
USING FRIENDS TO COMBAT INTERNALIZING PROBLEMS AMONG PRIMARY SCHOOL CHILDREN IN HONG KONG

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Abstract

The primary objective of this study was to evaluate the effectiveness of FRIENDS, a well-validated emotional resiliency program, to reduce internalizing problems among primary school children aged 8-10. 47 children who reached at least the cutoff point for internalizing score, as measured using a standardized test on child behaviour, were allocated to either the intervention or the wait-list control condition. All children completed measures on internalizing symptoms and self-esteem both before and after an 8-week FRIENDS intervention or wait period. Results showed that children from the FRIENDS program showed significantly higher self-esteem and fewer internalizing symptoms when compared to those in the waitlist group. Modifications done on adapting FRIENDS to culturally and contextually appropriate content for Hong Kong children with internalizing problems were discussed. Limitations of this study were also addressed.

Key words: FRIENDS, internalizing problems, school children.

INTRODUCTION

Children's behaviour problems were broadly classified into two groups: externalizing behaviours and internalizing behaviours (Achenbach, 1991; Cocchetti & Toth, 1991). Externalizing behaviour patterns were directed towards the social environment and could be characterized as an under-controlled and outer-directed mode of responding. Examples included aggression, disruption, impulsivity/hyperactivity. In contrast, internalizing behaviour patterns were directed towards the individual and represent an over-controlled and inner-directed pattern of behaviours. Examples of these behaviours included social withdrawal, depression and anxiety. Algozzine (1977) characterized externalizing behaviours as "disturbing" to others in the social environment and internalizing

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behaviours as “disturbing” to the individual. As such, internalizing behaviour problems were not identified as frequently as those with externalizing behaviour because of its covert and non-intrusive nature. Compared to externalizing behaviour, internalizing behaviour problems often went unnoticed (Kauffman, 2001). In addition, children with internalizing problems tended to be impaired in various social and school activities, as well as in their perceived self-competence (e.g., Messer & Beidel, 1994; Silverman & Ginsburg, 1998). This impairment could hinder children’s readiness for learning (Pianta, 1997) and could increase the risk for suicide attempts (Lewinsohn, Rohde, & Seeley, 1998). Furthermore, these internalizing problems might intensify over time and were likely to develop into psychiatric conditions (Kendall & Chu, 2000; Lewinsohn, et al., 1998). For example, internalizing problems in childhood might play a causal role in the development of depressive disorders and anxiety disorders (e.g., Seligman & Ollendick 1998), conduct disorders as well as substance use disorders (e.g., Cheng & Myers, 2005). Failure to intervene early with effective treatments might render the child vulnerable to impairments in a wide range of functioning and result in deleterious effects on the person’s long-term emotional development. For instance, a longitudinal study found that children with anxiety disorders faced a two- to four-fold increased risk for having an adult anxiety disorder (Pine, Cohen, Gurley, Brook, & Ma, 1998). Increased understanding on how to treat these disorders in children was therefore imperative not just because of the frequency with which these disorders were encountered, but because, when present, they engender significant immediate distress and impairment and could often lead to lifelong difficulties in overall functioning.

Internalizing problems among children in Hong Kong also reached an alarming point. A recent report released by Health, Welfare and Food Bureau of HKSAR (Apple Daily, October 8, 2004) estimated that about 5 to 10 percent of children is suffering from anxiety disorders while 2 percent is suffering from depressive disorders. In a recent study published in late 2005 by Education Policy Concern Organization (EPCO) and Hong Kong Association for Careers Masters and Guidance Masters (HKACMGM) indicated that 75 percent of primary school children were unhappy. Their emotional problems were mostly on academic performance as well as on social relationship with others. It had long been noted that parents in Hong Kong, in general, pay most of their attention to their children’s school work and study-related behaviour, and focus less on their children’s emotions and mental health. In fact, primary school children also have their own frustrations in meeting their expectations from self and/or from others. As internalizing problems often went undetected at the earlier stage of life, problems such as depression, suicide tendency might occur (Centre for Suicide Research and Prevention, 2003). This may be particularly the case in Chinese children given the cultural endorsement of coping with personal distress through internalizing means (Chen & Swartzman, 2001). Hence, early identification of

children with internalizing problems was crucial (Babinski, Hartsough, & Lambert, 1999; Shiner, Masten, & Roberts, 2003).

