Health and Wellness Program Evaluation

A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Social Work

By

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in collaboration with

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Abstract

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By

Stephanie Morfitt

Master of Social Work

This program evaluation study examined the efficacy of the Health and Wellness program at the agency Miracles for Kids. The Health and Wellness program provides in-home therapy to families whose child has been diagnosed with cancer. Cancer patients and those caring for them are at greater risk of having depression and this study is important to help determine ways to address this problem. For the purpose of this evaluation, 31 participants received weekly in-home therapy sessions utilizing Cognitive Behavior Therapy (CBT) for a total of ten weeks, and pretreatment and posttreatment intervention measures were taken using the Beck Depression Inventory.

A pre and post test were given to all families who participated in this study and was used to measure the symptoms of depression reported before and after the in-home therapy was facilitated. This data is secondary data and was collected by the agency and given to these researchers for the purpose of this evaluation.

The results indicate a significant reduction in depression symptoms among family members, proving these researchers’ hypothesis that in-home therapy reduces depression symptoms.

Keywords: Beck Depression Inventory, depression, cancer, in-home, child, family
Introduction

Problem Statement and Research Question

This capstone project is a program evaluation study using secondary data from the agency Miracles for Kids. Miracles for Kids is a non-profit organization providing services to low-income families who have a child that has been diagnosed with cancer and are residing in Los Angeles or Orange County. The Health and Wellness Program at Miracles for Kids provides in-home family therapy to families currently receiving services from Miracles for Kids. These researchers will be evaluating the efficacy of the Health and Wellness Program.

As the literature shows, there continues to be a growing number of cancer diagnoses (Lim, Kim & Lee, 2013) and in this population people are three times more likely to experience symptoms of depression (Fisch, 2004). Jacobsen and Jim write, “Improving cancer patients’ access to psychosocial care remains a critical issue. Many patients who could benefit from psychosocial care do not receive the help they need (2008).” However, it is not simple to treat patients and their family members experiencing symptoms of depression given the complex nature of a cancer diagnosis (Fisch, 2004) and not just any service offered will be beneficial, but in fact unsuccessful interventions to treat depression could have a negative impact (Jacobsen & Jim, 2008). This program evaluation can add to the growing number of studies being done, and according to Lim, Kim and Lee “identification of optimal methods for promoting the psychological health and well-being of both cancer patients and their families is essential (2013).”
In this quantitative study, these researchers will use secondary agency data to reach their objective by evaluating this program to determine if in-home family therapy decreases symptoms of depression in family members who have a child that was diagnosed with cancer. This program evaluation aims to discover if ten in-home family therapy sessions are successful in decreasing symptoms of depression in all family members by answering the research question: Does in-home family therapy decrease symptoms of depression in family members who have a child that was diagnosed with cancer?

The intention of this program is to reduce depression symptoms in cancer patients and their families and the findings of this study will allow Miracles for Kids to determine if the program should continue, expire, or if elements of the program should be adjusted. As social work students, these researchers believe that the findings should have potential implications for future programs similar to the one offered by Miracles for Kids. Not only will the clients that participate in the program benefit from the therapeutic services, but the community can also benefit from the potential for similar programs to be offered by multiple agencies. If the program is found to be effective the findings can be used to create similar programs in local agencies and potentially be used as a model for programs to be used across a larger population. If the program is found to be lacking efficacy, the model can be re-evaluated by Miracles for Kids to better serve families.
Literature Review and Conceptual Framework

The review of the literature provided these researchers a foundation in which to begin their proposal for their pilot program evaluation of the Health and Wellness Program at Miracles for Kids. Park and colleagues (2013) and Cipolletta (2013) concentrated on key terms like family caregivers, depression, and cancer. Friðríksdóttir and colleagues (2011), and Lim, Kim and Lee (2013) focused also on depression and cancer but family members were not necessarily caregivers.

Ammerman and colleagues (2005) was a unique article in this literature review in that the population studied was at-risk mothers. The overlapping themes in this particular article related to these researchers’ project because the authors observed the impact of in-home Cognitive Behavioral Therapy (CBT) and symptoms of depression, which align closely with the Health and Wellness Program that the researchers evaluated. Fisch (2004) and Ammerman and colleagues (2005) had similar main terms consisting of CBT and depression, and their focus related to cancer patients.

