light of local needs *and* local resources available for implementation. Specifically, the program received only lukewarm administrative support in West Mostar, and died out within 3 months as a consequence despite assertions by the local program supervisors that it was needed in West Mostar, Siroki Brijeg, Vitez, and other regions. An additional implementation failure consists of Tuzla Canton, comprised of 36 secondary schools. The Canton has extremely high rates of traumatized students due, in large part, to its close proximity to Srebrenica. Unfortunately, only 6 schools were selected to participate in the program because only they had at least one pedagogue or psychologist. The program was later discontinued due to a lack of administrative support from the local Pedagogical Institute, which demanded (but did not receive from UNICEF) a substantial payment for “overhead costs”. A counterexample, illustrating a case of appropriate discontinuation, is found in Tomislavgrad, whose

Gymnasium has two excellent school counselors. After administering screening surveys to their students, the counselors determined that only one student in the school had a history of significant war exposure. The program was (appropriately) discontinued due to a lack of local need. In summary, a weakness of the program is that it depends on the availability of at least one pedagogue or psychologist in the school when they are often not present, and when there is no clear association between whether a school counselor is present at a given school and the level of local need for mental health services in the region served by that school.

Summary of Findings

The evaluation revealed consistently positive results across a broad variety of outcome dimensions. In particular, focus groups conducted with the school counselors and students revealed a broad program impact that touched individual student group members, their families, their peers, the classroom and school environment, and the larger community to a lesser extent. The outcomes and impacts observed included:

1. The great majority of participating school counselors reported that they incorporated the program materials and training into their other professional work at the schools, including lecture materials, psychoeducational presentations to students, parents, and administrators; and individual work with referred students. These efforts led to a much larger number of direct beneficiaries than the 6-10 group members treated at each participating school.
2. The school counselors generally reported that participation in the program had brought about a change/expansion in their roles in the schools from one of “disciplinarians” of disruptive students to valued providers of mental health services. They reported that the types of referrals they received from students, student peers, parents, and teachers now included more students with mental health-related problems. The counselors reported that they welcomed this change, and they attributed their participation in the program as instrumental in increasing their expertise and expanding their professional roles.
3. A valuable but unplanned outcome of the program is the formation of a large and skilled professional network of school counselors, community mental health professionals, and local universities. This network has great potential for assuming an advocacy role for public policy, defining the professional role of the pedagogue/psychologist in the schools, and mental health program development and implementation in the schools.
4. The primary positive outcome identified by student group members was an increase in effective coping skills, particularly the capacity to be “open” and to communicate effectively with others. Other skills identified included self-esteem, believing in the future, and problem solving.
5. Students reported that they often advocated for the program by passing on skills and materials to family and peers, making referrals to the school counselor, and “sticking up” for other students with similar problems.
6. Students also identified program impacts at the level of improvements in relationships with family members, peers, and teachers. They reported that they were generally more effective in communicating openly, resolving disputes, and in demonstrating empathy for others.
7. Quantitative analyses revealed significant pre- to post-treatment reductions in targeted distress symptoms (as measured by measures of posttraumatic stress, depression, and grief symptoms). Rates of reliable improvement were, for most indices, significantly higher in the treatment group compared to the wait list control group, indicating that treatment was of greater benefit than holding intermittent “assessment” visits with the school counselor.
8. Decreases in distress scores were significantly associated with increases in measures of positive psychosocial adjustment, as measured by students’ and teachers’ reports of task orientation, classroom rule compliance, peer relationships, and school interest.
9. Therapeutic group processes, including engagement, catharsis, cohesion, and insight, were significantly linked to positive outcomes. These outcomes included increased school interest, improved peer social skills, reduced anxious/withdrawn behavior, self-criticism, and hopelessness.
10. The supervision structure of the program (in which the counselors meet with community mental health professionals in group supervision meetings) worked well throughout the 2000-2001 school year. In particular, the program operated with only minimal off-site support by the UCLA/BYU Team throughout the entire 2000-2001 school year, demonstrating a high level of autonomy.

SECTION 2: WHY AND HOW DID IT HAPPEN OR NOT HAPPEN?

Implications

The qualitative and quantitative results of this program evaluation reveal a generally broad and positive set of program impacts ranging from individual students to schools, families, and the local community. Taken together, these findings suggest that the program was generally successful in achieving its main objectives of reducing distress and promoting positive psychosocial adjustment in severely traumatized youths.

Notably, the rates of reliable improvement reported herein are somewhat lower than reliable improvement rates observed in the general psychotherapy outcome literature with mixed treatment populations and treatment modalities, which rates range from 57.6% to 67.2% depending on the method of calculation (Hansen, Lambert, & Forman, in press). However, when critically examining the percentages of students reporting reliable pre- to post-treatment changes in the targeted outcomes, it is important to keep three points in mind: First, these changes are reported by students reporting chronic, severe distress symptoms nearly 5 years after the war, who thus constitute a difficult population to treat therapeutically. Dramatic treatment gains are generally not observed in these populations, notwithstanding the effectiveness of the treatment program. Second, trained school counselors, who worked under the supervision of local mental health professionals, provided the mental health services at local schools. That these therapeutic gains were largely the result of the work of school counselors, who are not formally educated to conduct such demanding work and who conducted it with often inadequate material resources, is quite remarkable and praiseworthy. Third, the wait-list control group should not be viewed as a “no-treatment” group, given the repeated personal contacts made between the school counselors and the wait-listed students. These students met with, and were quite thoroughly assessed, on three separate occasions throughout the school year; many were promised that they would receive services during the following school year. These repeated contacts, in combination with expressions of concern and support, and the promise of future assistance, may be at least partially responsible for the improvements noted in the control group’s scores.