Looking into research on childhood internalizing disorders, most major reviews of the evidence of intervention effectiveness (e.g., Kazdin, 1994; Target & Fonagy, 1996) concluded that the principal issues were still to be resolved, i.e., what works for whom under what conditions? Nevertheless, meta-analytic reviews of intervention effectiveness research literature supported two general conclusions. First, it was confirmed that effectiveness of “therapeutic intervention” was better than “no intervention” (Shirk & Russell, 1992). Second, there was more evidence that cognitive-behavioural therapy was more effective than non-behavioural therapies (Weisz, Weiss, Han, Granger, & Morton, 1995). In the recent reviews of empirically supported psychological interventions for children (as cited in Chambless & Ollendick, 2001; Ollendick & King, 2000), cognitive-behavioural therapy (CBT) has demonstrated efficacy for a range of conditions, including generalized anxiety disorders (e.g., Kendall et al., 1997; Ollendick & King, 1998) and depressive disorders (e.g., Harrington, Whittaker, & Shoebridge, 1998; Kaslow & Thompson, 1998). Results from the randomized controlled trials of CBT with children suggested that children can benefit from CBT for depression (e.g., Harrington, Whittaker, & Shoebridge, 1998) and anxiety (e.g., Kendall, et al., 1997). In addition, Weisz and his colleagues (Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997) identified 48 elementary school children (third to sixth grades) exhibiting clinical levels of depressive symptoms on diagnostic rating scales. 16 of these children were administered an eight-session CBT program. The other children served as the no-treatment control group. The treatment group showed significant symptom remission, about twice the reduction in depression scores as the control group. Moreover, among the 60% of the children undergone treatment participated in the nine-month follow-up analysis. Results from the follow-up study showed that significant treatment gains were maintained (Weisz, et al., 1997).

There are many interventions that cater for reducing or preventing childhood internalizing problems. Examples include Penn Optimism Program (POP; Jaycox et al., 1994) and Adolescents Coping with Emotions (ACE; Hannon, Rapee, & Hudson, 2000), and Coping Koala Program (Barrett, Dadds, & Rapee, 1996). Most of them are cognitive-behavioural in nature. FRIENDS, a well-validated intervention program for children, was tested to be effective in individual as well as in group formats.

An empirically validated program for children using CBT: “FRIENDS”

FRIENDS was a cognitive behavioural intervention program for children with internalizing problems (Barrett, Lowry-Webster, & Turner, 2000a, 2000b,

2000c). In addition to learning important personal development skills (e.g., building self-esteem, problem-solving, self-expression of ideas and beliefs, and establishing positive relationships), FRIENDS taught children how to cope with and manage anxiety and depression. This program integrated key elements from a cognitive-behavioural perspective and combined strategies from interpersonal approaches. The CBT components included identifying feelings, its links with thoughts, relaxation strategies, cognitive restructuring, problem solving, self-reward and relapse prevention. The interpersonal component included the establishment of a social support network, managing conflict, and helping others. FRIENDS for children consisted of 10 weekly sessions. This program encouraged children to: (i) think of their body as their friend because it tells them when they are feeling worried or nervous by giving them clues; (ii) be their own friend, and reward themselves when they try hard; (iii) make friends, so that they can build their network for social support; and (iv) talk to their friends when they were in difficult situations. The program name, "FRIENDS", is an acronym for the strategies taught. These include: F – feeling worried?; R – relax and feel good; I – inner thoughts; E – explore thoughts; N – nice work so reward yourself; D – don't forget to practice; S – stay calm, you know how to cope. The program also incorporated sessions for parents, which are scheduled at regular intervals throughout the 10 weeks of the program. These psycho-educational sessions provided parents with an opportunity to learn about the program their children were completing, and to discuss parenting and reinforcement strategies.

The FRIENDS program addressed children by focusing on the physiological, cognitive, and learning processes that are believed to interact in the development, maintenance, and experience of anxiety (and other internalizing problems). *Physiological skills* taught include increasing children's awareness of somatic cues to let them know they are feeling worried (e.g., heart beating fast). Children learnt deep breathing and progressive muscle relaxation. *Cognitive skills* included recognition of how one's thinking affects how one feels and what one does. Children are taught to recognize negative self-talk and to cope with worrying situations by learning to challenge unhelpful thoughts (e.g., thought terminators), to identify help whenever needed (e.g., my support team), and to concentrate on the positive aspects of a situation and what they did well. *Behavioural skills* taught include problem solving (e.g., 6-block problem-solving plan) and rewarding oneself for using positive coping skills.