The research methods in the articles varied as much as the key terms used by the authors of the literature reviewed. Fisch (2004) and Jim and Jacobsen (2008) wrote articles that were a review of previously published articles. This allowed these researchers access to even more published work. Jim and Jacobsen (2008) reviewed previous publications in order to recommend evidence based psychosocial interventions for cancer patients experiencing depression. The literature review done by Fisch (2004) was not as specific in terms of treatment and intervention methods but was a comprehensive review of studies spanning several decades about cancer patients and depression.
Svavarsdottir (2005) included 26 families in Iceland who were caring for a child with cancer who participated in a longitudinal study. Ammerman et al. (2005) reported their study consisted of 26 participants, however the participants were first time mothers. The mothers had major depression and were voluntarily participating in a program that was a long-term study consisting of 17 in-home therapy visits. This study used the methods of CBT and spanned over the course of one year.

Friðriksdóttir and researchers (2011) completed a cross-sectional, descriptive study via telephone followed by a questionnaire sent by mail to 223 family members of cancer patients. Park and researchers (2013) did something similar by conducting a multi-center, cross sectional survey with 897 family caregivers in different clinics. Cipolletta (2013) also surveyed families, but only included 50 primary caregivers.

The methods of these previous studies were very difficult to compare to each other due to the variation in types of studies in the articles. However, in a critique of the methods in these studies, these researchers found the articles by Fisch (2004) and Jacobsen and Jim (2008) helpful as they compared and summarized multiple studies and provided a vast amount of information. Ammerman and colleagues (2005), Cipolletta (2013) and Svavarsdottir (2005) were studies that consisted of small sample sizes, so although interesting, it was difficult to make strong conclusions about the studies. The articles by Friðriksdóttir and researchers (2011) and Park and colleagues (2013) consisted of cross-sectional surveys and were not only helpful in understanding a similar population to the one in the program evaluation, but the results were valid due to their method of research.
The review of the literature produced many strengths and similarities. Ammerman and colleagues (2005), Fisch (2004) and Jacobsen and Jim (2008) all operationalized depression using the Beck Depression Inventory (BDI), a widely used and evidence based measurement tool. They conceptualized depression using the *Fifth Edition* of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. These researchers operationalized and conceptualized depression in the same way making this literature relevant to the program evaluation.

There were also promising results in Ammerman and colleagues when they reported “that 69.2% fully and 15.4% partially absolved major depressive symptoms” (p. 8, 2005) in both the regularity and significance of the symptoms and that by using the theoretical framework of CBT, symptoms of depression will decrease. Jacobsen and Jim (2008) used a model very similar to the one being used by the Health and Wellness Program that these researchers evaluated, which consisted of sessions using CBT conducted once a week for 8 weeks for at least 60 minutes.

There were also weaknesses in the review of the literature. It should be noted that the sample size of Ammerman and colleagues (2005) study was limited. Additionally, the mothers were considered at-risk parents at the time of program, a different population characteristic of those in the literature reviewed. Cipolletta’s (2013) work only captured psychosocial implications of caregivers and did not study interventions that might be effective. Although studying interventions for degrees of effectiveness is also important, these researchers were interested in finding out more about the theoretical framework and effectiveness of CBT on decreasing symptoms of depression among cancer patients and their family members.
Of the 565 family members of cancer patients that participated in the study done by Park and researchers (2013) there were also 2,260 participants in a control group that allowed every member in the family to complete the survey increasing the validity in the results. This was the only study in the review of the literature that had a control group. Despite this strength, the information is limited because it did not include cancer patients.

Patterns arose throughout the review of the literature. Although studying a different population, Ammerman and colleagues (2005) discovered that medications are difficult to use on pregnant or nursing women so another option had to be considered. This can be the case for cancer patients as well. Fisch (2004) and Jacobsen and Jim (2008) explained that cancer patients are already on multiple medications and it is difficult to determine if the symptoms of depression are coming from psychosocial issues related to cancer or from the physical side effects of the illness and medication. In the literature review it was discovered there is a need for an alternative intervention to treating depression other than with the use of pharmaceuticals.