Lessons Learned

The results of this program evaluation also indicate that it is possible to design and implement a large-scale post-war program in an international setting, given the requisite levels of close collaboration, human and material resources, and administrative support. However, in reviewing a program that has survived for nearly five years in a Bosnian post-war environment where many humanitarian programs have failed to take root or terminated prematurely, we propose that the question whether (and how) the program works is only half the picture. How the program has survived is equally as important, particularly when it is understood that the school counselors received no supplementary financial remuneration for implementing this labor-intensive and professionally challenging program. In particular, since the spring of 1997, a total of 43 secondary schools located in 6 major regions throughout the country have been trained to implement the program. At the close of the 2000-2001 school year, a total of 26 schools were participating in three regions throughout the country, producing a retention rate of 58% among the schools and 50% among the regions. Why did the program “take root” in some regions, and die out in other regions with equal or higher levels of need for psychosocial support? Lessons learned will now be reviewed and summarized in the form of good practice recommendations.

1. Design a program that the local participants perceive and treat as “locally owned and operated” rather than as an externally imposed set of obligations. This recommendation has three facets.
 - a. Collaboration with local mental health professionals in all phases of program planning, design, training, and implementation is critically important.
 - b. Regular program monitoring plays an important role in identifying problems with implementing the program as they come up, which can then be the focus of ongoing training seminars and regular supervision meetings.
 - c. The program will take root and become sustainable only when the local participants become personally convinced that the program helps them to carry out their professional work in a more competent, effective fashion. Once this perception was generated, the school counselors have

demonstrated an often-remarkable level of commitment to implementation, such as traveling long distances to attend supervision meetings.

2. Select the right government administrators to support program implementation. During the past three years, two regions (Mostar and Tuzla) have dropped out of the program due primarily to a lack of local administrative support. In addition, a third region (Sarajevo) struggled for two years until the removal of a problematic program administrator brought about a dramatic improvement in implementation. In contrast, the program has generally flourished in regions where informed, competent, and committed administrative support is present. Thus, the importance of selecting, educating, supporting, and regularly coordinating with the activities of government coordinators cannot be overstated.
3. Recruit and retain competent and committed community mental health professionals to work as program supervisors. These committed individuals have been indispensable in anchoring a support network among school counselors and community professionals, in maintaining morale and motivation of the school professionals, in advocating for the legitimacy and relevance of mental health in the public schools, and in providing a “safety net” that bolsters the courage of the school counselors in expanding their traditional roles. If the supervisors become demoralized, frustrated, or unmotivated, the program is at high risk for failure.
4. Recruit school counselors to implement the program who have good rapport with their students, good interpersonal skills, a desire to expand their professional competencies, and who are compassionately dedicated to helping their students. Somewhat surprisingly, the particular professional degree obtained by school counselors is not significantly linked to their level of commitment to implementing the program, or of the quality of their treatment groups in general. Notably, the counselors’ initial level of commitment to joining the program often changed noticeably between the first and second training seminars, during which time the counselors administered risk screening surveys and screening interviews to their students. Many returned with comments such as “I thought I knew my students, but I did not know how severe and widespread the problems are” and “What can we do to help these students?—there are so many with problems!”
5. The program must contain built-in incentives to continue implementation, such as observing improvements in students, receiving recognition for the counselors’ increased expertise and specialized role in the schools, and receiving expressions of gratitude from parents and teachers. Additional incentives include the professional support exchanged through the program network, ongoing training seminars designed to enhance the school counselors’ professional skills, and the expansion of the counselors’ professional roles at their schools to include that of provider of mental health services. Many counselors describe their work in the groups as one of the most rewarding aspects of their professional work.
6. Create a local program administrative infrastructure that is as self-supporting and self-sustaining as possible. In particular, the group supervision component has facilitated program training, effective and timely supervision and consultation, effective program monitoring, appropriate adaptation of program materials and methods, exchanges of professional support and camaraderie, and has increased participants’ perceptions that the program is “locally owned and operated”. It is important to note that the program was implemented independent of the UCLA/BYU Team during the 2000-2001 school year, with all clinical supervision/training responsibilities carried by local program supervisors. This demonstrates a high degree of program autonomy.
7. As needed, especially in the initial stages of implementation, support sustained external commitment. For example, repeated and intermittent “pulsed” visits by the UCLA/BYU Team that focused on current problems and upgrading skills have helped to generate momentum, maintain local commitment, reinforce interpersonal and inter-institutional ties, update understanding of local needs, and to promote the quality of program implementation and evaluation. As an illustration, Dr. Layne, the Bosnian Field Director for the program, has traveled Bosnia 15 times between 1997 and 2001 in field visits ranging from 3 days to 3 months. The role played by personal and professional relationships that have been built up over time in promoting effective implementation should not be underemphasized, especially when beginning a new program or moving into a new phase. Additional consultative/training visits by external experts, as needed, may thus play a role in promoting effective implementation.

SECTION 3: “WHAT SHOULD BE DONE ABOUT IT?”

Recommendations

The results of this program evaluation strongly support the work of the local Pedagogic Institutes of the RS and the Federation, in collaboration with the German humanitarian organization GTZ and UNICEF BiH, to develop the trauma group program into a general psychosocial support program. Specifically, these results support the need for (a) a systematic review and adaptation of existing program materials, (b) development of plans to develop other needed materials based on a survey of local needs, and (c) development of an implementation strategy and plan for widespread dissemination of a general psychosocial support program.