Recent research suggested that FRIENDS program was an effective one for children with internalizing problems. In Shortt, Barrett, and Fox's (2001) study, seventy-one 6 to 10 years old children were randomly assigned to FRIENDS for Children treatment program or a 10-week wait-list control. At the post-treatment, 69 percent of children who completed treatment were diagnosis free, compared to 6 percent in the wait list condition. Similar results comparing treatment group to wait-list control groups were also obtained from studies by Flannery-Schroeder and Kendall (2000). The FRIENDS program had also been

adapted for culturally diverse primary school children, such as Chinese and Yugoslavian migrants (Barrett, Sonderegger, & Sonderegger, 2001). Children under treatment showed improved coping skills and were better able to combat anxiety and other internalizing problems.

Effectiveness of the FRIENDS program had been documented in the recent literature. A controlled clinical trial, conducted in 1994-1995, to evaluate the program as a clinical intervention for children diagnosed with DSM-IV anxiety disorders (Barrett, Rapee, Dadds, & Ryan, 1996). The intervention was successful, and, at post-intervention, 80 percent of those treated were free from an anxiety disorder, and have remained so for up to six years following the intervention (Barrett, Duffy, Dadds, & Rapee, 2001). The intervention was later tested in a group format, with equal success (Shortt, Barrett, & Fox, 2001).

Application of CBT on Chinese children

Despite the fact that CBT has been highly evaluated as an evidence-based treatment approach for working with adults and children, and that it was commonly used by clinicians in the local setting, very few articles on discussing the effectiveness of CBT in young children have been identified from a literature search performed through PsyINFO for relevant publications on CBT with Chinese/Hong Kong children over the past ten years.

As FRIENDS is a well-validated program in CBT for children, it would be worthwhile to explore the cultural appropriateness of its program contents to children in other parts of the world. Given that local situation in Hong Kong has very limited research on program effectiveness for working with children having internalizing problems, the major purpose of this study is to explore the feasibility of adopting the FRIENDS program in Hong Kong for children who are at risk for developing internalizing disorders such as depression and anxiety. It was anticipated that if these children's internalizing behaviour were reduced, they would be more confident in themselves and would eventually lead to higher self-esteem. Specifically, it was hypothesized that participants in the FRIENDS program would have a significant decrease in symptoms relating to internalizing behaviour, as well as a significant increase in self-esteem when compared to those from the control group.

METHOD

Participants

A total of 85 children who were identified as at-risk for developing internalizing disorder (according to the Child Behaviour Checklist – Chinese version; CBCL, Achenbach, 1991; Leung, Ho, Hung, Lee, & Tang, 1998) were recruited from three government-aided primary schools based on convenience. These children ranged in age from 7 to 10 years. There were 39 boys and 46 girls. Among these children, 47 agreed to participate in the current study. The mean age

Articles Section

was 8.4 years old (standard deviation, $SD=1.15$). The remaining 38 children refused to join. Among those who refused to join, 19 of them indicated that they did not want to miss tutorial classes, 12 of them stated that they had to attend extra-curricular activities, 3 children indicated that they were not feeling comfortable about being in an intervention group with other schoolmates and the rest did not provide specific reasons as to why they did not join the program. Among the participating children and their mothers, none of them were currently receiving any form of counseling or psychotherapy. In addition, the intellectual level of these children was at least within the normal range (as reported by their teachers). The breakdown of the demographic variables for the participating children under the two conditions is presented in Table 1.

Table 1
Demographic details of participants in each condition.

	<u>FRIENDS</u> <u>condition</u>	<u>Waitlist control</u> <u>condition</u>
<i>Gender</i>		
Male	12	13
Female	11	11
	23	24
<i>Grade level</i>		
Grade 2	9	9
Grade 3	7	9
Grade 4	6	7

Measures

Standardized questionnaires were used to assess the effectiveness of the FRIENDS program on children. As these standardized questionnaires were in English (except the Child Behaviour Checklist, CBCL; Achenbach, 1991, whereby there was a formalized Chinese version translated by Leung, Ho, Hung, Lee & Tang, 1998), translation of items was done with the help of two bilingual students in graduate school, one major in English and the other one in Chinese. Forward and backward translations on the questionnaire items were conducted before a satisfactory Chinese version of the questionnaires was adopted for use in this study.

