

Contents lists available at [ScienceDirect](#)

Journal of Adolescence

journal homepage: [www.elsevier.com/locate/jado](http://www.elsevier.com/locate/jado)

## Building psychosocial assets and wellbeing among adolescent girls: A randomized controlled trial



Katherine Sachs Leventhal <sup>a,\*</sup>, Jane Gillham <sup>b</sup>, Lisa DeMaria <sup>c</sup>, Gracy Andrew <sup>d</sup>, John Peabody <sup>c,e</sup>, Steve Leventhal <sup>a</sup>

<sup>a</sup> CorStone, 250 Camino Alto, Suite 100A, Mill Valley, CA 94941, USA

<sup>b</sup> Department of Psychology, Swarthmore College, 500 College Avenue, Swarthmore, PA, USA

<sup>c</sup> QURE Healthcare, 1000 Fourth St., Suite 300, San Rafael, CA, USA

<sup>d</sup> CorStone India, A 91, Amritpuri, First Floor, Opp. Isckon Temple, East of Kailash, New Delhi 110065, India

<sup>e</sup> Global Health Sciences, University of California, San Francisco, 550 16th St., 3rd Floor, San Francisco, CA 94158, USA

### ARTICLE INFO

#### Article history:

Available online 11 November 2015

#### Keywords:

Resilience  
Self-efficacy  
Psychological wellbeing  
Social wellbeing  
Adolescent girls  
India

### ABSTRACT

We conducted a randomized controlled trial of a 5-month resilience-based program (Girls First Resilience Curriculum or RC) among 2308 rural adolescent girls at 57 government schools in Bihar, India. Local women with at least a 10th grade education served as group facilitators. Girls receiving RC improved more (vs. controls) on emotional resilience, self-efficacy, social-emotional assets, psychological wellbeing, and social wellbeing. Effects were not detected on depression. There was a small, statistically significant negative effect on anxiety (though not likely clinically significant). Results suggest psychosocial assets and wellbeing can be improved for girls in high-poverty, rural schools through a brief school-day program. To our knowledge, this is one of the largest developing country trials of a resilience-based school-day curriculum for adolescents.

© 2015 The Authors. Published by Elsevier Ltd on behalf of The Foundation for Professionals in Services for Adolescents. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Today, 90% of the world's children and adolescents live in Low and Middle Income Countries (LMICs),<sup>1</sup> where chronic adversity, such as child labor, physical or sexual abuse, teenage marriage and pregnancy, parental death, and poverty is prevalent (Benjet, 2010; Kieling et al., 2011). Such chronic adversity predicts poor mental health, with studies suggesting that childhood adversity accounts for nearly half of all childhood-onset disorders and more than a quarter of adult or later-onset disorders (Green et al., 2010). Poverty, in particular, exists in close, cyclical relationship with poor mental health in LMICs,

\* Corresponding author. Tel.: +1 415 388 6161.

E-mail addresses: [kates@corstone.org](mailto:kates@corstone.org) (K.S. Leventhal), [jgillha1@swarthmore.edu](mailto:jgillha1@swarthmore.edu) (J. Gillham), [ldemaria@quirehealthcare.com](mailto:ldemaria@quirehealthcare.com) (L. DeMaria), [gracya@corstone.org](mailto:gracya@corstone.org) (G. Andrew), [jpeabody@quirehealthcare.com](mailto:jpeabody@quirehealthcare.com) (J. Peabody), [stevel@corstone.org](mailto:stevel@corstone.org) (S. Leventhal).

<sup>1</sup> Abbreviations used throughout this manuscript: AIC (Akaike Information Criterion); BIC (Bayesian Information Criterion); CD-RISC 10 (Connor-Davidson Resilience Scale 10-item version); CYRM-B (Child and Youth Resilience Measure Brief version); DiD (Difference-in-Difference analysis); ES (Effect Size); GAD-7 (General Anxiety Disorder scale 7-item version); GENVP (Gramin Evam Nagar Vikas Parishad, an NGO in Patna, India); HC (Girls First Health Curriculum); HIC (High Income Country); IDF (Integrated Development Foundation, an NGO in Patna, India); KIDSCREEN-PW (KIDSCREEN-52 Psychological Wellbeing subscale); KIDSCREEN-SW (KIDSCREEN-52 Social Wellbeing subscale); LMIC (Low and Middle Income Country); MT (Master Trainer); NGO (Non-governmental organization); OLS (Ordinary Least Squares); PF (Program Facilitator); PHQ-9 (Patient Health Questionnaire 9-item version); RC (Girls First Resilience Curriculum); SC (School as usual control); SDQ (Strengths and Difficulties Questionnaire); T1 (Time 1); T2 (Time 2); WHO (World Health Organization).

where living in poverty predicts poor mental health, which in turn predicts poverty (e.g., Lund et al., 2011; Saraceno, Levav, & Kohn, 2005).

Globally, girls and women are at higher risk than boys and men for many psychological disorders, particularly internalizing disorders (e.g., depression, anxiety; Kessler, 2003; Lewinsohn, Gotlib, Lewinsohn, Seeley, & Allen, 1998; Nolen-Hoeksema, 2001; WHO, 2002). A combination of biological (e.g., hormones), psychological, and social factors (e.g., lack of control or power) are likely responsible for this difference (Nolen-Hoeksema, 2001; WHO, 2002). Adolescent girls in LMICs may be particularly at-risk as they often face much greater adversity than their male peers, including gender-based discrimination and violence, early discontinuation of their education, and child trafficking (International NGO Council on Violence Against Children, 2013; Rafferty, 2013).

