DIFFERENCES IN RESILIENCE AMONG AFRICAN-AMERICAN, INNER CITY STUDENTS WITH AND WITHOUT SEVERE DISRUPTIVE BEHAVIORS

A Chapter Style Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Education Specialist

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DIFFERENCES IN RESILIENCE AMONG AFRICAN-AMERICAN, INNER CITY
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ABSTRACT


Students labeled as EBD have the poorest academic and life outcomes of any category of special education students, due to inappropriate, problematic behaviors and lack of social skills and problem-solving skills. The current study examined differences in resilience between African American inner city students placed in EBD/MRP classrooms due to severe behavior problems and African American inner city students in regular education to see if lower self-ratings in resilience (social bonding, personal competence, and/or social competence) to deal with the life stresses and risk factors might account in part for students being placed in EBD/MRP classrooms. Data was collected through self-ratings on the Individual Protective Factors Index: A measure of adolescent resilience and results for the samples were compared using an independent samples t-test. No significant differences were found between the two samples on the domains of Social Bonding, Personal Competence, and Social Bonding. A statistically significant difference was found between Personal Competence as compared to Social Competence and Social Bonding for the combined sample, with Personal Competence being significantly higher. Strategies for schools, teachers, and school psychologists to increase positive outcomes for students labeled as EBD as well as suggestions for promoting resilience among all students were discussed.
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CHAPTER I

REVIEW OF LITERATURE AND OVERVIEW OF THE PROBLEM

Review of Literature

Definition of Emotional Behavioral Disability

An Emotional Behavioral Disability (EBD) is an educational disability category used in the schools for children with emotional or behavioral problems that are so significant that they severely impact their ability to learn and succeed in the regular classroom.

The state of Wisconsin’s criteria for special education categories is guided by federal standards, delineated in the Individuals with Disabilities Education Act. According to federal criteria outlined in the Individuals with Disabilities Education Improvement Act (2004), EBD is defined as social, emotional, or behavioral functioning that so departs from generally accepted, age-appropriate ethnic or cultural norms that it adversely affects a child’s academic progress, social relationships, personal adjustment, classroom adjustment, self-care, or vocational skills. These behaviors must be severe, chronic, and frequent; they also must occur in school and one other setting (home or the community). These behavior and emotional concerns exhibit themselves as depression or anxiety, aggression, an inability to form relationships, or withdrawal. By the very nature of their disability, students with EBD can be some of the most difficult students to manage within the school, and these difficult behaviors significantly impact their
learning. Kutash and Duchnowski (2004) conducted a study on the psycho-social characteristics of students labeled as EBD in urban communities. Ten schools in urban cities participated in the study; the sample consisted of 158 students with a mean age of 11.8. The sample was 85% male and 83% African American. The parents of 158 students labeled as EBD were administered the Child Behavior Checklist and the Columbia Impairment Scale. The students were administered the Wide Range Achievement Test-III. Kutash and Duchnowski (2004) found that students labeled with EBD have low average to average intelligence yet they are often almost two years behind their regular education peers in academic achievement. Students with this disability have difficulties across multiple domains of life that often affect them often throughout their lives. This study also found “elevated scores on the Child Behavior Checklist indicating a high level of symptomology that was interfering with functioning as measured by the Columbia Impairment Scale” (Kutash & Duchnowski, 2004, p. 245).

**Risk Factors for Being Labeled as EBD**

Research has shown that certain factors increase the chances that a child will be labeled EBD, including being African American, male, coming from poverty, and coming from a single parent household. Based on the findings from the National Longitudinal Study-2, African American students were “more likely to be identified as being EBD than any other racial/ethnic group” (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005, p. 80). The National Longitudinal Study-2 was a study intended to create a national picture of the lives of high school youth with disabilities and their transition to early adulthood. For this study, 1,077 students ages 13-16 were selected from 501 randomly-selected school districts and parents of the students were interviewed (Wagner,
et. al.). This study found that 25% of students labeled as EBD are African American, even though African Americans only represent 14% of the population of the United States (Wagner & Cameto, 2004). African American children are labeled as EBD at a disproportionately high rate.

Regardless of race, boys are more likely than girls to exhibit academic and behavioral problems. According to national data from the National Longitudinal Study-2, the biggest difference in identification for boys and girls is in the EBD category, which is 80% male (Wagner et al., 2005). Gender differences could be related to how boys and girls respond to life stressors and risk factors. Research suggests that girls tend to have higher rates of eating disorders and depression while boys are more likely to demonstrate impulsivity problems or acting out behaviors (Cove, Wiseman, & Popkin, 2005). That is, girls tend to internalize stress whereas boys tend to externalize and demonstrate behavior problems. Although both forms of mental health issues cause problematic functioning, externalizing problems are more likely to be referred and identified in schools because they are more disruptive to the classroom and school environment, therefore more easily observed and intervened upon.

It is critical to note the particularly high rate at which African American males are identified as EBD. Coutinho, Oswald, Best, and Forness (2002) used data collected by the U.S. Department of Education Office of Civil Rights to compile an Elementary and Secondary School Civil Rights Compliance Report to examine the status of civil rights in the schools. Coutinho et al. (2002) used a sample from this data set consisting of 4.151 school districts serving over 24 million students to examine the effects of gender, ethnicity, and sociodemographic factors on the proportion of students in a school district
who were identified with EBD. Coutinho et al. (2002) found that “both individual student characteristics such as gender and ethnicity and communities’ demographic characteristics influence the likelihood of being identified as a student with EBD” (p. 120). Coutinho et al. (2002) found that, in their sample:

“African American males were 5.5 times more likely to be identified as EBD as compared to Caucasian females; African American females were 1.4 times as likely to be identified as compared to Caucasian females; and Caucasian males were 3.8 times as likely as Caucasian females to be identified as EBD” (p. 116).

Could disproportionate identification as EBD by race be related to actual differences in emotional and behavioral problems? The research would suggest not. According to Coutinho et al. (2002):

“Previous epidemiological data has indicated that, when other risk factors such as parental socioeconomic status are controlled, racial and ethnic differences in the prevalence of behavior problems are minimal; this suggests that race and ethnicity are neutral in relation to actual incidence of emotional and behavioral disorders” (p. 110).

This suggests that, in reality, race and ethnicity in and of themselves are not related to actual differences in rates of emotional and behavioral disturbance, suggesting bias in assessment or external factors, such as socioeconomic status, being related to differential identification rates. The reasons for the high identification rate of African-American males appear to be complex, including bias in the referral and assessment procedure, cultural and environmental differences, and the socio-historical context in which minority individuals are perceived (Kutash & Duchnowski, 2004).
Students attending inner city schools have an increased chance of coming from poverty, which is at the root of many other risk factors. Poverty is “positively associated with identification of emotional disturbance in children” (Coutinho et al., 2002, p. 120). According to a report from the National Longitudinal Transition Study-2, 30% of children identified as EBD live in poverty, whereas national data indicates that only 20% of all children live in poverty (Wagner & Cameto, 2004). That is, children living in poverty are labeled as EBD at a disproportionately high rate. It is hypothesized that students living in poverty are more likely to be identified as EBD because of a complex interaction between student characteristics, socio-demographic factors, and many other negative factors associated with inner city poverty and racial bias. As noted by Kutash and Duchnowski (2004), almost every aspect of family life such as health, productivity, physical environment, emotional well-being, and family interactions are negatively impacted by poverty. Coutinho et al. (2002) found that there are student characteristics along with socio-demographic factors that interact with poverty to impact student outcomes. Specifically, “disproportionally for students of color increases as poverty increases, indicating that the differential effect of poverty across gender/ethnicity groups is greater in districts with relatively high poverty rates” (Coutinho, 2002, p. 120).

One specific risk factor that is often related to poverty is single parenthood. According to Shonkopf and Phillip (2000), poverty plays a big role in identification of EBD, but it is unclear if poverty alone is the major contributor or if it is the circumstances that often accompany poverty that contribute to these outcomes; the negative effects associated with coming from a single-parent household may be particularly serious. The National Longitudinal Transition Study-2 found that only 49% of students labeled as
EBD came from a two parent household as compared to 74% for national data (Wagner & Cameto, 2004). Children from single parent households are labeled as EBD at a disproportionately high rate. Overall, the National Longitudinal Transition Study-2 found that the chance of a child being identified as EBD increases with being African American, male, coming from poverty, and coming from a single-parent household (Wagner & Cameto).

In addition to the effects of poverty and single parenthood, the association between poverty and mental health also contributes to overidentification as EBD. According to Wagner et al. (2005), poverty is correlated with mental illness. The U.S. Department of Health and Human Services (2001) estimates that people in the lowest strata of income, education, and occupation are two to three times more likely to have a mental health disorder than people in the highest strata. This suggests that both parents and children living in poverty have a greater risk of developing a mental illness; thus adding additional stress to a family living in poverty. Parental mental illness may negatively impact a parent’s ability to raise their children, keep a job, and lead their lives and the lives of their families in a positive way. Overall, a single parent with mental illness contributes additional risk factors for social, emotional, and behavioral difficulties in their children.

Research has shown a clear constellation of risk factors for being labeled as EBD, many of which occur at a higher frequency in the inner city. In summary, students labeled as EBD have a cluster of characteristics that are associated with poorer outcomes than the general population, including being African American, being male, living in poverty, having a head of household with no formal education beyond high school,
coming from a single parent household, and having a parent suffering from mental illness. (Wagner & Cameto, 2004).

**Educational Quality and Outcomes for Students with EBD**

Some concern exists with regard to the quality of special education for students labeled as EBD. Specifically, students with EBD are more likely to be served in more restrictive settings when compared to students with other educational disabilities (Boreson, 2006). This problem is more significant for inner city students labeled as EBD. Once inner city students are identified EBD, chances are that they will spend more time in a special education setting when compared to national data for students with EBD. In a study conducted by Kutash and Duchnowski (2004), students with EBD in inner cities on average spend more time in special education when compared to the national average. Specifically, throughout the course of the school day, an average of 81% of the students with EBD in inner city schools spend between 61% and 100% of their school day in the special education classroom compared to 52% of students with EBD in non-inner city schools (Kutash & Duchnowski, 2004). This discrepancy is particularly alarming because of the implications it has on the nature and quality of education that inner city students with EBD are receiving when compared to both their regular education peers and to other students with EBD living in suburban or rural settings. Being serviced in more restrictive settings is problematic because it limits students’ access to appropriate peer models, rigorous curriculum, school-based opportunities, and to regular education on the whole.