Measures on symptoms relating to internalizing behaviour

Child Behaviour Checklist (CBCL). Mothers were administered the Child Behaviour Checklist – Chinese version (CBCL; Achenbach, 1991; Leung, Ho, Hung, Lee, & Tang, 1998) for items relating to the relevant syndromes for their children on internalizing, i.e., subscales on *Withdrawn*, *Somatic Complaints*, and *Anxious/Depressed*. There were 9 items in *Withdrawn* (e.g., “likes to be alone”), 10 in *Somatic Complaint* (e.g., “feels dizzy”), and 14 in *Anxious/Depressed* (e.g., “inattentive, easily distracted”). Parents indicated the degree or frequency of each

behaviour described in the item on a scale of 0 (not true), 1 (somewhat or sometimes true) or 2 (very true or often true). By summing 1s and 2s on all items, total scores on different problem behaviours, including a score on internalizing behaviour, were obtained. These CBCL behaviour scales have been normed according to age and gender categories (boys: 4-11, girls: 4-11, boys 12-18, and girls 12-18) on both clinically referred and non-referred samples of children. In addition, clinical cutoffs on normalized T-scores have been specified for distinguishing referred and non-referred children. Similar pattern of cutoff point for *Internalizing* were identified from Leung, et al. in the Hong Kong norm for CBCL. Scores at or above 13 in the CBCL-Chinese version were considered as "high risk" for having internalizing problems.

Reynold's Child Depression Scale (RCDS; Reynolds, 1992) was a 30-item questionnaire and used a 4-point likert type response format. The last item used a response format consisting of five faces depicting emotions ranging from happy to sad. The child was asked to indicate the frequency of occurrence or duration of item-specific symptoms as *Almost Never*, *Sometimes*, *A lot of the time*, or *All the time*. Score for each item ranged from 1 to 4. Children were asked to endorse the response that best indicates how they have been feeling in the past two weeks. Examples of items include: "I feel happy", "I feel sad", "I have trouble sleeping". The total score was calculated by summing the scores (after all the necessary reverse-scoring) for all items. There is a correlation of 0.73 between the RCDS and *Children's Depressive Inventory* (CDI, Kovacs, 1979, 1986). The RCDS has been used as a treatment outcome measure in a study examining treatment of depressed children (Stark, Reynolds, & Kaslow, 1987). It has also been used as a screening measure for assessing the symptoms of depression for elementary-age children (Merrell, 2003).

Screen for Child Anxiety Related Disorders (SCARED; Vandecreek & Jackson, 2003) was a screening tool for childhood anxiety disorders. It is developed to measure the DSM-IV (American Psychiatric Association, 1994) anxiety disorders and to differentiate children with anxiety disorders and those with other psychiatric disorders. It was a 41-item questionnaire and respondents are asked to rate statements on a 3-point scale ranging from 0 (not true) to 2 (very true). The SCARED was sensitive to treatment effects. The total score on anxiety consisted of 5 subscales on different types of anxiety symptoms, namely: Somatic (e.g., "When I feel frightened, it is hard to breathe"), Generalized Anxiety (e.g., "I worry about being as good as other kids"), Separation Anxiety (e.g., "I worry about sleeping alone"), Social Anxiety (e.g., "I feel nervous with people I don't know well"), and School Avoidance (e.g., "I get headaches at school"). A total score of 25 or above may suggest the possible presence of one or more of the anxiety disorders. SCARED demonstrated good internal consistency (Vandecreek & Jackson, 2003) and good discriminant validity between anxiety and nonanxiety disorders (Birmaher et al., 1999).