1. Notably, group members identified skills as being the most important and valuable positive outcome for the trauma group program. The great majority of these skills are adaptable for use in a classroom setting with a well-trained and well-supported teacher or pedagogue, and carry a relatively low risk of negative impacts. Thus, efforts should be undertaken to systematically review the trauma group program materials and to import and/or adapt them for classroom instruction.
2. As was reported in our evaluation of the pilot implementation of the Ann Vernon psychosocial program last year, teachers and pedagogues requested in-depth training regarding prior to implementing the psychosocial program. Specifically, they requested training in the underlying theoretical model, and in the correct practice and presentation of the specific skills and concepts covered. Thus, the development of an implementation strategy should also include plans for a formal initial training of the implementing teachers/pedagogues.
3. The working group that is charged with developing recommendations and methods for guiding this adaptation/development of a general psychosocial program should draw liberally on the experiences of the school counselors and their supervisors who have taken personal initiative in adapting the program for use in their regular counseling work and in the classroom. These counselors will likely give good feedback regarding which materials work well in various formats (head teacher presentation, psychology/pedagogy class, etc.).
4. An unforeseen but very valuable impact of the program was the development of a large professional network of highly trained school counselors, and the establishment or strengthening of formal ties between local schools, mental health clinics, universities, and Pedagogical Institutes. This network has the potential of evolving to become an advocate for the role of the pedagogue/psychologist in the schools and the professional training of pedagogues and psychologists during and after their formal schooling. Indeed, it is not an overstatement to assert that this body may become an important mechanism for expanding mental health services in various forms throughout Bosnian schools. Thus, we recommend that the support and continuation of this network be designated a high priority, and that it be provided the support needed to continue its work and evolution.

The UCLA/BYU Team:

Christopher M. Layne, Ph.D.

Rob Davies, M.A.

Gary M. Burlingame, Ph.D.

William R. Saltzman, Ph.D.

Nicole Thomas, B.A.

Robert S. Pynoos, M.D.

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Appendix A:

Historical Overview of the Program

Historical Overview of the Program

In 1996, UNICEF contracted the UCLA Trauma Psychiatry Team (hereafter referred to as the Team) to consult with Bosnian government agencies in designing and implementing a school-based program to promote post-war adaptation in war-exposed youths. During a 7-week initial visit to B&H during the summer of 1996, Dr. William Saltzman conducted an extensive review of the psychosocial needs of adolescents in the post-war period and the local resources that were available, or potentially available, for meeting those needs (Saltzman, 1996). Based on Dr. Saltzman's observations, the UCLA team recommended that a school-based, three-tier program be instituted. This three-tier program would provide basic support to many students in the form of psychoeducational materials and presentations (Tier 1), and specialized school-based support for severely war-exposed students at risk for experiencing chronic, severe posttraumatic stress, depression, or grief reactions and developmental disturbance (Tier 2). The proposed program also included a professional support network, to be formed by linking school counselors with local mental health professionals in regular supervision meetings. This network was intended to provide the counselors with timely professional support and consultation, and where needed, to facilitate the referral of students reporting severe depressive, suicidal, or psychotic symptoms to community mental health resources for professional psychiatric treatment (Tier 3). Based on its field observations, in which it documented a lack of services at the secondary school level, the UCLA Team proposed that intervention efforts be primarily directed towards assisting severely war-exposed secondary school students who were at risk for persisting severe posttraumatic stress, depressive, and grief reactions.

UNICEF then accepted the Team's proposal. In the spring of 1997, newly-developed "pilot" program materials were field-tested in two Bosnian "pilot" schools, the Nursing School in Sarajevo and the Gymnasium in Banja Luka. On the basis of field observations, focus groups, and clinical observations by local implementing clinicians, the original program materials were extensively revised during the summer and fall of 1997. The newly revised materials included a guide for leading classroom-based psychoeducational discussions, psychoeducational materials for parents and teachers, a screening survey, a risk screening interview, a pre-group interview conducted by the group leader, and a structured trauma/grief-focused group treatment manual.

The UNICEF School-Based Psychosocial Program for War-Exposed Adolescents was first implemented on a wide scale during the 1997-1998 academic year at 22 schools throughout Bosnia and Hercegovina (B&H). These schools were provided ongoing support by 3 teams of local clinical supervisors (based in Sarajevo, Banja Luka, and Mostar, respectively). The implementation was also supported by a 3-month on-site visit by Drs. Christopher Layne and Jenifer Wood in the fall of 1997, and by two additional follow-up visits in the spring of 1998. The fall 1997 visit was devoted to training, consultation, and making numerous "on site" visits to participating schools to support program implementation. These "on site" visits always involved a visit with the school director and a discussion of the need to support the program in order for it to succeed in the school and benefit as many students as possible. The Team's spring 1998 visits were devoted to consultation, supervision, program evaluation, and planning for the upcoming 1998-1999 school year. Using the data collected from these visits, the program materials were further revised in the summer of 1998. The success with which the program was implemented during the 1997-1998 school year varied greatly across sites. Regarding retention, an important indicator of program sustainability, 9 of 10 schools completed the program in the Republika Srpska, 2 of 3 schools completed the program in Sarajevo, 2 of 2 schools completed the program in Gorazde, 0 of 4 schools completed the program in Croatian-affiliated regions in Hercegovina (Tomislavgrad, Vitez, West Mostar, and Siroki Brijeg), and 0 of 2 schools completed the program in East Mostar.

The Program was expanded to a larger scale—to 32 total school sites—during the 1998-1999 school year. Program retention during this year was quite good to excellent: 9 of 9 "veteran" schools (those which completed the program during the 1997-1998 school year) in the Republika Srpska returned, 2 of 2 "veteran" schools in Sarajevo returned; unfortunately, 2 of 2 "veteran" schools in Gorazde declined to participate. The expansion of the program took the form of the addition of 21 new schools, recruited throughout B&H, to the 11 veteran schools. New expansion sites included Travnik, Novi Travnik, Tuzla Canton, and a number of schools from throughout the Republika Srpska and from Sarajevo. All schools were supervised by a total of 6 program supervisors (2 in the RS, 2 in Sarajevo, 1 in Travnik, and 1 in Tuzla). The RS supervisors were "veterans" from the previous year, whereas the other supervisors constituted new recruits. As in the previous year, supervision took the form of regular

group supervision meetings, telephone consultations, and on-site visits.