Regardless of where they live, students labeled as EBD struggle in school and in life in general as a result of their disability. Jolivette, Srichter, Nelson, Scott, and
Liaupsin (2000) conducted a review of previous research conducted in the area of post-school outcomes for students labeled as EBD. According to Jolivette et al., previous research tends to demonstrate that students with EBD experience the least favorable outcomes of any group of students with disabilities, although it is important to note that these authors reported methodological concerns with sample sizes used and lack of consistent methodology. As compared to students with other disabilities, students with EBD are more likely to have lower grades, fail more classes, fail minimum competency exams, be retained, skip school, be served in more restrictive settings, have more encounters with the juvenile justice system, and fail to graduate from high school (Boreson, 2006). Another factor that affects the quality of education that students receive is the number of schools they have attended. Data from the National Longitudinal Transition Study-2 indicates that students labeled as EBD experience more school mobility than other youth with disabilities, with 40% of students labeled as EBD having gone to five or more schools since starting kindergarten through graduation (Wagner & Cameto, 2004). Frequently, these changes in schools are due to reassignment to another school in the district, rather than family relocation (Wagner & Cameto). This causes disruption in their learning and in the relationships they can build with school staff and other students. Different schools means different teachers, students, behavioral expectations, and curriculum. For students who struggle to succeed in school, community, and home environments, these drastic changes could negatively impact their abilities to adjust and fit in.

In terms of school experience, students labeled as EBD are more likely than students with other disabilities to be involved in bullying or fighting (as victims or
perpetrators) while coming to, being at, or going home from school; they are also suspended twice as frequently as students with other disabilities (Wagner & Cameto, 2004). In terms of grades, even though their reading and math abilities are, on average, closer to grade level than those of students with other disabilities, students labeled as EBD are more likely to receive poor grades (Wagner & Cameto). Bullying and fighting, frequent suspensions, and poor grades in spite of skills all contribute to a negative school experience for these students. These negative experiences may be connected to another alarming fact for students labeled as EBD—the high school graduation rate with a regular high school diploma. The Condition of Education is a national study on the state of education in the United States conducted for the U.S. Department of Education. According to findings cited in The Condition of Education 2009, between 1996–97 and 2005–06, the percentage of students with disabilities exiting school with a regular high school diploma was 57 percent (Planty, et al., 2009). Only 43% of students labeled as EBD earned a regular high school diploma; the only disability with a lower rate of earning a regular high school diploma was Cognitive Disability (37%) (Planty et al.). For students in regular education, the graduation rate with a regular diploma within 4 years was 73.2 percent (Planty, et al.). Obviously, obtaining a high school diploma impacts a student’s enrollment in post-secondary education, as well as their quality of future employment.

Clearly, the school outcomes of many students labeled as EBD are negative, but what are the reasons for these outcomes? As cited by Jolivette et al. (2000), the reason for poor outcomes—in school, society, and adulthood in general—are the maladaptive characteristics that define the EBD label, including the lack of ability to maintain
appropriate social relationships, academic difficulties across multiple domains, and the display of chronic behavior problems (noncompliance, aggression, and disrespect towards authority figures). The behavior problems and academic difficulties tend to create a cycle in which each problem exacerbates the other (Arnold et al., 1999). The very symptoms that define an emotional behavioral disorder—the very reasons that they were labeled and given special education—are the proximal cause of most of the problems that lead to a high rate of school and life failure.

School is a struggle, but even after school completion or dropout, problems plague these students into and throughout adulthood. As cited by Boreson (2006), later in life, students with EBD have the highest risk for unemployment and becoming homeless when compared to students with other labels. Females with EBD are six times more likely to have multiple pregnancies at a young age and lose custody of their children (Boreson). In the workforce, individuals with EBD experience longer delays in finding employment after leaving school, lower percentages of employment, and more unstable employment (Jolivette, et al., 2000). In terms of long-term social adjustment, individuals with EBD struggle more than other demographic groups, often as a result of the social, emotional, and behavioral problems that originally qualified them to receive services under the EBD label, such as lack of appropriate social skills, emotional regulation, and problem-solving skills. Specific reasons for these difficulties in adjustment can include an inability to form constructive relationships with people who can positively contribute to their lives and provide support and the lack of positive, healthy support networks (Jolivette et al.). Poor social adjustment and lack of positive influences, when coupled with emotional and behavioral problems, increases the chances of negative interactions.
within their communities, which lead to much higher chances of arrest and incarceration (Jolivette et al.). These risk factors (lack of social skills, emotional regulation, positive adult supports, etc.) lead to a lower resilience in the face of life stressors, such as finding and holding a job, maintaining stable relationships, and making healthy choices.

**Resilience**

When looking at outcomes for students growing up in adverse conditions, such as poverty, the concept of resilience is often cited as the reason for differential outcomes for children growing up in environments with similar stressors and risk factors. For instance, many inner city students have to cope with poverty, single parenthood, violence, and a plethora of other risk factors; however, most also are not labeled as EBD. Why do many children function adequately in school, yet some suffer academically and behaviorally? Perhaps the difference could be in disparate levels of resilience. Resilience is often defined as “adapting well in the face of major life stress” (Magnus, Cowen, Wyman, Fagen, & Work, 1999, p. 473). Expanding on that definition, Cove et al. (2005) further describe resilience as “a process of, or capacity for, successful adaptation despite challenging and threatening circumstances” (p. 2). Research has tied resilience to positive outcomes in the face of the many negative risk factors confronting children growing up in the inner city. Several longitudinal studies have found that “between half and two-thirds of children growing up in families with mentally ill, alcoholic, abusive, or criminally involved parents or in poverty-stricken do overcome the odds and turn a life trajectory of risk into one that manifests as ‘resilience’” (Bernard, 1995, p. 2). The good news is that even in the face of many risk factors, approximately over half of these students overcome this adversity due in part to their own resilience.
Meta-analysis of research in the area of resilience has yielded two categories of protective factors that are consistently associated with resilience: children’s own psychological characteristics and family characteristics (Cove, et al., 2005). There are individual, internal resilience (skills, traits, and coping strategies unique to the child) and external resilience factors (such as parenting, school, Socio-Economic Status, positive relationships with adults) (Cove, et al.).

Touching briefly on external factors and their impact on resilience for African American youth, previous research has indicated that parent factors and parenting style can significantly impact child resilience. The HOPE VI Panel Study looked at resilience of children living in public housing that participated in the HOPE VI program. The HOPE VI program targeted impoverished public housing projects across the United States, aiming to improve physical living environments as well as supporting the social and emotional needs of those who live in them. The data was collected from interviews with the heads of households of 374 children between the ages of 6 and 17 in 2003. According to results from the HOPE VI Panel Study, external factors that promoted resilience and more positive outcomes included “parents who have completed high school, are more engaged in their child’s education, and are not depressed” (p. 13).

Jambunathan and Burts (2003) conducted a study using 205 three to five-year-olds of Asian-American, Asian-Indian, Hispanic, native European-American, and African-American preschoolers, comparing children of different races on self-competence (feeling of confidence in achieving certain tasks) as measured by the Pictorial Scale of Perceived Competence and Social Acceptance. This study found that African American children consistently had higher perceptions of self-competence than
children from other racial groups (Jambunathan & Burts, 2003). The researchers postulated that this could be linked to previous research suggesting African American parents tend to be stricter in their parenting styles than Caucasian parents, requiring higher levels for accepting personal responsibility, self-help care, more independent decision-making, and encouragement to openly express their positive and negative emotions (Jambunathan & Burts, 2003).

A study conducted by Kwon et al. (2006) examined the relationship between maternal expressed emotion (as measured by the Five Minute Speech Sample) and children’s perceived self-competence, behavior, and intelligence in a community sample of 190 urban, African American children ages six to seven as measured by self reports and standardized measures. This study found that, “compared with low emotional expressiveness, high emotional expressiveness was associated with children’s decreased cognitive self-concept, increased anxiety, and greater levels of hyperactivity” (Kwon et al., p. 195). According to Kwon et al., “high maternal emotional expressiveness in the form of criticism and emotional over-involvement has been found to be associated with identification as EBD, child anxiety, hyperactive behaviors, and lower perceived cognitive competence at the early school age” (p. 195).

For the purposes of this study, only a select piece of resilience was examined—individual resilience—as this is an area that schools can target for improvement. Specifically, this study will examine individual protective resilience factors, as some of these skills can be taught and developed within the schools. Individual protective resilience factors are generally described in research as characteristics or personality traits of the child, such as activity level, disposition, responsiveness to people, social
orientation, communication skills, ability to focus, self-concept, internal locus of control, and desire to improve self (Werner & Smith, 1993). According to Cove et al. (2005): resilient children tend to have “strong social skills and personal characteristics that protect them against stress, such as internal locus of control, strong ego development, perseverance, optimism, and self-efficacy” as well as the ability to deal with change, and a repertoire of social problem solving skills (p. 6).

Smith-Harvey (2004) cited that positive attitudes, positive emotions, and the ability to express emotions increased resilience as well as positive social competence, as it can lead to positive relationships and positive life choices.

The focus of this study was specifically on African American, inner city youth. As such, it is critical to take into account race and culture when considering levels of resilience and resilience factors. The HOPE VI Panel Study found that many students living in inner city housing projects struggled in school and experienced behavior problems; only 1 in 5 appeared to be more resilient than others (Cove et al., 2005). The HOPE VI Panel Study found that “children with higher levels of self-efficacy and social competence are higher in resilience” and less likely to struggle in school and demonstrate behavior problems (Cove et al., p. 13). In addition to these empirically-supported, important resilience factors, African American children may have other factors that exist in part due to the fact that they are still impacted by racism and oppression (The APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008).

Magnus et al. (1999) conducted a study related to the Rochester Child Resilience Project with highly-stressed 4th to 6th grade urban students, 62% of which were minority and 40% of parents on welfare. For the study, the parents of 656 children in nine inner-city
schools rated their children on a number of resilience factors. This study found that, among highly stressed African American children living in urban settings, resilience factors included “perceived competence, positive self-views, empathy, and realistic control attributions” (Magnus et al., p. 1). Barrow, Armstrong, Vargo, and Boothroyd (2007) explored factors associated with resilience in African American children, both internal to the child and ecological, in a review of previous research to provide recommendations for clinical psychologists. Their research found that, for African-American adolescents, “having a strong ethnic identity can act as a protective factor and helps to promote healthy psychological well-being, coping skills, self-esteem, and academic achievement” (Barrow et al., 2007, p. 396-397). In addition to racial identity, their research found racial differences in coping strategies between African American students and Caucasian students. According to their review, African American youth were more likely to use diversions, self-reliance, spiritual support, close friends, demanding activities, and relaxation more frequently than Caucasian students (Barrow et al.).