The other overarching theme was that cancer has a major impact on all parts of the lives of the patient, family members, and caregivers and it is hard to determine if the psychosocial stressors experienced, including depression, are medical in nature and due to the physical illness and energy required to endure treatment.

Major methodological strengths are that the studies were from all over the globe including Italy, Korea, Iceland, United States, and Great Britain. Mixed methodologies from surveys to systematic reviews of published literature and individuals participating in
long-term studies increased the depth of knowledge for researchers and colleagues in the review of the literature.

There were gaps found in the review. The implications of a cancer diagnosis and how caregivers might access resources to gain additional support were only discussed in one article and cancer patients often have limited access to addressing mental health concerns (Cipolletta, 2013). There is limited data in the relationship between cancer and depression within the last 30 years, especially when it comes to people of color and those under the age of 25 (Fisch, 2004). Jacobsen and Jim (2008) point out that in the review of their own articles, the gaps identified in the literature were; lack of men included in studies, lack of ethnic and racial minority groups, lack of grouping cancer patients by specific disease and grouping by the stage of disease. One purpose of this program evaluation was to sort out some of these gaps found in this literature review and are noted in the discussion section.

These researchers hypothesized that the Health and Wellness Program’s in-home family therapy would decrease symptoms of depression in family members who have a child that has cancer. The results of this program evaluation helped Miracles for Kids determine whether or not the program is achieving its intended goals. The rationale for this evaluation was to assist Miracles for Kids in determining if the in-home family therapy services will continue to be offered.
Methods

Research Design

This program evaluation used a pre and posttest research design by using secondary data collected by the agency. A staff member at Miracles for Kids administered the BDI scale prior to the first in-home therapy session and at the conclusion of the final session to all family members participating in the therapy. The time duration of each part of the research was 10-15 minutes for participants to complete the BDI scale prior to and at the conclusion of the ten in-home therapy sessions and this scale can be found as a supplemental document to this report. Miracles for Kids provided these researchers with the data that was collected, and this information was used for the evaluation of the program. These researchers had no direct contact with the participants in the program.

Sample

Secondary agency data was used therefore no subject recruitment was needed and there was no exclusion criterion. All agency data included all participants in the Health and Wellness Program and was previously collected by a representative at Miracles for Kids from twenty-five family members of ten different families who are members of low-income families and have a child diagnosed with cancer between the ages of six and twenty-one years. Family members are English speaking and reside in Los Angeles or Orange County and are current and active clients of Miracles for Kids.

Data Collection

There was no direct data collection by these researchers as all data was previously collected by the agency. The pre and post test results were collected by a representative
of the agency Miracles for Kids and prior to the administration of the pre and post tests, a number was assigned to each subject so that their name would remain confidential. All confidential data was then given to these researchers to be used for this program evaluation. All data was destroyed at the conclusion of the evaluation.

**Measurement**

For this study, the two study variables were in-home therapy (independent variable) and symptoms of depression (dependent variable). Depression was conceptualized using the *Fifth Edition* of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* that defines depression as the exhibition of at least five of the listed symptoms for a two-week period. These episodes are disabling and will interfere with the ability to work, study, eat and sleep. Major depressive episodes may occur once or twice in a lifetime, or they may recur frequently. They also may take place spontaneously (American Psychiatric Association, 2013).

The level of depression experienced amongst family members was operationalized using the Beck Depression Inventory (BDI). Aaron T. Beck created the BDI and is a 21-question self-report inventory used to measure the severity of depression in an individual. There are three versions of the BDI. The first was created in 1961 and then later revised in 1978, and the latest version was created in 1996 and named the BDI II. The 21-questions on the BDI are multiple choice and require the individual who is taking the survey to answer questions about their symptoms related to the following topics; sadness, the future, failure, satisfaction, guilt, punishment, disappointment, suicide, irritability, physical appearance, relationships, sleep and appetite.
The four response categories for the BDI range in intensity for each question and use words such as “I don’t”, “I feel”, “I am not”, and “I can’t” to describe the individual’s symptoms (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). A value of 0-3 is assigned for each answer and the total score of the test is added and applied to a key to determine the severity of the depression. Individuals who receive a score of 17 or higher are requested to seek medical attention (Beck et al., 1961). The BDI has been used in a wide variety of psychiatric and normal populations as well as Caucasians of the male and female population (Beck, A. T., & Steer, R. A., 1984). Reliability has been reported to be high, regardless of the population and construct validity has also been established (Beck, Steer & Brown, n.d.). These researchers felt confident in the reliability and validity of this measurement tool to assess depressive symptoms in individuals.
Results