Measure on self-esteem

Culture-Free Self-Esteem Inventory-III (CFSEI-3, Battle, 2003) was a self-report inventory used to determine the level of self-esteem in children. It was also used to assess therapeutic progress and evaluate post-therapy effects. The global score included four areas: *Academic*, *General*, *Home/Parental*, and *Social*. Academic self-esteem referred to a child's perception of his/her abilities, attitudes, and values as he/she relates to school, academic skills and intelligence. Examples of items from this subscale included: "I am proud of my schoolwork." General self-esteem measured an individual's perceptions about himself/herself as a person. The items asked about one's perceptions of his/her emotional states, successfulness, and self-acceptance. Examples of items on this subscale included "Most boys and girls are better at doing things than I am." Parental/Home self-esteem measures self-esteem of the child within the family unit. Items were related to one's perception of his/her abilities, attitudes as they related to the quality of interactions within the home and family unit. Examples of items included: "My parents make me feel like I am not good enough." Social self-esteem measures self-esteem in social situations and interpersonal relationships with peers. The items asked about one's perception of his/her abilities, attitudes as they related to the quality of interactions with peers outside of the family unit. Examples of items on this subscale included: "Boys and girls like to play with me." The total score of the subscale refers to the summation of the scores collected. The average internal consistency coefficients ranged from 0.81 to 0.93; time sampling coefficient range from 0.72 to 0.98. For the purpose of this study, only items from the relevant scales (i.e., *General*, *Home/Parental*, and *Social*) were used.

Design

This is a study on intervention effectiveness. Pre- and post-measures were conducted before and after the intervention to determine the effectiveness of using FRIENDS to combat children's internalizing problems. There were two conditions, namely the "FRIENDS" condition and the waitlist control condition.

Experimental Condition – the FRIENDS group. The content of the FRIENDS program (Barrett, et al., 2000a, 2000b, 2000c) was followed, with a few modifications as presented below. First, given the limited amount of time allocated by the schools for this program, the original FRIENDS program, which consists of 10 sessions, had to be shortened to 8. The sessions were conducted on a weekly basis. Second, the FRIENDS parent program was done in a group format for two one-hour sessions during the program in each participating school. One session was between week 2 to week 4 of the program and the other between week 5 and 7. Such arrangement was made to meet the busy schedule of the local (working) mothers. Should mothers be absent in any of the sessions, close contact (such as phone call) would be made in order to ensure that these mothers knew what was going on in the sessions and the what the follow-up tasks were. In these

sessions, mothers were explained the rationale of the sessions and were taught how to use appropriate reinforcement strategies to encourage children's desirable behaviour (Barrett, 1998; Silverman et al., 1999). Third, several of the FRIENDS program's writing tasks were conducted out loud (i.e., children verbalized their ideas while the facilitators wrote down their responses on the board.). Due to the differences in abilities among the participating children in their comprehension skills, the language in the exercises was simplified accordingly. Fourth, modifications of terms specific to the Chinese (Hong Kong) culture were replaced. For example, the characters used in the worksheets had a Chinese name instead of a translated English name. The stories like "Megan's difficulties talking in front of class" as well as home activities like "Sam's unhelpful thoughts" were translated into Chinese with elaboration in relation to pressure from local school settings, such as facing exams and dealing with peer pressure.

Wait-list control condition. Children and their mothers were told that the arrangement for the group sessions would be made at a later time. They were asked to complete the assessment measures for pre-treatment period. No contact was made with this group of participants till two months later whereby they were contacted again for completing the same set of questionnaires as post-treatment measures. A schedule for the upcoming group treatment sessions would be announced. School guidance personnel would follow-up on those children in scheduling and conducting group sessions for them.

Procedure

Recruitment of participants: Screening and selection. A cover letter explaining the purpose of the study, together with the CBCL-Chinese version, was distributed to the three schools with mothers whose children were from Grade 2 to Grade 4. Children who scored at or above the cut-off point of the CBCL for internalizing problem, as well as meeting other criteria for at-risk children, were invited to join this study. The purposes of the intervention program and the informed consent were explained to the parents. Participation was voluntary on the part of the mothers and it was clearly explained that no child would be forced to participate if he/she did not want to. Their participation would in no way related to their grades at school.

Allocation of participants to conditions. Children were randomly assigned into the experimental condition ("FRIENDS") and the waitlist control condition. Before the start of intervention, participating children were asked to fill in the questionnaires (RCDS, SCARED, CSFEI-3) as pre-intervention measures. Questionnaires for the participating children were administered in groups, with the school personnel explaining the statements to these children. The exercise was done in the classroom, with the help of a volunteer recruited by the researcher. Children in these classes were informed that no one in their school would see their responses and that the volunteer would not know who the children were in processing their collective responses. At the end of this session,

children were briefed about the absolute anonymity of their identities as well as the arrangement for the future exercises of similar nature.