As resilience is associated with positive life outcomes in spite of stressful life conditions, lower levels of resilience to cope with life stressors and risk factors might be associated with school and behavior problems and being labeled EBD. Perhaps differences in resilience to the adversity of living in inner city poverty could in part explain why some students display problematic behaviors that result in referral and identification of EBD.

According to Benard (1995), “everyone is born with an innate capacity for resilience, through which we are able to develop social competence, problem-solving
skills, a critical consciousness, autonomy, and a sense of purpose” (p. 2). Resilience is something that can be fostered and taught. Based on the research, two strongly supported areas of individual resilience factors appear to be social skills and social problem solving (two skills which can be taught) and internal views of the self and the world (which can be altered) (The APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008; Bernard; Cove et al., 2005; Magnus et al., 1999; Smith-Harvey, 2004; Werner & Smith, 1993). This suggests possible preventative programming that could teach all children the skills they need to function successfully in school and life through increasing resilience; this programming would be particularly important for schools working with students in highly stressful environments, such as the inner city. The resilience framework could point to areas of intervention for students already labeled as EBD to help increase their resilience, thereby increasing the chances that they will experience more positive life outcomes.

**Overview of the Concern**

The school district used in this study was a large, urban school district. The schools which participated in the study were both considered inner city schools. In the school district, there are two different placement options for students labeled as EBD: OHI (Other Health Impairment), and SLD (Specific Learning Disability) with significant behavior problems—resource rooms or Most Restrictive Placement (MRP). A resource room is a special education room where students go to receive services at particular times of the day or during particular classes that are more challenging for them. Students who receive special education services in a resource room still spend at least past of their day in regular education classes, such as science, social studies, or specials (i.e., physical
education, music, art, etc.). MRP rooms are self-contained rooms designed for students whose behavior is so disruptive or uncontrollable that they cannot function within any regular education setting with success. These students are students with any special education label (i.e., not exclusively EBD) whose behavior is so severe that they cannot participate in the regular education classroom at all. Within the Milwaukee Public School District, students were educationally placed in the EBD/MRP classroom based on individual need, regardless of whether or not they were officially labeled as “EBD.” In other districts, the students in EBD/MRP rooms likely would have been labeled EBD, as their behavior problems generally do fit the criteria for EBD. The educational quality in EBD/MRP rooms varies significantly based on a number of factors, including the academic needs and behavioral severity of the students in the class, as well as teacher quality and level of classroom structure.

In response to the need for more effective instruction and support in the EBD/MRP rooms, the school district used in this study created a new initiative called the EBD/MRP Initiative. As a part of this initiative, school psychologists and school social workers go into the EBD/MRP classrooms to provide several different services, including supporting the development of effective classroom management techniques; modeling effective behavior management; fostering positive relationships with the students; and implementing social skills, team-building, or anger management curriculum to help increase functional skills. The ultimate goal of this initiative is to support the students in the classroom to help them better engage in learning and generalize skills learned in the EBD/MRP rooms to a general education setting (and to life in general) so that students can eventually be moved to a less restrictive placement.
The purpose of the current study was to examine differences in social bonding, personal competence, and social competence (resilience) between students in regular education and students in EBD/MRP classrooms. Are there significant differences between students in regular education and students in EBD/MRP classrooms in social bonding, personal competence, and social competence? If so, what are the specific differences? Results from this study could benefit both students in the EBD/MRP classrooms as well as the students in regular education. By comparing differences in social bonding, personal competence, and social competence between students in regular education and students in EBD/MRP classrooms, areas could be targeted for specific intervention within the EBD/MRP classrooms. The group data from regular education students could show overall at-risk targets for preventative intervention through class-wide presentations and activities.
CHAPTER II

METHODS

Participants

The present study was conducted at two schools that were a part of the EBD/MRP Initiative within an urban public school district within a large city located in the Midwest. For the purposes of this study, they were referred to as School A and School B.

Demographically, School A had 92% of students on free and reduced lunch and 94% of students were African-American; during the school year data were collected, 30% of the students were in special education. The EBD/MRP room at School A consisted of nine students ranging from 5th to 8th grade with a range in academic abilities. All nine of the students were African American. Seven of the students were male and two were female. Two students were labeled as SLD, three students were labeled as EBD, and four students were labeled as OHI for Attention Deficit/Hyperactivity Disorder or lead exposure. The teacher in that class had been teaching in EBD/MRP classrooms for approximately ten years. There was also an educational aide present to help assist the students and manage behavior; he had been working in the EBD/MRP room for approximately two months and this was his first time working in that kind of setting. According to personal observations, teacher reports, and incident referrals, primary behavior concerns included physical aggression, talking out, inappropriate language use, non-compliance, walking out of the classroom without permission, and arguing with staff.
School B had 97% of students on free and reduced lunch and 98% of the students were African-American. During the school year data were collected, 40% of the students were in special education. The EBD/MRP classroom at School B consisted of seven students ranging from 5th to 8th grade with a range of academic and cognitive abilities. All of the students were male and African American. Four were labeled as EBD and three were labeled as OHI for ADHD or lead exposure. The teacher in that room was working on her Masters in Education so she could be a fully-licensed special education teacher; that was her first year teaching in a classroom of her own, but she spent a year and a half as a substitute teacher. There was also an educational aide present who had worked as an aide for fifteen years and had spent two years in the EBD/MRP classroom. According to personal observations, teacher reports, and incident referrals, primary behavior concerns included physical aggression, talking out, using inappropriate language, non-compliance, arguing with staff, refusing to work, walking out of the classroom without permission, and running through the hallways after leaving without permission.

As noted in the previous section, although the students placed in the EBD/MRP classrooms were not all labeled EBD, they all had severe behavior problems. The students who participated in this study were placed in EBD/MRP classrooms because their behaviors were unmanageable with less restrictive levels of special education support. For the purposes of this study, these students’ severe behavior problems were considered significant emotional and behavioral problems, even though they were not labeled EBD within this school district.
For the purposes of this study, there were two different samples, students in regular education and students in EBD/MRP classrooms. For the sample of regular education students, the target sample size was 100 participants, 25 students from each of the following grades: fifth, sixth, seventh, and eighth. For the sample of EBD/MRP students, the target sample size was 16 students.

**Data Collection and Evaluation**

**Measure**

Students in EBD/MRP classrooms were compared to students in regular education using a measure called the Individual Protective Factors Index (IPFI): A measure of adolescent resilience. The IPFI was a 71-item questionnaire designed to measure adolescent resilience (Springer & Phillips, 1997). Specifically, the IPFI measured three domains (Social Bonding, Personal Competence, and Social Competence), with each domain having attitudinal dimensions. The IPFI constructs incorporated dimensions most prominently referenced in literature addressing protective factors associated with healthy personal and social development among youths in high-risk environments (Springer & Phillips). The Social Bonding domain was composed of school, family, and pro-social norm dimensions; the Personal Competence domain was composed of self-concept, self-control, positive outlook, and self-efficacy dimensions; and the Social Competence domain was composed of assertiveness, confidence, and cooperation/contribution dimensions. For each domain, an adjusted mean was computed to reflect an overall score in each area. Higher scores on these adjusted means indicated more skills reported by the individual in that particular area. The IPFI included a Risk Factors
portion in addition to the Protective Factors portion. For the purposes of this study, only the Protective Factors portion was used.

The IPFI was piloted on 642 youths ages 10 to 16 and then validated on a sample of 2416 youths; through these studies, reliability and validity has been established (Springer & Phillips, 1997). In terms of reliability, within the Social Bonding domain, the alpha coefficients for the three different dimensions ranged from .48 to .61. Within the Personal Competence domain, the alpha coefficients for the four different dimensions ranged from .56 to .65. Within the Social Competence domain, the alpha coefficients for the three different dimensions ranged from .46 to .65. The overall IPFI had an alpha coefficient of .93. According to Springer and Phillips (1997), “since the analytic focus of evaluation instruments is mean differences, not individual diagnosis, the range of alpha coefficients for subscales indicates adequate internal consistency” (p. 3). In terms of construct validity, the authors looked at convergent and divergent validity. Overall, Protective Factors were negatively correlated with Risk Factors, with correlations ranging from -.04 to -.45. Alcohol and Other Drug Attitudes/Non-Use (the factor within the IPFI that was not used in this study) was positively correlated with Protective Factors, with correlations ranging from .30 to .58.

Procedure

The IPFI was administered to both EBD/MRP classrooms (a total of 16 students), and 102 regular education students in 5th through 8th grade. Active, informed parental consent was obtained prior to the IPFI being administered; students were given the informed choice to participate. Informed consent forms were sent home with students in each grade at two different schools. Parent informed consent forms can be found in
Appendix A. Teachers had to sign and give consent showing that they were willing to let their students be excused from class to complete the survey and also that they were willing to allow their class to participate in a competition between the other classrooms at their school. Teacher informed consent forms can be found in Appendix B. The class that returned the highest percentage of consent forms at each school earned a pizza party. Parents had the option of checking one of two boxes: “I give consent” or “I do not give consent.” This allowed students to still bring back forms to participate in the contest, yet allow parents to withhold their child from participating if they are not comfortable.

For students in the EBD/MRP classrooms, I called each parent initially to explain the research project. I asked the parents if they would allow their child to participate. If they granted verbal consent over the phone, I asked parents what the best way was to get the consent form home to them and back to school (whether with the child or through the mail). I also went on two home visits with the school social worker to obtain consent. Students in the EBD/MRP classrooms were also rewarded with tangible incentives for returning their forms.

The IPFI was administered to pairs of students from the EBD/MRP classroom in a quiet location. The regular education students for whom parental consent was obtained were pulled out of their classrooms and taken to the cafeteria in groups of ten to fifteen. Each student was given their own copy of the IPFI and instructed not to write their names on the forms to ensure confidentiality. A script with directions was included as the second page in the questionnaire given to the students. I read the script (the directions) and instructed the students to follow along. The script explained the importance of answering all questions and that all answers are confidential. It also explained what each
response meant and included a sample question for practice. This script was derived directly from the original IPFI. I read the items to each group with the students answering each question as it was read. A small, tangible incentive was given to students for coming to the cafeteria.

