Social and Emotional Learning in the Classroom: Evaluation of *Strong Kids* and *Strong Teens* on Students' Social-Emotional Knowledge and Symptoms

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ABSTRACT. This article describes the results of three pilot studies that were conducted to evaluate the recently developed *Strong Kids* and *Strong Teens* social-emotional learning programs in increasing students' knowledge of healthy social-emotional behavior and decreasing their symptoms of negative affect and emotional distress. The first study included 120 middle school students (in grade 5) from a general education student population. The second study included 65 general education students in grades 7–8. The third study included 14 high school students (grades 9–12) from a regional

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special education high school, who were identified as having emotional disturbance. The three groups participated in either the *Strong Kids* (groups 1 and 2) or *Strong Teens* (group 3) programs, receiving one-hour lessons and associated assignments once a week for 12 weeks. Social-emotional knowledge and negative emotional symptoms of participants were assessed using brief self-report measures, in pretest-posttest intervention designs. All three studies showed that, following participation in the respective programs, students evidenced statistically significant and clinically meaningful changes in desired directions on the target variables. Implications for future research are discussed, as is the importance of social and emotional learning as a prevention and intervention strategy to promote mental health among students in schools.

KEYWORDS. Social-emotional learning, prevention, intervention, schools

Social emotional learning (SEL) is an important emerging focus in education and children's mental health. SEL includes a broad range of methods and techniques to promote mental health and resilience, to teach social, emotional, and life skills, and to prevent negative life outcomes, through effective curricular programming, as an integral part of a school program (e.g., Greenberg et al., 2003; Ragozzino, Reznik, O'Brien, & Weissberg, 2003; Zins, Weissberg, Wang, & Walberg, 2004).

Although there is no single definition of SEL, one of the most influential and widely-read definitions of the construct is from the Collaborative for Academic, Social, and Emotional Learning (CASEL), a leading group of researchers and policy analysts who have championed the use of SEL in schools. CASEL's most visible definition of SEL from the organization's Web site reads:

> Social and emotional learning (SEL) is the process of acquiring the skills to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. Research has shown that SEL is fundamental to children's social and emotional development—their health, ethical development, citizenship, academic learning, and motivation to achieve. Social and emotional education is a unifying concept for organizing and coordinating school-based programming that focuses on positive youth development,

> health promotion, prevention of problem behaviors, and student engagement in learning. (CASEL, 2006)

SEL has an impressive emerging research base. Empirical evidence to date supports the notion that school-based SEL programs may be effective in reducing emotional and behavioral problems and enhancing children's social and emotional competence, as well as showing a strong corollary impact on academic achievement (e.g., Wilson, Gottfredson, & Najaka, 2001; Zins et al., 2004). Although SEL is not the province of any one discipline or professional field, we believe that these efforts should be of particular importance for educators, administrators, and mental health professionals such as psychologists, counselors, and social workers who work in school settings, in their efforts to promote and to provide comprehensive educational and mental health services for children, adolescents, and their families. SEL is a natural extension of efforts within the fields of education and mental health to promote effective school-based mental health and life-skills training (Merrell, 2002). Furthermore, SEL programs are consistent with an approach to providing these services in a way that they may positively affect large numbers of students simultaneously rather than focusing on solving problems "one child at a time" (Shapiro, 2000, p. 561).

School-based interventions targeting mental health needs of a range of students are increasingly important. Research has indicated that approximately 25% of students in schools will struggle with school adjustment at some point (Weissberg, 2005), and that as many as 15%–22% of students will develop serious enough social-emotional and mental health problems to warrant treatment (Greenberg, Domitrovich, & Bumbarger, 2001). However, over 70% of the students in American schools who would benefit from mental health interventions are not provided with appropriate services (Greenberg et al., 2001, 2003). Further, the impact of untreated social, emotional, and mental health problems extends beyond the current needs of individual students. The behaviors of these students may disrupt the learning process for other students, these students may experience learning difficulties, and teachers may tire from working with students who are not reaching their full potential (Elias, Zins, Graczyk, & Weissberg, 2003). Failing to appropriately treat existing social, emotional, and mental health problems can place children at risk for later, more serious problems including psychopathology, school failure, or substance use (Doll & Lyon, 1998; Greenberg et al., 2003). Addressing the social, emotional,

and mental health needs of youth in schools is a critical target for researchers and school-based professionals. Researchers promoting social and emotional learning programs are building a research base for intervention efforts that focus on children and adolescent's social, emotional, and mental health needs (Greenberg et al., 2003).