As of spring 2001, the program has concluded its fourth full year of implementation and is in place at 26 secondary schools throughout Bosnia and Hercegovina. Throughout this time, the Team and its Bosnian counterparts have collaborated in revising and adapting the program to meet local needs. Three teams of trained local Bosnian mental health professionals served, during the 2000-2001 school year, as clinical supervisors and carried out their activities in the form of regular (bi-weekly to monthly) group supervision meetings, telephone consultations, on-site visits to participating schools, and participation in the training seminars. Throughout the program's history, the Team has supported program implementation with intermittent on-site visits devoted to training, consultation, advocacy, needs assessment, program evaluation, and program revision.

Appendix B:
Program Evaluation Activities

Overview of Program Evaluation Activities Conducted

An evaluation of the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents was conducted throughout its 2000-2001 school year implementation. A total of 10 secondary schools located in the Central Bosnia (Travnik and Novi Travnik) and Sarajevo Cantons took part in the evaluation. Drs. Gary Burlingame and Christopher Layne traveled to Bosnia in September 2000 to consult on the evaluation methodology. During this visit, Drs. Burlingame and Layne worked with the program supervisors, the group leaders, and with UNICEF Project Officers Berina Arslanagic, M.D., and Mary Black, M.D., in developing an appropriate quantitative evaluation methodology. Issues given particular attention included the use of a “wait list” control group and the use of random assignment to conditions. This question was ultimately put before the group leaders, who decided to implement this rigorous method of program evaluation. Quantitative data were collected throughout the school year as indicated by the implementation plan and utilized measures completed by the student group members, their primary caretakers, and their teachers. The post-treatment follow-up was conducted at the end of the school year and utilized the same sources.

Qualitative data collection. The qualitative portion of the program evaluation was conducted by Gary Burlingame, Ph.D., and Rob Davies, M.A. These consultants assumed the role of external evaluators to minimize positive bias. Data were collected from both students and group leaders using a semi-structured focus group format. The student and leader groups were held at the end of the implementation period (post treatment) in late May to early June, 2001. Student groups ranged from 7-9 members and were held in participating Sarajevo and Travnik area schools. Group leader focus groups ranged from approximately 10-15 members and were held at the end of the post-year supervision meeting in Travnik. The questions posed by the focus group leaders began with open-ended questions that were broad in scope; these questions were then systematically narrowed down to identify specific positive and negative program impacts.

For example, the first question asked in both leader and student groups was: “How would you describe the impacts of these groups? Follow-up questions then addressed, in order, any and all positive and negative impacts of the program on students, the school, families or the community, and the country. Each focus group was video and audio recorded to permit a rigorous qualitative analysis.

Qualitative data analysis. As a first step, transcripts of the focus groups were created from the audio and video tapes. Each statement was first translated into English and then back-translated into Bosnian and compared to the original statement to verify the accuracy of translation. Responses to each question were then analyzed using the following procedure. First, two readers independently identified and numbered each statement. Agreement was typically above 95% across the transcripts; any differences were resolved by consensus agreement after discussion. Out of the six focus groups used in this analysis, a total of 1,208 separate statements were identified.

A group of eight trained coders then read two randomly selected transcripts from the leader groups and two transcripts from the student groups in order to code each statement. Grounded theory, a rigorous qualitative analysis procedure, that allows codes to emerge from the data rather than being imposed from previous conceptions of the researchers, was selected as the guiding method for coding the statements. Following this method, a consensus code was developed for each statement in each of the transcripts. The resulting codes were then used to analyze all transcripts. For the purposes of this evaluation, three leader groups and three student groups were analyzed. Each transcript was read by two independent readers and coded using the previously developed code books. Agreement between these two coders was approximately 75%. Disagreements were discussed and usually resolved between the two raters; when the raters did not agree, the transcript was reviewed and discussed by the team of eight raters until consensus was reached. The process of developing codes and subsequently coding the transcripts involved over 400 person hours.

Once coding was complete, frequency distributions were created for each code. These frequencies are presented in the following pages in accordance with the domain of impact discussed. Notably, percentages were calculated using as a denominator the number of *unique responses* to a given question (not the number of respondents—that is, a given respondent could have given more than one unique response to a question). In addition, statements made by respondents that were judged to be not relevant to the evaluation (e.g., “I am eighteen years old and was born in tutin, Kosovo”; “I have lead three groups using this program”; “I am a professor of pedagogy at my school”) were coded as such and are not included in this analysis. In the leader groups, 24.3% of the statements made were coded as not

relevant, whereas 22.1% of the statements made in the student groups were coded as not relevant to assessing program impact.

Comments on the appropriate interpretation of qualitative data. These data and the associated frequency counts should be interpreted carefully in light of the strengths and weaknesses of qualitative methods. One of the advantages of qualitative analysis is that open-ended questions elicit “free-responses” that are not prompted or structured by preconceived response categories. This method allows respondents to speak their mind, and allows the researcher access to their freely considered attitudes, beliefs, assumptions and feelings. However, the absence of predefined categories necessitates great care in comparing responses across respondent groups. In particular, respondents are not making “either-or” selections from a list of response categories, and thus the presence of a given response should not be taken as a negation of other possible responses. For example, when Respondent A mentions a particular idea or experience that is different from one mentioned by Respondent B, it should not be assumed that A did not also think, feel, or experience what B did. In addition, categorization for the purpose of analysis does not imply strict separation. Many responses expressed similar idea in somewhat different terms.