For the purposes of this study, several scores were computed: Social Bonding Domain, Personal Competence Domain, Social Competence Domain, as well as dimension scores within each of the domains. Each of the three domains was considered a factor for the purposes of hypothesis development and data analysis. The factor scores of the students in EBD/MRP classrooms were compared to those of the students in regular education, testing to see if there were any significant differences across factor scores using t-tests. The dependent variable was the factor scores and the independent variable was educational classification (regular education or EBD/MRP).

**Hypotheses**

In terms of hypotheses for this study, the null hypothesis was that there are no significant differences between Social Bonding, Personal Competence, and Social Competence factor scores for students in regular education and students in EBD/MRP classrooms. Based on previous literature the alternative hypotheses for this study include:

1. Students in regular education will have significantly higher factor scores on the Social Bonding factor than students in EBD/MRP classrooms,
2. Students in regular education will have significantly higher factor scores on the Personal Competence factor than students in the EBD/MRP classrooms,

3. Students in regular education will have significantly higher factor scores on the Social Competence factor than students in EBD/MRP classrooms.
CHAPTER III
RESULTS

The current study was conducted to examine differences in Social Bonding, Personal Competence, and Social Competence between students in regular education and students in EBD/MRP classrooms to see if there were any significant differences in those three areas of resilience. Students in 5th through 8th grade at two different schools, School A and School B, completed the Individual Protective Factors Index (IPFI). This chapter will begin with a description of demographic information of the research study population, followed by presentation of results of the preliminary analyses, as well as results of main analyses addressing the hypotheses of this study.

Demographics

All demographic information was collected through student self-report. A total of 118 participants were included in this study. In terms of response rates, 240 regular education students were solicited in 5th through 8th grade and 102 students (42%) returned consent and participated. The response rate for special education students was much higher. Specifically, of students in the EBD/MRP classroom, 16 students were solicited and 16 students (100%) returned consent and participated. The main demographic information is summarized in Table 1. Of the study participants, 16 students (13.56%) were from EBD/MRP classrooms and 102 students (86.44%) were from regular education. Forty-three students (36.4%) were from School A and 75 students (63.6%)
were from School B. In terms of grade composition, 20 students (25.4%) were from 5th grade, 32 students (27.1%) were from 6th grade, 37 students (31.4%) were from 7th grade, and 19 students (16.1%) were from 8th grade. Students ranged in age from 10 years to 15 years (M=12.48, sd=1.24). Frequency of males and females were not calculated because there were only two females in the EBD/MRP classrooms and it would have negatively impacted confidentiality. Data on race was not collected because the final sample of students placed in EBD/MRP classrooms was all African American.

Table 1: Student Participants School, Special Education Eligibility, and Grade (N=118)

<table>
<thead>
<tr>
<th>Grade</th>
<th>School A</th>
<th>School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3 (30%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>6</td>
<td>2 (20%)</td>
<td>10 (30.3%)</td>
</tr>
<tr>
<td>7</td>
<td>2 (20%)</td>
<td>15 (45.5%)</td>
</tr>
<tr>
<td>8</td>
<td>3 (30%)</td>
<td>8 (24.2%)</td>
</tr>
<tr>
<td>Total (n=118)</td>
<td>10</td>
<td>33</td>
</tr>
</tbody>
</table>

Survey Results

Preliminary Analyses

Before the primary research questions of the current study could be addressed, reliability analyses were conducted for the scale used in this study. The Chronbach’s Alpha values of the three IPFI factors (Social Bonding, Personal Competence, and Social
Competence) were calculated with the data obtained from the current sample.

Acceptable internal consistency values must be higher than .60 for group data purposes (Ysseldyke, 2007). In this study, internal consistency values were all higher than .70, providing good evidence for the internal consistency of the IPFI; Social Bonding ($r=.74$), Personal Competence ($r=.76$), and Social Competence ($r=.76$). The Means and Standard Deviations for each factor for the combined sample, as well as for all the items within in factors, are summarized in Table 2. Lower scores suggest lower self-rated resilience on that item; higher scores suggest higher self-rated resilience on that item.

Table 2: Means, Standard Deviations, and Range of Scores for the IPFI

<table>
<thead>
<tr>
<th>Item/SCALE</th>
<th>M</th>
<th>SD</th>
<th>Range (Minimum-Maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOCIAL BONDING FACTOR</td>
<td>58.11</td>
<td>7.16</td>
<td>18-72</td>
</tr>
<tr>
<td>1. I can tell my parents the way I feel about things.</td>
<td>3.07</td>
<td>0.95</td>
<td>1-4</td>
</tr>
<tr>
<td>2. I like to see other people happy.</td>
<td>3.42</td>
<td>0.73</td>
<td>1-4</td>
</tr>
<tr>
<td>7. I really want to graduate from college.</td>
<td>3.75</td>
<td>0.62</td>
<td>1-4</td>
</tr>
<tr>
<td>12. My family expects too much of me.*</td>
<td>3.63</td>
<td>1.7</td>
<td>1-4</td>
</tr>
<tr>
<td>17. Finishing high school is important.</td>
<td>3.87</td>
<td>0.53</td>
<td>1-4</td>
</tr>
<tr>
<td>18. Sometimes I am ashamed of my parents.*</td>
<td>2.75</td>
<td>1.2</td>
<td>1-4</td>
</tr>
<tr>
<td>22. School is a waste of time.*</td>
<td>3.47</td>
<td>0.94</td>
<td>1-4</td>
</tr>
<tr>
<td>26. My family has let me down.*</td>
<td>3.33</td>
<td>0.95</td>
<td>1-4</td>
</tr>
<tr>
<td>27. Following the rules is stupid.*</td>
<td>3.32</td>
<td>0.95</td>
<td>1-4</td>
</tr>
<tr>
<td>32. I try hard to do well in school.</td>
<td>3.75</td>
<td>0.56</td>
<td>1-4</td>
</tr>
<tr>
<td>33. I like to do things with my family.</td>
<td>3.61</td>
<td>0.76</td>
<td>1-4</td>
</tr>
<tr>
<td>34. Most people can be trusted.</td>
<td>2.38</td>
<td>1.08</td>
<td>1-4</td>
</tr>
<tr>
<td>42. It is more important to play fair than win.</td>
<td>3.56</td>
<td>0.76</td>
<td>1-4</td>
</tr>
<tr>
<td>47. A lot of days, I would rather not go to school.*</td>
<td>2.63</td>
<td>1.16</td>
<td>1-4</td>
</tr>
<tr>
<td>48. There is something good in everybody.</td>
<td>3.41</td>
<td>0.96</td>
<td>1-4</td>
</tr>
<tr>
<td>53. I would quit school as soon as I can.*</td>
<td>3.67</td>
<td>0.84</td>
<td>1-4</td>
</tr>
<tr>
<td>54. I enjoy talking with my family.</td>
<td>3.24</td>
<td>0.99</td>
<td>1-4</td>
</tr>
<tr>
<td>60. I don’t like most people.*</td>
<td>2.53</td>
<td>1.14</td>
<td>1-4</td>
</tr>
<tr>
<td>Item/SCALE</td>
<td>M</td>
<td>SD</td>
<td>Range (Minimum-Maximum)</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>------------------------</td>
</tr>
<tr>
<td>PERSONAL COMPETENCE FACTOR</td>
<td>80.1</td>
<td>8.82</td>
<td>25-100</td>
</tr>
<tr>
<td>3. Sometimes you have to physically fight to get what you want.*</td>
<td>2.86</td>
<td>1.06</td>
<td>1-4</td>
</tr>
<tr>
<td>4. I will probably die before I am thirty.*</td>
<td>3.61</td>
<td>0.76</td>
<td>1-4</td>
</tr>
<tr>
<td>8. I like the way I act.</td>
<td>3.1</td>
<td>0.96</td>
<td>1-4</td>
</tr>
<tr>
<td>9. I get mad easily.*</td>
<td>1.94</td>
<td>1</td>
<td>1-4</td>
</tr>
<tr>
<td>13. People usually like me.</td>
<td>3.19</td>
<td>0.85</td>
<td>1-4</td>
</tr>
<tr>
<td>14. Other people decide what happens to me.*</td>
<td>3.32</td>
<td>1.03</td>
<td>1-4</td>
</tr>
<tr>
<td>15. I think I will have a nice family when I get older.</td>
<td>3.67</td>
<td>0.64</td>
<td>1-4</td>
</tr>
<tr>
<td>19. I can be trusted.</td>
<td>3.51</td>
<td>0.75</td>
<td>1-4</td>
</tr>
<tr>
<td>20. I am afraid my life will be unhappy.*</td>
<td>3.14</td>
<td>1.05</td>
<td>1-4</td>
</tr>
<tr>
<td>23. It is important to think before you act.</td>
<td>3.58</td>
<td>0.79</td>
<td>1-4</td>
</tr>
<tr>
<td>24. Bad things happen to people like me.*</td>
<td>3.04</td>
<td>1.02</td>
<td>1-4</td>
</tr>
<tr>
<td>28. My life is all mixed up.*</td>
<td>3.08</td>
<td>1.07</td>
<td>1-4</td>
</tr>
<tr>
<td>29. I do whatever I feel like doing.*</td>
<td>3.03</td>
<td>1.07</td>
<td>1-4</td>
</tr>
<tr>
<td>35. I can do most things I try.</td>
<td>3.52</td>
<td>0.77</td>
<td>1-4</td>
</tr>
<tr>
<td>36. If I study hard, I will get better grades.</td>
<td>3.81</td>
<td>0.55</td>
<td>1-4</td>
</tr>
<tr>
<td>37. When I get mad, I yell at people.*</td>
<td>2.09</td>
<td>1.1</td>
<td>1-4</td>
</tr>
<tr>
<td>38. I think I can have a nice house when I grow up.</td>
<td>3.79</td>
<td>0.43</td>
<td>1-4</td>
</tr>
<tr>
<td>43. Sometimes I break things on purpose.*</td>
<td>2.69</td>
<td>1.17</td>
<td>1-4</td>
</tr>
<tr>
<td>44. I will probably never have enough money.*</td>
<td>3.27</td>
<td>0.96</td>
<td>1-4</td>
</tr>
<tr>
<td>49. When I try to be nice, people notice.</td>
<td>3.19</td>
<td>0.96</td>
<td>1-4</td>
</tr>
<tr>
<td>52. If you work hard, you will get what you want.</td>
<td>3.63</td>
<td>0.7</td>
<td>1-4</td>
</tr>
<tr>
<td>56. I like the way I look.</td>
<td>3.53</td>
<td>0.84</td>
<td>1-4</td>
</tr>
<tr>
<td>57. If I feel like it, I hit people.*</td>
<td>2.66</td>
<td>1.19</td>
<td>1-4</td>
</tr>
<tr>
<td>58. To make a good decision, it is important to think about what will happen afterwards.</td>
<td>3.33</td>
<td>1</td>
<td>1-4</td>
</tr>
<tr>
<td>61. I am responsible for what happens to me.</td>
<td>3.53</td>
<td>0.85</td>
<td>1-4</td>
</tr>
</tbody>
</table>