These researchers analyzed the data using IBM SPSS Statistics, a statistical analysis program used most commonly in the social sciences, for the purpose of finding out if the in-home therapy received by families who have a child with cancer was effective in reducing their symptoms of depression. This analysis will answer the proposed research question, does in-home family therapy decrease symptoms of depression in family members who have a child that was diagnosed with cancer, by providing statistical evidence of the reduction of depression symptoms. A before and after test (the Beck Depression Inventory) was used to study the effect that in-home therapy had on the same group of people, therefore a paired-samples t-test was run.

In our sample of 31 participants the mean age was (M= 30.55) with a standard deviation (SD) of 12.21. The sample was mostly women with a total percentage of 71%, (n=22) and the average age of the subjects was 30.55 years (SD = 12.20). The majority of the participants were Hispanic (58.1%, n=18), followed by 22.6% Caucasian and 19.4% African American. The research shows that prior to starting the in-home therapy 22.6% of participants reported having no symptoms of depression, 29% reported mild symptoms, 12.9% of the participants reported experiencing borderline clinical depression, 25.8% experienced moderate depression, and 9.7% reported severe depression. After these participants received 10 weeks of in-home therapy, the Beck Depression Inventory was administered again and the following results were collected; More than half of the participants (54.8%) reported having no symptoms of depression, 22.6% reported mild symptoms, 12.9% reported feeling borderline depressed, 9.7% felt moderately depressed
and 0% of the participants reported severe and extreme depression symptoms. The results of the descriptive analysis are reported in Table 1.

The paired samples t-test shown in Table 2 depict the level of the depression symptoms before (M=17.55, SD=9.48) and after (M=9.32, SD=8.94) the in-home therapy was received, t(30) = 5.266, p<.001. The t-test shows that there is a statistically significant difference between the reported symptoms of depression before and after the subjects received the in-home therapy. Based on the findings, the researchers were able to conclude that in-home therapy reduced symptoms of depression among family members who have a child diagnosed with cancer.
Table 1 Characteristics of Demographic Variables (N= 31)

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>%</th>
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<td>Clients Age</td>
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<tr>
<td>Male</td>
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</tr>
<tr>
<td>Ethnicity</td>
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<tr>
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<td>22.6</td>
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<tr>
<td>Hispanic</td>
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<td>58.1</td>
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<td>African American</td>
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<tr>
<td>Pre Beck Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Depression</td>
<td>7</td>
<td>22.6</td>
<td></td>
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<tr>
<td>Mild Mood Disturbance</td>
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<tr>
<td>Borderline Clinical Depression</td>
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<td>Moderate Depression</td>
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<td>Post Beck Score</td>
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<td>Moderate Depression</td>
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<tr>
<td>Severe Depression</td>
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Table 2 Paired Samples T-Test (N=31)

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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Score</td>
<td>17.55</td>
<td>9.48</td>
<td>9.32</td>
<td>8.94</td>
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</table>
Discussion

These findings demonstrate a correlation between in-home family therapy and a decrease in symptoms of depression in families whose child has cancer. Although the decrease varied with each family member, there is enough of a negative relationship to demonstrate the need for further studies. The practical application in the area of Social Work will be the ongoing use of Cognitive Behavioral Therapy during in-home family therapy as a modality to assist family members who are experiencing depression. For professionals in the field of Social Work, they will have the opportunity to adapt this therapy model and put it to actual use during in-home therapy sessions.

This program evaluation also allowed these researchers to address some of the gaps found in the literature review. There was little information about cancer and depression amongst men and ethnic and racial minority groups. According to Erford, Johnson and Bardoshi (2016) gender is an important variable to consider because results vary between male and female who utilize the Beck Depression Inventory to assess for depressive symptoms, the tool used by Miracles for Kids.