In keeping with basic qualitative methodology, in cases where a given response is repeated by a large number of students or group leaders, the endorsed opinion or experience is interpreted as being widely held among the population of program participants. In contrast, rarely repeated responses are not assumed to generalize to other respondents, even when those opinions are expressed forcefully. As a general strategy, an attempt is made to balance “common” and rare responses in an attempt to understand the common and unique features of participants’ experiences in and with the program.

Quantitative data analysis. The potential impact of the group was examined using several methodologies. First, a Reliable Change Index score was calculated at the level of individual students (Tingey, Lambert, Burlingame, & Hansen, 1996). This index is a much more precise index of whether the degree of change (pre- to post-treatment) reported by individual students is sufficiently large to be attributable to treatment versus random variation. Second, correlations were calculated between pre- to post-treatment change in distress symptoms and measures of psychosocial adjustment. These correlations helped to address the question whether reductions in distress symptoms—a targeted outcome of the group program—are associated with improvements in general functioning.

Program Evaluation Terminology

This evaluation of the UNICEF School-Based Program for War-Exposed Adolescents will utilize an evaluative framework developed by UNICEF (UNICEF, 1991). Primary dimensions of program evaluation that will be featured in this report will now be defined.

Program monitoring is defined as “the periodic oversight of the implementation of an activity which seeks to establish the extent to which input deliveries, work schedules, other required actions, and targeted outputs are proceeding according to plan, so that timely action can be taken to correct deficiencies detected. In contrast, *program evaluation* is defined as “a process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, efficiency, and impact of activities in light of specified objectives.”

Inputs are defined as resources invested in a program. Inputs include cash, supplies, personnel, time, administrative costs, equipment, training, physical facilities, and monitoring activities.

Outputs are defined as the specific products, goods, or services that a program is expected to deliver as a result of receiving the inputs.

Processes are defined as mechanisms that transform inputs into outputs. More specifically, processes may be regarded as the steps specified in the implementation plan.

Program relevance refers to the degree to which outputs are valued and used by the intended beneficiaries of the program. Evaluations of relevance involve assessing the current importance of the problem targeted by the program, and weighing the importance accorded to the targeted problem against the importance accorded to other problems.

Effectiveness is defined in terms of whether a given program works, or delivers outputs in accordance with its objectives.

Program efficiency involves evaluating whether outputs are achieved at the lowest practicable cost. Evaluations of efficiency also may involve comparing the value of the outputs to the value of inputs, and considering whether alternative activities might yield a higher ratio of outputs to inputs.

Outcomes are defined in terms of peoples’ responses to a program, and how people are doing things differently as a result of the program. In contrast to impacts, outcomes are shorter-term effects relating to specific program objectives.

Impacts are defined as the long-term social, economic, technical, environmental, and other effects of the program on the targeted population and their surroundings. These effects may be intended or unintended, positive or negative, macro-level or micro-level.

Sustainability refers to the likelihood that an activity will continue after donor funding ends. Two essential aspects of sustainability include social-institutional issues (do the beneficiaries accept the program as their own? Is the host institution developing the capacity and motivation to administer it?) and economic issues (can the activity become partially or completely self-sustaining financially?)

An *indicator* is defined as a measure that is used to demonstrate the change or result of a program. An indicator may either be a direct measure of a targeted output or impact, or an indirect “proxy” measure.

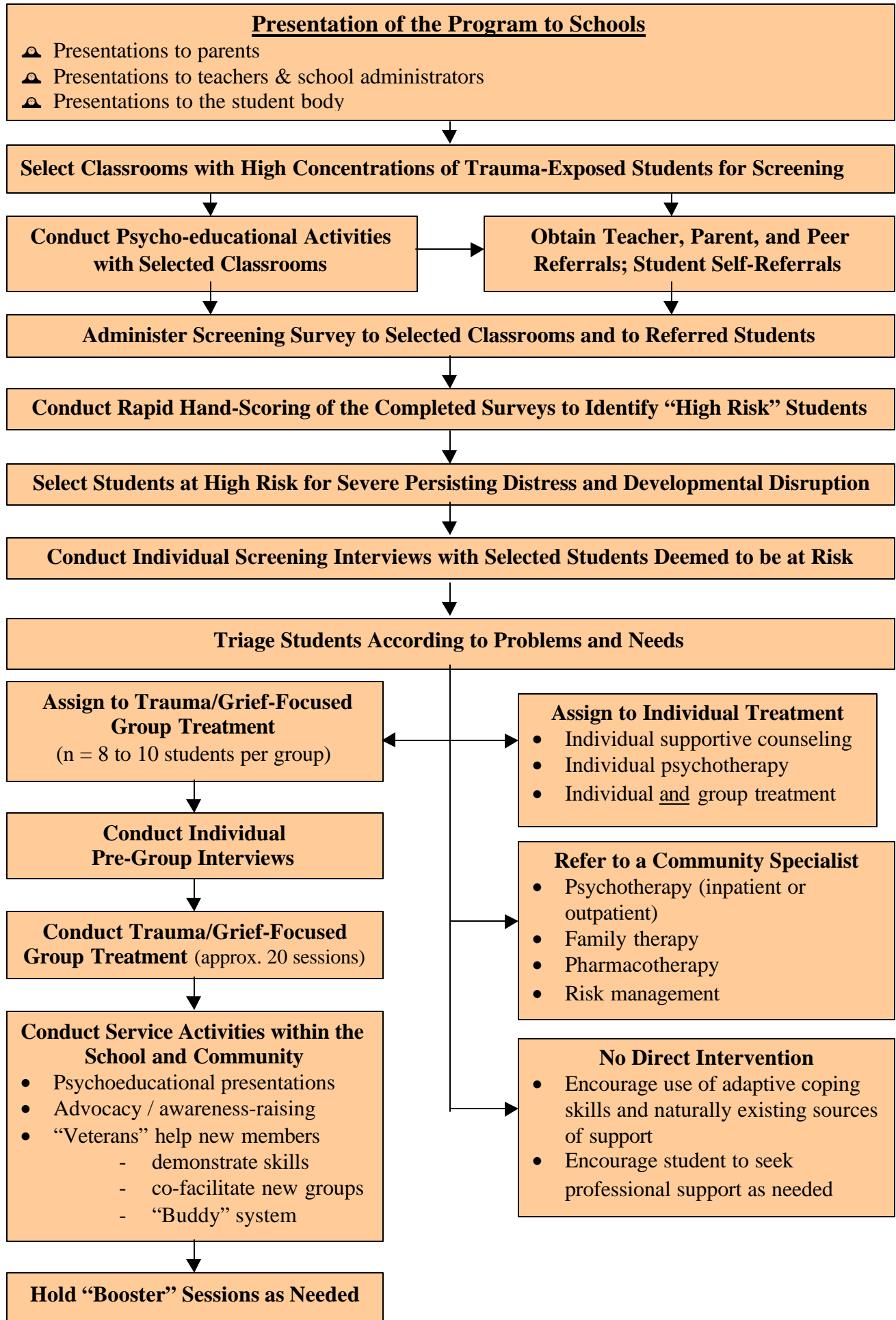
School-Based Psychosocial Program for War-Affected Adolescents: Implementation Plan for the 2000- 2001 School Year