SOCIAL COMPETENCE 57.34 7.59 18-72
<p>| 5. I will always have friends.      | 3.29| 0.95| 1-4                    |
| 6. I like to help out around the house. | 3.21| 0.96| 1-4                    |</p>
<table>
<thead>
<tr>
<th>Item/SCALE</th>
<th>M</th>
<th>SD</th>
<th>Range (Minimum-Maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. I get along well with other people.</td>
<td>2.87</td>
<td>0.94</td>
<td>1-4</td>
</tr>
<tr>
<td>11. Being a part of a team is fun.</td>
<td>3.20</td>
<td>0.92</td>
<td>1-4</td>
</tr>
<tr>
<td>16. If I disagree with a friend, I can tell them.</td>
<td>3.38</td>
<td>0.93</td>
<td>1-4</td>
</tr>
<tr>
<td>21. I like being around people.</td>
<td>3.06</td>
<td>1.01</td>
<td>1-4</td>
</tr>
<tr>
<td>25. Helping others makes me feel good.</td>
<td>3.42</td>
<td>0.86</td>
<td>1-4</td>
</tr>
<tr>
<td>30. If I have a reason, I will change my mind.</td>
<td>3.17</td>
<td>0.97</td>
<td>1-4</td>
</tr>
<tr>
<td>31. It is hard for me to make friends.*</td>
<td>3.32</td>
<td>0.95</td>
<td>1-4</td>
</tr>
<tr>
<td>39. If I don’t understand something, I will ask for an explanation.</td>
<td>3.46</td>
<td>0.82</td>
<td>1-4</td>
</tr>
<tr>
<td>40. My friends respect me.</td>
<td>3.26</td>
<td>0.9</td>
<td>1-4</td>
</tr>
<tr>
<td>41. I always like to do my part.</td>
<td>3.44</td>
<td>0.84</td>
<td>1-4</td>
</tr>
<tr>
<td>45. I am often too embarrassed to ask questions.*</td>
<td>2.87</td>
<td>1.17</td>
<td>1-4</td>
</tr>
<tr>
<td>46. I often feel lonely.*</td>
<td>3.06</td>
<td>1.08</td>
<td>1-4</td>
</tr>
<tr>
<td>50. I hate being in front of a group.*</td>
<td>2.64</td>
<td>1.18</td>
<td>1-4</td>
</tr>
<tr>
<td>51. It is important to do your part helping at home.</td>
<td>3.53</td>
<td>0.81</td>
<td>1-4</td>
</tr>
<tr>
<td>55. Helping others is very satisfying.</td>
<td>3.32</td>
<td>0.84</td>
<td>1-4</td>
</tr>
<tr>
<td>59. I often disappoint people.*</td>
<td>2.82</td>
<td>1.11</td>
<td>1-4</td>
</tr>
</tbody>
</table>

*Reverse scored item

Additionally, paired samples t-tests were conducted to determine if the overall adjusted mean scores of the factors differed significantly from one another across the entire sample due to anecdotally-noted differences in means for certain items and for the factors. A Bonferroni correction was performed to correct for alpha slippage due to multiple comparisons. Therefore, the alpha level was set at .017. Table 3 presents the results of these paired-sample t-tests. Based on these analyses, the adjusted mean of the Personal Competence Factor (M=12.76, sd=1.47) was significantly higher than the Social Bonding Factor (M=9.64, sd=1.21), t(117)=-27.68, p<.000; as well as the Social Competence Factor (M=9.53, sd=1.28), t(117)=37.40, p<.000.
Table 3: Paired Sample t values Examining Differences Among the Three Adjusted Mean Scores of the IPFI (N=118)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Social Bonding</th>
<th>Social Competence</th>
<th>Personal Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Bonding</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Competence</td>
<td>1.15</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Personal Competence</td>
<td>-27.68**</td>
<td>37.40**</td>
<td>-</td>
</tr>
</tbody>
</table>

**=Differences between scores is significant at the .005 level (2-tailed)

Main Analyses

The primary purpose of this study was to determine if there were significant differences between students in EBD/MRP classrooms and students in regular education classrooms in Social Bonding, Personal Competence, and Social Competence. Three hypotheses were developed to guide the analyses of the data and to answer questions about differences between the two populations. Using an independent sample t-test (again correcting for alpha slippage due to multiple t-tests), the level of significance needed to determine if groups are significantly different is .017. The three hypotheses followed by corresponding results will be presented in the following sections.

Hypothesis 1: There are no significant difference between Social Bonding factor scores between students in regular education classroom and students in EBD/MRP classrooms.

An independent samples t-test was conducted to determine if differences existed between self-ratings of students in EBD/MRP classrooms and students in regular education classrooms in Social Bonding, which indicated that students in EBD/MRP
classrooms \( (M=9.36, \text{sd}=1.07) \) did not rate themselves as being significantly different than students in regular education classrooms \( (M=9.69, \text{sd}=1.23) \) in Social Bonding, \( t(116)=1.00, \ p=.318 \). See Table 4.

**Hypothesis 2:** There is no significant difference between Personal Competence factor scores between students in regular education classroom and students in EBD/MRP classrooms.

An independent samples t-test was conducted to determine if differences existed between self-ratings of students in EBD/MRP classrooms and students in regular education classrooms in Personal Competence, which indicated that students in EBD/MRP classrooms \( (M=12.60, \text{sd}=1.29) \) did not rate themselves as being significantly different than students in regular education classrooms \( (M=12.79, \text{sd}=1.50) \) in Personal Competence, \( t(116)=.47, \ p=.638 \). See Table 4.

**Hypothesis 3:** There are no significant difference between Social Competence factor scores between students in regular education classroom and students in EBD/MRP students.

An independent samples t-test was conducted to determine if differences existed between self-ratings of students in EBD/MRP classrooms and students in regular education classrooms in Social Competence. An independent samples t-test indicated that students in EBD/MRP classrooms \( (M=9.55, \text{sd}=1.49) \) did not rate themselves as being significantly different than students in regular education classrooms \( (M=9.53, \text{sd}=1.26) \) in Social Competence, \( t(116)=-.076, \ p=.94 \). See Table 4.
Table 4: Comparison of EBD and Regular Education Students on the Three Adjusted Factor Scores of the IPFI (n=118)

<table>
<thead>
<tr>
<th>Score</th>
<th>M</th>
<th>SD</th>
<th>T</th>
<th>df</th>
<th>P</th>
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<tbody>
<tr>
<td>Social Bonding Factor</td>
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<tr>
<td>EBD</td>
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<td></td>
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<tr>
<td>Regular Education</td>
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<tr>
<td>Personal Competence Factor</td>
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<tr>
<td>EBD</td>
<td>12.60</td>
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<tr>
<td>Regular Education</td>
<td>12.79</td>
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<td>Social Competence Factor</td>
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<td>EBD</td>
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<td>Regular Education</td>
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Level of significance utilized due to Bon Ferroni’s p< .017
CHAPTER IV
DISCUSSION

The purpose of the current study was to examine differences in resilience between inner city students placed in EBD/MRP classrooms and inner city students in regular education to see if lack of Social Bonding, Personal Competence, and/or Social Competence to deal with the stresses of inner city life might account in part for students being placed in EBD/MRP classrooms. Differences in resilience could potentially suggest targets for preventative intervention for students with behavior problems and also interventions for students placed in EBD/MRP classrooms to help improve academic and life outcomes. Additionally, resilience for all students was examined to look for targets for intervention and strategies for schools, teachers, and school psychologists to help promote resilience for all students.

Summary of Findings

Based on data collected for this study, there were no significant differences in resilience in terms of social bonding, personal competence, or social competence between students in regular education classes or students in EBD/MRP classrooms. This appears to be contrary to research that has demonstrated that students labeled as EBD have significant problems with personal and social adjustment, leading them to be labeled as EBD and potentially causing negative outcomes throughout life (Boreson, 2006; Coutinho & Oswald, 2000; Jolivette et al., 2000; Kutash & Duchnowski, 2004). It also
appears to conflict with the very definition of EBD, which centers around “social, emotional, or behavioral functioning that is significantly different from peers and adversely affects the student’s academics, social relationships, and personal adjustment” (Boreson, 2002, p. 6)

There are many possible reasons for why no differences in IPFI factor scores were found. First, it could be due to a lack of difference in resilience between students in regular education and EBD/MRP classrooms in this population; both groups of students are living in the highly stressful life situation of inner city poverty. That is, resilience as measured by the IPFI (using the factor scores) is not related to placement in an EBD/MRP classroom. Or, it could be that both groups have comparable levels of resilience factors and that other factors contribute to some students struggling more behaviorally and academically, being evaluated for special education, and then placed in an EBD/MRP classroom. Perhaps students placed in an EBD/MRP classroom have comparable levels of resilience factors but are exposed to increased or different risk factors. Specifically, it is possible that students placed in EBD/MRP classrooms, although they have similar levels of resilience, do not have enough to cope with the more maladaptive world in which they live, which then leads to more negative outcomes. Perhaps it is due to something else internal to the child such as mental illness or Attention Deficit Hyperactivity disorder. According to the National Longitudinal Transition Study-2, 63% of students labeled as EBD having a diagnosis of ADHD (Wagner & Cameto, 2004). Last, it is possible that the lack of difference in self-reported resilience has more to do with more external protective factors, like parenting.
Given that previous research established that students with EBD on the whole suffer from poor self-management skills, social skills, and problem-solving skills, it could also be that there is a significant difference in resilience skills between students placed in EBD/MRP classrooms and students in regular education but that the study as conducted did not appropriately measure resilience. One possible reason for the lack of difference could be lack of self-awareness among students placed in EBD/MRP classrooms; it is possible that students placed in EBD/MRP classrooms may have less insight into their behaviors and competencies than students in regular education, which could lead to them rating their behaviors higher than others in their lives would. This potential lack of self-insight could contribute to problems in controlling behaviors and interacting appropriately with others, which in turn could lead to an increased risk of developing and being identified with a behavior disorder. Future research could remediate this potential problem by having parents or teachers rate both students placed in EBD/MRP classrooms and students in regular education rather than having students rate themselves.