In addition to addressing social, emotional, and mental health needs, there is evidence to indicate that SEL programs can have a positive impact on academic achievement, antisocial behavior, and substance use (Greenberg et al., 2003; Zins et al., 2004). Given the wide-reaching impact of social, emotional, and mental health problems of students, we need interventions that are capable of not only remediating existing problems but also of preventing them from occurring from the start. Many SEL programs take this prevention-oriented approach by teaching students skills to regulate their emotions and to appropriately interact with others (Greenberg et al., 2003).

Although social and emotional learning efforts include a broad array of methods and techniques, there are some commonalities. SEL programs and practices tend to focus on preventing negative school and life outcomes by focusing on positive youth development. Some of the specific focus areas of successful social-emotional learning and positive youth development programs have included mental health promotion, substance use reduction, and substance abuse prevention, reducing antisocial behavior and school avoidance, and enhancing academic performance and learning (Greenberg et al., 2003). Although the existing programs vary considerably in their approach, focus, and amount of efficacy evidence available, there is reason to be optimistic that such tools can be used to produce meaningful positive changes in students' lives. For example, in their review of a large number of such positive youth development programs, Catalano, Berglund, Ryan, Lonczak, and Hawins (2002) concluded that "Promotion and prevention programs that address positive youth development constructs are definitely making a difference in well-evaluated studies" (p. 62). The finding that social and emotional learning strategies have been shown to have a positive impact on academic performance (Elias, 2004) is of strong potential interest among professional educators and shows that benefits may be complex and far-reaching. In effect, the integration of appropriate social and emotional learning programs into a school curriculum may have three general types of beneficial outcomes: Reducing current levels of students' behavioral and emotional problem symptoms, helping to reduce the number of future occurrences of such problems, and enhancing students' abilities to successfully engage in academic learning (Elias et al., 2003).

In 2003, the State of Illinois mandated the use of SEL efforts in all schools, through the 2003 *Illinois Children's Mental Health Act* (Public Act 93-0491, SB 1951). Section 15(b) of this law states "Every Illinois school district shall develop a policy for incorporating social and emotional development into the district's educational program. The policy shall address teaching and assessing social and emotional skills and protocols for responding to children with social, emotional, or mental health problems, or a combination of such problems, that impact learning ability." More recently, the State of New York adopted similar legislation, the *Children's Mental Health Act of 2006* (New York Office of Mental Health, 2006). Among other things, this $62 million initiative provides resources and a system to encourage communication and collaboration between New York's department of education and the office of mental health, to promote positive social-emotional development practices in schools. We believe that these legislative acts are important and encouraging developments, and that all school-based mental health professionals and educators would do well to consider these particular promotions of SEL as harbingers of things to come in other states and nationally in the near future.

Although SEL is a promising development with an increasing evidence base, there is still a pressing need for development of unique SEL programs and additional research efforts to answer questions related to how to best implement these curricula and programs. For example, the minimum amount of time required for meaningful implementation of SEL curricula is still an open question. Some proven or promising programs/curricula are designed to be implemented frequently across an entire school year, and other efforts are even multiyear and extremely difficult and expensive to deliver. Such efforts are admirable and often effective; however, they may also be difficult or unrealistic to implement in many settings. With instructional time being a precious commodity in educational settings, it seems desirable to determine whether briefer, less time-consuming SEL curricula may result in meaningful change at less cost. In addition, there is a wide variation in personnel and training requirements for SEL programs, with some requiring the use of specialists and expensive "certified trainer" processes. Again, given the importance of making SEL efforts universal and easily available, it seems desirable to investigate the efficacy of programs that are more self-contained in design, and appropriate for implementation or delivery by a wide range of educators and mental health personnel.