The data provided by the agency consisted of 29% male participants and 77.4% were from ethnic and racial minority groups. This study did not analyze men and minority groups specifically in relation to therapy and depressive symptoms, but given the initial results found in this program evaluation, these researchers believe additional analysis could be done to benefit the agency and Social Work practice in general. Another gap found in the literature was determining how accessible mental health services are to this population and if the type of or stage of the cancer affects families
differently. Since this data was not provided to these researchers, the recommendation would be that the agency would collect this data for further examination.

In substantial terms this program evaluation will be influential in future programs developed for cancer patients and their families to meet their emotional needs. The basic and essential meaning to Social Work is that this study will encourage further studies as well as the ongoing application of CBT during in-home therapy sessions with cancer patients and their families.
Implications

According to Wedding and colleagues (2007) the implications of such findings for Social Work practice is the importance for professionals to differentiate between the physical symptoms and the emotional symptoms that cancer patients and their families’ experience. Fisch (2004) also remarked that the nature of this disease is complicated and many times symptoms of depression can be confused for physical side effects of treatment for cancer or the energy required to care for a person with cancer. In this program evaluation only one tool was used to identify depressive symptoms, which could significantly limit the accurate measurement of the symptoms. It is difficult to determine the difference between the somatic symptoms and the affective symptoms of a cancer patient. Therefore, multiple assessment tools should be used, specifically the DSM IV based clinical interview by the in-home family therapist (Wedding et al., 2007).


**Limitations**

Blackman, Liptak & Recklitis (2014) reported that the use of the Beck Depression Inventory for Youth (BDI-Y) maybe also prove to be another tool to assess for depressive symptoms in youth. These researchers hope the tools used to assess depressive symptoms at Miracles for Kids and other agencies are reconsidered to ensure a comprehensive and appropriate assessment.

Another limitation was that the study was small in size, only including 31 participants. Additionally, the program evaluation was limited because the type of illness and stage of disease was not included in the data. Cancer diagnoses and stage of illness can greatly impact levels of depression depending on the intensity, duration and frequency of treatment and expected outcome. These researches also believe the way in which the pre and posttests were collected could have influenced the outcomes of the program evaluation. These were collected while a staff person at Miracles for Kids was present in the room and could have influenced how the participants answered the posttest knowing the program was being evaluated.

More consideration should have been given to the BDI which was given to all participants who were who were age 16 years and older. As Erford, Johnson and Bardoshi (2016) articulated in their analysis of the BDI, there are significant limitations due to the length of this measure tool for youth. As previously mentioned the BDI-Y may be a tool used that is beneficial to the client, clinician and agency. These researchers believe the condensed version of the Beck Inventory is just as valid, and may allow participants of a certain age or those living with disabilities, the opportunity to more adequately and accurately articulate their symptoms of depression.
Conclusion

This program evaluation is a contribution to the previous studies done and demonstrates the need for further research. The results of this study highlight the positive implications to the field of Social Work and the benefits that those experiencing depressive symptoms will have after participating in programs utilizing CBT. Cancer patients and their family members are a growing population that will require further studies and ongoing services.
References


Appendix A

ADDENDUM – Health and Wellness Program Evaluation

Health and Wellness Program Evaluation is a joint graduate project between Stephanie Morfitt and Ali Moses. This document will explain the division of responsibilities between the two parties.

**Stephanie Morfitt** is responsible for all the following tasks/document sections:

- Reviewing the reference section to ensure APA guidelines were followed
- Sourcing peer-reviewed articles for the literature review
- Liaison with the agency that we worked with
- Coordinated the collection and pick up of all data

**Ali Moses** is responsible for all the following tasks/document sections:

- Formatting and layout of the project
- Refining the title of the project and research question
- Research pertaining to SPSS and the appropriate analysis to run
- Liaison with Dr. Park regarding meetings to review the project

Both parties shared responsibilities for the following tasks/document sections:

- All sections of report
- Reviewing and entering data into SPSS
- Editing for spelling and grammar errors
- All revisions suggested by Dr. Park

___________________________  ____________________________  ____________________________
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Student ID                      Student ID

_______________________________  ________________________________
Dr. Hyun-Sun Park, Committee Chair                                Dr. Amy Levin, Graduate Coordinator
Date                                                                Date

_______________________________  ________________________________
Dr. Jodi Brown, Committee Member                                   Dr. Amy Levin, Department Chair
Date                                                                Date

_______________________________
Dr. Amy Levin, Committee Member
Date