Procedurally, students in the EBD/MRP classrooms were given the scale individually or in pairs to assist with reading because many of the students had low skills in reading. Students in the regular education classrooms were administered the scale in groups of 10 to 15 students. Because I was sitting next to each of the students placed in EBD/MRP classrooms and reading the questions to them, it is possible that they may have presented themselves in a more positive light because they knew I could see what they were saying or because they were worried that rating themselves in a negative fashion could hurt them in some way. Additionally, it is also possible that the anonymity of doing the survey in a larger group may have allowed regular education students to feel
more comfortable about being honest. To further complicate matters, I also had worked closely with all of the students placed in EBD/MRP classrooms since the beginning of the school year; this may have caused a social desirability effect, especially because I was sitting with them while they completed the survey. Some of the students may have rated themselves more positively because they were afraid I would judge them. In the future, this problem could be remedied by having another adult help the students in EBD/MRP classrooms complete the IPFI or administering the survey in a large group for all students; it could also be remedied by having other sources of information, such as parents or teachers, rate all the students.

One other possible significantly limiting factor could be the large difference in sample size between the two groups and the small sample size for students in the EBD/MRP classrooms. There were 16 students placed in EBD/MRP classrooms as opposed to 102 in the regular education classroom. The smaller sample size likely made it harder to achieve statistical significance. Future researchers could remedy this problem by increasing the sample size of students in EBD/MRP classrooms. In the case of this study, I used all of the students placed in EBD/MRP classrooms at the schools I worked for; I could have attempted to solicit participation of students placed in EBD/MRP classrooms at other schools within the school district. Additionally, having a larger sample size in general could produce more reliable, conclusive results. One other potential issue with the sample used was that data was not collected on gender because there were only two girls in the EBD/MRP classrooms. It is not known how many girls participated from the regular education classroom; it could be possible that girls may rate
themselves differently, more or less accurately, than boys on Social Bonding, Personal Competence, and/or Social Competence.

Another limiting factor of the study was related to the measure. There were no normative or comparison data on what obtained scores on the IPFI represent. Specifically, there were no mean or standard deviation scores available from standardization samples. Very limited research has been conducted using the IPFI and what research was done was not available. As such, I could not compare mean scores for the sample I used to other samples to see if inner city, African American students rated themselves higher or lower than the standardization sample (or any other research samples) on Social Bonding, Personal Competence, or Social Competence.

Although none of the original three hypotheses were supported by data, one trend was observed during data analysis—the adjusted mean for Personal Competence was significantly higher than the adjusted mean for Social Bonding and Social Competence for the entire sample. This suggests that students (both regular education and EBD/MRP classrooms) rated themselves higher in resilience for Personal Competence than in Social Bonding or Social Competence. Personal Competence measured things such as self-concept, self-control, positive outlook, and self-efficacy. Social Bonding measured things such as connectedness to family and school. Social Competence measured things such as assertiveness, confidence, and attitudes towards cooperation. Anecdotally, it was observed during data analysis that on the whole, in the Social Bonding domain, students tended to rate themselves lower on family connectedness (being ashamed of parents, feeling that parents expect too much) and relating to others, (being able to trust others, and not liking most people) than school connectedness. Within the Social Competence
domain, it was anecdotally observed that students rated themselves lower on not getting along well with others and feeling that they disappoint others often. Additional anecdotal observations indicated that many students rated themselves low in the area of self-control, which looked at things such as fighting to get what one wants, getting angry easily, hitting others, breaking things when angry, and yelling when angry.

Previous research may shed some light on why Personal Competence might be significantly higher than other domains, although no research could be found that looked at this directly for pre-adolescents or adolescents. According to the APA Task Force of Resilience and Strength in Black Children and Adolescents (2008), risk factors for poor life outcomes do not stem so much from internal deficits as they do from things external to the child, deriving from “proximal concerns, such as under-resourced schools, family disruption, or negative peer influences” (p. 1). Perhaps the reason that personal competence was rated higher was because it measured things directly internal and individual to the child as opposed to external things related to family, school, and friends.

Past research has also suggested that the development of a strong ethnic identity is a protective factor for African American adolescents. According to Barrow et al. (2007), “racial identity serves as a buffer against stress and helps African American youth function with competence under adverse conditions” (p. 397). The students who participated in the study were all African American and lived in neighborhoods that were vastly African American and attended schools where the vast majority of the students and a good proportion of the staff were African American. Both schools actively promoted African American history and African American pride. Based on this, it is likely that
these students have developed a strong ethnic identity which may promote a stronger sense of personal competence.

In addition to racial identity, one study highlighted in the literature review section of this paper, found racial differences in coping strategies between African American students and Caucasian students (Barrow et al., 2007). It could be that a greater variety of coping strategies might lead to higher perceptions of personal competence among the sample in this study. The same study found that African American youth had “just as high, if not higher, self-esteem when compared to Caucasian children” (Barrow et al., p. 398). It is possible that a higher self-esteem among participants may be related to higher self-ratings in the areas related to personal competence, such as self-efficacy.

Based on the findings of this study, it appears to be important to consider external resilience factors in addition to individual resilience factors. According to literature and previous studies, parenting may play a big role in resilience. Some research suggests that African American parenting styles may increase or decrease personal competence among African American children, indicating an interaction between individual protective factors and external factors. According to Jambunathan and Burts (2003), stricter parenting styles requiring more independence on the part of the child and encouraging the expression of positive and negative emotions was correlated with an increased self-perception of self-competence for African American children. A study conducted by Kwon et al. (2006) found a relationship between high maternal emotional expressiveness and lower child-perceived cognitive competence as well as behavior problems. Parenting styles likely continue to impact resilience throughout adolescence.
Implications for Schools

Although it has been noted that students labeled with EBD possess low average to average intelligence and have academic skills that are closer to those of their regular education peers than students with other special education labels, they continue to be the special education group at the highest risk for negative school and general life outcomes (Kutash & Duchnowski, 2004; Wagner & Cameto, 2004). Schools have the responsibility to prepare these students for successful adult lives. Schools are required by law to create individualized education programs (IEPs) for all children found to have a disability and need special education; these programs need to be developed based on the individual needs of the child and include transition planning so that children can go on to be successful adults. These facts call into question the appropriateness of the education that students labeled as EBD are receiving. Are schools appropriately servicing students labeled as EBD? The national data would suggest not. Schools have the opportunity and obligation to teach these students the academic and life skills they need to be more successful as adults. The question is, what can schools do? How can they approach and attempt to remediate the difficulties that have resulted in the label of EBD? The answer is relatively simple: schools need to do what they do for students labeled with any disability—meet the students where they are at and teach them the skills they need to succeed, whether it is academic skills, vocational skills, or social-emotional skills (Boreson, 2006; Clark & Davis, 2000; Jolivette, et. al., 2000; Kutash & Duchnowski; 2004).

According to Boreson (2006), one of the predictors of students with EBD dropping out is a failure of schools to address counseling issues such as social skills and
anger management; further, it is effective, preventative programming focusing on academics, social and emotional, vocational, and life skills that is critical to their success. One thing that schools can do to help remediate the behaviors that lead to poor school and life outcomes is through addressing the psycho-social barriers to learning—social skills deficits as well as chronic behavior and self-management problems (Adelman & Taylor, 2000). This implies that students with EBD must be provided specific instruction in the social, self-management, and problem-solving skills they lack so they can function more successfully in school and society overall. Although social skills instruction is critical, it must be tailored to meet the unique learning needs of the students. According to Jolivette et al. (2000), social skills training is one of the most effective interventions for highly challenging behaviors, but only when students are taught specific behaviors based on their individual needs. Following this line of thought, school personnel (teachers, school psychologists, school social workers, etc.) who work with these students should identify specific social and self-management skills deficits present among students with EBD and target interventions towards remediating those deficits. Teaching social skills, self-management skills, and problem-solving skills while also actively working to build positive relationships with these students will help to promote greater resilience and give them a better chance at school and life success. According to Jolivette et. al. (2000), one specific strategy to use when teaching social and emotional skills is getting students labeled as EBD trained and involved in peer mediation; this allows them to practice appropriate social interactions with peers and uses peers as agents for behavior change as well as teaching conflict resolution skills. A possible starting point for schools is working to create new initiatives to help promote the development of social and self-management
skills among students labeled as EBD, such as the EBD/MRP Initiative being implemented within the school district in which this study was conducted.

Additional ideas beyond targeting social and emotional functioning include transition planning with on-site work training in multiple fields, indentifying counseling agencies for students labeled as EBD to utilize post-graduation, teaching and practicing goal-setting, and teaching how to self-advocate (Jolivette et. al). For both prior to and after graduation, wrap-around planning also helps promote success. Wrap-around planning matches individual and family needs with services in the community, such as counseling services, financial services, job training and mentoring, and health services (Jolivette et al.) Other things schools should do include having a low staff-to-student ratio to allow teachers to build strong relationships with students, and provide close supervision (one teacher to 12 to 15 students), and operate under a model of zero reject and unconditional care (Boreson, 2006).

Promoting resilience in students placed in EBD/MRP classrooms is just a starting point for schools to promote the best outcomes for their students. Ideally, resilience should be supported school-wide for all students, particularly for students coming from high-risk environments. Students living in the inner city, particularly students placed in EBD/MRP classrooms, face many risk factors and may lack basic skills needed to be resilient. They face many more real dangers in the world than children living elsewhere, including poverty and violence. Positively, research has demonstrated that the presence of “supportive adults and organizations at the neighborhood, school, and family level can counteract any negative impact of neighborhood dangers” (Barrow et al., 2007, p. 401). Schools can do a lot to promote resilience, even in the face of so many risk factors.
Promoting resilience for all students may help teach students skills needed to be successful in school and life and act to prevent some at-risk students from developing behavior disorders. Fortunately, there are many things schools can and should do to help promote resilience. Promoting resilience can decrease behavior problems and increase academic achievement.

According to Bernard (1995), research suggests that “when schools are places where the basic human needs for support, respect, and belonging are met, motivation for learning is fostered” (p. 4). By helping to foster resilience of all students, particularly students placed in EBD/MRP classrooms, students are more likely to be motivated to learn. Reciprocal caring, respectful, and participatory relationships are critical determining factors in whether a student learns; whether parents become and stay involved in the school; whether a program or strategy is effective; and ultimately whether a youth feels he or she has a place in this society (Bernard). Research strongly supports that, by promoting resilience, all students are more likely to succeed. Bernard promotes the idea that schools have the power to “serve as a ‘protective shield’ for all students and a beacon of light for youth from troubled homes and impoverished communities” (p. 4).