The particular focus of this article is the intervention impact of the *Strong Kids* social and emotional learning programs. These companion programs are semiscripted SEL curricula, focusing on prevention and early

intervention of internalizing problems, promotion of social and emotional competence, and teaching students skills to increase their resilience to life stressors. There are four different curricular components of the *Strong Kids* programs, each one for a specific developmental level. *Strong Start* (Merrell, Parisi, & Whitcomb, 2007) is for use with children in grades K–2. *Strong Kids* (Merrell, Carrizales, Feuerborn, Gueldner, & Tran, 2007a, 2007b) includes separate curricula for students in grades 3–5 and grades 6–8. *Strong Teens* (Merrell, Carrizales, Feuerborn, Gueldner, & Tran, 2007c) is designed for students at the high school level, grades 9–12. These curricula are practical and easy-to-use, brief (10–12 lessons of 45–50 minutes each, plus optional booster lessons for use two or three months later), adaptable across a range of students and settings and designed to be taught in small groups or with entire classrooms by educators or support service professionals. Minimal training is needed to teach these curricula, and the manuals for each program include guidance for becoming proficient in delivering the curricula. Additional information on the four programs, including free downloadable assessment and progress monitoring tools, is available on the *Strong Kids* Web site at http://strongkids.uoregon.edu.

The programmatic focus of the studies presented in this article is on both the elementary and middle school versions of the *Strong Kids* curricula, as well as the *Strong Teens* curriculum. These three programs are essentially different age-level adaptations of the same curricula concepts. They are similar in design features and content and differ only with respect to the examples and language used, so that they are more age appropriate to the specific developmental periods targeted. The lesson titles and content focus of the 12 basic lessons in *Strong Kids* and *Strong Teens* include:

About Strong Kids/Teens (pretesting, curriculum overview, rules, ice-breaker activities)
Understanding Your Emotions, Part 1 (increasing emotional vocabulary, defining emotions)
Understanding Your Emotions, Part 2 (appropriate expression of emotions)
Dealing with Anger (understanding anger, cognitive-behavioral anger management training)
Understanding Other People's Feelings (empathy training, taking perspective of others)
Clear Thinking, Part 1 (identifying thinking errors and maladaptive beliefs)
Clear Thinking, Part 2 (actively changing maladaptive beliefs and thinking errors)

The Power of Positive Thinking (learned optimism training)
Solving People Problems (interpersonal conflict resolution skills and practice)
Letting Go of Stress (practice in cognitive and behavioral methods of relaxation)
Achieving Your Goals (goal-setting, behavior education, behavior-affect connection)
Finishing UP! (cumulative review of major concepts, planning for future, posttesting)

The *Strong Kids* and *Strong Teens* programs use a combination of cognitive-behavioral and affective education techniques, with each lesson containing opportunities for review of prior concepts, instruction and practice of new skills, corrective feedback, generalization activities, and student handouts/worksheets. Although the lessons are scripted, they are easily adaptable for specific circumstances, and the manuals include suggestions for adapting the curricula for specific social, cultural, geographic, or other circumstances.

Given the need to establish efficacy of the recently developed *Strong Kids* and *Strong Teens* curricula, and the need to evaluate the impact of brief, scripted SEL programs in general that are designed for a broad range of applications, the purpose of the three pilot studies described in this article was to determine the impact of *Strong Kids* and *Strong Teens* on the knowledge and social-emotional functioning of selected groups of students. These three pilot studies were the first efforts to empirically evaluate the efficacy of these curricula.

Pilot studies are a useful tool for researchers who develop new interventions and are interested in examining intervention effectiveness on modest-sized populations prior to investing in large-scale randomized clinical trials (Breakwell, Hammond, & Fife-Schaw, 2000). Pilot studies also allow researchers to work through technical and theoretical questions related to the intervention such as level of training needed to deliver the intervention, amount of time for each intervention session, and participant response to the intervention (Breakwell et al.). Summarizing the findings from multiple pilot studies offers researchers the opportunity to integrate and to contrast findings. Studies utilizing similar materials, strategies, and statistical analyses can be effectively compared and contrasted to provide more robust evidence for the intervention (Cooper & Hedges, 1994). This integration of findings can strengthen one's confidence in the results obtained from individual studies, thus enhancing the external validity of

the studies themselves as well as the intervention as a whole (Cooper & Hedges). The utility of integrating findings is particularly important with studies related to the social and behavioral sciences, given the complexity of human behavior (Wolf, 1986). Interventions in educational settings often differ across multiple variables. For example, participants may come from a variety of socioeconomic, educational, cultural, ethnic, and linguistic backgrounds. Given that social and behavioral research is complex, a synthesis of pilot studies applying the same intervention across different settings allows researchers to build a body of evidence in which professionals in the field can have confidence.