Adolescence in LMICs therefore provides a critical window for psychosocial intervention with girls. One intervention approach of particular relevance is based on a resilience framework. Over the last decades, researchers have studied “resilient” individuals who achieve positive life outcomes despite adversity, challenges or risks, including poverty (e.g., Luthar, Cicchetti, & Becker, 2000; Masten, 2001). Interventions developed from this research aim to build assets or protective factors that increase the likelihood that those at-risk will achieve positive outcomes (Masten & Obradovic, 2006; Zolkoski & Bullock, 2012).

Resilience-based interventions often target psychosocial assets such as persistence, tolerance of negative affect, self-efficacy, planning, and prosocial behaviors (e.g., empathy, kindness, teamwork, and other social skills). In previous studies, aspects of resilience (e.g., persistence and tolerance of negative affect) have moderated the relationship between adversity (e.g., childhood trauma) and psychological problems (e.g., depression and anxiety; Campbell-Sills, Cohan, & Stein, 2006), and self-efficacy has predicted psychological wellbeing (lower depression; greater life satisfaction; Karademas, 2006). Prosocial behaviors have been found to predict child and adolescent social adjustment and attachment (Crick, 1996; Wentzel, 1994).

Interventions targeting these assets (often termed resilience, social-emotional learning, life skills, or positive youth development interventions) have been shown to improve children’s behavioral symptoms (e.g., aggression, school suspensions), emotional distress (e.g., depression, anxiety), attitudes towards themselves and others (e.g., self-efficacy, beliefs about helping others), social and emotional skills (e.g., problem solving, decision making), and physical and academic wellbeing (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Gavin, Catalano, David-Ferdon, Gloppen, & Markham, 2010; Martin & Marsh, 2006; Payton et al., 2008). Though such interventions could confer large benefits for LMIC adolescents, 90% of randomized controlled trials of mental health interventions for youth have been conducted in HICs (Kieling et al., 2011).

In HICs, many such interventions have been conducted in schools (e.g., Gillham et al., 2013; Schultz & Mueller, 2007). While school-based delivery may present a low-cost, direct, and scalable point of access to LMIC youth, a recent review of mental health promotion interventions in LMICs revealed only 13 school-based interventions with studies using a comparison or control group since 2000 (Barry, Clarke, Jenkins, & Patel, 2013). Only six were life skills or resilience-based programs implemented universally (i.e., not confined to high-risk children). Results from the review were promising, however, as many programs positively affected psychosocial assets and wellbeing, including self-efficacy, coping skills, anxiety and depression (Barry et al., 2013). Unfortunately, none of the programs targeted girls specifically.

This dearth of programs (for LMIC youth in general and girls in particular) may be in part due to the many challenges of conducting school-based psychosocial programs in LMICs, such as the lack of mental health providers (e.g., Saxena, Thornicroft, Knapp, & Whiteford, 2007), the potentially different manifestations of psychosocial issues across cultures (e.g., Kleinman & Good, 1985), the multiple language barriers, and the lack of qualified and motivated teachers (e.g., Chaudhury, Hammer, Kremer, Muralidharan, & Rogers, 2006). Working with girls in LMIC schools presents specific challenges, as girls often face harassment and discrimination from peers and teachers alike, while in school and on the way to school (Global Campaign for Education, 2012). Thus, it will be necessary to develop and test programs that address these challenges from the outset.

Since 2009, CorStone, a US-based non-profit organization, has developed and piloted one of the first resilience-based curricula for middle-school girls in LMICs. The curriculum, called the Girls First Resilience Curriculum (RC), is designed to be low-cost, flexible, and scalable. RC pilots in India suggest high feasibility and acceptability, and preliminary evidence shows positive effects on psychosocial assets and wellbeing. For example, in a 2009 uncontrolled trial in Delhi among low-income Muslim girls at a non-formal school,<sup>2</sup> 81% of girls attended all program sessions, and the percentage of girls with normal mental health scores on the Strengths and Difficulties Questionnaire (Goodman, 2001) increased during the RC from 53% to 64% ( $p < 0.05$ ). In Surat, India, in a 2011 observational pilot with matched controls among high-poverty, low caste, urban slum-dwelling girls, qualitative reports indicated girls enjoyed the RC and found it highly relevant to their lives. Program attendance predicted greater increases in self-reported optimism and prosocial behavior and decreases in conduct and peer problems, which was maintained through follow-up assessments conducted 8-months after program completion ( $p$ 's  $< 0.05$ ). Despite these promising findings, the RC has not yet been evaluated with a large randomized controlled design.

<sup>2</sup> Though definitions of non-formal schools vary, in this case we refer to a school that targets children who are currently not participating in the formal government or private school system. A non-formal school often operates outside of normal school hours and often on an as-needed basis, providing specialized attention as needed, with the goal of ultimately transferring children back to the formal government or private school system when they are ready.

Download English Version:

<https://daneshyari.com/en/article/7241432>

Download Persian Version:

<https://daneshyari.com/article/7241432>

[Daneshyari.com](https://daneshyari.com)