Group sessions were conducted once a week by two trainers (who were studying their postgraduate degree in counseling). A clinical psychologist conducted two briefing sessions to these trainers to facilitate them in understanding the rationales of the FRIENDS program and to equip them with the necessary skills in conducting the sessions. When all the sessions were over, participating children, as well as their mothers, were asked to complete the same set of questionnaires they did at post-intervention again as post-intervention measures. These children were arranged in groups to complete the questionnaires in the classroom. School guidance personnel, who were blind to the conditions in the study, helped out with the data collection for these questionnaires. Questionnaires for mothers were distributed through the class teacher and were returned to the school for later collection by researcher. The researcher helped in reminding mothers to complete and send in the questionnaires should they fail to return them on time. Mothers who failed to return the completed questionnaires within the extended period were regarded as drop-outs.

RESULTS

Characteristics of the participants

A total of 85 children from the three schools reached at least the cutoff point for CBCL-internalizing score. No significant difference for the internalizing scores among schools was found. Among the 47 children who participated in the study, no significant difference among grades was identified. There was, however, a significant difference in CBCL-internalizing score in children between those whose mothers agree to join the program and those who declined, with $F(1, 83)=21.64, p<.01$. The mean of CBCL-internalizing score for those who participated in the program was 17.61 ($SD=3.29$) while for those who did not was 21.15 ($SD=3.47$). Hence, care must be taken in interpreting the result of this study. With this sample of children and their mothers, attrition, however, may not be a major concern in this study. Only 8 students missed one of their sessions for once. All mothers also handed in their questionnaires according to schedule.

Intervention effectiveness

Pre-intervention. Before the start of the intervention program, children in the two conditions were compared on all measures using t-tests. These measures were CBCL-internalizing score as reported by mothers, child-reported scores on RCDS (depression), and SCARED (anxiety); as well as child-reported scores on CFSEI-III (subscales on *Parental/Home, Social, General*). No significant difference between these two conditions was found.

Pre-post comparisons. To examine intervention effects, paired t-tests were conducted on all outcome measures for comparing children before and after the intervention. Significant differences between pre- and post-intervention were

identified. With reference to the broadband score on internalizing behaviour, as reported by mothers using the *CBCL*, there was a significant decrease in students who participated in the *FRIENDS* program ($t=21.47$, $p<.01$). There was also significant drop in scores on depression and on anxiety for the *FRIENDS* group, as measured by students in *RCDS* and *SCARED* ($t=9.04$ and 14.94 respectively, with $p<.01$). As for self-esteem, participants from *FRIENDS* reported significant increase in *Social* self, *Parental* self as well as *General* self ($t=-10.96$, -9.87 , -9.29 respectively, $p<.01$).

Post-intervention. Comparison at post-intervention indicated that there was a significant difference between children from *FRIENDS* condition and from the waitlist control condition in all measures. The *F*-values (1, 45) for behaviour symptoms, as reported in *CBCL*-internalizing score, *RCDS* and *SCARED* were respectively at 40.75, 12.74 and 20.26. As for self-esteem, the values of *F* (1, 45) were at 17.34, 25.75 and 23.09 for *Parental*, *Social* and *General* self. Table 2 showed the pre- and post-intervention means (*M*) and standard deviations (*SD*) of all measures used in this study.

Table 2. Pre- vs post-intervention means (and *SD*) of all the measures used for intervention and waitlist control conditions.

	<i>Intervention: FRIENDS</i>		<i>Waitlist Control</i>	
	Pre M (SD)	Post M (SD)	Pre M (SD)	Post M (SD)
Symptom-reduction				
<i>CBCL</i> -internalizing**	17.13 (3.88)	12.17 (3.09)	18.08 (3.09)	17.79 (2.93)
<i>RCDS</i> **	54.52 (5.33)	51.39 (4.95)	55.87 (4.58)	57.00 (4.54)
<i>SCARED</i> **	31.69 (4.48)	23.30 (2.51)	31.00 (6.72)	30.95 (6.68)
Enhancement of self-esteem				
<i>CFSEI</i> -III				
Social**	10.04 (1.33)	12.39 (1.69)	10.16 (1.30)	10.08 (1.41)
Parental/Home**	6.86 (2.34)	8.69 (2.34)	7.08 (1.28)	6.50 (1.03)
General**	5.56 (2.93)	8.21 (2.02)	5.20 (1.88)	5.54 (1.79)

Note:

** significant at $p<.01$ for participants in the Intervention condition.

CBCL = Child Behaviour Checklist; *RCDS* = Reynold's Child Depression Scale; *SCARED* = Screen for Child Anxiety and Related Disorders; *CFSEI*-III = Culture-free Self-Esteem Inventory-III.