STUDY 1

Participants and Method

Participants in Study 1 included 120 students in grade 5 (ages 10–11; 64 boys, 56 girls) who attended an elementary school located in the Midwestern United States in a region that is currently changing from a rural to a suburban setting and is near a major metropolitan area. The sample was drawn from the fifth grade general education student population that was 97.9% Caucasian and 2.1% Hispanic. These students were primarily from middle-class families with 4.3% of the students classified as at the low-income level and eligible for free/reduced lunch. The *Strong Kid* curriculum for grades 3–5 was taught to all students in each of five different home rooms by the school principal, an experienced classroom teacher, for 45 minutes once per week for 12 weeks. The principal had received prior training from a consultant for the school who was had prior experience implementing the program. Students completed pretest and posttest measures of their knowledge of healthy social-emotional behavior (20 items) and their current levels of internalizing symptoms (10 items). The knowledge test was scored 1 point for each correct response from a multiple choice format for the 20 items, whereas the symptoms test was scored on a 0–3 scale for each of the 10 items, with higher scores reflecting greater levels of distress. Sample items from the two measures are presented in Table 1. These tools were developed by the researchers specifically for evaluating the impact of *Strong Kids*. The knowledge measure has demonstrated adequate internal consistency reliability for research and administrative purposes (.60 to .70). The symptoms test has demonstrated adequate levels of reliability for research, administrative, and screening purposes (.70 to

TABLE 1. Sample Items from the Knowledge and Symptoms Tests

Knowledge Test (correct answers are indicated in italicized text)
Conflict resolution is best described as
a. Discussing a problem until there is a winner and a loser
b. Arguing with another person until they sec your point and give in
c. Problem-solving so you can reach an agreement
d. Talking about the problem until something changes their mind
Which of the following statements best describes empathy?
a. Knowing how you are feeling
b. Wondering why another person is feeling sad
c. Understanding another person's feelings
d. Thinking about another person
Which of the following is a positive way to express how scared you are for your parents to get your report card?
a. Tell them why you are scared
b. Hide your report card
e. Tell your parents they are expecting too much from you
d. Say that your grades were bad because other kids at school distracted you
Symptoms Test
• can't deal with my problems
• I argue with other people
• get so mad that 1 break or throw things
• worry about things
• feel depressed or sad
• Things don't work out for me
• argue with my parents

Note. For the symptoms lest, students rate items according to the folio wing choices: *Never True* (0 points), *Hardly Ever True* (1 point), *Sometimes True* (2 points), *Often True* (3 points)

.80) and has also evidenced strong convergent validity coefficients (.70 to .88) with established social-emotional self-report measures, including the *Children's Depression Inventory* and the *Internalizing Symptoms Scale for Children*.

Results

The mean pretest and posttest scores of students in Study 1 were contrasted to determine statistical significance of mean differences, as well as effect size estimates. Mean scores were contrasted using a *t* test for dependent means (matched-sample *t* test) to ascertain statistical significance of mean score differences between pretest and posttest. In addition, effect size (*ES*) estimates were computed for pre-post mean score differences

using Cohen's (1988) recommended method of analysis and interpretation to evaluate the practical meaning or clinical import of the score differences. Cohen's suggested interpretation guidelines are that *ES* estimates of less than .20 are not meaningful, *ES* estimates of .20 to .49 are meaningful and small, *ES* estimates of .50 to .79 are meaningful and of medium size, and *ES* estimates of .80 and higher are large. The *t* test revealed a statistically significant increase in social-emotional knowledge and effective coping strategies (the knowledge test) from pretest ($M = 11.39$, $SD = 2.82$) to posttest ($M = 14.35$, $SD = 3.47$): $t(119) = -9.80$, $p < .001$. In addition, the obtained *ES* of .94 reflected a large effect, slightly less than a full standard deviation difference between pretest and posttest scores. However, differences with respect to the emotional symptoms checklist scores between pretest ($M = 12.39$, $SD = 4.84$) and posttest ($M = 12.14$, $SD = 4.23$) were neither statistically significant, $t(118) = 0.60$, $p > .05$, nor clinically meaningful ($ES = .05$). In sum, the students in Study 1 showed large and statistically significant gains in knowledge, but no meaningful change in self-reported problem symptoms after participating in the *Strong Kids* program.