School-wide, resilience can be promoted through the environment and culture of the school. Schools need to create a caring, positive atmosphere for all students. According to Bernard (1995):

“Schools need to create a school-wide ethos of caring by providing opportunities for caring student-to-student, teacher-to-teacher, and teacher-to-parent relationships; this is not a program or strategy, but rather a way being in the world and relating to youth, their families, and each other that conveys
compassion, understanding, respect, and interest; this helps to promote all other areas of resilience” (p. 5).

Schools need to promote caring relationships between students and staff and promote high expectations for academics and behavior while also providing supports to ensure students can meet these expectations (Bernard, 1995). Findings from the National Longitudinal Study on Adolescent Health found that in the schools, caring relationships, high expectations, and opportunities for participation have tremendous protective and connective powers to influence youth (Bernard & Marshall, 2001). The APA Task Force of Resilience and Strength in Black Children and Adolescents (2008) found that the following factors were important skills to promote resilience:

“Critical mindedness to protect against discrimination and stereotypes; proactive and positive involvement at school, home, and in the community; the ability to socially, emotionally, and cognitively adapt to different demands; good physical health; and social bonds and a sense of social duty. They must develop self-motivation for critical thinking, engage with academic material, demonstrate flexibility in thinking, and give their expertise back to the community; schools can help do this by increasing parental involvement, helping to promote a feeling of school belonging for all children, and displaying sincere concerns for students’ academic success” (p. 3).

Another important component of school climate is giving students a chance to actively participate in and give back to their schools. According Bernard (1995), giving students opportunities for “meaningful involvement and responsibility in the schools so they can give their gifts back to the school community helps foster all resilience traits” (p.
4). Schools also need to actively promote parent involvement in school, as parental involvement is very strongly correlated with resilience and academic success (Cove et al., 2005).

Additionally, schools should promote physical health as well through school-based health facilities if possible. Parents may lack the resources to meet the physical health needs of their children. According to APA Task Force of Resilience and Strength in Black Children and Adolescents (2008), “African American children who are in good physical health are more likely to experience positive mental health, fewer behavior and social issues, and sharper and more responsive cognitive functioning” (p. 6). Also, school staff should be aware of community health resources and ways to access these resources in order to share this information with parents in need (Cove et al., 2005). School staff should be aware of community parenting and mental health resources as well.

Schools can develop and implement high quality, highly supervised afterschool programs, which can improve social skills and self-efficacy, leading to more positive social adjustment (Cove et al., 2005). Afterschool programs provide children with positive, safe places where they can learn socialize appropriately and learn new skills, as well as provide them more opportunities to form positive relationships with adult role models. Research suggests that these afterschool programs for inner city, African American students need to include “high-quality, culturally sensitive afterschool programming that is a preventative intervention program focusing on multiple health-compromising behaviors and include a school focus with family, peer, and community
components” (APA Task Force of Resilience and Strength in Black Children and Adolescents, 2008, p. 5).

Schools can also adopt and implement school-wide programs to teach skills that promote resilience, such as self-regulation, self-efficacy, communication skills, and problem-solving skills. According to the APA Task Force of Resilience and Strength in Black Children and Adolescents (2008), it is important to “teach African American children emotional regulation, the balanced and appropriate emotional expression for particular situations and circumstances” (p. 4). One approach for teaching these skills at school is through the Social and Emotional Learning (SEL) framework. SEL is “the capacity to recognize and manage emotions, solve problems effectively, and establish positive relationships with others” (Zins & Elias, 2006, p. 1). The process of social and emotional learning can help individuals learn to make good decisions, behave ethically and responsibly, and avoid negative behaviors (Zins, Weissberg, Wang, & Walberg, 2004). SEL could be taught to all students, but targeting students with behavior problems is particularly important. Research suggests that SEL can be targeted and taught to even the most difficult students (Zins et al., 2004).

By targeting and teaching SEL, schools can work to enhance students’ abilities to integrate thinking, feeling, and behaving to achieve important life tasks, ideally so they can recognize and manage their emotions, establish healthy relationships, set positive goals, meet personal and social needs, and make responsible and ethical decisions (Zins et al., 2004). Teaching these skills will help to promote internal, personal resilience and individual protective factors. Particularly for students placed in EBD/MRP classrooms, promoting and teaching SEL will help give them the skills that can better help them
succeed socially and emotionally, therefore contributing to increased success in all arenas of life. By identifying and targeting the SEL skills students placed in EBD/MRP classrooms, schools can tailor SEL interventions to target and remediate so that students can better function in school and society and have better life outcomes. By teaching these skills, schools can better meet the individual needs of students placed in EBD/MRP classrooms, helping to remediate the symptoms of their disability. Schools can also implement preventative SEL programming as a universal intervention to help increase SEL and personal resilience for all their students, helping students learn to better function and hopefully prevent some students being placed in EBD/MRP classrooms. Along the same lines as SEL, the APA Task Force of Resilience and Strength in Black Children and Adolescents (2008) found that teaching African American students “empathy and understanding of others helps promote resilience” (p. 4).

There are several simple things teachers can do to help promote resilience for students placed in EBD/MRP classrooms and for all students. The simplest, and possibly most powerful, thing teachers can do to help promote resilience and positive academic and social outcomes for all students is to actively work to build a positive relationship with all students; that positive relationship is even more critical for students who are struggling academically or behaviorally. According to Barrow et al. (2007), many inner city, African American youth turn to their teachers for emotional support and encouragement. Findings from the National Longitudinal Study on Adolescent Health found that families, schools, and organizations serving youth must make the development and maintenance of strong relationships the top priority in their work; teachers and school staff need to develop “genuine rapport and deep listening when working with students”
(Bernard & Marshall, 2001, p. 6). All-too-often, inner city children, particularly inner city children with significant behavior problems, lack positive, caring adult role models. Studies suggest that among children, “the most frequently encountered positive role models in the lives of resilient children (outside the family circle) was a favorite teacher who helped motivate them and acted as a positive, caring role model” (Bernard, 1995, p 3). Furthermore, children are motivated to work harder for those individuals that they love and trust (Bernard). Having a positive role model who has high expectations, an adult who generally cares, can go a long way in helping children succeed.

Teachers need to establish high expectations for all youth while providing the necessary support for success in order for students to have high rates of academic success; “through relationships that convey high expectations, students learn to believe in themselves and their futures, which helps to develop the critical resilience traits of self-esteem, self-efficacy, autonomy, and optimism” (Bernard, 1995, p. 3). People have a tendency to live up to the expectations that are laid down for them by others; the higher the expectation (with support), the higher the child will achieve.

Another important piece for teachers in helping foster resilience in children is discipline, which presents the potential of a teachable moment. When developing a class-wide discipline plan, the “purpose of the discipline should be to teach and promote successful behaviors at school, not to punish the child” (Payne, 1996, p. 86). According to the APA Task Force of Resilience and Strength in Black Children and Adolescents (2008), teachers should set behavioral norms and expectations that promote cooperative engagement, and present themselves as “warm demanders and compassionate disciplinarians” (p. 5). Before discipline comes into play, teachers need to set clear
classroom procedures and set high but achievable academic and behavioral expectations, taking the time to teach both. Teachers need to support students in learning and following through on expectations and procedures. According to Payne:

“Effective discipline which moves children towards self-governance is classroom structure and choice with clearly-taught behavioral expectations and clearly delineated consequences for making the incorrect choice. When developing a discipline plan, teachers need to consider what behaviors the child needs to be successful, whether or not the child has the resources to develop those behaviors, how the behaviors will be taught, and what kinds of things will help the child repeat the behaviors. Students may need to be taught that they need to have two sets of behaviors: home behaviors and school/work behaviors” (p. 86).

When disciplining, teachers need to approach it as a teachable moment, focusing on teaching students alternative behaviors and identifying alternative choices.

Beyond building relationships and setting high expectations, teachers also should “help foster a positive sense of self for minority students in a society that often devalues African American children through negative stereotypes, assumptions, and expectations” (APA Task Force of Resilience and Strength in Black Children and Adolescents, 2008, p. 3). Curriculum and instructional strategies should focus on a broad range of learning styles; build from perceptions of student strengths, interests, and experience; and be participatory and facilitative, creating opportunities for self-reflection, critical inquiry, problem-solving, and dialogue (Bernard, 1995). The APA Task Force of Resilience and Strength in Black Children and Adolescents (2008) found that, to promote resilience, “teachers should focus on giving students the opportunity to master and apply skills,
develop competency in any area, and use and apply their skills in service to others” (p. 6).

Some culturally sensitive teaching practices include engaging in playful banter and humor with students, incorporating linguistic and colloquial student expressions, considering possible cultural underpinnings for behaviors traditionally considered disruptive, allowing for a higher level of noise and more talking, and allowing students to work more in groups (VanDeWeghe, 2005). Additionally, teachers should draw from students’ cultural backgrounds and experience and connect this with the curriculum and use materials that represent their students’ cultural backgrounds.

School psychologists can do a lot both to promote positive outcomes for students placed in EBD/MRP classrooms as well as to promote resilience in their schools. In terms of promoting outcomes for students placed in EBD/MRP classrooms, school psychologists have an ethical obligation to ensure that they are receiving the training in the skills they need to succeed. School psychologists are trained in working with students on developing social skills, problem-solving skills, and anger management skills. School psychologists should be working with teachers to ensure that these students are learning these skills, whether this be in sharing curriculum responsibilities with the teachers or actually providing interventions. Additionally, schools psychologists should work to promote the mental health of students placed in EBD/MRP classrooms through individual counseling or in sharing outside resources with families. The school district in which this study was conducted started the EBD/MRP Initiative with growing success. School psychologists should also work hand-in-hand with teachers to develop positive behavior plans that meet the individual needs of the students, focusing on teaching them the behavior skills they need. Finally, school psychologists should work to
be advocates for students placed in EBD/MRP classrooms, ensuring that they receive the services they need and also have as much access as possible to the regular education curriculum.

Because of the unique roles that schools psychologists play in the schools, they have the power to promote resilience on multiple levels, school-wide, individual and small group, and familial. In terms of promoting resilience, school psychologists should work on a systems level to implement the school-wide strategies described earlier, particularly if they work in schools that have a high at-risk population, such as in the inner city. School psychologists could work for the implementation of resilience-based programs promoting social and emotional learning. In order to identify evidence-based SEL programs, school psychologists can consult the following resource, developed by the Collaborative for Academic, Social, and Emotional Learning—Safe and sound: An educational leader’s guide to evidence-based social and emotional learning (SEL) programs (2003). School psychologists could assist in the implementation of SEL curriculum. The Response to Intervention (RTI) model requires Tier 1 universal interventions for teaching academics and behaviors, and the SEL and resilience-based programs could serve as a universal intervention to improve behavior and emotional functioning.

