

BACKGROUND

Preventing youth from dropping out of school is an enormous challenge for school systems; when effective strategies can be implemented there are with extraordinary benefits for youth, communities, and society. According to the National Center for Education Statistics (NCES), in 2001 approximately 3.8 million 16-24 year olds were not enrolled in a high school program and had not completed high school, representing approximately 11% of this age group nationally (Kaufman, Alt, & Chapman, 2004). We know that Hispanic students drop out at the highest rates and that males still outnumber females in dropping out of school. We know that a higher percentage of students in the southern U. S. drop out than in any other region in the country (NCES, 2001). What compounds this issue is that many of these students also have disabilities. The federal government has kept track of dropout/graduation rates for students with disabilities, but until 2004, they have not integrated this information into the national dropout databases (NCES, March 12, 2004).

The National Center on Secondary Education and Transition published a report discussing the issue of dropout among students with disabilities. They have reported several alarming and continuing findings from the literature. For example, in the 1999-2000 school year, just 57% of students with disabilities who completed or left school were graduated with a regular diploma (U.S. Department of Education, 2001). And we know that proportionately almost twice as many students with disabilities drop out as typical students and that the very highest dropout rates among students with disabilities is found among students with emotional and/or behavioral disorders (Blackorby & Wagner, 1996). We also have recent documentation that high school graduation requirements and high stakes exit examinations in high schools are

increasing (Johnson & Thurlow, 2004) possibly making it more difficult for these students to stay in school.

A number of narrative reviews have been published in recent years addressing the problem of dropout and correlates of dropout for youth with disabilities. In an exhaustive review conducted a decade ago, Whitaker (1993) concluded that behavioral, contingency management approaches were the most effective, although he found a number of studies recommending social skills training and self-control management techniques as well. Kashani, Jones, Bumby, and Thomas (1999) examined the literature set on controlling youth violence, similar to Whitaker (1993), and concluded that while cognitive-behavioral, parent training, and family treatment models have been shown to be effective in reducing mildly aggressive, non-violent behavior in younger youth, multisystemic therapeutic approaches were recommended for chronically violent youth. Finally Spekman, Herman, and Vogel (1993), reporting the results of a symposium held in 1991 on increasing resiliency in youth with learning disabilities, recommended among other things, mentoring systems and other external supports. The findings of this symposium were echoed by the review conducted by Nettles, Mucherah, and Jones (2000).

Summary

There are literally dozens of current reviews of dropout prevention programs for at-risk students (c.f. Martin, Tobin, & Sugai, 2002; McPartland & Jordan, 2002). Additionally, there are many reviews of cognitive-behavioral interventions (e.g., Kendall, & Panichelli-Mindel, 1995). This review adds to the literature base of reviews in several important ways. The focus (our ecological perspective notwithstanding) includes only studies that combine the use of a cognitive-behavioral treatment and measurement of one or more dropout prevention outcomes exclusively (or in large part) for secondary aged youth with identified disabilities. Most prior

reviews have focused largely on the effects on academic outcomes, and not dropout prevention outcomes. Indeed, those reviews of cognitive-behavioral interventions that have focused on the reduction of problem behaviors have described those behaviors as an impediment to learning academic content and not as a threat to school completion. Also, most prior reviews have included both studies conducted in elementary school contexts as well as secondary schools and the results of those reviews must be generalized to that broader k-12 context.

We have also required every study included in this review to meet minimum standards of internal and external validity (see Table 1 for an example of the standards and rubric used to assess the studies that employ a between groups design; similar rubrics adapted to the unique features of one group pretest/posttest designs, qualitative designs, and single participant designs are available from the review authors). The standards and assessment rubric in Table 1 were adapted from early design work completed by meta-analysts and systematic review experts at both the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) at the University of London, and at the What Works Clearinghouse (WWC) in the U. S. Department's Institute of Educational Sciences (see their respective websites at <http://eppi.ioe.ac.uk/EPPIWeb/home.aspx> and <http://www.whatworks.ed.gov/>). Hence, our review would be considered evidence-based. Most prior reviews are exclusively narrative reviews with no attempt to screen studies with weak designs out of the review, and no attempts to calculate effect sizes.

Description of Practice

Cognitive-behavioral therapy/interventions (CBT/I) have been described in the literature for nearly 30 years. Meichenbaum's (1977) integrated approach to cognitive and behavioral interventions is generally regarded as one of the most seminal works in building this intervention

approach to address a variety of disorders such as anxiety, depression, and aggression.

Cognitive-behavioral therapies/interventions, as their name implies, typically combine meta-cognitive skill building with classic contingency management systems. Kendall and Panichelli-Mindel (1995) describe CBT/I as follows:

“CBT focuses on how people respond to their cognitive interpretations of experiences rather than the environment or the experience itself, and how their thoughts and behaviors are related. It combines cognition change procedures with behavioral contingency management and learning experiences designed to help change distorted or deficient information processing.” (p. 108)

Although the specific therapeutic or instructional nature of the cognitive and behavioral intervention components may vary greatly in reported studies of CBI/T, there are some distinct commonalities that are present in all of these interventions. First, participants in these interventions are almost always taught, in classroom or therapy environments, a sequential strategy for recognizing one or more stimuli that have historically produced anxiety, stress, or violent responses by the participant, resisting the automaticity of the historical response, and identifying and implementing an alternative strategy that is more socially or emotionally appropriate.

Etscheidt (1991) provides a prototypical description of these strategies as a series of steps in which students are trained to engage through a variety of self-monitoring processes:

- “Step 1: Motor cue/impulse delay;
- Step 2: Problem definition;
- Step 3: Generation of alternatives;
- Step 4: Consideration of consequences; and

Step 5: Implementation” (p. 111)

Often the instruction will involve training students to actively resist impulses for a period of 10-30 seconds, engage in self-relaxation and/or self-talk activities, and cycle through a series of problem-solving processes as alternative behaviors are envisioned and differential consequences of those behaviors are considered. Frequently role-playing is used as an instructional technique to train students.

The second feature of CBT/I is some form of behavioral contingency management. In the studies included in this review, this component of the CBT/I intervention were often described with much less precision. For example, Barkley, Edwards, Laneri, Fletcher, and Metevia (2001) described this component of their CBI intervention as positive parental attention to appropriate behavior, the use of a home point system, the use of grounding or privilege loss to deal with unacceptable behavior, and training parents to anticipate impending problems. In the Etscheidt (1991) study, the behavioral contingency was described as 10 minutes of listening to audiotapes in a class period as a reinforcer for an appropriate reduction of aggressive behaviors.

In general, CBT/I interventions are taught in a series of 10-20 traditional classroom periods (or therapy sessions). They can be implemented in schools, residential treatment centers, or in group, individual, or family counseling venues. And they can be implemented by teachers, therapists, peers, and family members at home (or some combination of these individuals).