STUDY 2

Participants and Method

Participants in Study 2 included 65 general education students in grades 7–8 (ages 12–14; 36 boys, 29 girls) in a public junior high school located in a small town near a major metropolitan area in the upper Midwest region of the United States. The entire sample was Caucasian or European American, which was essentially reflective of the population from the school and surrounding community. Although socioeconomic status of individual participants was not assessed, the school population from which they were drawn was in a primarily middle-class and working-class community. These students participated in the *Strong Kid* curriculum for grades 6–8, taught by study skills class teachers in one 50-minute session per week for 12 consecutive weeks. These teachers had received previous training in the curriculum from a consultant, one of the authors of *Strong Kids*. The teachers also received ongoing curricular support as needed from a consultant who was familiar with the curriculum and experienced in social-emotional group interventions. Students completed the *Strong Kids* pretest and posttest measures of their knowledge of healthy social-emotional

behavior (20 items) and their current levels of internalizing symptoms (10 items)—the same instruments as were used in Study 1.

Results

The mean pretest and posttest scores of students were contrasted using the same analysis techniques described for Study 1, a paired t test to ascertain statistical significance of mean score differences, with effect size (*ES*) estimates also computed to evaluate the practical or clinical importance of score differences. These score contrasts evidenced statistically significant increases in knowledge of social-emotional concepts and coping strategies (the knowledge test) from pretest ($M = 12.46$, $SD = 2.68$) to posttest ($M = 14.80$, $SD = 3.25$): $t(64) = 6.10$, $p < .001$. In addition, the obtained *ES* of .79 was indicative of a meaningful effect of medium size, approximately four-fifths of a standard deviation difference between pretest and posttest. With respect to the emotional symptoms checklist, statistically significant decreases were found in student's self-reported internalizing problem symptoms and negative affect between pretest ($M = 12.80$, $SD = 4.73$) and posttest ($M = 11.14$, $SD = 4.68$): $t(64) = 3.33$, $p < .001$. The resulting *ES* of .35 reflected a meaningful change of small magnitude, slightly more than one-third of a standard deviation difference between pretest and posttest. In sum, the students in Study 2 evidenced significant and clinically relevant gains in social-emotional knowledge and decreases in negative social-emotional symptoms, after participating in the *Strong Kids* program.

STUDY 3

Participants and Method

Participants in Study 3 included 14 students in grades 9–12 (ages 14–17; 10 boys, 4 girls) who attended a regional special education high school in a large urban area in the Midwestern region of the United States. These students had all previously been identified as eligible for special education services under the IDEA *emotionally disturbed* classification category. They were considered to have severe emotional and behavioral problems and thus received educational services at a special program in a regional high school rather than in their home school district. Approximately 75% of the sample was African American, and 25% was Caucasian. These students were primarily from lower middle-class, working-class, and economically

disadvantaged families. The *Strong Teens* curriculum was taught in a life-skills class, co-taught by the student's primary special education teacher and a psychologist/consultant who had received previous training on *Strong Teens* by one of the authors and was familiar with the curriculum. The *Strong Teens* curriculum consisted of 12 lessons, which were taught on a once-a-week basis in sessions of 45 to 50 minutes. The students completed researcher-developed pretest and posttest measures of knowledge of social-emotional concepts and coping strategies (35 items) and current levels of emotional problem symptoms and negative affect (35 items). These measures were an alternate version of the tools used in Study 1 and Study 2, similar in aim, design, and scoring scheme, and differing only with respect to the number of items and adolescent-oriented wording of some items.

Results

The mean pretest and posttest scores of students in Study 3 were contrasted to ascertain statistical significance and clinical relevance of mean score changes. Because of the small sample size and skewed distribution (all students were previously identified as having serious behavioral and emotional problems) in this study, use of a parametric statistical test such the t tests used in Study 1 and Study 2, which are based on the assumption of normal distributions of data and require a moderately large sample size for statistical power, is problematic (Howell, 1982). Therefore, the scores were contrasted using a nonparametric or distribution free test, the Wilcoxon Signed Ranks test for two related samples. This test provides a Z value for differences across ranks of the related samples, as well as an exact p value for the statistical significant of obtained differences. Statistically significant increases in student's knowledge of curriculum-related healthy social-emotional behavior on the knowledge test were found between pretest ($M = 20.36$, $SD = 5.44$) and posttest ($M = 22.36$, $SD = 4.01$): $Z = -4.95$, $p = .001$, and the resulting ES of .42 indicated a meaningful, small effect, slightly less than one-half a standard deviation in magnitude. Student's emotional problem symptoms and negative affect scores from the symptoms test decreased significantly between pretest ($M = 43.00$, $SD = 18.50$) and posttest ($M = 37.00$, $SD = 16.72$); $Z = -3.07$, $p = .002$. The resulting ES value of .34 reflected a clinically meaningful, small effect, approximately one-third of a standard deviation. In sum, the students in Study 3 evidenced statistically significant and clinically relevant changes in their knowledge of social-emotional behavior/coping strategies and in

their negative social-emotional symptoms, following participation in the *Strong Teens* program.