Timeline	Tasks
1. 4-15 September	<ol style="list-style-type: none"> 1) Meet with school administrators, describe plan for the 2000-2001 school year. 2) As appropriate, present the program plan to administrators, teachers, parents, and students. 3) As appropriate, invite administrators, teachers, parents, and students to refer students to you whom they believe are suffering from trauma-related distress. 4) Select classrooms in which to conduct the screening survey. 5) Conduct psychoeducational discussions with your selected classrooms to prepare them for the screening survey.
2. 18-29 September	<ol style="list-style-type: none"> 1) As needed, conduct psychoeducational discussions with your selected classrooms to prepare them for the screening survey. 2) Administer the <u>Screening Survey</u> to the selected classrooms AND to any students who have been referred to you by teachers, etc., for an evaluation regarding the students’ trauma-related histories and distress. 3) Create a (confidential) master list of student’s names and identification numbers to use throughout the school year. (Make sure that exactly the same identification number is used for each student throughout the remainder of this school year.) 4) Hand-score the screening surveys using the Screening Survey Scoring Sheets. 5) Select your 20 most distressed students. Consult with your Supervisors as appropriate. 6) Store the screening surveys and scoring sheets in a secure place (preferably a locked cabinet). Store the confidential master list of student names and identification numbers in another secure location.

Timeline	Tasks
3. 1-21 October	<ol style="list-style-type: none"> 1) Conduct the <u>Screening Interview</u> with your 20 selected “high risk” students. Be sure to administer the <u>Screening Interview Self-Report Form</u>. This form contains many important “pre-intervention” measures that are critical to our evaluation. 2) Ask the Head Teacher of each student with whom you conduct the Screening Interview (approximately 20 students) to complete the Teacher Child Rating Scale. (UNICEF will pay them 4 DEM for each questionnaire they complete). 3) Ask each student with whom you conduct the Screening Interview to take home the Parent Child Rating Scale and to ask his/her parent to complete it and to return it to you in the sealed envelope. 4) Review the results of your screening interviews and sort the students into as many as four piles (depending on their needs): <ol style="list-style-type: none"> a. students who are appropriate candidates for group work b. students who need individual support only c. students whom you judge do not need any form of specialized support, or who decline offers to receive support d. severely distressed students—such as students with serious suicide intentions or psychiatric problems—who require professional mental health services. Consult with your Supervisor on each of these students. 5) Link students in the piles with the services they need: <ol style="list-style-type: none"> a. Write the names of all students in pile “a” above on strips of paper. Then, draw out names at random until you have drawn out <u>one half</u> of the names, up to a maximum of 10 names. You will invite these students to participate in your group; the remaining half of your students will be assigned to a wait-list for the next school year. b. Arrange supportive individual visits as needed for students in pile “b” above, either with you or with another school professional. These “individual support” students will not be included in the group treatment evaluation. c. Reassure students whom you judge do not need any form of supportive service (pile “c” above). Invite them to call on you as needed. These students will not be included in this group evaluation. d. Consult as soon as possible with your supervisor regarding how to properly refer all severely distressed students (pile “d” above). Make the referral, then follow through to make sure that they receive the professional help they need. Involve your supervisor in this process. In addition, involve parents as appropriate/needed. 6) As appropriate, contact the parents of group members and inform them about the program. Seek to recruit their solid support for their child’s participation in the group.
4. 21-31 October	<ol style="list-style-type: none"> 1) Conduct pre-group interviews with students assigned to the group. Please focus on building a healthy therapeutic alliance and gathering information to help <u>you</u> work together in the group—no data collected in this interview will be used in our evaluation. 2) Prepare group materials, meeting place, arrange meeting schedule, etc.
5. 1 November	<ol style="list-style-type: none"> 1) Implement Module I 2) One session BEFORE the last session of Module I, administer “Process Questionnaire” to each group member. 3) The last session of Module I, administer “Mid-Group Questionnaire” to each group member. 4) During the week of the last session of Module I, ask the Head Teacher of each group member to complete the Teacher Child Rating Scale. (UNICEF will pay them 4 DEM for each questionnaire they complete). 5) During the week of the last session of Module I, ask each group member to take home the Parent Child Rating Scale and to ask his/her parent to complete it and to return it to you in the sealed envelope. UNICEF will contribute 4 DEM to your group for treats for each set of group member/parent questionnaires that are completed.