School psychologists would likely provide the most help at the Tier 2 and Tier 3 levels for students who are still struggling in spite of the Tier 1 programming. School psychologists could further teach students about emotional competence and emotional regulation. School psychologists could teach students at-risk for behavioral failure SEL skills, problem-solving skills, emotional regulation, and social skills through individual
and small-group counseling. School psychologists could also implement programs for students promoting helping others, and should be available to address the mental health needs of students through individual and small-group counseling. Additionally, school psychologists should also work to be that positive adult role model for as many children as possible. School psychologists also can educate teachers and school staff about the importance of resilience and provide training and in-services on how to promote resilience in the schools, focusing on the positive impact promoting resilience can have on academics and behavior.

Because school psychologists often interact with parents, they are in a position to educate parents on the important role they play in developing their child’s resilience and increase the likelihood of academic and life success. Data from this study may support the importance of parent education in this area, as Social Bonding was significantly lower than Personal Competence, and it was anecdotally noted that, on the whole, this was largely due to family-related concerns. According to Cove et al. (2005), “parent involvement, warm family environments, and authoritative parenting styles were all associated with higher levels of competence and resilience as well as lower levels of problem behavior” (p. 6). Teaching parents about authoritative parenting styles may be particularly important, as “authoritarian, permissive, and neglectful parenting were all associated with somewhat higher rates of problem behaviors” (Cove et al., p. 6). The National Longitudinal Study on Adolescent Health found that parental connectedness (feelings of warmth, love, and caring from parents), parental involvement in children’s lives, high parental expectations for school achievement, parental presence in the home, and shared activities were all associated with healthy adolescent behaviors and fewer
risky behaviors (Bernard & Marshall, 2001). School psychologists can share this information with parents through consultations and recommendations, parenting classes, and informational brochures, to name a few options.

**Personal Impact of Research**

Research for this thesis has affected the way that I operate at my school. As a result of the work on this project, I have changed what I am doing with the students in the EBD/MRP classrooms, focusing more on teaching specific skills, such as problem-solving, anger management, and emotional expression. I am also trying to work more one-on-one with students on specific skills they may be lacking. Beyond working with students in the EBD/MRP classrooms, I decided that I needed to do more with students in regular education to promote social and emotional skills and resilience. One of the factors that came up again and again in the research on resilience in African American students was the importance of promoting community involvement and community contribution; in light of this, I have started several programs at my school to help promote resilience and social competence. I started a student council for middle school students in order to give them a voice in their school, to increase involvement and investment, and also to do pro-social activities such as Food Drives and fundraisers for children with cancer. I also started a group called the Peer Educators, which focuses on having middle school students teach younger students about resolving conflicts peacefully and making good choices. Peer Educators also mediate some conflicts between students. Additionally, I am working with kindergarten students using a curriculum called Woven Word, which promotes early literacy skills as well as social and emotional competence. Finally, I have been actively working to make connections with as many students as
possible so that hopefully I can be a positive role model in their lives, as many children lack this.

**Future Research Directions**

Future research could look for differences in resilience specifically for students labeled as EBD living in the inner city and students labeled as EBD beyond the inner city. Future researchers could further examine differences in resilience for African American inner city students as compared to a national sample; comparisons between both students in regular education and students labeled EBD to a national sample could help identify specific ways to promote resilience for all African American inner city students. Differences in resilience and gender could be examined in the future as well. Additionally, data could be collected comparing exposure to risk factors and familial differences for inner city students in regular education and students labeled as EBD, as it is possible that students labeled as EBD may have to cope with more life stressors or risk factors. Other areas that could be examined in the future include examining differences between students in regular education and students labeled as EBD in anger management skills, self-control, social skills, and impulse control. Future researchers could further examine levels of self-control and family and social bonding of students labeled as EBD and inner city students. Additional future areas of research could also include looking at the relationship between resilience and neighborhood factors, religious affiliation, and parental incarceration.

**Summary**

The current study examined differences in resilience between inner city students placed in EBD/MRP classrooms and inner city students in regular education, specifically
looking for differences in Social Bonding, Personal Competence, and Social Competence. No difference was found in any area between the two samples. A statistically significant difference was found among the overall sample between Personal Competence as compared to Social Bonding and Social Competence, with Personal Competence being rated significantly higher. This may highlight the importance that parental education and SEL instruction can play in promoting resilience. Children living in the inner city face many obstacles above and beyond what other children face, regardless of whether or not they are labeled EBD. The good news is there is much that schools, teachers, and school psychologists can do to help children labeled as EBD to develop the life skills they need to experience more success and also to help all children be as resilient as possible.
REFERENCES


Federal Register: Assistance to states for the education of students with disabilities and preschool grants for students with disabilities; Final rule/No. 156, Volume 71, 34 C.F.R. § 300.8(c)(4) (2006).


APPENDIX A

CONSENT TO PARTICIPATE IN RESEARCH (PARENT FORM)
CONSENT TO PARTICIPATE IN RESEARCH

Protocol Title: Social and Emotional Learning Skills of Inner City Students with Emotional Behavioral Disabilities

Principal Investigator: Sarah Carlson, School Psychology Intern at Lee School and the Dr. George Washington Carver Academy of Mathematics and Science
921 W. Meinecke Ave
Milwaukee, WI 53206
(414)267-1726

- **Purpose and Procedure**
  - The purpose of this study is to examine differences in social bonding, personal competence, and social competence between students in regular education and students in special education classrooms.
  - This study is being conducted as a part of a thesis, which is a part of requirements for degree completion at the University of Wisconsin-La Crosse.
  - Participation will involve your child completing a written questionnaire in which they rate themselves on things such as friends and relationships, school, and perceptions of family life.
  - The questionnaire will be administered in a small group setting outside of the classroom. It will take 20 to 30 minutes to complete. Each child only completes the questionnaire one time.
  - The students will be instructed not to write their names on the questionnaire to ensure confidentiality.

- **Potential Risks**
  - Your child may feel uncomfortable answering some of the questions.
  - Your student will miss 20 to 30 minutes of a class.

- **Rights and Confidentiality**
  - Your child’s participation is voluntary.
  - Your child can chose to stop answering the questions at any point, or chose not to participate at all, with no penalty.
  - Your child’s name will not be on the questionnaire, so all responses from your child will be confidential.
  - The results of this study will be used as a part of a thesis and may be published in scientific literature or presented at professional meetings using grouped data only (meaning your child’s name will never be used).

- **Possible benefits**
  - Results from this study could show classroom targets for prevention and intervention in things such as problem-solving and social skills for regular education students.
Results from this study could guide direct intervention for students in special education classrooms to target skills to teach them so they can be more successful in school and in life.

- **Compensation**
  - Children who participate in this study will receive a small tangible reward.

Your child does not have to participate in this study. Participation is completely voluntary. If you give permission for your child to participate and then your child later decides that he or she does not want to participate, he or she may withdraw.

Questions regarding this study may be directed to Sarah Carlson (414-267-1726), the principal investigator, or the study advisor Dr. Betty DeBoer (608-785-6891). Questions regarding the protection of human subjects may be addressed to the UW-La Crosse Institutional Review Board for the Protection of Human Subjects, (608-785-8124 or irb@uwlax.edu).

Student Name _______________________________________________________

Please check a box:

☐ I **GIVE** permission for my student to participate in this study.

☐ I **DO NOT** give permission for my child to participate in this study.

Parent Name _______________________________________________________

Parent Signature_________________________ Date___________

Researcher_______________________________ Date_________
APPENDIX B

CONSENT TO PARTICIPATE IN RESEARCH (TEACHER FORM)
CONSENT TO PARTICIPATE IN RESEARCH

Protocol Title: Social and Emotional Learning Skills of Inner City Students with Emotional Behavioral Disabilities

Principal Investigator: Sarah Carlson, School Psychology Intern at Lee School and the Dr. George Washington Carver Academy of Mathematics and Science
921 W. Meinecke Ave
Milwaukee, WI 53206
(414)267-1726

• Purpose and Procedure
  o The purpose of this study is to examine differences in social bonding, personal competence, and social competence between students in regular education and students in EBD/MRP classrooms.
  o This study is being conducted as a part of a thesis, which is a part of requirements for degree completion at the University of Wisconsin-La Crosse.
  o To provide incentive for students to return informed consent forms, I will establish a competition between your classroom and other classrooms to see which class can bring back the highest percentage of signed informed consent forms. The class with the highest percentage will earn a pizza party at my expense.
  o Participation will involve your students completing a written questionnaire in which they rate themselves on things such as friends and relationships, school, and perceptions of family life.
  o The questionnaire will be administered in a small group setting outside of the classroom. It will take 20 to 30 minutes to complete. Each student only completes the questionnaire one time.
  o The students will be instructed not to write their names on the questionnaire to ensure confidentiality.

• Potential Risks
  o Your students may feel uncomfortable answering some of the questions.
  o Your students will miss 20 to 30 minutes of a class.

• Rights and Confidentiality
  o Your students’ participation is voluntary.
  o Your students can chose to stop answering the questions at any point, or chose not to participate at all, with no penalty.
  o Your students’ names will not be on the questionnaire, so all responses will be confidential.
  o The results of this study will be used as a part of a thesis and may be published in scientific literature or presented at professional meetings using grouped data only (meaning your students’ names will never be used).
**Possible benefits**
- Results from this study could show classroom targets for prevention and intervention in things such as problem-solving and social skills for regular education students.
- Results from this study could guide direct intervention for students in EBD/MRP classrooms to target skills to teach them so they can be more successful in school and in life.

**Compensation**
- Students who participate in this study will receive a small tangible reward.

Your students do not have to participate in this study. Participation is completely voluntary. If you (and the students’ parents) give permission for your students to participate and then a student later decides that he or she does not want to participate, he or she may withdraw from the study.

Questions regarding this study may be directed to Sarah Carlson (414-267-1726), the principal investigator, or the study advisor Dr. Betty DeBoer (608-785-6891). Questions regarding the protection of human subjects may be addressed to the UW-La Crosse Institutional Review Board for the Protection of Human Subjects, (608-785-8124 or irb@uwlax.edu).

Please check a box:

☐ I GIVE permission for my students to participate in this study.

☐ I DO NOT give permission for my students to participate in this study.

Teacher’s Signature_________________________________ Date____________

Researcher_________________________________________ Date____________