DISCUSSION

The three pilot studies described in this article included similar pretest-posttest intervention designs, but very different participant samples: General education students in an elementary school in an upper middle-class suburban area (Study 1), general education students in a junior high school setting in a working-class rural/suburban area (Study 2), and special education high school students with emotional-behavioral disorders in a large metropolitan area (Study 3). Thus, the findings that replicated consistently across two or more pilot studies increase the confidence with which the results might be interpreted and generalized. This combined use of pilot data greatly enhances the viability of the results in comparison to reporting each study separately.

Each of the three studies showed that participation in the *Strong Kids* or *Strong Teens* social-emotional learning program resulted in statistically significant and clinically meaningful increases in student's knowledge of social-emotional concepts and effective coping strategies. Two of the three studies showed that participation resulted in significant, meaningful decreases in self-reported social-emotional problem symptoms.

These results support the continued use, refinement, and research of the *Strong Kids* and *Strong Teens* curricula and offer encouragement for the notion that even brief social-emotional learning curricula (12 lessons, 45 to 50 minutes each, with supplemental assignments and classroom enrichment activities) taught within school classrooms may provide a benefit to students. The specific curricula used in these studies appear to be unique and promising tools for promoting social-emotional learning among students.

The significant and generally sizable increases in social-emotional knowledge of students over a relatively short period of time are encouraging because of the possible "sleeper effect" that increased social-emotional knowledge may provide over a longer period of time. Although we can only hypothesize this effect because it was not studied directly, increased knowledge regarding healthy and appropriate social-emotional behavior may provide one element of protection that may lead to students making better decisions in the future when faced with emotional and social challenges. Although we are encouraged by the fact that two of the three pilot studies demonstrated significant reductions in students' self-reported

social-emotional problem symptoms, it is not surprising that the general education sample in Study 1 showed no such effects. General education student samples are typically relatively low in such symptoms on the average, and it may be rather difficult to reduce these symptoms with even the best social-emotional learning programs when the symptoms are not problematic in the first place. Although problem symptom reduction in an at-risk or clinical sample would be a desirable outcome, such reductions in a general education sample may not be realistic and perhaps akin to expecting an antibiotic or analgesic medication to produce temperature reductions among children who are not currently experiencing a fever.

Although the combined results of these three studies are promising and encouraging, we consider these efforts to be initial pilot studies because of their limited scope and relatively simple design features. Some of the limitations in this regard include use of existing or intact single groups in a pretest-posttest design rather than randomized clinical trials using experimentally derived treatment and control groups (Isaac & Michael, 1995), relatively modest or small sample sizes, brief experimenter-devised assessment instruments to gauge change (rather than multimethod, multisetting, multirater assessment batteries), and the fact that we measured improvements in affect and knowledge only in the short-term (i.e., without longer term follow-up assessments). In addition, it would have been desirable in retrospect to assess students' social-emotional strengths and assets in addition to measuring their knowledge and negative symptoms. A strength-based approach to evaluating the outcome of a social-emotional learning program may be a positive direction in future research.

In addition to the inclusion of strength-based assessments of social-emotional assets of students, future research with the *Strong Kids* and *Strong Teens* curricula and other brief social and emotional learning interventions should focus on intervention efficacy across differing conditions of lesson delivery (e.g., two lessons per week versus one lesson per week), differing school populations (e.g., with at-risk students, students from various types of cultural-ethic backgrounds, and types of schools), long-term maintenance of observed changes, generalization of intervention effects across settings, isolation of the most important aspects of the curricular content, and appropriate adaptations for use with culturally and linguistically diverse students. In sum, the three studies presented in this brief report offer encouraging findings regarding the efficacy of brief social and emotional learning curricula delivered in school settings. Social and emotional learning is increasingly being viewed as an important and even essential focus for educators and school-based mental health professionals.

The findings presented here may be useful in the further advancement of such efforts. The fact that our findings are derived from and replicated well across three separate samples in pilot studies help to overcome concerns regarding design or sample problems with any single sample and to enhance the confidence with which the results may be interpreted.

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