Timeline	Tasks
6. 1 Feb	<ol style="list-style-type: none"> 1) Implement Module II 2) One session BEFORE the last session of Module II, administer “Process Questionnaire” to each group member 3) The last session of Module II, administer “Mid-Group Questionnaire” to each group member 4) During the week of the last session of Module II, ask the Head Teacher of each group member and each wait-listed student to complete the Teacher Child Rating Scale. (UNICEF will pay teachers 4 DEM for each questionnaire they complete). 5) During the week of the last session of Module II, ask each group member and each wait-listed student to take home the Parent Child Rating Scale and to ask his/her parent to complete it and to return it to you in the sealed envelope. UNICEF will contribute 4 DEM to your group for treats for each set of group member/parent questionnaires that are completed.
7. 1 May	<ol style="list-style-type: none"> 1) Implement Module IV 2) TWO sessions BEFORE the last session of Module IV, administer “Process Questionnaire” to each group member. 3) One session BEFORE the last session of Module IV, administer “Post-Group Questionnaire” (to be delivered to you) to each group member. 6) During the week of the last session of Module IV, ask the Head Teacher of each group member and each wait-listed student to complete the Teacher Child Rating Scale. (UNICEF will pay teachers 4 DEM for each questionnaire they complete). 4) During the week of the last session of Module IV, ask each group member and each wait-listed student to take home the Parent Child Rating Scale and to ask his/her parent to complete it and to return it to you in the sealed envelope. UNICEF will contribute 4 DEM to your group for treats for each set of group member/parent questionnaires that are completed.
8. Fall 2001	<ol style="list-style-type: none"> 1) Administer 4-month Follow-Up Post-Group Questionnaire to group members and wait-listed students who are still attending your school.

Implementation Plan Flow Chart



Appendix C:

Overview of Trauma/Grief-Focused Group Treatment

Overview of Trauma/Grief-Focused Group Psychotherapy

Group Treatment Component	Module I (6 sessions)	Module II (8-12 sessions)	Module III (4 sessions)	Module IV (3 sessions)
Module Title	Group Cohesion, Psychoeducation, and Basic Coping Skills	Working Through Traumatic Experiences	Coping with Traumatic Loss And Grief	Re-Focusing on the Present, and Looking to the Future
Therapeutic Tasks	<ul style="list-style-type: none"> • Introduction and program overview • Discussion: Barriers to group participation • Group contract • Psychoeducation: posttraumatic stress, grief, and depression symptoms • Psychoeducation: trauma and loss reminders • Skill: Distinguishing thoughts from emotions • Skill: labeling emotions • Skill: The event-thought-feeling link • Skill: Challenging hurtful thoughts with helpful thoughts • Skill: “Five steps to good communication” • Relapse prevention exercise: Developing a coping plan for the winter holidays 	<ul style="list-style-type: none"> • Relapse prevention exercise: Developing a coping plan for trauma narrative work • Selecting a traumatic event to work on • Constructing the trauma narrative • Exploring the worst moments • Making links between trauma reminders and worst moments • Using trauma reminders to understand the nature and personal meaning of traumatic experiences 	<ul style="list-style-type: none"> • Psychoeducation: Grief symptoms and the loss reminders that evoke them • Psychoeducation: How is grief beneficial? • Psychoeducation: Grief processes (how we grieve) • Psychoeducation: Barriers to healthy grieving (how traumatic loss can interfere with healthy grieving) • Coping with anger • Using loss reminders to understand the impact and personal meaning of a loss • Guided imagery exercise: Constructing a non-traumatic image of the deceased with which to reminisce • Group grieving exercise: Reminiscing with mementos 	<ul style="list-style-type: none"> • Resuming developmental progression • Challenging maladaptive beliefs with adaptive beliefs • Skill: Problem-solving current life adversities • Skill: Learning to tell when a problem is my job to handle • Investing in new and existing relationships • Making plans for the future • Saying goodbye in a good way

Appendix D:

2000-2001 Program Evaluation Instruments Used

Assessment Instruments:

UNICEF Post-War Program for War-Exposed Adolescents

A. Wide-Scale Risk Screening

1) UNICEF Adolescent Post-War Program Screening Survey

Objective: To assist in identifying a small group of adolescents whose histories of trauma exposure and current psychosocial distress place them at high risk for severe, persisting distress and developmental disruption. These adolescents will serve as candidates for specialized trauma/grief-focused group treatment.

Assessment Instruments:

- a. Pre-war life events (Yehuda, 1999; 10 items)
- b. War Trauma Exposure Scale (Layne, Stuvland, Saltzman, Steinberg, & Pynoos, 1999; 55 items)
- c. Open-ended written description of the student's "most traumatic war-related experience" (7 items)
- d. Post-War Trauma Exposure Scale (Layne, Steinberg & Pynoos, 2000; 14 items)
- e. Trauma Reminders Screening Inventory (Layne, Steinberg, & Pynoos, 1998; 17 items)
- f. UCLA Reaction Index-Revised (Pynoos, Rodriguez, Steinberg, & Frederick, 1999; 17 items)
- g. Post-War Adversities Scale (Layne, \apo, & Pynoos, 1999; 26 items)
- h. Depression Self-Report Scale (Birelson, 1987; 19 items)
- i. Youth Outcome Questionnaire Somatization subscale (Burlingame, Wells, & Lambert, 1999; 8 items)
- j. Loss Reminders Screening Inventory (Layne, Savjak, Steinberg, & Pynoos, 1999; 17 items)
- k. Grief Screening Inventory-Brief Form (Layne, Steinberg, Savjak, & Pynoos, 1999; 13 items)

□ **Total number of items in the screening survey = 195 items**

2) **Personal Referrals**

Objective: To assist in identifying a small group (approximately 20) of adolescents whose histories of trauma exposure and current psychosocial distress place them at high risk for severe, persisting distress and developmental disruption. These adolescents will serve as candidates for specialized trauma/grief-focused group treatment.