DISCUSSION

With the prevalence of anxiety and depressive disorders in children and its long-lasting impact onto adulthood, effective early intervention programs are needed for children who showed anxious/depressed symptomatology. FRIENDS is an evidenced-based anxiety prevention program (Barrett, 1998). Effectiveness of this program on children with anxiety has been tested in many countries (e.g., Barrett, Moore, & Sonderegger, 2000; Barrett, Sonderegger, & Xenos, 2003). The present study supported that FRIENDS can be adapted and applied to a group of primary school children in Hong Kong who showed internalizing problems and are at risk for developing psychiatric problems. Although the theoretical foundation of the program remains the same regardless of the type of children involved, it is worth exploring the factors that make the FRIENDS program appropriate for a population that was culturally and contextually different from the children for whom the FRIENDS program was initially developed. By working out the feasibility of FRIENDS on Hong Kong children, local researchers can then make requisite modifications, and then test out its efficacy in a large scale. The result of this study indicated that the FRIENDS program is feasible for use with a local Hong Kong sample, with few modifications.

A total of eight sessions were held over eight weeks which was different from the FRIENDS manual spreading over ten weekly sessions. This increased intensity may have helped children in grasping the key focus of the program. It also reduced the disruption made to students as they had to be taken out from normal classes. The disadvantages, though, was that there was less time in sessions for open discussion and sharing. Hence, the behavioural homework became an important task for reflection. Second, written feedback on the scenario cases were replaced with think-aloud tasks. The latter format was more interactive. It enabled teachers to understand more about how much the children were following through. Less written work also reduced difficulties for children with poor reading and writing skills. Teachers facilitated children's discussion by dropping down their ideas (in words) on the board so participants can take their own time to take down important notes. Third, the relaxation games were replaced with a well-known script on relaxation (HKPS, 2004). This relaxation script was specially written for young children. Fourth, modifications were made in relation to contextual elements. For example, in Home Activity #4, children were asked to underline unhelpful thoughts that the friends were saying to each other. Instead of talking about playing musical instruments, the discussion would focus on dealing with homework assignments. Throughout the program, attempts were made to relate experiences that were conceptually relevant to local children, including their fears (in getting low marks, speaking in front of class). Other changes may also adapt to the Hong Kong Chinese culture by using pictures and scenarios commonly heard in the local community as examples in the worksheets. For example, in the Feeling Good exercise, the activities could be made to be more

more relevant to the local cultural context.

The current program is a pilot study on the feasibility of using the FRIENDS anxiety prevention intervention program in the Hong Kong sample. Given the small sample involved, sophisticated statistical analyses could not be performed. However, the statistical significance could be obtained in the pre- and post-intervention analyses, as well as between group analysis for comparing the intervention of FRIENDS and control conditions.

The current study has several limitations. First, caution should be taken in interpreting the result of the intervention in concluding the decrease in symptoms as a result of intervention. The participants in this study were those whose internalizing problems were at .less severe level. Parents who were willing to sign consent forms for joining the program were different from those who did not. Second, a variety of sources of information could be gathered to ensure objective evidence-based outcome. For example, treatment effectiveness of various programs would benefit from clinical observations of parent-child interaction. Structured-interviews with the parents, teachers or significant others may provide different perspectives on understanding children's behaviour and the effectiveness of the intervention. Inter-subjective perspective from different parties might provide further insights into the assessment procedures and the evaluation of intervention programs. More systematic ways to collect qualitative data might help in evaluating the effectiveness of the intervention. Third, the sample size for the intervention outcome study was small and this could also have an impact on the external validity of the conclusion (Graziano & Raulin, 2004). Future studies with larger samples would allow further exploration of treatment outcome moderators. Effectiveness of this intervention program on children at different ages could be explored by incorporating children in other grade levels.

Despite the limitations of this study, the data support the feasibility of using the FRIENDS program in a Chinese context. Further studies can be done to make the program culturally and contextually appropriate for children in Hong Kong who are at-risk for developing internalizing problems.

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