Assessment Instruments (all of which are informal and involve referrals):

- a. Psychoeducational presentations to students, teachers, school administrators, and parents (as appropriate) regarding the long-term effects of trauma exposure (PTSD, depression, grief, somatic problems, academic problems, etc.)
- b. Teacher, administrator, parent, peer, and student self-referrals to the school pedagogue or psychologist

B. Individual Screening Interview

1) Screening Interview

Objective: To evaluate (approximately 20) high-risk candidates concerning their appropriateness for (a) group treatment, (b) individual work, or (c) referral to highly specialized mental health services in the community. The Screening Interview will be used to collect very important pre-group information that will help us to evaluate program effectiveness. All measures are contained in the Screening Interview Self-Report Form.

Assessment Instruments:

- a. Student Self-Rating Scale (Hightower, 1999; 40 items)
 - b. Youth Outcome Questionnaire Social Problems subscale (Burlingame, Wells, & Lambert, 1999; 8 items)
 - c. Grief Screening Inventory (Layne, Steinberg, Savjak, & Pynoos, 1999; 23 items)
 - d. Cognitive Distortions Scale (Briere, 1999; 40 items)
 - e. Adolescent Self-Efficacy Scale, Social Interaction, Self-Regulation, Enlisting Support, and Self-Assertiveness subscales (Bandura, 1992)
 - f. Attitudes towards help-seeking, and towards participation in group treatment (Burlingame, Davies, & Layne, 2000; 15 items)
 - g. Locus of Control Scale (Mirowsky, 1992; 8 items)
 - h. Provision of Social Relations Scale (a measure of social support; Turner, Frankel, & Levin, 1983; 15 items)
 - i. **Total number of items in the Screening Interview = 149 items**
- 2) **Parent Observational Report**
- a. Parent-Child Report Scale (Hightower, 1999; 43 items).
 - b. Youth Outcome Questionnaire Social Problems and Somatization subscales (Burlingame, Wells, & Lambert, 1999; 16 items)
 - c. **Total number of items in the Parent Observational Questionnaire: 66 items**
- 3) **Teacher Observational Report**
- a. Teacher-Child Report Scale (Hightower, 1999; 32 items).
 - b. Youth Outcome Questionnaire Social Problems and Somatization subscales (Burlingame, Wells, & Lambert, 1999; 16 items)
 - c. **Total number of items in the Parent Observational Questionnaire: 56 items**

C. Pre-Group Clinical Interview:

1) **Pre-Group Clinical Interview**

Objective: To prepare (between 8-10) youths who have been selected to participate in group treatment.

Assessment Instruments:

- a. Pre-Group Individual Interview (Layne, Saltzman, Steinberg, & Pynoos, 1999).
- b. NOTE: No formal evaluation data will be collected in the pre-group clinical interview (to be held only with students who have been selected to participate in the group). Please devote your efforts to building rapport and to preparing the student/group leader team to work together in the group. Please do not use the "supplementary self-report form" used in the clinical interview in past years. Instead, focus on identifying a traumatic experience and constructing a time-line that will help each new group member to develop a "developmental" perspective.

D. Mid-Group and End-Group Evaluation

Objective: To reduce psychological distress and increase positive adaptation in trauma-exposed youths.

Assessment Instruments:

A. Group Process Instruments (to be administered to group members only, at the second-to-last session of Modules I, II, and IV):

- a. Self-Satisfaction Survey (10 items)
- b. Group Climate Questionnaire (12 items)
- c. Curative Climate Inventory (30 items)

B. Measures of Distress (to be administered to group members at the ends of Modules I, II, and IV; to be administered to wait-listed students at the ends of Modules II and IV).

- a. UCLA Reaction Index-Revised (Pynoos, Rodriguez, Steinberg, & Frederick, 1999; 17 items)
- b. Depression Self-Report Scale (Birelson, 1987; 19 items)
- c. Grief Screening Inventory (Layne, Steinberg, Savjak, & Pynoos, 1999; 23 items)
- d. Cognitive Distortions Scale (Briere, 1999; 40 items)
- e. Youth Outcome Questionnaire Somatization and Social Problems subscales (Burlingame, Wells, & Lambert, 1999; 16 items)

C. Parent Observational Report

- a. Parent-Child Report Scale (Hightower, 1999; 43 items).
- b. Youth Outcome Questionnaire Social Problems and Somatization subscales (Burlingame, Wells, & Lambert, 1999; 16 items)
- c. **Total number of items in the Parent Observational Questionnaire: 66 items**

D. Teacher Observational Report

- a. Teacher-Child Report Scale (Hightower, 1999; 32 items).
- b. Youth Outcome Questionnaire Social Problems and Somatization subscales (Burlingame, Wells, & Lambert, 1999; 16 items)
- c. **Total number of items in the Parent Observational Questionnaire: 56 items**

C. Social Support (to be administered to group members at the ends of Modules I, II, III, and IV; to be administered to wait-listed students at the ends of Modules II and IV).

- a. Provision of Social Relations Scale (Turner, Frankel, & Levin, 1983; 15 items)

- **Total number of items in the Mid-Group and End-Group Questionnaire = 182 items for group members (including group process measures), 130 for wait list students.**